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**