

Surrey Police Deepcut Investigation Final Report



■ SURREY ■
POLICE

The Deepcut Investigation Final Report

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Executive Summary

On 23 March 2002, Private (Pte.) James Collinson died from a gunshot wound at the Princess Royal Barracks, Deepcut. Surrey Police then began an investigation into his death. Following the death of Pte. James Collinson, the families of three other soldiers who had also died of gunshot wounds at Deepcut between 1995 and 2001, expressed concerns that the deaths may have been linked and that the earlier deaths had not been fully investigated by the Army or Surrey Police.

In response to these concerns, Surrey Police undertook a review of the investigations into the deaths of Pte. Sean Benton (1995), Pte. Cheryl James (1995) and Pte. Geoff Gray (2001). The review revealed that the investigations into these deaths had been unsatisfactory. This in turn led to the recognition that although it was the custom and practice of the day, it was inappropriate to delegate investigations into deaths that appeared to be self-inflicted to the Army at an early stage in the process.

In response to these findings, Surrey Police launched a re-investigation of the first three deaths, which ran concurrently with the investigation into the death of Pte. James Collinson. Surrey Police has also led the revision of national police policy on the investigation of deaths at military establishments where criminal conduct cannot be conclusively ruled out at the outset.

On 19 September 2003, Surrey Police reported details of the investigations into each of the four deaths to the Surrey Coroner. Each of the four reports sets out an account of the evidence in relation to the respective deaths. On delivery of the reports to the Coroner, Surrey Police indicated its intention to produce a fifth and final report. The purpose of this report is to examine wider organisational and cultural issues in the Army that were identified by Surrey Police as being germane to the overall enquiry into the four deaths.

As early as August 2002, some two months into the re-investigation, Surrey Police became concerned about the apparent lack of safeguards built into the Army's care regime. The duty of police to prevent crime and protect life prompted the decision by the Chief Constable to raise these concerns with the Army immediately, in order that urgent remedial action could be taken to tackle areas of risk and vulnerability.

This led, in turn, to the development of the joint Surrey Police/Army Learning Account against which key lessons about risks, vulnerabilities and opportunities to improve the overall care regime, were logged and progress recorded. The Army has made a significant contribution to the Learning Account. The Deputy Adjutant General of the Army holds responsibility for its maintenance.

This report recognises that the Army has acted energetically to progress the initial lessons identified by Surrey Police and the Army

which were logged onto the Learning Account in 2002. Both the Army and Surrey Police have since identified other lessons. These have been included in this new programme of work to introduce improvements across a wide range of practices and procedures relating to the care of soldiers in training. However, this report highlights a more fundamental issue: The essentially reactive and fragmented nature of the training, care, welfare and accountability regimes that operated between 1995 and the initiation of the Learning Account in 2002.

While, to the Army's credit, the regime continued to evolve and improve during this period, the urgency afforded to change in the light of accumulating evidence of risk and the ability of the Army to follow through on its own recommendations following the deaths of Pte's. Sean Benton and Cheryl James in 1995 through to 2002, is called into question. However, it is acknowledged that, following a watershed in 2002, the Army has made significant improvements.

In undertaking the overall investigation and producing this final report, Surrey Police has had full regard for the international reputation of the British Army as one of the world's most proficient and professional fighting forces. The capability that the Army has demonstrated in recent years, to undertake large scale combat, peacekeeping and humanitarian aid operations, all on a global scale, belies its relatively modest number of personnel, and underlines the effectiveness of its overall training regime. Surrey Police has also recognised throughout the need for this regime to be tough in order to provide and sustain a world class Army.

However, despite these considerations, Surrey Police has remained concerned that more needs to be done to address areas of risk and strengthen the care regime for young soldiers in training.

It is inevitable that, in any training regime fit for the Army's purpose, trainees will be severely tested. However, the Army has a duty of care as an employer to take reasonable steps to safeguard its personnel from avoidable harm. This is particularly pertinent to the issue of young soldiers in training who are removed from the care of their family or guardians into a closed environment, where there are obvious and particular risks not experienced in other forms of employment.

This report has four principal objectives:

- i) To highlight evidence of the vulnerability of young soldiers in training found during the investigation.
- ii) To provide a commentary on the development of the Army's approach to the care of young soldiers in training since 1988.
- iii) To outline the case for a broader enquiry that would address the sufficiency of the Army's care regime in respect of young soldiers in training at Deepcut and beyond.
- iv) While recognising the need for special safeguards for young soldiers in an occupation which has less transparency and significantly greater risks than most civil occupations, to examine the potential benefits of the introduction of a continuous independent oversight mechanism to ensure improvements are sustained.

Chapter 1

Introduction

- 1.0 *'Soldiers will be called upon to make personal sacrifices – including the ultimate sacrifice – in the service of the Nation. In putting the needs of the nation and the Army before their own, they forego some of the rights enjoyed by those outside the Armed Forces. In return, British soldiers must always be able to expect fair treatment, to be valued and respected as individuals, and that they will be sustained and rewarded by commensurate terms and conditions of service... This mutual obligation forms the Military Covenant between the nation, the Army and each individual soldier; an unbreakable common bond of identity, loyalty and responsibility which has sustained the Army and its soldiers throughout its history'. – Army Doctrine Publication, Volume 5, Soldiering. The Military Covenant, February 2000.*
- 1.1 Princess Royal Barracks, Deepcut, is the Headquarters and training establishment of the Royal Logistic Corps (RLC). On joining the RLC, the majority of recruits attend the Army Training Regiment (ATR) at Pirbright and complete a 12-week basic training course known as Phase 1. During this period recruits are instructed in 'the common military syllabus'. This includes weapon handling, live firing, duties of a sentry, guarding and patrolling.
- 1.2 On successful completion of Phase 1, recruits are posted to 25 Training Support Regiment, Princess Royal Barracks, Deepcut, where they commence trade-training. This is known as Phase 2.
- 1.3 While the majority of trade-training is undertaken at Deepcut, a number of courses take place away from the barracks, for example, driver training takes place in Leconfield. Deepcut is, in effect, a training hub where recruits and trained soldiers attend trade-training courses. Phase 2 recruits remain at Deepcut pending deployment to the Field Army. Over the past seven years, more than 12,000 trainees have passed through the Deepcut Barracks.
- 1.4 A course programme is currently published a year in advance, with places allocated to recruits prior to their arrival at Deepcut. At times, place availability and the soldiers' performance result in some individuals remaining at Deepcut pending further training. This is known as Soldiers Awaiting Trade Training (SATT). While it is understood that this has now been reduced to a maximum of two weeks, historically, this resulted in soldiers experiencing extended periods of inactivity at Deepcut. It will be seen later in the report that SATT can have a de-motivating effect on the Phase 2 trainees.
- 1.5 Between 1995 and 2002, four soldiers, Ptes. Sean Benton, Cheryl James, Geoff Gray and James Collinson, died at the Princess Royal Barracks at Deepcut, Surrey. All were members of the RLC and were in Phase 2 of their training. Each one of them died from gunshot wounds. Three of the four were employed on guard duty at the time of their deaths. The other soldier, while not on guard duty, was able to access a weapon at a guard post immediately prior to their death.
- 1.6 To date, three of the deaths have been the subject of inquests. In the case of Pte. Sean Benton the coroner reached a verdict of suicide. In the cases of Ptes. Cheryl James and Geoff Gray open verdicts were returned. The inquest into the death of Pte. James Collinson has yet to be held. As part of its overall investigation, Surrey Police has submitted individual reports in relation to each death to the Coroner.
- 1.7 In the event of any military death, relevant Army procedures include convening a Board of Inquiry (BOI) to investigate and report on the facts relating to the death. Generally speaking, a BOI will not be held until any Police investigations and Coroners' inquests have been completed.
- 1.8 In response to expressions of concern about the original investigations by the families of the soldiers in 2002, Surrey Police commenced a new enquiry. This was intended to examine the precise circumstances surrounding each death and any links between them. In addition, the new investigation did not delegate investigative work to Army investigators. Heavy delegation had characterised the earlier Deepcut investigations, reflecting common custom and practice.
- 1.9 Terms of reference were set for the Surrey Police investigation, which included considering whether there were any underlying causes in these soldiers' personal or military lives that might have been associated with their deaths. In addition, Surrey Police set out to identify any policy, procedural or partnership issues, either at local or service level, that required remedial action.

Improvements to Future Investigations

- 1.10 For Surrey Police, the Deepcut investigation has prompted a review of and improvements to both local and national police policies and procedures. This outcome acknowledges the weaknesses of the accepted contemporary convention and practice for dealing with such incidents. Apologies have been made to the families for the shortcomings of the original investigations. Surrey Police has been influential in suggesting the type of changes that should be made to national policy on the investigation of military deaths; identifying important lessons in the way unexplained deaths are dealt with and promulgating new standards of best practice.

- 1.11 The Surrey investigation team has been able to provide advice and guidance to a number of other police forces that have investigated deaths on military establishments. During this process, issues of concern that have featured during the Deepcut investigation, such as recruit screening, supervision and firearms, have been identified elsewhere.
- 1.12 These lessons are now being taken forward through the Association of Chief Police Officers (ACPO) Homicide Working Group with a view to establishing national best practice for the investigation of deaths at military establishments. Training has also been influenced through the Management of Series and Linked Crime Course. This is a nationally accredited course aimed at senior detectives and ACPO officers with responsibility for the investigation of major crime. The lessons identified through the Deepcut investigation now form a major input on this course.

Historic Concerns

- 1.13 As the investigation into the four deaths progressed, some obvious and immediate concerns, such as the proper regulation of access to firearms, emerged. However, as the terms of reference were applied, they enabled a broader set of possible influences on the deaths to be considered. Factors such as the Army culture, systems of accountability and operational standards exert a subtle and complex effect but can be equally powerful in determining the standards of care and protection of young soldiers in training.
- 1.14 From primarily Army sources, the investigation readily identified long-standing concerns about the Army between 1988 and 2002 that were remarkably similar to those being raised by the Surrey Police investigation between 2002 and 2004. A number of key concerns have recurred with such frequency that Surrey Police was prompted to examine them in greater depth.

The Police Duty to Protect Life and Prevent Crime

- 1.15 In any police investigation, the priorities will always include the protection of life and the prevention of further crime. These basic and fundamental responsibilities were embedded in the founding principles of the modern police service when it was established in 1829. These principles, also reflected in Article 2 of The Human Rights Act, have underpinned the approach of Surrey Police to this investigation.
- 1.16 Therefore, in enquiries of this nature, police forces have a greater responsibility than just the investigation of how a tragic event occurred. There is an explicit duty to seek to identify opportunities to reduce the risk of, or prevent, such incidents in the future. This is particularly so when a series of such incidents has occurred over time. Surrey Police has thus felt compelled to report on

some significant areas of concern, which have implications for how, as an organisation, the Army discharges its duty of care.

- 1.17 In response to emerging concerns and to provide the Army with the opportunity to take early action to identify and manage risks, Surrey Police proposed a joint Police/Army Learning Account. In August 2002, the Chief Constable of Surrey Police held a meeting with the Adjutant General. The Chief Constable raised issues such as access to firearms, screening of recruits and guard duty as being areas of risk that had been identified during the Surrey Police investigation.
- 1.18 Following this meeting these issues formed the basis of the first version of the Learning Account. A process was agreed whereby any other areas of concern found by the Police would be reported immediately to the Army to allow timely and appropriate remedial action to be taken. In a similar vein, any lessons identified by the Army themselves would also be added to the account, together with details of what action they had taken. The Learning Account, administered by the Army, provided it with a properly auditable assessment and implementation process.
- 1.19 Surrey Police will argue that the evidence presented in this report indicates that, if not fully addressed, these areas of concern will continue to present clear risks to young soldiers in training at Deepcut and implicitly beyond Deepcut. These risks, taken individually or in various combinations, contribute to an environment where the overall risk to life may be unnecessarily elevated.

The Nature of the Risk

- 1.20 To place the issue of undetermined deaths in the Army in context, research by the Defence Analytical Services Agency (DASA) has shown that the Army has higher rates of suicide than the Royal Navy and the Royal Air Force (RAF). All three services have proportionately fewer deaths from suicides when compared to the UK general population. However, the rate of suicide among young Army males is higher than experienced within the equivalent UK general population, with 1.5 times more deaths from suicide, although it is the view of DASA that these analyses are based on a small number of deaths that make complex statistical analysis inappropriate.
- 1.21 A critical question emerging from this analysis is whether all reasonable steps are being taken to minimise or offset the risks posed to young recruits who are known by the Army to have an above average rate of vulnerability. This is the focus of this report.
- 1.22 It is important to recognise the significant challenges faced by the Army in reconciling the potentially conflicting demands of maintaining a necessarily robust training regime, designed to sustain it among the most professional armies in the world, while at the same time discharging its duty of care to young recruits.

1.23 It is intended that the examination of these issues by Surrey Police will make a significant contribution to improving the training and care regimes for young soldiers so as to reflect contemporary standards in risk awareness and management.

A Broader Enquiry

1.24 The extent of Surrey Police's remit, in what is a wider controversy, is limited. Our principal focus has been to conduct a thorough criminal investigation relating to deaths within a confined geographic area. It has not been within the remit of Surrey Police to conduct an in-depth investigation of the level of bullying at Deepcut or throughout the Army Training and Recruiting Agency (ATRA). However, evidence of such behaviour has been uncovered in sufficient quantity to raise concerns. Accordingly, brief samples of relevant evidence identified by the investigation are detailed below. They clearly indicate that the issue of bullying requires further examination and should form part of any subsequent broader enquiry:

i) A female ex-Private reported that, in 1995, there was a distinct lack of privacy and respect shown toward females. She had woken up one night to find a Corporal abusing her. When she reported this incident to a supervisor, it was laughed off as a joke.

ii) A male Private alleged that in 1999 he was regularly assaulted by a Non Commissioned Officer (NCO) and on one occasion was attacked by two NCOs.

iii) In 2000, as a result of bullying, a soldier seriously considered taking his own life while on armed guard duty.

1.25 Other examples and further details of the above incidents are available if required. Some of these allegations may be subject to further investigation in due course.

1.26 Due to the remit of the Surrey Police investigation it is not possible to calculate precisely how commonly such incidents have occurred at Deepcut or elsewhere. In the investigation of the deaths, accounts of bullying were uncovered incidentally to the main task of establishing the precise events leading up to each death and were not borne from a specific attempt to quantify the problem via a bespoke investigation into bullying. It is known that a post-training survey was commissioned by the Army in November 2002. This revealed that 8.4 per cent of respondents at Deepcut claim to have experienced bullying and 42.6 per cent claim to have witnessed such incidents.

1.27 It is also recognised that bullying is an issue that is present in most public service organisations in one form or another. However, the particular episodes of bullying revealed during the investigation show the potential for it being a factor in escalating the risk of harm.

1.28 In 2003 Surrey Police asked the Army for details of self-harm incidents that had taken place at Deepcut. They were unable to provide reliable records, as they did not have a standardised reporting and collating mechanism. Details of 59 self-harm incidents were elicited by Surrey Police from an examination of the Deepcut guardroom logs for the years 1996 to 2001. Analysis of the logs revealed that the number of entries recording self-harm incidents peaked in 1999, with 24 reports being made.

1.29 The Army has acknowledged that, due to the nature of their recording processes, these figures are estimated to only represent half the true levels of self-harm incidents. This is despite the fact that recommendations were made in both 1995 and 1998 (see Evans and Walton) regarding the need to introduce a standardised recording process. The absence of such a process has clearly prevented any assessment of the potential significance these incidents may have. It is known that a number of soldiers who have died at Deepcut have previously self-harmed.

1.30 While the investigation by Surrey Police has been geographically focused, the advice and guidance provided to other forces investigating deaths on military establishments throughout the United Kingdom has identified parallels with some of the issues apparent at Deepcut and other training establishments which warrant a broader examination.

1.31 The evidence gathered has led Surrey Police to conclude that a broader enquiry, which takes account of these issues beyond Deepcut, would have the potential to identify more important lessons and safeguards to help reduce risks in the Army. Such an enquiry would have the capacity to reveal more information about why younger soldiers, including trainees, are particularly vulnerable to undetermined death, suicide and self-harm. A broader enquiry may also help provide a clearer explanation for the number of undetermined deaths in the Army over recent years. This could be accomplished by examining and evaluating evidence available beyond Deepcut relating to the deaths of other young soldiers.

1.32 An enquiry could also consider whether the momentum of change and improvement of procedures might be better maintained by qualified external oversight. This suggestion is made after due consideration of the apparent vulnerability of the Army's recruit population. Army recruits enter a closed environment where the oversight of parents or guardians, where potentially available, is much reduced when compared with civilian circumstances. It is also recognised that the Army has less regular and detailed independent review of its activities than most public bodies. Accordingly qualified external oversight may be desirable.

Methodology

- 1.33 Recognising both the limitations of the police investigation to resolve these questions and the obligation to draw attention to potential opportunities to prevent harm, the following method of working was adopted to ensure a balanced and informed view that takes account of the inherent dangers in Army training.
- 1.34 The evidence adduced to highlight key areas of risk or concern has been primarily sourced from a chronological audit of documentation provided by the Army and other material obtained during the investigation. A number of significant risk areas or headings were identified from these documents and other sources which cover the time period from 1988 to 2003. It has become apparent that there are a number of recurring themes that have been the subject of Army scrutiny over this period. Where a recurring problem or issue has been identified, the Army has been asked to clarify the nature and scope of any remedial action taken.
- 1.35 It is clearly evident from this process of investigation that from time to time concerns or risks have been identified and either not acted upon or, if acted on, the actions have not been followed through with sufficient rigour to ensure the intended purpose was achieved.
- 1.36 This appears particularly evident in the period between 1995 (after the second Deepcut death; namely that of Pte. Cheryl James) and 2002 when the Surrey Police investigation began and when attendant publicity and press scrutiny increased. During this seven-year period the accumulation of concerns and identified risks coincides with significant gaps in the response. It seems reasonable to infer from this pattern of evidence that the Army was, during this period, finding it difficult to discharge fully its doctrine: That is its responsibility for the well-being of soldiers, as it applies to recruits in training.
- 1.37 The more recent policy/actions of the Army in response to the new Deepcut investigation and its findings appear appropriate. However, Surrey Police is unable to judge whether these responses will be effectively impactful or are sufficiently comprehensive for either Deepcut, in particular, or for the Army as a whole. However, in view of the history of gaps between the identification of risks and the effective implementation of risk control measures by the Army in the period 1995-2002, there would appear to be merit in a broader independent enquiry into, or examination of, all the issues involved.

Chapter 2

Chronology

1988-2001

- 2.0 The layout of the report is designed to help the reader identify when and how key areas of risk surfaced and then recurred, through an analysis of a series of documents.
- 2.1 The series corresponds to a chronologically arranged list of episodes in the history of events examined by Surrey Police.
- 2.2 The series of documents/episodes reviewed is as follows:
- Hansard (Ashley, Thorne and Freeman) 1988-91
 - House of Commons Defence Select Committee 1993-94
 - Pte. Sean Benton BOI, Evans Review, Pte. Cheryl James BOI 1995-96
 - Period prior to the death of Pte. Geoff Gray; Walton and Hawley reports 1998
 - Haes report 2001
 - Deaths of Ptes. Geoff Gray and James Collinson 2001 and 2002
 - The DAG report, Army Suicide Management Working Group, the DOC report, Learning Account 2002-3.
- 2.3 During the analysis of the documentation obtained, several recurring themes were identified. These can be categorised into the following key risk areas:

2.4 Supervision

The Army acts in loco-parentis for trainees under the age of 18 and has a duty of care for the remainder. Risk arises as a result of the selection and training of supervisory staff and from the ratio of supervision to those supervised, which can fall below minimum efficient levels.

2.5 Screening

Recruits are subject to two phases of screening. At the point of recruitment individual vulnerabilities in respect of military training should be identified. Thereafter recruits should be continuously monitored throughout training and their subsequent career, to identify the emergence of new risks associated with their changing circumstances and to test existing risk assessments.

2.6 Welfare

Trainees' welfare may be adversely affected by their personal/emotional concerns, changes in their physical/mental health and the associated support structures relevant to these matters. Trainees may also be put at risk by environmental factors such as living and working conditions and the availability of satisfactory recreational facilities.

2.7 Accountability

Trainees are put at risk if there is a gap between how they should be managed and treated and what happens to them in practice. The Army and indeed all organisations seek to minimise such gaps between policy and practice by systems of accountability. At lower rank levels such systems should involve capturing data on the treatment and behaviour of trainees and relaying it up the chain of command. At more senior levels accountability necessitates checking policy against organisational behaviour and where required either changing policy or reinforcing the control of behaviour down the line.

At the most senior rank levels accountability to the State is usually managed by a strategic policy review process to check that existing policy stays in line with best practice, Human Rights legislation and other relevant statutory provisions.

2.8 Army Training Structure

The structure of Army training in the Logistic Corps, in two phases, as already described, has historically posed a morale threat to trainees left at Deepcut with too little to occupy them while they wait for trade-training places.

2.9 Firearms/Guarding

While access to firearms and live ammunition is a prerequisite of soldiering, there is a particular threat posed by issuing arms and ammunition to young vulnerable trainees so that they may mount guard duty. This threat can be exacerbated by other factors that can collectively act on individual soldiers.

For ease of reference a chart appears at the end of each document review section, which identifies how that document contributed to the progressive pinpointing of new risk issues and/or demonstrates the recurrence of issues already identified.

Hansard (Ashley, Thorne & Freeman) 1988-1991

- 2.10 In recent years the effective care of young soldiers in the Army became an issue of public concern when, in 1987, a number of revelations in the media about the extent of bullying in the Army triggered renewed public and Parliamentary debate.
- 2.11 Between 1988 and 1991 there was a series of Parliamentary exchanges which underlined the levels of public concern that existed at that time surrounding the care of young soldiers in training.

2.12 This first episode commenced in January 1988 when the then MP for Stoke-on-Trent South, Mr. Jack Ashley (now Lord Ashley), raised the issue of bullying in the Army in Parliament and publicly questioned the effectiveness of the Army care regime, particularly for young soldiers.

2.13 In response, the Parliamentary Under Secretary of State, Mr. Roger Freeman MP, made recommendations with a view to improvement. These recommendations fall naturally into the risk areas that have been identified by the Surrey Police investigation:

2.14 Supervision

The re-examination of the selection and induction of NCO instructors.

2.15 Screening

The need for more thorough screening at the recruiting stage.

2.16 Welfare

- i) The welfare support provided for single soldiers to be improved.
- ii) Reorganisation of administrative commitments to allow more time for supervisory responsibilities.
- iii) More effective deployment of volunteers who work with soldiers.
- iv) Review the content and degree of man management training.

2.17 In June 1988 Mr. Ashley tabled a question in Parliament asking the Secretary of State for Defence what progress had been made in implementing the recommendations. Two of the key measures outlined were:

- i) The re-establishment of 100 extra supervisory posts in the Army's training organisation in the UK by March of the following year.
- ii) An additional 92 Women's Royal Volunteer Service (WRVS) posts to be established with roughly one third being within the Army's training organisation in the UK.

2.18 It was noted that the cost then of implementing the recommendations in full would be £500,000 for the current financial year, rising to £2 million a year thereafter. Unfortunately, due to the passage of time, it is not possible to determine what specific actions were taken as a result of the recommendations. As a consequence, the effect of the recommendations cannot be judged.

2.19 Accountability

Mr. Ashley also proposed that an element of external oversight, in the form of an ombudsman, should be introduced.

2.20 In the latter part of 1991 Mr. Ashley twice pursued this request for Parliament to consider the establishment of a military ombudsman. However, the Secretary of State for Defence stated that he felt the provisions in place at that time were adequate.

2.21 Commentary

Mr. Ashley was responsible for surfacing a number of concerns that have presented throughout the series of documents reviewed in this enquiry. It will be apparent from what follows that Mr. Ashley's qualitative recommendations about welfare support, supervision and screening, still seem relevant today. His one quantitative recommendation, that supervising ratios should be improved, remained unresolved until 2003 when it was raised in the Learning Account.

2.22 One of the principal conclusions of the Surrey Police investigation is that, at the highest level, the system of accountability would benefit from external oversight. This view echoes Mr. Ashley's contention that there is a need for a military ombudsman to safeguard the interests of soldiers when and if internal accounting procedures fail to deliver.

ISSUE	1988 Ashley	1993/4 HCDSC	1995/6 Benton BOI Evans Review James BOI	1998 Walton Hawley	2001 Haes	2002/3 DAG ASMWG DOC Learning Account
Supervision	•					
Screening	•					
Welfare	•					
Accountability	•					
Army Training Structure						
Firearms/Guarding						

House of Commons Defence Select Committee (HCDSC) 1993-1994

2.23 Prior to 1993, each Corps trained its own entrants at a large number of disparate establishments. A new system introduced in 1993, known as Single Entry (SE) involved recruits from the various Corps being trained together. They attended one of five basic training centres to receive generic 12-week basic military training.

2.24 It appears that prior to the implementation of this revised process, the Army conducted a study (Mountford Report) considering the effects of combining 16 and 17-year-old recruits with more mature recruits in the same training regime.

2.25 The potential impact of these changes was in part recognised in 1993. While giving evidence to the HCDSC in July of that year, Major General McAfee stated:

'...Accepting young servicemen and servicewomen into the Army at the age of sixteen and a half or slightly older, has of course created an element of concern in terms of acting in 'locus parentis' in terms of generally avoiding any unfortunate incident or examples where we have not fulfilled our responsibilities and discharged our responsibilities in every respect to their parents and the education system...

So a study is running at the moment led by Brigadier Mountford, which will report in the summer, which will look at the ways in which we must carefully handle these young men and women as they come into the Army and to make sure that we make the transition from Phase 1 Training at the Army training regiments to Phase 2 Training at the Arms and Service centres as painless and as happy as possible because that is the time at which a young soldier may elect to leave the Army. We want to assure (sic) that our wastage rates in that respect are kept as low as possible and that the Army continues to attract a reputation as a good employer of young people'.

2.26 Surrey Police has requested details of the conclusions reached by Brigadier Mountford, any recommendations he made and action taken as a result. Unfortunately, the Army has been unable to provide this, hence this report relies on the proposals outlined by the Army to the HCDCS and documented in their minutes. The contribution of this document to the investigation is as follows:

2.27 Supervision

i) NCOs should be available in sufficient numbers and in such a manner to ensure that recruits are properly supervised and have access to advice and guidance.

ii) Additional Physical Training (PT) instructors to be established to allow for the introduction of simple streaming by age and physical ability during PT periods and to support remedial platoons.

2.28 Welfare

Recruits in training should be segregated in 'recruit areas' within which:

i) Trained soldiers do not share rooms with the recruits; soldiers under 18 years of age may not buy or consume alcohol; non-alcoholic recreation facilities are made available where practical, and wherever possible, Phase 1 and 2 recruits should have exclusive use of bars in Junior Ranks Clubs.

ii) Auxiliary welfare agencies in Army Training Regiments to be enhanced and a clear welfare focus should be identified for Phase 2 recruits.

2.29 Accountability

Phase 2 recruits should be placed in a sub-unit clearly identified and properly organised for recruits undergoing training with a command structure that has clear responsibilities for all non-instructional matters.

2.30 Army Training Structure

Remedial platoons should be established for recruits who have failed a stage of training or have had their Phase 2 period extended due to injury.

2.31 Commentary

These proposals attempted to deal with some of the difficulties and risks presented by the new training regime. They demonstrate a contemporary organisational recognition that trainee soldiers have specific requirements.

2.32 The potential risk to young soldiers during Phase 2 Training is acknowledged. This was later to become a key feature in the Army's internal investigations into the two Deepcut deaths in 1995 (see Evans Review). This and other key issues were not effectively tackled until after the deaths of Pte. Geoff Gray (2001) and Pte. James Collinson (2002), the commencement of the Surrey Police investigation and the notification to the Army of the first tranche of Learning Account issues.

ISSUE	1988 Ashley	1993/4 HCDCS	1995/6 Benton BOI Evans Review James BOI	1998 Walton Hawley	2001 Haes	2002/3 DAG ASMWG DOC Learning Account
Supervision	•	•				
Screening	•					
Welfare	•	•				
Accountability	•	•				
Army Training Structure		•				
Firearms/Guarding						

Deaths of Pte. Sean Benton and Pte. Cheryl James 1995

2.33 Following the death of Pte. Sean Benton, the Army's response focused on procedural issues. For example, Deepcut Security Instructions were revised to cover all sentry posts, instructions regarding the issue/access to weapons and ammunition were amended and all Guard Orders were clearly displayed in the guardroom. It was not until after the death of Pte. Cheryl James that any consideration was given to the possibility that systemic risks were involved in Phase 2 Training.

2.34 A review conducted by Brigadier Evans in December 1995, immediately after the death of Pte. Cheryl James, examined Phase 2 Training at Deepcut. There is evidence to show that he considered there might have been a direct link between the structure and nature of Phase 2 Training and the issue of self-inflicted death and self-harm. The review produced 30 recommendations prior to the BOI into the death of Pte. Cheryl James, some of which identified issues relating to Phase 2 Training beyond Deepcut.

2.35 Death of Pte. Sean Benton

On 9 June 1995 Pte. Sean Benton died from gunshot wounds to his chest. At the time of his death, he was a Phase 2 trainee at Deepcut. An inquest was held on 6 July 1995 where a verdict of suicide was recorded.

2.36 Later that month the Army held a Board of Inquiry, the terms of reference for which were to examine:

- i) The circumstances leading to his death.
- ii) The adequacy of orders and procedures for guards and ammunition within the Training Regiment and Depot RLC.
- iii) Whether there should be a review of orders and procedures in light of the occurrence.

2.37 The BOI made a series of recommendations regarding security instructions and orders governing armed guarding duties specifically at Deepcut. The Army has stated that these recommendations were rapidly implemented. Although the Army has provided the information available to them, it contains insufficient detail to allow Surrey Police to establish what actions were taken and whether this claim is accurate. It follows that the effects of what was done cannot be evaluated.

2.38 Death of Pte. Cheryl James

On 27 November 1995 Pte. Cheryl James died from a single gunshot wound to her head. Her death, coming so soon after Pte. Sean Benton's, led to a review of training at Deepcut prior to the commencement of the BOI. This review appears to have presented the Army with an opportunity to make significant changes to the RLC training regime.

Review by Brigadier Evans of Phase 2 Training System in Deepcut 1995

2.39 This Review was prompted not only by the death of Pte. Cheryl James but also by the death of Pte. Sean Benton four months earlier. An additional cause for concern was that ten self-harm incidents had been reported at Deepcut Barracks during the months between the two deaths.

2.40 The aim of the review was defined in the following terms:

'To identify any underlying reasons for the suicides and attempted suicides within Training Regiment and Depot RLC. The review will also highlight procedures and working practices, which may have a bearing on the attitude and motivation of both soldiers and instructors serving within B Squadron'.

2.41 Evans clearly had concerns about a potential link between the two deaths, the self-harm incidents and the care and supervision regime within Phase 2 Training at Deepcut. The review stated:

'... It is possible that the Unit regime had contributed to the unhappiness of these soldiers. I have therefore looked at a

number of suicide attempts or self-harm incidents in order to identify possible trends'.

2.42 The recommendations of the report contribute to the developing picture of key areas of risk in the following way:

2.43 Supervision

- i) Develop and introduce an induction course for newly arrived instructors within Deepcut and make recommendations to the Training Executive, HQ RLC Training Group.
- ii) Review existing induction procedures for newly arrived instructors and make recommendations as to the content of the induction course to the Training Executive.
- iii) Review the welfare training required by instructors.
- iv) Review procedures for the selection of instructors.
- v) Review the instructor to soldier ratio.
- vi) Ensure that at least 20-25 per cent of instructors are female. One of the Troop Commanders should also be female.

2.44 Screening

- i) A review of screening procedures prior to enlistment to minimise the number of unsuitable recruits entering training.
- ii) A review of assessment procedures within ATR to ensure soldiers are not only physically fit but also mentally and psychologically capable of coping with the rigours of Army life.

2.45 Welfare

- i) Examine the feasibility of making use of local civilian welfare services.
- ii) Develop existing Phase 2 management procedures to involve military welfare agencies more often and increase awareness of their role among the military staff.
- iii) Make available to soldiers information on local welfare services.
- iv) Establish a welfare group comprising all interested agencies, which is to meet on a regular basis to review welfare cases and to co-ordinate support.
- v) Identify and establish a single focus for welfare of all soldiers under training.

2.46 Army Training Structure

- i) A reconsideration of recruiting procedures in order to even out the distribution of recruits.
- ii) Introduce systems and procedures, which ensure that soldiers spend the minimum time within the RLC Training Group prior to posting.

iii) Review the programme of Phase 2 courses against the output from ATR Pirbright with a view to reducing the time between the completion of the Induction Course and commencement of Phase 2 Training.

iv) Introduce an imaginative and progressive training programme for soldiers who are forced to remain within the regiment prior to Phase 2 or posting. The training programme must be published on a regular basis and made available to all trainees.

v) Ensure that, where appropriate, greater use is made of leave and unit attachments.

vi) Ensure that soldiers who are forced to remain within the Training Group for an extended period are given worthwhile employment.

vii) Increase liaison with ATR Pirbright to identify trends and to reduce the number of Premature Voluntary Retirements (PVRs) on arrival at Deepcut.

2.47 Firearms/Guarding

i) Funding of an increase in Ministry of Defence Guard Service (MGS) at Deepcut and other security enhancements.

ii) Revisit the recent review of guard commitments. The review should concentrate on a further reduction of the military manpower requirement.

2.48 Commentary

Evans regarded the majority of these recommendations as local issues and their circulation was limited to Deepcut. This indicates that at this point it was not recognised that the risks associated with Army recruit training at Deepcut had potentially systemic properties.

2.49 The review drew a clear distinction between the deaths of Ptes. Sean Benton and Cheryl James and the ten incidents of self-harm, which had occurred during the four months between these deaths. The review made the following observation:

'All but the two deaths appear to be attention or sympathy seeking, copycat behaviour or, conceivably, calculated malingering'.

2.50 The report concluded that the ten self-harm incidents 'represented no serious threat to life' and stated that these were merely the actions of individuals 'barely at the minimum training standard required'. This assessment meant that the Army failed to recognise that two deaths within four months interspersed with ten self-harm incidents, may have been significant and could have been symptomatic of a higher than expected risk associated with this environment.

Board of Inquiry for Pte. Cheryl James 1996

2.51 On 21 December 1995 an inquest was held into the death of Pte. Cheryl James and an open verdict was returned by the Coroner.

2.52 The Army BOI was convened 11 January 1996 to examine the death of Pte. Cheryl James.

2.53 Notwithstanding that Evans had been commissioned to conduct a review, the BOI drew its own conclusion that the structure of Phase 2 RLC Training 'failed to provide, for immature recruits, sufficient opportunity for character development'.

2.54 The Board also concluded that Pte. Cheryl James 'shot herself' and that this 'was not accidental'. The board absolved the Army or any other group or individual of any responsibility. These conclusions were recorded despite the fact that the Coroner had reached an 'open' verdict.

2.55 The Board made a series of recommendations, the most significant for the purposes of this report being:

'The Board recommended that a radical review of Phase 2 RLC training is conducted to identify how the training structure can achieve synergy between the functions of Command, Training and the Administration of recruits'.

2.56 It is important to note that the BOI recommendation entailed a review of the whole of the Phase 2 RLC Training whereas the Evans Review only studied Deepcut. Following the BOI, the findings and recommendations were reported to the chain of command. The recommendation for a 'radical review of Phase 2 Training' was rejected on the grounds that it was 'outside of the terms of reference for the Board of Inquiry' and had been addressed by the Evans Review.

2.57 Of the 30 recommendations made by Evans in his review, 23 were deemed by him to be internal to the RLC training regime. As the Commander of the Deepcut Garrison, Evans had the necessary authority to implement them locally. He defined the remainder of the recommendations as external, meaning they would have to be actioned by the chain of command.

2.58 Documentation provided by the Army indicates that no further action was taken by the Army regarding the external recommendations, including some that fell in the key risk area of screening. The 23 local recommendations do not appear to have been assessed for relevance to other training establishments.

2.59 Commentary

The commissioning of the Evans Review following the deaths of Ptes. Sean Benton and Cheryl James implies official recognition that there may have been some features of Phase 2 RLC Training that increased the vulnerability of young soldiers.

2.60 The significance of the self-harming incidents in the context of suicide prevention was not explored in an adequate manner at this juncture. A more sophisticated analysis, together with expert interpretation of the facts, would have yielded different results.

2.61 While the Review had made a basic link between conditions within Phase 2 RLC Training and the effect they might be having on vulnerable young recruits, no evidence was found that this insight had been applied beyond Deepcut. The Learning Account identified many of the same generic issues. Evans' external recommendations provided an opportunity to promulgate the Deepcut lessons across the Army. This opportunity was missed.

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Welfare	•	•	•			
Accountability	•	•				
Army Training Structure		•	•			
Firearms/Guarding			•			

Period Prior to the Death of Pte. Geoff Gray 1996-2001

2.62 Following the Evans Review, Army action appears to have been restricted to further research and review that continued to highlight dimensions of risk. The following sections detail this process but we have been unable to find concrete evidence in this period that any significant and coherent remedial actions were taken.

Walton Report 1996

2.63 In 1996 the Director Personal Services (Army) (DPS (A)) commissioned research into suicide in the Army. This was on the direction of the Adjutant General. The purpose was 'to address the circumstances relating to unnatural death'.

2.64 The research by Dr Walton commenced in late 1996. The study examined suicide in the British Army using data from 1990 to 1996. The research report was written in five parts over a three-year period, with each section being reported on as it was completed.

2.65 Walton undertook a comparative review of existing methodologies for preventing and minimising suicides, both within the civilian domain and foreign armies. From this analysis, combined with her own research, Walton tailored her recommendations to the needs of the British Army. The report also considered possible etiological factors in Army organisation and the individual characteristics of soldiers and drew prevention lessons from this analysis.

2.66 The report comprised five main topic areas. The final part of the report made observations and recommendations, which can be categorised in the key risk areas:

2.67 Supervision

Material specifically related to suicide should be added to all staff training programmes.

2.68 Screening

i) A Psychological Autopsy Technique should be adopted. The technique involves studying the background of victims of what are believed to be self-inflicted deaths to identify common features, thereby facilitating the recognition of vulnerable recruits during the screening process.

ii) The implementation of a Suicide Vulnerability Questionnaire (SVQ) was recommended to assign a vulnerability score to each recruit. If, by virtue of their score, a person is considered at risk, they should be tagged by placing their SVQ documentation in their personal notes that accompany them on each posting.

2.69 Welfare

i) A suicide prevention aide-memoire should continue to be distributed and training given on the content. This should be checked and if necessary revised annually.

ii) The Confidential Support Line should continue to operate offering immediate access to trained counsellors.

2.70 Accountability

i) The focus for suicide prevention should remain a command responsibility with professionals such as Chaplains or Medical Officers (MOs)/Psychiatrists under remit to deliver particular prevention or management packages.

ii) A data management system should be implemented to record and analyse suicide trends across the whole Army. Preventative measures should be informed by the analysis.

iii) Self-harm should no longer be a disciplinary offence but instead should be viewed as a symptom of an underlying problem.

iv) There should be specific, clear, formal policies and directives governing areas of responsibility and procedural requirements for suicide prevention, which should be documented in a single source.

2.71 In 1998, the Army Suicide Management Working Group (ASMWG) was formed. It was established to take the prevention work forward from Walton and shape the Army self-harm and suicide prevention policies and procedures. The work of the ASMWG will be discussed later in this report.

2.72 Commentary

The Walton Report recognised the need to identify potential self-harm cases on a proactive basis and establish systems and processes which would generate a scientific approach to future prevention. This is illustrated by the suggested use of psychological autopsies and the creation of a data management system. The report also acknowledged the need for improved awareness among supervisors and commitment from the command structure. Walton observed that:

'The issue of suicide prevention is an emphasis on the importance of commitment 'from the top'. For suicide rates to fall leaders must pay more than lip service to the concept of prevention'.

2.73 While the creation of the Working Group was another positive step, the previously identified tendency to review, recommend and discuss with only limited consequential implementation of remedial action continued following the Walton Report. Indeed, it has not been possible to track any progress made by the group in developing Walton's findings, as the ASMWG does not appear to have been under any direct mandate to action Walton's specific recommendations. This is in spite of the fact that the group was formed with the general remit to take suicide prevention work forward.

2.74 Walton's research and report clearly shows the benefits of an external perspective. The suggestion made in the Evans Review, that self-harm incidents were likely to have amounted to 'malingering,' was challenged by Walton. She identified such incidents as significant indicators of risk.

Hawley Report 1998

2.75 In 1998 Lt. Col. Hawley, a member of the Faculty of Occupational Medicine, conducted a study to scope the scale and nature of self-harm in the Army. This study was not commissioned by the Army but formed part of a thesis undertaken by him. The study analysed data from a ten-year period between 1987 and 1996 inclusive. A total of 1,620 hospital in-patient notes were examined. The study focused on identifying individual patients both at the recruitment stage and thereafter whose vulnerability might have been predicted.

2.76 While the rate of self-harm reflected by the 1,620 patients approximated to that of the general civilian population, Hawley remained concerned about the risk attaching to young, non-commissioned recruits, particularly females.

2.77 Both the study itself and the content of the report demonstrate that from 1998 at least, the Army clearly recognised the

significance of self-harm incidents. Hawley acknowledged the Army's duty of care, but also recognised the effects this duty could have on the effectiveness of the Army in combat, stating:

'Any suggestion that avoidable psychological morbidity is being tolerated, is inimical to the tradition of a caring employer. It can also be seen as an indictment of the benign paternalism, which epitomises most of the man management systems inherent in the regimental system. For these reasons, the examination of the problem of attempted suicide in the Army is important. It has obvious implications for the whole question of corporate well-being and ultimately how capable the Army is in its primary role of the delivery of combat power'.

2.78 Hawley conducted extensive bibliographic research in an attempt to define potential 'risk factors', including those external to the Army, knowledge of which might assist the Army in the prevention of self-harm. These factors included socio-economic status, social deprivation and a number of other socio-demographic characteristics.

2.79 Hawley suggested that self-harm, attempted suicide and suicide were on a continuum and while intervention therapy and ultimately discharge from the Army were viable management options, the most effective technique for managing the problem was correct initial selection. He also recognised that the Army was facing recruiting difficulties and it was becoming ever more important to ensure that only appropriate individuals were accepted for training and service. Hawley identified that contemporary recruiting policies would not help increase the effectiveness of Army selection.

2.80 Hawley also recognised the need for a continuous screening process carried out by Army supervisors and leaders:

'As far as prevention is concerned the requirement must be on recognition of at risk individuals by their officers and non-commissioned officers. This is a function of their roles as leaders; medicalisation of the problem is undesirable'.

2.81 The report generated recommendations, which contribute to the emerging overall risk profile as follows:

2.82 Supervision

Training in the identification of individuals at risk should be introduced to all leadership courses.

2.83 Screening

i) A review of the current selection criteria for entry into the Army should be undertaken in order to help select individuals appropriately.

ii) The criteria for dealing with and disposing of individuals who have attempted suicide should be formalised.

2.84 Commentary

Hawley acknowledged the potential vulnerability of the Army in

terms of its duty of care as an employer. He also recognised the potential for tensions between duty of care issues and the effectiveness of the Army in discharging its combat duties. The need for screening, both at the selection stage and as a continuing process, was emphasised. He saw supervisors playing a crucial role in this regard.

2.85 Hawley's recommendation for a review of selection criteria echoes the previously observed tendency to make such recommendations without investigating whether past reviews in the same or contiguous fields have generated any appropriate remedial action.

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Haes Report 2001

2.86 In October 2000 the Chief of Staff (COS) of ATRA directed that a duty of care report was to be produced. This was intended to provide an objective analysis of duty of care and supervision, to assess the Army's capability to deliver legal duty-of-care requirements and adequate levels of supervision, both for staff and trainees.

2.87 The report was primarily intended to inform a subsequent resourcing proposal. However, in its analysis of duty-of-care and supervision issues faced by the Army, it also provided a detailed assessment of the risks created by the status quo.

2.88 Haes made observations and recommendations which also add to the body of evidence about key risk areas:

2.89 Supervision

i) Both in general terms and specifically in relation to self-harm cases, Haes identified the guardroom, in relevant units, as being the first line in the duty of care and supervision functions. He also saw the absence of female staff in the guardroom as contributing to the risk that duty-of-care and supervisory functions would not be effectively discharged. The reason behind this conclusion was not specified.

ii) Haes gave extensive details of instances in which supervisors were over-extended. He formed the view that it was critical the Army either reduced the throughput at training establishments or significantly increased the number of supervisors. He also suggested an alternative solution: To adopt a more minimalist

approach to duty of care and supervision, placing more responsibility on the individual.

iii) The Haes report stated that an estimated '80 per cent (of trainees) are grey faces who pass through ATRA without being known. The other 20 per cent are mainly known for adverse reasons and take up most of the ATRA welfare capacity'. Haes quoted a number of examples of the adverse consequences of lack of contact between supervisors and trainees. These included the case of an under 18-year-old female with a history of alcohol misuse and a suicide case whose body lay undiscovered in his accommodation for a number of days. There is no indication of when or where these events took place.

2.90 Welfare

i) Haes recommended developing a system of monitoring and assessment. The system included a proposed 'risk assessment committee'.

ii) He suggested formalising the duty-of-care and supervision working group and making better use of the Padre network.

iii) Haes also advocated a welfare forum.

2.91 Accountability

i) Haes identified the need to give greater clarity to the Ministry of Defence definition of duty of care in terms of binding obligations versus moral responsibilities.

ii) He observed that:

'The system of delivering and evaluating ATRA duty of care and supervision is ad hoc... ATRA lacks a coherent policy on duty of care and supervision and there is lack of clarity over which obligations are a legal requirement or a binding responsibility or only if affordable'.

2.92 Firearms/Guarding

Haes identified the over-extension of guardroom resources out-of-hours thus putting security at risk. He also commented on the use of trainees for guard duties and stated that:

'Security may be in the hands of dissatisfied, disinterested or unqualified soldiers with live ammunition'.

2.93 Commentary

Haes presented his 'conclusions in a nutshell' as follows:

'ATRA does not have a coherent D of C&S (duty of care and supervision) policy that can be costed/measured. ATRA is failing in certain aspects as a result of reduction in the military workforce and increased obligations. There is an unrealistic and therefore false expectation of the staff, but without a clear definition, to what degree (sic) remains subjective. The current situation is tenable only as long as there is no major incident or complaint. There is no suggestion of complaint by staff about working long hours to achieve professional standards, however,

training standards are now being traded to try and maintain traditional methods of D of C&S and to meet non-core tasks. Action is needed to reduce the gap in care capability. Gapping should be reduced by all practical means or output should be reduced. Non-core commitments should be reduced and a review of traditional attitudes to D of C&S should be conducted to establish a balanced D of C&S policy for its staff and trainees that would satisfy reasonable expectations of both. This is a dynamic subject and needs annual reassessment to assess the impact of changes and stay legal'.

2.94 Haes' report attempted to put a case for change, but was dismissed by the chain of command as an inadequate analysis. This was on the grounds that its assessment of the number of the extra staff required was impractical in a climate where resources were over-stretched and functions were therefore under-manned. This response missed Haes' main point, that it is exactly this over-stretch and under-manning that has taken the care and supervision functions in ATRA to breaking point. This is the crux of his evaluation and is best illustrated by Haes' choice of opening line for the report, where he cites a quote from General Sir Charles Guthrie, Chief of Defence Staff, Dec 2000:

'We have coped thus far, but, goodness, it has been difficult, and we cannot keep doing more and more for less and less. No-one can expect us to keep this up'.

2.95 Haes expressed a concern that:

'Unless an incident occurs that exposes a problem, it is unlikely to be discovered before the individual reaches the field Army or becomes a wastage statistic'.

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Chapter 3

Chronology

2001-2003

The Death of Pte. Geoff Gray September 2001

- 3.0 On 17 September 2001 Pte. Geoff Gray died at Deepcut from gunshot wounds. At the time of his death he was on guard duty.
- 3.1 On 19 March 2002 the inquest into the death of Pte. Geoff Gray was held and an open verdict was recorded. His death has not to date been the subject of a BOI as the Army has declared its intention to delay the Inquiry until after the conclusion of the Surrey Police investigation.

The Death of Pte. James Collinson March 2002

- 3.2 On 23 March 2002, four days after the inquest into Pte. Geoff Gray's death, Pte. James Collinson died at Deepcut from a single gunshot wound. He, again, was on guard duty. In accordance with Army procedure a BOI will not be convened until after the date of the inquest, which has yet to be set.
- 3.3 Following Pte. James Collinson's death, Surrey Police instigated an investigation. By July 2002 this had been extended to include the deaths of Ptes. Geoff Gray, Cheryl James and Sean Benton.
- 3.4 As previously mentioned in this report, a joint Police/Army Learning Account was agreed in August 2002.
- 3.5 On 13 September 2002, some six months after the death of Pte. James Collinson, the Adjutant General (AG) tasked the Deputy Adjutant General (DAG) to 'assist the Surrey Police by conducting a supporting military investigation in order to identify further lessons to be learned from all four (Deepcut) cases and to make recommendations'.
- 3.6 Following this directive, the DAG assumed Army responsibility for the Learning Account. Given the activity that followed, this appears to have been a watershed. Thereafter a much more structured response to tackling the recurring issues that had been raised over a number of years was discernible. The previous absence of an over-arching organisational response to implement risk control measures was remedied.

- 3.7 The DAG was given sole responsibility for developing the improved Army response. For the first time, the Army established a comprehensive programme with senior level leadership to implement systemic solutions to systemic issues. From the audit of the documentation provided to Surrey Police, there is a clear demonstration of increased focus and urgency from August 2002 when the Learning Account was established.

Review by the Deputy Adjutant General 2002

- 3.8 Having commenced his investigation, the DAG produced a series of interim reports that in broad terms compared Deepcut with a number of other Army training establishments.
- 3.9 The DAG's review ran in parallel with the Surrey Police investigation. Subsequent conclusions in his Final Report of December 2002 demonstrate the adoption of a more holistic strategy by the Army. The DAG report was fundamentally different in character from earlier reviews, in that it adopted a broader systems perspective.
- 3.10 The report stated that it was primarily concerned with the environmental factors that may have influenced the soldiers' behaviour, and with any systemic failures of prevention and protection.
- 3.11 The report adopted a risk-management methodology. Its starting point was the assumption that the risk of individuals taking their own lives is influenced by a combination of interrelated factors. These influential factors form the framework of the report into which the findings are presented.
- 3.12 These interrelated influences, or 'stimulation' factors, as the DAG report terms them, echo the key risk areas around which this report is structured. The DAG report defines stimulation as those factors that 'may combine to take an individual over the threshold of self-restraint to inclination'.
- 3.13 The DAG investigation found 'several sources of adverse stimulation' at Deepcut. These fall naturally into the risk areas defined by this report.

3.14 Supervision

- i) The DAG calculated supervisory ratios at Deepcut and quotes a figure of 1:60. He compared this with Catterick and Larkhill where the ratios were 1:12 and 1:40 respectively. He observed that the latter levels would be appropriate at Deepcut. His assessment was that the level of supervision was wholly inadequate and greatly magnified the level of risk. He attributed the Deepcut ratio to reductions driven by the serious level of under-manning and cost savings in the Army since the early 1990s. He believed the rectification of this position was a matter of urgency. He recommended a supervision ratio of 1:38 at Deepcut and a rationalisation of the ratios throughout ATRA along with a clearly defined and endorsed policy.

ii) The DAG recommended that a common induction training package for ATRA Phase 2 instructors and supervisors should be implemented in order to raise standards towards those prevailing in Phase 1.

3.15 Screening

The report stated that recruits at Deepcut 'often come from the lower 50 per cent of the ability range'. It deemed that soldiers from this category suffer the highest rates of welfare, behavioural and disciplinary problems, and have the lowest capacity to resolve their difficulties. The report also stated that the in-built turbulence and unpredictability of Phase 2 Training contributed to the vulnerability of young soldiers at Deepcut.

3.16 Structure of Army Training

i) The report recognised the scale and complexities of the management tasks faced by the Defence Logistics Support Training Group (DLSTG) were at, or beyond, the limits of feasibility.

ii) The concept of SATT was identified as a significant issue as the inactivity caused led to de-motivation and indiscipline. It was stated that, in the absence of close supervisory restraint, peer-group bullying and harassment could exacerbate this stress. These conditions were evident at the time Ptes. Sean Benton and Cheryl James died. Although the regime has improved considerably since that time, levels of SATT remain high and the attendant risks remain significantly greater than is desirable.

3.17 Firearms/Guarding

The report focused on the four deaths and acknowledged that each one involved the use of service weapons. The DAG produced a brief summary of the circumstances of each death and concluded that:

'The evidence suggests that all four soldiers either had direct access to a weapon, or were able to obtain it with relative ease'.

3.18 In cases involving firearms, the DAG considered that opportunity was generally exacerbated by isolation:

'Protracted isolation may also contribute to stimulation, which may have been the case in many of the instances involving singleton sentries on guard or operational tours'.

3.19 The report stated that generally the risk of suicide increases with the frequency with which someone who is inclined to take their own life by predisposition and stimulation is presented with both the means and breadth of opportunity. In this respect, the investigation found that the frequency with which trainees experienced guard duty and the quality of supervision of guards at Deepcut created those circumstances. This, combined with other factors, led the DAG to suggest a level of opportunity risk at least six times greater than the norm. The DAG also identified two additional exacerbating factors:

i) Trainees were able to exchange duties with others with minimal restriction.

ii) Soldiers subject to SATT, who were previously identified as a potential risk, inevitably carried out more guard duties than others, owing to the length of their stay in the barracks and their ready availability.

3.20 This led the DAG to the conclusion that the guarding regime at Deepcut inadvertently created an extraordinarily high level of opportunity risk. This level of opportunity risk on its own might not have been the critical factor in these four deaths. However, in combination with other risk factors operating at Deepcut, and given the vulnerability of some of the individuals involved, the DAG believed it may indeed have been the most significant of the causal factors.

3.21 The DAG recommended that the routine security and guarding of the Deepcut site should be taken over by Military Provost Guard Service (MPGS) as soon as practicable.

3.22 Commentary

The DAG summarised the environment at Deepcut by stating the following:

'The range and combination of mutually reinforcing stimulants at Deepcut is especially adverse. They exist at a level well above that found anywhere else in the ATRA during this investigation. Although the majority of the trainees are content and well motivated, the risks are concentrated amongst the weakest and least competent, and especially those with underlying problems, which such a psychological environment would exacerbate. The earlier analysis underlined that this group may include those most likely to take their own lives. Taken together these adverse stimulation factors may have played a part in all 4 deaths'.

3.23 The DAG Report reflects the benefits of external questioning and internal review coming together to strengthen the regime. This review arguably represents the first occasion that the Army recognised and acknowledged that elements of the regime may have contributed to the deaths of the four soldiers at Deepcut.

3.24 The risks associated with Phase 2 RLC Training were again a significant issue identified in the DAG Report. This is despite the fact that this issue had regularly featured in the various reviews and reports undertaken during the previous 16 years.

3.25 The DAG's statement of the appropriate supervisory ratios at Deepcut both mirrored and superseded the recommendations made by Haes. Although the recommendations of the Haes Report were not adopted by the Army because the methodology used to calculate supervision levels was insufficiently justified, the DAG report vindicated Haes' findings.

- 3.26 The Army appears to have taken no action on the Haes Report's recommendations, not because the arguments in the review lacked credibility but because no alternative was proposed to the over-costly solution of improving supervisory ratios. These matters then remained unaddressed until the DAG arrived at similar conclusions, via a different route after the deaths of Pte. Geoff Gray and Pte. James Collinson.
- 3.27 The DAG was of the view that, in terms of suicide prevention policies and practice, there had been a radical transformation since 1998 when the ASMWG was formed. While the creation of the ASMWG is to be applauded, the view that its work was of major significance prior to its refocus in 2003 is not supported by the evidence analysed by Surrey Police.

Army Suicide Management Working Group (ASMWG) 1998 onwards

- 3.28 As previously mentioned in this report, the ASMWG was established in 1998. It provided the Army with the opportunity to identify and deal with many of the issues that have been highlighted throughout this report.
- 3.29 It has not been possible to identify the terms of reference for the group that were in use prior to 2003 and until this time it appears that it operated in an ad hoc manner with limited ability to assess if it was making any progress.
- 3.30 The Army has provided Surrey Police with a schedule of what they perceive to be the achievements of the ASMWG but it has proved very difficult to assess in real terms how much influence this group has had or what it has achieved.
- 3.31 What is clear is that the group has discussed many of the important issues relating to self-harm and suicide, but with the exception of the publication of revised instructions, amended training syllabuses and the distribution of glossy handouts, little evidence has been provided of how the ASMWG deliberations were translated into practical remedial action.
- 3.32 In February 2003 there appears to have been a change in the emphasis of the group. This coincided with the appointment of a new chairperson who identified a need for directional focus. Significantly, the title of the group was then changed to the Army Suicide Prevention Working Group (ASPWG). This was 'to better reflect its overall aim'.
- 3.33 In addition, the ASPWG adopted the following terms of reference:
- i) Shape – to shape the Army's self-harm and suicide prevention policies and procedures by:
- Targeting research to better understand the phenomenon and the organisation's part in it and response to it

- Sponsoring the use of psychological techniques in post-incident investigation in order to improve in-depth primary data gathering
 - Establishing best practice through benchmarking Army policy and practices against other services, other public-sector bodies and other nations' services.
- ii) Educate – to promote awareness of self-harm and suicide prevention by developing training and educational programmes throughout the Army.
- iii) Audit – to audit the delivery of self-harm and suicide preventative measures:
- Awareness, education and training
 - Prevention, policy and procedures.

3.34 Commentary

The introduction of these terms of reference gave clarity to the ASPWG direction and purpose. The Working Group appears to have subsequently made progress towards developing influence in terms of delivering measurable improvements.

- 3.35 The ASPWG has developed from a body that appeared to have had no significant direction, to a group with the structure and focus to positively influence policy and procedure. It is notable that this enhanced approach did not take place until after the introduction of the Learning Account process.

Directorate of Operational Capability Training Appraisal 2002

- 3.36 Between 3 October and 18 December 2002, the Directorate of Operational Capability (DOC) led an appraisal of initial training across all three armed services. The DOC is an MoD departmental branch responsible for auditing all operational capability across all three armed services and is independent of the chain of command.
- 3.37 The terms of reference for the appraisal were set by the Minister of State for the Armed Forces. Its purpose was to conduct a 'health check' on training regimes and examine issues of morale, motivation, training practices and culture.
- 3.38 The DOC's findings also fall into the risk areas around which this report is structured.

3.39 Supervision

- i) The DOC maintained that all three service initial training systems were stretched and running at risk due to supervisory under-resourcing and a throughput of trainees that exceeded the system's capacity. It identified that this was resulting in a compromise of training standards, which directly impacted on the personal development and general welfare of trainees.

ii) In the DOC's view, the most significant human risk was being carried in the larger Phase 2 Army training establishments.

iii) The DOC concluded that to address these issues would require additional investment and the quality of instructors would be key in rectifying the situation.

3.40 Accountability

The DOC took the view that the initial training system was 'inherently fragile' due to the absence of reliable routine strategic insurance mechanisms and indicators.

Directorate of Operational Capability Re-appraisal of Initial Training 2003

3.41 In April 2003 the DOC conducted a re-appraisal of initial training to gauge the progress made in addressing the issues raised in the initial appraisal of December 2002. The findings were as follows:

3.42 Supervision

During the re-appraisal the DOC noted that under-resourcing of supervision, along with persistently high throughput of trainees, was continuing to render initial training fragile and at risk.

3.43 Welfare

The DOC re-appraisal concluded that the most significant human risk remained in the larger Phase 2 Army training establishments. This was attributed to poor base services and dilapidated accommodation as well as shortages of supervisory staff.

3.44 Commentary

The DOC re-appraisal's overall assessment stated that:

'Remedial action has been implemented at local unit level where practical and when resources allowed... However, real progress will, for the most part, require either additional investment in the Initial Training pipeline or adjustments to intake flows... significant progress in addressing the major issues raised by the original Appraisal will rely on a positive outcome in STP 04 (budget bid for the period 04-08). This has the potential to transform radically the Initial Training environment and reverse years of under-investment in this key area of operational capability'.

3.45 As a result of the issues raised by the DOC appraisal and re-appraisal, the Army produced an action plan. Although it was clear that the Army was able to make some changes at local level, the more significant issues required additional funding and relied on the acceptance of the budget bid known as the Short Term Programme 2004 (STP 04). It is understood that many of the matters subject to STP 04 have already been implemented, including the provision of an additional 166 supervisory staff.

3.46 Many of the issues highlighted in the DOC appraisal arose because of a lack of resources. This financial inhibition has consistently featured throughout the last 16 years. The potential improvements likely to be realised if the additional funding is agreed are welcomed. However, the questions of why funding has not previously been forthcoming and why structural changes were not made to reduce the repeatedly identified risks remain unanswered.

Joint Police/Army Learning Account 2002

3.47 As mentioned earlier in this report, the joint Police/Army Learning Account was established in August 2002 to allow Surrey Police to report to the Army issues that required timely and appropriate remedial action. It also provided the Army with a properly auditable assessment and implementation process.

3.48 The current Learning Account now contains 27 recommendations relating to the risks identified by both Surrey Police and the Army during the course of the investigation at Deepcut. The areas of concern that the Learning Account highlights can be categorised into this report's key areas.

3.49 Supervision

The Learning Account seeks to establish an over-arching supervision policy. Other measures identified include the provision of out-of-hours supervision and enhanced supervisory training and selection.

3.50 Screening

i) There is recognition of a need to develop a more effective risk assessment/identification process, both at the recruitment stage and continuously throughout soldiers' Army careers.

ii) Trainees should be encouraged to react to and report concerns about colleagues.

3.51 Accountability

i) The Army is exploring how lessons learned and best practice can be identified and shared across the organisation.

3.52 Firearms/Guarding

The Army has sought to change or reinforce instructions regarding the handling of firearms, the frequency, nature and supervision of guard duty and the risk assessment process necessary prior to arming a young person.

3.53 Commentary

The Army has since advised Surrey Police that the vast majority of the recommendations made through the Learning Account system have been actioned. A cyclical approach to review, implementation and inspection is essential to ensure all the recommendations are fully implemented and improvements sustained.

3.54 The Learning Account process is evidence that significant benefit can accrue from the different perspective that comes with external involvement and oversight. The Army has recognised in this case how this process can be used to support organisational learning and improvement. An example of this is the recent introduction of a Learning Account structure to the Board of Inquiry procedure.

ISSUE	1988 Ashley	1993/4 HCDC	1995/6 Benton BOI Evans Review James BOI	1998 Walton Hawley	2001 Haes	2002/3 DAG ASMWG DOC Learning Account
Supervision	•	•	•	•	•	•
Screening	•		•	•		•
Welfare	•	•	•	•	•	•
Accountability	•	•		•	•	•
Army Training Structure		•	•			•
Firearms/Guarding			•		•	•

3.55 As is clearly demonstrated by the above final grid, the issues of supervision and welfare, in particular, have consistently recurred from 1988 to the present. They should therefore be considered as key risk areas for the Army.

Chapter 4

Conclusion

- 4.0 The chronological audit of documents carried out by Surrey Police and described in this report identifies a number of recurring key risks. The dangers posed by these risks are particularly apparent for recruits in the closed environment of training. Training can be considered a significant point in soldiers' vulnerability, as it marks the transition point at which recruits, some as young as 16 years old, move from civilian to service life, and the time at which the Army knows least about them. At this point recruits may be in barracks up to 24-hours-a-day, away from the immediate support of family and friends. They are contained in a training environment, which is in itself inherently demanding and turbulent.
- 4.1 The issues covered in this report were identified primarily through the examination of documents provided by the Army and secondary sources such as Hansard. The chronological analysis of these documents illustrates how, over the 15 years from 1988-2003, the Army has consistently identified issues of concern but practical implementation of risk reduction measures has often not followed.
- 4.2 The deaths of Ptes. Sean Benton and Cheryl James in 1995 prompted a review by Brigadier Evans, which recognised that there could be deeper causal influences at work including the training regime itself. However, Evans' examination was confined to the Deepcut environment and his recommendations were not considered for relevance beyond Deepcut.
- 4.3 The significance of the review's findings to the Army generally appears not to have been considered. Crucially, despite a recommendation by Pte. Cheryl James' BOI to 'Radically review Phase 2 Training', no such review was ever carried out and it was not until after the death of Ptes. Geoff Gray and James Collinson and the start of the Surrey Police investigation that comprehensive review procedures were initiated.
- 4.4 The protracted failure to institute proper review procedures and the absence of any structured implementation of recommendations for managing risk in respect of suicide and self-harm need explanation. This failure must in part derive from the Army's inability to consider the possible relationships between the Army care regime, the training regime and episodes of undetermined death, suicide and self-harm.
- 4.5 These relationships might well have been addressed earlier and more robustly if the Army's approach to issues of risk management had been less localised and therefore less fragmented. Individual sets of recommendations and accumulating evidence of the worth of particular recommendations stretching over many years should have impelled the Army to act decisively some years ago.
- 4.6 However, such a judgement fails to take into account the overriding issue of competition for the resources needed to implement the welfare and supervision recommendations in successive Army reports. A case for the additional expenditure needed to implement the most important and persistent recommendations in respect of welfare and supervision might have been made, if the full implications of the Deepcut episodes had been realised earlier. This report has endeavoured to indicate why this did not happen.
- 4.7 The resolution of many of the issues identified by the Army has appeared dependent on the availability of additional resources. The inadequacy of funding for welfare and supervisory resources is clearly a strong undercurrent running through these events. It has been regularly cited to explain lack of attention to recommendations. However, this does not explain why alternative cost-neutral remedies, such as moderating the throughput of trainees, appear not to have been considered.
- 4.8 It is of course recognised that Services such as the Army have finite resources and consequently, senior commanders have to balance risks by making professional judgements about where investment is made and where it is not. It is, therefore, important to examine more closely the scope the Army has had to invest greater resources in safety and care-related issues in training and how these may compare with other safety-related investment options in other areas, for example, operations.
- 4.9 This needs to be considered against the background of the Army's commitments over the period under examination and whether options such as reducing trainee throughput are ever really available to the organisation. The funding issue remains central even today and the current DOC Action Plan for Army training is, to an extent, conditional on the latest funding bid (STP 04).
- 4.10 It is clear that the Army was aware of a number of areas where risk was evident. The reports of Walton, Haes and Hawley and the minutes of the ASPWG all show how problems were identified and discussed at some length. However, there does not seem to have been any over-arching mechanism to risk assess the findings of these reports and determine, direct and monitor a credible and effective organisational response. Because the reports were never considered together, the first convincing evidence of the recognition of the systemic nature of these risks, and of a coherent practical response to them, was in October 2002 when the DAG produced his report.
- 4.11 The DAG's rapid redeployment of supervisory staff into training following the introduction of the Learning Account in 2002, along with the implementation of the other initial lessons identified by Surrey Police, is fully acknowledged. However, Surrey Police is bound to draw attention to the time gap between this remedial action and the dangers pointed out by

Evans (1995), reiterated by Hawley (1998) and confirmed by Haes (2001).

4.12 The Surrey Police examination of the Army response to the issues covered in this report reveals a step change in the scale and sophistication of activity occurring after August 2002. There is compelling evidence that, following the involvement of the Deepcut families, the start of the Surrey Police investigation and increasing public scrutiny, a fundamental change occurred in the Army's approach to reducing risks faced by young soldiers and consequentially by the Army itself.

4.13 The Army is now viewing risks as a product of dynamic combinations of risk factors or 'stimulants' coming together. This recognises the potentially systemic nature of both the problem of risk and risk control measures. This development is to be welcomed.

4.14 However, as this history has demonstrated, the most crucial enabling element in the process of initiating and maintaining change is the existence and effective operation of a comprehensive system of accountability. Clarity of ownership of organisational problems improves the chances that effective remedies will be implemented and sustained. The Learning Account has bolstered the Army's systems of accountability.

4.15 Evidence of the difference in approach adopted since the 2002 watershed can be seen in the DAG's Final Report. This report demonstrates a more refined analysis of the identified risks. It not only takes a much broader view of the problem, but also recognises the need for action at an organisational and structural level. If Army systems of accountability continue to be developed, then systemic and cultural change may be achieved and sustained.

4.16 The Army must be given credit for the positive approach it has taken since August 2002. However, even though appropriate developments in Army systems of accountability are now being made, it would be irresponsible for Surrey Police to ignore the self-evident lessons of this chronological audit.

4.17 While it is clear that a change process has been initiated, it is outside the remit and capacity of Surrey Police to establish whether the recent progress has been impactful or sufficiently far reaching. It is the view of Surrey Police that a broader enquiry is necessary to provide assurance that the current momentum in the development and implementation of regime improvements is sustained. Such an enquiry should consider the need for independent oversight of Army recruit training to support the Army in striking the right balance between tough training and the control of avoidable risk. Such oversight would also provide a safeguard for young soldiers in training who are isolated from their families and do not enjoy the protection afforded by the transparencies of civil occupations.

4.18 In addition to the findings of our evidence-based approach to the audit of organisational activity, Surrey Police also encountered evidence of incidents and episodes, which indicate that bullying may be contributing to the levels of risk. Evidence of bullying was discovered incidentally as the investigation into the deaths progressed. This additional evidence further supports the case for a broader enquiry.

4.19 The DAG recorded in his Final Report, dated December 2002, that 'several sources of adverse stimulation' had been found at Deepcut. A number of these adverse stimuli paralleled the issues identified in this report. The DAG concluded that:

'Taken together these adverse stimulation factors may have played a part in all 4 deaths'.

This acknowledgement marked a significant change in the approach the Army is now taking to risks within the training regime.

4.20 In the writing of this report, Surrey Police has not sought to link any of these risk factors specifically to the four individual deaths. Instead the report seeks to highlight the broad pattern of risks facing young soldiers in the Army training environment. It is hoped that urgent action will continue to be taken to better control these risks and that risk control will become a dynamic and sustained activity in Army training.

4.21 Accordingly, it is the summary recommendation of Surrey Police that the Ministry of Defence considers a broader investigation of:

i) Whether the risks identified at Deepcut are replicated across the wider ATRA and how these may relate to the issues of self-harm, suicide and undetermined deaths.

ii) How the Army's care regime may be further improved.

iii) How independent oversight might help the Army define and maintain appropriate standards of care for young soldiers.

Glossary of Terms

ACPO	Association of Chief Police Officers	MGS	Ministry of Defence Guard Service
AG	Adjutant General	MO	Medical Officer
ASMWG	Army Suicide Management Working Group	MOD	Ministry of Defence
ASPWG	Army Suicide Prevention Working Group	MP	Member of Parliament
ATR	Army Training Regiment	MPGS	The Military Provost Guard Service
ATRA	Army Training and Recruiting Agency	NCO	Non Commissioned Officer
BOI	Board of Inquiry	PT	Physical Training
COS	Chief of Staff	Pte	Private
D of C&S	Duty of care and supervision	PVR	Premature Voluntary Retirement
DAG	Deputy Adjutant General	RLC	Royal Logistic Corps
DASA	Defence Analytical Services Agency	SATT	Soldiers Awaiting Trade Training
DLSTG	Defence Logistic Support Training Group	SE	Single Entry
DOC	Directorate of Operational Capability	STP 04	Short Term Planning 2004
DPS	Director Personal Services	SVQ	Suicide Vulnerability Questionnaire
HCDSC	House of Commons Defence Select Committee	WRVS	Women's Royal Voluntary Service
HQ	Headquarters		

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