HIS HONOUR PETER ROOK QC

ASSISTANT CORONER FOR SURREY

INQUEST INTO THE DEATH OF GEOFF GRAY

FACTUAL FINDINGS

20 June 2019

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INQUEST INTO THE DEATH OF GEOFF GRAY

SECTION 1: INTRODUCTION

1. Introduction

1.1 In the early hours of 17 September 2001, whilst performing guard duty at the Princess Royal Barracks at Deepcut, Surrey, ('Deepcut Barracks'), Private Geoff Gray sustained two fatal gunshots to the head. He was only 17 years 7 months old.

1.2 The investigation carried out by the Surrey Police during the immediate aftermath and the weeks that followed Geoff's death was rudderless and of a very low quality. The early assumption that the death was a suicide led to the most cursory of investigations. Even the most basic of checks that might have helped to reduce years of uncertainty, pain and anguish for Geoff's parents were not undertaken. Weaknesses in that initial investigation have affected all subsequent investigators' ability to re-investigate the death.

1.3 Surrey Police have long accepted that the initial investigation into Geoff's death was not of a standard that Geoff's parents were entitled to expect to have happened. They failed to appreciate that they ought to have retained primacy for the investigation rather than yielding it to the military. Such investigation as there was stopped at a very early stage, and lacked leadership and direction.

1.4 Furthermore, it is surprising that after two deaths of young soldiers at Deepcut only six years earlier, a third death of a trainee at the same camp and by the same means did not prompt more concern and hence a more intensive investigation by the Special Investigations Branch ('SIB') of the Royal Military Police ('RMP'), even if they believed Surrey Police were taking the lead.

1.5 The original inquest was held on 19 March 2002. It lasted only four hours. From today's perspective, it was very brief. It was highly regrettable that Geoff's parents were unrepresented. Mr and Mrs Gray were placed at a serious disadvantage in exploring the circumstances of their son's death in that they had not received witness statements and documents in advance and had only had a limited time to look at relevant papers before asking questions of witnesses. Key witnesses were not available and key documents such as the contemporaneous guard log only came to light towards the very end of the proceedings. In the event, the previous HM Coroner for Surrey recorded an open verdict.

1.6 Just four days after the inquest into Geoff's death, on 23 March 2002, another teenager, Private James Collinson, died from a gunshot wound whilst at Deepcut. This was now the fourth death by gunshot wounds of a trainee at the barracks since 1995. The families of the soldiers, including Mr and Mrs Gray, expressed concerns that the four deaths may have been linked and that the earlier deaths may not have been fully investigated by the army or the police.

1.7 On 17 April 2002, Surrey Police decided to undertake a review of the earlier investigations into the deaths in 1995 of Private Sean Benton and Private Cheryl James, and that of Geoff. That review concluded that the investigations into these deaths had been far from satisfactory. A 'Learning Account' was established in 2002 between the Adjutant General and Surrey Police. In Summer 2002, in response to the review findings, Surrey Police embarked on an investigation into the first three deaths, which ran concurrently with the investigation into the death of Pte Collinson.

1.8 Although I have seen correspondence from 5 April 2002 which reveals that a proposal from the Army Directorate of Personnel Services around that time was to "encourage the police to prove" to Mr and Mrs Gray that Geoff's death was suicide, I have seen no evidence that either the recipient of that inappropriate suggestion,[1] or the investigating police bowed to any such improper pressure. In stark contrast to the calibre of the original investigation into Geoff's death, Surrey Police pursued the 2002 – 2003 investigation in an ethical and thorough manner, keeping an appropriate 'open mind.'

1.9 On 19 September 2003, Surrey Police reported details of the investigations into each of the four deaths to the Surrey Coroner. The four reports set out an account of the evidence in relation to the respective deaths. They then began a fifth and final report in order to examine wider organisational and cultural issues in the army that the police had identified as being relevant to the overall inquiry into the four deaths. In October 2003, HM Senior Coroner for Surrey at the time decided not to seek permission[2] to quash the three inquests which had already been heard.

1.10 On 15 December 2004, the Minister of State for the Armed Forces commissioned Nicholas Blake QC (as he then was) to "urgently" conduct a review of the circumstances surrounding the four deaths at Deepcut. 'The Deepcut Review' report was published in March 2006.

1.11 The Surrey Police investigation had generated a substantial body of fresh evidence including several thousands of pages of documents and several hundreds of witness statements. However, the product of the Surrey Police investigations into the respective deaths and the reports summarising their conclusions was not initially disclosed to any of the bereaved families. It took Sir Nicholas Blake's explicit recommendation "that the families of Sean Benton, Cheryl James and Geoff Gray be provided with copies of the respective Surrey Police report, and supporting witness statements, into their child's death, for the purpose of considering whether an application should be made to the High Court to set aside the previous inquest into their child's death" before disclosure was, eventually, given.

1.12 Sir Nicholas Blake had concluded that "it would be appropriate" to give the bereaved families "the opportunity provided by a fresh inquest to examine for themselves the

[1] Lieutenant Colonel Laden, the commanding officer.
[2] Under section 13 Coroners Act 1988.

product of the Surrey Police investigations", and that a fresh inquest offered "the best opportunity for a focused examination and, to the extent possible, closure of issues that remained of concern for the families." It was 2014 before Surrey Police began the exercise of disclosing to the families evidence collated during their investigation.

1.13 In January 2017, Geoff's parents sought permission to apply for that fresh inquest on a number of grounds, including the fact that a substantial volume of new evidence had now become available following the investigation by Surrey Police. Neither the Senior Coroner nor the Ministry of Defence contested the application. The Attorney General granted a *fiat* on 19 July 2017 and, on 28 November 2017, a Divisional Court which included the Chief Coroner quashed the original inquisition, set aside the original determination and directed that a fresh inquest should be held.[3]

1.14 Against this background it is wholly understandable that Geoff's parents' legitimate questions left unanswered after 17 years have led them to lose confidence in the public authorities which should have been reviewing and investigating Geoff's death.

2. The Article 2 ECHR procedural obligation

2.1 Having considered the judgment of the European Court of Human Rights in *Stoyanovi v Bulgaria*[4] I determined at a Pre-Inquest Review Hearing that the circumstances of Geoff's death engage the state's procedural obligations under Article 2 of the European Convention of Human Rights. No Interested Person sought to dissuade me from my view that the Article 2 investigative 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 the possession of a rifle and ammunition whilst unsupervised and alone.

2.2 That determination means that section 5(2) Coroners and Justice Act 2009 ('CJA') will apply. My statutory obligation is not only to investigate and determine who the deceased person was, and when, where and how they died, but also to inquire into the broader circumstances of how Geoff came by his death.

2.3 In his Guidance Number 17, on "Conclusions: Short-Form and Narrative", the Chief Coroner invites me to adopt a three-stage process when completing the Record of Inquest. First, to make relevant findings of findings of fact on the evidence; second, to distil from those findings of fact 'how' Geoff 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 always been clear. How Geoff died, in so far as that relates to the medical cause of Geoff's death

[3] *R(Gray & Gray) v HM Coroner for Surrey* [2017] EWHC 3648 (Admin); [2018] Inquest Law Reports 66
[4] [2010] ECHR 1782

has also never been seriously in question. It is the wider circumstances of how Geoff came by his death that have been the focus of my inquiry.

2.5 The short-form conclusions which might potentially be returned are:

(i) Unlawful killing (on the basis that if a third party fired the shots there could be no legally justified explanation for doing so);
(ii) Suicide;
(iii) Accident/Misadventure; or an
(iv) 'Open' conclusion, if the relevant standards of proof are not satisfied.

2.6 None of the Interested Persons argue that I should limit my findings on the Record of Inquest to a short-form conclusion alone. I wholeheartedly agree that more is needed. Given the length and complexity of this inquest, a short-form conclusion without more would be insufficient, and I propose to provide some narrative within box 3 of the Record of Inquest. This will enable me to (a) reflect as far as practicable the full facts of how Geoff died; (b) expose any culpable or discreditable conduct that is found to have occurred where the conduct is possibly causative of death; and (c) allay suspicions of the involvement of others in Geoff's death, if such suspicions are unwarranted.

2.7 The critical and most contentious determination in this inquest relates to *(i)* whether Geoff took his own life and, if so, whether he intended to do so, or *(ii)* whether he was killed by another. Those questions have occupied the majority of the 28 days of evidence that I have heard and it is to those and the related key issues at the heart of this case that I now turn.

2.8 My consideration of "in what circumstances" Geoff came by his death has also included whether Geoff's death was contributed to by any systemic shortcomings in policies and systems in place at Princess Royal Barracks in respect of guard duty and the provision of weapons to trainees, and in policies and systems in place at the barracks in respect of supervision and welfare support of trainees. However, in respect of the latter, it is apparent that there is absolutely no suggestion that Geoff was ever the victim of bullying or mistreatment at Deepcut. Nor has there been any evidence whatsoever to suggest that he was in any way in need of the army's welfare services.

3. The Evidence

3.1 Before setting out my findings, I should say something of the evidential difficulties that beset an inquest taking place so many years after the primary events.

3.2 This inquest has over 28 days of sittings heard the live evidence of 67 factual witnesses and four experts, whether in person or via video-link; 34 other witnesses' statements were read under Rule 23.[5] I have heard evidence about events that took place over 17 years ago.

[5] Coroner's (Inquests) Rules 2013.

Such a long passage of time inevitably poses major difficulties both for witnesses and for the evaluation of the reliability of their evidence. Undoubtedly, the task of this inquest has been made significantly more demanding by the many important forensic opportunities that have been lost.

3.3 To some extent, those difficulties have been compounded by the limited number of contemporaneous accounts. However, with some notable exceptions, such as the route the search party took after the shots were heard on 17 September 2001, this inquest has not involved the resolution of multiple factual disputes. Rather, it has been an exercise in interpreting the facts which are now available to me.

3.4 In assessing the witnesses' evidence, I make due allowance for the fact that memories fade with time. This is particularly so where a witness did not make 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.

3.5 Some key witnesses first made statements within a few weeks of Geoff's death before the first inquest in March 2002 when, with the exception of Lance Corporal Craig Filmer, they also gave oral evidence. However, the majority of witnesses were not asked to look back and recall events for their statements until they were asked to participate in Surrey Police's investigation in 2002 – 2003: in many cases, this was already a year after events. A significant number of witnesses then gave evidence at the Army Board of Inquiry in 2007.

3.6 Where witnesses have given their accounts at various times over an extended period it has given me an opportunity to consider those accounts together with the evidence they have given before this inquest.

3.7 I have not made any assumption that because a fresh account was not given earlier, the subsequent account must necessarily be untrue. I have considered the reasons why the witness may not have mentioned the matter earlier in the context of how important the witness would have considered it to be. Similarly, I acknowledge that just because an account was made at the time does not necessarily mean it was true. I have, where relevant, made allowance for the reasons for delay in recalling matters. I have looked at all the circumstances including the particular reason the witness gave for not having given that account at the time.

3.8 I have borne in mind that material inconsistencies between a witness' oral evidence and a previous statement may mean that less weight should be given to that evidence. I acknowledge that honest witnesses can make mistakes. Inconsistencies need not necessarily undermine a witness' evidence just as a consistent account does not necessarily mean it is true.

3.9 Confident delivery does not necessarily mean the evidence is accurate. Although a witness' demeanour whilst giving evidence can be revealing, experience has shown that it can be

dangerous to draw conclusions from it as to a witness' reliability. It follows that I have not attached any significant weight to the manner in which evidence has been given, but focused instead on the content of the witnesses' accounts.

3.10 Where evidence that is contentious has nevertheless been read under Rule 23, 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 section 4(2) Civil Evidence Act 1995.

3.11 Throughout I have borne in mind that important and potentially determinative forensic evidence that would have assisted to illuminate what happened on 17 September 2001 was not gathered at the time and is now irrecoverable.

3.12 Even by the contemporary standards of 2001, the investigation was not conducted in the way to be expected following a sudden and violent death. Whilst I am quite satisfied that neither the Surrey Police nor the RMP/SIB officers attending acted deliberately to 'cover up' matters, it is clear that the very early assumption of suicide made at the scene led to a limited scene investigation, an absence of contemporary ballistics evidence and a failure to seize relevant documents. Relatively brief contemporary witness accounts were recorded and an early opportunity to explore important inconsistencies between search witnesses was lost.

3.13 Consequently, the forensic evidence that has been available to me in 2019 is inadequate in a number of respects. Despite the careful attention of the doctors and scientists who have assisted me as expert witnesses, all have been hampered in coming to their opinions by incomplete information.

3.14 It is an inescapable fact that there are substantial gaps in the evidence which might have been filled if earlier action had been taken more promptly. I have to decide whether these gaps are of such a nature and scale that I have been deprived of sufficient evidence to enable me to make determinations. I accept that neither considerations of sympathy nor undesirability should in any way impact on the issue of sufficiency of evidence.

3.15 Surrey Police have apologised for their failures to interpret policy correctly and to retain primacy. Detective Chief Superintendent Denholm has frankly acknowledged to this inquest how the forensic shortcomings at the time have hampered all subsequent investigations. However, an apology and acknowledgement cannot replace what has been lost.

3.16 Geoff's parents were entitled to expect that when their child died in the service of his country there would be a thorough and immediate investigation and a full and prompt explanation to them of the circumstances of his death. They did not receive this. They should have done. They have waited too long for such explanations as this inquest has now been able to provide. It is with regret that I recognise that those explanations will, to some extent, always remain incomplete.

SECTION 2: GEOFF GRAY

1. Geoff Gray

1.1 Geoff Gray was a young man with everything to live for. He had a wide circle of friends, he was popular, physically fit and athletic, mature for his age and had a generally cheerful character. Geoff was often the joker in the group, he enjoyed himself; if there was a party he would be there. He was someone who everybody who met him seemed to like. Men and women alike seemed to want to be associated with Geoff. Whilst memories of specific facts might have faded with time, the enduring impression that this 'happy-go-lucky' character with a 'zest for life' left upon so many of the witnesses has been plain to see throughout this inquest hearing.

1.2 Geoff came from a very close family. Born in Sunderland on 28 January 1984, he was his parents' second son. The Gray family had moved from Seaham in County Durham to London in 1989. Growing up, Geoff enjoyed similar activities to many teenagers. He loved ice-skating, his music, and he was an accomplished runner. His early years in the Beavers, then the Cubs and onto Adventure Scouts had provided Geoff with an important aspect of his social life as a child and adolescent. There he met his first serious girlfriend and he would later return and help out with his local scouts when on army leave.

1.3 Geoff had no problems reported either at home or at school. A bout of pneumonia at age 14 was Geoff's only physical illness of any note. There is no suggestion from any source that Geoff had ever had any mental health difficulties whatsoever.

2. Geoff and the Army

2.1 Geoff has been described as "army barmy" from a young age. Geoff's interest in joining the army began seriously when still at school and he had begun the application process (with his parents' consent) on 17 August 1999 when still 15. The reference from his Group Scout Leader described Geoff as "polite and well mannered, honest and considerate for others" and "having developed into a young person who is well liked by all Troop Members. As a Patrol Leader he motivated and encouraged members, maintained a high level of enthusiasm for all troop activities invariably allowing his sense of fun and good humour to show through and achieved all the targets he set for himself."

2.2 Geoff was, however, still too young to sign up. He finished his schooling in Summer 2000 with a clutch of GCSEs and found himself a well-paid job on a building site. He was a young man of 16 with money in his pocket. But having to take a cut in wages did not deter Geoff from still pursuing an army career. Geoff passed his army selection and medical examinations in August 2000. He wrote on his assessment form at the time:

> "For many years I wanted to join the army. I see it as a new experience giving me a challenge and chance to learn new skills. I always work my best and like to be pushed to new extremes both physically and mentally. I think the army will help me build myself up to a new person teaching me many new things"

2.3 The assessing officer recorded that Geoff was "cheerful, articulate and easy to interview", and was potential NCO material. Geoff formally enlisted on 16 January 2001 and reported for duty on his seventeenth birthday just 12 days later.

2.4 Geoff entered RLC Phase 1 training at Pirbright Barracks. He passed through the course with apparent ease, completing his weapons handling and all other tests to the required standard. His final Section Commander's report on 18 April 2001 stated that: "Recruit Gray has matured from a very quiet recruit with little self-confidence into a capable and confident recruit over the last 12 weeks. His personal admin has also improved dramatically. He is always hardworking giving 100% in all lessons and has shown [no] difficulties throughout."

2.5 From the perspective of his parents, Geoff "loved every minute of being in the army". He would regularly call home telling his parents and his younger brother about all the exciting things he had done that week. His parents have described how watching Geoff's passing out parade was such a proud day for his family.

2.6 After nine days leave in April 2001, Geoff began the second phase of his training with the RLC at Princess Royal Barracks, Deepcut on 30 April 2001.

3. Deepcut in 2001

3.1 In 2001, the Princess Royal Barracks was the headquarters of the RLC and was home to 25 Training Support Regiment. This was a holding unit for soldiers completing Phase 2 of their training. The unit supported, administered and accommodated trainees during the 5 – 9 months it would, on average, take to complete Phase 2 training and be posted to the field army. During this time trainees would conduct specialist trade training either on courses provided at the barracks or away from Deepcut at specialist schools.

3.2 Trainees being held at Deepcut during Phase 2 were part of 86 Squadron, which was composed of two troops, 'Arnhem', and Geoff's troop, 'Normandy'. The number of trainees in each troop was constantly fluctuating. The subsequent Boards of Inquiry into the deaths of Geoff and of Pte Collinson found that there were generally 400 – 600 trainees in each troop.

3.3 The MOD accepts that there was a consistent and serious problem with delays in the progression of trainees through Deepcut: many specialist courses were infrequent and trainees' arrival was not scheduled in line with course availability. Trainees would be considered 'Soldiers Awaiting Trade Training' (or 'SATT') for long periods of time in between aspects of their specialist training. A particular bottleneck was driver training.

Many young trainees arrived at Deepcut without even a provisional driving licence. They had to obtain that licence then undertake driving tuition at Deepcut provided by civilian driving instructors to a standard to pass a car driving test before they could progress on to do the advanced driver training at Leconfield in the north of England that would qualify them to drive heavy vehicles.

3.4 In stark contrast to the regime during Phase 1 training at Pirbright, life as a SATT at Deepcut had the potential to be unstructured and disorganised. Many of the soldiers were young, with money in their pockets for the first time, and socialising involving alcohol, both on and off camp, was the norm. The problems this could cause were compounded by a persistent shortage of supervisory staff and startlingly poor ratios of non-commissioned officers ('NCOs') to trainees: there were times when the ratio was as low as one officer and four NCOs to 500 trainees. This situation, driven by resources and by the army's 'front line first' policy, created an obvious potential for discipline problems to arise, for bullying to take place unchecked, and for welfare problems to go unnoticed or unaddressed.

3.5 The particular problems that this situation had given rise to in 1995 were investigated by me during the inquest into the death of Sean Benton in 2018. It is of note that by 2001 the ratio of NCOs to trainees had not notably improved despite the entreaties of successive Commanding Officers, although I heard evidence that welfare structures were much improved. The arrival in June 2001 of a new Commanding Officer, Lieutenant Colonel Ronald Laden,[1] had led to a greater focus upon curbing indiscipline and providing structure for the SATT soldiers.

3.6 While this forms the background to Deepcut at the time of Geoff's death, this inquest is not a public inquiry into the Deepcut regime and my role is to investigate matters which might help me answer the question of how and in what circumstances Geoff died. There is no evidence from any witness that even remotely suggests that Geoff was bullied or subject to excessive discipline at Deepcut, or that he had any obvious or unobserved welfare problems for which he was not receiving support. Those aspects of the wider culture of Deepcut will not form part of my core findings as to how Geoff died.

3.7 One feature of the regime at Deepcut that is of direct relevance to Geoff's death is the requirement for the trainee soldiers to undertake armed guard duty. The Princess Royal Barracks had "a complicated layout, an extensive boundary, and accommodation at sites outside of the main barracks which meant that the requirements for guard duty at Deepcut were considerable." Outside the perimeter fence of the main camp lay the Officers' Mess and the Sergeants' Mess, each effectively small compounds with their own access gates and perimeters that also needed guarding. The Guard Commander and the second in command at the guardroom had to rely upon a radio held by one of the guards for communication with these guard posts.

[1] Throughout these conclusions I will refer to all army personnel by the rank they held in September 2001, and where surnames have changed, by the surname used at that time.

3.8 The manpower for guard duty at Deepcut was predominantly met by utilising Phase 2 trainees. This was consistent with the practice at many similar army establishments and the army's historic practice of guarding itself. At a normal state of alert around 22 trainees would be required to guard the camp, deployed at 5 gates or posts (including conducting prowler patrols of the camp interior), or on standby as part of a quick reaction force.

3.9 Trainees worked 12-hour day or evening shifts during the week and weekends. A night guard duty would start with a parade after 18.00 hours and ending at 07.00 the next day. Most of the guards were allocated to what were known as guarding 'stags' on a 2 hours on 2 hours off basis with some retained in the guard room throughout the shift as a 'quick reaction force' and completing other administrative duties.

4. Geoff's Progress at Deepcut

4.1 As Geoff was under 18 when he started at Deepcut, he was accommodated in a block with the other under-18 year old boys. At least one friend who came through Pirbright with him was in that block, Private Carl Hine. Other close friends from Pirbright, Private Stephen Sidgwick and Private Thomas Vick, were in a different block, although they spent a lot of social time together both on and off the camp and did the same trade training course together.

4.2 Geoff's chosen trade in the RLC was to be a supply controller, involved in organising all of the army supplies from food items to missiles. In common with all RLC Phase 2 trainees, Geoff had to wait for a place on his trade course. Trainees were kept occupied in the meantime by a cycle of exercises, including physical training and some weapons handling, in particular to prevent 'skills fade'. Geoff was not unusual when he said, at times, that he was bored and frustrated by waiting around to learn a trade before he could be posted to a squadron and his army career might properly start. But there is little evidence that this was a pervasive feeling or anything unusual given the circumstances in which young soldiers eager to start their army career found themselves. No one who knew Geoff suggested he was characteristically complaining. He was said to have much enjoyed some aspects of Phase 2 training, particularly an outdoor survival/training exercise off camp in Otterburn, Northumberland. There are two sick days on Geoff's file from May 2001 for minor health matters but no other problems recorded.

4.3 Geoff's Supply Controller course eventually began on 4 June 2001, two months after arriving at Deepcut. The course involved around a month of classroom-based work. Geoff qualified successfully as a Global Stock Control Operator and Supply Controller on 6 July 2001. Geoff would not, however, be posted to his unit until he had also completed his driver training.

4.4 After two attempts at his driving theory test Geoff passed his Driving Licence cat B on Thursday 6 September 2001. His father recalled the excitement when they went together

to look at cars to buy on his final weekend trip home over the weekend of 7 September 2001.

4.5 Much of the trainees' time was taken up with guard duty. There is some uncertainty over the exact dates on which Geoff undertook guard duty, partly due to the coincidence of there being another Private Gray at Deepcut at the same time.[2] It appears that Geoff did 20 sessions of guard duty at Deepcut. This number of allocated guard duties was probably typical and certainly not excessive for a four and a half month period spent at the barracks.

4.6 Whilst weekend guard duty was said to be unpopular as it curtailed socialising in the local towns and prevented weekend home leave, Geoff does not appear to have been disproportionately allocated to weekend duties. According to Pte Hine, Geoff preferred weekday guard duties and doing it with friends but he did not suggest that he expressed any particular feelings of upset at being allocated occasional weekends.

4.7 After finishing consecutive day shifts of guard duty in the week beginning 10 September, Geoff had a Saturday of free time before being been allocated to a Sunday night duty on 16/17 September, amid extra demand for guarding that arose following the "9/11" attacks in America on 11 September 2001. The Normandy Troop Duties sheet suggests that Geoff was to be on additional guard for the 12 hour night shifts from Sunday 16 until the morning of Friday 21 September, the day he was due to leave for Leconfield.

5. Geoff's discipline and his passage through Deepcut

5.1 Sergeant William Graham, Geoff's Troop Sergeant at Deepcut, gave evidence that Geoff stuck out – quite literally – due to his height, which was over six feet tall. He said Geoff was a very bubbly character, very willing and able and keen to volunteer for any tasks. Pte Sidgwick described Geoff as canny enough to stay in the background when he wanted to, but who would at times be very amicable and helpful to NCOs – perhaps partly taking on extra duties to break up the monotony of daily existence at Deepcut.

5.2 In 2001, WO2 Sandra Robson[3] was the Squadron Sergeant Major, in charge of discipline. She told me that Geoff was never in trouble and had no discipline issues. Geoff was capable and disciplined, and appeared to get on well with his peers. No-one came forward after Geoff's death to report any hidden issues. His disciplinary record was entirely clean. Geoff's ex-girlfriend Ms Claudia Webb told me that Geoff said he once got in trouble for rubbing his nose on parade, which irritated him. That appears to be the height of it. Pte Sidgwick spoke of a Geoff who never got into any trouble. He told Surrey Police that

[2] I accept the evidence provided to me by the MoD, through Brigadier Coles, that Geoff most likely was on guard at Deepcut on Friday 4 – Saturday 5 May, Monday 14 May, Tuesday 22 – Wednesday 23 May, Friday 15 June, Friday 22 – Saturday 23 June, from Monday 16 – Thursday 19 July and from Friday 31 August – Sunday 2 September, and probably again from Monday 10 – Friday 14 September 2001.

[3] Now Major Sandra Hodgson.

Geoff "never got any shit jobs, never got dibbed for anything…he was playing it really well."[4]

5.3 The evidence before me shows that Geoff was making good progress and was on the threshold of an army career that he enjoyed. There was nothing to mark him out as someone who was underperforming, struggling or was personally unsuited to army life. Lt Col Laden noted in his evidence how Geoff would have been expected to become a successful soldier: Geoff's time in the Scouts had given him past experience of teamwork, he had not come from an unsettled or disadvantaged background, and he was not a person who have been considered "at risk" of having an unsuccessful spell in the army.

6. Geoff's mood and demeanour in Summer 2001

6.1 Throughout his time in the army, Geoff kept in touch with several girlfriends. It is apparent from many sources that his long-standing and ongoing friendship with Ms Webb was particularly important to him. Geoff's popularity with girls was remarked upon by many witnesses at this inquest. He had liaisons with a number of girls and women over Summer 2001; with some of them he had sexual relations. A number of these women were traced and interviewed by Surrey Police. None of these young women told Surrey Police that Geoff disclosed to them that he was experiencing any particular problems or worries about army life.

6.2 The fact that Geoff had a habit of hoarding keepsakes from many of his girlfriends, such as mementoes of dates like cinema tickets, suggests that some of these liaisons mattered to him more than might be assumed from the fact he had multiple relationships at the same time. Any suggestion that these were weighing on his mind or causing him stress at the time of his death would however be speculative, and does not have a foundation in any explicit evidence: if Geoff was bothered by his relationships, one might expect him to have confided this in friends or family.

6.3 It is also clear that Geoff made many friends in the army. He had a busy social life and numerous people with whom to spend the weekends, usually out drinking in towns close to the barracks. He was not isolated and had plenty of people to talk to, and potentially to confide in if he wished, particularly some soldiers with whom he had formed a bond during Phase 1 training.

6.4 Pte Sidgwick told me "everybody liked him, so nobody would ever have a go at him". While Geoff may have occasionally been subject to teasing or the target of 'banter' (including in the guardroom on the night he died), there is no evidence to suggest that this was an overbearing feature of his army life. Geoff's sense of humour and fun perhaps

[4] Another girlfriend of Geoff's, Ms Stafford, told Surrey Police that Geoff had once told her he was put in the "army jail" and had been beaten up there. There is no record of Geoff ever being disciplined nor any suggestion from any quarter, including his close friends at Deepcut, to corroborate this having actually happened, and I am satisfied that it did not.

made it unlikely that army 'banter' would bother him unless he was extremely adept at masking any inner torment.[5]

6.5 Pte Hine described the feelings of boredom and frustration that some trainees had at Deepcut as a result of the repetitiveness of the training, and considered that Geoff coped with that better than most: he would be the one who would cheer other people up, reassuring them and making them laugh.

6.6 Pte Sidgwick said Geoff was "always happy…there was nothing that you would say would be down or miserable about him." That is not to say that Geoff positively enjoyed all aspects of his time at Deepcut, and there is no doubt that everyday life at Deepcut could be boring. Pte Sidgwick told me that Geoff had the same attitude as everyone else: they "hated" Deepcut, but Geoff wasn't "depressed about anything in particular". No-one enjoyed having to spend time waiting at Deepcut for the next stage in their army career. Geoff told Charlotte Chandler, a civilian friend he met while socialising in Woking, that a common saying at Deepcut was *"join the army be the best, go to Deepcut be depressed"*. Geoff's father recalled that his only 'whinge' about the army was being held at Deepcut: he wanted to get on with his driver training and get to Leconfield. This was a feeling that was shared by many trainees, and it was in no way remarkable that Geoff expressed such a wish.

6.7 As an under-18, Geoff was subject to somewhat stricter discipline than older trainees, but there is no evidence that he resented this or chafed against the army's standards and expectations. There is no evidence that Geoff had any enemies during his time at Deepcut, or that he felt or had any reason to fear aggression or retribution from any trainee, NCO or Officer. No witness has told me Geoff was picked on or singled out, let alone subject to any kind of physical or emotional abuse, from either a fellow trainee or anyone in the chain of command. Ms Webb felt Geoff would tell her things that he did not tell others, and she felt that if Geoff had been bullied, he would have told her. Geoff did not report any bullying to her, and in any event her view was that he was not someone who could easily be bullied.

6.8 Ms Barbara Walsh of the Women's Royal Voluntary Service ('WRVS') was an important potential source of welfare support for trainees at Deepcut. She told Surrey Police that Geoff had never confided any problems in her. Private Philip Burns was Geoff's roommate in the under 18s block. They got on very well, and he recalled playfighting with him and teasing him about being a Sunderland supporter. He never saw any hint that Geoff was depressed. Nor was there anything to suggest to him that Geoff was involved in fights with anyone, or that anyone was acting aggressively towards him. He recalled that Geoff was "army daft" and seemed "dead keen" for his training.

6.9 It is largely on the basis of these impressions of Geoff that many of his fellow trainees have, over the years and at this inquest, and notwithstanding their qualms about the

[5] Pte Sidgwick, for instance, told me he was "the kind of guy [who] if he slipped and fell down the stairs, and nobody saw it, he would tell people."

unhappy environment at Deepcut, expressed disbelief that Geoff could possibly have taken his own life.

6.10 One witness however gave a different impression, that while Geoff's outward demeanour was typically extroverted and ebullient, he had a sensitive side. Private Kate Ward, a fellow trainee, gave a statement to Surrey Police in September 2002 describing how Geoff felt able to confide in her. She said there were two sides to Geoff and she saw the "true side". He could be sensitive, and while he would brush off teasing from mates, she thought that "deep down it would hurt him". She said he was homesick and missed his girlfriend – as far as she was aware, his only girlfriend – and his family. She told Surrey Police that in August, she and Geoff both decided they were going to leave the army, partly for Geoff because he "didn't like Deepcut". Unfortunately she was unable to answer any questions of substance about her 2002 statement when she gave oral evidence in 2019, and due to the passage of time, she said she now had no recollection at all of what she had said in her statement given to the police 17 years ago. While I do not doubt that she gave an accurate account of her best recollection to Surrey Police, her evidence, which stands in stark contrast to all other witnesses, cannot establish any kind of settled intent by Geoff to leave the army, or any deep-seated antipathy towards army life.

6.11 The clear picture from the evidence of Geoff's progress at Deepcut is that there is no basis on which to suggest he was demonstrating any obvious, long-term or persistent despondency or low mood. Nor is there any reason to suggest he was personally at risk of being the target of any premeditated wish to cause him harm.

7. The last weekend of Geoff's life

7.1 By Saturday 15 September 2001, Geoff had been told he was due to go to Leconfield for his HGV driver training on 21 September. According to Pte Hine, Geoff was "over the moon". Private Martin Eales had returned to Deepcut from Leconfield on the weekend before Geoff died, and recalled telling him about Leconfield and how much he had loved it: Geoff was excited. Geoff's father also recalled that Geoff was excited about going to Leconfield and earning an HGV licence.

7.2 Private Epi Naiova recalled that on the night Geoff died he expressed some frustration that he had not been allowed two days' leave to prepare for his posting to Leconfield. The request was made to Sgt Graham as Geoff's troop sergeant. Sgt Graham could not remember this, but told Surrey Police that trainees would normally have been granted at least one day off duties prior to leaving Deepcut for Leconfield – not really a true day of leave, but a day for administration tasks to enable them to be cleared from the Regiment.

7.3 Geoff, who had just completed a week of daytime guard duties, spent much of his free time on the weekend before he died with Pte Vick. They went out drinking in Camberley on the Saturday, and that night Geoff was particularly drunk: at one point he went to have a snooze in a skip. Walking back to Deepcut, they found an old bike in a scrapyard, and

after walking with it for a while, Geoff threw it over a bridge onto a railway line. Pte Vick considered this unusual behaviour and said it was the drunkest he had ever seen Geoff.

7.4 Ms Sarah Wood, a civilian who Geoff had met in a pub in Camberley and with whom he had struck up a relationship, also recalled a time she met up with Geoff and that he was particularly drunk. Geoff acted very out of character: they had an 'altercation' in which he insulted her. It is likely she is recalling events that occurred on Saturday 15 September.

7.5 There is therefore some evidence that on the weekend before he died Geoff was behaving unusually for him and in a more volatile and impulsive manner. There is a danger in using hindsight to place too much weight on these events. None of this behaviour is out of the range of what might well be considered normal for a 17 year old away from home and with access to their own money and a considerable amount of alcohol.

SECTION 3:
THE EVENING GUARD DUTY - 16 SEPTEMBER 2001

1. Guard duty

1.1 Following 9/11, the alert state at Deepcut was raised. This had an immediate consequence on guard duties: an additional guard was now required on each fixed post. Rather than having just two guards, a third unarmed guard was added to each stag in order to enable armed prowler patrols from the post to be accompanied by that unarmed guard, whilst the other armed guard remained at the gate. The overall demand for trainees to undertake guard duty hence increased from 22 to around 40 per shift. As a result of this, having completed a week of guard duty between Monday 10 – Friday 14 September 2001, Geoff had a Saturday off before he was allocated to an additional night-time guard shift on the night of Sunday 16 - 17 September 2001. It appears that Geoff faced the prospect of further night-time guard duty up until the time he was due to leave for Leconfield. Many other trainees would also have been similarly affected by the increased requirement for guards in the immediate aftermath of 9/11.

1.2 The evening guard of 16 September 2001 was a twelve hour shift from 19.00 to 07.00 hours. The guards' pattern of duties (known as 'stags') was to be two hours on, two hours off. Trainees were to be shuttled to and from their stags in a minibus and returned to the guard room for their breaks, during which time they could snooze, chat, make phone calls, and play on a PlayStation.

1.3 Armed guards were to carry an SA80 rifle.[1] All rifles at Deepcut were either secured in the armoury, or kept in the guardroom, where the pool of rifles was stored in a locked rack at the rear. The Guard Commander and the second in command ('2ic') held the keys to the rack. When the rifles were unlocked to be issued, each guard was to sign out a rifle with the serial number or butt number recorded. The rifles would later be returned and secured in the guard room after each stag.

1.4 The sheet from the guard shift of 16-17 September, showing which rifle had been signed out by which trainee, is no longer available. Whilst this is not a document anyone would expect the army to have routinely kept and archived, any competent investigator would have reviewed and taken possession of this document on 17 September 2001. This could then have provided important confirmation as to whether the rifle found next to Geoff's body was or was not the rifle that had been issued to him at the outset of his stag.

1.5 The 5.56.mm rounds were also kept under lock and key, in a locked box in the guardroom. Ten live rounds were to be issued to each guard, and would be counted out and counted back in at the start and end of each stag. Rounds were then loaded into the magazine. A

[1] The minimum age to conduct armed guarding as set by army land command was 17 years. However local policy at Deepcut had set a minimum age of 17 ½ years.

tally of rounds was kept in the guard room and the Guard Commander was required to confirm, by signing the guard report, that all rounds were accounted for at the end of each guard shift.

1.6 That evening duty the guard commander was Staff Sergeant Patrick Crimin and the 2ic was Lance Corporal Craig Filmer. L/Cpl Filmer was then serving with a Logistics Regiment based in Devon but was attending a course at Deepcut and had been required to do a single evening shift supervising the guard.

1.7 After parading for guard sometime around 18.20 hours Geoff was allocated to do all his stags at the HQ RLC Officers' Mess with Private Faye Mulraine and Pte Naiova. The Officers' Mess was situated approximately a mile from the main barracks site with a self-contained fenced perimeter of around 1km. The three of them were posted to the 'rear' car park gate (actually the main point of entry) and began their duty with a two hour 'break' as their first stag was allocated between 21.00 and 23.00 hours: after a further two hours rest they would return to the gate at 01.00 hours.

1.8 Two of the trio were to be armed and it was left up to the trainees to decide how to allocate those guarding roles. The men chose to take the rifles and Pte Mulraine was unarmed, and in possession of the radio. Pte Mulraine could not recall how that decision was made, but thought it was because she didn't want to carry the rifle.

1.9 Post-9/11, the requirement was that any armed prowler patrol of the Officers' Mess grounds during the 'silent hours'[2] should be conducted in pairs at all times. The order was communicated to the guards by S/Sgt Crimin in his briefing. Orders also specified that the guard room was to be contacted before the conduct of the patrol.[3] To undertake a lone, armed prowler patrol would be a direct breach of the trainees' orders. Pte Mulraine said that she was aware that patrols were to be conducted by two guards.

1.10 L/Cpl Filmer was responsible for the allocation of weapons and ammunition. In normal circumstances, guards would be expected to keep their magazines separate from their rifle. However on the night of 16 – 17 September 2001, in the raised alert state post-9/11, the standing orders for guard anticipated trainees being supervised as they loaded their magazines onto their rifles in the loading/unloading bay on arrival at their post.[4] Weapons were not made ready, so firing a round would still require the weapon to be cocked with the safety-catch disengaged.

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[2] 20.00-05.00 hours.

[3] S/Sgt Crimin could not now recall if this aspect of the orders was directly communicated to the guard.

[4] L/Cpl Filmer recalled that he had monitored Ptes Gray and Naiova loading their magazines onto their rifles on arrival in the unloading bay at the Officers' Mess.

2. At the guard room: 19:00 to 21:00

2.1 On the August bank holiday three weeks before he died, Geoff was part of a group that had spent the day celebrating another trainee's birthday in Frimley. The other trainees were under the impression that a sexual liaison had happened that afternoon between Geoff and a woman who was deaf who he had just met. Geoff was teased about this by some of the other privates. Private Sonia Porter thought that when the laughing and joking was going on, Geoff had seemed "a bit embarrassed, but he was still happy". Later, he told her directly that he felt ashamed of and regretted what had happened with the woman, although she did not know the detail of what had occurred.

2.2 Pte Porter recalled that whilst waiting to go onto the 21.00 hours guard on the evening of 16 September, another private in the guardroom made a joking reference to Geoff having slept with a disabled woman. She felt that Geoff took this badly: he went really quiet, he didn't seem himself and didn't look happy. She then stayed with him until he felt better. Geoff seemed to her to return back to his normal, happy self, and was affectionate towards her. Later, at some point after 23.00 hours and while waiting for the guard stag that commenced at 01.00, Geoff said to Pte Porter that he wanted to speak to her when he came back from the stag: she was left with the impression he may have had some romantic intention.

2.3 According to Private Stuart Bown, Geoff was "quite buoyant, seemed normal, his fairly bouncy self" that evening. However that evidence is in contrast to that of Pte Vick who recalled that Geoff was annoyed and moaning about doing guard duty when they were pressing their kit together before the duty commenced. He said that when they paraded for guard, Geoff had "done a long run" of guard duty so "he was pretty peed off by that stage" and was "agitated".

2.4 Pte Vick said that Geoff's mood got worse when waiting for the stags: he recalled Geoff being frustrated, particularly because he was on guard with two people he was not expecting to be able to chat with, as the two hour shifts on guard passed more quickly if you had someone to chat to on the gates. Pte Vick told police Geoff seemed "depressed" and "down" and that he was surprised by this drop in morale. However Pte Vick only spoke to Geoff for two to three minutes at the guardroom as he was then allocated to work at the guardroom front desk where one could not easily chat.

2.5 Pte Naiova recalled Geoff also whingeing about being "pulled into" guard when he was supposed to be getting ready to go to Leconfield. Pte Mulraine however remembered that at the outset of their stag together, she was the one who was whingeing about being back on guard. Whilst Geoff didn't want to be there either, she said that he reassured her: she said that his attitude was just to get on with it.

3. Geoff's telephone call and teasing

3.1 One matter which could, potentially, have had some impact upon Geoff that evening was a telephone call with Ms Webb. Geoff had known her since they were 10 years old. They had been boyfriend and girlfriend "on and off" as teenagers. They had not seen each other at all since Geoff had joined the army although they had kept in regular contact by phone and by text.

3.2 On the evening of 16 September, Geoff rang Ms Webb's mobile. Phone records show that this call was made at 19.10 and was the last number Geoff dialled before he died. Ms Webb was working that night until 20.00 and could not answer the phone. She recalled that Geoff then sent a text along the lines of "If you don't want to talk to me, just tell me to fuck off'. She replied explaining she was working and telling him not to be silly. Ms Webb thought this was unusual for Geoff, as he did not normally swear or send belligerent texts after a missed call. She thought, looking back, that he had been feeling "a bit crabby" because of having to do guard duty.

3.3 Geoff was not crabby when they then spoke on the phone. Ms Webb called him back only 5-10 minutes later while she was still working. He was in a good mood: telling her proudly about passing his driving test, and that he was going to Hull to learn HGV driving. He was excited and pleased with himself. They chatted about him coming to see her where she lived.

3.4 Their conversation took place in the presence of Ms Webb's then boyfriend, who had come to pick her up. At the end of the call, Geoff said "I love you", which they would normally say to each other at the end of their conversations. On this occasion, unusually, Ms Webb did not say "I love you" back because her boyfriend was in earshot.

3.5 It appears this phone call led to some further teasing of Geoff by the other trainees. Private Brendan Comiskey, who didn't know Geoff at all, overheard the call – which Pte Comiskey thought sounded like a happy phone call – and on hearing Geoff say "I love you", he and others assumed he was on the phone to his mother. They teased him, calling him a 'Mammy's boy' and a 'suck'. Pte Vick did think that Geoff seeming to him "down" and "depressed" was to do with potentially having an argument with a girlfriend, although Geoff denied this was the case. Pte Vick commented how Geoff was normally quite private about his romantic and home life.

3.6 It would be speculation to draw any conclusion about the impact of this phone call upon Geoff's overall mood during his final guard duty. The text Geoff sent when his call was not initially answered indicates a degree of irritability and volatility of mood, but hardly out of the range of an ordinary 17 year old's behaviour. It is clear that Geoff had strong affection for Ms Webb: he had kept a number of mementoes from their relationship and he had retained a text on his phone that she sent him in June about a personal problem. That personal issue was a matter he had told some of his female friends about over that summer. I cannot however draw the conclusions that his mood was materially unsettled

by Ms Webb not answering his call immediately and/or not saying 'I love you' back to him, or by the teasing that followed. The teasing seemed rather low-level and, as Private Carl Worgan explained, nothing that stood out from normal army banter and mickey-taking. Furthermore Geoff's response to it was not extraordinary.

3.7 There were no other phone calls made by Geoff that evening. The phone record confirms that at 21.23, Geoff's roommate Pte Hine rang his mobile because he had lost his keys. Pte Vick answered the phone, as Geoff had left the mobile phone behind when he went out on guard duty. Pte Bown told Surrey Police that Geoff had given his mobile to another soldier in the guardroom, asking them to look after it.

4. Comments allegedly made by Geoff

4.1 Private Paul Craig was part of the guard force on 16 September. He was on the same stag sequence as Geoff but not allocated to the same post.

4.2 During a break between stags Pte Craig was lying on one of the top bunks in the rear of the guardroom, with his beret over his face trying to get some sleep, when he overheard a group of privates having a bit of banter. He overheard a voice say "I wonder what it would be like to have a bullet in the head." The group were laughing and sniggering. It was said twice. In his statement made on 24 July 2002, Pte Craig stated that this was Geoff's voice, and that he spoke "just out of the blue".[5]

4.3 I have taken note that this was not the only evidence regarding statements purportedly made by Geoff that evening about shooting oneself: I shall set out the evidence and my findings regarding a second incident later on. However similar these comments might superficially appear, they arose in sufficiently different circumstances that I consider that I should appraise each purported incident separately. It would not be appropriate to rely upon the evidence regarding either comment as potentially probative or dis-probative of the other comment having been made.

4.4 Pte Craig recalled that on the comment being made a male had replied "It would probably hurt" and another said "you wouldn't feel a thing". When giving evidence Pte Craig recalled that Geoff was the last one to speak before they all started laughing, then afterwards when outside having a cigarette just before going out on stag Craig heard a couple of the young ones saying words to the effect "did you hear Geoff say that?" and "I cannot believe that Geoff has come out with that." He could not now say who had said this.

4.5 Pte Craig also recalled in 2002 that when Geoff was dropped off from the bus for his final stag he "did not look happy…he had no smile on his face".

[5] When giving his statement in 2002 he thought the comment was said between 19.00 and 21.00. In his evidence, until reminded of his statement, he thought it was said between 23.00 and 01.00.

4.6 In oral evidence Pte Craig stated that after making his July 2002 witness statement and saying that the comment about shooting oneself was made by Geoff, the matter of the comment had played upon his mind: he was sure he had heard the reported conversation, but he could not be 100% sure that the relevant comment had been said by Geoff and felt maybe he had made an assumption that it was Geoff.

4.7 Pte Craig agreed that it was likely that Geoff was playing video games including Grand Theft Auto ('GTA') on the PlayStation when in the guardroom. GTA involves instances of people being shot in the head and he postulated that whoever spoke about being shot in the head could have been referring to the computer game.

4.8 In the circumstances, I find that the statement may have been a reference to GTA and, in the light of Pte Craig's own doubt about who spoke, I cannot be satisfied that it was probably Geoff who made the statement. No other witness speaks of such a conversation. None of those who Pte Craig recalled in July 2002 as responding to the 'shooting in the head' comment have been identified or come forward. Indeed, Private Jeremy Searle, who Pte Craig remembers was on the bottom bunk at the time, below Pte Craig, did not have any recollection of anything Geoff said that evening. All that Pte Searle recalled (in a witness statement given in January 2003) was that Geoff was "quieter than normal" and "not his usual self" that evening between stags, although not cross or upset in anyway.

5. The first stag: 21:00-23:00

5.1 Mr Billy Murphy was a fire officer training soldiers and officers at Deepcut. In September 2001, he was living in a room on the ground floor of the Officers' Mess. This meant that he had to pass through the Officers' Mess guard post when returning to his quarters.

5.2 During the afternoon of Sunday 16 September, Mr Murphy had spent several hours in a local public house watching football. At about 21.45 he returned to the Officers' Mess in a severely inebriated state. Geoff was by now doing his first stag of the evening there along with Ptes Mulraine and Naiova.

5.3 Mr Murphy presented his civilian military ID card to Pte Mulraine. Pte Mulraine was unfamiliar with such a civilian pass and was unaware that anyone other than military personnel lived at the Officers' Mess. As was her duty, she queried the validity of the pass.

5.4 When Mr Murphy was refused entry he became extremely verbally abusive. The three privates on guard remained calm and professional in the face of a torrent of drunken abuse. Some of the abuse was of a racist character. Mr Murphy shouted and swore so much that the commotion was heard by Major Daniel Park and his wife, who lived in the residential accommodation close by the Officers' Mess, a short way outside the perimeter fence. The Major came from his home to the gate. Of the three privates, Geoff took the lead and tried to calm down Mr Murphy. Pte Naiova stated that he was glad that Geoff had engaged with Mr Murphy.

5.5 The Privates contacted the guardroom and L/Cpl Filmer drove to the Officers' Mess to deal with the situation. Together with Geoff he escorted Mr Murphy into the Mess building where he was identified by the night porter, Mr Greenaway.

5.6 Mr Murphy was also accompanied into the Officers' Mess by an acquaintance, Mr Thomas McSeveney. Mr McSeveney has died so his statement dated 23 February 2003 was read under Rule 23. Mr McSeveney was part of the RLC training development team and was also living in the Officers' Mess. He had just returned after a weekend's break. When in his room, he was informed that Mr Murphy was causing a disturbance in the reception area. Upon finding Mr Murphy there being abusive to L/Cpl Filmer, he indicated that he would take Mr Murphy away and to bed. He had had to remonstrate with Mr Murphy on a couple of occasions on the way when he had attempted to return to the reception.

5.7 Major Park also went with them to the Officers' Mess. He recalled that by the time they reached the building, Mr Murphy was apologising for his behaviour, although, according to Mr Greenaway, he was still being argumentative and raising his voice with L/Cpl Filmer at the reception. L/Cpl Filmer stated that Mr Murphy had just wanted to "go to bed and sleep it off." He did not think Mr Murphy had physically meant him any harm.

5.8 Mr Murphy went to his bedroom where, according to Mr McSeveney, he managed to get himself undressed and dropped into bed where he slept off the alcohol. Mr McSeveney checked on Mr Murphy 15 to 20 minutes later and found him on his bed.

5.9 In the early hours of the next morning, after shots had been heard but before Geoff's body had been discovered, Mr Murphy was again checked on in his room, this time by Major Paul Duncan.

5.10 Major Duncan already knew Mr Murphy by sight. He knocked on the door. Mr Murphy took a while to answer it. After some 25-30 seconds of knocking Mr Murphy answered the door in his dressing gown. He was "confused" and "groggy" and clearly appeared to Major Duncan to have been drinking. Mr Murphy's conduct was entirely consistent with being roused from sleep.

5.11 Although Mr Murphy himself had no recollection of being woken and checked upon during the night, there can be no question that this did happen, and that Mr Murphy was present in his room having been woken from a drunken sleep. I am quite satisfied that Mr Murphy had remained in his room after his return.

5.12 Mr Murphy has had the good sense to apologise at this inquest for what he described as the "unforgivable" "litany of abuse" he directed at the trainees. He acknowledged that his behaviour was lamentable. The truly disgraceful nature of his behaviour at the gate that night is aggravated by Mr Murphy's knowledge that since 9/11 just a few days earlier there was now a very high state of alert and the three young guards on the gate were likely to be feeling the pressures of the situation. Such self-important and insensitive conduct would be likely to intensify those pressures. However, Major Park records that none of the soldiers on guard had appeared particularly frightened of Mr Murphy.

5.13 After this episode, Major Park complimented L/Cpl Filmer indicating that the Privates had done the right thing stopping Mr Murphy coming through the gate. L/Cpl Filmer passed on the praise to the Privates commending them for the professional way they had handled the matter. In respect of Geoff, all the evidence confirms that he dealt with the situation very well.

5.14 On their return to the guard room at around 23.00 other privates learned of the incident and many commented that Geoff was in good spirits. Far from being de-stabilised, he gave every appearance of enjoying the praise he received. Both Ptes Mulraine and Naiova were clear that they did not feel the incident with Mr Murphy had upset Geoff.[6]

5.15 The episode with Mr Murphy does not appear to me to shed any light on the events that led to Geoff being shot shortly after 01.10 hours the following morning, although it may have made Pte Mulraine more ready to accept Geoff's later refusal of the offer to be accompanied by her on a prowler patrol.

6. Comment to Private Blackburn

6.1 Private Jack Blackburn had been at Pirbright on the same 12-week training programme as Geoff, passing out together in April 2001. Pte Blackburn had then gone to Aldershot arriving at Deepcut shortly after 9/11.

6.2 Pte Blackburn and Geoff saw each other briefly for the first time for several months between guard duties on 13 September 2001 but did not have time to talk.

6.3 They were then rostered on the same sequence of guard stags on 16 September 2001 although they were not on the same post. This did mean, however, that they had breaks at the same time, and at one stage around 20.15 took an opportunity to catch up whilst smoking a cigarette at the back of the guard house.

6.4 Geoff told Pte Blackburn that he had not been allowed to go home that weekend because of security needs. He described how he had been out drinking in town with Pte Vick. Geoff also mentioned how much he disliked guard duty. According to Pte Blackburn's statement of 17 September 2001, Geoff then said "I've done two twenty four hour shifts in the weekend. I feel like shooting myself." Pte Blackburn said that when he just laughed at this Geoff went on to say "If I shoot myself first, will you shoot yourself second?" Pte Blackburn had not taken this remark seriously and simply replied "Yeah, sure, whatever."

6.5 Pte Blackburn recalled no further conversations with Geoff that evening but said he sat next to Geoff on the bus taking them to their respective stags at 01.00. He described Geoff as quiet, although he thought this not unusual. He said when Geoff got off the bus he saw him staring straight ahead and "looking quite down" and "upset looking", but he

[6] Although later that evening, after shots had been heard, Major Duncan's impression was that Ptes Mulraine and Naiova had both been unsettled by the Murphy incident which they recounted to him, any disquiet they were then showing was equally attributable to the subsequent events and Geoff being missing at that time. Pte Mulraine recalled that after the incident she and Geoff had been chatting about going to Leconfield. He seemed happy and relaxed.

said he did not think much of it and put it down to doing guard duty a few days after 9/11.

6.6 Pte Blackburn took up his guard position at A3 (Dettingen House) at 01.00. He heard the burst of gunfire shortly after. Later he saw Regimental Sergeant Major Derek Hendry from whom he learnt that Geoff had died. According to Pte Blackburn he then told RSM Hendry what Geoff had said. He was instructed to go to the guard room and report it.

6.7 Pte Blackburn stated that he would have reported Geoff's comment at the time it was made if he had thought that there was any chance that Geoff might do what he said he was going to do. He was shocked by the realisation that if he had said something about Geoff's comment sooner the death might have been prevented.

6.8 I have had to consider whether Geoff did make this remark, and, if so, what weight to attach to it.

6.9 In my view there is nothing to suggest that Pte Blackburn has fabricated or exaggerated this evidence. His evidence does not have any of the hallmarks of those who invent so as to make themselves the centre of the attention. It cannot be said to be a late invention. Pte Blackburn had certainly given the account to someone by 04.25 hours on 17 September when the guard commander S/Sgt Crimin recorded it in the guardroom log.

6.10 RSM Hendry recalled that having been to the Officers' Mess after Geoff was found he had visited other guard posts early that morning to inform the privates on stags there of events and provide reassurance. When asked about Pte Blackburn's account in 2019 he could not recall being told of Geoff's comment.[7]

6.11 Pte Comiskey, who was on guard duty at Dettingen House with Pte Blackburn, also has no recollection of such a conversation with RSM Hendry although he did recall in his statement made in July 2002 that shortly after the RSM told them of Geoff's death, Pte Blackburn was "white and shaking". However, according to Pte Comiskey, Pte Blackburn did give him a similar account not long afterwards when they returned to the guard room. Pte Comiskey was now wholly reliant on his statement of July 2002 which "would have been gospel." He stated that back at the guard room, in the smoking area, Pte Blackburn told him that Geoff had said to him and Private Garry Urie words that he had taken to be a joke, "I will kill myself tonight, guard is rough."

6.12 According to the statement made in July 2002 by Private Michael Duffy, it was about 04.00 hours when he spoke with his friend Pte Blackburn who told him that Geoff had said "if I shoot myself, will you?" Pte Blackburn had taken it as larking about and he had

[7] In 2019 he could not recollect whether he went to the Dettingen House guard post, but when giving his witness statement to Surrey Police in November 2002 he had recalled that he had done so. RSM Hendry did not say anything about this comment in his 2002 statement. He was not asked about this before the Board of Inquiry in 2007. RSM Hendry says that he was not involved in the investigation but that in respect of something of that vital importance, had it been reported to him he would have been on the radio and made the guard room aware of it.

said that he would have done the same. Pte Duffy was on stag duty that night but not on the same sequence as Geoff.[8]

6.13 On any view, Pte Blackburn's account of the words Geoff had spoken during a break between stags had reached the guard commander that morning by 04.25. It was recorded by S/Sgt Crimin at serial 16 in the guard log. S/Sgt Crimin believes he asked Pte Blackburn to speak with the police.[9]

6.14 Pte Blackburn then gave his account that morning in a statement to Detective Sergeant Partridge of Surrey Police, only hours after the events in question.[10] His accounts have been broadly similar at every stage. There was absolutely no motive for Pte Blackburn to make up the account. He was exposing himself to criticism that he should have reported it earlier. Whilst any criticism would have been unfounded given the way Geoff spoke those words, it is wholly understandable that Pte Blackburn was shocked when he first appreciated the possible significance of those words. He has stated that he would have reported it straight away at the time it was said if he thought there was any chance Geoff had meant what he said.

6.15 Pte Comiskey's evidence confirms how profoundly Pte Blackburn was affected by the news of Geoff's death.

6.16 It is also notable that Pte Blackburn has not sought to "talk up" a hypothesis of suicide. Rather he has retained the view that he does not think Geoff had a proper reason to kill himself.

6.17 During his evidence, Pte Blackburn described himself in 2001 as immature, and not ready for the army. I do not consider that reflects upon his conduct that night or his reliability as a witness.

6.18 I have also considered whether Pte Blackburn's admitted involvement in two street robberies and an assault with intent to rob at the age of 16, before joining the army, and for which he was cautioned in January 2000 is relevant to his credibility.[11] Having

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[8] Giving live evidence, he now had no recollection of this conversation with Pte Blackburn.

[9] The log at serial 17 records at 04.29 Pte Blackburn being passed on to Corporal Thompson of the SIB. There is a contemporaneous entry in Cpl Thomson's notebook confirming this. Sergeant Dunford of the SIB also became aware of this account at an early stage through Cpl Thompson.

[10] In that signed statement he stated that he had told RSM Hendry about what Geoff had said to him. Had this discussion with RSM Hendry not occurred it would have been a foolish embellishment: Pte Blackburn could not have known that DS Partridge would not then question RSM Hendry about the matter. It follows that I do not consider RSM Hendry's failure to recollect such a conversation in any way undermines Pte Blackburn's account.

[11] In evidence, he described them as occasions between leaving school and joining the army when in association with others property, maybe a mobile phone, was taken from people in the street. He stated no weapons were used. Further information discovered some days after the witness had completed his evidence revealed that the police record of caution noted that the perpetrators had claimed they had a knife during the execution of one of the robberies. I considered whether to recall Pte Blackburn to deal with this collateral issue would assist me in determining whether his account of events in September 2001 was truthful. I am firmly of the view that it would not. I make allowance for the fact that Pte Blackburn may have sought to minimise his role and his awareness of the threat of use of a weapon in respect of the caution offences.

considered all the evidence on this issue, this does not affect my view as to the reliability of Pte Blackburn's account, given in September 2001, within two hours of the finding of Geoff's body.

6.19 It follows that I find that Geoff did utter the words to the effect that he might shoot himself later to Pte Blackburn during a break between stags that night. The words were spoken in a manner that it was entirely reasonable for Pte Blackburn (or, for that matter, anyone else who might have heard them) not to have taken them seriously. The weight to be attached to those words must now be considered together with my findings in respect of the rest of the evidence.

7. The second stag: 01:00-03:00

7.1 The second stag began at 01.00. Shortly before duty commenced Geoff was transported back to the Officers' Mess with several other trainees. Pte Searle thought Geoff was very quiet on the minibus, which was out of character for him. Pte Blackburn was also struck by Geoff seeming to give a blank stare into the distance when the minibus dropped him off, telling Surrey Police he was "staring…as if into an abyss…he looked quite down but I didn't think much of it." He said when giving live evidence that his meaning was that Geoff appeared withdrawn and disengaged with what was going on around him.

7.2 In contrast, Pte Mulraine had told Surrey Police in Geoff seemed to be in "high spirits". He was looking forward to going to Leconfield, teasing her for the fact he was getting to go, and was speaking about plans for the next week. She could not remember this when giving evidence to this inquest, but she did confirm she did not consider Geoff's mood at all unusual.

7.3 Pte Mulraine was again the unarmed trainee. When asked why at the second stag it was Geoff and Pte Naiova who had the rifles again – when normally it would be her turn – she told Surrey Police in 2002 that Geoff had "insisted" on carrying the weapon. She suggested in a later police interview in 2005 that this may have been because she was whingeing about the rifle's weight.

7.4 About 10 – 15 minutes after the beginning of the 01.00 hours stag, Geoff set off on a prowler patrol, leaving behind Ptes Mulraine and Naiova at the gate.

7.5 In Pte Mulraine's statement given a few days after Geoff's death, she had said that they had been talking, there were a few minutes of silence, and then Geoff said he was now going to do a foot patrol. Her later recollection when giving evidence at court was that one of them had said they needed to do a patrol, and Geoff had volunteered.[12]

[12] Another trainee, Private Lucene Black, gave hearsay evidence that nearer the time Pte Mulraine had said to her that Geoff had heard a sound and gone off to do a patrol as a result. Pte Mulraine unequivocally denied she said this and it has never featured in either her or Pte Naiova's accounts.

7.6 She offered to go with him, but Geoff said "No" – he said that because of what had happened earlier, meaning the incident with Mr Murphy, she should stay on the gate. She had thought Pte Naiova also asked Geoff if he wanted him to go on patrol. Geoff said he was just going to do a quick patrol, meaning he would not do the whole perimeter. She did not think much of Geoff doing the patrol by himself, as she had done solo patrols herself in the past,[13] and with three people on the gate, one would always be left alone, so it didn't seem to be a big deal even though she knew it was strictly contrary to the current orders.

7.7 Pte Naiova's recollection of how Geoff came to go on patrol alone is similar to Pte Mulraine's evidence from 2001. All of a sudden, Geoff said he was going to do a quick perimeter patrol. This surprised Pte Naiova. He recalled he told Geoff he needed to patrol with Pte Mulraine, as per their orders, and Geoff declined this, saying he would be quick.

7.8 Although there are some respects in which the details of their accounts have understandably changed through the many different occasions on which Ptes Naiova and Mulraine have been asked to give evidence, they have both consistently given evidence that Geoff chose to be the person to undertake a patrol and was offered the opportunity to be accompanied on that patrol, but declined this offer.

[13] Before the guards standing orders had changed post 9/11 only two guards would have been at the gate hence only one person would have conducted any prowler patrol.

SECTION 4: SHOTS HEARD

1. Shots heard

1.1 Several witnesses heard shots in the early morning of 17 September 2001 shortly after the 01.00 guard had been mounted.

1.2 At the guardroom S/Sgt Crimin had been outside when he heard what he described as a burst of automatic fire. As a small arms instructor, he had reason to recognise the sound of automatic shots. Private Stuart Wade, who was on the rest period of his guard duty, was making a call from the telephone box just outside the guardroom and he too heard "at least two rounds" that he thought were "definitely automatic" fire.

1.3 Three trainees (Privates Blackburn, Comiskey and Lyndan Mort) on guard duty at Dettingen House, the closest stag to the Officers' Mess, recalled hearing automatic fire, as did three others on duty at the Sergeant's Mess (Privates Craig, Searle and Urie). Privates Porter, Worgan and Hannah Markaski who were doing the prowler patrol, also gave statements to police in 2002 saying that they too had heard automatic fire.

1.4 Not everyone thought the same: Privates Duffy, Bown, John Liggins and Anthony Griffiths had been out the back of the guardroom, when they heard what they thought were three rapid-succession single shots. Both Ptes Naiova and Mulraine at the Officers' Mess thought what they had heard was a single shot followed by automatic fire, with a total of four or five rounds.

1.5 Major Paul Duncan lived in the residential accommodation across the road from the Officers' Mess, a maximum of 300 yards away. He was still awake having been watching television when he heard what he described as four or five shots of automatic gunfire. Having started his career as a soldier in the King's Own Scottish Borderers, a military regiment, Major Duncan was very familiar with the sound of gunfire. He had no doubt that this was automatic fire. Recognising that the noise did not come from the ranges, but sounded very close he "knew something was wrong" and so immediately phoned the guardroom to report what he had heard.

1.6 L/Cpl Filmer recalled receiving this call around ten minutes after he returned from dropping off the guards for their 01.00-03:00 hours stags.

1.7 For any witness to make any sort of judgment about an unexpected sound that lasted for no more than a 'split second' and was heard at a time when one was not already in anticipation of hearing something unusual is an extremely difficult task. Adding to this the passage of time before many of the witnesses were asked to retrieve their aural memory, it is unsurprising that there is not uniformity of recollection as to the sound of the shots heard that night.

1.8 Whilst I have taken into account that some[1] gave early accounts in which they said they heard something more like a single shot followed by automatic fire, I note that the majority of reports were of automatic gunfire. Those few who thought they had heard separate shots were all privates in Phase 2 training with little experience of the firing of live rounds. Those who could be expected to have more familiarity with the sound of live gunfire, particularly S/Sgt Crimin as a small arms instructor and Major Duncan, one of the nearest to the shots, were clear it was automatic. Weighing up all of the accounts, I am persuaded that the sound was of automatic fire.

1.9 Furthermore, it is no surprise that many could not discern or gave varying accounts of how many shots they heard, although I note that no one has suggested more than five rounds were fired. The expert evidence is that an SA80 rifle set on automatic will deliver up to 11 rounds within a second. Discriminating the number of rounds delivered in an unanticipated half-a-second burst would be extremely difficult. Some could only describe hearing a 'burst' of fire.

2. At the Guardroom

2.1 Major Duncan felt initially that his call to the guardroom was not being taken seriously. This chimes with L/Cpl Filmer's account that, having heard nothing himself, he was not overly sure how credible the first report of shots from Major Duncan actually was until the guardroom radio "crackled into life" and members of the guard began reporting what they had heard.

2.2 The guardroom log records the reports of shots from "all call signs" being received at 01.15 hours and that by 01.30, call sign A4 – the Officers' Mess - had reported Geoff had "gone missing from prowler guard". By then L/Cpl Filmer had already been dispatched from the guardroom to investigate the sound of shots. Ptes Liggins and Griffiths, who had recently come back from their own stag, volunteered to accompany him; both privates were armed.

3. At the Officers' Mess

3.1 Having made his call to the guardroom, Major Duncan put his jacket on and went straight to the Officers' Mess. As he approached across the open space from his house he could see two privates at the gate. He arrived two to three minutes after hearing the shots and was in the process of showing them his ID card when a Land Rover arrived from the guardroom with L/Cpl Filmer and two more privates. It seems likely that they arrived not long after 01.20 hours.

3.2 Major Duncan watched as L/Cpl Filmer took charge of the guards and made Pte Naiova's rifle safe – he said he was impressed with how L/Cpl Filmer took command of the situation.

[1] Including Ptes Naiova and Mulraine, closest to the events.

3.3 Pte Naiova and Pte Mulraine have both given consistent evidence ever since Geoff's death that neither of them left the security hut or went out of each other's sight in the time between Geoff's departure on patrol and hearing gunfire a few minutes later. I entirely accept their evidence on that point. There is no evidence suggesting they did leave, and moreover Major Duncan could see them at the gate together very shortly after he heard the shots himself.

4. Pte Naiova's rifle

4.1 L/Cpl Filmer spoke with Ptes Mulraine and Naiova. In his first written statement, given to police on 9 October 2001, L/Cpl Filmer described both privates as being "nervous and jumpy" and Pte Naiova as acting in a "very nervous way" when he arrived. This accords with Major Duncan's description of Ptes Mulraine and Naiova as "clearly upset", "shocked" and shaken" when he had arrived. Given the proximity to 9/11 it was inevitable that the possibility of a terrorist attack would have been at the back of the privates' minds which might explain why there was an element of nervousness in their behaviour.

4.2 On realising that Pte Naiova had already readied his SA80 to fire, L/Cpl Filmer ordered Pte Naiova to make his weapon safe at the loading bay. In his October 2001 statement, he described how, as Pte Naiova cocked the weapon's working parts to the rear, a round fell to the floor. One would expect this action to eject a round if the weapon had been readied, but L/Cpl Filmer then looked into the breech and saw a second round in the chamber of the weapon. L/Cpl Filmer ordered Pte Naiova to remove this round and put both rounds back in the magazine. He then ordered Pte Naiova to place the magazine back onto the weapon. L/Cpl Filmer said nothing about the state in which he had found Pte Naiova's rifle to Major Duncan on their return from the loading bay.

4.3 By some nine months later, when giving a further account to Surrey Police in a June 2002 interview, L/Cpl Filmer's account had developed. He now stated that his immediate perception on arriving at the Officers' Mess was that Pte Naiova was acting "shifty" and that "it appeared to me as if he had done something wrong". L/Cpl Filmer explained that "when I grabbed his weapon off him, it was warm. It felt warm. Which meant to me, means that it's been fired. Either that or he's had it down his jacket."

4.4 This was a very significant allegation if true, given the proximity of Pte Naiova to the scene of Geoff's death, and that he was the only person other than Geoff known to have a weapon and live ammunition at the Officers' Mess when shots were fired that morning. This suggestion that the weapon was warm and had been fired was not something L/Cpl Filmer had said at the time to anyone at the scene, nor did he mention this to the RMP when they took his lengthy statement in October 2001, less than a month after events. It cannot but have been apparent to L/Cpl Filmer that these would have been extremely important matters to mention if accurate.

4.5 When interviewed by Surrey Police in July 2002, a month after first making the assertion about Pte Naiova's rifle being fired, L/Cpl Filmer's description of Pte Naiova had developed even further. He now described Pte Naiova being "very unsettled" and "very shifty", "menacing" and acting "like a complete babbling psychopath". The possibility of two rounds in the rifle happening from double-cocking was mentioned in that interview by L/Cpl Filmer, however he obfuscated the point by telling police that the magazine had been off the weapon when Pte Naiova cocked it, a matter he has now retracted.

4.6 In August 2002, L/Cpl Filmer gave a second statement addressing rounds he found in Pte Naiova's rifle. At that point he said that he could not account for why there were two rounds, one chambered and one in the breech. In August 2004, in a further statement, L/Cpl Filmer again stated to police that "in my opinion [Pte Naiova's rifle] had been fired." Shortly before he gave evidence to this inquest, L/Cpl Filmer provided the court with another statement in which he sought to clarify aspects of his earlier statements and police interviews regarding other matters. However it was not until his oral evidence was examined that L/Cpl Filmer clarified his allegations regarding Pte Naiova.

4.7 L/Cpl Filmer now explained to this court that it was only "some months later" that he had recalled finding Pte Naiova's weapon to be warm. He said he had not thought at the time on 17 September 2001 that it had been fired, nor had he written anything about it being warm in his notebook at the time. He now said that he "would not like to speculate whether the weapon had been fired or not", although it was clear that he had had no such reservation when engaging in such speculation to Surrey Police in 2002. When his previous accounts were explored further in oral evidence, L/Cpl Filmer for the first time stated that when he said he had found Pte Naiova's weapon had been warm he had been referring to the pistol grip of the weapon as being warm. He now postulated that this could just have been because Pte Naiova had been gripping his weapon.

4.8 L/Cpl Filmer also withdrew the assertions he had made in his police interview about Pte Naiova's demeanour. When asked what led him to describe Pte Naiova as appearing "menacing" or like a "psychopath", L/Cpl Filmer stated "I can't imagine what I was thinking or why I would have said that." He now accepted that this was not how Pte Naiova had appeared to him that evening and it was an inappropriate description.

4.9 As for the explanation for two rounds being chambered, L/Cpl Filmer now expanded upon the evidence he had previously given to police. What he now described was that when Pte Naiova had gone through the clearing drill he had been nervous and so he had not done the safety drill correctly. L/Cpl Filmer said, for the first time in his oral evidence, that he had seen that Pte Naiova had forgotten to take the loaded magazine off the rifle before he cocked the weapon whilst clearing it. As the expert ballistics evidence described, leaving the magazine on at this stage of the process could lead to a second round entering the chamber from the magazine after a first round had been cleared. L/Cpl Filmer agreed that he had known at the time that there could be a perfectly innocent explanation for finding two rounds in the chamber of Pte Naiova's SA80 when clearing the weapon. He was unable to offer any explanation as to why he had never mentioned this innocent

explanation in any of his several police interviews or in any statement that he had made before giving oral evidence at this inquest.

4.10 Now that these fuller accounts have been given by L/Cpl Filmer, it is abundantly clear that there is no cogent evidence to support a suggestion that Pte Naiova had fired his weapon whilst at the Officers' Mess that evening.

4.11 For years, Pte Naiova has lived under the shadow of L/Cpl Filmer's suggestion that he may have fired his weapon that night. This was one of the grounds relied upon by Mr and Mrs Gray when seeking a fresh inquest. The only account that supported that suggestion was that of L/Cpl Filmer, who it now appears had given only a partial account of the events, bolstered by an inaccurate account of Pte Naiova's demeanour. L/Cpl Filmer had omitted to provide the innocent explanation, of which he now acknowledges he was always aware, for two rounds being in the rifle's breech.

4.12 L/Cpl Filmer stated to me that he had "meant no malice" when, as he now characterised it, his accounts in evidence had "creeped a little bit". He offered me the explanation that at the time he gave his earlier evidence he had been younger, naive and had not thought before he had spoken.

4.13 Be that as it may, it is extremely surprising that L/Cpl Filmer did not seek to clarify the serious questions he had raised over the actions of Pte Naiova at any time in the seventeen years before he came to give oral evidence to this inquest, particularly in the light of him providing the court with a clarification statement regarding other matters as recently as 27 March 2019. L/Cpl Filmer's lack of candour not only threw unjustified suspicions on a fellow soldier, but also risked misleading a bereaved family as to the potential involvement of Pte Naiova in Geoff's death.

5. The Searches

5.1 Having ascertained that Geoff was still missing, L/Cpl Filmer, Pte Liggins and Pte Griffiths set off in the direction that they understood Geoff had gone on prowler patrol, walking towards the cricket pitch in a clockwise direction along the perimeter fence.[2]

5.2 Because of how the land lies and the vegetation, they were soon out of sight of Major Duncan and the guards at the gate. Major Duncan, left behind with Ptes Mulraine and Naiova, recalled them then telling him of the incident with Mr Murphy.

5.3 Major Duncan recalled that the search party took some time. On their return they had found nothing and he recalled L/Cpl Filmer saying they had been around the whole perimeter and that he appeared "frustrated" and "a little shaken". Major Duncan

[2] Pte Naiova recalled also having been involved in the early search for Geoff, but given the clear evidence from L/Cpl Filmer and Ptes Liggins and Griffiths that he was not, coupled with Major Duncan's account that he remained at the gate with Ptes Mulraine and Naiova, my view is he is mistaken about this.

described L/Cpl Filmer as now "really flapping" and "clearly rattled". He was saying words to the effect of "I don't know what to do, this was going to be easy…something is up". At this stage Major Duncan felt all were becoming more worried about the incident which he had initially thought might be simply a negligent discharge with a private hiding from the consequences.

5.4 It seems likely that the party, carrying out what was from Major Duncan's perspective the first search, returned shortly before 01.40 hours. The incident log now being kept by S/Sgt Crimin at the guardroom recorded at 01.40 that L/Cpl Filmer "requested extra men to look for Pte Gray".

5.5 Major Duncan recalled trying to narrow down where the shots had come from in discussion with those at the gate. He suggested the area on a direct line with the cricket pitch behind the kitchen part of the Officers' Mess. More privates arrived and he suggested to L/Cpl Filmer that he should have a good search in that area. If this is indeed where that next search was focussed it would not have required going back to the area where Geoff's body was eventually found.

5.6 Major Duncan then recalled L/Cpl Filmer going off "generally towards the tunnel under the Officers Mess". However Major Duncan remained at the gate, so his line of sight was limited. As the search party was soon out of view he was unable to assist with which area this search actually covered.

5.7 Major Duncan's conversations with Ptes Mulraine and Naiova had led him to feel that they were still extremely upset by the incident with Mr Murphy. He said it was because of this he now decided to check that Geoff had not either gone to see Mr Murphy or vice versa.[3] After L/Cpl Filmer had set off on the second search, Major Duncan took some soldiers with him into the Mess and was directed to Mr Murphy's room. He had to rouse him from his sleep as I have already described.

5.8 At 02.00 hours the guardroom log records that L/Cpl Filmer reported back that there was "no sign of Pte Gray" and that the civil police and the Barrack Orderly Officer, Warrant Officer 2 Ballentine, were informed of events. At 02.13 hours the Royal Military Police ('RMP') at Aldershot were also called out by the guardroom.

5.9 When WO2 Ballentine arrived at the Officers' Mess, Major Duncan stepped back to let the Orderly Officer deal with the unfolding events.

[3] Although Pte Mulraine recalled this check having been at her suggestion.

SECTION 5: THE SEARCH FOR GEOFF GRAY

1. Finding the body

1.1 Geoff's body was eventually found at the foot of a tree close to the perimeter fence which separates the Officers' Mess from the cricket pitch. I shall append to these findings of fact a diagram which shows the place where the body was found.

1.2 The body was first discovered by Pte Liggins. He was in that area as he had accompanied L/Cpl Filmer over to the unused ceremonial gates. Private Ben Morgan, who was one of the trainees sent to aid the search, had been posted at those gates when he had heard a fence rattle and had whistled for assistance.

1.3 From the Ceremonial Gates, Ptes Liggins and Griffiths had commenced another perimeter search, followed some distance behind by L/Cpl Filmer, this time walking counter-clockwise towards the cricket pitch, near to the fence. As he was approaching a large tree, over halfway along the cricket pitch fence, Pte Liggins thought he saw something shining on the ground. This was Geoff's cap badge. This made him examine the ground more closely, and it was then that he saw Geoff lying on his back about five metres away[1] with a weapon to his left, close to but not touching his torso. He crouched down and called out for L/Cpl Filmer.

1.4 L/Cpl Filmer soon arrived. At first it was not clear to L/Cpl Filmer what he was looking at in the darkness. He issued a 'challenge' and then approached the body.

1.5 Although, understandably there were discrepancies in recollection between some witnesses as to the precise position Geoff was lying in when his body was found, photographs taken at the scene clearly show him lying with his head towards the fence approximately nine inches from the fence wire[2] and his feet nearer the tree. The cricket screen is visible just beyond the fence in some photographs. No one suggests the body was moved after discovery save to check for signs of life.

1.6 It was 02.20 hours when, back at the guardroom, S/Sgt Crimin logged a report that Geoff had been found. This was approximately an hour after the shots had been first been heard.

[1] According to his November 2001 statement. In a later interview with Surrey Police in December 2002, Pte Liggins thought he was even closer, only seeing Geoff's body when two to three metres away.

[2] As was later measured by Scenes of Crime Officer ('SOCO') Mullins.

2. The Searches

2.1 There is a substantial conflict of evidence between those who undertook the searches as to (i) the route taken on the first perimeter search and (ii) whether there was a second search of the perimeter.

2.2 It is readily apparent from the witness evidence, and having had the benefit of a site visit, that it would not have been possible to have walked a route that kept within arm's length of the perimeter fence without stepping on or over Geoff. Had anyone actually walked the fence line in the immediate area where Geoff was found during an earlier search or searches, their failure to find him would suggest the body had not been present at the site of its ultimate discovery for some time after the apparently fatal shots had been heard. In such circumstances, the only possible inference would be that Geoff had been moved to his final resting place by a third party.

2.3 It has therefore been necessary to consider the extent to which the area where Geoff was found was covered in earlier searches.

2.4 All witnesses agree that having arrived sometime after 01:20 hours and dealt with issues regarding Pte Naiova's rifle, L/Cpl Filmer and Ptes Liggins and Griffiths set off from the guard post, walking in a clockwise direction. They were in single file: Pte Liggins was at the front of the line, with Pte Griffiths at the rear and, at least initially, they followed the perimeter fence.

2.5 There were trees and vegetation along the initial route and within a few tens of metres, they were out of sight. Therefore those who watched them leave from the guard post could not assist with the route taken thereafter.

2.6 According to L/Cpl Filmer, the trio conducted two clockwise perimeter searches staying close to the fence, both of which would have covered the ground where Geoff's body was later found. Stephen Franklin, the Padre, who saw the three of them shortly after the discovery of the body, recalled that they were at a loss as to how they had missed the body during their earlier searches.

2.7 In his statement dated 9 October 2001, L/Cpl Filmer stated:

> "We patrolled all the way around the perimeter at a slow walk with no white light. Pte Liggins was at the point and I was in the middle leaving Pte Griffiths bringing up the rear. At no time during this patrol did we move more than arm's length away from the fence. The patrol found nothing.
>
> On our return to the rear gate I asked them if Pte Gray had come back yet, they said he hadn't so we commenced a 2nd search of the area, this time in extended line,

approximately 5m apart. On this occasion we used our torches and swept through the bushes and trees still finding nothing.

I then made a radio message back to the guardroom and informed them that Private Gray was gone and requested more manpower to be brought up and assist with the search. I also requested that the civil police be called.

We then completed a third circuit of the perimeter of the Officers' Mess compound, again in a clockwise direction, which again found nothing. On completion of this patrol five more members of the guard arrived and I detailed them off to make a thorough search of the area within the compound fence."

2.8 In contrast, both Pte Liggins and Pte Griffiths were clear that they had not searched the area where Geoff's body was found. In his statement dated 6 November 2001, Pte Liggins stated:

> "…Pte Griffiths, L/Cpl Filmer and I conducted a search of the area. L/Cpl Filmer had instructed us to conduct a search of the perimeter fence area. I recall we had not been issued with any torches and subsequently had to use the natural light of the moon and any street lighting available to see.
>
> All the while I was concerned about becoming a possible target and tried not to 'show out' where possible.
>
> I recall that whilst conducting this patrol, we came across a small hill/mound (located 25 metres from where I later found Pte Gray's body). Because of its location, L/Cpl Filmer went to the top of the hill before returning to us.
>
> It is fair to say that we did not stay within an arms distance of the perimeter fence, near the hill. I can also state we did not conduct a search of the area where I later found Pte Gray's body."

2.9 In his statement dated 8 November 2001, Pte Griffiths stated:

> "I did not really know what we were searching for, in that I was not sure if the Officers' Mess annex was under attack, so I concentrated my visual search to looking outside the perimeter fence into the treeline and bushes. I paid little attention to the ground inside the fence area. Whilst we walked in single file, with Private Liggins in front, L/Cpl Filmer in the middle and myself at the rear, we approached a hill area. L/Cpl Filmer advanced and conducted a check of the hill, whilst Private Liggins and I took up defensive positions. When L/Cpl Filmer dressed back down the hill we continued our search and cut the corner of the perimeter fence. I believe because we cut the corner to avoid the hill, we did not check the area where Private Gray's body was later discovered.

> We conducted a full check of the area inside the Officers' Mess annex and after 20 to 25 minutes still had found no sign of Private Gray. About 30 minutes after I first arrived at the annex, a handover with about five other guard members arrived and I was instructed to continue searching with Private Morgan of my unit, who had a torch. We did not have a radio and so L/Cpl Filmer told me to whistle three times if I saw anything."

2.10 These clear conflicts of evidence appeared to have emerged within two months of Geoff's death, although there is some evidence that L/Cpl Filmer's account given on the night was closer in line to those of Ptes Griffiths and Liggins.

2.11 Corporal Stephen Simpson of the RMP recalled speaking to L/Cpl Filmer within hours of Geoff's death who had told him that they had done "a sweep" and not found Geoff, but they had then found him on the second search. His recollection was that L/Cpl Filmer had said to him that the first sweep had been between the tree and the Officers' Mess but they had not searched between the tree and the fence line. Cpl Simpson recalled L/Cpl Filmer saying that it had only been on the second search that someone had walked between the tree and the fence and had found the body.

2.12 The implications of any suggestion that Geoff's body was not found on two earlier perimeter searches required close scrutiny by the investigators of all the search evidence. The failure to do so at an early stage was a casualty of the early assumptions that Geoff's death was suicide. Timely investigative opportunities were lost.

2.13 L/Cpl Filmer did not attend the first inquest in March 2002, as he was serving overseas. Although his November 2001 statement was read out at that inquest, little appears to have been done to test the different accounts until after the investigation by Surrey Police. This led to further interviews with all three of the searchers, as well as statements and videoed accounts from each man, separately recorded in early July 2002, as they walked through the scene and explained the route they took that night. Each then gave evidence to the Board of Inquiry in 2007. It is regrettable that the three witnesses were not asked to walk through the route as early as November 2001 when it was clear that there were significant conflicts between their accounts. I will have to consider the extent to which the lapse of time before the 'walk throughs' has deprived me of the ability to reach a conclusion now as to which route was taken.

2.14 L/Cpl Filmer and Pte Liggins have both given evidence at this inquest. Pte Griffiths did not give live evidence for reasons related to his vulnerability. He did however provide written answers to questions put to him in writing by Interested Persons at this inquest, including questions posed on behalf of Mr and Mrs Gray.[3] I have made allowance for this in my evaluation of his evidence.

[3] His statements, and relevant parts of his interviews include the video of his "walk through" and his evidence to the first inquest and the Board of Inquiry have all been read into the evidence under Rule 23.

2.15 After walking the route with the Surrey Police in July 2002, L/Cpl Filmer modified his position. In his initial accounts (his witness statement of October 2001 and interview in June 2002) he had maintained that they had patrolled at all stages close to the perimeter fence and that they were never more than two metres from it. After the "walk through", however, he remembered that he had made a tactical decision to move away from the fence and box around a hill as otherwise he would have cast a long shadow across open ground.

2.16 It follows that he accepts that they did cut a corner, but not to the extent stated by Ptes Liggins and Griffiths. L/Cpl Filmer maintains that in the first perimeter search, they did walk the track by the fence line before the tree where Geoff was found. He also contends that there was a second perimeter search which would have included the tree area.

2.17 In contrast, Pte Liggins and Pte Griffiths both give an account of avoiding silhouetting themselves on the mound and cutting the corner of the perimeter fence, in a way that they would have missed the tree, and so would explain why the body was not found earlier. Pte Griffiths stated to Surrey Police on 3 July 2002 that he did not think any of them went on the side of the rhododendron bushes in front of the tree where Geoff's body was found. He thought they had cut the corner mainly because, even taking that route, they could still see the fence.

2.18 Whilst L/Cpl Filmer states that there was a second perimeter search which included the wooded area behind the Officers' Mess, both Privates accept there was a search of the wooded area, but do not accept that there was a second perimeter search.

2.19 There is also a serious conflict as to the nature of the lighting. L/Cpl Filmer, in contrast to all other witnesses, contends that the cricket pitch was floodlit. Other witnesses state that there was street lighting along the road which lit up the corner, but that the area near the tree was very dark.

2.20 It is important to remember that this incident occurred just a few days after 9/11. After the shots had been heard, there was a possibility in the minds of the soldiers that the Officers' Mess was or had been under attack. The search party had to proceed slowly so as not to expose themselves to any would-be attacker. L/Cpl Filmer described in his interview how it was intended to be a "covert" check "with no white light or anything" hence, although L/Cpl Filmer had a torch with him, he did not use it on the first search.

2.21 Given they were operating in a difficult situation, it would not be surprising to find some inconsistencies between different accounts. I have made an allowance for this.

2.22 The overwhelming evidence from other witnesses was that light was poor, apart from the streetlighting which shed light on the eastern perimeter fence and the cricket pitch corner. L/Cpl Filmer's evidence that the cricket pitch was floodlit is at odds with all other evidence heard at the inquest.

2.23 L/Cpl Filmer now accepts that, contrary to his earlier accounts, there was some deviation from the fence line because of the hill. The vital question is where the search party re-joined the fence line and whether this was before or after the location at which Geoff was eventually found.

2.24 Whilst timings are necessarily approximate, L/Cpl Filmer's account of conducting two perimeter searches before he called the guardroom to request the assistance of further soldiers (timed at 01.40 hours in the occurrence book) sits uneasily with the nature of the searches he claims took place, during a period which could not have been any more than 20 minutes.

2.25 L/Cpl Filmer's evidence over the years contains many substantial inconsistencies which cannot readily be explained by lapse of memory. At times he has given accounts in confident terms diametrically opposed to earlier versions. Significantly, his accounts of the discovery of Geoff's body vary as to the position of the rifle, Geoff's beret, and the position of the change lever on the SA80 rifle. I find myself unable to place any weight on his evidence unless there is independent corroboration.

3. Lance Corporal Filmer's notes

3.1 A significant example of how L/Cpl Filmer's evidence has developed is shown when considering his account of his allegedly missing notebook.

3.2 In his first statement, given on 9 October 2001, L/Cpl Filmer said that his conduct of the incident with Mr Murphy had been praised by a Major, who had said the guards at the gate had done nothing wrong. He said he recorded these comments in his notebook, and on his return to the guardroom, tore out a page and handed it to S/Sgt Crimin who added them to the entry in the guardroom occurrence book. In this, his statement given closest to events, he made no other mention of having made any other notes on the day. This was a detailed statement, taken by the RMP, which ran to 14 handwritten pages.

3.3 L/Cpl Filmer did not know Geoff before 16 September 2001. In his police interview in July 2002, L/Cpl Filmer now mentioned that he had taken down Geoff's name and service number during the earlier guard shift in a small notebook which he habitually carried. He said this was because Geoff had expressed an interest in joining L/Cpl Filmer's unit. He said this notebook had been taken off him on 17 September by a member of the RMP and not returned. He said no more about the notebook's contents in July 2002.

3.4 In August 2002, when giving his second witness statement, L/Cpl Filmer mentioned the notebook again. He now said that he had also included in his notebook "details of the persons who had reported hearing the shots" that evening and "a basic account of what happened whilst at the Officers' Mess". He said that at the Officers' Mess he had handed this notebook to a male RMP officer, whose name he did not know.

3.5 In a further police interview, in October 2002, L/Cpl Filmer then said that, after handing his notebook to the RMP, he had re-written his notes on an A4 pad shortly after being released from the scene. However he could not, by October 2002, provide these notes to Surrey Police, as he said he had not retained them.[4]

3.6 At this inquest, L/Cpl Filmer said for the first time that his notebook had contained specific notes of the areas he had searched on 17 September 2001. He said he would have written down notes such as "full perimeter, internal, detailed around building". He now said that after each time he completed a search circuit, he had returned to the main car park and jotted down notes to say what he had done as each part of the search had been completed. He also mentioned for the first time that the notebook he had handed over in full to the RMP – on the same evening he apparently tore out a page specifically about the incident with Mr Murphy – contained notes from a course he was undertaking at the time. He said he was asked for the whole book, and so he handed it over. He said he had asked for a record of this, as it was his property, and was told in reply to "watch (his) mouth" as he was "just a lance corporal".

3.7 I cannot accept that L/Cpl Filmer made these near contemporaneous notes recording each aspect of the search as he now claims. No other witness reported seeing him do so. He was unable to identify the RMP officer who he said had taken the notebook from him, nor has any officer from the RMP or Surrey Police any recollection or record of taking it. He made no complaint to anyone about giving up and losing the course notes he said the notebook contained. He did not mention the existence of these notes before July 2002 despite giving a statement to the RMP. At no point before 2019 did he assert that it contained details of the searches he had undertaken. When he first mentioned the book in July 2002,[5] he did not say anything about recording shots or times or details of his searches. Given that this interview followed immediately after the videoed walk-through of the search route, it may seem unusual to have forgotten or failed to mention something of relevance to the search routes that day. His account has developed significantly over time. His late assertions that he had made, but could no longer produce, two near contemporaneous records of his searches has the hallmarks of someone seeking to bolster their evidence.

3.8 In my view L/Cpl Filmer has consciously or sub-consciously given accounts to demonstrate that he carried out his duties at all stages in a highly professional manner, even if that risked veering from the truth. That has led to his insistence that, notwithstanding his now admitted deviation from the perimeter during the first search, the area around the tree was not missed. He has also at stages embellished his evidence in line with his mindset that Geoff's death could not have been suicide. I shall discuss this further when I consider the change of tenor of his evidence regarding the position in which the rifle change lever was found.

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[4] He also said that he had asked the RMP for his first notebook back, and they had told him it had been given to the civilian police.

[5] When he only reported taking Geoff's name to assist him in joining his unit.

4. Lance Corporal Filmer's allegations about Surrey Police

4.1 L/Cpl Filmer's evidence and accounts contain many criticisms of the conduct of others. Whilst he has withdrawn many of them such as those against Pte Naiova and Pte Mulraine, he made serious allegations against Surrey Police. He claimed that in 2002 they had threatened him, and put pressure upon him to change his account, particularly in respect of the extent to which the search party had cut the corner in the first search. He was adamant that he had withstood this pressure and had not changed his account in any way. His allegation struck at the integrity of Surrey Police's investigation. L/Cpl Filmer suggested that pressure of this kind may have been responsible for Ptes Liggins and Griffiths giving an account that they had never searched the area where Geoff's body had been found. I totally reject this. Ptes Liggins and Griffiths have both stated that they have not changed their accounts, and it is clear they have not done so. They have been consistent on this point since they gave their first statements in November 2001.

4.2 I have taken into account that, in his answers to written questions, Pte Griffiths does go so far as to say he found the interviewing police officers intimidating. However, he makes no suggestion that they tried to make him change his account or that he did so. I have heard from the interviewing officer DC Archibald, and I accept that he did not put undue pressure upon L/Cpl Filmer. He may well have been told that it was important to tell the truth and that would not involve repercussions for him if he did so. That approach may have suggested the police did not accept his account, although they did not tell him of their view.

4.3 L/Cpl Filmer also suggested in oral evidence that a Surrey police officer who was part of the investigation team, DC Jamie Keech, had approached him in a public house, acted in an unprofessional manner by asking him off-the-record questions about what had happened that night, and there had been a limited degree of intimacy between them. The strong implication of his evidence was that this apparently random encounter was some sort of 'honeypot' conspiracy.[6] After seeing a written statement from DC Keech, L/Cpl Filmer was then keen to row back from the implications of his oral evidence: in a fresh statement he wrote that "I entirely accept that there is no evidence to show the meeting in the pub was a planned encounter in an attempt to interfere with my evidence".[7]

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[6] This matter was alleged for the first time during his oral evidence. It was not an issue he had chosen to raise in his statement of 27 March 2019 which he had prepared in anticipation of giving oral evidence and which outlined a number of other matters he wished to draw to the court's attention. This was despite L/Cpl Filmer having been assisted by his own lawyers when drafting that statement.

[7] Against her own interests DC Keech revealed that their relationship lasted longer and went deeper than L/Cpl Filmer had maintained. It is apparent to me that whilst L/Cpl Filmer raised the fact of his supposedly unexpected meeting with DC Keech to criticise Surrey Police, he was less than frank about the details of that relationship and their subsequent intimacy. I heard from DC Keech to investigate whether her alleged meeting with L/Cpl Filmer had been a misguided, targeted approach designed in some way to put pressure upon L/Cpl Filmer to change his evidence. I am satisfied that whilst she did have a liaison with him, which

5. Conclusions on the searches

5.1 In my view, there is compelling evidence that the search party did not cover the immediate area where Geoff was found in any of the earlier searches.

5.2 I am driven to the conclusion that Pte Liggins and Pte Griffiths are correct that the fence was not re-joined after the deviation for the mound until a point after the tree where Geoff's body was later to be found. In order to see Geoff's body, it was necessary to be within five metres of where it was lying as it was particularly dark in that area. It is wholly understandable that the search party would have felt it was not necessary to expose themselves any more than was necessary when they could clearly see the perimeter fence at that corner of the grounds, which was lit by the street lighting, particularly when, although they were looking out for Geoff on that first search, they were not at that time expecting to find a dead body lying on the ground. Unfortunately, in making that understandable detour, they failed to cover the area close to the tree where Geoff lay.

5.3 I also conclude that Ptes Liggins and Griffiths are correct that the second search was not a perimeter search, but more a search of the woods and the area around the accommodation block. This is supported by the evidence of Major Duncan as to the direction from which they returned.

6. Was Geoff's body moved?

6.1 L/Cpl Filmer's assertion about the search route has been the only basis for suggesting that Geoff's body was moved after he was shot. Not only do I now reject his evidence, but I note that other witness evidence also points to Geoff being shot where he was found.

6.2 In particular, there is persuasive evidence of body tissue being seen by witnesses in a number of different places close to where the body was found (the base of the tree; five to six feet up the tree; on the fence; and on the cricket screen through the fence) which supports the view that the body was not moved after Geoff was shot. A similar point can be made in respect of the blood. WO2 Ballentine, who was with L/Cpl Filmer and Pte Liggins when they found the body, took the view that there were no signs that the body had been moved. Geoff's head appeared intact, there was a lot of blood at the back of his head, and there were no trails of blood.

6.3 Nor has any body matter or debris ever been found elsewhere to suggest a shooting at another location. Whilst I accept the logging at the scene was perfunctory, it is inconceivable that the entirety of Geoff's body tissue, and the spent cartridges, could have been moved from one location to be distributed somewhere else, including even placing

appears unprofessional in the circumstances of an ongoing investigation, it did not in any way reflect upon the investigation by Surrey Police.

a piece of Geoff's skull outside the nearby fence. Given the inevitability that some tissue, signs of firearm discharge, or signs of disturbance would have been present at another location if Geoff was killed there, it is surprising indeed that no hint of such a location was discovered by the searchers on the night, or by the attendees on 17 September, or by Surrey Police during their investigations in 2002 – 3.

6.4 Furthermore, whilst not impossible to achieve, anyone seeking to move the body after a shooting would have been taking a major risk at a time when armed guards were searching the area. Moving the body would not have been an easy task and would have increased the risk of the assailant's discovery and of forensic evidence being deposited on the assailant. There is no logical reason why such a risk would be taken to move the body into an open area. There is no obvious advantage to be gained by such a risky and difficult course of action.

6.5 I shall discuss later in more detail how experts have been able to tell me from a pathological perspective that there was no evidence to support the view that the body had been moved any significant distance from where it was found.

6.6 Taking all these strands of evidence together, I conclude that Geoff was shot where his body was found.

7. Was an intruder present?

7.1 An issue nevertheless recurring is whether there was an intruder at the Officers' Mess that night. Pte Griffiths has consistently told investigators that he believed he saw the silhouette or shadow of a person moving outside the fence. This was before Geoff's body was found. In his statement of November 2001, he said he and Pte Morgan were standing at the rear ornamental gate. Pte Griffiths heard what sounded like chains rattling, and then saw a silhouette – he understood this was a person, sprinting across the cricket pitch about 50m away. The image appeared to run through the fence.

7.2 Pte Griffiths has given an account of this incident on several occasions, including to the original inquest, to Surrey Police, and to the Board of Inquiry. He made clear to Surrey Police in July 2002 that he did not see anyone climbing the fence: the person seemed to run through it. In November 2002, he believed the silhouette was 200-250m away, and he saw it for about three seconds, like the top half of a body shooting across the field. To the Board of Inquiry, he said he saw "(what) looked like a shadow, but it was too far away and too dark to make out if it was actually a person….it was a dark shape darted across the field *[sic]*…it was too big to be an animal." It is obvious that Pte Griffiths was extremely nervous at the time this happened.

7.3 Pte Morgan did not see anything. He did tell this inquest that he heard the fence rattling violently, "like somebody was messing with the fence or trying to climb the fence or

something like that". He thought that although it was a windy night,[8] the sound was too strong to be caused by the wind. It was very shortly after this that Pte Griffiths told him he had just seen the running figure. They then whistled for assistance, which led to the final search during which Geoff's body was found.

7.4 WO Ballentine told Surrey Police that the cricket pitch is by the side of Deepcut Bridge Road, and as cars came up the road they cast shadows on the cricket pitch, with the light hitting the trees. This provides a plausible explanation for what Pte Griffiths thought he saw.

7.5 Both Pte Morgan and Pte Griffiths were evidently and understandably extremely nervous and on edge that night: Pte Morgan told Surrey Police in 2002 that he felt "very nervous, and every time a bush moved I jumped and looked over my shoulder". Although precise timings are uncertain, it appears the fence rattling was heard by Ptes Morgan and Griffiths and the running silhouette seen by one of them at least 45 minutes to an hour after the shots were heard.

7.6 Just as I consider there was no logical reason for an assailant to have moved Geoff's body, nor can there have been any plausible reason why an assailant, having gained entry to the camp and shot a guard, would then wait for 45 minutes before making their escape, thereby giving time for extra soldiers to arrive. By this time it would have been obvious that there was activity inside the Officers' Mess compound, with a number of soldiers present, some of whom were likely to be armed. The suggestion that a person involved in something untoward at the Officers' Mess would then choose to run across the open ground of the cricket pitch is implausible.

7.7 None of the very many guards that night claimed to have seen an intruder or to have seen anyone climb over a fence. Pte Griffiths has always been completely candid that he thought he saw the shadow of a person going through the fence. His evidence cannot support a finding that there was an intruder fleeing the scene. Nor can I infer the presence of an intruder from reports of loud fence rattling, given these reports come from extremely frightened and anxious trainees on a windy night.

[8] The weather at this time was also referred to as windy by WO2 Ballentine. Ms Masters gave evidence that it was still, a "crisp September morning", but she did not arrive on the scene until two hours later. Inspector Smart heard the fence rattling in the breeze at some point after that and concluded for himself this was the same sound that had been reported as being heard.

SECTION 6: AFTER DISCOVERY

1. Immediate actions

1.1 Geoff's body was first approached by L/Cpl Filmer. He was using his torch for light and from the outset he could see injuries to Geoff's forehead and blood and body tissue on the ground. He shouted out - 'man down' – and WO2 Ballentine came running to the scene.

1.2 According to L/Cpl Filmer, the only part of Geoff's body that was moved was his head, very slightly, to try and check for vital signs. Geoff's arms or legs were not moved at all. Hence the position of the body in photographs later taken at the scene would be how he first found Geoff.

1.3 As WO2 Ballentine checked for a pulse, L/Cpl Filmer picked up the SA80 rifle lying beside Geoff to make it safe, and in doing so "moved it out of the way". A round was ejected from the weapon which he left on the ground. He replaced the rifle on the ground with the magazine beside it. There was blood and body tissue on the weapon.

1.4 I was assisted by evidence from Warrant Officer 2 Steve Muir of the army's small arms school corps. He showed me normal safety procedures ('NSPs') for making a weapon safe, which he told me did not include checking whether the change lever was set on repetition (i.e. delivering single shots). He explained that the change lever would be checked on making the weapon ready but not as part of NSPs. This contrasted with L/Cpl Filmer's evidence that it was standard procedure when doing any drill with a weapon to check the change lever to make sure it is on repetition.

1.5 In his first statement, of 9 October 2001, L/Cpl Filmer stated that he did not remember what position the change lever on the rifle was set at when he unloaded the weapon to make it safe. When asked about this in interview, eight months later in June 2002, he stated "At the time I could have sworn blind it was on repetition…I said at the time I believed it to be on repetition. However on going back a couple of hours later, and they asked me to check the weapon again and I had to pick up all the rounds and things...it was on automatic. I could have sworn it was on repetition but that might have been an error on my part".

1.6 L/Cpl Filmer's recollection of the position of the change lever has changed over time and has never been clear. He now accepts he may have been in error in coming to think (as he had done by Summer 2002) that it had been set on repetition. Given that he could not recollect the position of the change lever when he was first asked about this, less than a month after Geoff's death, I cannot rely on his subsequent suggestions, many more months after the events, that he had thought at the time that it was on repetition.

1.7 Furthermore, the lever appears to have been set to automatic when the weapon was examined later when still at the scene. It is highly improbable that L/Cpl Filmer would

wrongly have moved the lever to automatic as part of a safety drill. The most likely explanation is that when making the rifle safe, he neither checked nor moved the change lever, but had left it as it was found.

2. Early Assumptions

2.1 The log made contemporaneously by S/Sgt Crimin back at the guardroom recorded that on Geoff's body being found at 02.20 hours, an ambulance was called.

2.2 Cpl Simpson of the RMP arrived on the scene with his colleague at around 02.25 hours.[1] WO2 Ballentine led them to where Geoff lay. Cpl Simpson recalled that it was so dark that he could only see the body when a couple of metres from it. One had to get extremely close to see the body, as Geoff was wearing disruptive pattern material ('DPM'). He recalled that if one approached from the direction of the Officers' Mess building towards the tree, the body could not be seen unless one walked round to the far side of the tree.

2.3 Cpl Simpson noticed Geoff's injuries and scorch marks on Geoff's face. He also recalled seeing body tissue five or six feet up the tree and at its base.

2.4 Shortly after arriving at the scene, Cpl Simpson learned that L/Cpl Filmer thought he had heard someone climbing over the cricket pitch fence in the distance, although neither L/Cpl Filmer nor Cpl Simpson could see anyone. Nevertheless, acting on L/Cpl Filmer's report, all personnel withdrew from the scene. The RMP officers returned to their car and tried to illuminate the area using their car headlights shining from the car park, although they could not achieve direct illumination of the scene. Cpl Simpson then commenced a scene log.

2.5 Cpl Simpson was frank that he had quickly come to the view that Geoff's death was suicide due to the presence of 'scorch' marks on Geoff's face and the nature of his injuries. He nevertheless understood his role was to preserve the scene as if a 'crime scene' at the outset. He was anticipating that would be taken forward by the SIB of the RMP, who would then hand jurisdiction to the local civil police for any more serious matters.

3. Officers at the scene

3.1 As a matter of policy, as this was a sudden death on MOD property, primary responsibility for investigating Geoff's death ought to have rested with the civilian police. Surrey Police officers in September 2001 were under the misapprehension that, if a death was non-suspicious, responsibility for investigations could be relinquished to the RMP. Surrey Police thought they had done so, but as there was no formal agreement in respect of Geoff's death, Sergeant Linda Dunford of the SIB did not understand that the main investigation function to have been passed to them by Surrey Police. Nevertheless Sgt

[1] The RMP had already been contacted while Geoff was still missing and before his body had been discovered. They had been called to the incident from Aldershot.

Dunford remained active and undertook the lion's share of evidence collecting in 2001 The SIB thought they were still merely assisting Surrey Police, who retained the lead role. As a result, neither civilian nor military police took a proactive role in rigorously investigating the circumstances of Geoff's death and early assumptions about the cause of death were not properly tested against the available evidence. The Coroner's Officer also appears to have assumed there was no issue for her to investigate on the basis the death had been determined already to be non-suspicious.

3.2 Given Surrey Police had also failed to retain primacy for the investigation into Sean Benton's death at Deepcut in 1995, this a matter for extreme disappointment. There was no controlling mind of the subsequent investigation and hence opportunities to collect evidential material were lost. As well as missed forensic opportunities, which I will consider in detail in due course, relevant documents were not seized or collated, and no one seems to have recognised this had not been done until part of the way through the first inquest hearing in March 2002. That hearing had to be adjourned for an hour whilst documents were sought from the barracks to clarify confusion over the timing of the guard stags Geoff had undertaken that night. The guard declaration orders, which would have made it clear which weapon had been allocated to Geoff had not been retained.

3.3 Surrey Police had been notified of an incident at Deepcut at around 02.00 hours and armed response officers from the tactical firearms unit had been deployed as the report included shots being fired. Four officers in two armed response vehicles (ARVs) arrived at the scene at around 02.34 hours. The military personnel had by then withdrawn from the immediate vicinity of Geoff's body. The armed police approached the area in formation. As one of the armed police officers, PC Jason Sumpter, recalled, it was difficult to see much beyond a few feet without their night vision equipment.

3.4 PC Sumpter approached Geoff's body. Notes made by him at the time recorded the head injuries he saw and the presence of black residue on Geoff's face, eyes and forehead. He noted the presence of flesh and apparent brain matter at the base of the nearby tree and on the other side of the perimeter fence on the cricket pitch. He also noted the magazine that was, by now, off the rifle was also nearby and covered in blood.

3.5 The armed civilian police officers stayed at the scene for some time to ensure it was untouched by others until such time as someone with an investigating function arrived and the scene was handed over.

3.6 The RMP officers had white mine tape with them and placed an inner cordon round the scene at approximately a 20-25 metre range. Cpl Simpson considered that RMP now had control of the scene, they recorded witnesses' names and started a log of those who entered and left the area. SIB officers were also sent to Deepcut.

3.7 The MOD police had also been notified. A note made in the MOD police log at 02.45 recorded "we have had a report that a soldier has committed suicide at Deepcut". SIB

officers arrived at around 03.30. By 03.23 the Surrey Police 'ICAD' log, being kept at police control, recorded that "the ARV assessment would be that this is a suicide".

3.8 Dr Jakubowski, a local GP who was acting as a 'police surgeon'[2] that night had been called to the scene. He was not involved in advising the police in their investigations: his only role was to confirm death and record any observations of the scene. He arrived at 03.48 hours and formally pronounced Geoff's death, trying to disturb the scene as little as possible while doing so.[3] He observed blood tissue and fragments of bone on the ground around Geoff and some blood spatter on the fence.

3.9 Meanwhile DC Knight of Surrey Police was on the scene by around 04.10. Cpl Simpson's log recorded that control of the scene was handed over to civilian police at 04.25. DC Knight later recorded in his notebook entry for the incident: "Information Pte Gray had argument with Chef earlier today, was depressed, had told Pte Blackburn that was going to kill himself tonight… All enquiries point to suicide. Grease marks on nose, shot close to forehead."

3.10 DC Knight's notebook also records "no breach in security, no damage to fence". He told the court that when it was daylight, he did a whole walk of the perimeter fence to check for any insecurities, such as unlocked gates. There were none.

3.11 The Coroner's Officer, Ms Masters, arrived at around 04.29 hours, having been notified by Surrey Police. On arrival, she was not involved in directing any investigation and did not consider it to be her investigation. She understood Surrey Police to be "predominantly" in control, in "close liaison with" the SIB. When asked at court when the investigation became a coronial one rather than a police or army investigation, she replied "I think they are both the same thing." It is evident that she did not consider herself to have an investigative role. In due course, the only witness statement she would take would be from Geoff's father. She remained until around 06.26 when she and the funeral directors left with Geoff's body.

3.12 A Scenes of Crime Officer, Hugh Mullings, arrived at the scene at about the same time as Ms Masters and was there for 25 minutes. A Surrey Police photographer arrived a few minutes later. He took some photographs of Geoff's body and the immediate area. Cpl Simpson of RMP assisted SOCO Mullings with the search for spent ammunition. They found five empty casings lying to Geoff's left.

3.13 The precise position where the empty cases were found was neither measured nor photographed. A sketch of the scene drawn by SOCO Mullings shows Geoff's head lying nine inches from the perimeter fence with his body at a right-angle to the fence and with

[2] Also known as a Forensic Medical Examiner.

[3] Dr Jakubowski saw inside Geoff's mouth what he took to be in an entry wound; having later been shown the post-mortem report by Surrey Police he accepted what he took to be an entry wound was not but was caused by disruption to the skull.

the empty cartridges all to his left side, each situated between the tree root and the fence. The cartridges and the rifle were seized by DC Knight of Surrey Police as evidence.

3.14 By 06.26 Geoff's body had been taken away and Ms Masters also left the camp. The cordon was removed. At 08.20 hours the inner cordon was withdrawn, the scene tape was taken down and the scene opened up.[4]

3.15 A check was subsequently made by WO2 Ballentine at the request of Sgt Dunford of the RMP that all weapons and ammunition, other than Geoff's, were accounted for: they were. L/Cpl Filmer, who as 2ic had loaded the magazines of each of the guard that evening, was also asked by the police to check the contents of Geoff's magazine and found it contained four rounds which, with the round ejected from the rifle, made five live rounds accounted for and five rounds missing. In short, there is no evidence that any rounds or weapons were unaccounted for at Deepcut on 17 September 2001. The missing rounds were replaced by the regimental quartermaster, WO2 Darren Cummins, who recorded in the occurrence book that he had restocked the barracks' ammunition supply with six rounds.

4. Forensic examination

4.1 As is clear from the account just given, forensic containment and examination of the scene was limited. There was no search conducted beyond recovery of the spent cartridges and their position was not accurately logged. The presence of blood and body tissue was neither recorded nor comprehensively photographed. There was no search of the cricket pitch or at the very least the part close to where Geoff was found. Indeed, the examination of the scene was so cursory that over a year later on November 2002 a re-examination by Surrey Police led to the discovery of a one-inch square piece of Geoff's skull lying about 6 inches from the perimeter fence on the cricket pitch side.

4.2 The assumption that Geoff had killed himself had already pervaded the lackadaisical approach to any investigation that morning. No statements were taken from those who had found the body. No attempt was made to confirm whether or not the weapon found beside Geoff was the one issued to him that night. No attempt was made to formally check the condition of or ammunition in the only other weapon known to be at the Officers' Mess. Pte Naiova's rifle had been handed to another of the guard force when he was instructed to return to the guardroom and stood down. Although no one explicitly recalls checking his magazine, there was no suggestion it was missing rounds when it was later returned to the guardroom by another private. Had basic checks been made on 17 September, it would have been shown that Pte Naiova's rifle had not been fired, and the implications raised by L/Cpl Filmer's account could have been immediately dismissed.

[4] It is apparent the scene was not cleaned as later trainees reported seeing body tissue on the fence while on prowler patrol.

SECTION 7: INCIDENTS AT PRINCESS ROYAL BARRACKS

1. Incidents at Princess Royal Barracks

1.1 It is clear from the evidence that there was nothing known of by his family, his friends or his colleagues to suggest that anyone ever held any ill will towards Geoff. He was well liked by all who knew him. Nothing has been revealed that might suggest he ever made an enemy of anyone, whether in the army, or in civilian life.

1.2 However, it has been within the scope of this inquest to consider whether Geoff may have been attacked and killed by another person. This inquest has therefore investigated what is known of incursions into Deepcut and assaults or alleged assaults upon other trainees when conducting guard duty, in order to explore the possibility of Geoff being the unfortunate and random victim of someone simply intent on assaulting a Deepcut guard.

1.3 I have considered an array of documentary evidence taken from sources including camp occurrence books regarding breaches of camp security, and incidents of violence and assault on trainees, in the years before and subsequent to Geoff's death.

1.4 In terms of incursions more generally, there is a wealth of evidence that it was well known to the chain of command that trainees living at Deepcut or at other barracks would jump or even cut the fence to avoid detection when coming in after hours or after drinking, particularly if underage. Although there was no formal curfew in place, returning to the barracks severely inebriated might incur disciplinary sanctions.

1.5 As for assaults and violence against trainees, there are a great many records of trainees fighting and of trainees reporting that they have been assaulted. There are however no available records of trainees being assaulted whilst on guard duty in the period around Geoff's death, other than a single incident involving Private Andrew Rorke in 2002.

2. Assault on Private Rorke

2.1 An incident involving an intruder at Deepcut occurred on 26 June 2002. Pte Rorke was on guard duty with Private Lee Jensen and Private Corinna Bannister at the Sergeants' Mess. In the early hours of the morning, Pte Rorke heard footsteps coming from a wooded, bushy area. He issued a warning to 'halt' and cocked his weapon. On searching the bushes, he saw a white male run away from him. Pte Rorke went in pursuit, and on discovering the unknown person again hiding in the bushes, tried to apprehend him. There was a struggle during which Pte Rorke was punched or elbowed in the face and sustained a minor injury to his face.

2.2 Pte Rorke thought this might have been an NCO somehow testing or playing a game with trainees: "mad things…happen in the army", he said. Lt Col Laden told me he was aware

of this incident and thought at the time it may have been a journalist, this being at the time of intense press interest in Deepcut following the deaths of Geoff and Pte James Collinson. There is no suggestion from anyone involved in the incident that the intruder was armed or that he made any attempt to obtain Pte Rorke's weapon.

2.3 I do not doubt that Pte Rorke's account of what happened to him is true. I cannot make any finding at this distance of the identity of the intruder or their motivation for being there or for seeking to evade detection. The incident is not, however, one of a proactive, deliberate assault upon a trainee guard: the intruder fled upon detection, and it was only upon being pursued and apprehended by Pte Rorke that the intruder used physical violence, punching at him in an attempt to get away from him.[1]

3. Alleged shot fired at Private Jordan

3.1 Whilst there can be no dispute regarding the veracity of the incident involving Pte Rorke, the same cannot be said of an account involving an alleged shooting given by Private Nicholas Jordan.

3.2 On 3 January 2001 some nine months before Geoff's death Private Steven Barnes and Pte Jordan were on guard at the gates to the Officers' Mess in the early hours of the morning. Pte Barnes gave his first statement about the matter in September 2002 in which he recalled that Pte Jordan had set off on a prowler patrol but after no more than five minutes ran back towards him "in a panic", saying he had seen someone trying to climb over the main gate. Pte Barnes radioed for assistance whilst Pte Jordan returned to where he had seen the intruder. Pte Barnes recalled that he then saw a figure run across the road

[1] A hearsay account of the same incident is contained in a statement from Roy Sellstrom, the Provost Sergeant, which was provided to the solicitors instructed by the family of Pte James Collinson during the 2006 inquest into his death. He told me that he had never come across an incident like this before. Sgt Sellstrom had said he believed that the incident was neither taken seriously by the chain of command nor recorded in the guardroom occurrence book. He appears to have been incorrect on both points. There is a documented reference to the incident in the occurrence book which indicates that the RMP were informed. Sgt Sellstrom's opinion that the incident was not taken seriously is irreconcilable with the contemporary records showing the involvement of MOD Police and that Surrey Police were also promptly informed. Sgt Sellstrom also gave hearsay evidence about an incident where junior NCOs, who were drunk, were said to have racially abused and attacked a Fijian soldier on guard, and taken his weapon from him. This incident was said to have occurred in daylight in front of other soldiers. His statement placed this incident in the Summer of 2002. In respect of both incidents, Sgt Sellstrom sought to give exceptionally detailed evidence about incidents he had not witnessed, which occurred many years ago, and about which he gave no contemporary account. Regardless of what weight I can put on Sgt Sellstrom's reliability, and aside from the lack of any first-hand evidence about this incident, I do not see that it can shed any light on the events of 17 September 2001. If accurate, it would appear to have been an incidence of deplorable racist bullying, taking place in front of other people in daylight. It does not assist me in determining the potential for there to have been a clandestine fatal assault on a lone guard.

from the area of the cricket pitch running towards the army houses. Five or six other guards arrived and the RMP also attended the scene.[2]

3.3 Pte Jordan's first written account was given to Surrey Police in October 2002, he said that the intruder was climbing over the wall by the Main Gate trying to enter the compound. He was dressed in black and wearing a black balaclava. When the intruder saw Pte Jordan he dropped down off the wall and ran away. Pte Jordan said that as he headed back for the guard hut he saw the intruder was crossing the cricket pitch. He said that he could see the eye and nose holes in the intruder's balaclava, from a distance of 150 yards away.[3] He said that the figure stopped, pointed out an arm towards him as if aiming a handgun and that he then heard a crack like a gunshot with a silencer, and saw a tuft of grass explode in front of him. He said he went back to the hut and told Pte Barnes he had been shot at.

3.4 Pte Barnes had no recollection at all of a shot being mentioned. Neither does this account of a shot being fired feature in the statements of the two RMP officers who were called out that night to investigate the incident or the Corporal who was 2ic of the guard, all of whom also made police witness statements in 2002.

3.5 It has not been possible to question Pte Jordan any further about his account. He lives abroad. Although he was traced and contacted, regrettably, he thereafter repeatedly refused requests to engage with the inquest such as by giving evidence by videolink and I had no power to summons him to assist from outside the jurisdiction.

3.6 I cannot accept Pte Jordan's account that he was shot at that night is reliable. I consider that if Pte Jordan had told Pte Barnes and the others who attended at the time that he thought he had been shot at, they would have remembered and recorded it and no doubt this apparent attempt on his life would have been taken extremely seriously. It is inherently unlikely that a trainee being shot at would have been overlooked in daily occurrence books and forgotten by everyone else involved that evening by the time they gave statements in 2002. It appears that Pte Jordan gave an account in September 2002 that he had never shared with anyone before. In the light of his unwillingness to assist this inquest by providing his account under oath I cannot accept that the incident occurred as he described.

3.7 The fact that on some occasions in 2001 – 2002 armed guards at Deepcut felt panicked or jumpy whilst carrying weapons, and were concerned that someone was approaching them - as Pte Porter reported she felt the evening after Geoff's death (and as Pte Naiova presumably did when he cocked his weapon on 17 September 2001) – cannot assist me with any part of answering the question of how Geoff died.

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[2] To that extent it does appear that there may have been a person in or near the grounds of the Officers' Mess, although it would make little sense for an intruder with nefarious intent to run from the main gates across the open ground of the cricket pitch when there seem to have been several other routes to leave the vicinity without breaking cover.

[3] Longer than a football pitch.

4. Threatening Messages

4.1 Two incidents involving threatening messages at Deepcut came to light as part of the Surrey Police investigation. The first involved Ptes Jennifer Ansell and Benjamin Atherton who were on guard duty one night near the Sergeants' Mess. Pte Ansell told Surrey Police that, at around 22.00 hours, she and two other privates were on guard duty huddling in the shed by the gate. It "was really windy and lots of things kept hitting the shed, like branches" she said. They heard a sudden solid thud. Pte Ansell ventured outside and her eye was caught by a piece of paper, which turned out to be attached to a stone with a plastic band. The message she recalled written on it was "Hello Mr Caterpillar, enjoy your past life, you are all going to die. RIP." They reported the incident to the 2ic, who told them the note had probably been there for ages and not to worry about it. She could not remember when this incident happened.

4.2 Pte Atherton now had no recollection of this incident when he gave evidence to this inquest. He had spoken to Surrey Police in July 2002 when he had recalled the event, albeit he had a different recollection of the content of the note. His recollection had been that it said "You are all going to die. Enjoy your Happy New Year. RIP." He believed the incident took place in August or September 2001. He thought the note looked old: the 'Happy New Year' message would be consistent with this. Evidently, this was not a matter taken seriously by the army chain of command at the time.

4.3 Pte Matthews also discovered an unpleasant note when on patrol at Deepcut nearly a year after Geoff died. In August 2002, he discovered two sheets of handwritten paper saying "die" and "your next" *(sic)*. He considered this a "sick joke" or a "silly prank" which could be attributed to "soldier banter". The notes were found at the Officers' Mess, near the loading bay in the car park, on the ground by the perimeter fence.

4.4 There is some evidence in the occurrence book to suggest that there were incidents involving local youths driving close to the gates shouting and making life difficult for those on guard. RSM Hendry thought there was an increase in such incidents in the wake of the media attention on Deepcut that followed Pte Collinson's death in March 2002.

4.5 I cannot accept that these few occurrences, all of them bar the finding of the note by Ptes Ansell and Atherton, remote in time from Geoff's death, are material that could support the proposition that Geoff's death was the result of an intruder gaining access to the barracks on the night of 16/17 September 2001 who chose to murder a random guard at close contact.

4.6 I therefore find that none of the above incidents can be relied upon as part of circumstantial evidence from which one could infer that Geoff's death was the result of a homicide.

SECTION 8: FORENSIC & EXPERT EVIDENCE

1. The Post-mortem examination

1.1 The post-mortem examination of Geoff was carried out by Dr Robert Chapman on the day that Geoff died. Dr Chapman was and is a very experienced Home Office forensic pathologist, having been a forensic pathologist since 1988. He carried out the post-mortem on the instructions of the Coroner. Ms Masters was present as were two military personnel from the SIB. No one from Surrey Police was in attendance. Sergeant Mark Holland, attending from the SIB, noted in his statement that the death had already been classed as a suicide.

1.2 Dr Chapman conducted a routine 'coroner's post-mortem' rather than a 'forensic' post-mortem. This meant that the autopsy took place in a single session during which Geoff's was one of a number of bodies which Dr Chapman was tasked with examining. The process was therefore much quicker and less detailed than a forensic post-mortem would have been. No photographs were taken. The body was neither x-rayed nor scanned. Dr Chapman explained that the decision that this should be a routine post-mortem had been arrived at by the Coroner. Dr Chapman explained that in 2001 it would not have been routine practice for a coroner to request a forensic post-mortem in a case of death from gunshot wounds.

1.3 Dr Chapman was provided with a synopsis of the circumstances of the death by the Coroner's Officer. No information was provided that suggested to him that Geoff's death was suspicious. He said that had any such information been given to him he would have declined to carry out only a routine examination. Further he said there was nothing that came to light during his examination that raised any concern on his own part that this was a suspicious death. There was no guidance at the time (nor is there any guidance today) mandating that a firearms death must always be the subject of a forensic post-mortem.

1.4 The principal findings of the post-mortem were two gunshot entry wounds to the forehead with two exit wounds to the back of the head. The first entry wound was 1.5cm above the inner end of the left eyebrow, 2cm lateral to the midline of the forehead, measuring 0.8 x 0.8cm. The second was 2.3cm above the inner end of the right eyebrow and 2cm lateral to the midline of the forehead, measuring 0.7 x 0.7cm. The two exit wounds were very large (10 x 8cm, and 6 x 4cm) with severe underlying damage to the skull.

1.5 Black soot and powder-marking was recorded as present on Geoff's face, visibly apparent on the midline upper lip and right cheek, the right side of the nose, the bridge of the nose and the midline forehead. This represented gunshot residue from a close discharge of a weapon. It is universally accepted in the fields of pathology and ballistics that the presence of such soot blackening from gunshot residue indicates a weapon discharged with the

muzzle very close to the skin, if not in contact with it. Such discharge will not be present when someone is shot from more than a short distance away.

1.6 On the basis of the formal record of this gunshot residue by Dr Chapman, the observations by witnesses at the scene, and the blackening plainly visible in the photographs of Geoff's body at the scene, there can be no doubt that the fatal shots were fired at close range.

1.7 Dr Chapman observed and recorded some fading yellowish bruises over the front of Geoff's right shoulder. These were old bruises. Dr Chapman found no defence wounds or any pathological evidence that would indicate Geoff had been assaulted or had sought to defend himself from an assailant.

1.8 Geoff's father recalls seeing his son's body in the mortuary with what he believed to be a black eye. Dr Chapman specifically confirmed at this inquest that he did not observe any bruising to the eye, and was sure he would not have missed it had there been any. I do not consider it possible that Dr Chapman could have carried out the examination he did while failing to notice or record obvious signs of injury and assault such as a black eye, if they were present.[1] In 2002, Dr Chapman suggested to Surrey Police that any 'blackening' of the area around Geoff's eye was most likely the powder or soot marking from the weapon's discharge. I accept that this is the probable explanation of the discolouration that Mr Gray recalls seeing.

1.9 Dr Chapman gave a cause of death as "Gunshot wounds to the head." Toxicology results had shown no drugs or alcohol in Geoff's system.

1.10 Dr Chapman confirmed that he considered the appearances of Geoff's wounds were consistent with both self-infliction and infliction by another. He did not believe that the pathological examination alone could say who pulled the trigger.

1.11 Professor Crane, who was instructed by me to assist the inquest, was critical of the fact that a forensic post-mortem was not conducted. In his view "there was nothing routine about a soldier being found dead with two bullet wounds to the head". He personally would not have conducted a routine post-mortem and said that even if it were a routine case he would have x-rayed the body to look for bullet fragments.[2] He thought that most forensic pathologists would do so, however he was clear there were no standard guidelines regarding this at the time or now.

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[1] It was identified during questioning of Dr Chapman that he had not recorded a tattoo on Geoff's leg (although he had seen and recorded a tattoo on Geoff's shoulder), however his examination of Geoff's face was evidently thorough, as precise measurements of the entry wounds were taken.

[2] The actual bullets fired have never been recovered and it is unclear whether any bullet fragments would anyway have been identified on x-ray to be recovered as there were large exit wounds and the rounds may have passed through Geoff. It is unsurprising that rounds passing through or missing Geoff have not been found, nor would a search for them have been practicable at the time, given the high likelihood that any projectiles from this high velocity rifle would have travelled a very considerable distance after exit.

1.12 In my view, however helpful it would be for the purposes of my investigation today, it cannot be said that it was mandatory for Dr Chapman to perform a forensic post-mortem in 2001. He was not instructed to do so by the Coroner, he was not provided with any information that might have suggested the involvement of a third party in the death and nothing was revealed during the examination which should have given rise to suspicions of third party involvement: his findings were consistent with the account of an apparent suicide with which he had been provided.

1.13 Nevertheless, I accept the force of Professor Crane's comment, that even where a death is non-suspicious on the face of the bare facts known at the time, any coroner or pathologist should always turn their mind to whether the wider circumstances surrounding the death are sufficiently unusual that to merely conduct a routine post-mortem may be insufficient. Here the authorities were dealing with the death of someone who was still a child, and who had died violently in the unusual environment of an army barracks. The post-mortem being conducted within less than 24 hours of the death meant there had been little time for investigation to fully exclude suspicion. Assumptions made too early in any investigation will only serve to increase the probability that vital evidential material is lost.

1.14 Indeed, it is now clear that vital evidence was lost because of early assumptions. Following the post-mortem, all of Geoff's clothing, including the gloves he had been wearing, was destroyed and his army issue boots were returned to the army to be re-issued.

1.15 The only items retained by the Coroner's Officer were Geoff's beret and badge as Ms Masters had taken Geoff's damaged beret from the scene.[3] Geoff's clothing was left at the mortuary and was disposed of the following day. Ms Masters explained that as far as she understood, the army did not wish it returned as it was contaminated with blood and the police told her it was no longer required. The decision whether or not to dispose of the clothing was not one which Ms Masters had referred to the Coroner.

[3] She had shown it to Dr Chapman during the post-mortem.

2. **Forensic evidence obtained by Surrey Police**

2.1 Further expert evidence in pathology and ballistics was obtained during Surrey Police's 2002 – 2003 investigation.[4,5]

2.2 Dr David Rouse is a Consultant in Forensic Medicine and Pathology who has worked as a Home Office Forensic Pathologist since 1988. Dr Rouse's report was of course reliant on the documents: the few photographs from the scene and Dr Chapman's post-mortem examination report. He stated that he did not see anything that indicated to him third party involvement. Dr Rouse suggested that the position of the wounds was consistent with self-infliction, noting that Geoff would have had sufficient reach to effect discharge of the weapon with the muzzle pointing towards himself.

2.3 Dr Rouse considered that the position of the wounds was typical for self-infliction, with the centre of the forehead being a "site of election". The distribution of the soot and powder staining would suggest the muzzle was a very short distance away from Geoff, although the circular nature of the entry wounds suggested to him that weapon was not in direct contact with the skin. Wounds from a weapon held tightly against the skin are, according to Dr Rouse, associated with splitting of the entry wound margins and this did not appear to be present.

2.4 Dr Rouse suggested that the close proximity of the two entry wounds, together with the area of powder and soot deposition, suggested almost consecutive discharge with the rifle remaining in roughly the same position relative to the head. He drew from this an inference that, for this to have occurred, Geoff must have either been (i) holding the weapon or (ii) lying down at the time of discharge if another individual was involved. He observed that the latter scenario seemed contradictory to the distribution of body tissue

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[4] In their closing submissions Mr and Mrs Gray raise the issue of an unidentified fingerprint subsequently found on the SA80. I am aware that the weapon was checked for fingerprints as part of the Surrey Police 2002-2003 investigation and that there were a number of documents and reports arising. Those documents, which were made available to all Interested Persons, indicate some unattributed prints being found on the weapon. No Interested Person sought to address this issue with any live witnesses and I was not asked to admit the material under Rule 23. I had decided not to do so myself because the presence of an unattributed fingerprint on this weapon could not be of any probative value in any direction. In circumstances where this weapon came from a shared pool of rifles and so was repeatedly issued from the guardroom, any trainee or NCO who had formed part of the Deepcut guard force in the past weeks might have touched this weapon. Indeed it would have been surprising if there had not been other prints on the weapon given its provenance.

[5] Examination of Geoff's phone by Surrey Police revealed that under his stored numbers, at position 16, was recorded 'date died 1744'. It can not be established when this record was saved and no credible significance of that 4 digit number has been suggested by anyone, beyond it potentially being a PIN code. I consider that the issue has no probative value.

visible in the photographs, which suggested to Dr Rouse that Geoff had been upright rather than lying down when shot.

2.5 Ballistics evidence was provided to the police in 2002 by Mr David Pryor, who had worked in this field examining firearms and ammunition from the 1970s, working for many years for the Metropolitan Police and the Forensic Science Service.

2.6 Mr Pryor considered that the dispositions of the two entry wounds were consistent with shots from a rifle set to automatic fire. He explained how, if five shots had been fired on automatic, the weapon's movement under recoil could lead to three of these shots missing the body. He considered the SA80 to be "butt heavy", such that on firing in automatic with the butt unsupported, the muzzle will rise. Hence on firing multiple shots towards the head, it is likely some would miss completely.

2.7 Surrey Police subsequently sought expert evidence from an organisation entirely independent of the British establishment. The German federal police, the Bundeskriminalamt ("BKA") were instructed to produce expert reports into all the deaths at Deepcut. A detailed report into Geoff's death was produced in May 2003 by three forensic scientists: Herr Nennsteil, Dr Niewohner, and Herr Salziger. They were assisted by a forensic pathologist, Professor Urban. Herr Nennsteil also gave evidence to the army Board of Inquiry into Geoff's death in 2007.

2.8 BKA carried out tests on the SA80 rifle that had been found by Geoff's body and also examined the five cartridge cases recovered from the scene. BKA's analysis of the rifle indicated that it could fire at least 11 rounds per second when set on automatic. Hence the time between consecutive shots in continuous fire was less than 0.1 second and a single half second pull of the trigger could deliver five rounds.

2.9 Cartridge cases bear marks caused by their interaction with components in a firearm after firing. On microscopic examination, it is possible to match spent cases with the weapon from which they were fired. BKA were able to match the five cartridge cases with the rifle found at the scene.

2.10 BKA also reported that they could establish a difference in the intensity and prominence of markings left on cartridges discharged on automatic fire as opposed to single shot fire. Herr Nennsteil clarified to the Board of Inquiry that the cartridge markings they observed were not 'proof' of automatic fire, but were an indication which suggested it was more probable than not that the cartridges found at the scene were fired on automatic. However, for reasons I shall discuss below I do not rely upon this aspect of BKA's report.

2.11 It is not possible to draw any conclusions from the position of the cartridge cases as recorded in a sketch by SOCO Mullings. When an SA80 is held upright, cartridges are ejected to the right. Cartridges were found to the left of Geoff's body. Their position was consistent with having been discharged from a rifle close to Geoff. However little more can be ascertained from the ejection pattern. As Mr Pryor's tests had already shown,

cartridge cases are ejected erratically up to 1.5m from the rifle. They could then have bounced off the nearby tree or the body. The clear implication from the ballistic reports is that even more precise recording and photographing of the position where the cases were found would not have yielded any extra information regarding the position of the shooter.

2.12 BKA examined the nature of the damage to Geoff's beret and the gunshot residue found on it, and also conducted experiments using a comparison beret. Their observations confirmed those made earlier by Mr Pryor that the material showed signs of contact, or near contact discharge, with torn fabric and soot blackening from the muzzle blast. BKA were able to establish that the muzzle of the rifle had been in direct contact with Geoff's beret, on the basis of the extensive signs of scorching and melted fibres found. Both BKA and Mr Pryor considered that the beret was worn in the usual way at the time of the shots.[6]

2.13 The forensic evidence, analysed carefully, indicates that Geoff was wearing the beret at the time he was shot. I have also heard evidence that army cap badges were well known to be easily dislodged.[7] The separation of Geoff's cap badge from his beret is, therefore, unremarkable.

2.14 BKA considered whether, if five shots were fired at or by Geoff, how three of them might have missed him despite the rapid rate of automatic fire. Their calculations revealed that an angle of only eight degrees of displacement of the weapon or its target after the first two shots would lead to subsequent shots missing. Reconstruction experiments showed that Geoff or the weapon, (or both) moving backwards (recoiling), falling or rotating after the first two incapacitating shots would produce such displacement.

2.15 BKA did not believe that the available evidence permitted any conclusions about Geoff's posture at the moment of firing, or his position relative to the tree by which he was found.[8]

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[6] BKA found that the damage to the beret directly corresponded with one of Geoff's wounds. This is particularly important given Ms Masters' evidence and Dr Chapman's recollection that the beret was not markedly blood stained or contaminated with tissue. Ms Masters gave evidence at Geoff's 2002 inquest that the relatively undamaged condition of the beret suggested Geoff had not been wearing it at the time he was shot. It had been found by Cpl Simpson at the base of the tree, with the cap badge found lying a foot or two away. This evidence had underpinned a hypothesis that an assailant might have removed Geoff's beret and removed the cap badge from the beret either in a struggle or as a deliberate element of an attack.

[7] This is consistent with experimental work carried out by Mr Pryor who found that on firing an SA80 at a model head wearing a beret the beret came off the head and the cap badge came off the beret.

[8] At the time Mr Pryor observed the butt of the rifle, it looked clean, although no specific testing was done for the presence of soil particles. This issue was explored with my ballistics expert Mr Rossi who confirmed, as a general proposition, that he would expect a rifle falling onto damp ground to have gathered at least some mud. However there is no positive evidence available regarding the condition of the ground around Geoff such that one could say that had a rifle been dropped there by Geoff it would be expected to have become muddy. The photographs from the scene show the area to have a considerable covering of grass, it had not been raining that night and there are no obvious muddy patches. Given the uncertainties in knowing from what exact height or angle a dropped rifle would have fallen – especially in the light of uncertainty about Geoff's posture at the moment the rifle was fired – and the lack of evidence about the

3. **New expert evidence obtained for this inquest**

3.1 For this fresh inquest, I instructed two independent experts to look afresh at the pathology and ballistics evidence. These experts were Mr Leo Rossi, a firearms and ballistics expert who worked from 1974 - 2010 for the Forensic Service Laboratory of Northern Ireland, and Professor Jack Crane, an extremely experienced forensic pathologist who was formerly the state pathologist of Northern Ireland.[9] I am extremely grateful to both of them for the assistance they have provided this inquest, including by travelling from Belfast to give evidence at court.

3.2 Mr Rossi told me that he had no reason to doubt the findings of either BKA or Mr Pryor, who had each used best practice at the time. BKA's analysis was approved by Mr Rossi with respect to the likely sequence of events: that the first shot passed through the beret and head, throwing the beret off Geoff's head, with the second shot passing through the head only, the following three shots then missing.

3.3 Mr Rossi was able to carry out further experiments in January of this year using the rifle found next to Geoff's body. His findings from that testing differed from those of BKA in two respects.

3.4 Firstly, Mr Rossi was unable to replicate the firing of five shots with a single pull of a trigger that had been produced by BKA. His testing produced three or four shots. He was however satisfied this could be explained by *(i)* the 'dry' condition of the rifle which had not been maintained in the intervening years and had needed lubrication, and *(ii)* by the nature of the ammunition used which had produced some stoppages.

3.5 Secondly, Mr Rossi sought to replicate BKA's discrimination between cartridge cases fired on single shot and automatic modes. He was able to see differences between the prominence of the marks left on different cartridges, but he could not find consistent differences between those fired on single shot and automatic fire that would enable him to reliably determine the firing mode.[10] In the circumstances I have not relied on this aspect of the BKA report in coming to my own factual findings.

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condition of the ground, I cannot safely derive any inference from the fact the rifle was not noted to be muddy to the naked eye.

[9] Professor Crane provided independent expert evidence in 2018 when instructed by Liberty on behalf of the family of Sean Benton in respect of an earlier death at Deepcut. I did not consider this presented any conflict when instructing him on my own behalf in respect of Geoff Gray's death.

[10] He considered this difference in testing could be attributable to the condition of the rifle at the time, and to metallurgical differences in the rounds used. However he was not aware of any research literature suggesting that discrimination between single and automatic shots fired with an SA80 was achievable based simply upon the markings made on expelled cartridge cases.

3.6 In broad summary, whilst Mr Rossi did not find any evidence that could rule out infliction of Geoff's wounds by another, he did not consider there to be any evidence which was inconsistent with self-infliction.

3.7 As I have already noted, Professor Crane's report included a critique of the nature of Dr Chapman's post-mortem. However, he did not disagree with any of Dr Chapman's pathological findings or conclusions as far as they went.

3.8 Professor Crane confirmed the fundamental point that it was inconceivable that Geoff could have self-inflicted both the fatal gunshot wounds if the rifle had been set on repetition: the first shot would have been incapacitating. Nevertheless, if the rifle had been set to automatic he did consider it was possible for two shots to be self-inflicted, despite the impact of the first, if the shots were released in a single burst. He told me that there was no pathological reason why Geoff could not have kept pressure on the trigger for the short time needed to release five rounds, despite sustaining the two fatal wounds in the first shots.

3.9 The position of the wounds suggested to Professor Crane that there had been almost consecutive discharge of the shots, albeit with the head or weapon moving between shots.[11]

3.10 He agreed with Dr Rouse's analysis that the distribution of body tissue seen in the photographs suggested that Geoff was standing upright rather than lying down at the moment of discharge, although there were too many unknown factors to be able to establish Geoff's exact position.

3.11 Professor Crane was asked to comment on whether the tissue found at the scene might elucidate whether or not the body had been moved. In his view, looking at the scene photographs there was no evidence to support the body having been moved. He stated "I think that the tissue that was found was probably brain matter that has been extruded from one or both of the exit wounds on the back of the head, and they would be expected to be found fairly close to where the deceased was found". From a pathological perspective there was no evidence to indicate that the body had been moved any appreciable distance.

[11] Professor Crane commented that although the forehead was a usual site of election for gunshot wounds generally, it was a more unusual choice when using a long-barrelled weapon because of its slightly difficult positioning. Sites of election under the chin or in the roof of the mouth would, he said, be more common. However I note that the SA80 rifle has a "bullpup" configuration whereby a compact design houses the magazine behind the trigger group, resulting in a shorter overall length than a conventional rifle. All of the many experts who have considered Geoff's case agree it would be possible for a person to reach the trigger, which is 15 inches from the muzzle, and self-discharge the rifle towards their own forehead. It was readily apparent on seeing the SA80 that was brought to court, that one could easily turn the rifle towards oneself and use either the finger or thumb to pull the trigger.

4. **Conclusions on the ballistics and pathology forensic evidence**

4.1 Having weighed up all the expert forensic evidence, I make the following factual findings:

a. The cause of Geoff's death was two gunshot wounds to the head;

b. Geoff was shot at very close range, at contact or near contact;

c. Geoff was wearing his beret when he was shot;

d. Had the shots been fired with the weapon on single shot (repetition mode) Geoff could not have self-inflicted the wounds;

e. Geoff was not lying on the ground when he was shot but was in an upright position although no further determination can be made of his precise position or posture at the moment he was shot;

f. Geoff had no defence injuries and as such there was no pathological evidence supporting the rifle having been forcibly taken from him or him resisting an assailant in any way;[12]

g. The position of Geoff's wounds was consistent with self-infliction. Although also not inconsistent with infliction by another, for this to have occurred Geoff would have had to have submitted without resistance to an assailant standing at very close range;

h. The five cartridge cases found at the scene were fired from the rifle found at the scene, and hence at least five shots had been fired;

i. Five shots can be fired in a single burst from a single trigger pull in under half a second if an SA80 is set on automatic;

j. It is possible for someone self-inflicting a head wound to fire a single burst of five shots;

k. It is possible for a single burst of five shots to have been fired with two hitting Geoff and three missing him;

l. The evidence of the tissue found at the scene is consistent with Geoff having been shot where he was found. There was no evidence to indicate that the body had been moved any appreciable distance.

[12] It is not known if Geoff was wearing his rifle by the sling. If he was, its removal by force without leaving any injury would have been more difficult.

4.2 The ultimate position is that the forensic evidence is consistent with self-infliction but does not rule out infliction by another. The available forensic evidence alone cannot establish who fired the fatal shots.

5. Missed opportunities in evidence gathering

5.1 When deciding what weight to put upon the scientific findings above I have borne in mind the extent to which conclusions based upon the scientific evidence are limited or might be unreliable due to the absence of material that would have otherwise been available had the investigation of Geoff's death been more thorough from the outset.

5.2 It is accepted by Surrey Police that inappropriately premature assumptions were made that Geoff had died at his own hand, and that as a result, the standard of investigation was not as it should have been. The weaknesses in the initial investigation then affected all subsequent investigations' ability to reinvestigate the death. It is abundantly clear that those early assumptions were not only made by Surrey Police, but also the MOD police, the RMP, the SIB and the Coroner's Officer.

5.3 Whilst the impact of making early assumptions is perhaps obvious, I can do no better than adopting the words of Professor Crane:

> "First of all, if you make assumptions early on in the investigation, then there is the likelihood, and indeed the probability, that vital evidential material is lost. I am talking right from the very beginning from the scene examination, so that is often the crucial part of the examination. The difficulty is that when assumptions are made at that early stage, not only may important evidential material be lost, but that idea is perpetuated, so the next person that comes along is told, "We think this is a suicide" and that continues to permeate the investigation and permeates the thinking of people. Whereas the proper approach is to regard this as a suspicious death, the scene of the death to be regarded as a crime scene, cordoned off, a proper forensic examination done, proper photographs taken and for that detailed examination to continue right through the post mortem examination."

5.4 I add to his comments that the proper 'suspicious death' approach should continue right through to the collection of witness evidence and the early scrutiny of and inquiry into any inconsistencies in that evidence.

5.5 There are some aspects of the perfunctory approach to recording the scene and the forensic examination thereafter that have made no difference to the task I now face. There are however some fundamental gaps in the scientific evidence that could, at one time, have been filled.

5.6 L/Cpl Filmer immediately moving the rifle and not recording its position whilst he made it safe was a wholly reasonable action which any soldier approaching the scene was likely

to have carried out. In the disturbing circumstances of coming across Geoff, there can be no criticism that the precise place in which the rifle was initially found was not recorded. Given that there is no question but that the rifle was found very close to Geoff's body, and the number of different variables in play as a rifle falls or is thrown to the ground it is difficult to see that knowing its more precise position in relation to Geoff would have now revealed anything further about his death.

5.7 The precise position where each of the cartridge cases were found should have been, but was not, recorded. Only a rough sketch map was made, recording that two cartridges were found on Geoff's left at the very foot of the tree and three others further to Geoff's left, albeit still near the tree and between 20 – 30 inches from the fence. Again, given the variables involved in the expulsion of a shell and the potential to bounce off the nearby tree, it may be that little more could have been learned had their more precise location been recorded.

5.8 The scene photography, although limited, was sufficient to establish the position in which Geoff was found. There was however no formal logging of the presence of blood and body tissue at the scene. Although from the first hand witness evidence and photographs it is readily apparent that body tissue and/or blood was present on the tree, around the ground where Geoff lay, on the perimeter fence and on the cricket screens, a blood pattern analysis may have revealed more about where Geoff had been positioned and his posture when he was shot, albeit, in a dynamic situation, allowance would have had to have been made for a number of variables. Better scrutiny of the wider scene might also have provided much earlier answers to the question of whether his body had been moved after death.

5.9 In the absence of a forensic post-mortem there was no attempt to reconstruct Geoff's skull and so more precise evidence of the wound tracks is not available. A post-mortem that included CT scanning or an x-ray of Geoff's body would have enabled determination of whether there were any bullet fragments remaining in the cranium, and if so these could then have been recovered, examined and attributed.[13]

5.10 Perhaps the most significant omission in the forensic evidence is the failure to preserve and study Geoff's clothing for gunshot residue. Mr Rossi explained that even though generally there would have been some gunshot residue on Geoff's clothes because he was military personnel,[14] had Geoff fired the rifle, there would have been a definite clear pattern of residue on Geoff's sleeves had they been close to the muzzle at the time of the discharge. Had Geoff's clothes and gloves not been destroyed after the post-mortem examination, their analysis would probably have immediately answered the key question

[13] Although I note that Dr Chapman said it was arguable whether such fragments would have been present to be recovered at post-mortem, and that reasonably sized fragments could be recovered at post-mortem even without the benefit of imaging.

[14] So he might be exposed to gunshot residue contamination on a daily basis.

that has, understandably, plagued his parents for so long of whether or not Geoff fired the rifle that morning.

5.11 It is astonishing that Geoff's clothing was already earmarked for destruction by 18 September 2001, before any investigator could possibly have had proper opportunity to review the entirety of the evidence in Geoff's case and have re-considered the validity of the immediate assumptions that had been made at the scene.

6. Expert evidence in psychiatry

6.1 I instructed an independent expert in psychiatry to assist my inquiry. My chosen expert, Professor Louis Appleby, is a fellow of the Royal College of Psychiatrists and a Professor of Psychiatry at the University of Manchester, Centre for Mental Health and Safety, where he leads the suicide research group. Professor Appleby has chaired the National Suicide Prevention Strategy Advisory group at the Department of Health since 2002. He has written over 220 academic papers and reports, many on the topic of suicide and suicide prevention and self-harm.

6.2 Professor Appleby reviewed many of the statements made by Geoff's parents, fellow soldiers, and friends. He also met with Mr and Mrs Gray in January 2019 prior to the inquest, interviewing them about Geoff's personality and mental health and their view of what had caused his death.

6.3 He told me that in his view there was nothing that stood out in Geoff's background that was relevant to the issue of whether or not he took his own life. Geoff had few if any risk factors for suicide: no known history of mental illness or mental health problems; no history of self-harm, alcohol or drug abuse; no forensic history or history of violence. Professor Appleby understood the witness evidence as generally giving an impression of Geoff being a relaxed, cheerful person whose at times impulsive behaviour was no different from what might be expected in many young people. He did not see a recurring or persistent pattern of impulsive behaviour. There is little in Geoff's history indicating he was a suicide risk.

6.4 Professor Appleby stated that none of this can rule out a troubled state of mind, or even mild depression, as it is quite common for people with some depression or disturbance of mood to be referred to by other people as presenting as happy and cheerful. However several witnesses reported no change in Geoff's mood or behaviour in the period leading to his death, and that he was positive about his future.

6.5 In Geoff's case, Professor Appleby did consider that there was some evidence in the period leading up to September 2001 that indicated Geoff might have been less happy and optimistic, and more concerned than people around him thought: there were times when he was troubled by his relationships with girlfriends, and he may have been more affected by teasing at the barracks than others realised. He seemed to particularly dislike guard duty. In his report, Professor Appleby considered that on the final day of Geoff's

life, there were signs of "emotional vulnerability": several observations painted a picture of someone who was "unhappy, distracted or worried".

6.6 Professor Appleby had considered that the reports by Pte Blackburn and Pte Craig that Geoff had made a comment about shooting himself were very relevant and important. That the comments were made in a manner such that the other privates did not take them seriously does not necessarily detract from this assessment: they remained an unusual thing to say. He explained that people thinking about suicide can "test out" their method, including in a mental sense by "thinking it through".

6.7 Given my factual finding regarding the comment reported by Pte Craig, I consider there was only one relevant comment about shooting himself in the hours before he died that can be relied upon as having been said by Geoff. However I do not consider that significantly detracts from the weight I can place on Professor Appleby's opinion in this regard, as his opinion was also based in the factual evidence of Pte Blackburn which I have accepted.

6.8 Professor Appleby's evidence directly engaged with a central conundrum raised by many witnesses to this inquest: how could someone who seemed as happy-go-lucky as Geoff, who had very few risk factors for suicide, who was looking towards his future, and with no apparent reason to wish to take his own life, ever have done so?

6.9 Professor Appleby explained that from his experience the absence of indicators of suicidality did not undermine the possibility of suicide as a cause of death. A number of suicides did not follow a typical pattern. In particular he said that the apparent inexplicability of an incident of suicide "is a common feature of suicide in young people…throughout my career I have been hearing from families that suicides, particularly in young people, and perhaps particularly in young males, occurred out of the blue."

6.10 As Professor Appleby put it: "our cultural explanation that suicide happens to people who are explicitly suicidal is not right." He explained that it should not be surprising that many suicides have minimal warning. If there was a clear indication of suicidal intent it would be more likely someone would intervene.

6.11 Research which was carried out as part of the National Confidential Inquiry into Suicide and Young People, published by the University of Manchester's suicide prevention centre, of which he is director, had investigated what he called the "out of the blue" phenomenon in those aged under 20. Their data suggested that in as high as 29% of cases of suicide, the young person who died gave no direct indication of suicidal ideas or self-harm.

6.12 This research in particular challenges the assumption that when such an "out of the blue" suicide occurs, it was because a mental illness was present but not apparent, such as a masked depression. The evidence gathered by the study suggests instead a different explanation: that young people may quickly develop a highly vulnerable emotional state

in response to adverse life events. He stated that it "is a common feature of suicide, that inexplicability, that disproportion between what a person does and the possible explanations. That disbelief among people who are close to the person. Those are not evidence that a suicide didn't occur. Those are simply evidence of our difficulty in understanding such a final and terrible act."

6.13 Professor Appleby considered that Geoff's story was consistent with suicide. He made clear this was not a conclusion based simply on the fact that "out of the blue" suicides occur. Principally, this was because of how Geoff appeared to have taken steps to be alone. A highly lethal suicide method was available to Geoff and it could appear that he took steps to be in a position to use a rifle where no-one else might intervene. This is in the context of explicit references made by Geoff to death by gunshot a few hours earlier. Professor Appleby notes that if Geoff did intend to take his life, it was possible that the intent was recent and the consequences were not fully considered. Any warning signs on the day he died were "few, brief and inconsistent" and Geoff's tendency to laugh off problems may have concealed the way he felt.

6.14 However, whilst Professor Appleby went on to identify a number of recent matters that may have had a causal role he could not say that anything probably did. Professor Appleby explicitly acknowledged that any 'explanation' offered for Geoff's death, if by suicide, may seem inadequate. It is hard to believe that a young man with everything to live for, a supportive and loving family, a promising career, and no known history of mental health issues would have been so unbalanced by any of his recent experiences. However, Professor Appleby commented "disturbingly, the suicides of young people often seem to follow this pattern – a rapid and extreme deterioration of mood in response to upsetting events which, when there is access to a dangerous suicide method, quickly leads to tragedy."

6.15 I do not consider that the fact that the research paper by Professor Appleby and his colleagues cited above is relatively new and not yet fully peer-reviewed is a significant factor in diminishing the reliability of his evidence. Professor Appleby's opinion that 'out of the blue' suicides exist as a phenomena in young people was not solely based on the data gathered as part of that single recent study. Rather, Professor Appleby drew on a long career of pre-eminent expertise in his field to explain a matter within his knowledge and experience from his professional research and clinical experience. Nor did he put forward any probability-based theory about the likelihood of Geoff having died from suicide based on statistics alone, which in that circumstance I would naturally have expected to have been subjected to rigorous academic scrutiny.

6.16 Having considered Professor Appleby's evidence on this subject, my view is that whilst it is an expert opinion that offers an explanation for the seemingly inexplicable, my finding as to whether or not Geoff killed himself should not be based on Professor Appleby's report or opinion. Rather it should be based on my findings on the contemporary, first-hand evidence.

6.17 The point which I take from Professor Appleby's evidence is that if I am satisfied on the other evidence to the requisite standard of proof that Geoff self-inflicted the fatal wounds, it would be wrong of me to assume such a conclusion must nonetheless be incorrect or unsafe because of the absence of reason or motive or evidence that Geoff was obviously "suicidal".

6.18 I accept Professor Appleby's evidence that it is a known phenomena for young people to take their own lives, notwithstanding appearing to most people around them to be contented and emotionally stable. I make no finding as to whether this is because of "masked depression", the early onset of depression, or simply as a result of volatility and rapid mood changes. I accept that it is possible for young people to die from suicide despite having no prior history of mental illness or mental health problems. I accept that it is possible for emotional challenges that may seem objectively to be easily surmountable to have such a disproportionate impact on a young person that they contemplate suicide. But none of that evidence is in my view probative of this having been what actually happened in Geoff's case.

6.19 This is an investigation into 'how' Geoff died, not why, and it is not for me to attempt to make any finding such that a particular incident combined with the volatility of a young person's emotional state is 'the reason why' Geoff may have killed himself. No-one ever knows exactly what is going on in someone else's head. Indeed, that is precisely why some suicides can appear to those left behind to have been so inexplicable and heart-breaking. It is this lack of foreseeability that makes the task of taking preventative measures particularly difficult.

SECTION 9: CONCLUSIONS

1. Record of Inquest

1.1 Many matters that I must determine and record on the Record of Inquest have been uncontroversial. It is clear that the mechanism of Geoff's death was gunshot wounds to the head and I shall so record.

1.2 As to when and where Geoff's death occurred, again it is clear that Geoff died at around 01.10 hours on 17 September 2001 at the Officers' Mess Compound at Princess Royal Barracks, Deepcut in Surrey and again I shall so record.

1.3 As for registration of particulars: I have been told that Geoff Gray was born in Sunderland on 28 January 1984. He was a trainee soldier and unmarried. His parents have asked that his address is recorded as his home address, rather than his temporary army address, and I shall do so.

1.4 Other more contentious matters within the scope of this fresh inquest include:

- The search for Geoff on 17 September 2001 and whether or not Geoff's body was moved after his death;
- Who fired any shots on 17 September 2001 and whether any third party action was involved in the death; and
- Geoff's state of mind on 17 September 2001.

It is to my factual findings on those matters that I now turn.

2. Factual findings

2.1 At the core of this investigation and inquest has been the consideration of two potential, mutually exclusive, factual findings:

(i) that Geoff shot himself; or

(ii) that Geoff was shot by a third party (whether known or unknown and whether someone inside the barracks or an intruder).

2.2 There is no direct evidence as to who shot Geoff. I must look at the various strands of circumstantial evidence to consider whether, looked at critically and taken together in the round, they establish a particular factual conclusion. Before reaching any final determination of facts, I need to consider whether there are co-existing circumstances which weaken or destroy the inferences that a particular factual finding or conclusion is correct.

2.3 If the evidence is equally supportive of both the above possibilities, it must follow that neither fact can be established to the requisite standard of proof.

2.4 I start with matters upon which I can be sure:

(i) **whoever shot Geoff did so at the location where Geoff's body was found.**
I am driven to this conclusion by the combination of the evidence of Pte Liggins and Pte Griffiths, and the presence of body tissues and spent cartridges at the place Geoff was found.[1] As I have already indicated, I reject L/Cpl Filmer's evidence that any perimeter search had been conducted before Geoff was found that had covered the area where he lay. Furthermore, from looking at the scene photographs, Professor Crane found no evidence to support the contention that Geoff's body had been moved;

(ii) **the shots were fired within a few minutes of the time that Ptes Naiova and Mulraine said Geoff left to go on lone patrol.**
All accounts and the contemporaneous guardroom logs confirm that the single set of shots was heard shortly after the 01.00 hours stag had begun;

(iii) **the rounds that killed Geoff were fired from the SA80 rifle found beside him.**
Examination of the five cartridges from the scene put it beyond question that they were fired by the rifle found beside Geoff. Marks found on all five rounds matched this weapon;

(iv) **the SA80 rifle found beside Geoff was the one that he had taken to the Officer's Mess.**
I make this finding despite the absence of the guardroom documentation that might have confirmed the serial or butt number of the rifle which had earlier been allocated to Geoff. No other rifle was missing apart from the one seized by Surrey Police from beside Geoff's body. That rifle was one from the guardroom pool. The rifle must have been the one Geoff took out on the 01.00 stag unless someone on guard duty had swapped theirs with Geoff's and there is no evidence whatsoever to support that suggestion. In my view, the only reasonable inference is that the rifle found beside him was the one that had been issued to Geoff that evening;

(v) **the rifle was set on automatic when it was fired.**
I have concluded that the rifle was set to automatic after considering the evidence of those who heard the shots, particularly those who had extensive experience of gunfire. The finding is supported by the discovery that the lever of the rifle was set on automatic when the rifle was checked at the scene and the expert evidence regarding the close location of the two injuries;

[1] On the ground, the tree, the fence and the cricket screens. I also take into account the circumstantial evidence of a piece of Geoff's skull being found in that same vicinity several months after his death.

***(vi)* the two fatal gunshots were fired at very close range.**
The presence of gunshot residue, indicating close range shots, is unequivocal. Its distribution indicates contact or near contact shots, and the forensic evidence shows that when one of the shots was fired the muzzle of the rifle was in contact with the beret. The blood found on the weapon also supports this conclusion;

***(vii*) the firing of five rounds on automatic yet only two hitting the head is consistent with self-infliction.**
As the ballistic experts confirmed, given the deviation of angles of fire for an SA80 rifle fired in automatic mode, it is possible to fire five shots on automatic at one's own head and for only the first two rounds to impact oneself. That the first shot might be both fatal and incapacitating was not inconsistent with self-infliction of two gunshot wounds given the extremely rapid rate of fire of an SA80 set to automatic. The site of the wounds is also consistent with self-infliction;

***(viii)* no ammunition was unaccounted for in respect of those on guard that night.**
At the request of Sgt Dunford of the RMP, WO2 Ballentine checked that all weapons and ammunition, other than Geoff's, were accounted for. Five cartridges and one live round were recovered at the scene with four left in the magazine beside Geoff. None of the many witnesses who heard gunfire have suggested that any more than five rounds were fired;

***(ix)* none of the armed guards were near Geoff when he died**.
There is no evidence other than that Pte Naiova was with Pte Mulraine at the guard post by the car park entrance when the shots were heard. All other armed guards were in the presence of another trainee and would have been a significant distance away at their respective guarding positions or on prowler patrol within the main barracks;

***(x)* the rifle Pte Naiova was carrying was not fired.**
As I have already discussed, it is now clear that L/Cpl Filmer's suggestion to the contrary was unwarranted speculation;

***(xi)* during the course of the evening Geoff had made a remark to Pte Blackburn consistent with contemplation of self-inflicting a gunshot wound to his head.**
I have already described in detail why I make this finding. The fact that it was perceived as light-hearted, whilst relevant, does not diminish its importance in the light of the cause of Geoff's death not long afterwards; and

***(xii)* deliberate steps were required to fire the SA80 rifle.**
Although magazines were already pre-loaded and fitted onto the SA80s at the guard posts, several additional steps were required before this rifle might be fired. These include releasing the safety catch, moving the change lever to automatic, cocking the rifle, lifting the rifle and aiming it towards the target and then pulling the trigger.

2.5 There are a number of further factors which militate against third party involvement in Geoff's death:

(i) **there is no evidence whatsoever that anyone had any credible motive to harm still less to kill Geoff.**
Further, I am sure that Mr Murphy went to bed after the earlier incident at the gate, sleeping off his alcoholic excesses. However bad his drunken behaviour, there is no evidence he sought to inflict physical harm on any of the guards; nor is there any evidence to suggest he left his room in the early hours or that he had access to a weapon;

(ii) **there is no reliable evidence of the presence of an intruder at the scene.**
A significant time after the shooting, a lone witness thought he saw a figure running across the cricket pitch. I am not persuaded that this was indeed a person and, even if it was, it is highly unlikely to be an attacker still at large who was now choosing to cross open ground to expose themselves an hour after the shooting. Furthermore, the history of intrusions at Deepcut does not support the presence of an intruder seeking to disarm, attack and kill a guard. The only potentially relevant assault was in the wholly different context of an intruder being apprehended by a guard; it did not involve a weapon or any intent to kill;

(iii) **there is no direct evidence of involvement of another person.**
There were no defensive injuries found on Geoff's body. Whilst this, of course, does not rule out a shooting by a third party, any assailant is likely to have had to use substantial force to be able to successfully remove the rifle from Geoff's possession and turn it on him;

(iv) **it is inherently unlikely that a third party would or could have taken the series of steps necessary to achieve the scene as found.**
Had a third party killed Geoff that person would have had to have:

(a) been present by the open fence area of the cricket pitch or lying in wait for a lone prowler guard;
(b) been prepared to risk that guard discovering and shooting at them;
(c) attacked Geoff within minutes of Geoff embarking on prowler patrol;
(d) somehow relieved Geoff of the SA80 rifle without Geoff resisting, shouting for help or running away;
(e) stood within 15 inches of Geoff to fire two shots at Geoff's head at contact or near contact range;
(f) achieved Geoff not ducking or turning away from a rifle muzzle placed at his forehead; and
(g) left the barracks without being apprehended.

2.6 I have considered all the above matters in the round. I acknowledge the difficulties caused by the serious investigative shortcomings, not least the absence of forensic consideration of Geoff's clothing and its subsequent destruction, which might have provided critical evidence obviating the need for years of further investigation. However, the evidence is

very far from being equally consistent with a deliberate act of self-harm or an intervention and attack by a third party. In my view the evidence does permit a clear conclusion.

2.7 Taking all matters together I reject the contention that Geoff was shot by another person. Close examination of the evidence reveals that such a suggestion is highly speculative and not supported by the evidence.

2.8 The evidence drives me to the conclusion that it is more likely than not that Geoff engaged in a deliberate act and fired the SA80 rifle at himself.

2.9 Furthermore, whilst the present law requires me to determine the matters going to a potential conclusion of suicide only on the balance of probabilities, having considered all of the above I am satisfied so that I am sure that Geoff fired the fatal shots himself.

3. Consideration of Suicide Conclusion

3.1 Having come to the factual determination that Geoff fired the fatal shots himself I must go on to consider whether his death was intentional and hence was suicide, or whether the discharge was probably accidental.

3.2 For a conclusion of suicide the two elements that must be established are that: (i) the deceased took his own life; and (ii) the deceased had the specific intention to end his life.

3.3 Both elements must be found proved when assessed against the civil standard of the balance of probabilities. Earlier authorities which have suggested that test of sufficiency of evidence for suicide is whether all other possible explanations for the death have been excluded[2] were based on application of the criminal standard and so do not in my view survive the recent Court of Appeal decision in *Maughan*.[3]

3.4 Suicide still may not be presumed, but must be based on some evidence that the deceased intended to take his own life. As Lord Widgery CJ stated in *ex p Barber*:[4]

> "what is perhaps one of the most important rules that coroners should bear in mind in cases of this class, namely that suicide must never be presumed. If a person dies a violent death, the possibility of suicide may be there for all to see, but it must not be presumed because it seems on the face of it to be a likely explanation. Suicide must be proved by evidence and, if it is not proved by evidence, it is the duty of the coroner not to find suicide but to find an open verdict."

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[2] For example, *R(Lagos) v HMC London* [2013] Inquest LR 34 at §41.

[3] *R (Maughan) v HM Senior Coroner for Oxfordshire* [2019] EWCA Civ 809.

[4] *R v City of London Coroner, Ex Parte Barber* [1975] 1 WLR 1310.

3.5 When a clear declaration of intent is not available, evidence of the circumstances may still support an inference of intent to die, such as where it would be obvious without any special knowledge that an action would inevitably be lethal and a deliberate series of steps have had to be undertaken to bring about the final act.

4. Geoff's intent

4.1 Geoff had no history of mental health difficulties and I have taken into account the overwhelming body of evidence to suggest that Geoff was not depressed and appeared to be planning for a bright future. Most of those who encountered him at the time found the notion that he could kill himself to be completely inconceivable.

4.2 There is some evidence of a lowering of Geoff's mood during the hours before his death. This would be wholly consistent with having to perform another guard duty. I note there are some matters which occurred that evening which *might* have upset a young man of Geoff's age (the interaction with Ms Webb, teasing from colleagues and the encounter with Mr Murphy). Nevertheless, the powerful consensus of those around him was that Geoff was unaffected by these matters. He was if anything, pleased with his performance in dealing with the Murphy incident.

4.3 In so far as there may be limited evidence of a troubled frame of mind, what evidence there is is not of a nature to provide significant support to the contention that Geoff had a specific intention to end his life. However, in determining intent, I look to other factors surrounding the firing of the shots by Geoff.

4.4 I firstly bear in mind that, contrary to the guard orders at the time, Geoff created the opportunity to be alone with an SA80 rifle by electing to go on prowler patrol on his own and positively declining an offer to be accompanied. I acknowledge that there is some evidence to suggest that there was not necessarily strict compliance with the requirement to prowl in pairs after 9/11, but nevertheless Geoff actively encouraged Pte Mulraine to stay with Pte Naiova.

4.5 Secondly, I have considered the location where the shots were fired. It was away from the buildings and out of sight from the guard post. Clearly this was not a place where one might anticipate a bystander would come across a person considering self-harm and intervene. The scene and nature of the act rule out any suggestion that this may have been functional or attention-seeking behaviour not intended to be carried through to its inevitable conclusion.

4.6 Thirdly, I take into account that deliberate steps are required to release a safety catch, move a change lever to automatic, cock a rifle, turn it towards oneself and position the rifle on the forehead and pull the trigger. It follows that such intentional actions are wholly inconsistent with the discharge of the rifle being an 'accident' given the control Geoff would have had to exert over the weapon to achieve what he did.

4.7 Fourthly, the nature of the fatal act itself can say something about the intent and expectation of the actor. Although still a relatively inexperienced trainee, Geoff would have been well aware of the capabilities of an SA80 rifle. He would have been in no doubt that the overwhelmingly likely outcome of even one shot directed at the forehead would be death. That the change lever of the rifle was set on automatic, and would have had to have been purposefully moved to fire more than one shot, I consider was an attempt to put the fatal outcome of pulling the trigger beyond doubt.

4.8 I have taken into account the absence of any final letters from Geoff or any explicit statement that he had a wish to die. None of the factors I have taken into account above could on their own be determinative of suicidal intent, but considered cumulatively, they do, logically, point to the conclusion that Geoff intended to inflict what he knew would be fatal shots. It follows that I conclude that at the moment he pulled the trigger, Geoff had the specific intention to end his life.

4.9 I have reached that conclusion without taking into account Professor Appleby's opinion that the evidence is consistent with suicidal intent. He placed weight on some of the matters upon which I have relied and so I have been astute to avoid the 'double counting' that would arise if I did so.

4.10 I have also arrived at my finding that, on the balance of probabilities, Geoff intended to die, without placing any reliance on the remark about shooting oneself which he had made to Pte Blackburn.

4.11 As Professor Appleby observed, although the remark made to Pte Blackburn was spoken in apparent jest, it was also consistent with suicidal ideation. The remark does, however, add weight to my finding of intent, arrived at on other grounds. It suggests that Geoff had death by means of shooting within his contemplation earlier that evening: both the act, and its likely consequences. When considered in addition to all the other evidence, the relevance of the remark to Pte Blackburn leads me to be satisfied so that I am sure that when Geoff administered the shots himself he intended to end his life.

5. Conclusion

5.1 Given my findings as to Geoff's deliberate act and the intended consequence, the only short form conclusion I can arrive at is that Geoff's death was a suicide. I shall record this as my conclusion in box 4 of the Record of Inquest.

5.2 My task as Coroner is to determine how Geoff died and not why. I have not sought to explain why he fired the rifle that evening. The fact that this may be unknown or unknowable does not alter my factual findings. I have, however, considered whether a conclusion of suicide must nonetheless be incorrect or unsafe because of the absence of identified reason or motive or evidence that Geoff was obviously "suicidal".

5.3 The evidence of Professor Appleby was that there are significant numbers of recorded cases where young people have intentionally killed themselves in the absence of mental health difficulties, with minimal warning signs and without any prior indication of any tendency to self-harm let alone to kill themselves.

5.4 I have not gone so far as to take the view that these 'out of the blue' apparently inexplicable suicides are prevalent. Rather, I accept that regrettably they can occur. The fact that an individual appeared happy and apparently looking forward to his future career cannot rule out suicide, just as an earlier expression of suicidal ideation does not, on its own, establish suicide intent.

6. Other matters and reports to prevent future deaths

6.1 The Chief Coroner's Guidance on conclusions urges that "wherever possible", Coroners should conclude with a short-form conclusion, because this has the advantage of being simple, accessible for bereaved families and the public, and clear for statistical purposes.

6.2 However, it appears to me that satisfaction of the procedural obligations of Article 2 ECHR requires more than a single word short form conclusion to this inquest. The evidence examined has touched on the wider circumstances of Geoff's death and, although I am not obliged to come to a finding about every matter explored, there are some key issues regarding the background circumstances of Geoff's death which I have drawn out of the evidence that I have heard.

6.3 In doing so I keep in mind my powers to make a report where I think action might be warranted to prevent future deaths.[5]

7. Trainees and armed guard duty

7.1 As Professor Appleby explained, there is clear evidence that a significant proportion of suicides amongst young people occur without any warning. The rapid onset of mood change at what might appear to others to be trivial issues or slights can put a young person into a suicidally-destructive state of mind. This presents an extremely serious risk if that person then has ready access to lethal means.

7.2 Guard duty at Deepcut meant easy and unsupervised access to a lethal weapon. Clearly the availability of a weapon capable of administering high velocity rounds and the opportunity to shoot oneself when alone provided the opportunity for Geoff's death.

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[5] Coroners have a duty not just to decide how somebody came by their death but also, where appropriate, to report about that death with a view to preventing future deaths. The duty is found in paragraph 7, Schedule 5, of the CJA 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013. For short they are referred to as PFD reports or Regulation 28 reports.

7.3 Given that Geoff's state of mind may only have been transient, had Geoff not been on guard duty that night with access to a firearm together with the opportunity to use it out of the sight of others, he might well have never taken his own life. Whatever the reason for Geoff's actions, his case seems very far from those where an individual with a mental illness or in a persistently despondent state of mind is so bent on self-destruction that deprivation of one particular opportunity to kill oneself will only lead to the adoption of an alternative means.

7.4 Yet despite the sad history of the Princess Royal Barracks being that two young trainees had already used the opportunity presented by unsupervised armed guard duty to turn an SA80 on themselves and take their lives, Phase 2 trainees were still doing unsupervised guard duty six years later. The army's increasing attention to suicide risk and prevention had not yet translated into action to eliminate guard duty by Phase 2 trainees in certain prescribed cases.

7.5 The MOD now accepts that greater attention should have been paid to the self-harm risks of young trainees carrying out guard duty.

7.6 The MOD had failed to learn from the deaths of Sean Benton and Cheryl James and failed to heed the prescient warning within a report produced in December 1995. Following the deaths of Sean Benton and Cheryl James, Brigadier Paul Evans, who was Commander of the RLC training group, reviewed the Phase 2 training system at Princess Royal Barracks and made an external recommendation that resources other than Phase 2 soldiers should be for guarding such as the Ministry of Defence Guard Service (a civilian unarmed guard). That recommendation had only been implemented on a very limited basis at the barracks' main gate by 2001.[6]

7.7 By 2001 the MOD had still not taken action to avoid the need for Phase 2 trainees to perform guard duty. Brigadier Coles told this inquest that the issue was not strictly within the training organisations' remit to resolve and, in any event, an appeal for resources was always going to be flying in the face of army policy. I acknowledge that in respect of those in chain of command of 25 Trg Sp Regt (up to and including Lt Col Laden as the Commanding Officer) the continuing requirement to use trainees to do guard was beyond the control of the unit.

7.8 Phase 2 trainees would have been trained in the skill of how to make a weapon work, but would have had little or no experience as to when to use one. As well as guard duty often being a demoralising experience in itself, on any view, guard duty in the middle of the night at an isolated location could be a deeply unsettling and lonely experience for young

[6] The Military Provost Guard Service ('MPGS') were deployed at Deepcut in March 2001, but this was not in sizeable numbers and they were not used on locations other than the main camp entrance gate until after the implementation of the recommendation in the Deepcut Investigation Deputy Adjutant General's final report in 2002.

inexperienced trainees. It should also be borne in mind the extent of the responsibility that was being placed on the young and inexperienced when, regrettably, a terrorist attack had become something which had to be regarded as a possibility.

7.9 It is deeply disappointing to discover that the MOD was so slow to recognise the risks of Phase 2 trainees being required to do guard duty, in terms of exposing them to the opportunity to self-harm whilst alone and isolated with a lethal weapon. There was a failure to appreciate that whatever new welfare measures were being introduced, on occasions it will not be foreseeable that a particular young trainee is at risk.

7.10 Furthermore, it is important to acknowledge that the risks emanating from a lack of supervision whilst on armed guard cannot be eliminated by standing orders or rules in that young trainees left to their own devices may, as in Geoff's case, break rules such as the prohibition on lone prowler patrol.

7.11 No Phase 2 trainee should have been on unsupervised armed guard duty in 2001.

7.12 There is no evidence to suggest that full consideration was given, by senior policy makers in the army to the risk of self-harm posed by granting trainees unsupervised access to firearms before the military investigation which led to the production of the Deepcut Investigation Deputy Adjutant General's final report in December 2002.[7] That report warned that "generally the risks increase with the frequency with which someone who is inclined to take their own life by predisposition and stimulation is presented with both the means and scope for opportunity. In this respect the investigation found that the frequency, size and limited supervision of guards at Deepcut created these circumstances." It recommended that the routine security and guarding of the Deepcut site should be taken over by the Military Provost Guard Service (MPGS)[8] as soon as reasonably practicable. It is disappointing that it appears to have required the deaths of both Geoff Gray and James Collinson whilst on guard duty before proper and full consideration was given to the risks of armed guard duty.

7.13 The problem has now been addressed.[9] In Geoff's case, it was too late.

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[7] A review designed to support Surrey Police's investigation in 2002.

[8] Typically made up of personnel who have previously served in the Armed Forces, the MPGS was first formed on a trial basis in 1997 and made permanent in 1999.

[9] Army policy today is that soldiers under 18 must never undertake armed guard duty and the MPGS is to be used for armed guarding at all Phase 1 and Phase 2 training establishments. Should a security state require an increase in guarding, Phase 2 trainees can only provide guard if they are supervised and have been assessed by the Commanding Officer as being suitable and prepared for armed guard duty. At the Defence Logistic School, policy is even more restrictive and no Phase 2 trainees may undertake armed guard at Deepcut. The MPGS eventually took over all guarding duties from trainees and also the guard commander responsibilities. This was a phased process and was well under way by the end of 2005 /early 2006. I understand that it is thought by the current Chain of Command that no trainees at Deepcut have conducted guard duty since 2009.

7.14 Today in army training establishments, it is only possible for trainees to conduct armed guard duty in very prescribed circumstances. I have been assured by Brigadier Coles that it would only occur in truly exceptional circumstances, and even then, the trainee guard would not be guarding alone or just with their peers, but would have to be supervised by a junior NCO.

8. Reporting of comments about self-harm

8.1 No criticism can properly be levelled at Pte Blackburn for not immediately reporting the remark that Geoff had made to him only hours before Geoff's death. He had no reason to appreciate that Geoff was being serious and as a fellow young private it is not surprising he treated it as a flippant remark. However, Geoff's death does emphasise the potential need for increased awareness when reference is made to self-harm, even if it appears to have been made in jest.

8.2 Professor Appleby suggested that to aid suicide prevention, soldiers might be instructed to report even apparently flippant comments about fatal self-harm, which would allow senior army personnel to take steps to intervene, (including by preventing access to weapons).

8.3 This may not always be realistic and I accept there may be an element of judgement as to what constitutes an untoward comment that should lead to removing somebody from duty. As Brigadier Coles put it "there are some aspects of life and the requirements of the army that mean to react to every single instance without considering nuance and simply removing somebody from duty would be untenable."

8.4 Nevertheless, Brigadier Coles agreed that soldiers and officers should be alert to potentially concerning remarks by others and not gloss over them, particularly in context of exposure to dangerous activity. He saw this as part of every soldier's responsibility to their colleagues. Whilst he did not support any mandatory removal from weapons in response to all comments that allude to self-harm, he agreed that reporting is to be encouraged so that someone better experienced can make the assessment of whether or not action may need to be taken. In my view, that vigilance for the fellow soldier will best be achieved by promoting a culture where mental health difficulties, stress and psychological distress are recognised as issues that can touch anyone and so are not stigmatised.

8.5 The army now has a far more co-ordinated and professional approach to welfare issues with a range of support mechanisms. For instance, there is a relatively new initiative called OPSMART designed to optimise human performance through mental health and resilience training. This encourages trainees to ask for help and flag difficulties to an understanding audience that accepts this is the best approach to build their mental resilience assisting trainees as to how to resolve any issues.

8.6 Much is now being done to educate the wider army about vulnerability risk management. Vulnerability and risk management policy (VRM), a preventative strategy that aims to reduce the annual suicide rate, is now formally embedded in the army. Additionally a key part of the army's programme is its current partnership with the Samaritans, focusing upon suicide prevention.

8.7 I have considered the 2018 Ofsted report on the 25 Regt RLC dated as recently as 18 November 2018 which gave a favourable report on the welfare staff and the quality of welfare and duty of care. Soldiers and trainees have access to two telephone support lines. I have been impressed to learn that there is a wide array of material in respect of mental well-being and welfare in the form of posters, leaflets and flyers. It is displayed throughout units and given to trainees and is accessible through the defence Intranet. The material is designed to help de-stigmatise mental health issues and to encourage those who are suffering to seek help from the many sources available both within the army and externally.

8.8 It is made very clear to trainees when they join the army that they have a responsibility to look after each other. Every trainee is briefed in these terms as part of their induction and throughout their training. Soldiers are now encouraged to report such comments as well as unexpected behaviours.

8.9 Whilst there is still work to do, and the army should not be complacent, I accept that progress has been made in removing the stigma that might have attached in the past to those who sought help from welfare. The army is already striving to change the culture and to encourage troubled soldiers to seek help.

9. Welfare support of soldiers after a traumatic event

9.1 There is no doubt that the trauma of Geoff's death and the finding of the body profoundly affected a number of soldiers. It is of concern that Pte Liggins, one of the search party who found Geoff's body, was scheduled to undertake guard duty the next night and would have done so had not his father intervened on his behalf. There is clear evidence that those who were present when Geoff's body was first found all suffered from the trauma that night and may well have benefited from counselling which was not offered to them. This might have helped to eliminate or reduce the long-term trauma that some of these soldiers have suffered.

9.2 I am satisfied that this failure has now been properly addressed in that the army have now adopted Trauma Risk Management ("TRiM") which can be deployed where a soldier is exposed to a traumatic incident. The system pioneered by the Royal Marines was formally adopted by the army in 2007. It involves structured risk assessments by TRiM-trained personnel of those exposed to the event, identifying whether individuals might benefit from additional support.

9.3 Another matter of significant welfare concern is that the inadequate clearance of the scene once released by the investigators led to blood/body tissue remaining in situ and in sight of guards on subsequent duties. I am told that since the heightened awareness that civilian police should retain primacy for the investigation of such a death (including forensic aspects at the scene), it is less likely that the scene would be left uncleared or that (as occurred in Sean Benton's case) MOD personnel would now be called upon to be involved in the distressing task of the removal of blood or body tissue from the scene. If the Civilian Police Force did not task a civilian company to clean up the scene, the relevant Quartermaster responsible for the MOD Land/Premises could employ a civilian company or seek to dispose of any hazardous materials.

10. The poor NCO/Private supervisory ratio within 25 Trg Sp Regt

10.1 As I have already indicated, the MOD accepts that by the time of Geoff's death it failed to remedy or even alleviate the poor instructor/trainee ratio at Deepcut.[10] That would have impacted upon:

(i) what the chain of command could achieve in terms of the regime for those on SATT;
(ii) the ability to maintain appropriate disciplinary standards;
(iii) maintenance of morale with purposeful and constructive activities; and
(iv) the ability to develop good working relationships and build awareness and cohesion which are regarded as important to Unit welfare.

10.2 Furthermore, although it would not have made any difference in Geoff's case, the low supervisory ratio of permanent staff to trainees meant that welfare problems may often have gone unnoticed. There is no suggestion that this admitted failure in any way contributed to Geoff's death. There was nothing in his conduct to suggest that Geoff presented with any welfare concerns that ought to have been detected and addressed by the Chain of Command. I stress Geoff was not bullied or ill-treated at Deepcut and it is clear that bullying did not play any part in Geoff's death.

11. The circumstances in which Geoff came by his death

11.1 In view of my findings above and in accordance with my duty under s.5(2) Coroners and Justice Act 2009 to record the circumstances in which Geoff Gray came by his death I shall record the following in box 3 of the Record of Inquest:

At approximately 01.10 hours on 17 September 2001 in the grounds of the Officers' Mess of the Princess Royal Barracks, Deepcut, Surrey, Private Geoff Gray shot himself with a SA80 rifle that was set to automatic, causing two wounds to the head. He died rapidly at the place where his body was found. No third party was involved in the shooting. At the

[10] There is now a mandatory minimum supervisory ratio of 1 to 30 for daytime working and 1 to 16 for physical training.

time Geoff fired the shots he intended to take his own life, although that state of mind may have only been transient.

Geoff's actions could not reasonably have been anticipated at the time. He did not suffer with any known psychological difficulties nor had he been the recipient of any ill treatment. Any concerns Geoff may have had did not relate to the camp regime. However the army had failed adequately to address the risk of self-harm that might arise in respect of young and inexperienced trainees performing guard duty with unsupervised access to firearms. Proposals that trainees should not provide the Barracks' guard, but be replaced with a professional guard force had not yet been acted upon.

Whilst it was entirely Geoff's decision to take his own life, the above failures provided Geoff with an opportunity to go to an isolated location with a firearm where he could act as he did.

12. Deepcut in 2001 as compared with Deepcut in 1995

12.1 Having addressed the failures, for the sake of achieving balance I should record this. I have had the advantage of hearing evidence in respect of Deepcut in 1995 during Sean Benton's inquest. It is right that I should make observation that in some areas such as the provision of welfare measures and administration of discipline there was evidence before me of significant improvement during the 6 years that followed the death of Sean Benton.

12.2 I shall not detail all of those changes here, but I direct that the statement which Brigadier Coles provided to this inquest dated 17 April 2019 which sets out the changes the Army has made, and continues to make in the relevant areas is made publicly available.

12.3 I also note that major changes are now underway at Princess Royal Barracks: 25 Trg Regt RLC there now consists of its Regimental Headquarters and 109 Sqn only. In July 2019, they will move to the Defence School of Transport in Leconfield, in the East Riding of Yorkshire. It is likely that there will not be any Phase 2 trainees at Deepcut beyond this summer.

12.4 Brigadier Coles told me that, as a consequence of the four deaths at Deepcut, the army has completely reviewed how it trains and supports the young men and women joining the army.

12.5 In the light of the changes in structure, culture and practice since Geoff's death, the evidence at this inquest has not revealed to me any area where it appears that the army either have not already taken action or are not cognisant of and already pursuing the relevant action to prevent future deaths. In those circumstances I shall not be directing any report under Regulation 28 to the army or the MOD.

13. The nature of the post-mortem after firearms deaths

13.1 There is however one area where the evidence I have heard gives rise to a concern that circumstances creating a risk of other deaths will occur and I consider action should be taken to prevent the occurrence of such circumstances. I shall be making a report about this matter.

13.2 The deaths in 1995 of Sean Benton and Cheryl James were both investigated with 'routine' coronial post-mortems. I am told that extremely few photographs were taken at the post-mortem in the case of Cheryl James. In Sean Benton's case, the post-mortem was carried out by a general histopathologist who had no experience of performing an autopsy after a death from high-velocity gunshot wounds, and no photographs were taken.[11]

13.3 In Geoff's case, by chance, the 'routine' coronial post-mortem was performed by an experienced forensic pathologist, but he was told that the death was not suspicious and was not directed to carry out a forensic post-mortem by the Coroner. The question of what to do with Geoff's clothing was not referred back to the Coroner by the Coroner's Officer, and it was destroyed the next day, almost by default, when the police did not ask for it to be kept and the army did not wish for its return. Dr Chapman told me that generally photographs and x-rays would not be taken at a routine post-mortem and that he would never do so. He said the examination would have been one of many in a session and so would not be very lengthy.

13.4 As Professor Crane put it, "shooting cases are not routine". In his view, a pathologist should avoid making assumptions before the examination is commenced. He recommended the attendance of a police officer at every post-mortem following a shooting (as he tells me is the standard practice in Northern Ireland) who can properly inform the pathologist about the background to the case and the investigative findings to date.

13.5 I have considered the evidence of Professor Crane regarding the investigative inadequacies caused by the absence of a forensic post-mortem. I heard from him and from Dr Chapman that there remains no specific guidance to either pathologists or, as I understand it, to coroners, that urges them to give particular consideration to the nature

[11] I concluded the inquest into the death of Sean Benton in July 2018. The two expert Forensic Pathologists, Dr Nat Cary and Professor Crane, produced a joint report in which they agreed that much potentially useful evidence had been lost due to *inter alia* (i) the absence of post-mortem photographs and (ii) the lack of adequate post-mortem description in relation to both the external and internal features of the gunshot wounds.

of the post-mortem examination in cases of death by firearms, even when that death is of a child. [12, 13]

13.6 I do not suggest that a full forensic post-mortem examination should be mandatory in every case of death from gunshot wounds, even though Professor Crane indicated to me that every firearms death will be subject to a forensic post-mortem in Northern Ireland. However it is of concern that where assumptions of suicide lead to cursory post-mortem investigations, this creates a risk that homicides will go undetected.

13.7 The use of a forensic post-mortem, or at very least something more than a basic 'routine' examination, in all cases of sudden death by gunshot may, by enhancing the quality of investigations and ensuring that assumptions of suicide are properly tested, reduce that risk. The higher the likelihood that homicides will be distinguished from self-inflicted deaths, the greater the deterrence to those who might have reason to try to make a murder look like a suicide.

13.8 I therefore intend to issue a report under Regulation 28 to the Chief Coroner and to the Royal College of Pathologists, so that each might consider the issues raised by Geoff's case and consider whether there is a need for any amendments to their current guidance to suggest that in cases of death from gunshot wounds, even where initial evidential inquiries point towards self-infliction, fuller consideration should be given to the nature of the post-mortem examination to be carried out.

13.9 Where the circumstances are deemed not to require the extremely invasive and costly procedure of a forensic autopsy, consideration might nevertheless be given to whether a 'routine' coronial autopsy should be enhanced by (i) photography, (ii) x-ray or CT imaging, (iii) the clear recording of the presence or absence of projectiles, (iv) drawing body maps (v) the identification of likely wound tracks, (vi) hand swabbing, (vii) recording of any damage to clothing and (viii) the preservation of clothing for potential chemographic analysis by others. If such steps are not taken at the outset because of early assumptions regarding suicide it increases the risks of relevant information being lost and homicides going undetected.

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[12] I note that the Royal College of Pathologists' "*Standards for Coroners' pathologists in post-mortem examinations of deaths that appear not to be suspicious*" (in force from February 2014 and due for review in 2017) make the generic statement that "consideration should be given to what issues – pathological or other – are raised by the circumstances of death and how these issues are best addressed. Where these issues require the use of other investigations, such as radiology or the retention of human material, there must be discussion with the Coroner to seek agreement." However there is no specific guidance in respect of firearms deaths.

[13] The Chief Coroner's Guidance No.1 on '*The use of post mortem imaging (adults)*' (January 2016), which is aimed at setting minimum standards where CT imaging is used, states that "Where an examination of the body is required, the coroner must decide in each case with the assistance of a pathologist (and where appropriate a radiologist) what type of examination is appropriate."

SECTION 10: CLOSING REMARKS

1. I would like to acknowledge the enormous assistance that I have received from those who have worked with me on this inquest.

2. A long inquest such as this can be difficult to accommodate at a busy Coroner's court. I am deeply grateful to both Richard Travers, the Senior Coroner for Surrey, and Simon Wickens, the Area Coroner, for giving us the time, accommodation and assistance so that the inquest could start at the end of February this year. We have all had a high level of support from the court staff including a dedicated team of ushers. The service provided by the Epiq transcribing team has been impeccable, even when we have had to sit long days.

3. Each legal team has sought to provide me with assistance to help me navigate through the evidence and resolve the issues in this case and I want to place on record my gratitude to all legal teams including my own Ms Bridget Dolan QC and Mr Jamie Mathieson. My Coroner's Officer, Mary Coller, has carried out her duties with enormous efficiency. With the help of Ms Tominey and her colleagues at the Defence Inquests Unit, she traced every witness, which is an extraordinary achievement in a case dealing with events that took place over 17 years ago. Ms Coller has played a vital role in ensuring that these proceedings have run smoothly.

4. Whatever the shortcomings of the original investigation, I wish to pay tribute to Surrey Police for the thorough nature of their subsequent investigations. I also wish to acknowledge the massive disclosure exercise undertaken by the MOD. I found nothing to suggest anything less than full, scrupulous and proper disclosure.

5. I must not forget the witnesses themselves. Some of them found these proceedings very distressing. I want to recognise their courage in coming and giving evidence. I appreciate the appropriate adaptations made by all the lawyers with my encouragement to minimise the stress they inevitably felt when in the witness box.

6. I come to the greatest of all, the ordeal undergone by Geoff's parents.

7. Any parent would expect at the very least a full and detailed exploration of how their son came to die. Mr and Mrs Gray are totally justified in feeling that the initial investigations of Geoff's death were far from satisfactory. It should not be forgotten by any of us that although Geoff Gray was a soldier he was also still a child. Were he to have died today his death would at very least have required a joint-agency response including a multi-professional Child Death Review meeting with close involvement of his parents in the process, and with support offered to them from the outset.[1]

[1] See Children Act 2004 s.16M and the related child death review guidance at https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/777955/Child_death_review_statutory_and_operational_guidance_England.pdf

8. Unfortunately the investigation at the time was cursory and with a closed mind. Mr and Mrs Gray should not have been put in this position. They were correct to pursue a fresh investigation and inquest.

9. A lesson from Geoff's death is the danger of early assumptions and fixed mind-set seriously prejudicing the quality of an investigation. The poor quality early investigation has led to the necessity of further protracted investigations in an endeavour to make up for those early deficiencies. By the time this inquest commenced, memories had become impoverished and it became necessary to examine matters in great detail in the attempt to discover what had occurred.

10. Better collection of forensic evidence, such as examination of Geoff's clothing, could have saved or at least reduced the ordeal of the last 17½ years for Mr and Mrs Gray. If the investigation had been conducted properly at the time, there would have been no need for this second inquest which has taken 30 days.

11. It is quite clear that Geoff was a fine young man with huge potential. No one in this court could not have been impressed by the high regard in which Geoff was held by his peers and anyone else who encountered him. It is a testament to him that the admitted shortcomings of the regime at Deepcut Barracks did not impact upon him save in one critical respect.

12. The army failed Geoff in that unsupervised trainees should not have been on armed guard duty at all, let alone at such a tense time just a few days after 9/11.

13. Geoff's legacy includes a major contribution to the re-evaluation by the army of the use of trainees as armed guards with a growing appreciation that the risks of self-harm are such that even where there are no warning signs, the risks of requiring the young and inexperienced to perform unsupervised armed guard duty are unacceptably high.

HH PETER ROOK QC

ASSISTANT CORONER FOR SURREY

20 JUNE 2019

Record of an Inquest

Following the Inquest heard before His Honour Peter Rook QC, Assistant Coroner, sitting at HM Coroner's Court, Surrey and concluded on 20 June 2019, the following statutory determinations and findings were made:

1. Name of Deceased: **Geoff Gray**

2. Medical cause of death: **Gunshot wounds to the head**

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 or her death:

At approximately 01.10 hours on 17 September 2001 in the grounds of the Officers' Mess of the Princess Royal Barracks, Deepcut, Surrey, Private Geoff Gray shot himself with a SA80 rifle that was set to automatic, causing two wounds to the head. He died rapidly at the place where his body was found. No third party was involved in the shooting. At the time Geoff fired the shots he intended to take his own life, although that state of mind may have only been transient.

Geoff's actions could not reasonably have been anticipated at the time. He did not suffer with any known psychological difficulties nor had he been the recipient of any ill treatment. Any concerns Geoff may have had did not relate to the camp regime. However the army had failed adequately to address the risk of self-harm that might arise in respect of young and inexperienced trainees performing guard duty with unsupervised access to firearms. Proposals that trainees should not provide the Barracks' guard, but be replaced with a professional guard force had not yet been acted upon.

Whilst it was entirely Geoff's decision to take his own life, the above failures provided Geoff with an opportunity to go to an isolated location with a firearm where he could act as he did.

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	**28 January 1984, Sunderland**
(b)	Name and surname of deceased	**Geoff Gray**
(c)	Sex	**Male**
(d)	Maiden surname	**n/a**
(e)	Date and place of death	**17 September 2001 at Princess Royal Barracks, Deepcut, Surrey.**
(f)	Occupation and usual address	**Occupation: Phase 2 Trainee Soldier (Private) in the Royal Logistic Corps.**

Signature of Coroner	**20 June 2019**

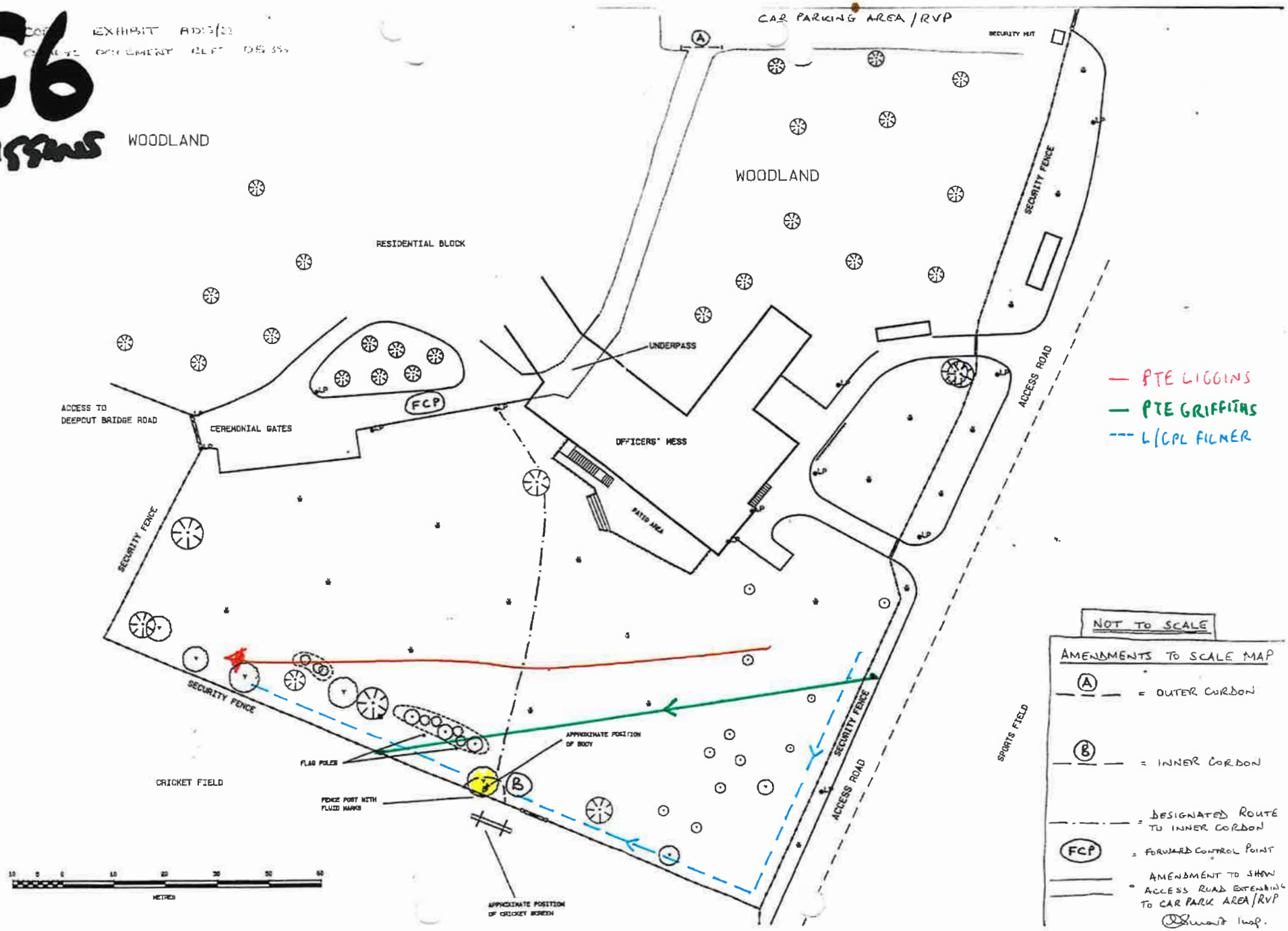
Geoff Gray Inquest
Scope:

1. The mechanism of death;
2. When and where the death occurred;
3. The events during the evening guard duty of 17 September 2001;
4. Who fired any shots on 17 September 2001 and whether any third party action was involved in the death;
5. The search for Geoff on 17 September 2001 and whether or not Geoff's body was moved after his death;
6. Geoff's state of mind on 17 September 2001;
7. Whether any systemic shortcoming in the following areas caused or contributed to the death;
    a. policies and systems in place at Deepcut Barracks in respect of guard duty and the provision of weapons to trainees. To include consideration of any relevant recent history of incursions into the barracks and incidents during guard duty.
    b. policies and systems in place at Deepcut Barracks in respect of supervision and welfare support of trainees.
8. The extent to which any inadequacies in earlier investigations has impacted upon the nature and quality of the information available in 2019.

C6

EXHIBIT AD5/23

PTE LIGGINS



REGULATION 28: REPORT TO PREVENT FUTURE DEATHS FOLLOWING THE INQUEST INTO THE DEATH OF PRIVATE GEOFF GRAY

	THIS REPORT IS BEING SENT TO: **1. The Chief Coroner of England and Wales** **2. The President of the Royal College of Pathologists**
1	**CORONER** I am HH Peter Rook QC, an assistant coroner for the coroner area of Surrey
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 26 February 2019 I commenced an inquest into the death of Pte Geoff GRAY. The investigation concluded at the end of the inquest on 20 June 2019 The conclusion of the inquest was that Geoff Gray's death was by suicide.
4	**CIRCUMSTANCES OF THE DEATH** At approximately 01.10 hours on 17 September 2001 in the grounds of the Officers' Mess of the Princess Royal Barracks, Deepcut, Surrey, Private Geoff Gray was found shot. Beside him was a SA80 rifle that was set to automatic, he had two fatal wounds to the head. Geoff was 17½ years old. At the very outset the assumption was made by attending civilian and military police and by the coroner's officer that this death was a suicide. A 'routine' coronial post-mortem was requested and was performed on the day of Geoff's death. The examining pathologist was told the death was not-suspicious and was not directed by the coroner to carry out a forensic post-mortem. The examination was therefore one of several bodies examined in that session. There were no investigating police officers present who could give further information to the pathologist if required (albeit for training purposes two members of the RMP had attended). In the course of the post-mortem examination: no photographs were taken; there were no x-rays or other imaging undertaken; a body map was not drawn; there was no attempt to reconstruct the skull or track the bullets; there was no attempt to match entry wounds to the relevant item of clothing (a beret). The deceased's clothes were sent for destruction the next day rather than retained for chemographic analysis.

	The examining pathologist, who was a forensic pathologist, told me that generally photographs and x-rays would not be taken at a routine post mortem and that he would never do so. Other investigative inadequacies in the investigation of Geoff Gray's death were added to by the absence of either a forensic post-mortem, or at least additional steps being taken within a 'routine' coronial post-mortem and the retention of Geoff's clothes. Two earlier deaths of young trainees from gunshot wounds at the same barracks in 1995 (Private Sean Benton and Ms Cheryl James), were also both investigated with 'routine' coronial post-mortems. In Sean Benton's case I have earlier heard the fresh inquest into his death, which concluded in July 2018. His post-mortem was carried out by a general histopathologist, who had no experience of performing an autopsy after a death from high velocity gunshot wounds. At the inquest into the death of Sean Benton two expert Forensic Pathologists, Dr Nat Cary and Professor Crane produced a joint report in which they agreed that much potentially useful evidence had been lost due to *inter alia* the absence of post-mortem photographs and the lack of adequate post-mortem description in relation to both the external and internal features of the gunshot wounds.
5	**<u>CORONER'S CONCERNS</u>** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – 1. I instructed Professor Jack Crane as an independent expert in forensic pathology. He told me that the practice in Northern Ireland is that every firearms death, whatever the circumstances, will be subject to a forensic post-mortem. 2. Both Professor Crane and Dr Robert Chapman, the forensic pathologist who conducted the post-mortem told me that that there is no specific guidance to either pathologists, and as I understand it to coroners, that urges them to give particular consideration to the nature of the post-mortem examination in cases of death by firearms, even when that death is of a child. 3. It is of concern that where assumptions of suicide lead to cursory post-mortem investigations this creates a risk that homicides will go undetected. The higher the possibility that homicides will be distinguished from self-inflicted deaths, the greater the deterrence to those who might have reason to try to make a murder look like a suicide.

	4. The use of a forensic post-mortem, or at very least something more than a basic 'routine' examination in all cases of sudden death by gunshot may, by enhancing the quality of investigations and ensuring that assumptions of suicide are properly tested, reduce that risk.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action. 1. I consider that the Chief Coroner and the Royal College of Pathologists, should review the issues raised by Geoff Gray's case and those of the other deaths of trainees at Princess Royal Barracks and consider whether there is a need for any amendments to their current guidance to suggest that in cases of death from gunshot wounds, even should the initial evidential inquiries point towards self-infliction, fuller consideration should be given to the nature of the post-mortem examination to be carried out. 2. Where the circumstances are deemed not to require the extremely invasive and costly procedure of a forensic autopsy, consideration might nevertheless be given to whether a 'routine' coronial autopsy should be enhanced by (i) photography, (ii) x-ray or CT imaging, (iii) the clear recording of the presence or absence of projectiles (iv) drawing body maps (v) the identification of likely wound tracks, (vi) hand swabbing; (vii) recording of any damage to clothing and (vii) the preservation of clothing for potential chemographic analysis by others. 3. If such steps are not taken at the very outset of investigations because of early assumptions regarding suicide it increases the risks of relevant information being lost and potential homicides going undetected.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 16 August 2019. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.

8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: Mr and Mrs Gray, the Ministry of Defence, the Chief Constable of Surrey Police, and Lt Col Laden. I have also sent it to the Local Safeguarding Board (as the deceased was under 18), and to Professor Jack Crane, Dr Robert Chapman, Dr Nathaniel Cary, Mr and Mrs James (via Liberty), Ms Lewis and Mr Benton (via Liberty) who may find it useful or of interest. I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**HH Peter Rook QC** **20 June 2019**