HIS HONOUR PETER ROOK QC

SITTING AS NOMINATED CORONER IN SURREY CORONER'S COURT

INQUEST INTO THE DEATH OF SEAN BENTON

FACTUAL FINDINGS

18 July 2018

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INQUEST INTO THE DEATH OF SEAN BENTON

1. Introduction

1.1 Sean Benton's parents, Harry and Linda Benton, long campaigned for a second inquest into their son's death but, sadly, they did not live to see these proceedings. After Sean's[1] father died in July 2011, his mother remained determined to explore many unanswered questions. It is deeply regrettable that she too died in May 2015 and so could not know that the High Court would rule on 14 October 2016 that their campaign was justified and that a fresh inquest must be held.

1.2 Sean's older sister, Tracy Lewis, and his twin brother, Tony Benton, have carried on their parents' legacy. They have listened with dignified composure to accounts of events over two decades ago of their brother's life and how he came by his death. Their parents have good reason to be proud of all of their children.

2. The Article 2 ECHR procedural obligation

2.1 Before the evidential hearings commenced, having considered the judgment of the European Court of Human Rights in *Stoyanovi v Bulgaria*[2], I ruled that the investigative obligation under Article 2 of the European Convention of Human Rights was engaged. No Interested Person sought to dissuade me from my view that the Article 2 procedural obligation arose in circumstances where the army as a state agent had undertaken or organised the potentially dangerous activity of allowing trainees to be on armed guard duty, where those trainees might be left in possession of a rifle and ammunition whilst unsupervised and alone.

2.2 That determination means that s.5(2) Coroners and Justice Act 2009 ('CJA') will apply and the broader circumstances of how Sean died must be explored and recorded.

2.3 In his Guidance number 17 on "Conclusions", the Chief Coroner invites me to adopt a three-stage process when completing the Record of Inquest. First, to make relevant findings of fact on the evidence; second, to distil from those findings of fact 'how' Sean came by his death; and third, to come to my conclusion on the basis of those facts.

2.4 Many of the findings that I must record on the Record of Inquest have been known from the outset. Who the deceased person was, when he died, and where he died has never been in issue. How Sean died, in so far as that relates to the medical cause of Sean's death, has also never been seriously in question.

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[1] Sean's sister and brother indicated at the outset of these hearings that they would prefer their brother to be referred to as Sean throughout.

[2] [2010] ECHR 1782 at §61

2.5 Furthermore, all the Interested Persons contend that if I am to come to a short-form conclusion then suicide, which was the verdict at the original inquest, must remain at the forefront of my contemplation. However, none of the Interested Persons argue that I should limit my findings to a short form conclusion. I wholeheartedly agree that more is needed.

2.6 It is "in what circumstances" Sean came by his death that was for Sean's parents, and remains for his siblings, the far more important, and more contentious aspect of this case. That question has occupied the majority of the 40 days of evidence that I have heard and it is to that and the related key issues at the heart of this case that I now turn.

2.7 Before doing I should say something of the evidential difficulties that beset an inquest taking place 23 years after the primary events.

3. The evidence

3.1 This inquest has heard the evidence of 174 witnesses over 40 days of sittings. 117 witnesses attended, whether in person or via video-link. I have been hearing evidence about events that took place over two decades ago. Seven years passed after Sean's death on 9 June 1995 before the Surrey Police investigation in 2002-2003, and then there was over a decade between the Blake Review[3] and this inquest. Such a long passage of time inevitably poses major difficulties both for witnesses and the evaluation of the reliability of their evidence. Some important witnesses have died and others have not been traced. Undoubtedly the task of this inquest has been made significantly more demanding by the paucity of contemporaneous witness accounts and the many forensic opportunities that have been lost.

3.2 Memories fade with time. This is particularly so where a witness has not made a statement close to the time of the episode which they are seeking to remember so they are not in a position to refresh their memories from a contemporaneous account. At this inquest some witnesses only gave limited statements at the time, the original inquest was brief and the army Board of Inquiry's focus was narrow, involving relatively few witnesses and focusing entirely on the guarding orders and procedures on 8 to 9 June 1995. Many witnesses first made statements when asked to do so by Surrey Police during their investigation in 2002 and 2003 by which time their memories may well have deteriorated. Some had not made a statement at all until relatively recently.

3.3 Fading memories only represent part of the problem. A fixed mental record is not formed at the time of the event. Remembering distant events involves reconstructive processes leading to re-interpretation which may be largely unconscious. Memories are fluid and malleable and vulnerable to interference and suggestion. They can be re-written whenever they are retrieved. External information can be introduced from other

[3] The Deepcut Review by Nicholas Blake QC, as he then was, published in March 2006.

sources during the reconstructive process from such apparently innocent processes such as the sight of contemporary documents compiled by others.

3.4 It must be remembered that the difficulties that may arise from the passage of time have the potential to affect all witnesses, whether former trainees or witnesses from the chain of command. For example, very many in the chain of command, including those who acknowledged they had some responsibility for Sean's welfare, gave no accounts at all in 1995 and thus did not have the benefit of a more contemporaneous recall of their interactions with Sean.

3.5 The problems are further compounded by the exposure of some witnesses to extensive coverage in the media and social media commentary. Some of that coverage has been of a sensational nature, both about the regime at Deepcut Barracks and the deaths that took place there. Furthermore, in a closed society such as an army barracks, rumours are rife. In the circumstances, a witness may find difficulty in distinguishing between matters that now feature in their 'mind's eye' as a result of the rumour mill and episodes that they actually saw themselves. Even when recognising that difficulty, they may not be able to distinguish between the two. It is clear that rumours about Sean's death were many and varied even in the days and weeks immediately after his death. Thereafter, such rumours and speculation have grown and multiplied in the intervening years. There is a risk of reckless, malicious or innocent adoption of false rumour. I have been astute not to place reliance upon evidence which bears the hallmarks of contamination (whether innocent or deliberate) as a result of exposure to the media or rumour.

3.6 When a witness has made an allegation of misconduct against another person, delay can place the alleged perpetrator at a material disadvantage in challenging allegations arising out of events that occurred many years before. The longer the delay, the more difficult it is for a person to meet the allegation because of fading memories and the fact that other evidence is no longer available – indeed it may be unclear what has been lost. In assessing the reliability of witnesses I have made due allowance for these factors.

3.7 In many cases there was no contemporary complaint made about the misconduct subsequently alleged. Some matters were not even raised during interviews with Surrey Police in 2002-2003. Whilst it might be said this points towards unreliability or more recent fabrication, I have not made any assumption that because a complaint was delayed it must be untrue. Similarly, I acknowledge that because an allegation was made at the time does not necessarily mean it was true. I have, where relevant, taken into account the reasons for delay. I have looked at all the circumstances including the particular reason the witness gave for not having complained at the time. The vulnerable position of those who would wish to complain about persons who hold authority over them within a hierarchical structure are of course relevant here.

3.8 I have been careful not to make any general assumptions about the behaviour of young trainees, but clearly I need to consider the immaturity of some witnesses at the time events occurred as well as whether there existed fears that reporting might lead to

reprisals. A recurring theme was the difficulty in raising matters through the chain of command when it would involve reporting to those perpetrating the misconduct.

3.9 I have borne in mind that material inconsistencies between a witness' evidence and a previous statement may mean that less weight should be given to that witness' evidence. I acknowledge that honest witnesses can make mistakes. Confident delivery does not necessarily mean evidence is accurate. At this inquest I have heard evidence from witnesses who, understandably, admitted a reluctance to talk about a period of their lives which they had chosen to blank out of their memories. Inconsistencies need not necessarily undermine a witness' evidence just as a consistent account does not necessarily mean it is accurate. Experience has shown that inconsistencies can arise where a person is telling the truth. This is because the memory of someone who has undergone a traumatic experience may be affected by it in different ways and this may have a bearing on that person's ability to take in, register and recall it. Also after such experiences, some people go over and over it in their minds with the result the memory becomes clearer, whilst others may seek to blank out deeply disturbing experiences and avoid thinking about them. Consequently whilst the incidents did occur, they may have difficulty remembering the detail accurately.

3.10 The demeanour of the witness, by which I mean their appearance and behaviour when giving oral evidence, can potentially be revealing. However as the appellate courts have recognised, it can be unreliable and dangerous to draw conclusions from witnesses' demeanour as to the likelihood that they are telling the truth.[4] I have not attached any significant weight to the manner in which evidence has been given, but have focused instead on the content of the witnesses' accounts.

3.11 Where evidence has been read under r.23,[5] albeit not agreed, hence not tested in examination, or where hearsay accounts have been admitted, my consideration of the weight to be given to that evidence has been guided (although not determined) by the factors set out within s.4(2) Civil Evidence Act 1995.

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[4] As recently stated by Leggatt LJ in *R (on the application of SS (Sri Lanka)) v Secretary of State for the Home Department* [2018] EWCA Civ 1391, §41: "No doubt it is impossible, and perhaps undesirable, to ignore altogether the impression created by the demeanour of a witness giving evidence. But to attach any significant weight to such impressions in assessing credibility risks making judgments which at best have no rational basis and at worst reflect conscious or unconscious biases and prejudices. One of the most important qualities expected of a judge is that they will strive to avoid being influenced by personal biases and prejudices in their decision-making. That requires eschewing judgments based on the appearance of a witness or on their tone, manner or other aspects of their behaviour in answering questions. Rather than attempting to assess whether testimony is truthful from the manner in which it is given, the only objective and reliable approach is to focus on the content of the testimony and to consider whether it is consistent with other evidence (including evidence of what the witness has said on other occasions) and with known or probable facts."

[5] Coroners (Inquests) Rules 2013

3.12 It is not only the fading of witness memories that has been the challenge for this inquiry. The forensic evidence that would have assisted to illuminate what happened on 9 June 1995 was not gathered at the time. Successive Chief Constables of Surrey Police have frankly acknowledged that Surrey Police should have but did not retain primacy for the original investigation into Sean's death. An apology to Sean's family for this failure to retain primacy was made in 2003 and reiterated at this inquest; but an apology cannot replace that which has now been permanently lost.

3.13 Even by the contemporary standards of 1995 the incident was neither controlled nor investigated in the way that one might have expected of a sudden and violent death. Early assumptions made at the scene led to an absence of contemporary ballistics evidence, a paucity of scene investigation and only very brief contemporary witness accounts being recorded. Dr Cary, an independent forensic pathology expert, identified as many as nine fundamental failings in the quality of the original scene investigation. Consequently, the forensic evidence that has been available in 2018 is woefully lacking. Despite the efforts of the doctors and scientists who have assisted me as expert witnesses, Surrey Police's shortcomings in 1995 means that all have been hampered in coming to their opinions by incomplete information.

SEAN'S EARLY LIFE

4. Sean Benton at Hastings

4.1 Sean Benton was born in Hastings, East Sussex on 11 October 1974. His parents, Harry and Linda Benton, had four children and Sean was brought up with his twin brother, Tony, his older sister, Tracy, and their younger brother, Lee, who sadly died in December 2012. The family home was in Hastings and Sean was particularly close to his maternal grandmother, who lived nearby.

4.2 Looking back on Sean's childhood, his sister Tracy Lewis told me that he was kind, sensitive, fun, thoughtful, helpful and lovely. As a young man too, he was kind, generous and sensitive. She remarked on his good sense of humour, something that many of his army colleagues also later recalled.

4.3 In the statement Sean's father provided for the original inquest Harry Benton described his son as having been fit and healthy all his life. In 2002 Sean's mother described how at school Sean was an "average pupil", someone more interested in sport and being outdoors than academic work. He liked playing football and joined a local team. He left sixth form to join a mechanical engineering course at a college, but left that to work as a labourer for a construction company.

4.4 Psychiatric records from August 1991 set out Sean's mother's account to a psychiatrist of her experience of Sean as a teenager. She described Sean as being "fine until he was 14 when he began to be more disruptive and behave in a worse way. He was involved a little bit with the police and started spending time away from home with his friends. He was inclined to drink beer and come home drunk." His sister recalled that Sean was not a big drinker, because she thought "he couldn't handle it". After Sean left home for a few months his mother contacted local social services asking for help, the psychiatrist recording that she had been "at somewhat of a loss in knowing how to handle him".

4.5 Sean was briefly involved with police when he was convicted of criminal damage in 1993, an event which he disclosed on joining the army. He told the recruiter that he had "smashed a plate glass window" and received a 12-month conditional discharge and a £335 fine. His sister told me that Sean had kicked a window of a shop. According to his social worker in 1991, Sean's Nan paid his fine.

4.6 Tracy Lewis recounted how Sean loved his mother very much, although they sometimes argued. She recollected Sean moving out of the family home when he was about 16. Although Tracy, being older, had by then left home, she thought Sean had first moved to a hostel and then lived in his own flat in Hastings.

4.7 For around a year, Sean was involved with Ms Gill Barwick, of East Sussex County Council's youth offending team, who Tracy Lewis understood was involved "to put

peace between Mum and him…she guided him because he didn't want to go back home." She helped Sean find a new flat. Ms Barwick recalled Sean as being a "smashing kid" who was sensitive and "always able to talk things through and deal with things". Regrettably no notes have survived of Sean's engagement with social services.

4.8 The other significant matter in Sean's youth is that in August 1991 when he was 16 years old, he took two overdoses of paracetamol. His cousin, Mandy Mayhew, recalled one overdose in her statement in 2002. She thought that this was while Sean was living on his own, out of work, lacking money and lonely. She said that he was "down and depressed" and it was a "cry for help due to his situation of being out of work". His father had similarly understood it to be a "cry for help" when he recalled one of these overdoses in his statement for the original inquest in 1995.

4.9 After Sean died his GP in Hastings, Dr Rowan, wrote to the Surrey Coroner describing Sean's overdose as an "on the spur of the moment thing. He had simply had an argument with his parents about tidying his room and at that time it was a bit of a bone of contention between them."

4.10 As a result of the overdose, Sean was referred to a psychiatrist who he saw only twice. The available psychiatric notes are sparse. They do however suggest that Sean was living at home with his parents and three siblings when he took his first overdose in early August 1991. The context was a row over tidying his bedroom. When Sean saw the psychiatrist as an outpatient he reported that on that first occasion he "definitely intended to die". Before he could be seen again Sean was admitted to casualty on 18 August 1991 after a second overdose. That time he had taken 24 paracetamol tablets after what are described as "family problems". It was noted this was his second overdose in two weeks and was a "similar situation to the last occasion – [a] row over bedroom".

4.11 After that second overdose Sean is recorded as saying he "has been stupid and definitely won't do it again." The psychiatrist who reviewed him felt that Sean "did not have any deep-rooted psychological problems." When Sean did not attend either of two follow-up out-patient appointments offered in September and October 1991 he was discharged.

4.12 Dr Rowan told the Surrey Coroner that when he last saw Sean, in 1993, "he gave no appearance to me of a young man with any psychiatric problems."

5. Sean's army enlistment

5.1 Sean's decision to join the British Army in early 1994 was, according to his sister, "due to the employment situation in Hastings". However his mother had thought that Sean was "always fascinated with service life", both his grandfathers having been in the services. Tracy Lewis said it was listening to their grandad and his stories that had made Sean want to join up.

5.2 Sean's application was supported by two references, each written in January 1994. One from a family friend, Mr Harris, described Sean as a "very sound young man of even temperament, fairly quiet with a good sense of humour…he is able to follow orders to the letter." The other was from Ms Gill Barwick, who wrote that Sean was "a pleasant and co-operative young man" who had grown in maturity and confidence since she had known him. She had always found him to be "truthful, forthcoming and honest" and said he had thought carefully about his application to join the army and become a soldier.

5.3 At a recruiting interview in April 1994 Sean gave his reasons as wanting to serve: "[to] keep it in the family, I want to help keep peace in other countries, to serve this country for as long as I can." Sean had apparently told the recruiting sergeant that he had been "easily distracted" and so there had been "some ill discipline" at school. Sean said that he wanted to be a driver, in the Royal Engineers. He was unemployed and told the army that he had only been in part-time work since 1991.

6. Medical assessment on enlisting

6.1 Sean underwent his pre-enlistment army medical on 1 June 1994 when he filled out a self-report questionnaire giving information about himself. He said he smoked ten cigarettes a day and drank four pints a week. When asked to state whether or not he had any of a list of specified conditions, he answered 'No' when prompted to disclose 'nervous breakdown or mental illness', and 'No' to 'any self injury or poisoning?'. He did answer 'Yes' to the question 'any contact with child guidance services?'.

6.2 There is nothing in the records to suggest that Sean disclosed his two earlier paracetamol overdoses when he applied to join the army or subsequently. No information about these overdoses appears anywhere in his later army medical records. At that time it was not normal practice to review a potential recruit's GP records before enlistment. Had it been the two paracetamol overdoses and his contact with the psychiatrist in 1991 would have been revealed.

6.3 On 2 June 1994 Sean underwent a pre-enlistment fitness test. The recruiter recorded that Sean passed all elements of selection but, rather presciently, assessed Sean's "reaction to discipline" as "below average", his overall assessment being that "Benton is a fit young man who passed all aspects of selection, however [he] does have a slight problem regarding discipline and is inclined to answer back when spoken to. This he assures me is out of character and will be rectified."

6.4 On 24 June 1994, Sean's enlistment into the Royal Logistic Corps ("RLC"), in the trade of a driver, was confirmed. His basic training was to commence on 3 July 1994. He was then 19 years 9 months old.

THE RLC AND TRAINING

7. Introduction

7.1 This is not a public inquiry into the training of RLC soldiers at Pirbright and Deepcut in the mid-1990s, let alone an inquiry into the wider state of the army at the time. It is not within the scope of my statutory powers to consider or address every alleged adverse event or shortcoming at Deepcut or to make detailed findings about responsibility for any identified or admitted failings in the systems and structures in place. Nonetheless, it is within the scope of this inquest to consider how army policies and systems operated for those entering the RLC in 1995 in so far as consideration of this wider background is relevant to my investigation into the circumstances by which Sean came by his death.

8. The RLC

8.1 My inquiry has been greatly assisted by the lengthy statements and live evidence of Brigadier Christopher Coles, Head of the Army Personnel Services Group. He had no direct involvement with Deepcut himself in 1995 but provided me, as far as he was able to, with detailed and helpful evidence on the systems and policies in place in 1995 and how things have changed since then.[1] I have also heard direct evidence from Brigadier Evans (retired), who commanded all elements of the RLC training group, and was the garrison commander for Deepcut when Sean was stationed there.

8.2 Sean Benton's death followed a time of change for the army, following the fall of the Berlin Wall. The RLC was formed on 5 April 1993 by the merging of four corps and an element of a fifth.[2] In 1993, single entry training was also instituted, with men and women now training together for the first time. Such significant changes were likely to herald a difficult period within a largely untested establishment and structure.

8.3 Of particular relevance to Sean Benton's time in the RLC is the Royal Pioneer Corps, who worked in construction and logistical work. Several witnesses described a perception at the time that the Pioneers were held in less esteem than other corps and

[1] His statements drew upon evidence gathered during the Blake Review and the four Boards of Inquiry into the deaths of Sean Benton, Cheryl James, Geoff Gray, and James Collinson. He had also spoken personally with Brigadier Paul Evans, the Commander of the RLC training group in 1995, who published a report in December 1995, shortly after the death of Cheryl James, following his own investigations into what was wrong and needed to be changed within the training organisation.

[2] These were the Royal Army Ordnance Corps ("RAOC"), the Royal Corps of Transport, the Royal Pioneer Corps, the Army Catering Corps and the Royal Engineer Postal and Courier Service. These corps, who had different roles and 'cap badge' allegiances, were now brought together into an amalgamated corps of 1,700 officers and 15,000 soldiers.

that their work was not prestigious.[3] What is relevant is that Sean evidently considered a Pioneer role as far less preferable than the work of a HGV driver that he had hoped to be doing when he signed up to the army.

8.4 The Princess Royal Barracks at Deepcut, Surrey (which I will refer to as "Deepcut") was the former home of the RAOC, and was selected as the home of the RLC headquarters. It was also the hub of the RLC Training Regiment & Depot. RLC recruits would undertake 'Phase 1' basic training at the Army Training Centre at Pirbright in Surrey ('Pirbright'). Those recruits who passed out were then known as 'trainees' and moved on to Deepcut for 'Phase 2' of their training, during which they learned specialist skills or trades before being allocated to their field units.

9. Basic Training at Pirbright

9.1 The Phase 1 basic training at Pirbright was a 10-week intensive introduction to the military and basic military skills such as weapon handling, drill and field craft alongside developing recruits' fitness and learning to heed and implement orders.[4]

9.2 The training was highly structured and there was a high ratio of NCOs to recruits.[5] Brigadier Coles told me that during Phase 1, recruits would be "practically occupied and under direct supervision from sunrise to sunset." There was little free time. Numerous trainees gave evidence about the stark contrast between the structured and closely supervised Pirbright environment and their later experiences at Deepcut.

10. Deepcut in 1995

10.1 Following the RLC restructuring, the barracks at Deepcut became a holding unit, providing lodgings for soldiers during their Phase 2 training. Most Phase 2 soldiers did not undertake any further training at Deepcut but waited there until allocated a place to do their trade training at a specialist training school elsewhere, before being posted to the field army. Known as 'soldiers awaiting trade training' or 'SATTs' many, like Sean, undertook their driver training at Leconfield in the North of England.

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[3] As Cpl David Wakelin, himself a Pioneer, put it: "to give myself a black eye, the Pioneers are seen at the lower end of the gene pool". Some others, such as Lt Col Gillham, who had first-hand experience of the difficult work of the Pioneers from the first Gulf War, thought them an impressive group of people.

[4] Major Samuel Porter described the task facing instructors at Pirbright: "you were trying to take someone who was a civilian on day one and trying to mould them into a soldier in 10 weeks." Discipline was "essential": you had to be "firm but fair with the recruits, and you had to show them respect."

[5] There was a Platoon Commander and a Sergeant allocated to each Platoon of 36 recruits, sub-divided into sections of approximately 12 recruits each with a Corporal.

10.2 The RLC Training Group was under overall command of Brigadier Evans, whose headquarters were at Deepcut. Lieutenant Colonel Nigel Josling (later Colonel Josling) was posted as Commanding Officer ("CO") of the Training Regiment and Depot at Deepcut in 1994.[6]

10.3 The RLC Training Regiment and Depot at Deepcut comprised three squadrons: 'A' the enhanced training squadron; 'B' the holding squadron; and 'C' the support squadron. 'B' Squadron was made up of Phase 2 trainees, including Sean. As a holding squadron it was to provide induction, administration and some military skills continuation training for SATTs and to ensure progression onto their specific training courses before their posting to the field army.

10.4 B Squadron was led by an Officer Commanding ("OC"), a Major, with a second in command ("2iC"), a Captain. It was divided into two troops. Trainees were supervised by a Troop Commander, a Lieutenant, and a Troop Sergeant. Under them were a number of section corporals and other junior Non-Commissioned Officers (or "NCOs"). At the time Sean was at Deepcut, the Officer Commanding ("OC") was Major Robert Gascoigne (later Lt Col), with Captain Keith Cammack as his 2iC. The two troops were commanded respectively by Lt Sarah Delap with her Troop Sgt Andrew Gavaghan in 1 Troop, and by Lt Michael Radford with Sgt Adrian Stevens in 2 Troop.

11. Instructor/trainee ratios

11.1 A universal theme from the evidence of numerous witnesses, whether former Deepcut trainees or members of the then chain of command, was that the NCO-to-trainee ratio at Deepcut in 1995 was wholly inadequate to cope with a large transient population of trainees and the source of many of the difficulties encountered at Deepcut.

11.2 The army's ideal would have been to establish a ratio of NCOs to trainees akin to that of the field army: of around 12 Privates to one Corporal. In fact, the numbers attending Deepcut by 1995 made this aspiration wholly unattainable. The number of trainees in Phase 2 was not fixed, nor was the period that a soldier would spend in the second training phase. Whilst no accurate records are available, one document from March 1995 suggests that there were between 150 to 500 trainees garrisoned at Deepcut at any one time and that up to 2,000 went through the camp in a year. There were often so many trainees on camp that the usual junior-NCO ratio was 1 corporal to 100 privates (and rarely less than 1:80) with ratios of between 1:200 to 1:400 during the night. This contrasted with a ratio of 1:12 in the field army. As a consequence, there was little control over activities in the accommodation blocks in the evenings.

[6] Throughout these findings, I will refer to individuals in the army at Deepcut by the rank and surname by which they were known in June 1995.

11.3 However, the system proceeded to operate on the mistaken presumption that Deepcut did not require better resources because, in the main, trade training was not be delivered there. The situation was compounded by an unpredictable influx of new trainees and some trainees having to spend extended periods at Deepcut because smooth progression through the system could not be achieved.[7] Some trainees, particularly those who failed a course on their first attempt, might spend well over six months at Deepcut waiting to be loaded onto trade courses.

11.4 This meant that the personnel of B Squadron was permanently transient and in flux. Private David Hirstwood, for example, claimed that he frequently missed parade without consequence: the NCOs simply did not know who was in their squadron and so his absence went undetected.

11.5 It was not simply supervisory capacity that was lost. The hierarchical army structure relied upon corporals developing personal relationships with the soldiers under their command, allowing them to understand their soldiers' personality, their strengths and their weaknesses. This was simply unachievable given the large numbers passing through Deepcut. The consequence was that the Deepcut structure lacked the fundamentally important opportunity for those at the lowest levels in the chain of command to have sufficient knowledge of their privates to be able to notice a struggling soldier and offer support and pastoral care.

11.6 Brigadier Coles recognised these shortcomings in an apology to Sean's family at the outset of his evidence when he said:

> "Quite a number of things could and should have been better at the time of Sean's death and, in particular, the set-up at Deepcut and the ratio between instructors and the trainees for whom they were responsible was not then as it should have been, and indeed not as it would be now. That led to the risk that people in training at Deepcut were not looked after pastorally or their welfare was not properly attended to in the way it should have been, and for that I am very sorry."

11.7 In my view, the unbalanced instructor ratio did not just lead to a risk of adversely affecting welfare at Deepcut, it actually did so during Sean's period at Deepcut. It inevitably led to wholly inadequate supervision of trainees by NCOs who themselves had had insufficient training and guidance in welfare. It led to there being few purposeful activities, in stark contrast to the structured, intensive training at Pirbright. Whilst the pressure on trainees was relieved, insufficient alternative stimuli were

[7] Brigadier Evans told me how one of the assumptions when the initial Deepcut establishment was set up in 1993 was that the Phase 2 trainees would transit through Deepcut very quickly. They would arrive after having trained at Pirbright, transit quickly to a trade training placement, complete their Phase 2 training, return briefly to Deepcut and then transit again very quickly out towards their unit. By 1995 it was apparent that such a smooth progression was not the reality. Since 1993 there had been a significant reduction in staffing and a notable dilution of the instructor-to-trainee ratio.

provided. Combined with unpopular guard duty, this lowered morale. The slow throughput onto Phase 2 training courses and the extended purposeless stays were constant sources of frustration.

11.8 The overall impression was described by Lieutenant Delap, one of the Troop Commanders, as people going through the motions and a holding situation with not enough staff to keep the trainees properly occupied.[8] Squadron Sgt Major Graham Milne, who was in charge of discipline in B Squadron at the time, stated that there were considerable discipline problems as a result of the large number of trainees with relatively few staff.[9] There can be no doubt that the pressure brought about by the number of trainees each NCO had to supervise risked less tolerance of misdemeanours by trainees and NCOs straying into unacceptable disciplinary practices.

11.9 Lt Col Josling rightly described the situation as "a perfect storm".

11.10 The fundamental mistake in maintaining such a low instructor trainee ratio and its likely impact on management issues was appreciated by many at the time but it took the army a long time to respond to the turbulence it caused. Capt Cammack, explained that he had raised the matter with the OC Major Gascoigne who in turn recalls speaking with the CO. Major Gascoigne stated that, together with the issue concerning young trainees undertaking guard duty, the instructor-to-trainee ratio was a constant concern to him. However his efforts to raise the issue of the need for more properly trained instructors up the chain of command did not meet with success.[10]

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[8] Lt Radford told the inquest that at any one time he had between 150 and 350 privates in his troop. He felt that staff were asked to manage numbers well beyond what could reasonably be expected.

[9] Sgt James Russell, who was temporarily attached to the training team, described the situation as "ridiculous". In his view, whatever skill set members of the training team had, the sheer numbers posed difficult management issues. Although many Officers and NCOs expressed the view that "we did the best we could with what we had", it is clear that NCOs felt that holding soldiers in a training regiment with no real training or facilities and significantly reduced supervisory ratios risked them losing the discipline inculcated in the first intensive weeks at Pirbright.

[10] Major Gascoigne remembered going to the RLC Training Group asking for more resources to improve the continuation training available at Deepcut. A staff officer at Brigadier Evans' HQ told him that Deepcut was not established to undertake any continuation training and so should not be doing it. It was understood there would be no further funds for such activities. Brigadier Evans told me he was not aware of this request being made and would have been furious if he had known Major Gascoigne had received this response. As soldiers were then spending longer at Deepcut than envisaged, he took the view that continuation training was vital. Brigadier Evans explained to me how during the course of 1994 he became conscious that the establishment was proving inadequate for the number of trainees and that he would have raised these matters routinely with superiors. His impression was that, instead of increasing the establishment and resources, they were actually being encouraged to do quite the opposite, reducing training posts and the money that went with it. Cognisant of the time it would take to review and achieve an increase in the establishment and resources the Brigadier's approach was to implement

12. Daily life at Deepcut and guard duty

12.1 It is evident from the recollections of many trainees and NCOs that there was very little stimulating continuation training and that much of the work was perceived as being jobs done for the sake of being kept busy.[11] Brigadier Evans recognised this shortcoming himself in his December 1995 report when he wrote that Deepcut staff "must do better in providing trainees with meaningful and progressive training".

12.2 The work being done by trainees included spells of guard duty, when a trainee would be rostered on a guard position, known as a 'stag'. Typically guard shifts were over 12 or 24 hours with intermittent allocation to two hour stags throughout the shift. Trainees aged over 18, would be armed with an SA80 rifle when on a guard post, usually paired with another armed trainee.

12.3 Guard duty was generally deeply unpopular amongst trainees who found the regime of debilitating guard duty together with otherwise purposeless activity very difficult. I note that another perspective was offered to me by Pte Stan Munday, who said "many of us would volunteer for guard as it was a structured activity, and possibly for some, a safe haven from the daily routine and nights ruined by the troublesome, immature and easily influenced drunken individuals."

12.4 Lt Col Josling felt very strongly that the trainees should not have to do guard duty. He had concerns about immature young soldiers carrying a weapon when they had no experience of using one in the regular army. As he put it one did not know how they might react under pressure to make a split-second difficult decision whether to engage. To his credit, and supported by Brigadier Evans, he lobbied for reform including requesting the use of the MOD police who guarded Pirbright and exploring re-routing the perimeter fence among other ways to reduce the number of access points that required guarding. However these efforts did not achieve success.

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administrative measures to address the unpredictable fluctuations in the numbers of soldiers arriving from Phase 1 and to streamline the process of loading soldiers onto external courses, so that soldiers spent less time at Deepcut. Brigadier Evans told me how by December 1995 the fluctuations in numbers had swung the other way leading to far too few trainees at Deepcut to cover the guard rotas. This created its own problems putting an excessive guarding burden on those who remained. During the period that Sean was at Deepcut however, the problematic low numbers of NCOs persisted.

[11] Daily life at Deepcut for a Phase 2 trainee typically began with a morning parade before assignment to some form of physical exercise, refresher weapons or field craft training, or quite often to various menial and boring jobs. Pte Kelly Tuck Brown and Pte Trevor Hunter mentioned being assigned to pick up cigarette butts. Cpl Kevin Walton claimed that trainees were so bored they would hide under sink units to avoid having to go on parade.

12.5 Historically the army guarded itself and, like other barracks in 1995, and in no way exceptionally, Deepcut relied on its occupants to guard the camp. The threat posed by the Provisional IRA remained, in Brigadier Coles' words, a "looming spectre". In recent memory attacks had taken place against army barracks on the UK mainland. In 1995 Deepcut was properly regarded as a continuing security risk and there was considered to be no alternative to the young trainees doing guard duty.

12.6 Lt Col Josling noted that it took the army a long time realise the need for a change in the policy on guarding and then resource it. Trainees now no longer perform routine guard duty and the barracks are protected by a Military Provost Guard Service ("MPGS").[12]

12.7 Cancellation of weekend leave because of allocation to guard duty was another strong source of grievance amongst trainees. Sean was no exception. Additionally, and apparently unknown to Senior Officers, guard duty was at being given out by some as a sanction for disciplinary breaches. This may have been a consequence of NCOs having too wide a discretion to give informal punishments. On any view it was inappropriate and risked disaffection.

12.8 Some trainees told me how they would informally swap with or pay others to do their guard duty. The inquest was told that NCOs in charge of the guard were aware and yet unconcerned about the change of attendee, just so long as sufficient numbers attended the guard parade to cover the stag rota.

12.9 In addition, the MOD now accept that greater attention should have been paid to the self-harm risks involved in young trainees carrying out armed guard duty. In particular, in 1995 there was no policy requirement for soldiers who had committed acts of self-harm but had not been medically downgraded to be formally risk assessed in terms of their access to a weapon. This was at the discretion of the chain of command. MOD now accept that this should have been formally clarified with a codified process to be followed. In the absence of such a protocol, there was a risk of confusion as to whose responsibility it was to take appropriate precautions.

12.10 Otherwise, no longer being under direct supervision in Phase 2, trainees theoretically had their evenings and weekends to themselves when not in the cohort assigned to guard duty. There was little to do for those remaining on the camp aside from drinking in the NAAFI. As Brigadier Coles frankly acknowledged social drinking is and remains part of army life but although the army prohibited drunkenness, at times the trainees drank to excess.

[12] Brigadier Coles told me the decision at the time was driven by "necessity and realism". MOD now consider that MPGS is a better and more appropriate way of dealing with guarding requirements, being a more efficient use of manpower which allows Phase 2 trainees to focus on the field army.

12.11 Brigadier Coles frankly acknowledged that Deepcut "was regarded as a highly unpopular 'holding establishment'. It is fair to say that many of the junior officers and NCOs who served there were not considered to be the very best."[13]

13. Welfare systems at Deepcut

13.1 Phase 2 trainees were invariably adolescents or young adults, some as young as 17, many of whom were away from home for the first time. The army, then as now, recruits from a diverse pool of the population some of whom bring with them vulnerability to welfare problems.

13.2 Welfare was considered part of an inherent command responsibility within the army. Lt Col Josling, accepted that, as the Commanding Officer, he held ultimate responsibility for the welfare of trainees. Even higher than him in the chain of command, Brigadier Evans also acknowledged his own responsibility saying: "Welfare is a chain of command responsibility from bottom to top, or top to bottom."

13.3 All those questioned about welfare within the chain of command acknowledged that their responsibility extended beyond simply ensuring the privates met the requirements of being a soldier in training and included attending to the wellbeing of the soldiers beneath them.[14]

13.4 Major Gascoigne said during his evidence that the first task of any welfare system was to be able to identify those soldiers with welfare issues at an early stage and the camp needed such a system. In 1995 Deepcut did not have a designated Officer with responsibility for welfare issues. Col Josling told me that he had asked RLC headquarters for a Unit Welfare Officer to be provided but he understood that, at that time, unless a unit was deployable, there was "no case for these welfare people" and so to provide one would be contrary to army policy. He accepted that had there been such a role this would have given welfare of trainees a clearer and more structured focus.

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[13] Vivid evidence as to the culture at Deepcut from the perspective of the staff came from Christopher Dickson, who was able to compare his spell at Deepcut in 1995 as Regimental Quartermaster Sergeant – which began on the day of Sean's death – with his earlier posting there in 1987 as an RAOC weapons instructor before the amalgamation of the different corps. He told me that he was "quite shocked" by the changes, in terms of the freedom soldiers were given and the lack of supervision. There were a lot of minor disciplinary issues which he attributed to Deepcut's "drinking culture". After working hours, he said, it was a "free for all". His observation was that the management systems were poor with a lack of staff and he thought junior staff were not trained to deal with the trainees. Although he thought some of the NCOs were excellent others found it very difficult and Deepcut which he said was not a popular posting.

[14] As one NCO [WO2 Dickson] put it instructors were not there just to deliver discipline and training but to assist with soldier's concerns: "you had to look after the soldier before you could train the soldier".

13.5 The chain of command was the primary channel for dealing with the welfare problems of soldiers, and self-evidently, the more soldiers each officer or NCO was responsible for, the harder it would be to achieve a satisfactory level of welfare support. It is accepted by the MOD that the low supervisory ratio of permanent staff to trainees at Deepcut in 1995 impacted on the welfare of trainees.

13.6 With no formal welfare policy in place welfare support services at Deepcut were provided through the Medical Centre staff, with informal support provided by the Unit Padre and the Women's Royal Volunteer Service ('WRVS').

13.7 Dr Alexandra McClenahan, a civilian GP, was the camp's Medical Officer for part of Sean's period at Deepcut. She said she considered herself the "first line of call" for any form of self-harm or emotional problems.[15] She had a direct line with a community psychiatric nurse at Cambridge Military Hospital and was on the phone to her several times a week. Whilst as a doctor she would be bound by the usual principles of medical confidentiality, she occasionally made formal referrals to the Padre or the WRVS, but mainly the trainees would seek out this informal help themselves.

13.8 Many witnesses spoke highly of Margaret, a volunteer at the WRVS whom trainees found to be extremely sympathetic and approachable. However, one former trainee, Pte Richard Cave, suggested that it would have been well-known that Margaret would not hesitate to speak directly to the person who was causing concerns to a trainee. To some extent this was confirmed by Major Gascoigne whose understanding was that his 2iC would regularly go down to see the doctors, and the WRVS to pick up on any welfare issues that had been brought up with them. Trainees needing to consult someone at Deepcut over a welfare issue may have been wary of divulging their problems out of concern their worries would not be kept confidential in the hierarchical, army environment.

13.9 The NCOs acting as instructors did not fill the gap. Brigadier Coles explained to me that the requirement for being an instructor was capability as a soldier. It was perhaps assumed that a good quality NCO would be a good quality instructor. There was therefore no formal induction or training for the NCOs and neither NCOs nor Officers were given any specific training in looking after the wellbeing of teenagers and young adults. It is telling that when Brigadier Evans conducted a review of systems at Deepcut in December 1995 following the death of Cheryl James he noted a "lack of awareness amongst staff, particularly junior NCOs and SNCOs of the role of welfare agencies" and

[15] WO2 Dickson expressed the view that there were not the resources at Deepcut to give the young people the care and attention they were due. He recalled that Dr McClenahan as the single the camp doctor would comment to him about the magnitude of 'niggling issues' with young soldiers that she had to deal with.

he commented that the instructors were often perceived to treat welfare support as an "unnecessary irritation".[16]

13.10 Major Gascoigne recalled that welfare was a topic on the agenda for general weekly meetings with senior NCOs. Capt Cammack also recalled that a weekly meeting was held with the senior NCOs to discuss that week's training programme. At this meeting any welfare problems could be brought up, although he said this rarely happened.[17]

14. Discipline at Deepcut

14.1 As Brigadier Coles agreed and common sense dictates, discipline is an essential aspect of army life for good reason. Soldiers need to react immediately and instinctively to orders, and not to backchat or question instructions. Units of soldiers all need to work together as a team and it is reasonable to engender collective responsibility for keeping up standards when the life of all could depend upon the actions of one team member.

14.2 Brigadier Coles told me that when he joined the army, he assumed he was going to get shouted at. It would be unrealistic to expect otherwise. I am alive to the possibility that the reports of some ex-trainees of their shock and even disgust at aspects of army discipline may reflect their own discomfort with army life and the required standards rather than being evidence of inappropriate training and discipline methods.

14.3 However it is telling that there was not complete consensus between officers and senior NCOs as to which informal sanctions were legitimate. Major Gascoigne said he approved of extra drill and PT or show parades being used, but he was clear NCOs were not allowed to lay hands on a trainee, scream in someone's face, or overstep the mark in terms of any harassment. He was adamant that extra guard duties should not to be used as punishment and added that the NCOs knew that. WO2 Milne who as the SSM had a key role in instilling standards, considered legitimate sanctions that might be given out informally by NCOs in response to breaches of discipline included ordering a run round the parade square, a small number of press ups or show parades. In contrast to Major Gascoigne, he endorsed giving out an extra guard duty as an alternative to a formal

[16] Brigadier Evans wrote in his report that NCOs lacked understanding of their potential welfare role and "lacked confidence to provide guidance on sensitive issues: particularly … psychological problems". Others suggested that the combination of lack of training, volume of recruits and lack of time meant that the NCOs were simply unable to fulfil a proper welfare role.

[17] Dr McClenahan's recollection that formal welfare meetings were in abeyance by 1995 accords with Brigadier Evans' December 1995 report. He identified that the Padre, Medical Officer and WRVS representative and other staff involved in welfare were working in isolation. He recommended that a welfare group, which might discuss the needs of individual cases, should immediately be established and meet regularly. He further recommended that in future the trainees' induction courses should include lectures by welfare professionals and that soldiers should be left in no doubt as to the support available and be given information about the range of confidential support organisations.

charge report to the OC: albeit he said, this should not be done so as to be "picking on an individual". He said he would never condone the loss of leave. Any physical violence of any sort was wholly unacceptable.

14.4 As a matter of policy, bullying and the abuse of physical strength or of a position of authority were clearly prohibited in the army. Brigadier Coles told me that it should have been known by NCOs that punching, kicking and the use of physical force as methods of discipline were completely unacceptable. However, the MOD accept that in the absence of clear policy setting out a list of standardised punishments and with considerable latitude afforded to NCOs with little interference from their troop commanders, the system was open to NCOs administering physically excessive or overly repetitive punishments that went beyond legitimate sanctions. Brigadier Coles told me there were "undoubtedly" incidents of junior officers and NCOs issuing punishments informally that were not recorded, regulated or authorised.[18]

14.5 The MOD was correct to accept the real dangers of having no clear criteria as to what a NCO can deliver by way of sanction. A system of informal punishments that are not recorded and subject to review, may lead to NCOs in their discretion to go beyond what could be justified as a legitimate sanction, with a risk that the limits of legitimate sanction might be extended to include excessive physical tasks.[19] In the absence of recording of sanctions there was no easy way to establish if a particular individual was constantly being pulled up by NCOs.[20]

14.6 It is not surprising that as a result of the apparent unchecked NCO discretion to deliver informal punishments, a significant number of trainees perceived that their lives were under unsupervised control of the NCOs. This was compounded by an apparent feeling

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[18] Pte Deborah French described Deepcut as a "camp run on fear and humiliation". She had been shouted at and disciplined at Pirbright, but Deepcut was "on a different level". A former NCO, LCpl Christopher Reid, gave similar evidence. He described Deepcut was a "shower of shit…the help given to soldiers and the way that they were treated at Deepcut was appalling."

[19] I have intentionally avoided the use of the term 'beasting'. Whilst used by many witnesses it has an elastic definition. To some 'beasting' described a legitimate albeit informal sanction for minor infringements such as fast drill. Others used it to describe merely being pushed very hard on a legitimate army exercise, to others it referred to an exhausting physical exercise meted out as punishment for a misdemeanour.

[20] A constant theme amongst former trainees was the importance of adopting a strategy to avoid attention. Pte Richard Cave and Pte Thomas Rowlands described the importance of being a "grey man"; getting through without the NCO knowing your name. For Pte Robert Stevens, Deepcut was about "playing the game… it was all about keeping your head down, it was about conforming, it was about not raising your head above the parapet, drawing attention to yourself, and Sean seemed to be the negative of that."

that there was no effective channel of complaint against these NCOs who regulated every aspect of their lives including home leave.

14.7 Numerous former trainees at Deepcut gave evidence that their time there was awful. Pte Allan Drury, for example, described Deepcut as "…intimidating. I felt unsafe, and we did our best to hide. It was structureless, rudderless. It was a big waiting room with nothing to do, to be honest, apart from quick change parades, litter picks, being run ragged, there was nothing -- it was just waiting. We were in a waiting room."

14.8 It is clear that morale amongst many trainees at Deepcut was very low – indeed Brigadier Evans recorded his own finding to this effect after he spoke directly with groups of trainees himself when conducting his December 1995 review. Brigadier Evans' report in late 1995 was frank and excoriating about the problems within the squadron he ultimately commanded.

14.9 He observed the trainees' frustration with the frequent guard duties, their disappointment with the "lack of structured training and overuse of fitness training", their "complaints of skill fade during trade training", their "general frustration with a perceived over-use of minor punishments", and the lack of opportunities for trainees to develop team spirit and unit identity or engender pride. He noted a general perception amongst trainees that B squadron was "letting them down". The result was unsurprisingly an "animosity towards the regime" that trainees openly expressed to Brigadier Evans.

14.10 That animosity, so keenly felt as young adults, has unsurprisingly remained and was expressed by many of those who have given evidence to this inquest 23 years later. It was not limited to those who soon chose to leave or were discharged from the service. A number of those who successfully progressed and were promoted within the army spoke of their Deepcut attachment as the worst period of their army career.

SEAN'S ARMY CAREER

15. Basic training at Pirbright Barracks

15.1 Sean's Phase 1 training began on 3 July 1994. It did not go smoothly. Pte Joanna Scaife, who trained with Sean at Pirbright, told Surrey Police in 2003 that Sean had problems with basic training and with keeping fit. As a result he would get frustrated and angry with himself and would fly off the handle for no reason. She described Sean as having mood swings and recalled seeing him in tears.[1]

15.2 Pte Scaife's evidence of Sean's difficulties at Pirbright is consistent with others. His OC, Major Samuel Porter, recalled that Sean "did have a great deal of trouble, at least initially, in dealing with the army way of life". He believed that Sean experienced a "culture shock" and recalled Sean "not [as] a troublemaker, but someone who needed a lot of help and assistance in progressing through the course." On the ground, Sean's troop sergeant during Phase 1 training, Sgt Peter Wilkinson, remembered Sean as "easily agitated", "irritable" and "unaccepting" of being told what to do.

15.3 Pte Ryan Cook, who was a friend of Sean at Pirbright, recalled him "struggling slightly" with his uniform during Phase 1 training. He and Sean helped each other out. There were instances when Sean became frustrated when "he had done something wrong he would get told off," but Pte Cook did not think that Sean was singled out or picked on at Pirbright, saying "we all seemed to get our fair share". In 2002 Sean's mother was to recall Sean phoning home from Pirbright saying he found the basic training hard but he was enjoying it; he did not indicate any concerns to her.

15.4 Formal assessments of Sean made by his Section Commander, Cpl Tracy Wagstaff, at Weeks 2, 6 and 10 of his basic training paint a picture of Sean generally struggling and finally only just making the grade thanks to improvement towards the end.[2] At Week 10 she recorded that Sean had "struggled with everything and scraped through". Sean had done enough to pass out, as he had passed all of his military skills tests, albeit after

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[1] Pte Scaife recounted an incident when Sean appeared to "flip" and, she said, held Cpl Wagstaff by the throat up against a locker. Cpl Wagstaff made no mention of this event in her contemporary appraisal reports from 1994. When she was asked about this incident by the police in 2003 she said it did not happen as described, although she remembered that on one occasion Sean got up from his bed and pushed past her, causing a locker to rattle, and another time he broke from the ranks on parade and swore at her. She strongly believed if the incident as described by Pte Scaife had occurred she would have reported it and would now remember it. No other witness recalls anything like this happening and it is overwhelmingly likely that if it had happened and been reported, putting hands on a NCO would have been dealt with as a very serious disciplinary issue which may have led to discharge. In the circumstances I cannot accept Pte Scaife's evidence in respect of the specific incident with Cpl Wagstaff.

[2] At Week 2 Sean was described as "undisciplined" "struggling" and "well below average". With "two left feet" and lacking interest and enthusiasm, being "easily distracted". At Week 6 Sean was said to have improved but to be "a slow learner", with poor admin skills and "no self-discipline".

retaking some shooting skills tests. Her prediction was that Sean would "struggle" in the army "due to his attitude to discipline". Her appraisal in 1994 was that Sean should not pass out with the troop due to his lack of determination and ability.

15.5 Cpl Wagstaff's concerns were shared by Sean's troop commander, Lt James Priest. He described an incident where Sean had a "tantrum" following an exercise and stormed off from parade. Two weeks into the training, he wrote that Sean lacked discipline, had no motivation, and found learning difficult. Mid-way through the course[3] the same criticisms were repeated even more emphatically when he wrote: "his personal administration and self-discipline are non-existent". Sean was "doing the bare minimum to survive" and was "miraculously scraping through tests". On reaching week 10 Lt Priest concluded that "Benton is a liability and will need to be watched constantly".[4] He explained in court that he meant by this that if Sean were to progress, "he would need additional assistance and mentoring".

15.6 Despite his struggles and the strongly worded concerns of his section and troop commander, Sean did pass out from Pirbright on 9 September 1994. The decision to allow him to pass out was made by Major Porter who told the inquest that he considered Sean had shown a dramatic change in his behaviour between Week 7 and 10. In particular, Sean had put in such considerable effort during a 'march and shoot' competition it had "astonished" him. As Major Porter put it, Pte Benton may have appeared initially to be a "no hoper", but in fact had shown himself to be a "slow starter" who "took a lot longer [than others] to achieve the standard which was expected." Major Porter described Sean's having passed out as "an excellent example of how, with care and attention, a recruit could improve." He wrote that he "detected a glimmer of hope" that Sean would succeed in the army but ended his written assessment report with the prescient comment "only time will tell".

15.7 Neither Lt Priest nor his NCOs agreed with Major Porter's decision. Lt Priest told this inquest that the shared view was that Sean was of "the minimum military standard" and "would have benefitted from remedial training". He believed Sean ought to have been back-squadded. However, in line with military hierarchy, he accepted his superior officer's decision.

15.8 It is outside the scope of this inquest to judge Major Porter's decision, however some matters are apparent from Sean's time at Pirbright which are relevant to my consideration of subsequent events. First, it is clear that Sean struggled in Phase 1 training both in terms of his skills and his discipline. Second, it appears that with attention and support at the relatively intensive level which Pirbright was able to offer Sean did improve sufficiently to meet the objective standards required to progress. At

[3] On 15 August 1994.

[4] Lt Priest's final report noted that a "bolt of inspiration must have struck Benton somewhere in Week 7 because in the end he managed to pass both critical tests after failing them at the first attempt."

the very least, this indicated he was going to need assistance and mentoring to succeed in the next stage of his army career. Third, the need for this additional attention and support was recognised and recorded by his Pirbright Troop Commander at the time.

15.9 Such information was of course only useful if it was heeded and acted upon by those responsible for Sean's future progress and welfare. However, Sean's ongoing need for support does not appear to have been noted until February 1995 when Sean had failed his trade training as a driver for a second time, seriously compromising his career prospects in the army.

16. Phase 2 training at Deepcut

16.1 Sean commenced his Phase 2 training at Deepcut on 12 September 1994. The available documents do not establish to which troop Sean was allocated and the relevant NCOs and junior officers do not have a clear recollection. It seems likely that he was initially allocated to 1 Troop under Sgt Gavaghan.[5]

16.2 Although the difficulty in resolving to which troop Sean was allocated is partly a product of the passage of time, the very fact that such confusion exists is itself remarkable. It is a measure of the disorganisation at Deepcut and the lack of ownership and feeling of responsibility NCOs and officers felt for the soldiers nominally under their command. The ratios of NCOs to trainees meant NCOs were rarely able to know their soldiers as individuals. Lt Radford commented on the impact of the sheer numbers at Deepcut: when trainees met with him for their 'exit interview', he would have to ask them for their names so he could then retrieve their personnel file.

17. Information passed on to Deepcut from Pirbright

17.1 Major Porter was of the view that the staff at Deepcut should have been aware from the written reports in his file that Sean "did have a lot of issues". The recruits' files would follow them to the Phase 2 training location, but there was no verbal handover and he could not recall any occasion where those at Deepcut had reverted back to Pirbright staff for further information.

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[5] Sgt Gavaghan said he thought Sean was never in his troop. This was based on his first recollection of Sean being in January 1995, when he encountered him crying on the drill square. However it appears likely that Sgt Gavaghan was mistaken and Sean initially joined 1 Troop under Sgt Gavaghan and latterly Lt Delap and was switched to 2 Troop under Sgt Stevens and Lt Radford in March 1995 around the time a three month warning order was initiated. Sean's application for leave was authorised by Sgt Stevens of 2 Troop by Spring 1995 confirming that by then Sean was in 2 Troop. Sean's earlier period in 1 Troop was supported by Pte Claire Hodgson who remembered a time when she was in Sgt Stevens' 2 Troop whilst Sean was under Sgt Gavaghan in 1 Troop. Pte Adele Taylor also recalled Sgt Gavaghan being both her and Sean's troop sergeant.

17.2 In any event, Major Gascoigne told the inquest that, even if these reports from Pirbright had been noted,[6] they would not necessarily have led to Sean having any extra support at Deepcut. Major Gascoigne told the inquest that there was a general feeling at the time that the standard of troops coming out of Phase 1 training was not as high as it should have been. Nevertheless the approach at Deepcut was to regard anyone coming from Phase 1 training as having reached the required standard and so, however much they may have struggled at Pirbright, having achieved the level to reach Phase 2 they were not provided with any additional assistance. Major Gascoigne explained that the staff "would have carried on doing business as normal" and if the lieutenant had been aware that Sean had a bad report from Pirbright, "he might well have kept an eye on him but he would not have been given additional resources."

17.3 It is remarkable that important information about trainees' progress in basic training and their likely future needs was not used to inform their subsequent management in later training, particularly when Sean then struggled with his first stint of trade training. No NCO or officer from Deepcut recalled having any knowledge of Sean's difficulties at Pirbright before February 1995, by which time Sean's difficulties with training, discipline and temperament were being actively manifest.

18. Sean at Deepcut: September 1994 to January 1995

18.1 Sean's initial few weeks at Deepcut appear to have been uneventful. In common with other trainees he was waiting for a place on a driving course. It is clear that Sean had a social life at Deepcut and made some close friends, including Pte Ryan Cook who came with him from Pirbright and others who were still part of his social circle at Deepcut at the very end of his life. There is no doubt that Sean was an engaging personality. Pte Claire Dilkes described Sean as caring and loving and someone who never saw any bad in anybody. He liked to make people laugh and at times could not resist the temptation to try to do so. A number of fellow trainees described how they spent social time in the NAAFI or local pubs with Sean who they saw as a "likeable rogue", a "fun lad" and a "joker". Pte Victoria McKinlay described Sean as a "character", "naughty but not outrageously naughty", "cheeky but not harmful" who "could give as good as he got". Cpl Kevin Walton remembered him as someone who was a "cocksure young lad" who was "good humoured" and said things to impress others and liked to have a laugh.

18.2 There are two anecdotes I found particularly striking. The first came from Pte Richard Lamine, who said it was a "standard joke" that Sean would be disciplined on parade:

[6] Lt Sarah Delap took over 1 Troop in January 1995. She described how the trainees' first week's induction programme included a short interview with the Troop Commander. Whilst she would look at the trainees' files, however, she did not induct Sean into Deepcut as his arrival had pre-dated hers. She told me that the sheer numbers of trainees at Deepcut meant she would not have been able to look at the files of trainees who were already at Deepcut when she arrived: although her predecessor may have done so. The other troop commander, Lt Michael Radford, is unlikely to have had any need to review Sean's personnel file until Sean later became his responsibility when he was transferred into Lt Radford's troop in March 1995.

"The one evening we were all lined up and Sean just walks into the muddy puddle and he starts marking time and his comment was "Well, I am going to be here anyway aren't I?" Or another time when Gavaghan walks out and he shouts "Benton" and Benton just comes straight out and starts marking time. I think some of it he probably took a bit of a happy role that he was a bit of the class joker." I was also struck by Pte Russell Uridge's story of Sean turning up for a group punishment in completely the wrong uniform and saying to a "flabbergasted" Sgt Gavaghan, "It is because I am colourblind, Sergeant". The other trainees "erupted with laughter". It led to Sean unsurprisingly being "singled out for gobbing off".

18.3 Sean was soon posted to Leconfield to undertake his first driver training course on 6 October 1994. Unfortunately he failed to pass the course. Leconfield reports from 10 November 1994 recorded that it was not felt that Sean would make the required standard. He was said to have "worked hard" but his progress on the course had been "too slow to reach test standard within acceptable limits". It was nevertheless thought that Sean still had potential to meet the standard and a training break was recommended.

18.4 Sean therefore returned to Deepcut around 15 November 1994, to await a second driver training opportunity. Sean had taken a short period of leave from 4 to 6 November 1994. He applied for and was granted a second period of home leave between 20 December and 28 December 1994. It seems that this leave may not have gone as well as he may have hoped, as he later reported to doctors that he had had some rows at home at Christmas.

18.5 When Sean returned to Deepcut for the New Year his good friend Ryan Cook had moved on to his unit. Sean clearly missed his friend as he mentioned his absence as still being on his mind some weeks later.

18.6 By 23 January 1995 Sean was back at Leconfield for a second attempt at driver training. On the second day of the course, he failed, apparently after losing his temper with his instructor and storming out of the cab in a "distressed and emotional state". The supervisor's report from 24 January 1995 stated that Sean had "the wrong attitude for HGV driving". The superintendent endorsed this report, writing that "this student seems emotionally unstable…his reaction to frustration is unstable causing him to react in a way that could be a danger to himself and other road users". The OC at Leconfield consequently deemed Sean to be "unsuitable for further driver training" as he was "not stable enough". This would inevitably put Sean's future in the RLC in jeopardy.

19. Transfer to Pioneers

19.1 Sean returned to his unit at Deepcut in late January and was interviewed by Major Corby, the Senior Personnel Selection Officer of the RLC who interviewed all soldiers for reallocation. Sean was told that he could not now continue in the RLC as a driver. The only options were to be discharged from the army or to become a Pioneer, a role

that Sean saw as far less prestigious than HGV driving. When Sean became emotionally upset, Major Corby asked Capt Cammack to see him.

19.2 Capt Cammack said that it was unusual for Major Corby to make such a referral to him. This was the first time he had met Sean as he had not had any disciplinary problems that had brought him to his attention previously. He then read his personnel file and noted the comments from Pirbright, which he agreed revealed someone who had struggled in basic training and was still failing at Deepcut. Nevertheless he saw his role as only to find out if Sean agreed to be a Pioneer, and if so make the practical arrangements for Sean's change of trade. He said it did not appear to him at the time that Sean had any real welfare problems. When asked how he knew this Capt Cammack told the inquest that he saw that Sean's record contained no disciplinary offences and beyond this could "only go on" what the instructors had written and Major Corby had told him.

19.3 Capt Cammack's comments are perhaps revealing of his attitude to welfare at the time. However, it is also apparent that around this time, on 2 February 1995, Sean attended the camp's locum Medical Officer, Major Gen Shaw, and discussed his emotional state. A reasonable inference from the contemporaneous entry in the medical records is that Sean did not present to this doctor on his own initiative. The entry commences "Interviewed because of his failure at Leconfield". This attendance could well have been prompted by a referral or advice from Major Corby or Capt Cammack that they now do not recall. Major Gen Shaw recorded that Sean was "emotionally upset by separation from best friend (also arguments with family over Xmas leave). Admits to short fuse. Very keen to continue as driver. No psychiatric disturbance - Emotionally labile and quick temper."

19.4 There is nothing to suggest that any additional attention or support from the medical centre or his troop was offered to Sean at this stage.

19.5 Six days later Sean injured himself when he broke the glass in a door at Deepcut.

20. Broken glass and injury: 8 February 1995

20.1 On 8 February 1995 after an evening spent in the NAAFI Sean was returning to his accommodation with Pte Ian Firth and Pte Tammy Jobling. In Pte Jobling's statement made the following day she described how Sean had been drinking heavily and was "mouthing off" saying he did not want to be a Pioneer, only a driver. A group of Pioneers heard and retorted there was nothing wrong with being a Pioneer. Sean then kicked the glass panel in the door of the accommodation block, and walked through what was left of the broken frame still in the glass[7]. She went to fetch the Guard Commander, Sgt Stevens.

[7] Pte Firth also described events in a statement he wrote in 1995 which confirm Pte Jobling's account. He said that Sean had been cheerful at the start of the evening but later said he felt depressed about

20.2 Sgt Adrian Stevens recalled being on duty when told that Sean had "tried to kill himself". He came to see Sean who was by then lying on his bed, bleeding from a cut on his neck[8]. Sean appeared to be drunk and angry, and he was crying. Sgt Stevens persuaded Sean to come downstairs and took him to the guardroom. As they walked Sean told him he did not want to live if he could not be a driver in the army and he had "had enough".

20.3 After receving first aid at the Pirbright medical centre Sean was placed on 15-minute observations in a guard room cell overnight (this was the usual observation protocol for drunk soldiers at the time). Although it also seems that Sean had been rostered on guard that day but had not attended Sean was not charged with any disciplinary offence for intentionally breaking the window on 8 February 1995. Instead Sean was referred back to Major Gen Shaw who in turn referred him to a psychiatrist. I shall discuss this referral and the consequential psychiatric assessments later. I only note here that the formal report from the psychiatrist did not come back until 17 February 1995; in the meantime on 9 February Major Gen Shaw had not detected any psychiatric illness himself and he recorded that he had therefore impressed upon Sean's Squadron officers his own opinion that Sean's future should be "resolved by management rather than medicine". It seems that this is largely what happened.

21. Insubordination charge: 13 February 1995

21.1 On 13 February 1995 Sean was sitting outside the Troop office when Sgt Gavaghan walked past. Sgt Gavaghan told the inquest that he heard Sean being told by someone inside the office to put his beret on and he also had reinforced that instruction. Sean responded by calling Sgt Gavaghan an "arsehole". Sgt Gavaghan told the inquest that he saw that Sean was emotional and was crying. However as others nearby had heard the insult Sgt Gavaghan felt he could not let it go and so he told Sean he would have to charge him. This led to a formal charge of 'using insubordinate language to a superior officer' being laid.[9]

21.2 One of Sean's fellow trainees Pte (later Captain) Robert Stevens, although a trainee at the time, was assigned to work in the B squadron offices while he recovered from an injury. He was aware that Sean had been psychiatrically assessed. He recalled this period saying that it had been "widely thought that [Sean] was psychologically unstable or unsuitable for military life". He described how Sean was 'gobby' and would answer

becoming a Pioneer and had been crying. Pte Claire Hodgson also said that she witnessed the event. Sean told her he did it because he "felt like it".

[8] Sean's cut was attended to at the medical centre. It was "not very deep" so it was just dressed with steristrips.

[9] The charge was heard by Capt Cammack on 14 February 1995: Sean was found guilty and fined £156 with 7 days restriction of privileges. Aside from an earlier fine issued for losing his military ID card in January 1995, this was Sean's first service conviction.

back and draw attention to himself, but that this was accommodated to a certain degree by NCOs who tolerated and dismissed some of Sean's back-chatting until he was psychologically assessed. At that point he felt Sean was no longer given any leeway and the toleration of his behaviour ceased.

22. Pioneer allocation

22.1 Whilst it has proved an impossible task to put an accurate timeline on some of the events involving Sean, the general tenor of the evidence is that Sean's time at Deepcut before Christmas 1994 was unremarkable but there did come a time when he began to struggle more obviously and this probably coincided with his failure of his driving test and the planned transfer to the Pioneers. Before then Sean does not seem to have particularly featured in his parents' or any NCO's mind as a cause for concern.

22.2 However, Sean was adamant that he wanted to stay in the army despite his driving failure and by mid-February 1995 he had agreed to become a Pioneer. An allocation form was completed on 15 February and shortly afterwards a Movement Order was signed by Capt Cammack that should have led to Sean leaving Deepcut on 27 February 1995 to be posted to the Pioneer Trade Training Base at Albermarle Barracks, Newcastle-upon-Tyne. However, because of subsequent events, Sean never did leave Deepcut.

23. Access to weapons from 8 February 1995

23.1 A direct consequence of the psychiatric referral on 9 February 1995 appears to have been that, for a short period, Sean was not permitted access to a weapon. There are no documentary records of this decision, but a number of witnesses including fellow trainees and NCOs had some recollection of this.

23.2 At the time, as Brigadier Coles told me, there was no policy requirement for a soldier, who had committed acts of self-harm but who had not been medically downgraded, to be formally risk assessed in terms of their access to a weapon. While such action could have been taken in the absence of medical downgrading, it was a matter for the discretion of the chain of command. The MOD has accepted that the issue of access to weapons amongst those at risk of self-harm should have been formally clarified as a matter of policy, and that there should have been a codified process that would be followed. In the absence of a policy and codified process, there was a risk of confusion in terms of who should take the lead in considering such precautions.

23.3 Lt Col Josling told me that either a person was fit for duty, and fit therefore for guard duty, or they were not. In other words, if there was any reason why they were not fit to conduct guard duty, including access to weapons, then by definition they should not be fit for training. Nevertheless SSM Milne told Surrey Police in 2003, and clarified at the inquest, that, on learning that Sean was to have a psychiatric assessment "as a safety

measure," he issued an order that Sean should not have access to firearms when conducting guard duty. It is likely that this decision followed representations from the Regimental Police ('RPs'). Sgt Patterson and Cpl Campbell, both RP staff, gave evidence that they had approached the squadron asking that Sean should not do guard duty because of concerns they had about Sean's stability.[10]

23.4 The SSM could not recall giving such an instruction on any other occasion. As there was no formal process for this, the order was not recorded and he could not now recall when or how the order came to be rescinded but believed it was a response to the psychiatric assessment. Whilst the detail remains unclear, I find it likely that Sean was temporarily removed from guard duty in early February pending the psychiatric assessment. It is unclear whether Sean remained off guard until after his second psychiatric assessment in April 1995. One handwritten document of unknown provenance which accurately records Sean's leave dates in 1995 does suggest that he did no guard duties between 10 February and 20 April 1995.

23.5 In any event it would appear that Sean was back doing guard duty with full access to weapons by 1 May 1995.

24. Second broken glass and injury: 22 February 1995

24.1 From the feedback from Sean's psychiatric assessment on 9 February 1995 it was understood that Sean had no psychiatric illness and so should now be subject to normal disciplinary measures. This seems to be what happened.

24.2 On 22 February 1995 there was a second incident[11] when Sean broke a window when drunk. He was said to have kicked a window in the accommodation block, breaking two panes of glass, injuring his shin in the process. He was formally charged with wilful damage to property and drunkenness and was remanded.

24.3 Both of these incidents in February 1995 were deliberate acts by Sean fuelled to a great extent by drink. These incidents echo Sean's having deliberately damaged a glass

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[10] It seems that in any event, the need for manpower could override such an informal instruction. Cpl Campbell, a provost corporal at the guardroom, stated that that there was an occasion when Sean was sent to the guardroom to go on guard. Because of his concerns about Sean being a "problem child" as he described it, Cpl Campbell contacted Cpl Jarrett to ask what was going on and why was Sean there? Cpl Jarrett had come back to him having spoken with someone to say that Capt Cammack was aware of the situation, they were short on manpower, so Sean would be on guard. If Cpl Campbell was not happy with the situation, he could stag on himself. Cpl Campbell then issued Sean with a wooden pick helve rather than a firearm. Cpl Campbell located this incident some months before Sean's death.

[11] Whilst some ex-trainees reported rumours that Sean had been thrown through a window at Deepcut this suggestion has not been corroborated by any eyewitness and I do not accept that it happened. Earlier interviews with Sean's parents reveal that in 2004 they understood Sean to have told his sister that he had kicked in the window, and hurt his leg. His cousin had also understood from Sean that he had put his foot through a window.

window, whilst drunk, in Hastings on his 18th birthday, before he joined the army. They appear to have been impulsive acts linked to anger, frustration and disappointment. Although Sean was injured in both incidents, neither episode reflects any true suicidal intent. As Professor Gillian Mezey, the psychiatrist instructed by Sean's family, has stated – Sean was prone to show extreme emotional responses and his self-harm was impulsive and linked to alcohol consumption[12].

25. Three month warning order: 6 March 1995

25.1 The charges arising from Sean's actions on 22 February 1995 were heard on 6 March 1995. Sean was convicted, sentenced to ten days detention and was released on 15 March 1995.

25.2 Sean told his family about this punishment when he went back to Sussex for a few days leave in mid-March 1995. What Sean did not share with his family at the time was that on 6 March he was also issued a 'three month warning order' signed by Lt Col Josling. This is a disciplinary tool issued as a warning regarding the power in the Queen's Regulations to discharge an unsuitable soldier. The soldier is warned that if their efficiency, conduct, indebtedness[13] or drunkenness does not improve in the next three months, an application will be made for his or her discharge. The document Sean signed also warned him that any breach of discipline will result in an immediate application for the soldier's discharge. As Major Gascoigne put it, this was now a last chance for Sean.

26. Review of Sean from March to June 1995

26.1 It was decided Sean should not be transferred to a fresh unit during the currency of the three month warning order and so Sean's Pioneer training was now postponed. A disaffected young soldier was now required to remain waiting at Deepcut for the next three months at a time when the camp offered very little daily routine or structure, and without any expectation that he would be undertaking any specific training in that period.[14]

26.2 Major Gascoigne told me that although the three month warning order meant Sean would not be training, he was not to be ignored. He thought that "the NCOs would

[12] Such impulsive and potentially dangerous behaviour occurred at other times. Pte Robert Gasson told me that Sean would boast of and demonstrate climbing out of windows and abseiling down the building, saying he once hurt his leg doing this to avoid being caught in the women's accommodation block. He also recalled Sean throwing all his money away on fruit machines, which he felt was in order to be the centre of attention.

[13] The option to warn for indebtedness was deleted on Sean's warning order.

[14] From a later letter to his grandmother in early June, it appears that Sean was expecting to go to Catterick at the end of June when the 3 months would have expired.

have been well aware that he needed to be looked after and looked after as a case that was highlighted to them and in the forefront of their minds at the moment". His recollection was that Sean was discussed more than anyone else at Deepcut, and that discussions were ongoing about Sean "every week" during this time. He told me there was a mechanism in place for ensuring Sean was not just left alone, but that there was feedback on what was going on. However in the absence of records few witnesses in Sean's direct chain of command appear to recall anything remarkable about that feedback.

27. Sean's subsequent deterioration

27.1 A common theme from the evidence of former trainee colleagues of Sean at Deepcut was that they observed a change in him as time went on. The standard of his kit, which had never been immaculate, dropped further and his tendency to answer back increased, making him a larger target for discipline. Recollecting this so many years later many could not now put timings on events but some located the change around the time of Sean's second driver training failure and Pioneer allocation. The ex-trainees painted a picture of the lighter side of Sean's personality becoming less evident. As Pte Glyn Boswell, a former trainee who used to drink with Sean, put it, he "was not as bubbly as he used to be". Pte Pankhurst who was at Deepcut from November 1994 described Sean as initially being happy and often laughing but that as time drew on he laughed less and "towards the end he started closing in on himself, his kit started to suffer. He just stopped caring".

27.2 Both Pte Neil Williams, with whom Sean bonded strongly and to whom he wished to leave his football shirt after his death, and Pte Drury were at Deepcut during Sean's final five weeks. Pte Drury told me Sean's kit "was not too clever" and he would look bedraggled and scruffy. He looked under pressure, like somebody who "had his cards marked". Pte Williams said that even though he only knew Sean for five or six weeks, he could see how his appearance "deteriorated over that time, so he put a lot less effort into his clothing and less effort into himself and his own appearance." Towards the end he had severe dandruff and would smell. Pte Claire Knowles recalled being in Deepcut in April and May and said "when I very first met [Sean] he was quite smart and by the end of it he kind of had given up…there was no point because he was going to get pulled up about his shirt anyway, so he didn't bother as much. He wanted to prove himself and obviously it didn't work for him. You'd often see him crying. In between crying, getting upset and losing his temper."

27.3 Some NCOs also noted this change. Sgt Stevens told the inquest that he spoke to Sean several times after his Leconfield failure and he seemed "slightly depressed": he put this down to Sean's failure as a driver. His impression is echoed in the evidence of Cpl Walton who was a military skills instructor based at Deepcut for some of the same period as Sean. He described Sean as initially happy and enthusiastic about the army, but after the failure of his driving test he saw Sean lose interest and his attitude changed, which he thought caused problems for Sean from that time forwards. Cpl Walton

remembered Sean's appearance worsening and that his time keeping suffered; he was late for parades and he drank more. Cpl Walton recalled Sean being given more guard duties and show parades because of his indiscretions. He did not think Sean was particularly singled out, but rather felt his misdemeanours were picked up as they would have been for anyone else. Although Cpl Walton thought Sean brought problems upon himself, he nevertheless felt that Sean "had it in him to be a soldier, but needed to understand himself a little bit better". In his view Sean "had fitness, he had confidence, [and] you don't need much else to be a soldier at that stage, apart from the ability to be able to listen to what you are being told to do and then go about doing it".

27.4 Capt Cammack recalled that at the weekly OC's "prayer" meeting he would ask "How is Sean getting on?" and, as there was nothing really raised, he understood that Sean seemed to be getting on all right. He said he had, however, heard about Sean being a bit dishevelled on parade, and being reprimanded and given show parades at the guard room but his recollection was that Sean "accepted it, there was no adverse come back."

27.5 It was not just those at Deepcut who noted the change in Sean. Looking back at events later in 2002 and 2003, Sean's mother told the police that it was around February 1995 that she noted Sean changed. He phoned home less often and when he did he complained that Deepcut was "boring and repetitive". In one phone call in Spring 1995 Sean told her he had been asked by an NCO whether he needed to see a psychiatrist. She said that she did not think Sean sounded any different or overly concerned at the time.

27.6 Major Gascoigne however said that he was not aware of the deterioration in Sean's mood that others now report. He said that had he known that Sean was not coping he would probably have said that the three month warning period should not continue and that Sean should be discharged. However one month into the warning order period on 11 April 1995 Sean took an Anadin overdose and was admitted to hospital. Whilst I shall set out my findings regarding the detail of this event later, the contemporaneous medical records show that there was a discussion about this episode between the camp medical officer, Dr Alexandra McClenahan, and Major Gascoigne on 13 April 1995. This was then followed by a letter from Dr McClenahan to Major Gascoigne on 26 April 1995 telling him that the psychiatrist's opinion was that Sean had an immature personality and that he was "unsure as to whether [Sean] would be able to continue army life."

27.7 It is notable that despite Sean also being on the warning order, this psychiatric assessment did not appear to have triggered a full review of Sean's position by the chain of command. Major Gascoigne said it was "very unusual" for someone to take an overdose at Deepcut at the time. He explained that because the overdose was not a disciplinary issue and Sean "had not punched anybody or got into a fight or kicked any

windows or anything like that" the powers to make a discharge application for a soldier who was considered to be either unsuitable or inefficient were not invoked.[15]

28. Transfer to 2 Troop: March 1995

28.1 Having been placed on a three month warning order Sean was transferred to Lt Radford's troop, as a transfer of squadron normally accompanied such an order.

28.2 Lt Radford also suggested to me that he personally reviewed Sean regularly during the currency of the warning order and that he produced weekly written reports about him.[16] These documents were not mentioned at the original inquest or the BOI and no trace of them exists. Given the warning order was extant at the time of Sean's death, and the nature of his death, it seems remarkable that such important documents would not have been preserved and placed in his personnel file. Given the informality of every other welfare structure I am not persuaded that there ever was a weekly written assessment of Sean.

28.3 Lt Radford anyway told me that he did not feel Sean's mental welfare was something he was able to monitor as this would "manifest itself in the quieter periods of the day when I would not be present". He did not recall seeing a deterioration in Sean's appearance.

28.4 Beyond his review, neither Lt Radford nor any other witness from within the chain of command could explain to me what methods, structures or plan was put in place to assist Sean to succeed, save for the use of normal disciplinary sanctions.[17]

29. Practical assistance provided to Sean

29.1 However it is evident that, as a high maintenance trainee whose standards were not up to scratch, there were rare occasions when Sean was provided with extra support. Sgt Gaynor Pike, who worked in 2 Troop for a brief period, was someone who would have "informal chats with Sean about his personal admin and ask him about his welfare". Whilst she did not think she did anything special for Sean but just helped him out as she would anybody else, she clearly made some impact on Sean, as he asked for her to be thanked in one of his final letters.

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[15] The CO had this power under Queen's Regulations 1975, para 9.405.

[16] Pte Robert Stevens recalled that there was a time when Lt Radford was asked to oversee Sean.

[17] Cpl Holder, for example, said he was first aware of Sean Benton as a "problem child". (The same phrase that had been used by Cpl Campbell.) He described Sean as one of the recruits whose "standards were lacking, their discipline was not up to the achievements of a soldier that they were expected to be". Sean was not unique and there were maybe 10 or so trainees in each troop like this. The consequence of their standards being lacking was they would be "picked up": extra show parades, repeat room inspections.

29.2 One vivid example was given by Pte Raymond Rowlands who recalled Sean getting a telling off from Sgt Russell for not having a properly ironed shirt. What happened next was that Sgt Russell took Sean away and showed him with one-on-one tuition how to iron a shirt properly. When Sean came back he was praised by Sgt Russell and Pte Rowlands saw that it "totally lifted him and he was buzzing for a couple of days". Sgt Russell is another of those specifically thanked by Sean in one of his final letters.

29.3 This anecdote is striking partly because it is so exceptional. As a result of the ratios of NCOs to trainees at Deepcut, support at this level is bound to have been very rare. Poorly turned out trainees are far more likely to have been subject to reprimand and sanctions rather than actually being helped to become better soldiers.

29.4 Cpl Fairhurst, who worked in administration in the stores, recalled that Sean would often have poor turn-out or mess about and so get picked out of the parade. He thought that Sean was not picked out alone as an individual, but that he was one of a group of trainees who would mess around. He said there were occasions when he would speak to Sean and try to give him "fatherly advice" about stopping messing about and on one occasion Sean had told him he felt he was being picked upon. Cpl Fairhurst gave advice to Sean about how to improve but he felt that Sean either did not listen or could not control himself.

29.5 Cpl Holder's evidence perhaps exemplified the more common approach of Deepcut NCOs – that this was simply not their role. As he put it, in the second stage of the army training NCOs were "not going back to basics again and showing them how to iron their kit and how to brush their boots. They have got that, they have passed out from Phase 1, they know how to be a soldier, they know the standards set to be a soldier on parade. It is not in the army curriculum to go back again and re-teach. That is why you use the people around you to enforce teamwork and help someone when they are not as good they need extra help."

29.6 Some NCOs took the view that the one of the most appropriate source of support for struggling trainees was other trainees. I was told of the 'buddy-buddy' system when, before a parade, trainees would check over each others' uniform, taking off fluff or loose hairs to make sure each others' turn-out and kit was the highest level ready for inspection. Sean would occasionally be given help with his kit by his roommates, such as ironing or shining his boots. However the overall tenor of the evidence is that even with help from fellow trainees Sean's standards still fell short.

29.7 Cpl Barrow recalled Sean as someone who "lacked discipline, he was late for parades, poorly turned out and his sleeping area was generally in bad order and he had emotional problems". He explained in court that there were reports from troop staff that Sean had been crying, self-harming, and had been referred for psychiatric assessment. He agreed that it was clear that the NCOs were aware that Sean was in tears more often than other recruits. Cpl Barrow commented that in his view the NCOs' demeanour showed a "lack of empathy" to Sean, from individuals and from "the system in general". Cpl Barrow

agreed that what Sean needed was support, but what he received was NCOs complaining about his appearance and his bed inspections.

30. Guard duty and leave

30.1 A number of former trainees perceived that Sean was allocated to guard duty more than others.[18] However this is not supported by the available documents. Copies of guard rotas for most of May 1995 are preserved and Sean's name appears on Monday 1, Tuesday 9 (as a reserve), Wednesday 17 and Saturday 20 May. In addition, a document of unknown provenance found in the records collated by Surrey Police suggests that Sean did no guard duty between 10 February and 20 April (until after his second psychiatric assessment) but then, in addition to the above dates, also did guard duty on 20 and 24 April, Wednesday 31 May and Saturday 3 and Monday 5 June. These latter three dates are likely to be accurate as they correspond with information from a letter Sean posted to his grandmother two days before his death.[19] The guard orders for 8 June 1995 show that Sean was allocated to the reserve guard that day.

30.2 According to his mother Sean would rarely come home on leave and he would tell her that this was because of guard duty. Sean did however have periods of leave in November 1994, over Christmas 1994, briefly in March 1995 and from 13-18 April 1995. A leave request for 11 – 18 May appears to have been refused, but Sean did have leave which allowed him to return to Hastings over the bank holiday weekend between Friday 26 and Tuesday 30 May. Comparing the frequency of Sean's guard duty with which other names appear on the guard rota, and bearing in mind that Sean was at this stage not otherwise occupied with trade training, the evidence does not support the suggestion that Sean was on guard duty overly frequently or was disproportionately allocated to weekend duties in the period approaching his death.

31. Sanctions and Sean

31.1 Many trainees felt the best way to get through Deepcut generally was by keeping their heads down and attracting as little attention as possible from the NCOs: becoming a "grey" person to avoid getting into trouble. Sean was anything but grey: many witnesses commented that Sean failed to follow advice from fellow privates "to keep his head down". Some would whisper to him on parade to be quiet, hoping to curb Sean's habit of answering back. A number of trainees gave evidence of perceiving that they ought to

[18] For example Pte Michelle Burgoyne, whose evidence was read, told Surrey Police he appeared to do extra duties.

[19] Sean wrote: "I've been on guard day on, day off, since Saturday and I'm bloody tired. Blackdown is still crap."

keep their distance from Sean for fear that being associated with him could lead to them being targeted for sanctions.[20]

31.2 It is clear that there were times when Sean complained vociferously to family and friends about the culture of Deepcut. He reported home that it was "crap" at Deepcut, it was "doing his head in" and he wanted to get away. He was however clear to his mother that he did not want to leave the army. When she asked him directly if he was being bullied when he was at home over the last weekend in May, Sean specifically denied this to her. He confided in some privates with whom he had built up close relationships and told them that he could not wait to leave Deepcut. This was not unique to Sean. Many shared this view.

31.3 Pte Claire Hodgson said Sean was "struggling and getting into trouble on a daily basis". She thought he partly brought this on himself because he would answer back. She said she encouraged him to be quiet and not to draw negative attention on himself, but he did not. She felt "it was part of his nature".

31.4 Pte Williams described Sean as taking on the role of "class clown" and he would particularly "play to the crowd" with the new recruits. He saw Sean be the "butt of the NCO's verbal abuse" as a result, but never saw his friend physically assaulted. The inevitable consequence of sloppiness or back-chat on parade would be informal punishments of show parades and "beastings" handed down by the NCOs. Much of this may have been legitimate sanctions to deal with unacceptable low level indiscipline. It is unsurprising that it appeared to others that Sean was singled out disproportionately.

31.5 There is no doubt that Sean was on the receiving end of many informal punishments from various NCOs simply because he was struggling and he failed to comply with requirements as to his kit and/or conduct. Sean's tendency to make joking comments or to answer back brought additional adverse attention upon him. To some trainees, who noted the frequency with which Sean was picked up, these sanctions were perceived as part of a deliberate policy to both target and humiliate him.

31.6 However, the evidence does not confirm that. I am not satisfied that there is sufficiently probative evidence that there was any informal policy, agreement or plan amongst the NCOs in general to target Sean for sanctions.

31.7 That is not to say that Sean was not frequently pulled up and disciplined; and even legitimate sanctions, if used frequently and repetitively, will become excessive and oppressive. Brigadier Coles acknowledged, that there was considerable latitude afforded to NCOs at Deepcut camp and the absence of a clear policy setting out what were

[20] Pte Gasson recalled a specific example of how he was required to attend a show parade with Sean because he was standing next to Sean when Sgt Gavaghan identified a painted over scratch on Sean's belt buckle.

acceptable informal sanctions meant that in some cases the frequency and severity of punishments strayed beyond what was appropriate. The impression of many ex-trainees is that this is what occurred with Sean.

31.8 Whilst I do not accept that Sean was being intentionally victimised by the NCOs in general, the NCOs' frequent meting out of informal punishments, unchecked and unmonitored by those in the chain of command, contributed to the toxic culture of Deepcut in which Sean was overly frequently the recipient of sanctions.

32. Alleged attack on Sean by other trainees

32.1 On occasions at Deepcut all trainees would be punished for the shortcoming of one trainee, with the entire troop completing a sanction together, such as extra PT runs or parades. Pte David Hirstwood described the effect of this saying "when it's constantly you and then the whole troop's being made to run down the bottom and back because of you, you're not very popular at all, and when that happens over and over again, your popularity just isn't there, so you do feel quite isolated and persecuted. I wouldn't blame the NCOs on that, because I don't believe there were enough of them."

32.2 I acknowledge that when training young soldiers, the sense of collective responsibility instilled in trainees by team discipline and collective punishment could lead to constructive and supportive behaviour. Whilst such techniques were aimed to generate collective responsibility it also risked individuals being disliked by those who had punishments unfairly vested upon them.

32.3 Pte Trevor Hunter told me how anyone not up to standard would be seen as the "weak link" and be treated differently from the rest unless they conformed with what was required. If they did not their lives "would be made a misery", and that is what he believed happened in Sean's case. Pte Claire Hodgson said she recalled that other trainees used to pick on Sean because they were living in communal rooms and subject to inspections and "if things were not done correctly or you had not pulled your weight, you were going to be in for it…Sean didn't pull his weight. He didn't see why he had to pull his weight…So he made himself a target for that." She did not however see anyone physically assault Sean nor did Sean report an assault to her.

32.4 Many trainees stated that they had heard rumours of the existence at Deepcut of a group of trainees who targeted underperforming trainees for beatings. Most knew only of the rumour but had not seen this gang who were said to disguise themselves with respirator masks. However a handful of witnesses did give direct evidence of their activities including being attacked by or being part of such a group.[21]

[21] Pte Alan Lonie recalled one occasion when he heard shouting and seeing some recruits who were wearing gas masks going into a bedroom: it looked to him like they were going to give somebody a beating with a tube filled with sand. He followed them into the room and managed to stop whatever was going on. Pte Lonie did not suggest this incident involved Sean.

32.5 Pte Richard Cave, a trainee at Deepcut during the first half of 1995, gave evidence that he was attacked at night by a group of five masked men. He was in his sleeping quarters that he shared with Sean and woke feeling his chest compressed and someone on top of him beating him. Words spoken by one of his assailants at the time suggest that they had mistaken Pte Cave for another. However, I cannot conclude that the intended target was necessarily Sean, nor am I in a position to decide who the perpetrators were given the circumstances and the risks of false identification. However I do accept that the incident occurred which, taken with the additional evidence that I discuss below, confirms the existence at times of such groups who appear to have carried out these cowardly attacks upon those who were perceived as weak links.

32.6 Pte Hunter did recall Sean telling him that he had been assaulted in his room by a group of people wearing respirator masks and the suits issued for protection from chemicals. Sean told Pte Hunter that he had been asleep in bed and woken by the gang. He told him he had cried after the beating. Pte Hunter said he had had not heard of this happening to anyone else at Deepcut and Sean only told him about it happening that one time.

32.7 In court, Pte Hunter recalled being alone at a pub with Sean when he was told of this attack. When reminded that in 2002 he had implied to police that others were present when Sean told him, he could not now recall this. None of those others who were questioned recalled Sean mentioning this attack to them. Pte Hunter had been absent from Deepcut between 11 April and 24 May 1995 on his driving course. He thought Sean told him about the attack a couple of weeks before his death – which would fit with it being recounted very soon after Pte Hunter's return from Leconfield.

32.8 On the basis of Pte Hunter's evidence, it seems likely that this attack on Sean occurred at least two weeks before Sean's death and most likely in April or May 1995. There is no evidence to suggest it was a more than single occurrence.

32.9 I also heard from Pte John Stone, who said he once heard a commotion in Sean's room and then saw two people run out of the room, wearing full combats with gas masks on or a respirator. One of them made a "shush" gesture as they saw him. He went into the room to find Sean cowering under the sheets.

32.10 Pte Stone said he did not know who these two masked people were and said they "could have been anyone". When interviewed by police in 2003 he had not suggested he knew their identity. In court fifteen years later he speculated that they were Sgt Gavaghan and Cpl Holder, saying that he had since put "two and two together". It was, however, readily apparent on further questioning that there was no good basis for him raising this suggestion as to the perpetrators' identity. I note that later in his oral evidence Pte

Stone suggested that he had witnessed other events that he had previously stated he had not seen. He also made sensationalist claims about the place where Sean died as being "a very convenient place if you wanted to murder someone" suggesting Sean was murdered in order to stop him leaving the Army. Pte Stone's allegations are all without foundation and this seriously undermines the weight I can attach to his evidence that named NCOs were part of the respirator gang.

32.11 Nevertheless, having weighed up all the above evidence, I do accept that there probably was a group of trainees at Deepcut who would hide their identity and assault other trainees, they assaulted Pte Cave and on at least one occasion such a group assaulted Sean. That conclusion is fortified by the accounts of two other witnesses who have admitted being part of the gang.

32.12 Pte John Scott told Surrey Police in 2003 that he had been part of a group of trainee soldiers at Deepcut who tried to "teach a lesson" to Sean Benton and "give him a wake-up call". He described Sean as always being in trouble and not seeming to care about his kit or the condition of his room. He said that this resulted in some trainees, including himself, putting on a respirator mask, and visiting Sean in his block where they would "slap him around and shake him about a bit". He said they did not cause Sean serious injury, it was "just body punches with verbal warnings to get his act together". He said this happened to other soldiers as well. He could not recall who else was part of the group who did this but said that trainees took action "off our own backs", without any direction to do so by NCOs.

32.13 Pte Scott does not appear to have been cautioned before he gave his statement to the police in 2003. At this inquest Pte Scott was offered, but declined the status of an Interested Person. When he gave oral evidence he was warned of his entitlement to decline to answer questions where, potentially, a response might be incriminating. He denied that the statement he signed for Surrey Police in 2003 was true, and sought to explain this by suggesting that it was written when he was having a difficult period in his life. He now said that the existence of a respirator gang was no more than rumours. However, there is no sensible explanation as to why Pte Scott should have fabricated his earlier account to the Surrey Police. Given that he made this major admission against his own interest, it is probable that he was a member of a group that assaulted Sean Benton.

32.14 I also heard from Pte John Donaldson. Pte Donaldson also told the police in 2003 that he had been part of a masked gang that attacked Sean Benton, who he described as a "liability". Pte Donaldson was also offered and declined Interested Person status at the inquest. As he lives outside the jurisdiction, I had no power to summons him to give evidence and I am grateful that he agreed to appear at the inquest by videolink. He too was warned of the privilege against self-incrimination.

32.15 Unlike Pte Scott, Pte Donaldson did confirm the earlier account he gave to police. He described the 'respirator gang' as a group of trainees wearing respirators and regimental tracksuit tops. He said he was the recipient of the gang's attention himself on one

occasion when he had dropped his rifle on parade. He said he was asked to participate in the gang and when he refused he was beaten up himself. He said that he then participated in the gang once and this was when Sean was assaulted: the gang wore padded gloves and he had hit Sean in the lower leg. Pte Donaldson suggested that this gang had assaulted Sean at the instigation of an unnamed corporal who had told these trainees to "give him a fright, give him a punch, and then tell him to sort himself out".

32.16 It was not easy to assess Pte Donaldson's evidence. Firstly he has frankly acknowledged that other things he has said about Deepcut, both to his family and to the police when interviewed in 2003 were simply untrue. He untruthfully said that he had been a member of the guard on the evening of Sean's death. He untruthfully stated that he had witnessed Sean being shot. He acknowledged that he had untruthfully implicated Sgt Gavaghan in some adverse events. He still maintained that he overheard a conversation related to a planned assault of Sean between a corporal and the Squadron Sergeant Major – who he said had an "extremely deep English voice" – however it is plain from having heard SSM Milne give his evidence that he has an identifiably Scottish accent. I cannot accept Pte Donaldson's evidence that any NCO instigated the respirator gang's activities. However I also bear in mind that Pte Donaldson has made an admission that is clearly against his own interests that he was part of a group who once assaulted Sean. He explained that he had participated in the gang as he was scared of what might happen if he refused and that he now felt guilty about his actions. Again, there is no sensible explanation as to why Pte Donaldson should have invented this account to the police and continued to maintain his admission against his interests. I accept Pte Donaldson's account that he was a member of a group that assaulted Sean Benton one night.

32.17 Clearly the cowardly and bullying attack must have been very frightening and potentially seriously de-stabilising for Sean and provided yet another reason to wish to leave Deepcut. However it appears to have been met by Sean with resignation.

32.18 Although in the course of the inquest some other trainees have been named as having been part of a masked gang, none have been named by more than one person as taking part and all others named have firmly denied their involvement. The evidence does not go so far as to suggest that this was a formal gang. Rather, it was a group of different individuals who acted together and appear to have operated in the evenings in the accommodation blocks. Whilst I am satisfied that the respirator gang existed and that Pte Donaldson and Pte Scott probably took part, there is insufficient evidence of the identity of any other participant to draw any further conclusions about the group's membership.

32.19 There is no satisfactory evidence that the existence of the group and its activities were known to the NCOs, still less that it was encouraged by them. I am not satisfied that the NCOs had any part in convening, directing or encouraging this gang, or that any NCO condoned the activities of those who did.

32.20 However, that any trainee could act in this unchecked way is in my view, attributable to the low ratio of staff to trainees and the lack of adequate night-time supervision provided by NCOs. This was wholly unacceptable behaviour by trainees that should have come to the attention of staff and been stopped. That trainees who received these serious beatings seem to have been reluctant to complain is yet another reflection of the inadequate welfare provision at Deepcut at that time.

SGT ANDREW GAVAGHAN

33.1 I begin this part of my factual findings by reminding myself that this is an inquest, not a trial of Sgt Gavaghan nor a review of his alleged behaviour to trainees other than Sean. However a central issue in this inquest has been the extent to which, if at all, Sean's death was contributed to by improper conduct towards him by others, including those in authority, and, if such conduct did occur, its impact, if any, on his state of mind on 9 June 1995.

33.2 The scope of this inquest has therefore included consideration of whether Sean was subjected to verbal intimidation or physical assaults by any NCO or officer at Deepcut. It has not been limited to allegations made regarding Sgt Gavaghan. However when applying the civil standard of proof, that is on the balance of probabilities, the scant evidence in support of the very few specific allegations made against other named NCOs and officers is, in my view, insufficiently probative to make any factual findings. The same cannot be said in respect of Sgt Gavaghan.

33.3 Andrew Gavaghan joined the army in 1980.[1] By March 1994 Sgt Gavaghan had completed training as a Military Training Instructor at Deepcut and soon after he became a Troop Sergeant for one of the troops of Phase 2 trainees. He described his role as being responsible for the day-to-day running of the Troop as a whole. He had to maintain discipline and look after the trainees' welfare. Those tasks encompassed instruction, leadership and mentoring.

33.4 Sgt Gavaghan had not been given any specific training by the Army in dealing with young people. Outside the military he had been a volunteer youth worker and whilst at Deepcut he had volunteered to be an in-service befriender and had completed some basic counselling training.

33.5 Sgt Gavaghan had an unblemished disciplinary record and most of the permanent staff at Deepcut respected him as a soldier. He was thought by some of his superiors to have a particular aptitude for welfare. Lt Col Josling told me his impression that Sgt Gavaghan "really had quite a sympathetic way with trainees" and said he had observed his "friendly but firm manner". When Sgt Gavaghan applied for a position in 1996, he received a reference from the nurse at Deepcut, Catherine Smith, who wrote:

> "I have had many dealings with him in connection with social and welfare problems. The soldiers, both male and female, find him very approachable and someone with whom they can share their troubles. He is sympathetic to their problems and shows a natural empathy at all times."

[1] Following service in the UK and abroad as an infantry NCO he was promoted to Sergeant in 1990 and worked in Army Careers and recruiting before transferring to the RLC. He was posted to Deepcut in 1993.

33.6 However, I have also heard from a number of witnesses who in their evidence before this inquest have made allegations against Sgt Gavaghan of misconduct. Allegations have included harsh treatment, verbal intimidation, and even physical attacks by Sgt Gavaghan on the witness themselves, or other trainees including Sean Benton.

33.7 The allegations presented were not limited to events before Sean's death but they all fell within the same general period and involved physical and/or mental abuse going well beyond an exercise of legitimate authority and discipline by Sgt Gavaghan in performing his role as troop sergeant. Sgt Gavaghan gave clear evidence denying such conduct.

34. Approach to the evidence

34.1 To what extent do the allegations of misconduct towards trainees other than Sean shed light on the allegations that Sean was subjected to similar acts which amounted to a significant abuse of authority?

34.2 Firstly, there are a number of instances where apparently independent witnesses dealing with different periods at Deepcut when they encountered Sgt Gavaghan have made allegations of very similar conduct against him. In those instances, I need to consider whether such evidence is likely to be the product of mere coincidence or malice. Where I find this unlikely, the evidence may, as a result, have particular probative force. I have only given such evidence weight where I have found that the witnesses are genuinely independent, and, where I am satisfied that it is not the product of collusion or innocent contamination. If so satisfied, I have considered that evidence as a whole together with any similar allegations in respect of Sean.

34.3 Secondly, over and above my consideration of the unlikelihood of coincidence, I need to decide whether any of the evidence shows a propensity by Sgt Gavaghan to abuse his authority against trainees at Deepcut. I have approached that evidence in the following way: I have considered whether, on a balance of probabilities, any or all of these episodes took place. Then, to the extent that I am so satisfied, I must consider whether those findings (taken together if more than one) show a propensity by Sgt Gavaghan to abuse his authority and act in such ways towards trainees at Deepcut. In making this decision, I will take into account the similarities and dissimilarities between any such act proved in respect of another trainee and the allegations of such conduct upon Sean. If I decide that it is not sufficiently compelling and/or does not show such a tendency or propensity, I shall disregard it. However, if it does, whilst my central focus will be upon the evidence of those making allegations of such conduct upon Sean, I will consider it as potential supporting evidence in respect of those allegations and will assess it together with any direct evidence. I have also borne in mind that a witness may well construe events differently looking back over 23 years which may not reflect either their objective experience or subjective feelings at the material time.

34.4 Lt Col Josling suggested that I should approach the evidence of those who had left the army soon after their time at Deepcut or not enjoyed successful careers in the army with particular care. It is apparent he was expressing a concern that such witnesses might have a particular hostility to the army and as a result be prone to fabrication. Such a blanket approach does not do justice to witnesses. Of course I must look at the evidence of each witness separately and bear in mind any possible animus when evaluating their reliability. Significantly, a number of witnesses, such as Brian Holmes, made serious allegations against Sgt Gavaghan even though they themselves enjoyed successful careers.

34.5 In addition, I bear in mind that the fact that such a great deal of factual and opinion evidence exists about Sgt Gavaghan in particular may have been contributed to by Surrey Police probing for evidence about Sgt Gavaghan in a way they did not do with other NCOs when they conducted their investigation in 2002-2003. Sgt Gavaghan has also been the subject of considerable media attention and focus throughout the time that events at Deepcut have been in the public eye and I am conscious there is a real risk of demonisation.

34.6 Since 2002, Sgt Gavaghan's name in particular has regularly appeared on TV broadcasts and in print media articles which directly or indirectly associated him with a regime of "bullying" at the barracks. I bear in mind that exposure, conscious or unconscious, to media coverage and social media commentary might have influenced the perceptions and recollections of witnesses. There is a risk that this causes some to metamorphose general memories of what they experienced as an unpleasant period at Deepcut, or specific memories of ill-treatment by other NCOs, into memories of ill-treatment by Sgt Gavaghan.

34.7 Furthermore, I am aware that, over time, rumour repeatedly voiced can become uttered like truth. Indeed some witnesses, such as Pte Craig Hill, doing their honest best to assist the inquest, were perceptive enough to tell me that they were themselves confused about whether they were now mixing up rumours they had heard with what had actually happened at Deepcut 23 years before. That risk is shown in its most extreme form by one witness (Pte Stuart Toye) suggesting that Sgt Gavaghan may have shot Sean Benton. That unwarranted speculation has not a scintilla of evidence to support it.

34.8 In the absence of direct evidence or contemporaneous complaints all hearsay evidence, including accounts said to have been given by Sean, must be treated with particular caution. When assessing the weight to give to the various allegations I have discounted all accounts that were mere rumour or multiple hearsay. If hearsay has been relevant, then before attributing any weight to it I have considered all the circumstances including how near to events the account was given, any potential false motives or other reasons for misperceptions, any corroborative first hand evidence, and any internal inconsistencies in accounts, particularly when the evidence has been tested in court.

34.9 It is however not difficult to see why Sgt Gavaghan may have been uniquely memorable. His notoriety is not purely something which post-dates the sensationalised media coverage which followed the further deaths at Deepcut of Pte Geoff Gray in 2001 and Pte James Collinson in 2002. Sgt Gavaghan was already a legendary figure in 1995. I was told by Pte Daniel Griffiths that recruits first heard about him whilst still undergoing their basic training at Pirbright. Cpl Barrow, a NCO who dealt with the trainees in their first week of induction into Deepcut, told me how he saw soldiers arriving on their first day already asking about Sgt Gavaghan and believing there were two brothers. Cpl Barrow's perception was that Sgt Gavaghan "manipulated" or at least did nothing to dispel the rumours that circulated about what he did and what he was capable of, but instead promoted it to engender fear in the arriving trainees.

34.10 Other evidence that Sgt Gavaghan may have courted the legend comes from the several witness accounts of him removing and burning a football shirt of a trainee who supported Newcastle United (the rival team to his Sunderland). This clearly did happen more than once, as Sgt Gavaghan acknowledged, but it seems that what appeared to many witnessing the event as erratic and destructive behaviour was a staged event that was not done vindictively, the owner of the shirt (in one case Pte Tucker) being aware of and so prepared for the "joke". I do not accept that such pranks were ever intended to frighten the on-lookers. They were however, at best, extremely ill-judged, and it is unsurprising if some of those who were not aware these were staged events might perceive them as a serious and unchecked abuse of power that added to their feelings of insecurity and lack of trust in the chain of command whilst at Deepcut.

35. **Temper and 'twin brother'**

35.1 What made Sgt Gavaghan particularly memorable was his use of what he called a "management tool" that consisted of him play-acting an alter ego, known to many as his 'twin brother'. Its notoriety was such that new trainees at Deepcut would be in awe of their first encounter with the phenomenon. Pte Hill recalled being warned by Sgt Gavaghan on his first parade at Deepcut that he would "not want to meet my twin brother". He described how he had not understood the warning until a later occasion when he witnessed Sgt Gavaghan "belittle" a friend of his by "ranting and raving" at him in very frightening way.[2]

35.2 Many other witnesses including his fellow NCOs spoke of Sgt Gavaghan's serious temper and his lack of control. Cpl Fairhurst, a NCO who had administration duties in 1995 said that Sgt Gavaghan would lose his temper more than others and would not just be shouting but would be screaming at and frightening the trainees.

[2] Pte Allan Drury explained how Sgt Gavaghan "was the standout figure that was notorious and everybody kept a wide berth from. He was somebody that was your best mate one minute and tearing your head off the next. He was quite schizophrenic and quite troubling and quite worrying, to be honest, as a teenager - and that is what we were, which was just teenagers."

35.3 This loss of temper was often seen during Sgt Gavaghan's 'twin brother routine.' What was striking from the evidence was the unpredictability of Sgt Gavaghan's change of persona. He was repeatedly described as changing from being nice one minute, to frightening the next. Pte Gilsenan, a trainee who said he was never on the receiving end of the temper himself, understood that on some occasions the appearance of the twin brother seemed to be a planned tool, but on others it would be reactionary loss of temper. Some described how Sgt Gavaghan appeared to physically change when his 'brother' came out. He would go round a corner and come back red faced and shouting seeming genuinely angry. Many witnesses spoke of knowing that once the twin brother had come out "you were in for a hard day."

35.4 Undoubtedly Sgt Gavaghan had his admirers amongst the trainees. Many formed the view he was very efficient, professional, a good Sergeant and good soldier. Some were deeply impressed by him. For instance one former trainee described him as "a top lad, a top Sergeant, who made things work." It is clear that for some this view never changed. It is also clear that not all trainees who witnessed his 'twin brother' routine were negatively affected by this. Pte Rachel White said that she understood it to be a "character building" technique directed at making the trainees into better soldiers. She said she respected Sgt Gavaghan and did not find his approach distressing at all, although she recalled that some of the other female recruits were more bothered by it; they would become upset and cry. Pte Gilsenan, who said he had forgotten all about the twin brother until this inquest when he heard another witness give evidence before him, had experienced the twin technique as "quite funny". He made no criticism of Sgt Gavaghan describing him as "sympathetic" and "a good motivator."

35.5 Others also spoke of a very good side of Sgt Gavaghan, yet drew a stark contrast between this and his 'twin brother'. Pte David Shortt spoke of how he recalled Sgt Gavaghan could be "brilliant…just nice and friendly, do anything for you. And then the next minute he would be just ranting and raving and just completely lose his rag…shouting and swearing at a very high pitch".

35.6 Sgt Gavaghan did not dispute the existence of this alter-ego, but explained that it had been his conscious decision to act in this way. He explained to me that his leadership style elsewhere through his army career had generally been quiet, unassuming, leading by example. At Deepcut sheer numbers, lack of people to help him, the inexperience of the soldiers there, and the lack of normal regiment structure led him to conclude that his "quiet style of leadership" was not going to be effective. He stressed the importance of discipline so as to achieve operational effectiveness and teamwork. He said that in order to maintain standards and keep discipline he had acted contrary to his natural leadership style at Deepcut, adopting a technique he had specifically created to deal with the sheer number of trainees and lack of staff. He said he felt that he "had to have a nasty side, but that was due to the role that [he] was doing". He said that his "nasty side" was a "play act that I had to do". He believed that those senior to him up to squadron level

(i.e. including Major Gascoigne) were aware of his alter-ego but said no-one had ever tried to dissuade him from it.

35.7 Even some of those who were critical of Sgt Gavaghan's methods recognised the pressure under which he operated. Pte Drury told me: "He had a very large number of people to deal with and look after. I don't think they did him any favours in that regard as some days there could be 10 people on parade and the next day 300, and there was not many staff and there was no structure to what we were doing". Pte Gilsenan similarly said that now looking back on the behaviour as an adult he felt the pressures on Sgt Gavaghan "must have been huge to be a Sergeant in charge of that many people…If he was going to lose his temper it would have been nice to have had someone acting as a safety net, maybe relieve him and send him away, but there wasn't, he was your Sergeant and if you pissed him off you were going to get the wrath of it."

35.8 Sgt Gavaghan attended many days of these hearings and told me that he had been "disturbed" by the evidence he had heard from people who had found him frightening and unpredictable. He emphasised that "at the time I was unaware of that. At the time I was doing it for what I believed was the right purposes." He said it was not until he heard the inquest evidence that he had realised that it had not been a good idea. At the time he was unaware that he might not have been considered approachable by some trainees because of the unpredictable existence of his twin brother because many other people found him approachable and caring. He claimed that he did not actually lose his temper or self-control. Any loss of temper was, he said, confined to his office. He also sought to explain some of the accounts now given by ex-trainees by suggesting that their stories had changed and become embellished.

35.9 However having taken account of the accounts of Sgt Gavaghan's fellow NCOs, which corroborate the ex-trainees' accounts, it does not appear to me that accounts of his temper have been embellished. Whatever Sgt Gavaghan's intentions, I have formed a clear view that at times he did lose control of himself and many found him extremely intimidating. The uncontrollable nature of his fits of temper is evidenced by his conduct in the presence of NCOs including those of his own rank and his physical expressions of violence to property.

35.10 One NCO, Cpl Julia Boulton, described how, after her initial favourable impression, she was "stunned and shocked" to see Sgt Gavaghan in what she described as a "verbal assault" of a female soldier during an exercise when he appeared to "lose control…throwing a tirade of abuse at the female" his face purple with rage only inches from the soldier's. Cpl Boulton was concerned enough to comment upon the event back at the squadron, only to be told "you have now met his twin brother".[3]

[3] There is an echo of this evidence in the account of Pte Michelle Griffin (whose evidence was not tested as she could not be traced) that Sgt Gavaghan kicked and hit a female trainee who fell on a run.

35.11 Cpl Barrow described Sgt Gavaghan as having a serious temper and losing it with trainees on numerous occasions and then returning to his office still irate, kicking bins over, throwing file trays and the paperwork from desks around and shouting. He said he had never before or since seen an instructor behave as Sgt Gavaghan did.

35.12 Sgt Paul Wood, the former squadron quartermaster sergeant described the routine saying: "He invented his twin brother who, when he became him, was a complete lunatic, a madman. The recruits could not reason with him, they could not do anything right when he was as his brother." Other NCOs did not want to be involved in the routine. Sgt Wood, whilst still opining that Sgt Gavaghan was a good soldier and good instructor, continued: "We all thought when he went into his brother we did not want to be part of that, and that included instructors. I had 14 years' experience of training and I thought it was totally wrong. It was as if he had no control over it."

35.13 Sgt Gavaghan claimed the twin brother legend had been exaggerated but it is clear that these 'twin brother' episodes were neither relatively rare nor was their impact upon the trainees exaggerated. They could happen as much as once a week, they could engender a general state of fear amongst some of the trainees, terrifying and humiliating some and reducing some to tears.[4]

35.14 Sgt Gavaghan has accepted in retrospect that "it was not a good idea" and that he had been blinkered in not appreciating how people might have been distressed by his conduct. His apparent lack of insight into the impact of his behaviour at the time is remarkable, particularly when, at its worst, his loss of temper could involve physical violence.

36. Physical violence towards trainees other than Sean

36.1 I now come to consider the evidence of numerous trainees of specific attacks by Sgt Gavaghan upon themselves, or of other trainees, including Sean Benton. Sgt Gavaghan has consistently denied any such misconduct.

36.2 In respect of some allegations of physical assault of Sean Benton, the evidence regarding the identity of the perpetrator was too vague to safely found any finding that the misconduct was by Sgt Gavaghan. For example, Pte Allan Drury described seeing an NCO holding Sean up against the wall holding him by the throat. When he gave his statement to police seven years later Pte Drury could not be sure who that NCO was. Pte Neil Williams reported that he and Sean were kicked in the head by a Sergeant on a training exercise, but his account left room for doubt whether the perpetrator was Sgt Gavaghan. Having heard each of these men's unembellished evidence tested in court, I

[4] It should however be noted that Sgt Gavaghan was away from Deepcut for significant periods, including important periods of time in the chronology of Sean's final months. He was on a course from 26 February to 9 March and from 13 March to 7 April, and was also away from 24 April to 5 May.

have no hesitation in accepting that the events themselves happened as they described, but I make no finding as to who was the perpetrator.

36.3 Other witnesses have made allegations of assault by Sgt Gavaghan which I cannot accept at all. Some accounts have clearly been embellished in a way that does a disservice to those who seek the truth about what happened at Deepcut and to Sean. Having considered how some evidence developed over the course of the witnesses' examination in court I find the uncorroborated account of Sean being head-butted by Sgt Gavaghan when on parade in front of up to 200 people and of a female private being required to run naked around the parade square to be unreliable evidence. An account of Sean being picked up and thrown through a glass door by Sgt Gavaghan and Cpl Holder is similarly not one that I can accept given the inconsistencies between the oral evidence given by that witness and their statement about the same event where that statement was first provided just a few months before this inquest.

36.4 Additionally, it is important that I record that as part of this investigation my Coroner's Officer has contacted some of those who have posted recent accounts on social media of misconduct towards Sean that they purported to have witnessed. One particularly sensational and graphic account alleging an unconscionable public humiliation of Sean was no longer maintained by the social media correspondent once they were contacted by my Coroner's Officer. That person freely acknowledged that the vignette that they had recently posted on a well known Deepcut discussion forum, implying it was the truth, was not accurate.

36.5 However, I nevertheless find that that Sgt Gavaghan probably did exceed his authority and engage in actions that went well beyond any reasonable disciplining of some of the trainees. In particular having heard the witnesses' accounts and noted similarity with other accounts I am satisfied on the balance of probabilities that Sgt Gavaghan did punch and kick some trainees.

36.6 Pte Clair Hirstwood gave an account of how Sgt Gavaghan, when not in any temper, was prepared to use a punch as a way of carrying out summary justice, and that he did this to her. Her account was made all the more compelling by her not seeking to embellish the events and matter-of-factly acknowledging that her own transgression of an army rule (her fighting with another private) had precipitated Sgt Gavaghan's action. She described how Sgt Gavaghan offered her a choice between being put on a formal charge or being punched by him. Knowing that she had broken a rule, she took the latter option as being preferable; he then hit her with full force in the right arm. I accept Pte Hirstwood's account of this and I accept her account that she also saw Sgt Gavaghan pull out another private from parade, punch him in the arm or body and then push him back into line.

36.7 Sgt Gavaghan's willingness to abuse his authority and hit others is also described in the evidence that I accept from other trainees, who give accounts of jabs with his fist to the lower ribcage area or pushes with a pace stick.[5]

36.8 The evidence of Pte Stan Munday was sought by my Coroner's Officer at my request after another witness had named him as someone who he had seen being hit by Sgt Gavaghan. Although Pte Munday contextualised the event, and did not portray it as graphically as did the eye-witness making the initial report, I am satisfied that during a 'punishment parade' one night, Pte Munday was poked in the chest by Sgt Gavaghan using a pace stick in a way that was mildly painful for a short period. Pte Burrows similarly recalls being kicked on parade by Sgt Gavaghan. Although she could not recall much of the details so long after the events I accept this probably did happen to her as did the kick to Pte Wells, who reported that Sgt Gavaghan kicked her, albeit only lightly such that she was not hurt, but was left shocked and embarrassed. These accounts are echoed in the, albeit hearsay, account of Cpl Barrow who recalled a private complaining to him that Sgt Gavaghan had lashed out at her with a clenched fist and punched her in the head. Similarly Pte Catherine Roberts reported being punched by Sgt Gavaghan for no apparent reason on the right side of her face when he was in his 'twin brother' guise. Although her statement was read and so her evidence is untested, the balanced nature of the rest of her evidence leads me to accept her account, which is similar to that of others.

36.9 Not all witnesses to events were trainees. In particular, Sgt Wood told me that he had seen Sgt Gavaghan lose control when in his twin brother persona and that on at least one occasion he saw Sgt Gavaghan strike a trainee in the chest with his fist during an exercise. I accept that this probably happened. Sgt Wood disapproved of this behaviour, however I note that he was also clear that he had never seen Sgt Gavaghan physically assault Sean.

36.10 Others have reported what appear to be wholly unprovoked attacks by Sgt Gavaghan when in the accommodation blocks. Having considered amongst other matters the consistency of the witnesses' evidence and the reasons given for the absence of any contemporaneous complaint including both shame and the fear of further reprisals, I accept that, on the balance of probabilities, the following events happened:

- that Sgt Gavaghan punched Pte Thomas Rowlands in the stomach and pushed his head against a radiator with force under the guise of failed room inspection in the accommodation block;
- that Sgt Gavaghan hit and punched Pte Trevor Hunter when he came across Pte Hunter sitting on his bed writing a letter in the accommodation block

[5] Whilst much was made of Pte Knowles' written account having changed the wording from a 'clip' to a 'hit' when her statement was drafted by the police, I accept the fundamental point of her account, which was that Sgt Gavaghan laid hands on trainees.

- that Sgt Gavaghan hit Pte Daniel Griffiths with a broom handle a number of times when in the accommodation block.

36.11 I also conclude that Sgt Gavaghan took active steps on occasions designed to humiliate other privates. For example, I accept Sergeant Gavaghan made trainees apologise to 'Private Jerry-can' in his room. Pte Knowles recalled Sgt Gavaghan as frightening when he would shout at her calling her 'Geordie scum' she told me that "this wasn't banter it was horrible". Sometimes the humiliation was carried out in front of the assembled troop. An instance was when Pte Robert Gasson was told to rub his own face in the dirt on morning parades to make himself look less young and on another occasion required to join in a gross 'game' involving excrement. Pte Gasson told me that he felt pressured to do these things which he thought were "nothing short of bullying" by Sgt Gavaghan "because you knew the consequences if you didn't in that he might punish you in some way…You never wanted to be on his bad side". I accept Pte Gasson's account, coming as it does from someone who in many other respects was a supporter of Sgt Gavaghan, telling me that "when he was actually acting professionally I thought he was very good…one week he really showed how professional he could be, I thought he was brilliant and he taught me an awful lot".

37. Sgt Gavaghan's actions towards Sean

37.1 It follows from the above that in my view Sgt Gavaghan had a propensity to abuse his authority and use physical violence to enforce 'discipline.' This propensity supports the evidence of Pte Glyn Boswell that Sgt Gavaghan punched Sean in the stomach when he was on parade. I accept this witness' account which in my view was presented with no appearance of exaggeration or elaboration and is reinforced by similar facts. Pte Victoria McKinlay recalled that Sgt Gavaghan made Sean lie on the ground in front of a parade shouting "arm or leg" before he or the person next to him hit Sean in the leg. She also gave an account, which I accept, of Sgt Gavaghan making Sean and another private remove their berets before smashing their heads together on parade.

37.2 The assaults on Sean continued during the days immediately before Sean's death. According to Pte Dilkes, during the days before Sean died, Sgt Gavaghan kicked Sean whilst he was on the ground whilst he was on parade. Pte Dilkes would have been an important witness at the Inquest. Sadly, she died some years before the hearing. In the circumstances a gisted summary of her interview with the Surrey Police from September 2003 and a subsequent statement she gave were read under rule 23. To evaluate her evidence I have read her interviews in full. I note that she did not give a statement at the time of Sean's death notwithstanding the potential importance of her evidence. She never had any contact with the media. I accept that, on the balance of probabilities, her account is reliable that, in the week before his death, Sgt Gavaghan goaded Sean on parade in an episode that included getting Sean to the ground to do press ups or squat thrusts and kicking him whilst he was there. Sean reacted defiantly by "laughing it off."

37.3 Although Sgt Gavaghan denied using press-ups as an informal punishment, several witnesses recalled press-ups being part of usual army discipline at Deepcut. SSM Milne agreed that press-ups were used as an informal punishment. I note that two witnesses recall Sgt Gavaghan specifically requiring Sean to do press-ups in a humiliating manner when it had rained. I find that he probably did so.

37.4 Pte Hunter is a witness whose evidence I have approached with particular care because of his multiple contacts with the media and the possibility of contamination through his discussions with another witness. However I am satisfied he was giving a truthful account when he described some events involving Sgt Gavaghan and Sean. Pte Hunter later became a reserve NCO so I do not find him to be someone with a general anti-army animus.

37.5 Pte Hunter described how Sean confided in him that he felt he was being picked upon and that he feared Sgt Gavaghan. It is noteworthy that Pte Hunter refrained from embellishing by saying Sean was ever physically assaulted but described Sean being picked on for not being up to standard and his life being "made a misery" when he did not raise his standard and conform. I accept his account of the verbal humiliation of Sean in an episode on the parade ground.[6]

37.6 I do not consider that Sgt Gavaghan was the only NCO to deliver verbal chastisement of Sean. Several trainees told the inquest how Sean's tendency to commit minor military infringement in respect of his turn-out and his drill meant that he drew the attention of NCOs upon himself. Sean was also someone who would answer back with cheeky quips and this inevitably meant that Sean frequently came to the attention of NCOs who might then send him for informal punishments to the guard room or allocate extra drill or PT. However, the nature and frequency of Sgt Gavaghan's actions set him apart. No other NCO has been identified as having repeatedly and intentionally placed trainees in general, or Sean in particular, in fear.

38. The other side of Sgt Gavaghan

38.1 It is important to note that not all witnesses spoke ill of Sgt Gavaghan. The strong divisions of opinion about Sgt Gavaghan's conduct can in part be explained by his tendency to build better working relationships with those he favoured. Some trainees clearly were never the focus of his negative attention and saw his conduct in respect of the football rivalry between Sunderland and Newcastle as nothing more than amusing

[6] Pte Hunter described how Sgt Gavaghan: "went crazy on [Sean] and just gave him a really hard time. … he burst into tears and they had a good scream at each other, then [Sean] was sent to the guard room. That was quite an unsettling situation, … Sergeant Gavaghan was having a right good go at him in terms of very loud, very in his face, getting right in his zone and giving him a real hard time, and Sean just said "I've had enough of that" and just walked off the parade, … stormed off, and Gav went after him and gave him a right good shouting down, but Sean just walked away from it and he just kept driving at him and driving at him and he'd just had enough and he was in tears and he was shaking with rage, gripping his hands."

banter. Others positively recall him assisting them when they had their own difficulties. He was clearly a man with two sides.

38.2 Those two sides were also shown towards Sean. Pte Richardson recalled observing Sgt Gavaghan's sympathetic and encouraging approach to Sean trying to re-assure him on 8 June when he was upset about his discharge. In one of his letters written on the night before his death Sean went out of his way to thank Sgt Gavaghan and apologised for calling him an 'arsol.' *(sic)* That is likely to have been be a reference to the insubordination incident on 13 February 1995. I have considered whether an inference can properly be drawn that a reference as far back as February suggests nothing adverse had happened between them in the interim. I am not persuaded by this argument. It runs counter to some compelling evidence. Sean was apologising for his own conduct towards Sgt Gavaghan which had resulted in a charge. It may, however, reveal what was then uppermost in Sean's mind at the time of writing the letter.

38.3 However, for those who, like Sean, also experienced the nasty side of Sgt Gavaghan there was, it seemed to them, nowhere to turn. Those NCOs who were aware of Sgt Gavaghan's behaviour were either inferior in rank to him and did not feel able to challenge it or of similar rank yet did nothing to curtail it. Against that background, and given the unpredictability of the violent behaviour, it is understandable that trainees would refrain from complaining for fear of provoking further reprisals.

39. The chain of command's awareness of Sgt Gavaghan's conduct

39.1 Whilst some of Sgt Gavaghan's misconduct was in private, there were occasions when it was on the parade ground. Whilst the public use of the twin brother technique did not necessarily involve physical assaults it was not harmless, in that it was calculated to instil fear into trainees. In any event, it is striking that Sgt Gavaghan had the self-belief and confidence to perform in this way without apparent fear of reprimand from those senior to him in the chain of command.

39.2 Officers at Deepcut all denied any knowledge of any abuse of authority or inappropriate conduct by Sgt Gavaghan. The senior officers were at pains to point out that they would have taken firm action if they had become aware of any such conduct. They claimed to have had either no knowledge or only a limited knowledge of Sgt Gavaghan's use of the 'twin brother managerial technique' and certainly to the extent that they were aware of it, did not consider it to be inappropriate. It is significant that no officer seems to have seen the twin brother conduct which was on any view very unorthodox, nor did any officer take steps to check upon it.

39.3 SSM Milne stated that he only learned about the 'twin brother' technique years later. If he had been told that Sgt Gavaghan was reducing recruits to a state of fear, he would have done something about it.

39.4 As positively encouraged at Sandhurst, Lt Delap, as a new troop commander, relied heavily on her Troop Sergeant, Sgt Gavaghan. She felt he was experienced and knew what he was doing. She found that he had a good authoritative manner. She said that she had never seen him lose control and/or lose his temper. She never saw him screaming and shouting. She said that she was aware of Sgt Gavaghan's 'twin brother' which she thought was a managerial technique he employed when he needed to be firmer and never appears to have challenged him. Rather, she relied upon Sgt Gavaghan for guidance.

39.5 In evidence at this inquest Lt Radford claimed that on two occasions he had passed information to Lt Delap, as he had learned that Sgt Gavaghan was being very aggressive, in particular, shouting in the face of trainees. He did not make reference to this in his 2002 interview with the police. Whether Lt Radford did or not do this, as Lt Delap very properly conceded, she should have checked on Sgt Gavaghan's 'twin brother management technique.' When told of this evidence, Brigadier Evans was of the view that Lt Radford should have taken it further at the time.

39.6 Capt Cammack was adamant that he never came across any bullying and there were no complaints to him about bullying. He was aware of the two sides of Sgt Gavaghan's character but said he never saw them. Nor did he see any inappropriate behaviour from Sgt Gavaghan. He felt Sgt Gavaghan could be compassionate and he had been told that when Sgt Gavaghan turned into his brother he would give people a beasting ie a legitimate informal punishment. He was not aware of Sgt Gavaghan losing his temper or shouting at recruits any more than anyone else.

39.7 Major Gascoigne stated that he was unaware of Sgt Gavaghan's 'twin brother technique'. He stated that endemic bullying would be a surprise. If a NCO was abusing his authority, that NCO would have made sure that he did not see it because NCOs knew full well the consequences if Major Gascoigne found out.

39.8 Lt Col Josling stated that he had only recently heard about Sgt Gavaghan's 'twin brother'. He had the impression that Sgt Gavaghan had a sympathetic way with trainees. He was very surprised that it had not come to the attention of Sgt Major Milne.

39.9 Stretched resources may have contributed to the failure of the chain of command to appreciate the full nature of what Sgt Gavaghan was doing. In the circumstances, I am not in a position to say that any member of the chain of command was aware that that Sgt Gavaghan was regularly abusing his authority. However, on any view, a closer check should have been kept on Sgt Gavaghan's management of the trainees including use of the twin brother technique. For instance, it is surprising that the B Squadron Sgt Major, who was in charge of discipline, was not aware of it. It is clear that this lack of appropriate monitoring contributed to his abuse of authority. Furthermore, it is clear that the existence of an independent welfare officer outside

the chain of command might have facilitated reporting and brought Sgt Gavaghan's conduct to a timely halt.

MEDICAL & PSYCHIATRIC SERVICES[1]

40. GP assessments: February 1995

40.1 Sean's consultations with the healthcare services at Pirbright and Deepcut were only for minor physical ailments before 2 February 1995 when he attended Major Gen Shaw following his second failure at Leconfield.[2] From the contemporaneous records it seems that Sean was open enough to tell Major Gen Shaw of his emotional distress and identify potential explanations for it. The note reads as follows:

> "Interviewed because of failure at Leconfield. Background – emotionally upset by separation from best friend (also argument with family over Xmas leave). Admits to short fuse. Very keen to be trained as a driver. No psychiatric disturbance. Emotionally labile and quick temper."

40.2 Sean's next contact with Army Medical Services followed less than a week later when Sean broke a window on the evening of 8 February 1995. Sean was given initial immediate medical attention at ATR Pirbright for a "small laceration" to the right side of his neck. The account recorded in the medical records was that Sean had been drinking when he had broken a door window and then walked through the broken glass. The cut to his neck was noted to be "not very deep" and only required dressing with steristrips.

40.3 Sean saw Major Gen Shaw for a second time the next day on 9 February 1995. This consultation was prompted by a formal referral from Capt Cammack using the standard form to 'Report on a Person for Psychiatric Examination".[3] Capt Cammack told me that any incident of self-harm would automatically generate a psychiatric referral. What was more unusual was that Capt Cammack was explicitly seeking Sean's discharge from the army through this referral. He wrote:

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[1] Primary healthcare services at Deepcut were provided through the healthcare staff at the Barracks' Medical Centre, with primary care being available out of hours at nearby ATR Pirbright. There was a single camp Medical Officer (a General Medical Practitioner or 'GP') supported by nursing staff. All secondary level mental health services, whether inpatient or out-patient were provided by the Army Psychiatric Services based in hospitals off-site.

[2] During the period that Sean Benton was at Deepcut the main Camp GP was Dr Alexandra McClenahan. She was a civilian GP who had been in post since June 1979. Dr McClenahan was temporarily away from work in late 1994 and early 1995 and in her absence the Camp Medical Officer was Major General (Retd.) Shaw. Major Gen Shaw had formerly been the director of Army Medical Services but had retired from the army in 1991 and was filling the position as a Locum GP. Major Gen Shaw had died by the time of the inquest. He had been interviewed by Surrey Police in 2003 but by then he had no recollection of Sean and so could not provide any additional information beyond his contemporaneous notes.

[3] F/Med8 form.

"Soldier seems to be emotionally unstable. Outbursts of crying. 8/2/95 drunk heavily and threatened suicide injuring himself when walking through a window. He was originally driver trade but considered to be emotionally unstable by driving instructor and returned to unit. Interviewed by SPSO and reallocated to trade of Pioneer. Soldier cannot accept this….

Have had reports from troop staff that he "plays" with his weapon when on guard pointing it at people.

Would wish to discharge as [temperamentally][4] unsuitable, soldier is considered by all staff to be unstable".

40.4 The source of the suggestion that Sean had "played" with his weapon on guard has not been established. Capt Cammack suggested that this was an unsubstantiated account reported to troop staff by other trainees on guard with Sean. He could recall no more about this allegation although he characterised it as "a serious disciplinary offence". It might be thought unusual that such a clear breach of army discipline, if it was suspected, was not formally reported, explored and dealt with by an appropriate sanction.

41. Psychiatric referral

41.1 Major Gen Shaw saw Sean on 9 February 1995 and referred Sean on to Lt Col Adrian Gillham, a Consultant Psychiatrist at the Cambridge Military Hospital in Aldershot. A brief entry in the notes[5] records:

"Depressed about change of trade, but not apparently mentally disturbed. Affray last night anger rather than attempt at self-harm."

41.2 In his referral note[6] Major Gen Shaw recorded his opinion that Sean was exhibiting an "abnormal emotional reaction" and that his behaviour was of a "very immature and angry personality". He noted Sean's failure at driver training after an altercation with his instructor in a tantrum, and that he "now refuses to accept change of trade to Pioneer and is unwilling to accept the remaining options open to him". Major Gen Shaw was aware that Sean had been said to be threatening suicide, but noted that Sean had denied this to him.

41.3 Major Gen Shaw did not think that Sean had any psychiatric illness. He also recorded that he had "impressed upon [Sean's] squadron officers, that his future has to be resolved by management rather than medicine."

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4 Capt Cammack confirmed that he had written "temporary" here in error.

5 Which is undated but is likely to represent this consultation.

6 F/Med7 form

42. First psychiatric assessment: 13 February 1995

42.1 Four days later, on 13 February 1995, Lt Col Gillham, a Consultant Psychiatrist, saw Sean as an out-patient at the Cambridge Hospital. Lt Col Gillham understood that he was being asked to consider Sean's suitability for continuing in the army. In addition to the referral documents he had also spoken by telephone with Maj Gen Shaw who had told him that he wanted a second opinion and that in his opinion discharging Sean was not the right thing to do.

42.2 Giving evidence in 2018, Lt Col Gillham stated that he still recalled his consultations with Sean because he was an unusual case. Normally, soldiers referred to him for assessment as to their temperamental suitability for the army were those who wanted to leave the army. Unusually, Sean did not want to be discharged but was keen to remain a soldier.

42.3 Lt Col Gillham recalled that during their consultation Sean was tearful but said that he was eating and sleeping okay. He denied having suicidal thoughts and also said that he did not recall feeling suicidal at the time he broke the window on 8 February, although he acknowledged that he had been drinking. Indeed Lt Col Gillham had recorded Sean telling him he had drunk 20 bottles of Fosters on 8 February – but that he had not drunk since then.

42.4 Lt Col Gillham told me that he had specifically asked Sean whether he had been bullied at Deepcut because he had previously heard accounts of there being bullying at the camp. Sean had denied experiencing bullying, indeed Lt Col Gillham recorded that Sean had told him that he had enjoyed the army. He said that he had had no problems until Christmas 1994 when he had arguments at home. He also said he was upset at the loss of his close friend, who had been posted out to Germany, and then was "gutted" at his failure as a driver. Sean's account of his present concerns was markedly similar to that given to Major Gen Shaw a week earlier.

42.5 Whilst a degree of reticence in discussing emotional difficulties with a doctor who is also of a superior rank within the hierarchical army system should not be discounted, Sean did divulge to both doctors his personal feelings and information about his sense of failure, his family relationships and loss of a close friend. If Sean was particularly troubled by any other matters it is perhaps surprising he did not mention them to either doctor when given the opportunity to do so.

42.6 Sean told Lt Col Gillham that he did not want to be a Pioneer as he felt that Pioneers were seen as less intelligent and considered to be of lower grade in the army. In Lt Col Gillham's view Sean experienced not being able to be a driver as a major loss. However, he encouraged Sean by telling him of his own good experiences of the Pioneer Corp. Sean said to him, as he had to others, that he would rather be a Pioneer than leave army service altogether.

42.7 In 1994 a recruit's GP records were not obtained and scrutinised as a matter of course during the recruitment process and so Lt Col Gillham was unaware that Sean had taken two overdoses and seen a psychiatrist previously and Sean did not volunteer that information to him. Lt Col Gillham was, however, aware from information given to him by Sean that Sean had been referred to child guidance services although Sean did not give any further information why and minimised the event saying he only went a couple of times. Lt Col Gillham asked if he could write to Sean's GP to get more details from his previous medical records. Sean declined to give him permission to do so saying "his parents might find out". [7] Lt Col Gillham's position was that even though Sean was in the army he required his consent to obtain these records.

42.8 Sean's reluctance to give his consent may have been explained by Sean being aware that he was being assessed for discharge by Lt Col Gillham. As Lt Col Gillham explained in his oral evidence, had he known at the time about the two earlier overdoses when he was assessing Sean this would not only have been relevant for his assessment and diagnosis but also relevant to whether Sean's initial application to join the service had been faulty due to his non-disclosure of these events.

42.9 Neither of the psychiatric experts who assisted this inquest were critical of the standard of Lt Col Gillham's assessment. I note however that Dr Jonathan Leach[8], the General Practice expert I instructed, did comment that there might have been more 'professional curiosity' about why Sean did not want there to be contact with his GP.

42.10 As it was Lt Col Gillham knew nothing of Sean's earlier history of overdose when conducting his assessment. He concluded that Sean was not suffering with any mental illness, but was exhibiting an 'adjustment reaction': an emotional or behavioural response to a stressful or upsetting event. In Sean's case he thought this was a reaction to three stressors: "family stress and loss of a friend and also to his change to Pioneer trade". He saw this as a temporary reaction to his current problems and so he did not believe there were grounds for discharging Sean from the army.

42.11 Lt Col Gillham told me that he "didn't want to rubber stamp the discharge of this young man at this time from the army, I thought he might make it," particularly when Sean was "very well motivated to stay in the army".

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[7] Lt Col Gillham told this inquest that he would have preferred to have third party information about Sean to aid his assessment and had asked if he could speak to Sean's parents, but Sean had refused as he did not want them to know he was in trouble. Sean also said that he did not want Lt Col Gillham to have any contact with his unit to obtain his conduct sheets.

[8] Dr AJ Leach MB ChB, MSc(Med), FRCGP, DRCOG, DIMC, RCS(Ed) served as an army Medical Officer from 1984-2008 reaching the rank of Colonel. He was a Professor of General Practice and is presently Clinical Lead and a Board member of the Redditch and Bromsgrove Clinical Commissioning Group.

42.12 Lt Col Gillham reported his administrative recommendations back to the CO at Deepcut stating that Sean was "not suffering from a psychiatric illness". He recommended that whilst "his reaction to disappointment at failing to be accepted as a driver might raise questions about his temperament", Sean should have "the opportunity to demonstrate if he can cope with the disappointment and the change of trade and normal disciplinary measures." He said in oral evidence that he meant by this "that they [should] treat him as a soldier".

43. Follow up and support: February 1995

43.1 Lt Col Gillham did not plan to follow-up Sean himself after this consultation, but reminded him of the availability of the GP service, Padre and WRVS at Deepcut if he needed any further support. He explained that he did not think Sean needed any formal psychiatric follow up and, furthermore, to offer this would give the unit a mixed message that Sean was psychiatrically unwell.

43.2 There is nothing to suggest that Sean proactively sought any psychological support from anyone within the Army Medical Services thereafter.[9] No witness recalled seeing Sean speaking with the Padre. Although some fellow trainees did recall that Sean was one among many privates who would spend some of their free time drinking tea and chatting with volunteers at the WRVS service no-one could provide any specific evidence as to when Sean was seen at the WRVS or why he was there.

43.3 Capt Cammack told me that on learning of Lt Col Gillham's assessment he understood the position to be that Sean should be "put back in the mix" and "treated the same as everyone else with no different measures in place". He described this as the problem being passed back to the squadron to deal with and try to manage. Capt Cammack said that he understood that Lt Col Gillham thought that Sean had nothing wrong with him, and although Capt Cammack did not agree with that assessment and was "disappointed in what we got back" from Lt Col Gillham, he did not feel in a position to question the psychiatrist's opinion.

44. Overdose: April 1995

44.1 Sean's next involvement with psychiatric services came about because he took an Anadin overdose on 11 April 1995. There is no evidence to suggest that he did this under the influence of alcohol.

44.2 Sean had told his fellow private, Alex Hayton that he was fed up and was going to take an overdose to get out of the army. Pte Hayton said he had not been concerned about

[9] Sean's medical records show that he was next seen at ATR Pirbright medical centre in the early hours of 22 February 1995 having lacerated his shin when he kicked a window, and that later in March he attended the Deepcut medical centre for consultations regarding minor physical ailments.

this, as he thought Sean was not being serious. However, about eight weeks before Sean's death Sean told Pte Hayton that he had taken two packets of tablets. Pte Hayton took Sean to the guard room at around 05:30 hours and he was seen at the Pirbright Medical Centre at around 06:10 hours on 12 April 1995. Sean said he had taken 22 Anadin extra tablets the previous evening at 22:30. The notes record that Sean stated that he "could no longer cope" but do not elaborate any further as to his intent.

44.3 Sean was transferred directly to Frimley Park Hospital where a nurse recorded Sean saying that he "hates work, unable to do what he likes as failed driving test... didn't want to kill himself, just needed attention… Slightly low in voice tone, feeling a bit embarrassed". In contrast the treating doctor recorded that Sean had told him that he had "wanted to end it all, [but] doesn't feel like that now". He was given supportive treatment and was fit to be discharged the next day.[10]

44.4 It therefore appears that despite having taken the overdose Sean proactively reported it to a fellow private and sought and accepted assistance. Whatever Sean's initial intent when taking the tablets, if there had been any motivation to end his life this clearly did not persist for long. Although a potentially serious act, Sean received timely treatment, and the consequences of the overdose were not life threatening.

45. Psychiatric assessment and management on 13 April 1995

45.1 As was routine for someone having taken an overdose, Sean was referred for a psychiatric assessment. Sean had been transferred to the medical ward at Cambridge Military Hospital where Lt Col Gillham saw Sean for the second time on 13 April 1995.

45.2 Sean told Lt Col Gillham that he had become used to the idea of becoming a Pioneer but over the past 2 weeks had become increasingly fed up with not being allowed to do his driver training again. Sean explained that when he saw others passing their driving tests "the wound had been re-opened" and he had been feeling jealous. His own Pioneer training had been put back because of the three month warning order. Sean said he was not looking forward to the Pioneer training and he was also worried about his finances.

45.3 Sean explained that he had bought the Anadin tablets in the NAAFI at 20:30 hours the previous evening intending to take them. Lt Col Gillham recorded that Sean had said that he had been "pissed off" and "tense" but that he had no suicidal thoughts at the time. Sean said he didn't want to die, but wanted to see what happened. Lt Col Gillham directly asked Sean about current suicidality and recorded Sean's response that he did not have any current suicidal thoughts.[11] Lt Col Gillham thought that this was another

[10] As the salicylate (i.e. Anadin) levels were reducing Sean did not require any active medical intervention.

[11] It was also recorded that Sean said he was sleeping well and his appetite was normal. He was making good eye contact, smiling, and was not depressed.

episode of an ongoing adjustment reaction in response to the unsuccessful end to his driver training. He understood that Sean "never meant to kill himself".

45.4 Lt Col Gillham provided a second brief psychiatric report back to the Deepcut Medical Centre that same day in which he recorded Sean's continued disappointment at not proceeding with driver training but that he nevertheless wished to remain in the army. He stated that he had encouraged Sean to try Pioneer training and told Sean that he would be happy to see him again and Sean could access him via the camp Medical Officer. Lt Col Gillham's report restated his earlier opinion that Sean was not suffering with any psychiatric illness but said that his personality was "immature" and he expressed uncertainty as to whether Sean would be able to "make it" in the army.

46. Follow-up and support April – June 1995

46.1 By 13 April 1995 Dr Alexandra McClenahan had resumed her role as the camp GP and she saw Sean later that day on his return to Deepcut from Hospital. She recorded "Took o/d because he doesn't want to be a Pioneer. Impression very immature. Discussed with OC." Dr McClenahan had no independent recollection of this consultation with Sean, but she said, and I accept, that she would routinely have said to a soldier that they could come back to see her if they had any more problems. She said that whilst she might occasionally refer a soldier to the Padre or to the WRVS volunteers she understood that soldiers usually approached these people for support themselves by a more informal route. The onus was left on Sean to seek any further help he wanted himself. Sean did not return to the Medical Centre again before his death.

46.2 Dr McClenahan followed her consultation with a phonecall and a letter to Major Gascoigne. In her letter she repeated the conclusions of Lt Col Gillham that Sean was "not suffering from any psychiatric illness but has merely got an immature personality" and noted that the Consultant Psychiatrist was "unsure as to whether Pte Benton will be able to continue with army life."

46.3 With Medical Services no longer formally involved with Sean, managing issues regarding his welfare reverted back to the squadron chain of command. Capt Cammack reacted in a similar way as he had to Sean's psychiatric assessment in February. He considered this was "passing the buck back to the squadron who were asking for help from the medical services"; as he put it, "we didn't know what to do." Capt Cammack's recollection was that the troop Lieutenants were, thereafter, asked to keep a close eye on Sean.

46.4 Whatever was observed by the chain of command in the ensuing eight weeks it is apparent that nothing further was reported back to Dr McClenahan.[12] She was not

[12] Dr Leach told me that if there were continuing concerns about Sean he would have expected this to have been raised through the chain of command and a re-assessment of risk requested from the medical authorities. Dr McClenahan agreed and said that she would expect that if there had been further

made aware by the troop staff of any unusual behaviour or of any general deterioration in Sean's presentation. Sean never came to her attention again.

47. Evaluation of the psychiatric and GP care

47.1 The psychiatric management of Sean was considered by my independent expert, Professor Tom Fahy,[13] and the expert instructed on behalf of Sean's family, Professor Gillian Mezey.[14] Both are Forensic Psychiatrists, each hold academic chairs and have a clinical position within the NHS. Both have many years' experience in the assessment and treatment of mental disorder.

47.2 Prof Fahy's opinion was that, given the information available to Lt Col Gillham, his formulation of Sean's problem was broadly correct, although with the benefit of hindsight he felt that the clinicians underestimated the severity of Sean's personality problems.

47.3 Based on her review of the documents alone, Prof Mezey described Lt Col Gillham's assessments of Sean as "detailed and comprehensive" and the psychiatric treatment and support of Sean and the communication between the psychiatric and GP services as "adequate". She described his care as "of the level that Sean would have expected in a non-military population" particularly in raising concerns about Sean in a timely fashion and communicating results and recommendations following psychiatric assessments.

47.4 In Prof Mezey's opinion Sean "was not presenting with symptoms that suggested a treatable mental condition" in Spring 1995.

47.5 Prof Fahy considered that it would have been appropriate, and potentially helpful in view of the self-harm episodes, to have offered Sean follow-up by a community psychiatric nurse in order to provide a brief series of supportive counselling sessions, but qualified this by stating that he could not confidently assume that Sean would have utilised this source of support effectively. He believed that, even if taken up, the impact of such support was likely to be modest, with a risk of Sean's premature disengagement.

47.6 Dr Leach, my GP expert similarly made no criticism of either of the GPs; he said that their care met the standards he would expect of 1995. Regarding the referral to Lt Col Gillham on 9 February 1995, Dr Leach said that for a patient who was not by then

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problems with Sean requiring her attention either Sean's troop commander, Major Gascoigne, or Captain Cammack would bring it to her attention. She said that had she been told that Sean was exhibiting any unusual behaviour, losing pride in himself or sounding as if he was going into some sort of depression her first port of call would have been to refer him back to Lt Col Gillham.

[13] MD, MPhil, FRCPsych

[14] MBBS FRCPsych

expressing suicidal ideation, to be seen by a Consultant within five days of referral was "exemplary".

48. Post-mortem psychiatric diagnoses

48.1 A post-mortem assessment of Sean's mental health and any potential psychiatric diagnosis is hindered by the loss of historic records such as Sean's child guidance records, social welfare notes and school records. Nonetheless from the documentary evidence and witness accounts available, both Prof Fahy and Prof Mezey felt able to offer an opinion as to Sean's likely psychopathology.[15]

48.2 Both agreed that Sean did not exhibit the symptoms of a mental illness. Any disturbances of mood were brief and transient, and there is no evidence to be seen of persistently depressed mood.

48.3 However, both experts independently of one another came to a similar view that Sean had an evolving personality disorder. They identified that Sean experienced problems with impulsivity, control of anger, heightened emotional reactivity, sensitivity in the context of disrupted relationships, episodic alcohol misuse and resort to self-harming and destructive behaviours in an effort to express and perhaps relieve intense emotions (sadness, disappointment, perceived rejection and anger) and to communicate and solicit help for short-lived but intense feelings of distress and despair. Some of these behaviours could be traced back to the age of 14 years.

48.4 Sean's clinical history of coping problems, impulsivity and poor distress tolerance was, in Prof Fahy's opinion, characteristic of dysfunctional personality traits. When such traits and behaviours become persistent and result in significant functional impairment (e.g. in domains of employment, education or relationships) these features reach the threshold where they can be characterised as a disorder of personality.

48.5 Both expert psychiatrists agreed that Sean's presentation was likely to reflect an evolving Emotionally Unstable Personality Disorder ('EUPD')[16].

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[15] Both with the caveat that one must be cautious when making a retrospective psychiatric diagnosis without directly assessing the subject.

[16] Using the WHO ICD coding; also termed Borderline Personality Disorder (using the American DSM-5 system of categorisation). The ICD-10 provides the following definition of EUPD: "A Personality Disorder in which there is a marked tendency to act impulsively without consideration of the consequences, together with affective instability. The ability to plan ahead may be minimal, and outbursts of intense anger may often lead to violence or behavioural explosions; these are easily precipitated when impulsive acts are criticised or thwarted by others. Two variants of this Personality Disorder are specified, and both share this general theme of impulsiveness and lack of control.

48.6 The diagnosis of EUPD reflects an enduring disturbance of personality characterised by fragile self-esteem, impulsivity, heightened emotional reactivity and efforts to manage emotional disturbance by self-harming or substance misuse.

48.7 Prof Mezey comments that Sean was still a relatively young man and his personality was still maturing so it is difficult to predict whether in time the features of personality disorder would have become more apparent. Prof Fahy relied upon the following features that he noted in Sean's history as supporting the existence of a clinically significant disorder of personality and coping ability which he thought most likely to be the evolving condition of EUPD:

1. Marked impulsivity, as evidenced by reports of recurrent disciplinary problems and behavioural disturbance over a short period of time.
2. Affective instability, evidenced by references to intense emotional reactivity especially in response to his failure to progress as a driver, but with other examples from as early as 14 years.
3. Recurrent episodes of self-harming behaviour.
4. Difficulty controlling anger, as evidenced by numerous angry outbursts and behaviours, leading to disciplinary problems.
5. A suggestion that he had a predisposition to intense relationships followed by intense feelings of loss or abandonment.[17]
6. The likelihood that Sean's final fatal act of self-harm was the consequence of an inability to cope with a change in his life circumstances and army prospects.

48.8 Prof Fahy considered that a diagnosis of Emotionally Unstable Personality Disorder was more apparent in retrospect, in the light of the totality of the clinical history, than it would have been when Sean was assessed by Lt Col Gillham in April 1995. As Prof Fahy stressed, he had far better information than the army doctors of Sean's pre-army history, most importantly the two overdoses before Sean entered the army. The army doctors would not have had sufficient evidence to confirm this diagnosis as they did not have evidence of Sean's childhood problems or earlier psychiatric consultations and only became aware of his coping and behavioural problems within the specific context of his failure to progress as a trainee driver. Nor would the army doctors have been able to

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Impulsive type. The predominant characteristics are emotional instability and lack of impulse control. Outbursts of violence or threatening behaviour are common, particularly in response to criticism by others.
Borderline type. Several of the characteristics of emotional instability are present; in addition, the patient's own self-esteem, aims, and internal preferences are often unclear or disturbed. There are usually chronic feelings of emptiness. A liability to become involved in intense and unstable relationships may cause repeated emotional crises and may be associated with excessive efforts to avoid abandonment and a series of suicidal threats or acts of self-harm (although these may occur without obvious precipitants).

[17] E.g. his relationship with Ryan Cook.

factor in, as Prof Fahy could, the circumstances of Sean's death, the content of the letters he wrote shortly before his death, and evidence of his mental state around 8 – 9 June. Furthermore, there has been significant development in psychiatry in respect of the diagnosis of EUPD during the last two decades.

48.9 Under these circumstances, Professor Fahy stated, and I accept, that it was reasonable for Lt Col Gillham to describe Sean's problem as an adjustment difficulty arising from problematic personality traits and to suggest that the problem did not constitute a diagnosable psychiatric disorder.

48.10 Lt Col Gillham's use of a non-clinical term "immature personality" was not unreasonable, and neither were the conclusions that Sean's prognosis was uncertain and that it was possible that Sean would mature in his coping ability and adapt to his circumstances within a manageable timescale.[18] Lt Col Gillham told me that if he had known about Sean's previous two overdoses, that would definitely have made a difference to his own assessment.

[18] Prof Mezey has also put forward another potential retrospective diagnosis, of Attention Deficit and Hyperactivity Disorder ('ADHD'). ADHD is a persistent pattern of inattention and/or hyperactivity-impulsivity, that is more frequent and severe than is typically observed in individuals at a comparable level of development. Symptoms are apparent in childhood and in most cases, they attenuate during late adolescence or early adulthood. A minority of individuals, however, do experience the full complement of symptoms into mid adulthood. Very often the disorder remains un-diagnosed and symptoms are often interpreted by others as due to laziness or simply bad behaviour. Prof Mezey considered that the symptoms exhibited by Sean after he joined the Army, would be consistent with the adult presentation of ADHD. Prof Fahy agreed that this was a reasonable suggestion, albeit ADHD was not a diagnosis he would venture without more detailed and quality information about Sean's childhood development, such as interviews with a parent or school records. He had not had the advantage that Prof Mezey had of speaking directly to Sean's family when he conducted his assessment.

EVENTS OF JUNE 1995

49. Events in Camberley: 1 June 1995

49.1 Sean's sense of grievance in respect of guard duty allocation appears to have been the catalyst for events at a pub in Camberley on Thursday 1 June 1995. Although Sean had recently returned from a long weekend's leave over the late May bank holiday, he returned to a guard duty on Wednesday 31 May. By 1 June Sean must have known that he was rostered to do guard duty on Saturday 3 June.

49.2 Lance Corporal Terri Lewis was B Squadron's rations and duties clerk. She also had the responsibility for guard duty allocation from early 1995. She explained that guard allocation would be rotational and would depend upon the manpower available. There was no deliberate policy to allocate more guard duty to particular individuals although she understood that extra guard duties were given out as an informal punishment. She was sometimes asked to do this by other NCOs – she said she thought it was not right to do this. The only occasion she was told to give extra guard duties to Sean as a sanction was, she said, after 2 June 1995; she had not been asked to do it before.

49.3 On 1 June 1995 LCpl Lewis was in a pub in Camberley with friends. Sean was also there and caught her eye because he was being loud and was quite drunk. At around 23:00 Sean came over to her; he was upset and angry. She said he started to 'kick off', saying he was sick of doing guard duty and that he held her responsible. In a statement she wrote the following day, LCpl Lewis recorded that Sean was complaining of "being put on a weekend guard duty…[and was] very irate and aggressive". Her contemporary account described Sean persisting in a public threat, despite his male friends trying to calm him down. Sean threatened to shoot LCpl Lewis if she ever put him on guard duty again. In her police statement in 2002 she recounted that Sean had said something like "I know what car you have, a white Honda, and when I see you driving into the camp when I'm on duty I'm going to discharge my 10 rounds into your car". She told me he repeated that threat in front of other privates.

49.4 A second incident of insubordination by Sean occurred shortly afterwards. Some 15 minutes after threatening to shoot LCpl Lewis Sean swore at Lt Radford who was also off duty in the same pub. Lt Radford told me that he was leaving the pub when he heard a voice telling him to "fuck off". It was Sean. His contemporary account records that his first reaction was to say "excuse me" and to remind Sean that, even though he was out of uniform, he was an officer who should be spoken to in a more civilised manner. Sean replied "Fuck off you knob, who do you think you are telling me what to do?" Lt Radford then warned Sean to report to him the next morning. Lt Radford was of course already aware that Sean was on a three month warning order.

49.5 One of the trainees who was present in the pub that evening, Pte Alan Lonie, also recalled that it was Sean who began the conversation with Lt Radford, although he said

that Sean "maybe said something out of jest, a bit of fun" he said that Lt Radford replied "I will have you out of this man's army, you come and see me tomorrow". Lt Radford denied making that latter comment. Pte Lonie agreed that Sean then had said "fuck off Sir" or words to that effect to Lt Radford; he thought Sean had been unhappy that Lt Radford was standing too close to him. Pte Dilkes who was also present had told Surrey Police in 2003 that she thought Lt Radford said something to Sean first, Sean replied, and in the course of the exchange, Sean lost his temper. Her recollection was that words were said on both sides and that Sean later hoped that because they were in civvies the incidents would be forgotten about.

49.6 The accounts of that evening differ in some details and have not been helped by the passage of time (for example Lt Radford thought he was in the pub with Sgt Stevens which must be wrong as Sgt Stevens was on his honeymoon at the time). However there can be little doubt that Sean did swear at an officer and – whether he was being serious or not – threatened to shoot an NCO.

49.7 As a consequence Sean was charged with two counts of using insubordinate language to a superior officer. He did not dispute either charge. Indeed Sean wrote his own brief account of the events in a letter later found at the scene of his death. Sean had written to his parents:

> "I got drunk on the 2nd of this month down a pub called the Staff and I said fuck off, quite a few time to Lt Radford and then I said to LCpl Lewis if you put me on guard again on a weekend I'll shoot ya."

50. Insubordination charges: 2 June 1995

50.1 LCpl Lewis has said that she had not taken Sean's threat seriously. She felt it was borne out of frustration and fuelled by alcohol. When she saw Sean the following morning Sean had no memory of what had occurred. He was very upset with his actions and showed remorse, apologising profusely. However, as she knew Lt Radford had been at the pub she felt she should be taking some form of action. She said she told Sean that she was not going to charge him, but was going to put him on guard duty instead. Sean understood this and accepted it. She suggested that this was the first time she had ever decided to impose extra guard duty on a trainee as punishment herself.

50.2 If this account is accurate then imposing upon Sean something she believed it was not right for an NCO to do, and bringing about the very thing Sean had been complaining of and which had triggered his threats to shoot her in the first place, seems particularly ill-advised.

50.3 Subsequently, in accounts given after Sean's death, LCpl Lewis has said that she was unaware at the time that Sean was on a three month warning order. She has since claimed that her use of the informal punishment of extra guard duty was overruled, and

that Sgt Russell and Lt Radford placed her under some duress to charge Sean for insubordination instead. She said she was put in front of the 2iC Capt Cammack, was threatened with gaol herself if she did not bring a charge, and so she succumbed to the pressure and warned Sean for orders. It was only after this when Sean was taken to see Capt Cammack that she first learned that Sean was on a three month warning order and the severity of what was about to take place. She maintains that she had no idea that Sean had had a separate altercation with Lt Radford that evening, leading to Sean being charged with a second insubordination, until her preparations for giving evidence at this inquest.

50.4 This account does not accord with her contemporary statement which she signed on 2 June 1995. LCpl Lewis makes no mention of being reluctant to charge Sean; she did record that she mentioned the incident to Lt Radford and sought his advice about charging Sean. Lt Radford has no recollection of this, but accepted that she may have sought his advice. He firmly denied the suggestion that there was any plan to charge Sean twice so as to ensure he was discharged from the army.[1]

50.5 Irrespective of the truth regarding how Sean came to be charged of the offence against LCpl Lewis, there can be no question that Sean had committed insubordination. It is unlikely that something as significant as swearing at an officer in public and making a threat to kill an NCO could be overlooked, even if committed under the influence of drink. As Major Gascoigne told me it was a "5 out of 10" in terms of seriousness: "it wouldn't be the first time that a soldier has got necky with an officer, but it is not something that you can allow to pass."

50.6 I am not able to accept LCpl Lewis' accounts as to the events of 2 June 1995.[2] There is no evidence from her contemporaneous accounts that she actually spoke to Sean that morning and sought to give him an informal punishment or that she was placed under any duress to charge Sean. Furthermore, she has been inconsistent in her accounts as to who was present when she says improper pressure was exerted upon her. In 2003, she suggested that Sgt Russell told her to put Sean on additional guard duty after the hearing of the charge (which was on 8 June) and that she objected to this. Sgt Russell denies this, and, as Sgt Gavaghan said, it would make no sense to let a potentially disaffected soldier have the important task of looking after a security in the camp. When it was pointed out to Ms Lewis that Sean must have already been rostered for his 8 June guard

[1] Capt Cammack recollects speaking with Lt Radford about charges. As far as he was concerned, it was up to the victim to decide whether to bring the charge, and he had no discussion with LCpl Lewis, let alone brought pressure upon her.

[2] The Blake Review took the view that somebody considering LCpl Lewis's accounts given since 2002 would be compelled to treat those accounts with very considerable caution. I wish to make it clear that my approach has been to consider her evidence afresh. She had the benefit of representation, and her counsel, Mr Payter, took advantage of the opportunity to ask her questions after she had been examined by some of the Interested Persons. I heard her evidence over two days and I have considered her evidence with all the other evidence presented at this inquest.

duty before the hearing of the charge that same day she developed a new account, not mentioned in any earlier statement, and now suggested she had chosen to put Sean down as a reserve guard on 8 June in defiance of Sgt Russell because she did not want Sean to be punished with extra guard duty.

50.7 Ultimately it would have been LCpl Lewis' decision whether to charge Sean and produce the witness statement in support that she signed. However, it is hardly surprising that Sean's conduct resulted in a charge. It cannot be said that the charge was not a proportionate response to a threat to shoot an NCO. Similarly, whether Lt Radford made a remark about having Sean out of the army or not, Lt Radford's decision to warn Sean for orders cannot be criticised for being disproportionate.

50.8 I am satisfied that LCpl Lewis was not put under undue pressure, and the charge was her voluntary decision. I do not accept her suggestion that the incident involving her and Sean in the pub was used as leverage to get Sean out of the army against her wishes. Sadly the process of Sean's impending discharge had been set in motion by his own behaviour towards her and Lt Radford. If the chain of command was somehow seeking to engineer Sean's discharge (and I make no finding that it was) the incident with Lt Radford alone would have provided sufficient justification given the three month warning order was still current.

50.9 There have been allegations and counter-allegations aired at various times between LCpl Lewis and Sgt Russell and what they say or have alleged to have said about each other really has little bearing on the facts I am required to decide. The relevant issue is whether Sean was only placed on the guard roster on 8 June because Sgt Russell ordered that he should be. I do not believe that this is likely to be what happened. Sean was down as a reserve to do guard duty that day, which Major Gascoigne said was a "fortuitous coincidence" when it came to considering what to do with Sean next.[3]

51. Lance Corporal Lewis

51.1 LCpl Lewis has portrayed herself in her evidence as someone who had defended Sean from the negative attention of other NCOs. There are indeed a number of witnesses who described LCpl Lewis as one of the more approachable NCOs, particularly for female trainees. However her evidence that she felt she and Sean had a bond and that she complained when others acted badly towards him is largely uncorroborated.

[3] Major Gascoigne and Capt Cammack both told me that it was on 8 June that Sean learned he was being formally charged and an application would be made for his discharge. However Cpl Palmer recalled that a few days before Sean died Sean looked unhappy and said something like: "I am pissed off, they are going to kick me out on Monday." The 5 June was a Monday; Sean may well have predicted before 8 June that the writing was on the wall. However if this was the case it is of note that he undertook guard duties on 3 and 5 June when he would have access to a rifle.

51.2 Pte Michelle Griffin for example told Surrey Police that LCpl Lewis did not like Sean and that they were always arguing.

51.3 LCpl Lewis' evidence that between April and June Sean would seek her out for support and they would have frequent conversations about how he was feeling does not sit easily with her acknowledgment that she did not know about him failing his driving test at Leconfield, or that he had seen a psychiatrist in February and April, or that he had taken an overdose. She also said she did not know he was on a three month warning order. LCpl Lewis gave a fresh account at the inquest saying that she remembered being in Captain Cammack's office sharing her concerns with him about Sean; but when later pressed on this point she changed her evidence and said she could not actually recall doing this. LCpl Lewis is not mentioned in Sean's final letter to Sgt Gavaghan in which he thanked him and three other NCOs who he felt had helped him.

51.4 Because of the substantial inconsistencies in her evidence I find that little reliance can be placed upon LCpl Lewis' account of her supportive relationship with Sean or that she stood up for Sean against others in the regime. Furthermore it would appear that her account developed at a late stage, possibly for reasons which are connected to her animus towards the army, and unrelated to Sean's death.

52. Guard Duty: Thursday 8 June 1995

52.1 Sean paraded with the guard at 06:30 hours on 8 June 1995. Pte Raymond Rowlands told me that, when on parade at the guardroom, Sean was pulled up for his uniform and "he sort of flips and went for the person inspecting us basically, lunged towards him". Although he thought this person was a Scottish sergeant this is likely to have been Cpl McDowell, an RP Corporal who took that morning guard parade.

52.2 Cpl McDowell told me that on the parade he had noticed Sean's boots were in a "shit state" and when pulled up for this Sean tried to punch him. The punch missed. Cpl McDowell ordered Sean into the guardroom cell and left him there for 10-15 minutes. He told me he thought the explanation for Sean's behaviour was that he was "just having a bad morning".

53. The insubordination hearing

53.1 Later on in the morning of 8 June the insubordination charges were formally heard by Major Gascoigne.[4] Sean admitted the charges and in Sean's own words, taken from his final letter to his parents:

[4] Whilst the precise time that Sean was brought before Major Gascoigne to answer the charges is not recorded, Cpl McDowell told the Board of Inquiry in 1995 that Sean was released from the cell in the guardroom at about 07:00 hours to prepare for the charges. Major Gascoigne recalled in 2003 that he usually commenced such business in the mornings and Capt Cammack believed Sean's charges were heard around lunchtime.

"I was then warned for orders and put in front of the OC and he charged me 7 days ROPs and a weeks fine. I got marched outside of his office by the SSM and then I was marched back into the OC's office and he said he was going to be apply for me to be discharged."

53.2 As well as a fine of £150 and the 7 days restriction of privileges, the significant consequence was that, in line with the terms of the three month warning order, Sean was told his discharge would now be applied for. Although Sean had only had 5 days of his warning order left to run when he committed the offences, and there was still an administrative process to complete, no one anticipated anything other than that the outcome would be Sean's discharge from the army. Major Gascoigne recalled that Sean was "mute" when the charge process took place and the administration process went through. This suggests a sense of resignation.

53.3 No one has suggested to me that but for the events in the pub on 1 June, Sean would otherwise have been discharged at the end of the three month period for overall poor performance. He had been due to start his Pioneer training later in June.

54. The discharge decision

54.1 Major Gascoigne was aware that the discharge application would have a significant impact on Sean. He said he "knew full well that we would have a very, very upset soldier on our hands and as a result we needed to take one or two extra precautions." Lt Radford similarly agreed that he too knew Sean would be disappointed and there was a possible risk of self-harm, however he could not recollect what measures were put in place to protect Sean from that risk. He said this would have been the responsibility of Capt Cammack.

54.2 Major Gascoigne also said he directed Sgt Gavaghan to make sure Sean got to bed without any trouble. He did not give him any specific instructions but said he trusted Sgt Gavaghan to know what to do in terms of looking after Sean.[5]

54.3 Sgt Gavaghan was to be the guard commander overnight on 8 – 9 June. When he commenced duty, at around 17:30, he was already aware that Sean's discharge was to be applied for. His recollection was that he had seen Sean who told him this himself. He then had sought out Capt Cammack to discuss whether Sean continuing as part of the guard that evening was the right thing to do given he was soon to be discharged.

[5] Major Gascoigne told me that home was now the best place for Sean, and that his plan was that Sean would be sent home the next day. Major Gascoigne did not mention this to the original Inquest in 1995 or in his statement made when these matters were fresh in his memory; it was first mentioned in his statement to Surrey Police in 2002. It was put to Major Gascoigne that he did not give thought to Sean going home at the time but has persuaded himself of this over the years: in my view this appears to have been the case.

54.4 Sgt Gavaghan's account at this inquest was that he did not know Sean well before that evening and he had not known that he had been on a three month warning order. However he was aware of the two window incidents in the spring and that Sean had self-harmed and had undergone psychiatric assessments. "More importantly," he said, he "knew that he never wanted to be discharged from the army". He said that he had concerns about Sean's potential for self-harm. However, because he thought Sean's risk of self-harm arose when he was drunk, his main concern was to keep him away from alcohol. Unlike Capt Cammack, Sgt Gavaghan did not know about Sean's overdose in April which had not involved alcohol.

54.5 The decision that Sgt Gavaghan and Capt Cammack came to was that Sean would continue to assist Sgt Gavaghan, in his guard commander role, but that he should not be used on the stag rota. [6] Their intention was that Sean should not have access to a rifle and ammunition but would be kept occupied and away from the NAAFI by assisting Sgt Gavaghan patrolling the RLC museum that was situated outside the camp.[7]

54.6 Sgt Gavaghan said that he briefed the trainees who paraded for guard at 18:30 hours that Sean would not be doing stags, but employed doing jobs including "mobile patrols" of the museum with him and then securing the NAAFI that evening before standing down. He said he also relayed this on their return to those trainees who were out on stags at 18:30.

54.7 What the trainees were not specifically told was that the chain of command intended that Sean should not have access to a rifle and ammunition.

54.8 In respect of weapon allocation, the Orders for Static Guards at the time stated:

> "Sign in and out your allocated weapon and ammunition at each change of duty on the allocation sheet held by the guard commander, you are personally responsible for the safe custody and handling of the weapon and ammunition in your charge during your tour of duty."

54.9 The SA80 rifles and magazines used by the guards were not personal to the soldier but were drawn from a pool of weapons held securely in the guardroom. Rifles were issued from and returned to the guardroom on two hourly rotation, being signed out each time. Trainees did not necessarily use the same weapon for the entire guard shift, so it would be understandable if they felt no particular 'ownership' of a rifle.

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[6] Major Gascoigne told me that, in retrospect, his view was that keeping Sean on reserve guard seemed like a sensible decision: if Sean needed to be kept close, the guard room was the only place which had military command 24 hours a day.

[7] There do not appear to have been any positive steps taken to restrict Sean's access to weapons before 18:30 hours. Cpl Holder arrived on duty as guard 2iC at around 18:30, he told the first inquest in July 1995 that he was briefed by Sgt Gavaghan that "in no instance" should Sean be allowed to take over one of the stags with a weapon. Pte Richardson also recalled Cpl Holder telling her that Sean was to be a 'runner' for Sgt Gavaghan.

54.10 There was no explicit order or instruction to trainees that they must not hand over their allocated weapon to another guard; clearly there should have been. The Board of Inquiry into Sean's death recommended that the orders to the guard commander be revised to ensure that there was specific reference to this whenever trainees were paraded for guard and this change was subsequently put in place.

55. Sean's movements on the evening of 8 June

55.1 Sean accompanied Sgt Gavaghan on patrols of the museum over the evening of 8 June and was also seen around the camp and at the NAAFI by others. Sgt Gavaghan recalled making three visits to the museum with Sean before 22:00 hours. He said that Sean's demeanour at the beginning of the evening was that he was unhappy as he did not want to be discharged. But as the evening went on he seemed to accept the fact of what was going to happen and to look more into the future. Sean told him he was concerned about getting employment, going back to Hastings and where he was going to live. He felt guilty that he had not made his family proud. However, as the evening went on, Sgt Gavaghan thought that his mood seemed to "perk" and he realised that he did have other options.[8]

55.2 Pte Sara Richardson, who was the duty driver that evening, drove Sean and Sgt Gavaghan to the museum. She knew Sean a little and noted he was upset and that Sgt Gavaghan was trying to reassure him. She heard Sean asking how to tell his mother and family what had happened – she later learned from Sean that it was his discharge he was discussing. She described this saying "It was the soft side of Sergeant Gavaghan that evening in the vehicle. He was reassuring. Very reassuring. Saying it will be okay… I think he was pacifying him and I do believe he was trying to keep him out of trouble". In her statement written the following day, shortly after Sean's death, Pte Richardson said that "at no time prior to Private Benton shooting himself did I hear him say anything which would indicate that he was intending to commit suicide."

55.3 Several of the guard (Ptes Claire Dilkes, Deborah French, Victoria McKinlay and Stephen Wilson) recalled seeing Sean back at the guard accommodation writing letters after dark.[9] Some also recalled Sean asking for stamps. Pte Adele Taylor remembered teasing Sean for writing a letter to his Mum: she ruffled his hair and he got embarrassed. He asked Pte Knowles for help with spelling and with different ways of saying things.

[8] Sgt Gavaghan also offered to provide Sean with a reference, saying it could not be a detailed character reference but a factual reference confirming that he had been in the army.

[9] Sean was not constantly under the eye of Sgt Gavaghan throughout the evening. Pte Hunter recalled seeing Sean in his combats at the NAAFI. He recalled that Sean told him he was on "open arrest", which he understood to mean that he could do whatever he wanted on camp but had to regularly check back in with the guardroom. Sean also became involved in a darts match with a celebrity player, who was visiting the camp.

She thought this was after her last stag between 03:00 – 05:00 hours. She said Sean was normally quite a "manicky", "jiggery" *(sic)* person, but at this time he seemed very calm and matter of fact.

55.4 Pte Michelle Griffin had been a friend of Sean's at Deepcut but had been posted to Catterick before June. She told Surrey Police in 2005 that Sean used to write to her after she left Deepcut and she had received 10-12 letters from Sean. In the last of these he wrote that he was going to be discharged and was leaving the army. She described it as "like a suicide letter"…"full of doom and gloom": "he wrote that he had ruined his last chance and was at a loose end. He wrote that there was nothing worth living for and he was at a low ebb and there was no point going on." Unfortunately Pte Griffin had no longer retained Sean's letters by the time of the Surrey Police investigation; she did not give evidence at this inquest as she could not be located.

56. Attempts to access a weapon

56.1 Pte Richardson recalled in 2003 that Sean said that he wanted to complete a guard stag and Sergeant Gavaghan would not let him. At that stage Pte Richardson did not know why. On returning to the guardroom Sergeant Gavaghan explained to her that Sean was not to have a weapon or be allocated to the gates as he was to be discharged.

56.2 In addition to Sean asking Sgt Gavaghan for a stag duty, there is evidence of two other attempts by Sean to gain access to a weapon during that guard shift. Pte Dilkes told Surrey Police that when she and Sean were together on the evening of 8 June, he told her he would "love to do a stag" explaining that it might be the last one he would ever do. He then offered her ten pounds if she would lend him her rifle and let him do her stag. Whilst others have told me that it was not unusual at Deepcut to pay others to cover one's own guard stag – offering to <u>buy</u> a stag from another trainee would have been unusual. Pte Dilkes said that Sean "begged and pleaded" but she refused. She told Surrey Police in 2002 that she feared he wanted to harm himself or another.

56.3 Pte Dilkes' account to police was that she went inside the guardroom and told the other privates what Sean had said to her and told them not to let Sean have their rifles. She thought Ptes Embleton, Sargeant and French were present. She also said she went up to the guardroom and told Sgt Gavaghan what had happened and he told her just to ignore Sean.

56.4 Pte Dilkes' evidence echoes that of Pte Adele Taylor, whose statement to Surrey Police was also read as she has not been traced. In 2002 she said she recalled that "there was a rumour going around that [Sean] was not supposed to be near weapons. I do not know if the rumour was true". She recalled that in the early hours of 9 June 1995 as she was going out onto duty Sean said "Oh let me do your stag": she refused. She said she

thought she recalled saying to one of her colleagues that Sean was not allowed to handle weapons. However seven years after events, she appeared to be unsure of this.[10]

56.5 Pte Dilkes' recollection was put to each of the three female privates she names. Pte French remembered her saying that Sean had been trying to buy her stag, but that this was said after Sean's death. Pte Embleton told me "categorically" that she was not told this before the death, but it was spoken about afterwards. Pte Sargeant, who was friends with Pte Dilkes, did not remember it being said at all.

56.6 Sgt Gavaghan's account was that he was unaware that Sean was apparently trying to buy a stag duty. If he had been aware, it would have concerned him.

56.7 Constrained as I am by not having heard Pte Dilkes' oral evidence, it does seem likely that Sean did approach her seeking to access a weapon that night by 'buying' her stag. However, although I also accept that Pte Dilkes did tell Pte French and Pte Embleton about Sean's request, it is most likely that the passage of time combined with her own grief and shock at the loss of her friend had altered Pte Dilkes' memory of the timeline, and that she did not mention the matter to anyone until after Sean's death. However, I do not believe that any proper criticism can be levelled at Pte Dilkes for not informing an NCO of Sean's request. She had robustly refused it, she had not been told that the Guard Commander's intention was to keep Sean away from a weapon, and there was nothing in Sean's demeanour that suggested the tragic events that were to follow.

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[10] I also heard of an earlier occasion when Sean may have attempted to get on stag when he was not allocated to armed guard duty. Cpl (now Major) Paul Davis told me that he recalled an occasion when he was in the guardroom and Sean came in and said he had been sent by Cpl Holder to relieve another private on duty, as Cpl Holder wanted to see her. That trainee was not due back from their stag for two hours, so Cpl Davis flatly rejected the request. In court and when speaking to Surrey Police in 2002, Cpl Davis suggested this event had happened in late to mid May 1995. However he has subsequently provided a statement which, reconstructing his movements in 1995 from his medical records, suggests this happened no later than early April.

Cpl Davis' attempts to reconstruct the timeline and, in particular, to provide times when he may have been on duty, do not resolve the position with any clarity. With the benefit of hindsight whenever it took place, it was unusual behaviour by a trainee upon whom chain of command say they were "keeping an eye", but being an instructor in A squadron, Cpl Davis did not know Sean at the time.

However, whilst this incident could have been an attempt by Sean to get a weapon, whatever the correct date I cannot accept the submission on behalf of Sean's family that this event necessarily indicated an increased self-harm risk that should have been identified and guarded against at the time. It is too speculative to conclude that this was an attempt to wrongfully obtain a weapon to self-harm, particularly given that Sean was anyway uneventfully rostered onto guard duty on two days in April and five dates in May 1995.

SEAN'S DEATH

57. How Sean obtained a weapon

57.1 On the morning of 9 June 1995, between 05:00 – 07:00, Pte Terri-Ann Embleton and Pte Beverley Garratt were posted to guard duty at A8 gate which was on the access route to Pirbright Barracks at the eastern perimeter of the Deepcut site, near the Officers' Mess. This was their final 'stag' of a guard shift which commenced the previous day. Pte Embleton began her shift at 06:30 hours. Pte Garratt had not been warned on the guard rota but had informally swapped into the evening shift at 18:30 hours, replacing another private who had wanted to go home that weekend.

57.2 Both privates were armed with SA80 rifles. The security status at the time required magazines to be carried in pockets and not fitted to the guards' rifles. The usual practice was for guards to be issued a magazine and ten live rounds of ammunition. In common with all the trainees allocated to stags, Pte Embleton had signed a 'weapons and rounds allocation' form to acknowledge the receipt of ten rounds.[1]

57.3 Both Pte Embleton and Pte Garratt gave a brief contemporary account of events in statements taken on the day of Sean's death. They subsequently assisted the Surrey Police investigation in 2002-3 and both gave oral evidence to this inquest. In particular, Pte Embleton gave detailed and helpful evidence about an extremely distressing moment in her life that has, understandably, profoundly affected her. I want to pay tribute to her courage in coming to court to recount the events of 9 June 1995 in detail, when publicly reliving that morning has inevitably caused further distress. I am extremely grateful to all Interested Persons who assisted in enabling her to give her best evidence by agreeing that all of their questions to Pte Embleton should be written in advance and presented through my counsel.

57.4 There are no inconsistencies of any significance between Ptes Embleton and Garratt and no reason to doubt their accounts of how Sean then came to obtain a rifle that morning.

57.5 At around 05:30 hours on 9 June 1995, Sean approached A8 gate from the direction of the guardroom. He was dressed as if for guard wearing his combat fatigues. Both privates were aware Sean was part of the guard force and Pte Garratt knew that he had been employed to run errands for Sgt Gavaghan. Sean spoke to Pte Garratt and asked her name; when she gave it he said she was not the one he wanted. He then asked Pte

[1] It was seven years after events when Pte Embleton was first asked in a police interview to recall how those rounds had been issued to her and, understandably, she was by then unable to recall whether she had been presented with a magazine already loaded or with separate individual rounds and whether or not she had counted the number of rounds she had been given.

Embleton for her name, and told her she was the one he was looking for. He said he had been told to relieve her because Sgt Gavaghan wanted to speak to her at the guardroom.

57.6 Pte Embleton had seen Sean earlier that evening in the guard accommodation when he had brought her sandwiches and offered to wake her up for her early morning stag. She had no reason to think he was not part of the guard rota. She did not know that Sean was on the cusp of being discharged and had not been told anything to the effect that Sean ought not to have a weapon. A few hours earlier, she had been speaking to Sgt Gavaghan about her future career, so his now wanting to speak to her was unremarkable. As far as she was concerned, she had received an order from a NCO which was to be followed. She told the inquest that she had been trained to trust her colleagues in the army and had no reason not to trust Sean. There was nothing unusual in Sean's demeanour.

57.7 Pte Embleton handed her rifle to Sean. She started to walk away then recalled she still had the magazine in her pocket. She handed that over along with the rules of engagement card that all guards carried. Then she ran to the guardroom, as she wanted to get there as fast as she could, to find out why Sgt Gavaghan wanted to see her.

57.8 Pte Garratt told the inquest that a trainee turning up to take over another trainee's guard post was unusual in the sense of not having happened before, but it did not feel strange at the time. After Pte Embleton left, Pte Garratt recalled asking Sean about Sgt Gavaghan, and whether he was in a good mood. He said he was. Sean then said that he was going to do a 'prowler' patrol and walked away parallel to the perimeter fence that led north towards the Officers' Mess car park.

57.9 It is clear that Sean had devised a carefully planned ruse to trick one of the guards into handing over her weapon. Whilst many soldiers would understand that they had individual responsibility for a weapon issued to them, these rifles were issued for two hour periods from a shared guard pool. There had been no general instructions given to trainees to never hand one's rifle to another member of the guard, nor were any specific instructions given to that guard shift regarding Sean not being allowed a weapon. Given that Sean was wearing combats and had been seen to be part of the guard cohort, it is not surprising that Pte Embleton handed over her rifle. Many trainees in her position would have done the same thing. I am in no doubt that Sean's approach would have been a convincing one. After his earlier attempts to obtain a rifle had not succeeded Sean had clearly taken some time to calculate this plan. It is not surprising that even as a more mature recruit Pte Embleton was duped in the circumstances. No-one – whether Sean's family, the Ministry of Defence, or this court – makes any criticism whatsoever of Pte Embleton or Pte Garratt, or attributes any responsibility to them for what happened next.

57.10 Pte Embleton told me "there is absolutely no way I would have given him my rifle had I have known that he had any issues or problems…I didn't even know he was not on full

guard. And I know myself…that I would not have given him my rifle if I had have been in any doubt as to the person he was at that time…he seemed genuine." Sean was "somebody I believed was part of the army, was part of my team". Pte Garratt was asked what they would have done had they been told before that Sean was not to have a weapon: "We both would have had the opportunity to talk about it and say no."

57.11 It is overwhelmingly likely that had Ptes Embleton and Garratt been specifically told that Sean should not have been allowed a rifle, they would not have allowed him to acquire one.

58. Response of the guardroom

58.1 Pte Embleton took about five minutes to reach the guardroom; on duty there were Cpl Martin Holder as guard 2iC and Pte Sara Richardson, the allocated duty driver. When she explained why she was there Cpl Holder, knowing Sgt Gavaghan was asleep, told her that Sgt Gavaghan had not asked for her. He immediately told her to go back to her post, get her rifle from Sean and tell Sean to come back. She returned to the gate, and found Pte Garratt there by herself who told her that Sean had gone on a prowler patrol and that she had heard the sound of a weapon being fired.

58.2 The primary sources of information about what happened next are the eyewitness accounts of Cpl Holder and Pte Richardson. The expert scientific, ballistic and pathological evidence is illuminating in some respects in that it is capable of excluding some possibilities. However, as I will discuss shortly, given the low quality of the 1995 investigation there are significant limitations on what the expert medical and ballistic evidence can positively establish so long after events.

58.3 The inquest has explored the evidence of several witnesses who recall hearing shots at the relevant time. There are numerous discrepancies in the timings and number of shots that different witnesses recall hearing and whether they believe they heard automatic fire or not. None of those witnesses saw what happened and most made no contemporaneous record but were reliant on memories first recorded, at best, seven years later. I can place little weight on these aural recollections where they are not grounded in contemporaneously recorded accounts – of which, regrettably, there are few. I have therefore drawn much of what follows from the evidence of those who did directly witness events or wrote contemporaneous statements.

58.4 Cpl Holder and Pte Richardson have previously given several accounts of that morning in different settings.[2] It is not at all surprising that there are some inconsistencies within the accounts each have given and between them over the past 23 years, particularly when dealing with a fast-moving and traumatic event. That there are a few

[2] First in brief statements written on 9 June 1995 in the aftermath of events when they were both clearly still in shock; second (in Cpl Holder's case) to the original inquest; third to the Board of Inquiry; then multiple times in interviews with Surrey Police during their 2002-3 investigation. Their evidence now runs to over 700 pages of documentation.

inconsistencies I take as some support for them not having colluded in their accounts, those inconsistencies do not undermine their evidence as a whole.

58.5 Cpl Holder and Pte Richardson also both gave lengthy oral evidence that was tested at this inquest. I consider that both strived properly to assist this inquest by giving their truthful recollections of the immediate circumstances of Sean's death to the best of their ability, impeded as they both were by the passage of time and by the stress and trauma of the events they witnessed. I appreciate their assistance.[3]

58.6 When Pte Embleton attended the guardroom Cpl Holder's first thoughts were that Sean was going to harm someone else. Explaining this to me, he said that knowing the difficulties and problems Sean had encountered, one could only assume the worst. He said he was also concerned that Sean might harm Lt Radford as he was aware of bad feeling between them. Pte Richardson said she shared that concern.

58.7 Having sent Pte Embleton back to the gate radio contact was made with Pte Garratt who relayed back to the guardroom that Sean had gone on patrol around the back of the Officers Mess. Pte Richardson recalled that very shortly after this there was another transmission saying Pte Garratt had heard shots fired. Cpl Holder in his contemporary statement also recalled a report of 'shots' (in the plural), although Pte Garratt recorded in her 1995 statement that she heard and reported just one shot.

58.8 Cpl Holder woke up Sgt Gavaghan, as the guard commander, to tell him what was happening. Cpl Holder then recalled that he took up a rifle and ammunition. He could not remember if he took a pre-loaded magazine or if he had found the rounds separately and loaded them into the magazine. There was no contemporaneous record that might assist his recall.

58.9 I heard evidence from Pte Jonathan Hossain who gave his first written account of events in 2002 when he told Surrey Police he was in the guardroom on the early morning of 9 June after completing a stag.[4] He recalled hearing radio traffic followed by a shout of 'guard'. He came to the front of the guardroom and saw a corporal he could not now identify trying to load a magazine in apparent agitation. The corporal was shaking and dropping rounds on the floor. Pte Hossain said that he started picking up the rounds and passing them to the corporal who then left in a Land Rover. When Cpl Holder was asked about Pte Hossain's account he had no recollection of dropping any rounds on the floor.

[3] For Pte Richardson in particular I recognise how young and inexperienced she was at the time of these events. Although permanently stationed at Deepcut as part of the 41 Squadron transport regiment she was only a year or so out of basic training herself.

[4] The records show that Pte Hossain was indeed part of the night guard on 8/9 June 1995 and had finished a stag at 03:00 hours.

58.10 Pte Richardson's memory of how Cpl Holder came to be armed was different. Her account was that she and Cpl Holder got into a Land Rover to go to the gate. Realising that neither of them were armed she told Cpl Holder to "get a gun". He returned with a SA80 rifle but when she asked if he had any rounds he had not brought any. Recalling these events in 2002 she said that she had been the one who had gone back to the guard room and obtained a magazine which she had thrown to Cpl Holder. Cpl Holder had no memory of this having happened.

58.11 By the time she gave her evidence in 2018, Pte Richardson could no longer remember who obtained the ammunition. I heard that normal practice would be that the SA80 rifles used by guards would be kept in a locked rack and the rounds and magazines would be separately secured in a drawer in the foyer of the guard room, with the NCO in charge of the guard holding the key. The ammunition would sometimes, but not always, be pre-loaded into magazines that could hold up to 30 rounds. A marked dipstick could be used to check the number of rounds if the magazines were preloaded. In the circumstances it seems to me more likely Pte Richardson was mistaken and that it was Cpl Holder who obtained the rounds that morning. However, whichever account is correct, no one suggests anything other than that the rifle and rounds were taken up in urgency and, whether the magazine was or was not preloaded, no one has suggested that there was any attempt made to check precisely how many rounds were taken from the guard room. If it was the case that the rounds were loose then Pte Hossain's account provides a plausible explanation for why there might not have been ten rounds in possession of Cpl Holder at the outset.

59. Corporal Holder and Private Richardson's attendance at the scene

59.1 Pte Richardson drove the Land Rover to the car park to the rear of the Officers' Mess near A8 gate. She recalled that as they drove she was telling Cpl Holder to attach the magazine and load the rifle. Cpl Holder did not remember her saying this, but he did recall fitting the magazine and putting a round in the chamber. He said he wanted to be prepared for whatever was going to unfold.

59.2 Pte Richardson told Surrey Police it was the "half light of morning" and the Land Rover had its headlights on.[5] It seems that Pte Richardson saw Sean first. He was visible from the car park even though he was beyond the wire mesh fence of a tennis court at the northern end of the car park. The camp perimeter fence and the fence of the tennis court ran parallel to each other approximately 3-4 metres apart at the baseline end of the court, effectively creating a corridor between them. Sean was situated in this grassy corridor between the two fences. The Land Rover pulled up in the car park and was still some distance from Sean who was towards the far corner of the perimeter fence.[6]

[5] The sun rose at around 04:47 on 9 June 1995.

[6] During their investigation in 2002 Surrey Police prepared a scale map (see appendix). It shows the tennis court baseline fence that formed the 'corridor' with the perimeter fence to be 17.2m long.

59.3 Pte Richardson and Cpl Holder have different memories about the detail of their next movements. Given the traumatic nature of what was to occur and the passage of time before either was asked to give a very detailed account of the further events it is unsurprising that there are some inconsistencies between their accounts of how Sean was approached and how exactly he was positioned; the general gist of their evidence is, however, the same.

59.4 Both could see Sean towards the corner of the perimeter fence. Cpl Holder estimated Sean was around 30-60 metres from the Land Rover, sat down in the corner with his arms either on his legs or down by his side. Cpl Holder was still by the Land Rover just forward of the driver's door when he shouted at Sean to "put the fucking weapon down". He said he could not see Sean's weapon, but assumed he had one, knowing Pte Embleton had given him hers.

59.5 Cpl Holder was holding his own rifle in the 'patrol position', the butt in his shoulder with the barrel lowered, pointing towards to the ground. He did not at any stage raise his rifle up to aiming position to direct fire towards Sean.

59.6 At this point, he told me that Sean then shot himself. Sean's rifle fired a burst of automatic fire. He saw Sean's body move from the sitting position, up to a half crouch. His body lifted and rotated as it fell. Cpl Holder believes he heard three shots.

59.7 Cpl Holder told me that he never saw Sean pointing the rifle forward and that Sean did not fire any shots at the Land Rover or towards him or Pte Richardson. SSgt Paul Ward told Surrey Police in 2002 that on the day of events, Cpl Holder had spoken to him and given him a brief account when he was still in shock. SSgt Ward recalled Cpl Holder telling him that Sean had fired two shots either as the Land Rover arrived or before they arrived (if the latter this would represent the discharge heard by Pte Garratt). However when Sgt Ward first gave this account after seven years he could not recall the precise details of the conversation, and he also said his understanding had been that Cpl Holder didn't have a weapon with him – which is clearly inaccurate. SSgt Ward describes having a "niggling doubt" as to whether Cpl Holder did actually say that Sean fired two shots at the Land Rover even in 2002. Given the passage of time and SSgt Ward's misgivings, I am not satisfied that Cpl Holder did give him that account.

59.8 Pte Richardson told Surrey Police she first saw Sean crouched in the corner of the perimeter fence. He was kneeling upright facing her. She could see Sean's weapon, which she thought was somewhere between his legs. She also shouted to Sean to put the weapon down.

59.9 Pte Richardson heard multiple rounds being discharged, but could not say how many. They were fired in a single burst. She saw Sean's body lift slightly and twist as Sean fell face forwards. At the point of discharge she thought she was something like 20 feet away from Sean.

60. Did Sean fire at Private Richardson?

60.1 In 2002, Pte Richardson said to Surrey Police that she believed that a round was fired from Sean's weapon and passed by her right side. She also said in 2002 that Sean first pointed the rifle at her with the butt in his shoulder and the barrel pointing in her direction and that Sean fired two shots towards where she was and then turned the gun on himself. Pte Richardson told the inquest she remembered hearing one whizzing sound.

60.2 Sean firing in her direction did not feature at all in Pte Richardson's statement taken at 11:15 hours on the day of these events. However several witnesses gave accounts to Surrey Police in 2002 or 2003 saying that nearer the time of events Pte Richardson had told them that Sean had pointed the rifle in her direction. Pte Maria Walton recalled Pte Richardson saying that Sean's rifle was "pointing forwards" when they arrived. Pte Emma Davies' recollection was that Pte Richardson said Sean pointed the rifle towards her, but as Cpl Holder moved closer Sean turned the gun around and shot himself. WO1 Karen Loftus similarly recalled being told by Pte Richardson that Sean had turned the rifle towards her and Cpl Holder then turned it back and shot himself. Only Pte Claire Braddock gave a hearsay account of Sean actually shooting his own weapon forwards: she understood in 2002 that Pte Richardson had said that as the vehicle arrived Sean had shot at the Land Rover (although Pte Braddock had no memory of this in 2018). These witnesses' evidence demonstrates that Pte Richardson's evidence to Surrey Police cannot be explained solely by reference to the passage of time.

60.3 This important detail was not however in Pte Richardson's statement made on the day. In that statement, she had described seeing Sean holding the rifle "somewhere in between his legs" and almost immediately hearing a single short burst of automatic fire. She explained this discrepancy to police in 2002 as that she had not realised at the time that Sean had fired at her, but it seems she later on came to think that this was what had happened because she had heard the 'whizz' sound.

60.4 Sean shooting at her is not the kind of mere detail which might be expected to be left out of even a brief account given on the day of events. Pressed in court some years later, Pte Richardson now just could not say whether she recalled that Sean fired in her direction. She was satisfied he did not purposefully aim and whatever happened she felt his actions were those of a frightened young man. She said she remembered "just seconds, just a burst and a whizz and fear."

60.5 Pte Richardson may have come to honestly believe that Sean pointed the rifle towards her and fired, but I do not accept that this happened. The hearsay evidence is inconsistent with Pte Richardson's own recollection: three hearsay witnesses do not suggest they were told Sean fired forwards at all and one suggests the shots were only at the vehicle. Pte Richardson's extreme fear for her own safety at the time still comes across in how she described events 23 years later. This would understandably have affected her later reflection on events. If Pte Richardson's account of a round or rounds

being fired in her direction and passing by her was accurate it would have involved Sean shooting forward then almost immediately turning the SA80 through 180 degrees and shooting himself. This is inconsistent with her account that there was only one burst of automatic fire. Whilst she may well have heard a whizz sound this is more easily accounted for by a round being shot by Sean at himself, but which missed him, as part of the single final burst.

60.6 I find that Sean did not fire any shots in the direction of Pte Richardson, Cpl Holder or the Land Rover.

61. Did Corporal Holder fire at Sean?

61.1 Both Pte Richardson and Cpl Holder have been consistently clear in every account they have given that Cpl Holder did not fire his rifle at any time. Indeed, Pte Richardson told Surrey Police in 2002 that she had been angry with Cpl Holder for not firing and had shouted at him that he should have done so. She wondered if Sean could have been disabled from firing at himself. Cpl Holder has always maintained he did not fire his weapon although he has no recollection of Pte Richardson berating him for not doing so.

61.2 Although there is neither any direct eye-witness evidence nor any hearsay account which suggests that Cpl Holder ever fired his weapon the question has arisen whether he did so because of a single detail in the statement he made on the day. Cpl Holder's statement, signed at 12:45 hours on 9 June 1995 states:

> "...I went to the weapon rack, armed myself with a SA80 plus what I thought was 10 rounds (I subsequently know it was 9 rounds) grabbed a radio and together with the duty driver, Pte Richardson I went to the scene in the duty vehicle."

61.3 There is no other contemporaneous record that might assist to explain why Cpl Holder understood that he had only nine rounds when he gave his statement. This issue of a potential missing round was not explored at the time by those investigating the scene, nor was it picked up at the original inquest or by the Board of Inquiry, despite Cpl Holder's statement being available to those earlier investigations.

61.4 It was 2002 before Cpl Holder was first asked to explain why he said he only had nine rounds on his return. By that time he had no recollection of how he knew this to be the case in 1995. He has always maintained that he did not fire his weapon and that he perceived no reason to do so. In his view, had Sean fired on them, it would have been reasonable and indeed right to return fire in self-defence, but firing at Sean did not enter his mind because he did not perceive Sean to be any threat. Cpl Holder was asked at this inquest whether he fired his rifle. He said he did not. At no point has Pte Richardson suggested that he did.

61.5 Cpl Holder had volunteered himself that he had only nine rounds. There had been no check on how many he started out with. Pte Hossain's account provides one explanation for him returning with less than ten rounds. Alternatively, as Cpl Holder had chambered a round on approaching the scene, it is possible that whoever cleared his weapon did not return the ejected round to the magazine on making his rifle safe. A further puzzling piece of evidence is that one of the RMP investigators, Cpl Joyner, who was called out to the scene did take the step of checking and counting out Cpl Holder's rounds before he allowed him to leave and he believed that he had counted ten. I am satisfied that, whatever the explanation for the 'missing round' in Cpl Holder's rifle (if there even ever was one missing) it is not that he fired a shot. I accept his evidence and that of Pte Richardson that Cpl Holder did not shoot at Sean.

62. Attention at the scene

62.1 After the shots were fired, Pte Richardson and Cpl Holder approached Sean. Cpl Holder believes he reached Sean first and recalls telling Pte Richardson to move Sean's weapon away and make it safe. She kicked it away and cleared the weapon. In the process a round would have been ejected from the chamber. Her 1995 statement says that she inserted the round back into the magazine. In 2002 she told police that the round remained on the ground. By 2018 she could not recall where the ejected round went.

62.2 Sean was still alive, but he was bleeding from a number of chest wounds. He was very quiet, but able to speak and Pte Richardson recalled him asking for his mother. I do not need to detail the immediate first aid provided by Pte Richardson and Cpl Holder save to note that they did their very best to help Sean and to stem the blood but there was little that could be done.

62.3 Cpl Holder told Pte Richardson to go back to the guardroom to bring a first aid box. She left in the Land Rover and returned shortly, accompanied back to the scene by a Regimental Policeman, LCpl David Wakelin who had come to the guardroom to begin his morning duty. LCpl Wakelin had armed himself with an SA80 that he brought to the scene.

62.4 Pte Richardson again tried to assist Sean but she discovered that the first aid box she had brought had no field dressings in it. Sean was still speaking quietly on her return and she comforted him. Before the emergency services arrived, she noted the colour drain from his face and it is likely that Sean died around this time.

63. Attendance of the emergency services and investigators

63.1 A call to the ambulance services was logged at 05:50 hours. The lead paramedic Mr Jones recorded in his log that on arrival at the scene at 06:01 hours there was no pulse, no respiratory movement and a deathly pallor.

63.2 A number of other people including Capt Cammack then attended the scene and much of what happened next was not in issue.

63.3 Two Royal Military Police ('RMP') NCOs, Cpls Joyner and Humphries, arrived from Aldershot at around 06:11 hours, shortly after the ambulance. A single Surrey Police Constable was already there, having arrived only minutes before. On his arrival Cpl Joyner was handed some folded sheets of paper by Capt Cammack which had been found lying near Sean's body by Pte Richardson. He was told that these were 'suicide notes'. They were three letters addressed to Sean's parents, his friend Pte Williams and Sgt Gavaghan.

63.4 Having been given a brief account of events Cpl Joyner asked that Cpls Holder and Wakelin and Pte Richardson leave the scene and return to the guardroom. They were upset and he wanted them away from the scene to be interviewed.

63.5 In a police interview in 2002 Cpl Joyner said that he asked the soldiers to identify their weapons to take back to the guard room with them. The corporals identified their rifles and he made them each remove the magazine and individually put the rounds into their hands for him to count. Cpl Joyner said that he expected to count ten rounds as he understood that to be the operational load for guards in the UK on army camps. He told the inquest that had there been any discrepancy when he checked the rounds he would have been surprised and would have retained the weapons at the scene and informed the SIB officers. He recalled that each soldier had ten rounds and so was surprised when he later learned that this was not what Cpl Holder's contemporary statement recorded.

63.6 Other Surrey Police Officers arrived at around 06:15 hours including Sgt Max Wall who briefed Cpl Jason Sherer and Sgt Eric Lurcock of the RMP Special Investigation Branch[7] ('SIB'), who arrived on the scene just ten minutes later. Cpl Sherer recorded that he was told by PS Wall that three 'suicide notes' had been found.

63.7 Sean's death was formally pronounced by Dr John Keeling, the senior medical officer at Pirbright at around 07:00 hours. Applying his knowledge as a medically qualified person with experience of firearms injuries, he commented to me that the entry and exit wounds were exactly what he would expect to see from a weapon fired at close range, although he was surprised by the spread of the wounds.

64. Primacy of the investigation

64.1 Whilst the guidelines at the time set out that responsibility for the investigation of any incident involving sudden death on an army base would rest with the appropriate local civilian chief constable, this guidance was not followed. The term 'suicide' was being

[7] The detective branch of the military police.

used in early conversations and contemporary notes by those visiting the scene indicating that discussion was already taking place attributing what had happened to Sean's apparent instability.[8]

64.2 The Coroner's Officer, Mr Chatt, arrived at around 06:50 hours. PS Wall then told Sgt Lurcock that the Coroner was now going to take charge of the scene and would deal with the body and the investigation. Within an hour of Sean's death, the decision had already been made that this was no longer a potential criminal investigation. Surrey Police stepped back from any investigation and the RMP SIB staff thereafter understood that they were assisting the coronial investigation by taking photographs and collecting statements for the Coroner. Neither the SIB nor the Surrey Police considered they had any ongoing responsibility to proactively investigate Sean's death.

64.3 The Chief Constable of Surrey Police has since accepted that this was an error. The Surrey Police should have assumed primacy for the original investigation. They should have investigated in a way that eliminated hypotheses of a suspicious death and challenged the early assumptions that Sean had taken his own life. They did not do this, but wrongly allowed the investigation to be left to the RMP and the Coroner.

65. Rounds found at the scene

65.1 Sean's SA80 was still at the scene when Sgt Lurcock called up Cpl Dickson, the armourer to check it and make it safe. There were four rounds with the weapon, leaving six to be accounted for. An immediate search of the scene had already identified four empty cases by 06:30 hours and two more empty cases were subsequently found after Sean's body had been removed.

65.2 There was no formal log made of where these empty cases were found although photographs suggest they were close to the perimeter fence and one may have been on the other side of the wire. These six empty cases alongside the four rounds left in the magazine accounted for all of the ten rounds that were thought to be in Pte Embleton's magazine at the outset of her stag.

66. The subsequent investigation

66.1 Even by the standards of 1995, the investigation into Sean's death was woefully lacking. There was wholly inadequate scene investigation, largely because no-one appears to have thought that any detailed scrutiny was required, despite the unusual and violent nature of Sean's death. An assumption that his death was suicide pervaded the approach taken to the investigation. The scene was not secured and preserved and so a large number of people were permitted to walk over it. The few photographs that were taken were of poor quality, and whilst there are some photographs of the cartridge cases on the

[8] Cpl Humphreys' notebook recorded that he was informed by LCpl Wakelin that the guards said Pte Benton was "going mad".

ground their position can not be established from these pictures. The search for cartridges was not systematic. The location of the spent cartridge cases that were found were not properly recorded so it was impossible to later know the distance they were found from where Sean lay. Given the number of people who were present at the scene, including some trainees were brought in to assist with the search, it cannot be established whether any or all of these cases had been moved before their discovery.

66.2 Even very basic forensic steps were not taken. The weapons of Cpl Holder and Cpl Wakelin were removed from the scene and returned to the guardroom at a very early stage without their serial numbers being noted or even rudimentary scrutiny being made of them to see if either had been fired. The check Cpl Joyner made of Cpl Holder's and Cpl Wakelin's rounds was not recorded. Forensic analysis of the weapons and scene was non-existent. No swab was taken of Sean's hands or indeed anyone else's for gunshot residue. No ballistic testing was contemplated let alone conducted, so there was never any attempt to match the cartridge cases that were found to the rifle that fired them. The cartridge cases were not preserved and it is unclear what later happened to them. When Cpl Holder's statement suggested he had only nine rounds no one thought to try and investigate or account for that unusual situation whilst matters were still fresh in witnesses' minds. A full audit of ammunition was therefore not conducted, and although a report by the ammunition technician records that there were 220 rounds at the outset of the guard shift and 214 left at the end, no one is now able to recall if this reckoning resulted from the rounds being physically counted or was a process of deduction, knowing that there had been six spent cartridges found at the scene.

66.3 Whilst contemporary witness statements were taken from Cpl Holder and Pte Richardson on the day, they were relatively brief. That may be explicable given the shock they each were dealing with on 9 June, but there was no attempt to return to either of them for a more detailed account before 2002. Notes of evidence from the inquest on 6 July 1995 and the later Board of Inquiry show that their eye-witness accounts were not scrutinised in very much more detail at a time when their memories would have been much fresher.

66.4 Sean's clothing was not retained; indeed it was earmarked for destruction after the post-mortem and it was only because that instruction was not fully complied with that fortuitously Sean's jacket was discovered in 2002. The mortuary assistant, Mr Houdoire, had retained it, although it had been washed and handled repeatedly over the subsequent years compromising its value to the experts who analysed the jacket in 2002-3.

66.5 Nor was any detailed toxicology carried out, beyond checking Sean's alcohol levels. Given Sean's history of overdose, Dr Cary described this as "fundamental".

66.6 As a result, the various experts who have considered Sean's case have been severely constrained in the extent to which they can come to confident conclusions. My own investigation has been greatly hindered by the inadequacies of the original investigation, inadequacies that could never be compensated for however thorough or well-resourced

was the investigation Surrey Police carried out in 2002 or however skilful the many experts who have considered the case since have been.

67. The post-mortem examination

67.1 On 12 June 1995 a post-mortem examination was carried out by Dr Michael Hall who was instructed to conduct a routine post-mortem by the Surrey Coroner. Dr Hall was a general histopathologist. He did not have any specialist knowledge of gunshot wounds and would not be expected to have conducted a forensic post-mortem.

67.2 The background information given to Dr Hall by the Coroner's Officer in advance of the autopsy included the following statement: "Police are quite happy that no other person is involved in this death. Notes were left, he has psychiatric problems and had taken an overdose in the past."

67.3 No photographs were taken at post-mortem and whilst there were some photographs taken of Sean post-death by Sgt Lurcock at the scene, which show the position of his chest wounds, they are of poor quality and do not allow for detailed assessment of the specific wounds.

67.4 Dr Hall found and documented five gunshot entry wounds on Sean's anterior chest. Three wound tracks were to the left side and two to the right of the chest with corresponding exterior wounds on the posterior part of the torso. Dr Hall recorded his opinion that the fifth chest wound was "suggestive of a contact or near contact injury". He found nothing that he considered inconsistent with self-infliction and gave Sean's cause of death as "Gunshot wounds of the chest."[9]

68. Subsequent medical and scientific evidence

68.1 For the purposes of this fresh inquest the post mortem findings and other evidence has been scrutinised by an expert in ballistics, Mr Colin Murphy a Forensic Scientist with the Scottish Police Authority, and two expert forensic pathologists: Professor Jack Crane, who as well as being a Professor of Forensic Medicine was the State Pathologist for Northern Ireland from 1990 to 2017, was instructed on behalf of Sean's family; and Dr Nathaniel Cary, Consultant Forensic Pathologist, instructed by myself. Both forensic pathologists found themselves hampered by the limited description of both the external and internal features of the gunshot wounds from 1995. Dr Hall quite candidly accepted in court that now looking back at his 1995 report it was brief and inadequate.

68.2 The fresh experts instructed for this inquest had made available to them the reports of a number of experts who previously assisted Surrey Police during their 2002-3 investigation of all the deaths at Deepcut Barracks, including the investigatory body of the German federal police, the Bundeskriminalamt or 'BKA'.

[9] He did not find any natural disease and the toxicological analysis showed no relevant alcohol present.

68.3 Dr David Rouse, a Home Office pathologist, was instructed by Surrey Police in 2002 and scrutinised the pathology evidence. Like Dr Hall, he found nothing inconsistent with the wounds being self-inflicted and no positive evidence to indicate third party involvement. Three of the wounds appeared to Dr Rouse to be contact or near contact wounds, but he recommended there should be further examination of Sean's clothing. In his opinion only one of the wounds, that involving the heart, would have been capable of causing immediate death. His opinion was that nothing could have been done at the scene to save Sean's life after his gunshot wounds had been sustained: even had a trained paramedic been on site able to give intravenous fluid and blood and/or prompt cardiothoracic surgery achieved, there would have been a high probability that Sean would have died.

68.4 Mr David Pryor a firearms examiner from the Forensic Science Service examined Sean's re-discovered jacket in 2002 and reported that three of the bullet impacts on the front of the jacket showed features consistent with muzzle blasts indicating contact or near contact discharge. Considering the evidence he noted that all wound tracks were essentially in front to back trajectory, and no shot showed an obviously angled entry from either side. Mr Pryor's report considered the published data on the rate of discharge of rounds from a SA80 rifle under automatic fire: this was between 610 and 775 rounds per minute. Five rounds could have been discharged in just under half a second. From the groupings and angles of the wound tracks he concluded that Sean's wounds were likely to result from two episodes of automatic fire.

68.5 Dr Graham Roe, a Senior Forensic Scientist of the Forensic Science Service was instructed by Surrey Police in 2002 to examine the photographs taken at the scene to see what could be learned by analysing the distribution of blood. The photographs are of insufficient quality for any expert to have assisted greatly, but Dr Roe reported that the height and direction of the bloodstaining on the fence strongly support the view that Sean was standing essentially upright, very close to the perimeter fence and almost at the corner when the first shots were fired.

68.6 The report of the BKA into Sean's death was very detailed. It was read out in part at this inquest and the findings have been considered in depth by my own experts. BKA conducted chemographic analysis of Sean's jacket, and found extensive deposits of gunshot residue over the five areas of damage that corresponded with Sean's wounds. They also investigated any heat effects on the cotton and viscose fibres. The test results led BKA to conclude that all five shots were fired at a range of less than 10cm from Sean's body and in one case it was a contact shot.

68.7 BKA's analysis of the grouping of wounds on Sean's body – carried out by Professor Dr Urban of Mainz University – supported the suggestion that there were two series of shots: the first two shots to the right side hitting the liver, diaphragm and right lung such that Sean could have retained capacity for action; the second set of three shots on

the left included one that injured the pericardium and left ventricle muscle after which there would have been no significant capacity for action.

68.8 Sean's posture and the position of the weapon could not be definitely established by BKA but it was said to be "plausible" that Sean was in a kneeling or crouched position at the time of the second series of shots. The distance between each shot could be easily explained by the body (or rifle) changing position during the course of the automatic fire. A missed shot could have occurred during either shot sequence. BKA found nothing inconsistent with self-inflicted injury.

68.9 My instructed ballistics expert, Mr Murphy agreed with the conclusions reached by the BKA in all material respects. Considering all the evidence he also concluded that the five shots which struck Sean were fired in two separate discharges, with the muzzle of the rifle being close to him at the time of discharge, and during at least two, but probably three shots being in contact with his outer clothing.

68.10 Mr Murphy did not wholly agree with Dr Roe's interpretation of the pattern of blood shown on the fence in the scene photographs. In his view the maximum height distribution of blood on the fence was more consistent with Sean kneeling or sitting at the time the first wounds were sustained. He considered it unlikely that Sean was standing as the weight of the rifle – which he told me is "butt heavy" due to its design – leads the butt of the weapon to fall with the muzzle coming upwards. He considered that the blood pattern on the fence was indicative of forward spatter from exit wounds, indicating that a number of shots were fired with Sean close to the perimeter fence.

68.11 Major Gary Palmer[10] assisted the inquest by bringing a SA80 rifle to court and demonstrating how it was easily possible to fire the weapon with it turned towards oneself.

68.12 Prof Crane and Dr Cary produced independent reports and then held a joint meeting to discuss areas of agreement and disagreement. I shall make available that joint report as an appendix to this document. They were in agreement on all points of substance, and I accept their evidence.

68.13 Both agreed with Dr Hall and Dr Rouse that Sean's cause of death was "Gunshot wounds of the chest" and I shall record this on the Record of Inquest as the medical cause of Sean's death.

68.14 They also agreed that the mechanism of death was principally blood loss and they joined with Dr Rouse in finding that only one of the wounds – the wound to Sean's heart – would have been rapidly fatal, although further shots could have occurred if this wound was part of a burst of automatic fire. From the post mortem findings and photographs

[10] A staff officer grade 2 from the Small Arms Corps School, responsible for training and safety for weapons systems and ranges.

alone, it was not possible to determine the effect of the other shots on Sean's ability to take further action - as both rapid immobilisation and further purposeful activity would have been possible. The witness evidence suggesting these serious injuries were sustained in two shot sequences some time apart was therefore medically plausible. From the pathological findings alone, it was not possible to determine the sequence in which the wounds were inflicted. However it was likely that the shot that injured Sean's heart was later in the sequence, and hence in the second burst of fire.

68.15 Prof Crane and Dr Cary found nothing inconsistent with self-infliction. Equally, there was nothing that was probative of self-infliction taking the pathological evidence alone. They observed nothing against the proposition from the blood distribution evidence that Sean was initially upright and subsequently crouched.

69. Findings as to the immediate facts of Sean's death

69.1 It is not possible to give a definitive analysis of what happened on the morning of 9 June 1995 from the forensic evidence alone. The pathology and ballistic evidence had to be considered alongside the other circumstantial evidence and witness accounts. However, there is nothing put forward by any of the many experts who have considered the available pathological, ballistic and photographic clues which is inconsistent with self-infliction.

69.2 Having considered that forensic evidence alongside the other witness evidence, particularly that from Pte Richardson and Cpl Holder, I reach the following conclusions on the balance of probabilities in respect of the events at the scene of Sean's death:

- Having obtained the SA80 rifle by tricking Pte Embleton, Sean walked, alone, to a quiet area between the barracks perimeter fence and the tennis courts.
- Sean then discharged a series of shots from his rifle into his own body before Cpl Holder and Pte Richardson arrived at the scene.
- Pte Garratt was mistaken when she reported only one initial shot.
- Sean sustained two wounds to the right of his chest that were not immediately fatal during this first burst of fire.
- When Pte Richardson and Cpl Holder arrived, Sean did not fire any shots in their direction or at the Land Rover.
- Sean discharged a second series of shots from his rifle into his own body soon after Cpl Holder and Pte Richardson arrived at the scene, whilst they were still some distance away from him.
- Sean sustained three wounds to the left side of his chest in that second burst of fire.
- In all, Sean fired six shots towards himself. There was a single shot that missed Sean as part of one of these two sequences of shots.
- The wounds Sean sustained were all contact or near-contact wounds.

- The cause of Sean's death was gunshot wounds to the chest.
- The mechanism of Sean's death was the effect of blood loss from these wounds.
- Sean died at or around 05:50 hours on 9 June 1995.
- There was no third party involvement in Sean's death.
- Cpl Holder did not fire his weapon at Sean. Whatever the explanation for the 'missing round' in Cpl Holder's rifle (if there was one missing) it is not that he fired a shot.

69.3 Considering all of the above matters together with the contents of four recent letters written by Sean which I shall discuss shortly, I am satisfied beyond all reasonable doubt that the fatal wounds suffered by Sean were self-inflicted.

70. Sean's state of mind and intent on 9 June 1995

70.1 All interested persons have agreed that when considering my conclusions a finding of suicide must be within my contemplation. Suicide has a particular meaning in Coronial law. It must never be presumed, it must be established by evidence and can only be found if all other explanations have been excluded. It is not enough to find that someone died at their own hand. Before coming to a conclusion of suicide I must be satisfied to the criminal standard, that is beyond all reasonable doubt, that Sean both (1) did the act that ended his life and (2) intended that the consequence of his act should be his death. I turn therefore to the question of Sean's intent.

70.2 The three letters that Sean left at the scene are illuminating as to his state of mind on the day of his death. There can be little question that these were the letters he had been seen writing in the guard accommodation earlier that evening by Ptes French, Dilkes, McKinlay and Wilson. Dr Kathryn Barr, a handwriting expert engaged by Sean's family has confirmed that there is conclusive evidence that Sean wrote the letters. It also seems likely that a fourth letter received by Pte Griffin, speaking of his pending discharge, was written that same evening.[11]

70.3 Sean's letter addressed to his parents read:[12]

"I don't know what to say really, except I'm sorry I'll always love you all. I'm not doing so well here, I'm getting into so much shit lately most of it through drink. As you know I was jailed for 10 ten days for braking two windows by the C.O, but you didn't know that he put me on a 3 month bender, which means if I get charged again I'll be discharged, but I got drunk on the 2nd of this month (THURSDAY) down a pub called the Staff and I said fuck off,

[11] Although Pte Griffin could not be traced to give oral evidence, her account of the contents of that letter (as given in her statement for the Surrey Police investigation in 2002) is consistent with the tenor of the three letters Sean took to the scene. I have no reason to doubt Pte Griffin's recollection.

[12] Transcribed here in full as written by Sean.

quite a few time to Lt Radford and then I said to Cpl Lewis if you put me on guard again on a weekend I'll shoot ya, I was then warned for orders and put in front of the O.C (officer, commanding) and he charged me 9 days ROPs & a week's fine I was marched outside outside of his office by the S.S.M (Squadron Sargent Major) & then I was marched back into the OC's office & he said he was going to apply for me to be discharged from the army. I really wanted to stay in and fight for the Country & I was ready to even die for this Country, I really wanted to make you proud of me, I don't think I could really come home again knowing that I've let you down after being discharged, I'm to embarresed by it, I'm sorry! My clothes can one of you sort it out between yourselfs, I'm leaving my white Spurs shirt to a good mate Pte Williams…I've been billed for clothing so can you get the army to sort out the insurance, also the insurance man said I could claim for the windows that I broke. For ages I been trying to apply for a week's leave but they wouldn't let me have it (B Sqn N.C.Os and the SSM that is) & they all knew that I needed a break from blackdown and that I was cracking up but they just said I wasn't entitled to it, so can see Gill Barwick & ask her if she could see a lawer to see if you can get anything out of this, ask her to get the lawer to have a look at my Army Medical reports, thanks.
Love Sean xxx."

70.4 To his friend Pte Williams, he wrote:

"You've been a good mate keep on smiling & you'll go a long way & don't let anything or anyone crack you up. Just learn by my mistakes, by the way I'm giving you my (white) Spurs shirt it needs washing, it's got a little bit of polish marks on it, I'll see you whenever.
Keep this letter for prove of the white Spurs shirt.
SH Benton."

70.5 To Sgt Gavaghan, he said:

"I'm sorry for what I'm doing but I just can't except being discharged I'm to embarresed to go home and I don't want to be on Civvy Street & I don't want to have a factory job I just wanted a career in the Army, I know it's my fault for the things that I done wrong but only if I got a weeks leave when I applied for it (many times that is) thing's could have been different, I could of calmed down, instead of building all my problems up & then getting drunk and bursting into flames. Sgt, I'm leaving my Spurs shirt to a Pte Williams…it needs washing it's got splash marks of polish. Oh by the way can you thank Sgt Russell, Sgt Stevens & yourself and Sgt Pike for helping me out when I were in trouble, & I didn't mean to say that you were an arsol, it just came out without myself thinking about it.
Benton."

70.6 I consider that these final letters reveal Sean's settled intent to die. They are letters which Sean intended to be read after his death, speaking to their recipients once he had died in order to explain his actions and pass on messages he considered important. He used the letters to settle his affairs: giving instructions and expressing his regrets to his parents; leaving his football shirt to his friend.

70.7 Prof Fahy appears to me to have encapsulated the position well when he described the letters as showing "a clarity of expression and calmness of emotional tone that suggests that [Sean] was purposeful in his intended actions, resigned to his decision and accepting of his inability to cope with the demands of army life or the consequences of returning to civilian life."

70.8 The whole incident on 9 June 1995 shows evidence of planning and strategy by Sean in his attempt to secure a firearm. There is evidence of earlier behaviour by Sean which can be considered likely to have been attempts to secure a firearm: particularly him trying to persuade Pte Dilkes and Pte Taylor to let him do their stags.

70.9 Sean would have been well aware from his weapons training of the power of an SA80 rifle and the likely outcome of his actions. He carried out an act he knew would be lethal. He did not terminate his behaviour when others arrived on the scene, indicating this was not some kind of 'cry for help'. These observations taken alongside his letters led Prof Fahy to conclude that Sean shot himself with intent to end his life. I agree.

70.10 I am satisfied so that I am sure that when Sean fatally shot himself he intended to die. Therefore, as my formal conclusion in Box 4 of the Record of Inquest, I shall be recording a finding of suicide.

CONCLUSIONS

71.1 As will now be clear, my conclusion of suicide is the same as the verdict returned by the Coroner at the original inquest into Sean's death which was held on 6 July 1995 within a month of Sean's death.

71.2 Despite the many shortcomings of the original investigations there have never been any reasonable grounds to doubt that Sean obtained a rifle and rounds in the way that he did and that the majority of the final gunshot wounds were self-inflicted.

71.3 Although ill-informed commentators who were not apprised of the facts may have suggested that it was impossible to shoot oneself five times with a SA80 rifle, they are simply wrong. Moreover the ballistic, pathology and factual evidence that I have now scrutinised leads me to conclude that the only person who fired a shot beside the tennis court that morning was Sean. All of his wounds were self-inflicted and his death was the foreseeable consequence of his actions.

71.4 Nor do there appear to be any substantive grounds to question Sean's intent. The three final letters found with Sean's body were all authored by him and disclose his expectation that his actions would be fatal. This, alongside the evidence from his fellow trainees who saw Sean writing letters that last evening, puts the matter of his intent well beyond all reasonable doubt. Those letters not only reveal Sean's intent but his primary motive: his inability to accept being discharged from the army and his embarrassment at the thought of going home.

71.5 However this is an inquest conducted, in part, to fulfil the state's obligations under Art 2 ECHR. Section 5(2) Coroners and Justice Act 2009 requires me to do more than come to a conclusion of suicide. I must also consider and determine the broad circumstances in which Sean came by his death.[1] An Art 2 compliant inquiry must be capable of identifying and holding to account those responsible for the death, including State officials or authorities involved in whatever capacity in the chain of events.[2]

71.6 Important questions about the circumstances of Sean's death that were not explored in any of the initial investigations have occupied the majority of the court's time. These include the extent to which Sean's actions were attributable to personal factors, such as his pre-existing psychological disposition and whether the adverse events that I have found that Sean experienced at Deepcut

[1] R (Middleton) v HM Coroner for Western Somerset [2004] 2 AC 182, [2004] Inquest LR 17
[2] R (Amin) v Secretary of State for the Home Department [2004] 1 AC 653, [2003] Inquest LR 1, at §20, §32

Barracks and any shortcomings in the systems at the camp caused or contributed towards Sean's decision to take his own life.

72. Causation

72.1 In coronial law causation has a specific meaning: an event or conduct will be considered to have caused or contributed to a death if, on the balance of probabilities, it made a more than minimal, negligible or trivial contribution to the death. It need not be the sole or even the main causative factor.

72.2 In an Art 2 inquest the circumstances of death are not limited to probable causes and, as Lord Justice Sedley said in *Lewis*, potentially causative circumstances can be just as relevant as actually causative ones. Therefore whilst only probable causes of death must be recorded as part of my conclusion, I have a discretion to consider and record possible causes in a narrative conclusion, even if less than probable.[3]

72.3 Having set out my findings of fact I shall now distil from them the main areas that appear to me to be potentially relevant when identifying the broader circumstances of how Sean came by his death, and then summarise the matters that I have found to have caused or contributed to his death.

73. Sean's personality difficulties and vulnerability

73.1 With the benefit of hindsight it is clear that opportunities were missed which could have led to an early appreciation by the army of Sean's psychological condition and the nature and scale of his vulnerability.

73.2 If the army recruitment process had involved a mandatory requirement of disclosure of Sean's medical records, particularly his GP records, his earlier attempts at self-harm in 1991, with apparently relatively low trigger points, would have been revealed, enabling a more informed selection decision.

73.3 It cannot now be said whether such disclosure would have led to his application to join the army being rejected, but it would have allowed those entrusted with his medical and pastoral care to make decisions during his army career based on full information.

73.4 In particular, Lt Col Gillham would have approached his psychiatric assessment of Sean in February 1995 in a different way. The incident when Sean walked through a glass door would not have been seen as an isolated incident readily explained by transient disappointments. Rather it would have been likely to have caused heightened concern as possible evidence of an evolving pattern. It

[3] See *inter alia* R(Khan) v HMC West Hertfordshire [2008] Inquest LR 200 at §43; R(Lewis) v HMC Mid and North Shropshire [2009] Inquest LR 294 at §28-29; Chief Coroner's Guidance no.17 at §50

may have led to a different decision as to whether it was appropriate to return Sean to normal Deepcut life as a trainee, however much Sean wanted to stay in the army.

73.5 Lt Col Gillham was astute enough to invite Sean's consent to disclosure of his GP records. However, in the face of refusal because of Sean's apparent concern about his parents' learning of his current difficulties, he had to assess Sean without important information about Sean's past.

73.6 Equally, Sean's April 1995 overdose could have been evaluated in a different light when seen not as a one-off event, but as the third such episode in an ever more concerning pattern of deliberate self-harm.

73.7 However, even without the benefit of evidence of significant self-harm in Sean's pre-army life, there was ample evidence available to those responsible for Sean's welfare at Deepcut that Sean was vulnerable and would require significant support:

(1) At the very outset of Sean's selection for the army his potential for discipline problems and his tendency to answer back was noted when his 'reaction to discipline' was rated as 'below average'.

(2) Whilst Sean was ultimately successful in passing out of Pirbright, early consideration of his P-file reports would have alerted the chain of command to Sean's struggles at Pirbright and the views of his Troop Commander that Sean was a "liability who would need to be watched constantly".

(3) In January 1995 Sgt Gavaghan had discovered Sean crying in public on the parade ground at the end of a parade.

(4) Leconfield reported on 25 January 1995 of Sean appearing "distressed and emotional" and his reaction to instruction also being "unstable" such that he was returned to Deepcut now considered as being "not stable enough to become a HGV driver".

(5) Sean's two failures at Leconfield and his resultant thwarted ambition to become a driver were known to have had a profound effect upon him; The extent of Sean's distress at being transferred to the Pioneers led Major Corby to take the unusual step of referring him to Capt Cammack the Squadron 2iC in early February.

(6) There were said to be pre-existing concerns amongst the senior NCOs that Sean was emotionally unstable before the February 1995 glass door incident.

(7) Capt Cammack determined and recorded on 9 February that the shared view of staff was that Sean was "temperamentally unsuitable" for the army.

73.8 Against that background, when the advice came that Sean had no formal psychiatric diagnosis and should return to normal Deepcut trainee life, it should

have been clear to the chain of command that this did not mean Sean had no problems. There was a feeling of surprise in the chain of command as demonstrated by Capt Cammack, who as 2iC was the focus of welfare. He described how they were disappointed not to have more direction from the medical services. Nevertheless Capt Cammack said he would have expected the NCOs to now treat Sean the way they would treat anybody else, with nothing different. Sean simply returned "into the mix" and was subject to normal military discipline at a point when a well-considered strategy to support him to succeed was required. As Major Gascoigne told the first inquest in July 1995, "the psychiatrist said he doesn't have a psychiatric problem but he does have a problem dealing with his failure".

73.9 Whilst during that era there was no formal welfare system and no dedicated welfare officer at Deepcut, this did not absolve the chain of command from identifying the need for a better understanding of Sean's problems and devising an approach to meet Sean's vulnerabilities. The solution to managing Sean was seen to lie in discipline alone but as Prof Fahy told me "it would be preferable if the discipline is offered within the context of enquiry, sensitivity and support, and that it is not just pursued in a rigid way that isn't interested in the individual's particular circumstances". To deliver this "doesn't require professional qualifications".

73.10 In my view there was no such strategy in place and, to the extent there was any strategy, there was no proper implementation. To some extent this may have been a product of overstretched resources and the lack of an appropriate ratio of NCOs to trainees. Sean's exchange with Cpl Palmer a few days before his death suggested he wished to talk to and seek guidance from a NCO who was unable, because of the pressure of time, to engage with him. But there appears to have been little guidance from those ultimately responsible for Sean's welfare beyond an instruction to "keep an eye on him" and a request for reports from Sean's new Troop Commander, Lt Radford, following the three month warning order being imposed in March. Lt Radford stated that when Sean came under his command, whilst he was not tainted with previous knowledge, he had "pretty much minimal information."

73.11 When, in the absence of accurate historical information, the subsequent April 1995 overdose was seen as a single impulsive act that was a 'reaction to his situation', the medical position did not change. Indeed it seems that soon after this, Sean returned to carrying a weapon on guard duty. Capt Cammack felt that after the April overdose the chain of command did not know what to do in the light of the fact Sean was said not to be suffering from psychiatric illness. However, if that was the case, then the chain of command should have recognised and addressed their quandary and formulated a management plan.

73.12 There was no coordinated strategy as to how to approach Sean's ongoing tendency to commit minor military infringements in respect of his turn-out, his drill and his tendency to answer back to authority. I find no evidence of Sean being given "leeway." But neither do I find that he was intentionally unfairly targeted. I accept that any apparent softer approach with Sean might have undermined general morale risking a perceived sense of unfairness. However, as a serial offender against the expectations regarding kit, turn-out and attitude, inevitably Sean frequently came to the attention of the junior NCOs who had no guidance or coordinated strategy for managing Sean's particular difficulties.

73.13 As the army has acknowledged, there was no clear policy setting out a list of standardised acceptable informal punishments. The system was open to NCOs to administer excessive punishments or overly repetitive punishments that went beyond legitimate sanctions, and some NCOs to varying degrees strayed beyond what was appropriate. That informal sanctions, even when legitimately applied, were not recorded meant that no-one was in a position to have an informed overview of how Sean was getting on. The extent of his difficulties and his deterioration was not heeded.

73.14 Although Sean did not commit any disciplinary offences involving him being subject to a military charge between the imposition of his three-month warning order on 6 March 1995 and 1 June 1995, there is clear evidence of a deterioration of his physical condition and mental well-being. However messages in the chain of command appear mixed. Squadron Sgt Major Milne as a senior NCO told me that his view was that Sean's code of conduct indicated that was not going to make it as a soldier. In evidence he attributed this to NCOs telling him that Sean was not improving his performance and was not up to the standard required. Indeed Squadron Sgt Major Milne considered that Sean's behaviour might well be malingering. More senior officers had a different view. Lt Col Josling felt that, there had been an initial improvement in Sean since March 1995, but that he began to have difficulties again later.

73.15 Major Gascoigne told me that he was not aware of Sean's deterioration and indicated that if he had known he would probably have kicked back against the psychiatrist's recommendation and applied for Sean's discharge. However I note that he told the first inquest that during the three month warning order Sean was to be looked at "very closely" and he had thought that "during this period [Sean] was letting things get on top of him a bit".

73.16 It was after all one month into the warning order period that Sean took the Anadin overdose and was admitted to hospital. Whatever the subsequent psychiatric opinion regarding the absence of any mental illness, there was nothing to prevent the chain of command reflecting for themselves and conducting a focused review of Sean's army progress at that point. This does not appear to have happened. When SSM Milne was asked at the inquest what if

anything was done to help a struggling soldier improve and make it in the army, he thought there had been no process in place to do anything other than monitor Sean and see if he got better.

73.17 Sean's Troop Commander Lt Radford stated in evidence that the staff were not given the right support and he believed Sean "fell through the cracks a little bit because of lack of support and lack of resource" available. In his view "it is a distinct possibility" that if Sean had been given proper support, Sean's death may have been avoided.

73.18 However, the extent to which these problems at Deepcut in terms of the unsupportive environment and the absence of access to welfare actually contributed to Sean's death is unclear. These could all, as Prof Fahy acknowledged, theoretically have increased Sean's stress and distress. But having identified theoretically plausible factors the pertinent question is whether these matters did, on the evidence, actually cause or contribute to Sean's death. The evidence does not support such an analysis.

73.19 Sean did not seek out welfare support for himself, although he was advised he could do so through the medical services, and it cannot now be known whether he would have taken up such support if pro-actively offered to him or, if he had done so, what impact any support would have had. As Prof Mezey put it, "welfare support may have been helpful, however such support can only be offered, and if an individual is unwilling or unable to use it or benefit from such support then they cannot be compelled to engage". Her report continues: "I have not seen evidence to suggest that Sean had ever asked for help or support. His contacts with psychiatrists had not been instigated by him and he had not taken up Lt Col Gillham's offer of further contacts".

73.20 Although I am satisfied that there were lost opportunities to review Sean's progress and offer him welfare support, and I agree with Lt Radford that the outcome might have been different, it would be wholly speculative to say what would probably have happened had a different approach to welfare provision for Sean been taken before 8 June 1995.

74. The discharge decision

74.1 Both Prof Mezey and Prof Fahy conclude that "the proximate cause of Sean's decision to take his own life was his intended discharge from the army". I agree. The timing of the incident and the content of his final letters strongly support this conclusion. As Prof Fahy explained, Sean's behaviour can be seen as a "gross over-reaction to his predicament which can be understood as a consequence of his personality difficulties".

74.2 It is clear that being told on 8 June that an application was to be made for his discharge from the army would have been devastating for Sean. As Major Gascoigne told the Surrey Coroner in July 1995, "I knew how he was going to react, I knew that he would be very disappointed….and I warned my NCOs in the squadron that quite clearly we were going to have a soldier in the squadron who was clearly very disappointed".

74.3 A decision was now needed as to how best to manage any risks Sean posed whilst he remained on camp. Firstly, it was vital for all significant information to be shared and to evaluate the nature and scale of the risk; secondly, it was necessary to put in place appropriate measures so as to achieve a proportionate response to that risk.[4]

74.4 Sean still remained on reserve guard, with no steps taken to manage any potential risks before Sgt Gavaghan took over as guard commander for the evening. It appears that the principal concern was that Sean should not obtain alcohol. This was based upon a fear that as a potentially disaffected soldier he might, in drink, become involved in incidents involving his fellow trainees. The information that Sean had taken overdose in April was not shared with Sgt Gavaghan.

74.5 The solution adopted by Capt Cammack and Sgt Gavaghan was to keep Sean's name on the roster for reserve guard duty, but to restrict Sean's activities to being a 'runner' for Sgt Gavaghan during the course of the evening. Whilst the guardroom had NCOs present throughout the night so that, to some extent, there was opportunity to keep Sean under intermittent supervision, it was also the location of firearms which Sean knew how to handle and which trainees might be expected to have access to when part of the guard roster.

74.6 It is apparent that the NCOs had not been monitoring Sean closely enough to appreciate the scale of his recent deterioration. His fellow trainees were seeing signs of chronic as opposed to acute deterioration of his mental state. Albeit that no-one suggests that Sean's demeanour on 8 and 9 June was such that his specific suicidal thoughts and plans would have been obvious.

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[4] As Prof Mezey suggested, consideration of how best to manage the risks that Sean posed could have taken place on 2 June when the senior chain of command came to learn of Sean's specific threat to shoot LCpl Lewis. Although uttered in the pub when Sean had been drinking, and after reflection not taken seriously by LCpl Lewis, the nature of the threat could not be dismissed. It is perhaps surprising that there was not a reconsideration at that stage as to whether Sean should undertake any more guard duty or have any access to weapons at all. This was particularly so when the decision of 2 June 1995 to charge Sean with insubordination must have meant that Sean, conscious of the terms of his three month warning, could have anticipated even at that stage that an application might be made for his discharge. Indeed, he had told Cpl Palmer a few days before his death that he expected to be kicked out of the army. As it was Sean remained rostered for guard duty on the 3 and 5 June and as a reserve guard on 8 June 1995.

74.7 Nevertheless, members of the chain of command such as Major Gascoigne and Sgt Gavaghan agreed that they were alive to the risk that Sean might self-harm. Although Major Gascoigne said that he "didn't think for one moment [Sean] would try and commit suicide", Sgt Gavaghan did consider the risk that Sean's self-harm might be by means of a firearm. In view of that perceived risk, it was imperative in the circumstances that Sean should not have access to weapons. Capt Cammack denied that the risk that Sean might self-harm was at the "forefront" of their minds. In my view, given what he knew of Sean's history, it should have been.

75. Restriction of access to weapons

75.1 It seems to have been simply fortuitous that Sean had not been called upon as a reserve to cover a stag earlier in the shift. Sgt Patterson who had been on the day shift had not known of any need to implement such a measure and said that as far as he was concerned, "if any soldier is on guard, they should have a weapon".[5]

75.2 Sgt Gavaghan recalls telling the trainees on the evening guard rota that Sean would be doing jobs for him and so would not be doing a guard 'stag'. I accept that he did so. Indeed Pte Garratt who paraded for guard at 18:30 hours said in her 1995 statement that she was aware of this.

75.3 However, what was not said to any of those on guard duty that evening was that the purpose of Sean acting as Sgt Gavaghan's 'runner' was that the chain of command had determined that Sean should be kept away from weapons. Ironically, being told Sean now had a role assisting the guard commander without further explanation may even have reinforced Pte Garratt's lack of suspicion when Sean appeared at A8 gate purportedly, bringing a message from Sgt Gavaghan.

75.4 At that time there was no clearly articulated protocol about handing over a weapon to another trainee. The SA80 rifles and magazines were neither personal to the soldier nor kept for the entire guard shift; they were issued from and returned to a shared pool in the guard room on two hourly rotation. The measures being taken to keep Sean away from a weapon would not be wholly effective unless all those who were to be given rifles were told that on no account should they allow Sean to have theirs.

75.5 I cannot accept the suggestion of Sgt Gavaghan and Capt Cammack that for them to make this clear to the trainees would have embarrassed Sean or been a

[5] Cpl Holder told the first inquest in July 1995 that when he arrived to take over the duty as guard 2iC at 18:30 hours on 8 June he was briefed by Sgt Gavaghan that "in no instance" should Sean be allowed to take over one of the stags with a weapon.

breach of his confidence. An instruction in the army does not need to be accompanied by an explanation as to why it has been given. Giving the simple instruction – Pte Benton is not to have access to a weapon or ammunition during this guard shift – would have made the situation clear to all. It was a failure not to do so.

75.6 In different circumstances in the *Staffordshire*[6] case, Tomlinson J spoke of the touchstone for identifying causative shortcomings at an inquest being the opportunity to render care "which would have prevented the death." I take this to mean an opportunity of doing something that would probably be effective, not just something that might have made a difference.

75.7 Pte Embleton and Pte Garratt told this inquest that had they known that Sean should not access a weapon they would not have allowed him to obtain one when he approached them that morning. I accept that evidence, which in my view is not merely an application of hindsight. As trainee soldiers their inclination would have been to follow their guard commander's instruction. Whilst the possibility cannot be discounted that Sean might have subsequently killed himself by another method, I find that it is more probable than not that, had adequate precautions been taken and the guard been given adequate instructions regarding Sean being banned from weapons handling, then Sean would not have obtained Pte Embleton's rifle and ammunition and killed himself when he did in the way that he did.

76. The culture of the camp and physical assaults on Sean

76.1 A significant question in the popular narrative regarding Sean's death at Deepcut is the extent to which the general culture of the camp and specifically any bullying, harassment or inappropriate use of force against Sean contributed to his decision to take his own life.[7]

76.2 There were multiple problems at Deepcut due in part to the sheer number of trainees and the wholly inadequate number of training staff. The regime provided insufficient purposeful and/or esteem enhancing activity, leading to low morale and a restless malaise amongst trainees particularly those undergoing extended stays.

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[6] R v HM Coroner Coventry ex p Chief Constable Staffordshire [2000] Inquest LR 35 §41

[7] At a Pre-Inquest Review Hearing I ruled that allegations of sexual misconduct by NCOs towards trainees were outside the scope of this inquest. There were no allegations raised by any witness of sexual impropriety of any sort that involved Sean. There has been no suggestion of Sean having anything other than platonic relationships at Deepcut. I only note that if alleged matters regarding both consensual and non-consensual sexual activity at Deepcut that were considered in the Deepcut Review (§6.120-6.173) are accurate it would have added to the culture where the trainees had little confidence in the chain of command as a route for complaints.

76.3 NCOs felt the need to impose multiple informal punishments to assert control and discipline. As Brigadier Coles acknowledged, the considerable latitude afforded NCOs, combined with the absence of a clear policy setting out acceptable punishments, meant that in some cases the frequency and severity of punishments strayed beyond what was appropriate.

76.4 However, with the exception of Sgt Gavaghan, I have not found that any other NCO went outside legitimate boundaries in their physical disciplining of Sean. I accept that Sean may well have felt he was being "singled out": this is unsurprising given that the weight of evidence suggests that he was frequently being pulled up. But it appears to me that this was because of the frequency of his personal transgressions rather than wholly unjustified imposition of authority over him by NCOs. It follows that I do not find that there was endemic bullying of Sean by NCOs at Deepcut if that term is used in the sense of intentional and targeted persecution of him in the months leading up to his death. But I am satisfied that Sean's own actions made him the focus of frequent and repetitive disciplinary sanctions and that these became excessive. In the absence of any method of recording these informal punishments the chain of command as a whole neither recognised Sean's predicament nor considered whether a different approach to his management was required. Given what was known of his emotional instability, they should have done.

76.5 In respect of Sgt Gavaghan, it is perhaps ironic that he was regarded by many as the NCO best qualified to deal with welfare issues. Indeed there is evidence to show that he was capable of showing compassion to trainees with personal or family problems. He specifically sought to reassure Sean during the course of the evening before Sean's death.

76.6 However there was another side to Sgt Gavaghan. On occasions he went too far and abused his authority in response to his perceived need to maintain standards and discipline. His 'twin brother' technique was wholly inappropriate. At times Sean was on the receiving end of his verbal aggression that went far beyond an acceptable level on the parade ground and was without justification. On some occasions this escalated into the inappropriate use of physical force against Sean.

76.7 It is also clear that Sean was, at least once, the target of a late night attack by his fellow trainees in his sleeping quarters. The motivation behind these cowardly attacks seems to have been to bring the victim into line. There is no credible evidence that any NCOs were involved. However, the fact that trainees were able to assault others at night without fear of discovery suggests that night-time supervision by the NCOs at Deepcut was wholly inadequate.

76.8 It follows that Sean Benton was being subject to legitimate but in his case excessive disciplinary sanctions from NCOs, whilst having to endure targeted

bullying in the form of verbal aggression and humiliation and unpredictable use of physical violence by Sgt Gavaghan during the day, as well as manage the fear of assault by other trainees at night. I have to consider whether these actions by others probably more than minimally or negligibly contributed to Sean's decision to take his own life on 9 June.

76.9 Professor Fahy accepted that any type of adversity would have an exaggerated impact on a person with vulnerable personality characteristics such as Sean. Bullying can exaggerate the adverse psychological impact on someone with a burgeoning personality disorder. It could induce a mindset where an individual sees no way out and there is no psychological exit or prospect of the problems coming to an end.

76.10 This inquest has had the advantage of having far more information about Sean than any of the clinicians who saw Sean during his lifetime. I accept the unanimous opinion of Prof Mezey instructed by Sean's family, and my instructed expert Prof Fahy, that it is likely that Sean had an emerging emotionally unstable personality disorder. One of the typical characteristics of this condition was emotional overreaction to distressing and destabilising events. As Professor Mezey wrote in her report:

"Sean was more prone to show extreme emotional responses, such as tearfulness, anger and aggression in response to stress and anger that **might** be in the form of verbal or physical aggression or internalised and self-directed in the form of self-harm or, in extreme cases, suicide acts."[8]

76.11 In her view Sean had an inability to tolerate stress or frustration with a tendency to overreact and decompensate in stressful situations. If he was bullied she said this was an additional stressor that <u>may</u> have made Sean more vulnerable to further episodes of self-harm. Importantly she did not say it <u>probably</u> would have done so.

76.12 Whilst a theoretical link between mistreatment and self-harming acts can be postulated, whether this actually made Sean more vulnerable to further episodes of self-harm is, however, difficult to establish.

76.13 Prof Mezey stated that she was "unable to identify any specific effects of mental and physical abuse on Sean". Sean did not refer to bullying in any of his medical or psychiatric assessments, he never complained to any family members about bullying, even when directly asked about this by his mother. He made no reference to being distressed by verbal or physical aggression or any other mistreatment in any of the three letters he wrote shortly before his death. Indeed Prof Mezey described the tone of the letter Sean wrote to Sgt Gavaghan as

[8] Emphasis added.

"benign with no evidence of underlying resentment or anger". This tends to suggest that if he had concerns about ill treatment by others these were not playing upon his mind.

76.14 The three letters are lucid. They are not suggestive of severe mental illness or clinical depression. But they provide powerful evidence of Sean's mental state. In particular, they reveal a significant degree of planning with a desire on Sean's part to "put his house in order" as far as he was able in advance of his death. They suggest a well-settled intention to take his own life in the near future. Sean deployed a strategy devising a ruse to deceive another trainee to hand over a highly lethal weapon by deliberately misleading her and choosing a method whereby he was not under direct observation. In his letters he explains the reason for his actions in terms of the end of his army career, without any reference to verbal or physical abuse. By this stage Sean's lack of complaint is not easily explained by reluctance to complain to the chain of command in case he made himself a target for further abuse. Given the plan he had by now settled upon Sean would have had little reason to withhold or obfuscate legitimate complaints.

76.15 He appears to have had a deep sense of foreboding about his own ability to cope with a return to civilian life, and his personality problems would have impaired his ability to work out a constructive solution. There can be no doubt the main focus of Sean's concern was the decision to apply for his discharge from the army and that was the immediate catalyst for his decision to kill himself.

76.16 The extent to which excessive disciplining, targeted acts of violence and inadequate welfare support may have contributed to Sean's state of mind that night is virtually impossible to assess. This does not rule out that Sean's adverse experiences may have reduced his resilience and ability to cope with his inevitable discharge; but they were not at the forefront of his mind. On the evidence I cannot go so far as to say any of these (alone or in combination) were probably a contributory factor, although it is clear that they could possibly have been.

76.17 On the face of his letters, the reasons Sean gave do provide a complete explanation for his actions that night and his army discharge appears to have been the critical factor. As Prof Fahy put it Sean did not make an allegation of bullying, his letters do not suggest that bullying contributed to the decision to kill himself so although conjectures that his adverse experiences lessened his resilience are theoretically plausible I am not in a position to make such a finding that they did so.

76.18 One of Sean's close friends at Deepcut – Pte Williams, to whom Sean wrote a final letter and wished to gift his Spurs shirt perhaps summed it up aptly when he said:

"Sgt Gavaghan was hard, and pushed and pushed Benton to the limit, and if I thought he or the Army had caused his death I would have said something and come forward, I was Benton's mate. I think that what caused his death was he was scared of leaving the army, perhaps he was worn down so much he – Benton – thought 'fuck it' I can't go on any more. Perhaps if he had got into a Corp he would have survived."

76.19 With his emerging personality disorder, it seems that Sean was not suited to life in the services, and crisis points were likely to have been reached regardless of whether or not Sean was ill-treated.[9] Sean's undiagnosed emerging personality disorder meant that he would have great difficulty dealing with significant disappointments and stressful life events. In the face of what to him was a momentous event, namely imminent discharge from the army, Sean decided to take his own life. That was the critical factor.

77. Distribution of Sean's letters

77.1 Before leaving the topic of Sean's final letters, the evidence reveals that Pte Williams did not learn that Sean had left him a letter until informed of this by Surrey Police in 2002. He never was given the Spurs shirt that Sean wished him to have. Similarly, Sgt Pike and Sgt Russell knew nothing of the thanks Sean wished to be conveyed to them until they too were interviewed during the Surrey Police investigation.

77.2 As a matter of principle, when letters from a deceased are found, not only should they be delivered to those for whom they were intended, but any wishes expressed in the letters should be respected if possible. Even if the original letters are required for other purposes, copies can be provided to the intended recipient. There would have to be a very good reason for departing from this practice.

78. Neglect

78.1 Sean's family has invited me to consider adding a rider of neglect to my conclusion. This term has a specific meaning in the coroners' court. It is not to be equated to negligence or even gross negligence as used in the civil courts.

[9] Although Sean does refer in his letters to the refusal of his application for a week's leave (most likely an application for leave from 11-18 May) he explains he wanted that leave to calm himself down – not to avoid any mistreatment. He was subsequently allowed leave for 5 days from 26-30 May.

For a finding of neglect to be returned, whether as a short-form conclusion or as part of a longer narrative conclusion, there must be "a gross failure to provide adequate nourishment or liquid, or provide or procure basic medical attention or shelter or warmth for someone in a dependent position (because of youth, age, illness or incarceration) who cannot provide it for himself." The failure(s) must have had a direct and clear causal connection with the death, and must contribute to the death in a more than minimal, negligible or trivial way.[10]

78.2 To summarise the family's position, they are correct that Sean was vulnerable, deteriorating and devastated by the decision to apply for his discharge. However it is contended that he was in a dependent position as a trainee who could not leave the camp and he was unable to procure for himself the 'basic attention' he needed. The 'basic attention' identified by the family is the NCOs and Officers taking steps to prevent Sean accessing a weapon where he could not provide that basic attention for himself because as they put it "[Sean] did not have control over the prevention of access to weapons". It is suggested that it was a gross failure to fail to tell the guard not to allow Sean to have access a rifle.

78.3 I have already found that the failure adequately to brief all those on guard duty afforded Sean an opportunity to take his own life. It may well be that, given Sean's evident determination to end his life, Sean would have found another means to kill himself that night, but a proper briefing would have prevented his death at that time by that means. To that extent a direct causative link between the omission and Sean's death is established.

78.4 Whether that failure was 'gross' is a value judgment and for me to assess. The inadequate guard briefing was a flaw in the management of the risk of self-harm which Sean presented. However that shortcoming, which enabled Sean to dupe another private on guard duty, was not in my view of such a nature that it could properly be characterised as gross when it was properly recognised that Sean should not have access to a firearm. The NCOs did not totally close their minds to the need to keep Sean away from weapons and some steps were taken: removing him from guard stags and keeping him under (albeit infrequent) review until the NAAFI closed. That the steps taken were insufficient, does not make the omissions gross. A plan to manage the risk was in place, albeit it fell short in an important respect.

78.5 As I am not persuaded that the circumstances of Sean's death disclose a failure of sufficient severity as to be characterised as gross my conclusions will not include any finding of neglect.

78.6 Further and in any event, I am not satisfied that this is a dependency case where neglect might arise. Sean was not in a "dependent position" in that he could not

[10] R v HM Coroner for North Humberside and Scunthorpe, ex p Jamieson [1995] QB 1. §§25-26

provide himself with the requisite care and attention. Sean was 20 years old. He was not a prisoner. He was a volunteer soldier and not a conscript. Sean was not suffering from a mental illness that left him in a position of dependency. The letters left by Sean make it clear that he was aware of the significance of his actions and indicate a degree of resolve. He obtained the rifle after apparently undertaking a carefully planned ruse. He had clearly decided what he was going to do and was aware of the consequences.

78.7 Whilst it does now appear Sean had an emerging Emotionally Unstable Personality Disorder and potentially ADHD the army doctors in 1995 would not have had sufficient evidence to confirm such a diagnosis. The view taken by Lt Col Gilham that Sean's problem was an adjustment difficulty arising from problematic personality traits was entirely reasonable given the information he had and the state of psychiatric diagnosis at that time.

78.8 Even if it had been known to the chain of command that Sean was suffering from EUPD or ADHD, it is abundantly clear that his suicidal thoughts and feelings were not apparent to those who observed him during the period of that final guard duty. No one who saw Sean through that last evening and early morning, whether the NCOs in charge of the guard, Pte Richardson who saw his demeanour during a museum trip, those who saw him playing darts in the NAAFI, Pte Hunter who he arranged to meet the following morning, his fellow privates who saw him writing letters in the guard accommodation, or his close friend Pte Dilkes, saw a man who appeared so distressed, suicidal or mentally unwell that he was in obvious need of care.

78.9 As Professor Mezey points out in her report: "There is no evidence that on being stood down by Sgt Gavaghan [Sean] was showing signs of acute distress…He was not noted to be distressed, agitated or tearful when he approached Pte Embleton in the early hours of 9 June." I agree: Sean does not seem to me to be someone who was not responsible for their own actions or whose dependent condition obviously called for care and attention.

78.10 I shall not, therefore, be returning a conclusion that includes neglect.

REPORTS TO PREVENT FUTURE DEATHS

79.1 Finally, I need to give anxious consideration as to whether any matters identified in the evidence at this inquest require me to write a report under regulation 28 of the Coroners (Investigations) Regulations 2013 to prevent future deaths (known as 'a PFD report'). If the evidence revealed in the course of my investigation leads me to believe that circumstances creating a risk of future deaths exist, and that action should be taken to prevent those circumstances continuing or arising again, then I must report the matter to the person, organisation, or government department who can act to reduce the risk of future deaths.

79.2 The evidence I have heard has led me to have concerns about a number of systems, policies and practices in 1995 where taking action to prevent future death was clearly warranted. But it is of course unnecessary to make a PFD report if appropriate action has already been taken. Inevitably during the 23 years that have elapsed since Sean's death, many of the shortcomings and systemic failings that have been examined in the course of this inquest have already been identified and major efforts made to address them. There has been a sea change in attitude towards suicide and deliberate self-harm within the army since 1995 with recognition of the importance of continued research in the area.

79.3 I have heard evidence from Brigadier Coles who has explained the substantial changes in training policies and practices in the Army Recruiting and Training Division since 1995. Furthermore, I note that Ofsted now scrutinise the army training organisations, and their recent reports have been brought to my attention.

79.4 The key matters which I have had under review as part of my PFD duties are as follows:

(1) Handling of weapons by trainees

79.5 A matter that in my view required immediate action, was resolved in the immediate aftermath of Sean's death. This related to the instructions regarding weapon handling by trainees. In June 1995 there were no explicit instructions preventing the handover of a weapon from one trainee to another. Although trainees were made aware of their individual responsibilities in respect of a firearm, they used weapons from the guardroom pool and were not expressly told that a guard should never in any circumstances hand over their allocated firearm to a fellow soldier. Clearly there should have been an explicit order to this effect.

79.6 The army Board of Inquiry after Sean's death recognised this omission. The orders to the guard commander had been revised by Autumn 1995 so as to

ensure that there was specific reference to this whenever trainees were paraded for guard.

(2) Trainees performing guard duty

79.7 One matter which would otherwise have been the subject of a PFD report was identified in 1995 by Col Josling who I accept was genuinely concerned that inexperienced young people were undertaking guard duty. He explained that when he was CO he was firmly of the view that trainees should not be doing armed guard until they were in the regular army. His efforts to find an alternative did not reap immediate reward. Brigadier Evans told me he understood the frustration felt by trainees having to take on guard duties, a frustration which figures centrally in his review in 1995. It was not feasible for the base not to be guarded, but he did take steps to reduce the guarding requirement. He asked for resources to bring in an alternative form of guard but resources were not available.

79.8 It was still some years before those concerns were acted upon. The army eventually came to share his view and do now resource a separate guard force. As a consequence guard duty is no longer conducted by trainees. Routine guarding is now performed by the MPGS, a significant and fundamental change to the position in 1995. The MPGS started conducting armed guards at Deepcut in March 2001, but not in sizeable numbers. Indeed two more young privates died whilst conducting guard duty before a company from MPGS was deployed from Sandhurst in 2004 to take over the guarding at Deepcut. Only in certain limited field training contexts is armed guarding now undertaken by trainees. They are not issued with ammunition.

(3) Primary healthcare records

79.9 I understand from Brigadier Coles that the practice that allowed Sean to be recruited without reference to his GP records has been discontinued.

79.10 The process of mental health assessment starts from the date of a soldier's enlistment. In addition to pre-service medical screening, a second assessment takes place within a week of entering basic training. At that assessment a recruit's Primary Health Care Records ('PHCR') are obtained and scrutinised. If the recruit is not passed fit their offer of employment is withdrawn or suspended. If their PHCR is not available their assessment is deferred.[1]

79.11 The PHCR of the Soldier Under Training is then summarised and, along with all other pre-service medical screening documentation, is retained in their electronic

[1] As a matter of policy, a psychiatric disease or dysfunctional behaviour at the time of assessment is an absolute bar to an applicant's recruitment into the army, as is alcohol dependence and severe or recurrent depressive disorder.

health care record. Not only does this enable the army to identify many applicants who, on account of their medical, psychological and social history, would be unsuited to army life, but the improved access to pre-army medical history ensures that, in the event of subsequent medical and psychological issues arising, those responsible for a trainee's medical and pastoral care have the fullest possible information to enable proper diagnosis and devise any necessary care plan.

79.12 As it is now clear that an applicant's GP records must be available before they can continue in the army, I make no PFD report in this respect.

(4) Need for an appropriate complaints system

79.13 In considering the facts of what happened to Sean I have found on the balance of probabilities he and others were mistreated at Deepcut in 1995. Although the evidence does not establish that those actions probably caused or contributed to Sean's decision to take his own life, I acknowledge that such conduct could de-stabilise an individual, sapping their resilience. It may bring about feelings of depression and worse sometimes leading to a sense of despair and hopelessness. Its impact is likely to be greater if the victim is young and vulnerable.

79.14 A constant theme in the evidence was that young trainees at Deepcut felt unable to complain through the chain of command for fear of becoming a target of reprisal. I accept that in 1995 it would have appeared that there was no realistic channel for complaint.

79.15 Whether fears of reprisal were well-founded or not, it is imperative that all trainees should be aware of how they could speak out without harbouring such fears and be encouraged to do so. Brigadier Coles explained that between 1995 and today there has been a real change of army culture and mindset which ensures commanders understand their obligations and very much empowers the individual to use the mechanisms at their disposal to complain about what they believe is a wrong, be it criminality or poor behaviour. For instance, the army now runs a bullying, harassment and discrimination 'speakout' helpline with trained counsellors fielding calls. These trained individuals can distinguish between ill-founded petty grievances and criminal activity, and can signpost the caller in all cases to the right organisation which might include the chain of command, the service complaints ombudsman or straight to the service or civilian police. Now an army sergeant major, the senior army soldier, plays the role of champion on the soldier's behalf for the army leadership code ensuring soldiers understand their ability to come forward and speak out. I am satisfied that the army does now has a significant array of helplines and literature available to its troops about redress where a crime has been committed against them, including a 'Victims of Crime' leaflet.

79.16 Brigadier Coles has sent me a further statement in response to questions raised on behalf of the family. He tells me that the army accepts that there is no difficulty with adding a direct report to the civilian police as a further outlet that is available if the complaint is to criminal misconduct. Accordingly, an instruction will be sent to the training establishments in the next induction rounds, and when handouts for induction programmes are next updated, the civilian police will be added to the list of those to whom trainees can take complaints of criminal misconduct.

79.17 As regards 25 Trg Regt RLC at Deepcut, Brigadier Coles tells me that this has already been actioned. During his induction talk, the Squadron Sergeant Major will inform trainees that they can take complaints direct to civil police in addition to other outlets for complaints.

79.18 I have also received evidence about action taken to improve awareness of the services ombudsman. In particular, I have considered findings in the Annual Report of the Service Complaints Commissioner (SCO) for 2017:

> At p. 3: "No matter how well structured a complaints system is, it cannot be effective if the target group it serves does not know about it, or have a good understanding of how it operates. This applies to both the internal system and external oversight. Although the Ministry of Defence indicates that a range of training on the complaints process is provided to Service personnel (see Chapter 4), Service personnel still report having limited knowledge of the system and awareness of the OSCO."
>
> At p. 35: "The Ombudsman also has concerns about the continued reports from personnel that they were discouraged from making a Service complaint or advised that it was not in the best interest of their career to do so. The Ombudsman is not only concerned about the apparent persistence of this attitude among Service complaint handlers and other individuals charged with providing advice to complainants, but also of the failure of the Services to act on this where they have been made aware of it."

Brigadier Coles explained to me measures that have been taken so as to increase the awareness of the SCO's role including the contact details of the SCO appearing on every army payslip in October 2017. In 2019 the army will adopt a new Command, Leadership and Management package. This contains formal training on the SCO and the Service Complaints System.

79.19 I am grateful to Sean's family for bringing to my attention issues that persist concerning the resources and powers, including investigatory powers, granted to the Ombudsman. However matters such as the extent of the powers of the Ombudsman lie well outside the scope of my inquiry and so will not be the subject of a PFD report.

(5) Welfare system

79.20 Another recurring theme in the evidence was the informal and patchy nature of the welfare system, without any dedicated Welfare Officers, irregular and infrequent welfare meetings, and a lack of specific welfare training for either NCOs or the senior chain of command. The army's approach to welfare was uncoordinated with different welfare agencies acting in isolation.

79.21 Having received evidence from Brigadier Coles, I accept that the provision of welfare support to Phase 2 trainees today is very different. There are clear principles underpinning the welfare policy. The policies are far more developed and comprehensive. There are now strictly defined minimum levels of supervision at Deepcut. Supervision is today closely monitored by the Chain of Command. Training in welfare is engrained from the outset of an instructor's selection to work at Deepcut. The most recent Ofsted Report dated July 2017 concluded that the overall effectiveness was at least good in seven of the nine graded establishments. I acknowledge that that this clear systemic failing has now been properly addressed.

(6) The delay to trade training and holdover

79.22 A fundamental change to the army's training system since 1995 is that all specialist training courses have sufficient capacity for recruits who have completed Phase 1 training. There are no longer routine delays in trainees being posted onto their specialist training course, and there is no longer a pool of trainees at Deepcut without meaningful occupation. Ofsted's welfare and duty of care inspections in late 2016 generated critical comments about soldiers awaiting training. Ofsted stated that the army must "urgently improve the effectiveness of the training pipeline management to reduce the number of service personnel awaiting training, the length of time trainees are service personnel awaiting training and to optimise training throughput".

79.23 Brigadier Coles explained to me the army's response to Ofsted's criticism and what has been done at Deepcut to implement changes to prevent excessive holdover. The Headquarters of the Army Recruiting and Training Division (ARTD) has launched a comprehensive review of holdover in response to the observations in Ofsted's July 2017 report. The aim was to scrutinise and enhance its management, administration, monitoring and reporting of holdover. The resultant holdover policy has introduced measures to minimise holdover, manage holdover soldiers effectively, and monitor holdover trends more closely. I was told that holdover numbers are much reduced and a good deal of holdover time is taken up with basic close combat skills training.

79.24 The family, quite properly, have raised issues as to whether there has been an appropriate response to Ofsted's criticisms in respect of continued holdover.

This is an area of fundamental importance but one which I am satisfied that Ofsted already have under review.

79.25 It follows that I am satisfied after considering the Brigadier's evidence that the army chain of command has, albeit on occasions relatively late in the day, recognised and addressed matters which would otherwise have led me to make a PFD report.

79.26 In the circumstances I shall not be making a PFD report given that the evidence I have received satisfies me that relevant action has already been taken or is going to be taken.

Inquest into the death of Sean Benton

Scope of the Inquest

1. The mechanism of death;
2. When and where the death occurred;
3. The events of the evening of 8-9 June 1995;
4. Who fired any shots on 9 June and whether any third party action was involved in the death;
5. Sean's state of mind on 9 June 1995;
6. How Sean was assessed and disciplined during his army career and the impact of this, if any, upon his state of mind on 9 June 1995;
7. How the process of Sean's pending discharge from the Army was managed and the impact of this, if any, upon his state of mind on 9 June 1995;
8. Whether Sean was subjected to bullying and harassment at Deepcut and, if so, the impact of this, if any, upon his state of mind on 9 June 1995;
9. How Sean's mental state and self-harming behaviour was assessed, understood and managed at Deepcut - including his contact with mental health professionals and the impact of this, if any, upon his state of mind on 9 June 1995;
10. Whether any systemic shortcoming relevant to June 1995 in the following areas caused or contributed to the death;
    a. policies and systems in place at Deepcut Barracks in respect of supervision and support of trainees; (including managing recruits who had difficulties in stage 1 training)
    b. policies and systems in place at Deepcut Barracks in respect of mental health assessment and care of trainees;
    c. policies and systems in place at Deepcut Barracks in respect of the disciplining of trainees;
    d. policies and systems in place at Deepcut Barracks in respect of managing discharged trainees;
    e. policies and systems in place at Deepcut Barracks in respect of guard duty and the provision of weapons.

54. U

SURREY POLICE 28/8 (Rev. 8/00)

S/Prop. No. _____

Identification Ref. No. ADS/1

Court Exhibit No. _____

R -v- _____

Description
SCALE PLAN
PRINCESS ROYAL BARRACKS
DEEPCUT

Time/Date Seized/Produced
20.00 SAT 7th SEPT 2002

Where Seized/Produced
COLLISION INVESTIGATION UNIT
MOBILE SUPPORT CENTRE
BRETLANDS ROAD
CHERTSEY KT16 9DN

Seized/Produced by
A. D. SILK PC1170

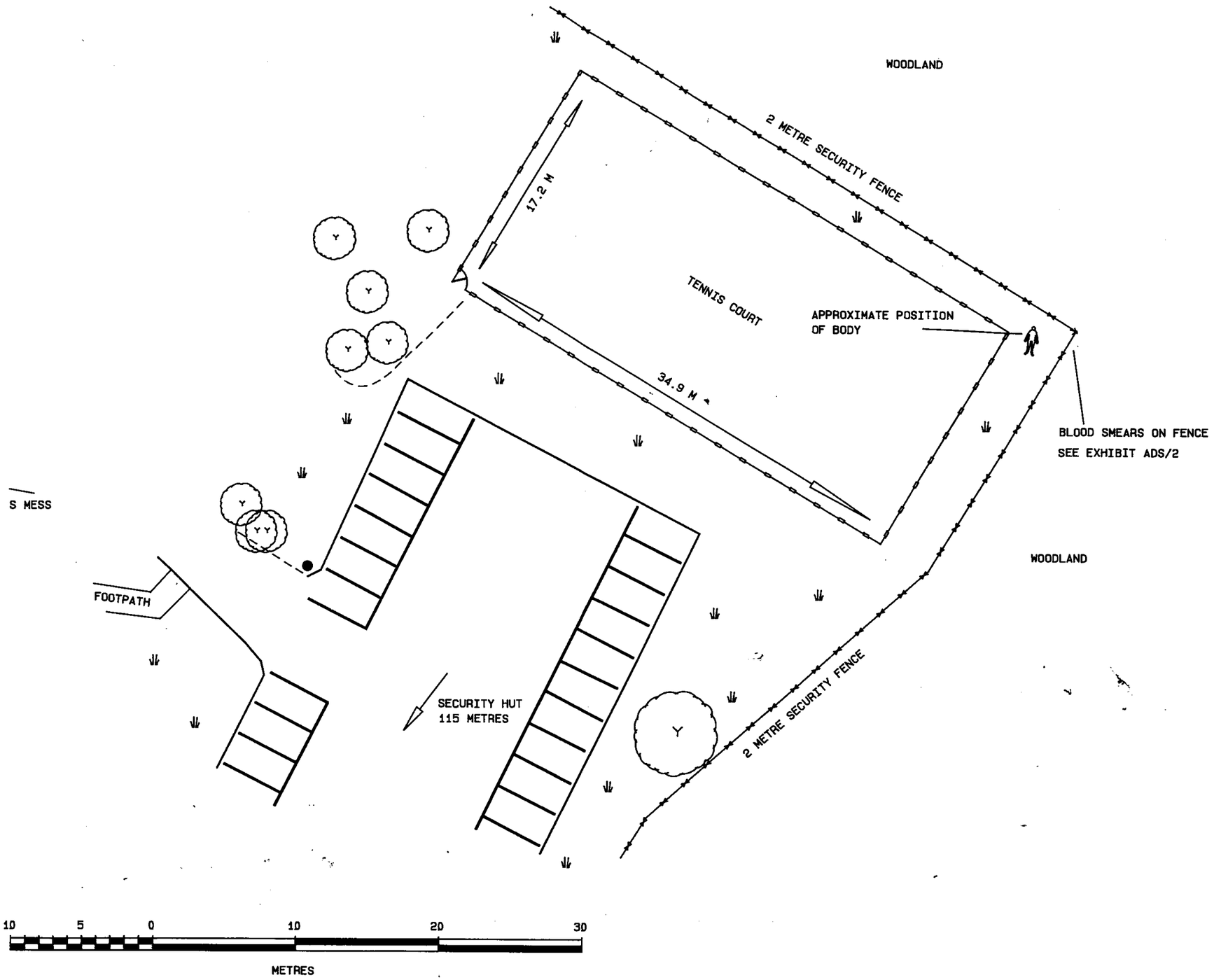
Signed

Incident/Crime No. _____

Major Incident Item No. _____

Laboratory Ref. MSI/P28/1170/02

S/Prop. No. _____



Key
- TRAFFIC LIGHT
- GUARD RAIL
- GRASS
- FENCE
- KERB
- WALL
- TREE
- SKID MARK
- HEDGE

Plan of:
SCENE OF SHOOTING
PRINCESS ROYAL BARRACKS
DEEPCUT SURREY

Notes
SCENE SURVEY CONDUCTED
30 AUG 2002
OPERATION NODULE

scale: 1: 300

MSI Ref: MSI/P28/1170/02

date: 7 SEP 2002

I Pc 1170 Andrew David SILK hereby certify that I have produced this plan from data obtained by me and it is correctly drawn to scale.

Exhibit: ADS/1

Signed: ..... PC1170 .....

SCHEDULE OF AGREEMENT
Dr Nathaniel Cary and Professor Jack Crane

17-O-0044

Concerning the death of Sean BENTON

1. The Cause of Death

We agree that the cause of death may be recorded as:

1a Gunshot wounds of the chest

2. The Mechanism of Death

We agree that the mechanism of death is principally one of blood loss.

3. Whether the death was caused or contributed to by a natural disease

We agree there is no evidence of natural disease that contributed to death.

4. Whether there was any toxicological cause or contribution to death

We agree that there is no evidence of any toxicological cause or contribution to death.

5. What, if anything, can be said of the severity of each individual gunshot wound and the effect each might have had on an ability to discharge further shots

We agree that the gunshot wound to the heart (gunshot wound 2) would have been rapidly fatal although further shots can still occur if this was part of a burst of automatic fire. Due to a lack of detail concerning internal findings and a lack of post mortem photographs, it is difficult to determine the likely effect of each of the other gunshots with both rapid immobilisation and some further purposeful activity possible.

6. In respect of each gunshot wound, whether the wound was or was not a contact wound or a close contact wound, (a) on the balance of probabilities and (b) beyond reasonable doubt. Please make clear your views based on the pathology alone and, if different, your view based on pathology taken together with the BKA view on range at sections 5.2 and 6 of its report

The scene photographs are inadequate for making an accurate determination on range of fire and there are no post mortem photographs; furthermore the post mortem descriptions are inadequate. We agree that it is likely on the balance of probabilities that gunshot wounds 2 and 5 show features in the scene photographs consistent with contact or close contact. Comment in relation to the other gunshot wounds is not possible. Clothing examination by BKA provides the most useful information in relation to these assessments.

7. Whether you have identified anything inconsistent with self-infliction of gunshot wounds

We agree that there is nothing inconsistent with self-infliction.

8. Whether you have identified anything inconsistent with infliction of the gunshot wounds by another person

We agree that there is nothing inconsistent with infliction of the gunshot wounds by another person from a forensic pathology point of view; this is a matter for the Court to determine on the basis of assessment of witness evidence.

9. Which, if any, of the gunshot wounds was fatal

We agree that gunshot wound 2 in damaging the heart would have been rapidly fatal. However, each of the other gunshot wounds, had they been the only wound, could have proved fatal though most likely less rapidly than gunshot wound 2 to the heart.

10. The sequence in which the wounds were inflicted including whether wound 2 was later in the sequence

No comment is possible in relation to the pure forensic pathological findings, although we agree that given the likelihood of rapid death once this wound was inflicted, this would tend to suggest the wound was inflicted later in the sequence if the Court accepts the witness evidence around the deceased still apparently alive when first observed.

11. Whether a suggestion of the gunshot wounds being inflicted in two series is credible in the light of the pathology evidence

We agree that it is credible that the gunshot wounds were inflicted in two series. However, there is nothing from the pathology evidence alone that would indicate this.

12. Whether if the gunshot wounds were inflicted in two series, anything the pathology evidence can identify the time period or a potential range of times between the series

We agree that infliction of the gunshot wounds in two series is possible on the basis of the pathological findings, but the timings are entirely dependent on the veracity of witness evidence.

13. The position Mr BENTON was in when the wounds were inflicted

We agree there is nothing against the proposition that the deceased was initially upright and then crouched, with the blood distribution providing evidence for the deceased being upright. However, much of the evidence around the position is dependent on the veracity of witness evidence.

14. Whether or not the description of the track of wound 3 in the initial post mortem is correct

We agree that there are inconsistencies in the track descriptions as highlighted by Professor CRANE.

15. Whether or not the pathological evidence has been lost as a result of the contemporary approach to the investigation

We agree that much potentially useful evidence has been lost due to the following factors:

(i) There was inadequate scene investigation.
(ii) The scene photographs are poor quality and do not allow detailed assessment of specific gunshot wounds.
(iii) There are no post mortem photographs to assess.
(iv) There is a lack of adequate post mortem description in relation to both the external and internal features of the gunshot wounds.

NC/cg 12.12.17

Dr N R B Cary MA MD MB BS FRCPath DMJ(Path) FFFLM
Home Office Registered Consultant Forensic Pathologist

Record of Inquest

Following the Inquest heard before His Honour Peter Rook QC, Nominated Coroner, sitting at HM Coroner's Court, Surrey and concluded on 18 July 2018, the following statutory determinations and findings were made:

1. **Name of Deceased:** Sean Harry Benton

2. **Medical cause of death**: 1a Gunshot wounds of the chest

3. **How, when and where, and for investigations where section 5(2) of the Coroners and Justice Act 2009 applies, in what circumstances, the deceased came by his death:**

At approximately 05:30 on 9 June 1995 at Princess Royal Barracks, Deepcut, Private Sean Benton shot himself with a SA80 Rifle causing five wounds to the chest. He died rapidly from blood loss. No third party fired any other shots during the incident that led to his death.

Private Sean Benton was a soldier in the Royal Logistics Corps and still in training. Sean had an undiagnosed evolving Emotionally Unstable Personality Disorder which meant that he would have had great difficulty coping with significant disappointments and stressful life events. On 8 June 1995 Sean had learnt that an application was being made for his discharge from the army, and, profoundly affected by this decision, Sean decided to take his own life.

During the course of the evening of 8/9 June 1995, Sean formed a plan to obtain a weapon and wrote final letters to his parents and others which made it clear that his intention was to kill himself.

Members of the army chain of command were aware that Sean would be very disappointed by the decision to apply for his discharge and that he had a recent history of self-harm. Although Sean was rostered as a reserve guard, it was determined that Sean should not have access to a weapon that evening. Standing orders did not, however, explicitly forbid trainees on guard duty from passing their weapon to a fellow guard, and the other trainees on guard duty that evening were not given the instruction that Sean should not be allowed to have access to a weapon.

Having failed to persuade two fellow trainees to allow him to take over their armed guard duties, Sean tricked another trainee into handing over her SA80 rifle and ammunition to him. Had adequate instructions been given to the trainees on guard duty Sean's trick is unlikely to have succeeded, and he would not have obtained the weapon and shot himself when he did.

In the face of clear evidence of deterioration in Sean's physical and mental condition during the weeks before 9 June 1995, there was a failure by the army properly to provide appropriate welfare supervision and support to Sean. Had he been offered and accepted such support it is possible that Sean would not have taken the fatal action he did. However, the evidence does not establish that this would probably have been the case.

Sean, who often fell below expectations regarding his kit and turnout and attitude, would frequently be picked up and sanctioned by NCOs at Princess Royal Barracks. In addition, Sean was the subject of verbal abuse and physical violence by an NCO on a number of occasions and was attacked on at least one occasion by his fellow trainees. It is likely that these events eroded Sean's resilience and

compromised his tolerance of stress. They may well have had a particularly adverse effect upon Sean because of his emerging personality disorder.

Whilst it is possible that these events, on their own or combined with inadequate welfare supervision and support, contributed to Sean's decision to take his own life, it cannot be established that they probably did so.

The broad circumstances of Sean's death and non-causative but admitted shortcomings

Even making proper allowances for the need for army training to be rigorous and disciplined, it is clear that events of Sean's death took place in an environment which was neither as safe for, nor as conducive to, the development of young soldiers as it should have been. Whilst the evidence does not establish that the following matters probably caused or contributed to Sean's suicide, as the army have acknowledged there were a number of shortcomings in the policies, systems and procedures in place at Princess Royal Barracks at the relevant time:

(1) There was an inadequate number of training staff at the camp to manage the number of trainees and the regime provided insufficient purposeful activity. The low supervisory ratios meant that there were insufficient staff to look out for potential problems amongst trainees and to provide the most appropriate level of care and supervision. This impacted upon trainees' welfare;

(2) There was no officer in the training regiment whose role was dedicated to dealing with welfare problems amongst trainees, nor was there any designated welfare committee in which those responsible for trainees' welfare met on a regular basis. The absence of a formal overall welfare policy left the approach to welfare uncoordinated. The system was ill-equipped to manage the kind of welfare issues generated by young soldiers living away from home for the first time;

(3) That considerable latitude was afforded to NCOs with little interference from their Troop Commanders or those higher in the chain of command, meant that at times the frequency and severity of some of the punishments given strayed beyond what was appropriate. In the absence of a clear policy setting out a list of standardised punishments and recording these the system was open to NCOs to administer physically excessive punishments or overly repetitive punishments that went beyond legitimate sanctions, and some NCOs to varying degrees strayed beyond what was appropriate.

(4) Trainees considered that there was no effective channel of complaint against their NCOs, who regulated every aspect of their lives. Many trainees perceived that their lives were in the unsupervised control of their Troop and Squadron NCOs and that the system for making complaints about bullying against NCOs was of limited effectiveness;

(5) NCOs were not authorised to hand out extra guard duties as punishments to trainees, however there was no policy or directive in place which expressly prohibited this and some NCOs awarded extra guard duties as informal and unrecorded punishment for misdemeanours.

(6) The Army failed adequately to address the risk of self-harm amongst trainees in a number of respects:
   a. there is no evidence to suggest that consideration was given to the risk of self-harm posed by granting trainees unsupervised access to firearms;
   b. the frequency of guard duty could also serve to contribute towards poor morale, which could be one factor in increasing the risk of self-harm;
   c. there was no policy requirement for a soldier, who had committed an act of self-harm but who had not been medically downgraded, to be formally risk assessed in terms of their access to a weapon. This should have been formally clarified as a matter of policy with a codified process to follow. However, the matter was left at the discretion of the chain of command.

Record of Inquest (continued)

4.	**Conclusion of the Coroner as to the death:** Suicide		
5.	Further particulars required by the Births and Death Registration Act 1953 to be registered concerning the death:		
	(a)	Date and place of birth	**11 October 1974 at Hastings, East Sussex**
	(b)	Name and surname of deceased	**Sean Harry Benton**
	(c)	Sex	**Male**
	(d)	Maiden surname of woman who has married	**n/a**
	(e)	Date and place of death	**9 June 1995 at Princess Royal Barracks, Deepcut, Surrey**
	(f)	Occupation and usual address	**Phase 2 Trainee Soldier (Private) in the Royal Logistics Corps, based at Princess Royal Barracks, Deepcut, Surrey**

Signature of Coroner HH Peter Rook QC		**18 July 2018**