

HIS HONOUR BRIAN BARKER CBE QC

SITTING AS NOMINATED CORONER IN SURREY CORONER'S COURT

INQUEST INTO THE DEATH OF CHERYL JAMES



FACTUAL FINDINGS

3 June 2016

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PART 1: APPROACH TO THE CONCLUSIONS

1. Introduction

- 1.1. I begin by recognising the patience and loving fortitude of Mr and Mrs James. They have waited far too long for a proper examination of the circumstances of their daughter's death and it is clear to all that they have devoted immense energy and emotion to achieving that end.
- 1.2. I acknowledge and underline the dignity Mr James (and Mrs James when she has been able to be present) displayed on each and every day of this hearing; and I respect the deep and proper desire of the family for a fair and thorough evaluation of all matters relevant to the terms of the Inquest, conducted with an open mind.
- 1.3. As I recount my findings of fact and explain my conclusions, at her parents' request, I refer to Cheryl James throughout as 'Ms James'. For the sake of clarity, I also refer to all military personnel mentioned in these findings by the rank they held in 1995. The Princess Royal Barracks at Deepcut in Surrey will be referred to by the common shortcut of 'Deepcut'.

2. The Inquest

- 2.1. This Inquest has heard the evidence of 109 witnesses over thirty days of sittings; 77 witnesses attended, in person or via video-conferencing. Those witnesses have been asked to recall what, for many, was an extremely traumatic event they had long wished to put behind them. Most did their best to assist me to understand events now more than twenty years ago, and I am grateful.
- 2.2. In considering the evidence those witnesses of fact provided I have at the forefront of my mind that, due to the passage of time, memories have faded. Some inconsistencies in honestly reported recollections are to be expected in any case and this is exaggerated where witnesses have to look back so far into their memory. In many instances, witnesses gave either no, or no significant, contemporaneous account before they were first interviewed by Surrey Police some 7-8 years after the events. By that time their memories had already deteriorated. Unsurprisingly, after twenty years, even some of those who made a contemporaneous statement in 1995 could remember no more than its contents. A few witnesses' evidence bore the hallmarks of (often innocent) contamination

following exposure to the various media, which have reported, often sensationally, on Ms James' story.

- 2.3. It is highly regrettable that the investigation of Ms James's death in 1995 was not more thorough, and the scene of her death not more fully and scientifically assessed. Had it been, some of the inconsistencies of memory might have been avoided and importantly the scientific evidence might have been of much better quality. The eight scientists from different disciplines from whom I heard all had to form an expert opinion on the basis of incomplete information.
- 2.4. Surrey Police has recognised and apologised for its error in failing to take primacy over the 1995 investigation. It is however also important to note that much of the evidence I have heard became available because of the efforts of Surrey Police during their 15 month investigation in 2002/2003. That investigation collected over 600 statements and thousands of documents, the large proportion of the information available.
- 2.5. Even with that large volume of evidence and following detailed examination of witnesses, much of the available evidence is incomplete. As those acting for Mr and Mrs James remind me the dangers of speculation are legion, and must be resisted. One should not be tempted to fill in gaps in the evidence where, as here, after twenty years, faded memories and/or reluctant witnesses mean the missing parts of the jigsaw are just that: missing.

3. Article 2 procedural obligation

- 3.1. The scope of my investigation and inquest has not been constrained by whether Article 2 of the European Convention of Human Rights is engaged. It is not in dispute that the manner in which this inquest has been conducted to date would meet the procedural requirements of Article 2. I have not, as yet, formally determined whether those obligations are engaged in relation to Ms James' death. I must now decide whether s.5(2) Coroners and Justice Act 2009 ('CJA') applies such that the broader circumstances of how Ms James died must be recorded.
- 3.2. The threshold for triggering an Article 2 investigation is whether there is an arguable breach of one of the state's substantive obligations under it. Those obligations are (i) not to take life without justification, and (ii) in certain circumstances to take steps to protect the lives of those within the state's jurisdiction.¹ A substantive breach need not be established, indeed, it is not for

¹ *R (Long) v SOS Defence* [2015] EWCA Civ 770, [2015] Inquest LR at §5

me or any Coroner positively to determine whether there has been a breach of a substantive ECHR right; to do so would infringe s.5(3) and 10(2) CJA 2009.

3.3. Ms James' case does not fit easily into any of the categories of 'automatic' engagement of Article 2 ECHR. First, because there is no meaningful evidence that state agents have intentionally or unintentionally taken Ms James' life. Mr and Mrs James do not argue for the engagement of Article 2 on that basis. Secondly, Ms James does not obviously fall into any of the other categories previously held automatically to engage Article 2 obligations. She was not a prisoner or in state custody, she was a volunteer soldier not a conscript, and she was not under the total control of the state.

3.4. On behalf of Mr and Mrs James I am urged to find an analogy between the position of the young trainee, such as Ms James, and the 'raw recruit' mentioned by Lord Rodger in *R (Smith) v Oxfordshire Assistant Deputy Coroner* [2011] 1 AC 1.

3.5. Lord Rodger suggested the Article 2 investigative obligation might arise where a recruit was:

"very young and away from their families and friends for the first time, may be unable to cope with the stresses of military discipline and training. In these circumstances I would regard such recruits as vulnerable individuals for whom the military authorities have undertaken responsibility. So the authorities must have staff trained, and structures in place, to deal with the potential problems which may, quite predictably, arise". (at §118)

I am urged to recognise a general vulnerability of Phase 2 trainees at Deepcut which could similarly give rise to an automatic requirement to hold an Article 2 compliant investigation.

3.6. However, not only were Lord Rodger's comments *obiter*, but Lord Hope expressly disagreed, pointing out that:

"To extend the substantive article 2 obligation to volunteers while they are undergoing basic or advanced training would go further than has so far been indicated as necessary by Strasbourg".(at §102)

3.7. I am not at first blush persuaded by the submissions on behalf of Mr and Mrs James. Ms James was at her death no longer a 'raw recruit' but a trainee soldier who had been through her initial training and chosen, having turned 18, to continue her army career. However, it is not necessary for me finally to

determine this matter given my positive conclusion in respect of the second limb of the submissions on behalf of Mr and Mrs James on the Article 2 issue.

3.8. Counsel have referred me to *Stojanovi v Bulgaria*² in the European Court of Human Rights. The Strasbourg Court considered an Article 2 procedural obligation did arise in respect of a death of a soldier during a military parachute training exercise. The Court said:

“61... Whenever a State undertakes or organises dangerous activities, or authorises them, it must ensure through a system of rules and through sufficient control that the risk is reduced to a reasonable minimum. If nevertheless damage arises, it will only amount to a breach of the State's positive obligations if it was due to insufficient regulations or insufficient control, but not if the damage was caused through the negligent conduct of an individual or the concatenation of unfortunate events.”

3.9. The facts with which I have been concerned involve the death of a young woman not just on guard duty but on lone guard duty undertaken by an unsupervised young trainee whom the state provided with a weapon and live ammunition. It seems to me that lone armed guard duty is a potentially dangerous activity.

3.10. The unchallenged evidence is that that whilst there was in place an army-wide directive requiring that women should not be left alone on guard duty, there was at Deepcut a wholesale lack of awareness of that provision. Ms James would not have been alone with a rifle at her death had the 1994 UK Land Forces ATSM Directive been followed.

3.11. That the relevant Non-Commissioned Officers (NCOs) and Officers, from the Provost staff through to the Commanding Officer, seemed unaware that the Rules for Carriage of Arms prohibited lone female guards suggests this was not an isolated individual failing, nor the concatenation of unfortunate events, but arguably a result of insufficient regulation or control in not having an effective system for recognising and implementing army directives.

3.12. Furthermore, it is at least arguable that the potential risk of the weapon provided to trainees on lone guard being used to harm that trainee, whether by his/her own actions or the actions of others, should have been identified and steps taken to reduce that risk before Ms James' death.

² [2010] ECHR 1782 at §61

3.13. I am therefore persuaded that the state's Article 2 procedural obligations are engaged; the effect of which is that, in accordance with s.5(2) CJA 2009, the circumstances in which Ms James came by her death, as well as the means by which she died, must be considered and, at very least, any causative matters be included in the Record of Inquest.

4. My approach to the Conclusions

4.1. The Chief Coroner has issued Guidance (No. 17) as to how a Coroner might approach conclusions and I have taken that guidance into account.

4.2. What may be entered on the Record of Inquest is governed by s.5 and s.10 CJA 2009 and, in addition to the particulars required for registration, is limited to four factual matters of (i) who the deceased was, (ii) how and in what circumstances she came by her death, (iii) when and (iv) where she died. Section 5(3) CJA 2009 prohibits me from expressing an opinion on any other matter.

4.3. In all types of Inquest there is a discretion to come to a short form conclusion either alone or in addition to, or as part of, a narrative conclusion. Clearly, given the evidence, I must consider the conclusion of suicide. The MOD teams and Surrey Police have submitted that there is sufficient evidence for me to reach this finding. Mr and Mrs James postulate scenarios of accident and of the involvement of another person, but urge me to return a short form 'open' conclusion as the only short form conclusion open to me on the facts.

4.4. No interested person contends that I should be restricted to returning only a traditional short form conclusion. I agree that more is needed and a longer narrative conclusion indicated. A Coroner's conclusion is not restricted to a narrow report on the direct mechanism of death. It is a broader and more flexible exercise that may encompass the circumstances in which the death arose. Matters probably causative of a death (whether in isolation or in combination with others) must form part of the Article 2 narrative.

4.5. I have adopted a three-stage process in accordance with the Chief Coroner's Guidance. First, I have made relevant findings of fact on the evidence, secondly, I have distilled from those findings of fact 'how' Ms James came by her death and third, I have come to my conclusion on the basis of those facts.

4.6. The inquest process has been appropriately visualised as a funnel, wide at the outset but narrowing as the process nears a conclusion. My findings of fact are

not a summing up. They will not cover every aspect of the many weeks of evidence. Indeed, some matters initially deemed within the scope of this inquiry are not now, following their exploration, sufficiently relevant to merit determination. However, as to the key issues at the heart of this sad case, my findings are as follows.

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PART 2: MS JAMES' EARLY LIFE

5. Ms James

- 5.1. Cheryl Marie James was born on October 22 1977 in Deeside and Alyn, Wales. Aged four she was adopted, along with her older brother, by Mrs Doreen and Mr Desmond James, although the children had lived with Mr and Mrs James for some years.
- 5.2. Mr James gave a moving account of Ms James' childhood. She had "character" from an early age and Mr James described how as a child she was a joy. A description echoed by others who knew Ms James was that when she came into the building you knew she was there – when she was at home the whole house came to life. Ms James' bubbly personality was remarked upon by all who knew her.
- 5.3. According to Mr James, Ms James had always known about her adoption: it was an open subject and never an issue. Although one of her teachers, Ms Williams, said she understood that Ms James was "emotional" about the discovery of her adoption, and a close friend, Ms Baksh, suggested Ms James might have been distressed at feeling she was not wanted by her birth mother, the weight of evidence suggests Ms James did not precipitously discover her adoption and that it was not a major issue for her. Whilst her adoption was not something she kept secret from her new acquaintances in the Army, there is nothing to suggest that any thoughts or feelings about it were a particular feature during Ms James' army life.
- 5.4. Mr James recalled how Ms James had no serious trouble at school although if anyone tried to correct her she would giggle, a trait displayed during her time in army training. As she got older however Ms James became "quite a rebel" according to her father. He described how his daughter could never wait for things, although he preferred to describe her behaviour at times as "impatient" rather than impulsive.
- 5.5. Although as an older teenager there were arguments between Ms James and her parents and times when Ms James left the family home to live independently, Mr James felt that he and his wife dealt with no more than many parents of teenagers might. There was clearly a close connection between Ms James and her parents and a rapprochement followed all fallings-out. Ms James seemed to have come through her somewhat turbulent adolescence by the time she started at Yale Sixth Form College in Wrexham in September 1994. It was with her parents'

assistance that she took a flat in Wrexham. At about Christmas 1994 Ms James left sixth-form college and returned to live at home so that by the time she joined the Army in May 1995, aged 17, she had been living at home for some months. After her army career commenced she continued to have a close relationship with both her parents. She would often write or call home and visited them in Wales some weekends, including for her 18th birthday weekend in October 1995. Indeed she had phoned home and spoken to her mother just a few days before she died.

- 5.6. Ms Kirstie Mansfield was a friend of Ms James' from home. She first met Ms James at infant school but they then followed different paths. They met again in September 1994 when both attended college in Wrexham. Ms Mansfield and Ms James spent a lot of time together and Ms Mansfield was invited to the James' home where she was made welcome. She described Ms James as beautiful and giggly with an infectious personality; as a consequence she was very popular with everybody. She was upbeat and they fired off each other. Ms Mansfield recalled Ms James only being in a good mood, they were two young women focused on having a good time. She described Ms James as making decisions impulsively and as someone who would "want it now".
- 5.7. Ms Lydia Baksh was another close friend, particularly from aged about ten to about fourteen, although she saw less of her as an older teenager. Ms Baksh also went to Yale College in Wrexham. Like others, Ms Baksh described Ms James as a happy and bubbly character and said "people loved her". She was free-spirited, shy but cheeky, and would stand up for herself if needed, although Ms Baksh also said she saw a vulnerable side of Ms James and thought that at times Ms James used laughter to cover her pain. Ms Baksh had an impression Ms James felt she was not living up to the expectations of her parents.
- 5.8. About the time of her moving out of home, Ms James confided in Ms Baksh, perhaps twice, that when in the shower she heard voices and was told to do irrational things like turning lights on and off. This was not mentioned by any other witness, and was not something that appeared to be a relevant feature of Ms James' later teenage years. I attach no weight to it as relevant to later matters.
- 5.9. Ms Heather Williams, Ms James' head of year at Llangollen School from years seven to eleven and her home economics teacher, described how Ms James was sometimes a handful, at times moody but this was mixed with sensitivity and potential. Typically of a teenage girl, she made snap decisions and would go off in a huff if told off.

6. Traumatic teenage events

- 6.1. Witnesses from Ms James' home town were not aware of any particularly distressing events in her life until Summer 1992 when Ms James was 14. Around this time Mrs James received a letter saying her daughter had requested to change doctors. She subsequently learnt that Ms James had sought the morning after pill. Some time afterwards her parents discovered that Ms James had been sexually assaulted, apparently by two local boys, although they were not aware of details, or of how it might have affected her. A clinic letter seems to indicate that Ms James had been raped, an account substantiated by her girlfriends.
- 6.2. Ms Baksh recalled becoming aware of what she described as Ms James being raped on the way home after a party. Ms James was distressed, crying and upset. It was Ms Baksh who advised Ms James to seek the morning after pill. Ms Baksh believed the incident really affected Ms James and lowered her sense of self-worth.
- 6.3. Ms James mentioned this event to a female colleague in the Army, Pte Jane Warboys. Whilst clearly an extremely upsetting event not forgotten, there is no evidence that Ms James particularly ruminated upon it in any unusual manner. Nor is there any evidence indicating that the trauma of this rape at age 14 remained something of itself adversely affecting Ms James' state of mind when she died some four years later.
- 6.4. A further major event in Ms James' teenage life was the suicide of her much-loved cousin, Mr James' 18-year-old nephew, on December 12 1992. Mr James described how the grief affected Ms James, as it did all the family. He thought it was about this time that the now 15 year-old Ms James became more rebellious. Her cousin's death clearly had a profound effect on the whole family. Ms James had been particularly close to her cousin and her loss of him to suicide was something that she was to share with friends in the Army three years later.
- 6.5. Ms James was affected by her cousin's death, and discussed it with friends at home and in the Army, but such conversations appear to have been a normal part of sharing one's life experiences. There is no evidence that Ms James was in some way pathologically affected by her loss. The fact that another family member had previously taken his life in wholly different circumstances in 1992 cannot be taken as any indication whatsoever of what happened to Ms James in November 1995.

7. Self harming behaviour

- 7.1. There is no evidence that Ms James suffered depression or any specific evidence of suicidal ideation at any time. However there is some evidence from family and friends of Ms James having self-harmed in her teenage years.
- 7.2. Both Mr and Mrs James linked some of Ms James' self-harming to her distress at her cousin's death. In the month afterwards she took a small overdose of paracetamol, which her mother was sure was a direct reaction to the tragedy. This overdose was not life-threatening. Mr James collected his daughter from hospital the same day. He understood it was a minor overdose of a few tablets, noting that on discharge Ms James was just told to drink a lot of water. He had no guidance as to her intentions or what she was going through or whether it was a cry for help. The family was subsequently assisted by the local child and family services. Ms James saw a consultant psychologist, who construed Ms James' difficulties as "*exaggerated ordinary teenage problems*". Once the initial therapy course was completed Ms James was discharged in Spring 1993 as there was no need to continue therapy. Ms James did not have further contact with mental health services of any type, and nor did anyone suggest that there was reason for her to do so.
- 7.3. Ms Baksh described Ms James beginning to "go a little bit off the rails" after the assault in summer 1992 and she thought the subsequent death of her cousin a few months later had a real effect. Ms Baksh noticed minor self-harm cuts on Ms James' arms around this time, described as like scratch marks which drew blood. There was no suggestion these represented suicidal intent. Ms Baksh felt they were "nothing serious...just trying to deal with what she was going through." She did not suggest this self-cutting behaviour persisted into Ms James' later teenager years and no other witness appeared even aware of it. Ms Baksh also recalled learning of Ms James taking an overdose of paracetamol with gin. This appears to be the overdose described above as known to her parents. It is notable that Ms Baksh, a close confidante of Ms James', knew only of this single overdose during the whole of her adolescence.
- 7.4. None of the self-harming behaviours described could be considered attempts at suicide, they were not potentially fatal. They appear as ways of managing difficult emotions at times of trauma and stress rather than expressions of any wish to die.
- 7.5. Furthermore, beyond these incidents in late 1992 early 1993, no witness suggested any type of self-harming behaviour continued or was a feature of Ms James' older adolescence. Certainly none of her army friends reported any issue

in respect of self-harm – something they might have been expected to have noted had it been manifest, given the close communal living of army life.

8. Funeral planning

8.1. One feature of Ms James' late adolescence which might be thought unusual was reported by her friend Kathryn Hughes, who met Ms James in September 1994 on their first day at college in Wrexham. According to Ms Hughes, Ms James expressed some unusual thoughts about death, she talked about death quite a lot, and "death intrigued her." Ms James often raised the subject of death and spoke specifically about her own. She listed people she wanted to attend her funeral. Ms Hughes said Ms James spoke on this subject in a matter-of-fact way, and most of the time was really happy, even when planning her own funeral guest list. Her statement was clear that Ms James never talked about active suicide in the sense of 'I'll take pills or shoot myself.'

8.2. Again this adolescent behaviour is not something which featured in Ms James' later life and cannot in my view be relied upon as any indication of Ms James' attitude to death in 1995.

9. Enrolment in the Army

9.1. Ms James commenced sixth-form college in September 1994 but did not complete her course. By Spring 1995 she was back living with her parents and working in a care home. Mr James understood that Ms James had decided she wanted a career, excitement and to go abroad, and wanted it "today", so she signed up for the Army.

9.2. It does seem, however, that Ms James had for some time been considering a career in one of the armed forces. Documents suggest an initial application in February 1994 to join the Navy. Mr James understood Ms James had failed the entrance examination although the documents suggest that it was because Ms James had failed a medical assessment when her history of suffering migraines four years previously was thought to have been more recent. Ms James had moved on to considering joining the Army by late 1994. In the December 1994 referee form to support her army application her former teacher, Ms Williams, described Ms James as keen to be successful, pleasant and lively and had good academic ability when she applied herself. Ms Williams felt the Army would be good for Ms James but unlikely to be her long-term career. Ms James had indicated on the application form that what she expected from the Army was

good training, good career prospects, a chance to travel, further qualifications, more self-discipline and an exciting job.

9.3. On May 10 1995 Ms James formally enlisted in the Regular Army in Wrexham. Her first and only choice of Regiment was as a Supply Specialist with the Royal Logistics Corps.

9.4. Ms Baksh was aware of Ms James' interest in joining the Forces and felt this would be a positive step giving her structure and discipline. It is clear Ms James looked forward to her army training with enthusiasm. Once Ms James started her training Ms Baksh, on a visit home, described her as being happier than before.

9.5. Mr James described the family's view of Ms James' decision being that it was "ok". He did not say he was delighted, as there had been hopes she might follow Mrs James into a career as a nurse, after good appraisals from a care home where she had been working. Mr James did not regard the Army as a long-term career for his daughter, but thought it might give her opportunities. However, both her parents were supportive of her decision and together they drove her from Wales to her first training placement in Surrey.

9.6. On May 14 1995 Ms James began her Phase 1 training.

PART 3: DEEPCUT IN 1995

10. Introduction

10.1. The role and scope of an Inquest is limited by the Coroners and Justice Act 2009. This Inquest is not and could not be a public inquiry into the regime at Deepcut in the mid-1990s. Whilst many witnesses had adverse experiences there, some touched upon in their evidence, it is outside the remit of this Inquest to inquire in any detail into events concerning people other than Ms James, or to make findings about those matters. For this reason I have left unexplored many alleged events and shortcomings of the Deepcut regime, save where there is some basis for asserting that they might have been connected to Ms James' death. It is outside my statutory powers to make detailed findings about individual or collective responsibility for identified or admitted shortcomings in the Deepcut regime, save insofar as those matters might touch upon the death of Ms James or are relevant to my consideration, under regulation 28, of reports to prevent future deaths.

10.2. Nevertheless, the initial scope of this inquest included consideration of a number of aspects of the regime potentially relevant to Ms James' death and so a large amount of evidence about the nature of Deepcut in 1995 was heard. Criticisms of the regime have been formally acknowledged by the MOD and many aspects of criticism also accepted by witnesses within the chain of command. That evidence provides the background to the circumstances of Ms James' death, so I summarise it.

11. The Deepcut regime in November 1995

11.1. Brigadier John Donnelly CBE, Director of Army Personnel Services and Commandant of the Royal Army Physical Corps provided on behalf of the MOD detail, as far as he was able, of army policies, structures and systems in place in 1995 at Deepcut. He had never served at or near Deepcut nor has he anything to do with the facts investigated, although he had consulted Brigadier Evans, the then Commander at Deepcut.

11.2. The testimony of Brigadier Donnelly brought together evidence from earlier reviews and investigations, whose overall conclusions the MOD had not sought to challenge. These included the meticulous Deepcut Review by Nicholas Blake QC ('the Blake Review'), and each of the four Boards of Inquiry ('BOI') into

the deaths of trainees at Deepcut between 1995 to 2002. The Brigadier also had access to the surviving policy documents and directives from the time.

- 11.3. The Brigadier's evidence was supplemented by that of others, including Colonel Nigel Josling, the then Commanding Officer. Much of their accounts were not disputed, and aligned with the evidence of those who were trainees with Ms James. The MOD, through Brigadier Donnelly, recognised and acknowledged the many and obvious inadequacies and shortcomings.

12. The Royal Logistics Corps

- 12.1. In April 1993 the Royal Logistics Corps ('RLC') came into being as an amalgamation of five other service and support Corps, in the Army's 'Option for Change' defence structure review after the ending of the Cold War. The changes were consequent upon the need for a smaller and more efficient army. The old Royal Army Ordnance Corp ('RAOC') training battalion and depot at Deepcut became the home of the newly formed RLC. The total Corps was made up of about 1,700 officers and 15,000 soldiers.
- 12.2. Regimental Sergeant Major Stephen Buchanan described how, in November 1994 he felt the different Corps had still not yet fully integrated and five regimental mind-sets were still not one. He took over what he described as "a leaderless Sergeants' Mess" and faced numerous challenges.
- 12.3. 1993 was also a time of significant change in army recruitment policy. Previously women soldiers had joined the Women's Royal Army Corps (WRAC) but a single entry scheme was instituted, women for the first time training alongside men. There was increased recruitment of young people with an inflow of slightly younger teens into this new single entry mixed sex scheme. All RLC recruits went through a ten-week basic 'Phase 1' training at one of five centres, including Pirbright Barracks adjacent to Deepcut, and then passed out as a 'Phase 2' trainee before being sent to Deepcut.
- 12.4. Whilst the hub of the RLC was at Deepcut much specialist training took place elsewhere, such as the Driving Course at the School of Mechanical Transport, Leconfield, near Hull where Ms James undertook her driving course in Autumn 1995. Deepcut was a holding centre where trainees (known as SATT - Soldiers Awaiting Trade Training) might wait days or weeks to be sent unpredictably elsewhere. Trainees were often passing through the camp and, as some

trainees failed or were unexpectedly held back, there was no synchronisation between completing Phase 1 and starting Phase 2.

13. The Deepcut Command Structure

- 13.1. Colonel Nigel Josling at the rank of Lieutenant Colonel was posted as Commanding Officer of the Training Regiment and Depot at Deepcut in Easter 1994. Colonel Josling's training had included the Commanding Officer Designate Course although, as was the approach at the time, it included nothing specifically aimed at dealing with the welfare and personality of adolescents and young adults.
- 13.2. The RLC at Deepcut comprised three squadrons: 'A' the enhanced training squadron; 'B' the holding squadron and 'C', the support squadron. Each had a Major as Officer Commanding, supported by a Captain as 2IC and a WO2 Squadron Sergeant Major. Among those soldiers within C Squadron some were in the process of leaving the Army. Some were awaiting discharge or were being held back from progression on medical grounds, some were coming to the end of their army careers and a proportion awaited Court Martial or dismissal. B Squadron, to which Ms James returned, was made up of the Phase 2 trainees. Major Robert Gascoigne was its Commanding Officer from November 1993.
- 13.3. In Autumn 1995 of some 400 trainees at Deepcut in B squadron, 25% were women. Something less than a third were, like Ms James, under eighteen. B squadron was further divided into two Troops but no Sections in any meaningful form because of the fluid situation of trainees. Each Troop was commanded by a Lieutenant, with a Troop Sergeant and a low number of Section Corporals and other junior non-commissioned officers.
- 13.4. Brigadier Donnelly described how in the Field Army the usual ratio of Corporals to soldiers would range from one to eight to one to twelve; whilst at a holding unit one to twenty or thirty would be appropriate. At Deepcut the ratio was rarely less than one to eighty and on occasions up to 200. This extremely high ratio, combined with the transient nature of the Phase 2 trainee population, made it near impossible for Corporals and other NCOs adequately to get to know the Privates in their charge and to discharge their duty of care. It is now well-recognised that the ratio of staff to B Squadron trainees in 1995 was inadequate.

14. Trainees at Deepcut

- 14.1. Brigadier Donnelly acknowledged a number of failures relating to how trainees were occupied when awaiting trade training or posting. Whilst some continuation training was provided, there were too few permanent staff and instructors to deliver it and to put in place a structured regime to occupy and so meet the duty of care owed to those young men and women. The result was a large number of teenagers in communal living without a proper structured environment. As the Brigadier said, the experience of moving from the very structured regime of Phase 1 training to the less structured lifestyle in the Field Army should have been progressive, not the “cliff edge” confronting RLC trainees on arrival at Deepcut in 1995.
- 14.2. The Brigadier quoted from The Deepcut Investigation – DAG’s Final Report December 3 2002 – which “found several sources of adverse stimulation at Deepcut that were all related and thus mutually reinforcing”. It cited the high numbers of soldiers awaiting dispersal leading to boredom and indiscipline and the turbulence caused by the combination of training at multiple sites. It noted a psychological environment which put the weakest, and those with underlying problems, at risk.
- 14.3. Colonel Josling told me one of his main practical problems as Commanding Officer was that with resources under strain the intensity of Phase 1 training could not be matched in Phase 2, and young people with time and opportunity to be bored easily resort to mischief. RSM Stephen Buchanan graphically described Deepcut as a “sausage machine that had become clogged”, meaning insufficient space for the irregular numbers of trainees coming through and an excess of trainees, many of them with not enough to do.
- 14.4. Squadrons could not provide stimulating activity all the time. Attempts were made to occupy trainees with sporting events and on occasion external activities. Both Major Gascoigne and Colonel Josling unsuccessfully lobbied for better resources. The pool of teenage manpower was mainly deployed to provide the 24 hour guard for the Garrison.

15. Guard duties

- 15.1. Although by 1995 there was a ceasefire in place with the Provisional IRA, the threat of terrorist attack on a logistics base with soldiers sleeping overnight remained and Deepcut was seen as a vulnerable target. At Ms James' death, Deepcut followed the direction by the Commander in Chief Land Forces that armed guarding was to continue.
- 15.2. In 1995 there was no permanent or specially designated guard corps at Deepcut as is today. In common with other Phase 2 training establishments, the resulting armed guarding requirement at Deepcut was met predominantly by Phase 2 trainees. Deepcut was unusual in having a long and complicated boundary of four perimeters with a number of entrances that needed guarding, and so imposed a considerable burden. The duties were two 12-hour shifts on weekdays usually requiring 14 trainees per shift and at weekends about 27 trainees covered a 24-hour duty with two hours on and four hours off and a return to the guard room between shifts. The minimum age for armed guard duty was 17. Those who were still in Phase 1 training could not conduct armed guard but all Phase 2 trainees over 17 could.
- 15.3. As guard duty was debilitating, a pattern any more intensive than day on, day off was considered unacceptable. At times, however, trainees would regularly do day on day off shifts over several alternate days.
- 15.4. As the Blake Review found, with the significant increase of armed guarding (post the IRA activity of 1988) came consideration of the risk of death through negligent discharge and the need for adequate training of guards. There was no similar consideration, however, of:
- the risk of intentional self-harm occasioned by unsupervised access to firearms;
 - the increased risk resulting from arming the young, including recruits and trainees, and the question of maturity of judgment in the light of age; or
 - the impact on training establishments of trainees doing guard duty.
- 15.5. In the absence of a comprehensive risk assessment, Brigadier Donnelly acknowledged that the risks of having relatively inexperienced trainees doing armed security duties in singleton locations with little or no supervision were insufficiently recognised. Policy at the time was more focused on what was outside the wire and the risk that trainees might present to others (for example, negligent discharge or not handling weapons properly) rather than the

likelihood of trainees causing damage to themselves. Nor was the wider impact of guard duty upon Phase 2 trainees' morale identified. The Brigadier apologised to Mr and Mrs James for the time it took the Army to recognise these failings and to rectify the position.

- 15.6. When Brigadier Evans reviewed Phase 2 training at Deepcut in December 1995, very shortly after Ms James' death, he was struck by the low morale of B Squadron as a whole and in particular the trainees' frustration with the frequency of guard duties. This was not news to Colonel Josling who told the Inquest that on his arrival in 1994, the frequency of guard duty was very unpopular and demoralising, which quickly concerned him.
- 15.7. Major Gascoigne, commanding B squadron, also recognised the difficulty in maintaining morale. He provided some courses and outside events but with limited resources the programme was not nearly as good as it should have been. At times the guard duty requirement was considerable, and he felt this was at the heart of the problem, undermining progressive programmes and contributing to what he described as "rock bottom morale".
- 15.8. Colonel Josling was opposed to using trainees as guards because of their lack of maturity and of experience and their possible overreaction. The risk he perceived was of trainees hurting others rather than themselves. He also feared a skills fade if weapons training was sacrificed to frequent guard duty. His requests to use the MOD Police, as at Pirbright, or other Crown servants as guards were rejected. Changing the camp layout to reduce access points to be guarded was also not an option.
- 15.9. It also appeared on the evidence, including findings of the Blake Review accepted by Brigadier Donnelly, that in breach of policy some NCOs would use guard duty as punishment. Policy set out who may award a punishment but was not explicit as to who could not. It was an abuse of power to hand out guard duties which prevented trainees leaving camp for home visits or other social activities. Yet, as Brigadier Donnelly acknowledged, it happened.
- 15.10. One senior NCO described Deepcut as the worst two and a half years of his time in the Army. He felt people did not care about the recruits and morale was low among the trainees. He agreed that minor infringements were dealt with by informal punishments by the NCOs, although he did not believe guard duties were given out in this way.

15.11. Despite steps from 1988 on to address bullying and harassment, NCOs continued to use guard duty as a punishment. The MOD accepted that, in the absence of a formal code, this was beyond what was appropriate. Unfortunately, within the culture which had developed, those who were doing this got away with it.

16. Guard orders

- 16.1. Two particular aspects of the guard orders and procedures at Deepcut are potentially relevant to Ms James' death. The first is the handling of ammunition.
- 16.2. Until October 1994 the heightened security state was such that orders required magazines to be fitted to weapons but not made ready while on guard duty. After that date, with the potential ceasefire of the Provisional IRA, the alert status was reduced. Unsurprisingly some witnesses, including those who had longer army careers and so had often guarded at earlier or later periods at Deepcut or elsewhere, could not clearly recall the weapon state in Autumn 1995.
- 16.3. The weight of evidence suggests that the position was as set out in a letter to the Garrison HQ. This specified the arming state as State 2 (prepared) that is to say firearms to be carried with a loaded magazines in pouches or pockets rather than attached. Magazines were not to be fitted to rifles save in the event of an immediately perceived threat. I accept Major Gascoigne's evidence that this would have been covered in the full day's induction provided before trainees undertook guard duty.
- 16.4. The second relevant matter was the prohibition on women undertaking armed guard duty alone. Whilst in most respects the female soldiers did guard duty in the same way as their male counterparts the 'United Kingdom Land Forces Anti-Terrorist Security Measures' (UKLF ATSM) directive from July 1994 included Rules for the Carriage of Arms by Service Personnel. These read:

'Service women may be armed and employed on the same basis as adult male soldiers. The only provision is that where possible armed service women should be accompanied by male personnel. If this is not possible, service women are to be employed in pairs.'

- 16.5. At Ms James' death, all guard posts at Deepcut were manned in pairs in the silent hours, but singly during daylight hours of the working week. The latter had the advantage of reducing the guarding burden on trainees. However, albeit during daylight hours only, it left trainees on lone guard duty. Inevitably if the guard were female, the UKLF ATSM Rules for the Carriage of Arms by Service Personnel were breached. This was not a one-off occurrence at Deepcut. Both the then standing orders and the witness evidence make clear that female trainees undertaking daylight lone guard duty was a regular occurrence in 1995.
- 16.6. Brigadier Donnelly's understanding of the policy was that there was no discretion to deviate and Ms James and other female trainees should not have been on lone guard duty.
- 16.7. Colonel Josling could not recall why these Rules for the Carriage of Arms by Service Personnel were not implemented. He suggested it had either not been brought to his attention or been misinterpreted as permitting a discretion for lone female armed guarding, then exercised to ease the burden of guarding duties. He considered it highly unlikely that had the rule been known, it would have been deliberately disregarded.
- 16.8. If there were misinterpretation it seems it was shared between the Regiment, the Garrison headquarters and all individuals whose areas of business it was to enforce the Rules for the Carriage of Arms, including the Provost staff in the guard room. Even amongst those whose responsibilities directly encompassed oversight of guarding duties, there is no evidence to suggest that anyone at Deepcut was aware of this specific rule. It is unlikely that Deepcut was alone in this respect. WO1 Vernam (the then recently appointed RSM, now a retired Lieutenant Colonel) was not aware of the provision. He explained that female trainees had also carried out lone armed guard at his previous establishment, Abingdon Barracks.
- 16.9. A recommendation from the July 1995 BOI which followed the death of Private Sean Benton was for adequate instructions for all guard posts. Colonel Josling did not specifically recall that recommendation or whether there had been a review of the Rules for the Carriage of Arms at that time, although he agreed that the BOI into Pte Benton's death was a missed opportunity to notice that the local standing orders at Deepcut did not comply with the Army Rules for the Carriage of Arms.

16.10. That the Rules were being breached was recognised in the aftermath of Ms James' death and had been rectified by the time of the January 1996 Board of Inquiry into her death. Present day military guarding practice is radically different with a separate professional guard force, the Military Provost Guard Service.

17. Sexual relations between trainees

17.1. Given the dearth of structured, productive or stimulating activities for trainees at Deepcut it is unsurprising that the trainees turned to each other for stimulation. Sexual relations between trainees were not prohibited as a matter of policy. Nor would it have been right wholly to fetter trainees' liberty in that way, given all were above the age of consent. As Brigadier Donnelly noted the position as between trainees in 1995 was a difficult area for those over the age of consent and who had completed their training and were experiencing some freedom. To police such relationships was extremely difficult, particularly when trainees were unsupervised off duty. The MOD has, however, accepted that the extent to which trainees were able to engage in consensual sex within the barracks was inappropriate. One solid piece of evidence of sexual activity at Deepcut was the finding of a great many used condoms around the grounds during an annual tidying up, shortly before Ms James' death.

17.2. It was forbidden for Phase 2 trainees to conduct sexual activity in army accommodation and rules banned entry to the accommodation blocks of the opposite sex. Despite the rules, the overwhelming evidence is that sexual relations between trainees at Deepcut were commonplace and, as many witnesses recognised, there was a sexualised atmosphere at Deepcut. The practical step of a key pad lock on the female block was wholly ineffective when female trainees simply gave their boyfriends the code. Sexual activity was dealt with if caught taking place within the accommodation, but was rarely detected.

17.3. The extent to which this atmosphere is relevant to Ms James' death is, however, difficult to ascertain. It would be unrealistic to suggest Ms James was sexually naïve and fell into potentially distressing sexual entanglements (such as concurrent boyfriends at the end of her life) only because of a sexualised atmosphere at Deepcut. The evidence suggests she enjoyed an active consensual sex life throughout her time in the Army. In a letter to a friend on May 19 1995, five days after arriving at Pirbright, she wrote that her expectation of the Army as "all good fun and sex" was not yet realised.

17.4. In a letter likely drafted at Leconfield around October 4 1995 and before her final return to Deepcut, Ms James boasted to another friend at home of eleven different sexual encounters with various male trainees and NCOs since she joined the Army. The first had been during basic training at Pirbright. All encounters described appear to have been consensual, including one of sharing sexual partners with a female friend.

17.5. These matters are not mentioned to suggest anything untoward in a young woman having sex. It is normal. As Ms Foster QC put it, Ms James' enthusiasm and openness about sex would not have been thought worthy of comment had she been a young man. But given the prurient media interest I emphasise there is no basis in the evidence for any suggestion that the Army or the Deepcut regime in some way sexualised her. She was a young woman looking forward to and enjoying such liaisons from the outset of her army career.

18. Sexual relations between NCOs and trainees

18.1. Brigadier Donnelly described how the policy on sexual behaviour in 1995 was shaped primarily by the Discipline and Standards Paper issued by the Adjutant General on October 21 1993. It directed that relationships between officers and soldiers was not acceptable. A sexual relationship between an NCO and a soldier was acceptable provided they were not in the same chain of command, but not acceptable for obvious reasons within a chain of command, even if consensual. This "was a paper of its time" and there has since been some relaxation of the general policy, although not that in relation to the chain of command.

18.2. Brigadier Donnelly accepted failings in relation to the risk and occurrence of instructors having relationships with trainees at Deepcut. First, the MOD accepts that there was a failure expressly to prohibit sexual relations between instructors and trainees. Notwithstanding this, Colonel Josling believed it was made clear at the time that there was to be no sexual fraternisation between instructors and trainees and it does not appear on the evidence that instructors were ignorant of that prohibition.

18.3. Secondly, the MOD accepts the conclusion of the Blake Review that it is more probable than not that such prohibited fraternisation between instructors and trainees not only took place in breach of military standards but was widespread. The evidence of former trainees shows that must be correct. This was entirely

unacceptable. Since instructors were in a position of command, it amounted to an abuse of power. Ms James' letter of October 4 1995 details her own sexual liaisons with an NCO at Pirbright and with three NCOs at Leconfield, although it is not possible to say whether any was in a supervisory role.

- 18.4. Thirdly, the MOD accepted that more could and should have been done by those in the chain of command to suppress or deter such sexual relations between instructors and trainees. Colonel Josling was confident the chain of command had taken steps to make the expectations clear, and to warn instructors and officers of the gravity and consequences of breach. He recounted how some instructors found their situation and the large numbers of trainees very challenging, and many did not have great experience in dealing with young women. There were rumours and allegations, but he eventually came to the view that rules were being broken. He said more staff were needed, a topic he frequently discussed at the garrison management group.
- 18.5. Fourthly, Brigadier Donnelly noted that in previous investigations evidence was that some male instructors saw young females as a sexual challenge. Colonel Josling also recognised this, although he did not accept it as a sweeping assertion.
- 18.6. The evidence in this Inquest, as the MOD recognised, supports the existence of consensual (but improper) relationships between instructors and trainees, and improper and unwelcome propositioning of trainees by instructors. Whilst probing the detail of this and other more serious allegations of abuse at Deepcut falls well outside the Inquest's scope, such behaviour and attitudes would have contributed to the general culture at Deepcut in 1995 and was far below the standard to be expected. As Brigadier Donnelly agreed, not only was there was a sexualised atmosphere but attitudes and language in certain parts of the Army also represented a misogynistic viewpoint, something he suggests should be viewed in context and as "of its time".
- 18.7. This situation is inextricably linked to the other challenges and shortcomings of Deepcut also recognised by the MOD, which include inadequate staff to trainee ratios, the relative lack of female NCOs and officers, the more widespread cultural change of female soldiers training alongside male peers, and suboptimal training of instructors. Brigadier Donnelly was candid in accepting that these and other factors made it impossible for the duty of care owed to trainees to be met.

18.8. Major Gascoigne accepted that as the ratio of NCOs to trainees was too low, it put a strain on the staff. They were unable to operate the old system of an NCO sleeping in the blocks and at times there were relationships between instructors and trainees. It was his view that all NCOs knew such relationships were unacceptable and if caught, transgressors would receive the full might of his displeasure.

18.9. The MOD recognised and admitted the many shortcomings and failures in respect of the 1995 Deepcut regime regarding sexual behaviour. However, for such matters to be relevant to Ms James' tragic death requires an evidential foundation. This aspect I consider later.

19. Alcohol

19.1. Drinking alcohol - including to excess - amongst young people is not a phenomenon peculiar to the Army. Although Colonel Josling said it was not brought to his attention that recruits and trainees spent a lot of their spare time drinking, Brigadier Donnelly recognised the Blake Review's observation that a substantial volume of evidence demonstrated alcohol-induced poor behaviour as commonplace at Deepcut in 1995. Excessive drinking was the source of significant disciplinary problems, and access to alcohol an ever-present problem.

19.2. As in any camp alcohol was prohibited in the accommodation blocks and there were clear rules in the NAAFI prohibiting serving alcohol to those under 18. Colonel Josling said he had no reason to doubt that that policy was implemented but information from other reports and evidence given at this Inquest, accepted by the MOD, suggests that even within the NAAFI bar, the prohibition on under-18s buying alcohol was not always adequately enforced. It was a concern to Colonel Josling that cheap alcohol was being smuggled into camp. There was nothing to stop someone over 18 bringing alcohol into the camp, as it was inappropriate and impracticable to search every soldier on return - particularly considering the need to respect the private life of adults. Although there should have been monitoring of the accommodation blocks in the silent hours by a duty Corporal, it seemed that spot checks of trainees' accommodation were rare and only partially successful.

19.3. Colonel Josling was not aware of drink parties in the blocks. The evidence of trainees, however, is clear that the consumption of quantities of alcohol including at 'block parties' was a feature of trainees' life. Indeed some trainees

believed that the block party on the last weekend of Ms James' life had been sanctioned by an NCO. Whatever the truth, the party was not discovered.

19.4. Although trainees' social drinking was not curtailed, several witnesses confirmed that obvious drunkenness, particularly on duty, was serious and prohibited. If attending for guard duty and obviously still under the effects of alcohol a trainee would be sent away at risk of being put on a charge.

19.5. The relevance of the Deepcut culture regarding alcohol to Ms James' death is, however, limited. No doubt drinking both at the barracks and in Camberley formed a significant part of her last weekend's events and some witnesses reported Ms James drinking heavily in the NAAFI and appearing drunk at a block party the evening before she died. But as I consider below, contemporaneous toxicology did not reveal alcohol in her blood at Ms James' death.

20. Supervision and support of trainees

20.1. Colonel Josling described the 1994-5 reduction of the permanent cadre of the regiment as a consequence of pushing limited resources towards the front line. Specialist 'military training instructors' with the skills required to educate were replaced with 'military skills instructors' from mainstream soldiering and without the same depth of experience. They were less versed in the 'soft skills' required for dealing with trainees and so could be more prone to errors of judgment. He felt this particularly affected B Squadron by leaving it with insufficient instructional capability. Although efforts were made to use senior NCOs and warrant officers from A Squadron to assist and supplement the B Squadron instructors, the human resources available were insufficient.

20.2. Alongside this was what Colonel Josling described as a 'concerning' lack of approachable female staff members. He said there was one "excellent" female commissioned officer in place when he arrived, followed by a further female Lieutenant, but the Corps was struggling to appoint female instructional staff and his requests for more women met no success. At the time the demand for female officers throughout the Army far exceeded supply. Colonel Josling recalled it was particularly difficult to encourage female soldiers to take on an instructor role although he and Brigadier Evans pushed hard. The net effect was very few role models for the new women trainees in B Squadron, but also a dearth of more senior females to whom female trainees could turn if they had a problem.

20.3. Colonel Josling accepted that the Army was *in loco parentis* to those under 18 and that pastoral welfare was fundamentally a commander's responsibility. In the absence of female NCOs and officers, women recruits could approach other adults, including the Padre, the unit medical officer, Dr McClenahan (a woman), and the WRVS. There were, however, combined and interrelated weaknesses: no overall welfare policy, no formal co-ordination of the welfare support in place, no unit Welfare Officer and no overarching welfare committee. Additionally NCOs were not as knowledgeable about welfare support agencies as was desirable. Given the number of young trainees potentially in need of support and guidance, the haphazard provision of welfare support was insufficient.

20.4. Encouraged by Major Gascoigne, however, an informal focus group for welfare kept a watch on any trainees who had come to attention. That committee which included the unit medical officer tried to meet monthly. It had a working list of problem or at-risk trainees and steps were taken to care for those who self-harmed. Ms James was never referred to this group, nor is there any evidence to suggest she should have been. Indeed, on November 21 1995 a required but private medical consultation with Dr McClenahan was an opportunity to raise personal matters with her or the nursing staff. None of her close girlfriends identified or were aware of any particular issues troubling Ms James in the last week of her life. She did not present, even to her closest friends, as in crisis or in need of welfare support.

PART 4: ARMY TRAINING AND PROGRESS

21. Pirbright and first period at Deepcut

- 21.1. Ms James's progress through her Phase 1 and 2 training was typical of any new recruit. After ten weeks of intensive basic training at Pirbright, Ms James passed out as a Phase 2 trainee to commence her first spell of five weeks at Deepcut from July 24 until August 31 1995. She underwent a Supply Specialist Class 3 training course from July 31 to August 22, and arrived at the School of Mechanical Transport at Leconfield for driver training on August 31 1995. She returned to Deepcut for her second spell on November 16 1995 to await her posting.
- 21.2. On June 29 1995 at Pirbright, Ms James was fined £50 for negligent handling of a rifle causing an unintended discharge of a round. She was homesick and rang home frequently, and found the fitness regime tough. However, Mr James described her on leaving Pirbright as like a "poster for the Army". The family attended her passing out parade at Pirbright, and Mr James described it as a proud moment.
- 21.3. Pte Daniel Griffiths recounted once at Deepcut seeing Ms James shouted at and reduced to tears by Sgt Andrew Gavaghan. Pte Griffiths did not know the context of the incident and it was not recorded in any statement until he came forward to this Inquest 20 years later. Although Pte Griffiths could not now be certain when the event occurred, reconstructing the time line from his memory of his own postings makes it most likely to have been during Ms James's first spell at Deepcut between July 24 and August 31 1995.
- 21.4. Pte Griffiths came across as an honest witness trying to assist and there is no reason to think he was not giving a truthful account so far as his memory allowed. NCOs shouting at recruits is not an unusual feature of army training and Pte Griffiths did not feel that a female recruit being reduced to tears was out of the ordinary. Sgt Gavaghan said he had no recollection of meeting Ms James, but accepted it was possible he reprimanded her.
- 21.5. Given this particular Sergeant has featured in others' negative accounts of the Deepcut regime and been the focus of media attention, it seems likely that if he were of any direct relevance to Ms James' story, others would have come forward. None of Ms James other, and closer, army friends described any interaction of note between her and Sgt Gavaghan. There is no evidence that

she said or wrote anything about any encounter with him. Nor have her close friends suggested she was a target of harsh reprimands, discipline or outright bullying from any quarter at Deepcut. There is no evidence from any witness that this one incident in Summer 1995, or any incident like it, was playing on Ms James' mind in late November 1995.

22. Personality in the Army

- 22.1. Ms James' vivacious personality has been remarked upon by almost every witness to this Inquest who knew her personally. Those who met her during her army training described her as bubbly, lively and fun, gregarious and outgoing. She was widely considered very attractive.
- 22.2. Ms James had an active social life during training. She was popular and formed strong friendships quickly. We have an unusual amount of evidence about some personal aspects of Ms James's life and her inner thoughts and feelings because she was often candid and forthright with close friends in letters and in person. Some witnesses suggested that her bubbly and positive demeanour went alongside and perhaps masked a less happy side. For example, her close friend Pte Helen Miller referred to an intense "heart-to-heart" when Ms James's "face came off and the real Cheryl came out".
- 22.3. The dangers of hindsight import difficulties when assessing the weight to be attached to such evidence, particularly from friends who may have reassessed their thoughts having been told by others that Ms James had killed herself. It is also hardly unusual for people's personalities to appear more complex to friends as they get to know each other better.

23. Relationship with Sapper Carr-Minns

- 23.1. In September 1995 at Leconfield, Ms James started a relationship with a Royal Engineer, Sapper Simeon Carr-Minns. He was almost 19. Spr Carr-Minns considered himself and Ms James boyfriend and girlfriend. Her letters home show her strong feelings for him and that she considered this a potentially serious relationship. She told him she loved him and on November 19 1995 wrote to a friend that he was "the only good thing that has come out of the Army so far".

- 23.2. He described her as excellent company, very chirpy, vivacious, fun, flirtatious and very physical. During the weekend before her death however, he realised that she had “deeper issues”, and “was not as happy as she was making out to be”.
- 23.3. He told the police that she liked men a lot and if she wanted to have sex, she was uninhibited, and he felt she would not have been able to stay faithful. He learned she wanted to leave the Army as she disliked being bossed around and seemed always to be getting into trouble.

24. Events at Leconfield

- 24.1. On November 9 at Leconfield Ms James and Pte Nina Fawcett were found in male accommodation in breach of standing orders. They were fined and awarded seven-day's restriction of privileges (“ROPs”). Three days were later added to Ms James' ROPs for sleeping in.
- 24.2. She told Spr Carr-Minns and her friend Pte Jane Warboys that whilst on ROPs at Leconfield she was fobbed off unwelcome sexual advances from an NCO. She told Spr Carr-Minns it had upset her. She told Pte Warboys on the day of her return to Deepcut but she did not mention it subsequently. To Surrey Police, the NCO denied the events. He was not called as there is no evidence that the alleged event was affecting Ms James' state of mind at her death and I ruled it outside the scope of this Inquest to try to explore or determine the truth of it.

25. Comments about self-harm

- 25.1. Whilst some evidence was heard of Ms James' occasional impulsivity, that is not unusual in adolescence and appeared to fall far short of pathological behaviour. There is no suggestion that thoughts or feelings of self-harm, impulsive or otherwise, were a general feature of her demeanour or known to her close friends in the Army.
- 25.2. In the few days before her death, however, Ms James twice referred to shooting oneself. Pte Sean Benton, an RLC trainee died at Deepcut on June 9 1995, whilst she was at Pirbright. His death was a matter of general conversation. The A8 gate at Deepcut was widely known as ‘Benton's Gate’. Pte Miller recalled Ms

James participating unremarkably in general conversations about Pte Benton's death.

- 25.3. On November 16, on the coach back from Leconfield to Deepcut, Ms James discussed Pte Benton's death with Pte Yvonne Sneddon. Pte Sneddon said they were in high spirits when Ms James said "wouldn't it be really easy to shoot yourself?" Ms James brought up Pte Benton, and said "It must have been dead easy, you won't feel no pain". Pte Sneddon, shocked, took the comment seriously. She responded that one might not feel pain but wouldn't be here afterwards. The subject changed abruptly. She mentioned this to a female NCO, but went on leave the next day and did not see Ms James again.
- 25.4. A similar comment was reported by Mr Keith Grieg, a local electrician, who was working in the female accommodation at Deepcut on November 23. During a tea break, Pte James and Pte Fawcett and others discussed getting out of the Army. Mr Grieg suggested buying themselves out, but was told that it was too expensive. Ms James said that the only way out was to put a gun to your head. Mr Grieg believed it was "purely said in jest". Ms James was laughing as she said it and he took it light-heartedly. He pointed out that it was a waste to take your own life, and talk turned to going AWOL if posted to Germany.
- 25.5. Pte Fawcett thought it banter, said for a laugh. Although they had no plans to go AWOL, she and Ms James wanted to leave and were both fed up with Deepcut.

26. Ms James' attitude to the Army and her posting

- 26.1. It appears Ms James was unhappy in the Army. Certainly from her time at Leconfield onwards, she spoke about wanting to leave. She chafed against the discipline and missed civilian life. In Pte Fawcett's words, her attitude towards the army showed she "still had a civilian head on." She particularly disliked guard duty, of which she and others perceived she did more than the usual share. She spoke and wrote to friends including Ms Baksh about going AWOL.
- 26.2. In a letter from Deepcut dated November 19 1995 she wrote that she and Spr Carr-Minns "*really want to leave the Army*" describing it as "*a total waste of time*". She noted her father would "*go mad*" if she did. She also appeared to be looking towards her future in the Army, however, writing:

“I’m just pretty glad I will be posted soon. The reason I hate it so much is I have got some real good mates and we’re all getting posted different places which is shite even though its easy to meet people here and most people are your mates anyway.

I really need a holiday just a week’s rest from the Army. I’ve been in six months and its hard without any time off. I’m due 4 weeks but I doubt I’ll get any at all.”

- 26.3. In a phone conversation the next day Ms Baksh recalled Ms James said she “wanted to abscond, she wanted to go AWOL and was serious about that”.
- 26.4. To put this in context, however, discontent with army life while at Deepcut was probably not unusual amongst her cohort and her particular group. Pte Gavin Trearty, for example, said Ms James complained about army life “no more than anyone else” and that “if there had been a bus outside we all would have got on it and gone”. Pte Andrew Carter suggested “at least half the camp” talked about seeking premature voluntary release.
- 26.5. Ms James’ parents were unaware she thought of leaving. They last saw her during her birthday weekend in October 1995. They had a family party, a nice occasion when she gave no indication she was reluctant to return to the Army. Her mother had told her several times that if she did want to leave her parents would pay for her to come out.
- 26.6. The Phase 2 trainees in her cohort were awaiting their postings at the time Ms James died. Pte Steven Storey recalled Ms James feeling that “if she didn’t receive a posting soon, she would leave the Army.” She had talked of applying to be sent to Germany but on November 17 wrote that she was going to ask for a UK posting to increase the chance of being near Spr Carr-Minns. Whilst some witnesses thought she had been made aware of her posting by November 27 1995, scrutiny of the documents shows this was probably not so. The order posting her to Bicester from 4 December had not reached the camp.

27. Attendance on Dr McClenahan

- 27.1. On Tuesday November 21 1995 Ms James saw Dr McClenahan, the GP at Deepcut, for her 22-week service medical. They had not met before. Ms James came across as a lovely, bubbly girl who did not seem to have a great many problems and was keen to get posted out. She was assessed as fully fit and able to be posted anywhere.

- 27.2. Dr McLenahan assessed and recorded Ms James's mental health as 'normal', although this was a cursory assessment, limited to perceiving Ms James' demeanour in the meeting and asking her if everything was alright. Dr McLenahan told this Inquest that she never assessed anyone's mental health as anything other than normal unless they had serious psychiatric problems. Had she had concerns about Ms James, she would have referred her on, but she saw no need to do so.
- 27.3. Dr McLenahan recalled Ms James asking "Can I get thrown out of the Army for having migraine?" Ms James explained that while she had not had them in the Army, she had had them before. Dr McLenahan told her she could have to leave if her migraines interfered with her career.
- 27.4. Although Dr McLenahan's impression was that Ms James was worried that migraines might preclude her posting, Ms James' correspondence suggests the opposite and that she was considering whether she might feign migraines as a device to leave. In an earlier letter to Ms Baksh she had written that her 22-week medical "*could be my chance to get out on migraines*". In unsent letters to Spr Carr-Minns dated November 19 and 22, she also suggested that she would use her history of migraines as a pretext for discharge. In the letter dated November 22 she wrote that the previous day she had mentioned getting migraines and "*the nurse said she wouldn't write it on my record but if I complained when I got to a unit I'd be straight out so really I wouldn't have a problem*".

28. Relationship with Pte Wilkinson

- 28.1. Although Ms James' relationship with Spr Carr-Minns continued on their return to Surrey he was based at Gibraltar Barracks approximately 10 miles from Deepcut. In the days before her death, Ms James entered into a new relationship, with Pte Paul Wilkinson, a fellow trainee at Deepcut. Pte Wilkinson thought their relationship began perhaps on Tuesday 21 November.
- 28.2. On Wednesday November 22 Ms James wrote to Spr Carr-Minns telling him she could not go home with him at the weekend, due to Sunday guard duty. She was not on duty. In the absence of documentation, however, it is now impossible to know whether a planned shift on Sunday was later altered or if this were an excuse to avoid going to Wales with Spr Carr-Minns.

28.3. Pte Wilkinson and Ms James were on guard duty together, probably on Thursday 23. They flirted, and amidst what Pte Wilkinson described as banter and messing about, Ms James punched him and gave him a nosebleed. Pte Wilkinson thought she had nearly broken his nose. He agreed she was a strong girl who could stand up for herself.

28.4. Pte Wilkinson, sixteen and unconfident, was smitten with Ms James. Pte Treaty encouraged him to get over his shyness, but Ms James took the initiative. A few days after they first flirted he recalled that in Camberley Ms James strolled over, kissed him and said something like "that is it, you are mine." Pte Wilkinson considered it a potentially serious relationship. He believed she was splitting up from her other boyfriend.

29. Friday November 24 1995

29.1. Ms James rang home at about 14.00 on Friday 24 November and spoke to her mother. It was the last time she spoke to either parent. They talked for about half an hour discussing amongst other things Christmas shopping. Ms James seemed excited about Christmas. She said she could not come home as she had to do guard duty; but the impression was that really she wanted to stay at Deepcut to socialise. Nothing in this phone call caused her mother any concern then or in hindsight.

30. Saturday November 25 1995

30.1. Spr Carr-Minns said that on Saturday November 25 he discovered that Ms James had begun a relationship with Pte Wilkinson. Spr Carr-Minns had arranged to meet her at Deepcut but she was not there. Told she had been seen in town with another guy, he went into Camberley and found her with friends shopping and drinking. During the day some of the trainees, including Ms James, took out store cards to buy goods on credit.

30.2. Spr Carr-Minns saw her later on Saturday in the NAAFI with Pte Wilkinson. Spr Carr-Minns said he was never angry, just upset. His motive in seeking her out was to convince her she should be with him. He did not succeed. Ms James and Pte Wilkinson had sex that night, interrupted by Pte Miller and Pte Treaty

who squirted them with a fire extinguisher in revenge for Ms James having done the same to them.

- 30.3. Spr Carr-Minns, carrying a red rose and hoping to make things up with Ms James, also walked in on her with Pte Wilkinson. Pte Wilkinson, at first angry, then left Spr Carr-Minns and Ms James alone. In a difficult conversation she made clear she could not help herself; she liked Pte Wilkinson as well and wanted to be with other men. Spr Carr-Minns stayed with her that night, but in separate beds.

31. Sunday November 26 1995

- 31.1. Next day, Sunday November 26, Ms James again went into Camberley to buy Christmas presents and go drinking. Her group included Pte Wilkinson and Spr Carr-Minns. Many trainees recalled a party that evening in an unused accommodation block. There was a widespread perception that it was informally sanctioned by NCOs, although some trainees thought it unauthorised and no trainee gave evidence of direct authorisation.
- 31.2. Spr Carr-Minns reported Ms James' mood as "swinging backwards and forwards" throughout the evening. "She would be laughing and joking one minute and then quite aggressive or sad or angry." She spent time with both Pte Wilkinson and Spr Carr-Minns throughout the evening. In the NAAFI Spr Carr-Minns overheard her arranging to meet Pte Wilkinson, which saddened him. Ms James then initiated sex with Spr Carr-Minns in a quiet part of the NAAFI behind a curtain.
- 31.3. Ms James was bothered about the situation in which she found herself. Spr Carr-Minns believed her "very confused...unhappy about the whole thing, guilty about me and that what she was doing was wrong." Pte Miller said she had been talking about it all day, "going round and round" because "she couldn't make up her mind", to the point where she told Ms James to go away because she had "heard enough about Wilkie and Jim". Pte Treaty remembered Pte Miller responding more bluntly, telling Ms James to "fuck off and grow up".
- 31.4. After the NAAFI closed, Ms James visited the guard room. Pte Rankin recalled Ms James seeming pretty drunk. She asked him to allege she had been in trouble and to put her into the cells, as she did not want to do morning guard duty. Mention was made of her not having her kit ready. She also had a conversation

with Pte Rachel Oakes, which made her angry and upset. Pte Oakes did not remember its content, but Spr Carr-Minns recalled Ms James saying “she wanted to punch somebody”, so he offered his hands as pads for her to punch. She was in a pretty bad mood about something but Spr Carr-Minns did not know what. He left for Gibraltar Barracks between 23.00 and midnight. His final impression of Ms James was that she was depressed and was “drinking to anaesthetise herself”. They arranged to meet the following Tuesday.

- 31.5. Both Pte Wilkinson and Spr Carr-Minns were upset by their inability to enjoy Ms James’s undivided attention. Both felt affectionate and caring and considered himself in love with her. There is no evidence that either was ever violent, threatening or angry towards the other despite their rivalry. Nor is there any evidence that either was violent or threatening towards Ms James.
- 31.6. That night, after Spr Carr-Minns had left, Ms James went to the male accommodation block and had sex with Pte Wilkinson. Pte Carter was in the room two beds along. At about 02.00 hours Ms James asked Pte Carter if he had ever done anything on impulse, and if he could obtain a fake passport. She asked if he had ever had anal sex, and if he would like it with her. He was shocked, surprised, and declined. Ms James was still in bed with Pte Wilkinson at this point and Pte Carter described Pte Wilkinson as agitated, his body language indicating that he was not happy.
- 31.7. After ten minutes Ms James asked Pte Carter to check for NCOs and then take her back to her own room. Pte Wilkinson wanted to take her back himself so it was agreed Pte Carter would check first. On his return he found Pte Wilkinson and Ms James coming out of the block relatively happily. Pte Wilkinson did not seem angry, but “obviously put out”. Pte Carter went back to the room and from the window saw Ms James walking back alone but looking up. Pte Carter said “You’re going to get it”, meaning sex, which she acknowledged by smiling and winking.
- 31.8. Pte Wilkinson spent the rest of the night elsewhere. Next morning Pte Courtney Clarke was understandably annoyed to find him asleep in a spare bed Pte Clarke kept immaculately made up for inspections.
- 31.9. Accounts of Ms James’s actions that evening do not suggest she was at all upset in the immediate wake of these events. On the contrary, this seems but one example of Ms James’ sexual confidence. Save for one single allegation, the

credibility of which I shall discuss, no evidence to this Inquest is other than of Ms James having consensual sexual relationships whilst at Deepcut.

32. Pte Beards' allegation

- 32.1. Only one allegation has come to the notice of my investigation that Ms James was sexually assaulted at Deepcut. Pte Mark Beards, a trainee, alleged that on the night before she died Ms James was required to go into a room with Pte Ian Atkinson, another recruit, on the orders of Sgt Gavaghan. Pte Beards understood this to mean she had been ordered to sleep with Pte Atkinson or as Pte Beards later put it, to be "raped". No other witness corroborates this and the allegations are strongly denied by Sgt Gavaghan, and Pte Atkinson.
- 32.2. Pte Atkinson has consistently said that the extent of his romantic or sexual involvement with Ms James was limited to one evening flirting in the NAAFI, leading to a consensual kiss. His account of that event is corroborated by Ms James who wrote on November 19 1995 to Spr Carr-Minns that she had been *"flirting round Atkinson"* and she *"didn't do anything at all. I just kissed him though I thought I had better tell you before one of the other lads does"*. Pte Slattery also recalled this episode.
- 32.3. On oath Pte Beards told this Inquest he first met Ms James on November 25 1995 for a couple of minutes. He said he had drunk about eight pints of lager on the evening of Sunday November 26 1995 when she spoke to him at about 23.00. She allegedly told him she had been ordered to go to a room with Pte Atkinson.
- 32.4. Questioned, Pte Beards said Ms James had never described the incident as involving sex. This reflected his September 2002 interview, when he told officers that Ms James had not actually said she was being abused but that he had "read between the lines." Therefore on his own account, if this interaction even happened, she had made no reference to sex. Pte Beards merely assumed sex was required of her.
- 32.5. At its highest his evidence was his own inference and assumption. At its lowest it was fantasy. Pte Beards' account does not fit in with the overwhelming preponderance of evidence about Ms James' movements on the evening of November 26. Both boyfriends were around and she spent a large amount of time with them and had sex with both that evening. It is unlikely that she would

have disclosed such a significant untoward event to Pte Beards, whom she barely knew, yet not to close friends, or to either boyfriend. Her candid nature makes it highly unlikely that she would not have shared such an event.

- 32.6. Furthermore she could stand up for herself and was sexually confident and experienced. Pte Miller recalled that “she was too full of herself and confident to allow anyone to take advantage of her”, and Pte Fawcett remembered her rebuffing a sexual approach from a Sergeant without any impact on her mood.
- 32.7. Moreover, only in a 2015 witness statement was Sgt Gavaghan’s name first cited by Pte Beards in this context. Elements of his account, such as his description of an alleged confrontation with Pte Atkinson next morning, have evolved in a way only explicable as exaggeration. Pte Beards admitted he had lied to the police in the past and parts of his story have a clear ring of fantasy. For example, he suggested he had not told the full truth of the encounter when interviewed by the Surrey Police in September 2002 because he was afraid of Sgt Gavaghan, yet he proactively contacted the press with this story in October 2002. His account became the basis of sensational media reports that Ms James was a ‘sex slave’ ‘forced to have sex with a gang of officers’. Pte Beards allowed his photograph to be published alongside this account.
- 32.8. It is an egregious act to accuse someone of rape without foundation, and even more so to make such unfounded and sensational allegations in the context of the death of a young woman. The media’s publication of Pte Beards’ allegations in October 2002 has been the source of significant misinformation. One purpose of this Inquest is to shed light upon Ms James’ time at Deepcut so that her parents and the public have a fuller picture. It is more than regrettable that Pte Beards’ evidence before me again generated such misleading headlines as *“Teenage soldier ‘forced to have sex with fellow recruit hours before she was found dead”*.
- 32.9. I find Pte Beards’ allegations to be wholly without foundation. I accept as true Pte Atkinson’s evidence that his earlier consensual kiss was his only physical involvement with Ms James.
- 32.10. I remind myself that this is not a public inquiry into the culture of Deepcut Barracks in 1995. The investigation of the widespread allegations of sexual abuse or bullying of recruits other than Ms James fell outside the scope of this Inquest.

32.11. On the evidence heard, neither sexual harassment nor abuse nor bullying were directed at Ms James on her return to Deepcut. Whether or not her experience of Deepcut was typical in this regard is a matter on which I cannot comment.

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PART 5: THE EVENTS OF 27 NOVEMBER 1995

33. Quality of evidence of timings

- 33.1. The events and timings on the morning of Ms James' death made up a large part of the evidence at this Inquest. Desirable though it would be to determine precise timings of the events that day, the reality is that the passage of time precludes it.
- 33.2. Each witness who saw Ms James that morning or who noted her absence was trying to assist the Inquest. It is, however, a truism that even honest witnesses can be mistaken, and no witness asserted that his or her estimate or in some cases 'guesstimate' of timings could not be wrong. Many did not give a first account until 2002 or 2003, seven to eight years after Ms James' death. The accuracy of their timings in the case of several witnesses who passed through the gate is open to significant doubt, and in some cases it is questionable whether even the correct day were recalled.
- 33.3. Notwithstanding this difficulty, the evidence of so many witnesses permits me to reconstruct a chronological account, albeit incomplete, setting out when key events probably happened.

34. Guard Duty

- 34.1. Despite the events of the previous evening Ms James paraded with eleven trainees at 06.30 hours for guard duty on Monday November 27 1995. She borrowed much of her kit: a combat jacket from Pte Miller, a jumper from Pte Alison Sharp and at the guard room Pte Nicola Mattinson lent her a waterproof jacket.
- 34.2. Some of her closest girlfriends were on the same guard shift and recalled that despite limited sleep she seemed her usual self. Pte Slattery recalled her laughing and giggling such that the Corporal told her to keep quiet. Pte Paul Arnold who knew her to chat to stood directly behind Ms James and recalled that she was laughing and messing about as usual. Pte Mattinson had never met Ms James before but recalled her demeanour as fine and she was pleasant.
- 34.3. Trainees coming off parade noted nothing untoward. Pte Clarke saw her as he came off his stag, and Pte Glen Rankin on the outgoing stag recalled she seemed quite happy, not under the influence of alcohol, but maybe quite tired.

- 34.4. Pte Claire Barnett on the previous shift was not one of Ms James' close group and had not been confided in about Ms James' love life, but was friendly with the Engineers at Gibraltar Barracks. She was "collared" by Ms James. She seemed all right although Pte Barnett now, perhaps in hindsight, says she "saw something in her eyes". Ms James asked Pte Barnett if she was around afterwards. She either wanted to ask or tell her something. Pte Barnett had no chance to discover why as there were people on the stairs. In her 2002 statement, she thought it unlikely this was to impart secrets or anything really important.
- 34.5. Some of her girlfriends had discussions with and about Ms James that morning regarding her love life. Pte Fawcett remembered people saying of or to Ms James that she was "a slag". Pte Miller remembered she and Ms James had a quick talk about deciding between the two men. It was nothing Ms James seemed massively worried about. The discussion was heated and not the friendliest, but not an argument. Pte Miller said this was the same sort of conversation they had been having for a couple of days. They agreed to talk again at lunchtime.
- 34.6. Pte Fawcett told Ms James that she had to decide who she was going out with. Ms James' response was basically "fuck off and mind your own business". Pte Fawcett said she possibly had "a good go at" Ms James but Ms James would give as good back. She told police in 2002 that Ms James shouted at a couple of the girls. Pte Fawcett recalled the discussion being left a stalemate and that after shouting Ms James was not totally back to her full happy self. As she left for her gate there was still a little tension.
- 34.7. Pte Lisa Slattery recalled female trainees telling Ms James she should make up her mind and was not being fair on the men. Pte Slattery's recall was that "slag" and expletives were used but that Ms James was not overly upset. She was saying words to the effect of "shut up and leave me alone, I know I've got to do it, I will do it when I'm ready, it will be my decision and no one else's." Pte Slattery thought that Ms James was going to end her relationship with Pte Wilkinson. Pte Slattery was keen the extent of the discussion should not be overplayed. She said "It was a group of 17-year old girls talking about boyfriends. It can be exaggerated but I wouldn't have said it was heated."

35. Allocation of the gate

- 35.1. Ms James' posting was to the rear gate of the main barracks at the Royal Way entrance – known as the Royal Way gate or A2A gate. Whilst some witnesses thought it had been allocated, the weight of evidence is that she probably volunteered.
- 35.2. Ptes Presho, Hands and Mattinson recalled Ms James volunteering, and the RP staff asking if she was okay with that. Pte Miller recalled that Ms James volunteered on the basis she was hung-over and it would be quiet. Pte Warboys thought that Ms James volunteered, along with others, for the Royal Way gate because it was “one of [the] more interesting gates” and was “popular” due to its proximity to the parade square and accommodation blocks. Pte Slattery remembered thinking volunteering for the first shift was surprising as it meant not being able to go back to sleep.
- 35.3. LCpl Neil Vousden, in charge of the allocation, explained that Ms James was posted to the gate alone as was routine. He was unaware the Rules for Carriage of Arms precluded a lone female being allocated to that duty.

36. Issue of weapons

- 36.1. At the guard room those going out on the first stag were issued with and signed for an SA80 rifle and rounds. The weapons were kept locked in the rear of the guard room and all other rifles at the camp were secured at the armoury. Soldiers had no access to weapons without permission.
- 36.2. LCpl Vousden described how the weapons were unlocked and issued, magazines given separately and ten 5.56 NATO rounds were counted out individually. The trainees' army number was recorded with the weapon and magazine number. Each guard was required to sign and the record was countersigned. Rules of engagement were issued and the Guard Declaration Orders and allocation forms signed. The serial number of the weapon issued to Ms James was noted and she signed for it just before 07.00.
- 36.3. LCpl Vousden could not recall if he specifically reminded the recruits that the magazine should be in a pocket, but in any event, he said there would have been no confusion as to what to do with the magazine. Not only was the standing

instruction that the magazine should be off the rifle but the instructions regarding arming state had not changed throughout Ms James' army service.

- 36.4. The instruction to keep the magazine off the rifle was not always obeyed. Pte Fawcett described how when bored on a night guard duty she put the magazine on the rifle, put a round into the chamber and cocked their weapon. She had taken the round out and fired the weapon. In the absence of a threat this would have been a disciplinary offence. Pte Fawcett recalled doing this at night on A8 gate in particular which she said was quite isolated, could be quite lonely and was eerie in the evening.
- 36.5. Such an action leaves a 'witness mark' on the round where the firing pin rests against the percussion cap. Given the later discovery of 'witness marks' on a total 13 of the 210 rounds available for issue in the guard room that day it seems likely Pte Fawcett was not the only trainee who chambered a round since first issue for the guard on July 28 1995. There is no positive evidence that Ms James ever did this.

37. At the gate

- 37.1. There were differing recollections of how Ms James arrived at the Royal Way gate, on foot or in the RP Land Rover. Pte Warboys recalls she and Ms James walked to their posts, but she was going to the main camp gate and she would have turned in the other direction on leaving the guard room and they could not have walked far together. Nothing turns on how Ms James got to the Royal Way gate, but given it was locked overnight and the trainee on the first morning shift was not given the key, it is more likely she went in a Land Rover with the RP staff. This accords with the recollection of Pte Grady coming off night shift who saw Ms James arrive.
- 37.2. As to what transpired at the Royal Way gate during the rest of the morning, the picture is fragmentary. There was no requirement to keep a log of passage or use CCTV cameras. It is impossible to reconstruct the exact order in which the many arrivals reached the gate. Very few could do any more than estimate their arrival time. This is unsurprising as few had reason to check their watches and many were not following their usual routines as this was a camp stand-down day. Those who now say they can achieve greater precision are still hampered by first seeking to recall this years later. Very few witnesses made statements in 1995 although those who did might be more accurate given how much closer this was to events. Drawing together the evidence, however, does paint a broad picture.

37.3. Initially during the early morning, the Royal Way gate might have been opened slightly later than the usual 07.00. Following its opening Ms James was sighted by a number of people carrying out her guard duties as expected until at least one and possibly two periods when the gate was unattended.

37.4. Due to the efforts of Surrey Police in 2002/3 this Inquest was able to identify and hear evidence from 21 witnesses who came to the Royal Way gate that morning. It is likely several others who have not been identifiable at this distance in time also came to the gate during the 90 minutes or so that Ms James was posted there.

38. Attendances at the gate

38.1. Two NCOs found the gate locked on arrival estimated at between 07.00 and 07.15. Both LCpl Alexander Campbell and Squadron Sgt Major Vance Parker found it closed with no one about, so drove to the main gate. Neither account, even if accurate, is of great relevance. They refer to a time before the gate was unlocked by the RP staff, and hence must be before Ms James arrived.

38.2. Ms James was thereafter seen conducting her duties at the large metal gates, pushed back, at least on one side of the carriageway, and controlling traffic by a striped barrier that could be raised and lowered.

38.3. Sgt Gavaghan recalled walking through the gate in civilian clothes at about 07.30. A female on guard did not ask for any identity. He said good morning, identified himself as a sergeant, and continued on his way.

38.4. LCpl Tyron Bancroft made a full statement on the day of Ms James' death. He said he had come through the Royal Way gate around 07.40 in civilian dress. The left gate was closed, the right open and the barrier down, as he would expect. He recognised the female guard who seemed happy and noticed nothing unusual about her dress or weapon. As a former RP staff member it would have been obvious to him were the magazine attached.

38.5. WO1 Karen Loftus of 41 Transport Squadron had a routine of driving from married quarters through the gate at about 07.45. She waited in a queue to enter and was aware of the female guard being told off presumably for talking to a boyfriend. A male then disappeared, although she did not see where. When she

was checked greetings were exchanged and the female guard seemed serious, consistent with being reprimanded.

- 38.6. Cpl Mark Fogarty came to work on foot through the woods. He would usually leave home about 07.50 to open up at 08.00. He had no detailed recollection but thought he exchanged pleasantries with the female guard at the gate as he showed his ID. As he went through he noticed a male on the right hand footpath approaching from about 30/40 metres. He was white, medium build, in smart civilian clothing. In his 2003 statement he said he looked back and saw them talking but he had no memory of this now. These timings from WO1 Loftus and Cpl Fogarty are impossible to reconcile if they are describing the attendance at the gate of Pte Wilkinson.
- 38.7. Mr John Rowney, a civilian driver with 41 Squadron, came forward only after seeing a TV report in 2002. He recalled leaving 41 Squadron at about 07.55 to pick up an officer at the Mess at the far end of the barracks at 08.05. At the back gate the guard was dealing with a couple of vehicles coming in. He recalled a happy, jolly female. They shared a joke and he said he would be back shortly. The officer was late and he waited for 15 minutes starting back at 08.20 or 08.25. He found a queue of about eight vehicles and was told by a pedestrian of the guard's death. His account to this Inquest had changed considerably from his account to the police in 2002. He now recalled details no-one else has mentioned, including a male standing dressed in a parachute regiment smock when he first passed through, and a number of others there. His memory, becoming more detailed as time went on, is unlikely to be reliable.
- 38.8. RSM Paul Vernam had been in post a matter of weeks when Ms James died. He is one of the few who has a recorded account of his timings much nearer the events. At the BOI he estimated his arrival at the gate at 08.20. He did not know Ms James but recalled having to give her a gentle reminder that she could identify officers by the six numbers on their ID card and that she should have added 'Sir' when she spoke to him. She saluted and he recalled again having to correct her as there was no need for her to salute an NCO. There was nothing else remarkable about the interaction. He did not see any trainee in civvies but the Adjutant, Capt Charles Whatoff, was at the gate behind him on his bicycle.
- 38.9. Capt Whatoff told the BOI in 1996 that he had come through the gate between 08.15 and 08.20. He was not now clear if he was in a car or on a bicycle. He

showed his ID to the female guard and noted nothing unusual nor did he see anyone with her.

- 38.10. Staff Sgt Terence McEleavey the training coordinator for B Squadron, was in regular contact with the recruits. He knew Pte James by name. In his 1995 statement he recorded that he arrived by car at the gate at about 08.30. Ms James was “one of the characters who would speak to you” and said “Hi Staff” and had a brief word about her being back from Leconfield. She seemed happy, there was nothing untoward about her dress and he did not notice anyone else.
- 38.11. Pte Michelle Clarke could not recall when she came through the gate. However in her 2002 statement she recalled walking out of the camp saying good morning to Ms James at the Royal Way gate. She could not recall seeing anyone else walking, driving or cycling towards her. At the back of her mind she thought she recalled hearing a single shot when she was at the top of the hill just prior to turning off into the married quarters.
- 38.12. WO1 Keith Rimmington after a fitness session at Dettingen Barracks from 07.00 drove to the gate in the hope that it was open as he was starting lessons late that morning. When he first tried to recall the time for his 2003 statement he thought it was 08.30 or 08.35. Although he noticed nothing unusual as he presented his ID, WO1 Stephen Shaw (on the same run with him earlier) arrived at the office in the School of Logistics five minutes later and commented there was no guard on the gate. When WO1 Rimmington explained he had seen a young girl there, WO1 Shaw phoned the Adjutant. Whilst WO1 Rimmington accepted it was possible that his timings of 8.30 or 08.35 were 5 – 10 minutes out, he doubted this. He felt he had a very good approximation of the timings. He had reflected at the time and since that he might have been the last person to see Ms James alive.
- 38.13. Cpl Ian Wilkinson, a Military Training Officer of NCOs, knew Ms James’ only by face. His first account in 2003 described how he drove up to the gate and saw no one on either side. He thought this probably 08.15, as he had to be at work 08.30. Ms James appeared dressed correctly her rifle in the front slung carriage position. He was satisfied the magazine was not on the weapon explaining it was “in his DNA” to notice what to look for on a young soldier. He thought Ms James seemed upset and miserable and tried to cheer her up by saying “it might never happen” and using his stock phrase “it’s a lovely day for the Corps” but she just got on with her work. He saw no one else. He had parked near the gym and within two minutes saw Sgt Philip Wood on his

pushbike. Sgt Wood asked Cpl Wilkinson if he had seen anyone on the gate as Sgt Wood had found it unattended. Cpl Wilkinson phoned the guardroom to report this. He too wondered if he had been the last person to see Ms James alive.

39. Pte Paul Wilkinson at the gate

- 39.1. Pte Paul Wilkinson provided statements in 1995 and gave evidence at the initial Inquest. He told this Inquest he now only had snippets of recollection of events twenty years ago. He suffered some head injuries leading to short term memory loss playing rugby in 2003, could get confused and sometimes things did not come across as were meant.
- 39.2. On the morning of her death he discovered which gate Ms James was guarding and set off to talk to her to find out where he stood. He had a medical appointment later that day and was in civilian clothes when he arrived at the gate at about 07.30. He spoke to her for about 45 minutes. He had the impression that Ms James was fine but a bit hung-over. His recollection was that he was giving her an ultimatum, as he did not want to be messed about. He said he can be quite forthright. He told her she should choose between him and Spr Carr-Minns, and if she wanted to stay with Spr Carr-Minns, they could still be friends. She said she did not want to be with Spr Carr-Minns and Pte Wilkinson was happy. At this Inquest he did not recall additionally complaining about what she had said to Pte Carter the night before, although he accepted he had mentioned this to the police in 2003.
- 39.3. Pte Wilkinson knew he should not be at the gate so stayed out of sight, mostly in the portacabin, whilst Ms James dealt with the arriving cars. He described how they spent some time cuddling and making plans to meet later after her second guard shift.
- 39.4. She kept her rifle across herself on its webbing so as to deal with the cars. He would have noticed had the magazine been fitted to the weapon and everyone knew guards should keep their magazine in their pocket. Ms James' radio was on the step outside the portacabin, a standard habit, as it was annoying to keep it clipped on.
- 39.5. In his statements in November 1995 Pte Wilkinson said that Ms James jokingly said that she was going to sit in the woods and let the traffic enter the camp. He

now had no recollection of saying this. This was not, on Pte Wilkinson's initial account, coupled with any suggestion or threat of self-harm.

- 39.6. Pte Fawcett told the police in 2002 that Pte Wilkinson told her that he left Ms James sitting down without a care in the world. In her oral evidence in 2016 she said that she now thought he had said Ms James was sitting by a tree up the hill up from the gate. Pte Wilkinson himself had no memory of saying something like this but specifically said he did not see Ms James sitting down without her rifle or sitting by a tree.
- 39.7. Pte Wilkinson estimated he spent 45 minutes to an hour at the gate when an officer on a bicycle told him to leave and "pretty much took (him) to the barracks".
- 39.8. Major Peter Harris commanded A Squadron, and made a statement two days after Ms James' death. He arrived at the rear gate between 08.10 and 08.15 on his bicycle, slightly late. The female guard was properly dressed, with nothing unusual about her weapon. As his I.D. was checked he was aware of a young man in civilian clothes looking as if he was 'chatting her up'. He did not know at the time that this was Pte Wilkinson. He said 'he was just passing'. Major Harris told him to leave. He got back on his bike and went to work. He did not accept that he had escorted him away, he said he expected the young man to act upon his command and did not look back to check.
- 39.9. Pte Wilkinson's accounts at this Inquest and to Surrey Police during their 2002-2003 investigation seven years after the events do not entirely align with those of Major Harris. However, Pte Wilkinson's contemporaneous accounts are reconcilable with that of the Major. Some inconsistencies in honestly reported recollections are to be expected and can be explained by the length of time between the events of 1995, the taking of statements in 2002 and 2003, and this Inquest. The difference between the current accounts of Pte Wilkinson and Major Harris are of perception and memory. I prefer Pte Wilkinson's first account; although he may have left the gate around the same time as Major Harris, he was not escorted away.
- 39.10. Pte Wilkinson when he gave his 1995 statement was not asked why he was at the gate. In his accounts in 2002 and 2003 he said a significant part of his motivation was to raise with Ms James that what she had said to Pte Carter the night before had been out of order. In his evidence to the Inquest Pte Wilkinson

now remembered things differently and suggested that he went to sort things out regarding Spr Carr-Minns and to find out where he stood.

39.11. Pte Wilkinson said that when he went back in to camp he met Pte Trearty and others having a smoke. He recalled Pte Trearty saying he had ridden to the gate to see Ms James who was not there. Pte Trearty told the Inquest that he did not and had no reason to go to the gate. If he had he would have remembered. Pte Trearty did not recall meeting Pte Wilkinson that morning, although neither did he dismiss it as not having happened. He indicated his memory of this period in his life was limited. Another soldier, Pte Shortt, did recall seeing Pte Wilkinson and others at the smoking area beside the accommodation very soon after the ambulances arrived. He broke the news to Pte Wilkinson of Ms James' death which he received with total disbelief saying "Fuck off I have just seen her".

39.12. Obvious internal inconsistencies in the accounts of Pte Wilkinson over the years I see as in the context of his youth, the traumatic impact of events, the passage of time, his own personal circumstances and his subsequent brain injury. In November 1995, aged 17, he was a minor, alone and likely still to be extremely shocked at Ms James' death. I do not accept the submission on behalf of Mr and Mrs James that his differing accounts "*display elements of careful crafting and targeted elaboration*". Pte Wilkinson appeared to be doing his best to assist me.

39.13. Before he gave his evidence to the Inquest I ruled that: "*there is no evidence to support any accusation, either oral or on the documents thus far to place him in the category of a suspect*". Having assessed his evidence my view remains the same. I understand it to be endorsed by Mr and Mrs James whose written submissions to me include "*It is not suggested by the family that there is sufficient evidence to reach any conclusion that Paul Wilkinson caused or contributed to Ms James' death, nor would that be appropriate or lawful.*"

40. Absence from the gate

40.1. Pte Michelle Burgoyne of 41 Transport Regiment in her statement of 2003 recalls jogging into the camp by the back gate at around 07.10 when she did not recall seeing anyone on guard duty. That evidence was first given eight years after events and, as she declined to attend this hearing, it could not be tested. Against that background little weight can be attached to her timings.

- 40.2. Staff Sgt Robert Collard was running a course for Pioneers starting at 08.00 and his routine was to open up at 07.30. He thought this day he was at the gate between 07.00 to 07.05. As he approached, his was the only car. He saw the gate open, the barrier up and no one there. He drove through slowly and could see no one in the portacabin. He decided to report matters to the guardroom. Cpl Campbell of the RP staff acknowledged it and other calls might have reported the gate unmanned. However Cpl Campbell was imprecise in his recollection of when these calls might have been made. Sgt Collard did not try to recall his own timings until 2002 and other evidence suggests he might be mistaken, as the gate would only just have been unlocked by 07.00.
- 40.3. Cpl Martin Barrow said he walked through the open gate but noticed no one on duty. His routine was to pass through about 08.00. He phoned the guardroom to report the guard's absence and they said that they would see to it. WO1 Loftus recalled her civilian drivers from about 08.15 reporting no one on guard so she automatically phoned the guard room to tell them. She recalled them at first doubting the accuracy of her message which might suggest that hers was among the first.
- 40.4. Capt Brian Dixon now has no recollection of events but made a near contemporaneous statement in 1995 and another in 2002. He was an Instructional Officer and would open his building for the first lesson at 08.30. He estimated he arrived at Royal Way gate at about 08.25 or a little later, and found the road barrier raised but no sign of the guard. The road was empty and he had passed no one driving toward the camp. On entering the hut he saw only a cigarette packet. He looked briefly in the area and in the woods opposite within the perimeter fence but found nothing. A civilian vehicle stopped behind him. He drove to the guard room, and as he put it, "stuck his head in and told them to sort it out". He continued to the Education Centre where he still arrived in time for 08.30.
- 40.5. Sgt Philip Wood normally cycled to work. He could not recall his arrival time on November 27 but said it might have been the 08.30 suggested by Cpl Wilkinson. His only recollection was that the gate was unguarded. He had a brief look then carried on to the training wing some 100 metres from the gate and near to where Cpl Wilkinson recalled them meeting. He opened up and phoned the guard room speaking, he thought, to Cpl Campbell who said he was dealing with it. He assumed he was not the first to report the matter.

- 40.6. WO1 Stephen Shaw cycled through the unsupervised gate between 08.15 and 08.30. He did not recall hearing anything and could not remember if he contacted the guard room, although it would have been his normal practice.
- 40.7. Staff Sgt Wayne Townsend cycled from Dettinger Barracks at about 08.10 aiming to arrive at 08.30 for a 09.00 class. He told me that he heard a shot as he came down from the hill near Dettinger House. He said he arrived at the gate about thirty seconds later to find the gate open but the barrier down. Whilst the actual time of his arrival at the gate was not recorded by him until 2002 and so, as with others, is open to distortion by the passage of time, he was very clear that it was just half a minute from hearing the shot before he reached the gate. There is no reason to doubt his estimate.
- 40.8. Several others within the camp perimeter also recalled hearing a shot. Some assumed it came from the firing range. However Pte Warboys on duty at the main gate said some people could pinpoint the shot as coming from the perimeter.
- 40.9. The shot was audible to some in the guard room. Pte Fawcett recalled someone from the front desk saying he had heard shots or a shot from the Royal Way gate. Pte Slattery was in the guard room kitchen with Pte Miller when she heard a single shot. They joked that Ms James had let off a round by accident. No one thought it merited immediate investigation. Pte Slattery recalled five to ten minutes later a call generated a frantic reaction. None of these witnesses gave a precise time for the shot. However, their evidence is that it was a single shot.
- 40.10. Reaching the gate thirty seconds after hearing the shot Sgt Townsend saw no one in the vicinity nor any guard on duty. He received no response to his calling out and a quick look in the portacabin and round the back revealed nothing. The short time he took to reach the gate after hearing the shot strongly suggests he was the first to approach the gate after Ms James' death.
- 40.11. Sgt Townsend, concerned about security, went to the nearest phone in A Squadron building and reported matters to the guard room and added that he would go back and cover the gate. It is possible that some of those mentioned above came through the unattended gate whilst he was away.
- 40.12. Sgt Townsend said he waited about 5 – 10 minutes at the gate. No one came through and there was no relief. He left and rang Sgt Patterson at the guard room and told him in no uncertain terms “to get his arse into gear.” He then

saw a RP Land Rover going past. He did not return to the gate, and only later learnt that there had been an incident.

- 40.13. A log sheet was started in the guardroom records the time of a single call from Sgt Townsend at 08.25. However, Lance Corporal Peckham who made this entry said it was not a contemporaneous or precise recording. LCpl Peckham was ordered to complete the first few entries on this log in a single sitting, on the direction of WO1 Vernam after Ms James had been found, at some time after 08.55.

41. Conclusion as to the time of death

- 41.1. It is not possible to reconcile all timings and sightings of Ms James, nor would I expect to do so. Most were estimates. Some of the divergence of timings might be explained by Ms James leaving the gate on more than one occasion, but there is no evidence to determine whether or not this probably happened rather than the witnesses being mistaken about when they got to the gate. The clear thrust of the evidence is that between 08.15 and 08.25 Ms James left the gate for the last time.
- 41.2. Similarly, it will never be possible to know with certainty when the shot that killed Ms James was fired. The evidence suggests it was at about 08.25.
- 41.3. PC Stephen Hawkes, an MOD Policeman stationed at Pirbright, received a call about 08.30 from the Deepcut guard room that a female soldier who was armed was missing from her post. His timing may not be accurate, but his account suggests that whoever called him did not know that Ms James was dead.
- 41.4. A guard missing from a gate was a significant security lapse and it is unsurprising that officers and NCOs thought it worth reporting. There had probably been at least one personal report of her absence and at least five persons including Sgt Townsend made phone calls to the guard room. Those at the guard room did not immediately react or seek to establish Ms James' whereabouts before Sgt Townsend provided the final catalyst at around 08.25.
- 41.5. It was unusual for a guard to be missing when on duty and even more unusual for two or three such calls to come in. Given the responsibility of those in the guard room for security it is surprising there was no documentation of the repeated calls. Earlier action from the RP staff in response to such a significant absence would be expected, yet there appears to have been a delayed and

incoherent response despite security being the core responsibility of the guard room.

- 41.6. However, whilst it is possible some calls reporting her absence preceded Ms James' death, it would be speculative to suggest that more immediate action by the RP staff could have altered the subsequent events.

42. The discovery

- 42.1. LCpl Vousden sent to investigate Ms James' absence arrived in the Land Rover. This was probably the vehicle seen heading to the gate by Sgt Townsend. He found no-one, but a radio was in the cabin. LCpl Vousden then acted as guard and checked the identification of vehicles coming through the gate. He flagged down LCpl Bancroft, who was leaving the camp, to help him look for Ms James. They noticed a camouflaged jacket in the low shrubs outside the gate to the right just into the tree line. LCpl Vousden approached Ms James and tried to take her pulse. She lay on her right with a weapon lying alongside her, stock towards her feet. He requested immediate attendance of his Sergeant on the radio.
- 42.2. LCpl Tyron Bancroft had earlier that morning seen Ms James on duty. In his statement of November 27 1995 he said that on the reverse journey he was flagged down by LCpl Vousden who pointed to the woods and said words to the effect of "check on her". He saw a waterproof jacket and the body. Ms James' feet were up the slope, higher than her head, the weapon slightly lower down the body. He moved her hood to check for a pulse.
- 42.3. Major Richard Simonds, the Deputy Chief of Staff, arrived on his bike. He gave a statement on the day of Ms James' death and gave evidence to the BOI describing his arrival at about 08.30. He remembered the time because of a TV news programme he had been viewing at home. It was not earlier than 08.30 and not much after 08.33. Once Ms James' body was pointed out, he could see her in a direct line of sight from the gate. He asked for clothing to be moved so that he could feel for a pulse. She was clearly beyond help.
- 42.4. Sgt Patterson arrived and they awaited the emergency services. LCpl Bancroft operated a cordon on the married quarters side of the gate where he stayed until relieved.

42.5. Lance Corporal Mark Corbett another of the RP staff attended. LCpl Corbett is a wholly discredited and unreliable witness. He has given multiple inconsistent accounts before and during his evidence to this Inquest. He has admitted telling lies about Ms James' death in the past and in the witness box he admitted he lied on oath during his evidence. He could give no explanation for having told so many different, sometimes bizarre stories about the events.

42.6. He agreed that his most serious lie was his false claim that four Privates had found Ms James having been sent out by him. This lie is likely to have been the source of the camp rumour that Ms James had been found by a trainee. There is no truth in it. No credence can be given to any of LCpl Corbett's evidence unless corroborated by reliable sources.

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PART 6: EVENTS AT THE SCENE

43. The initial scene

- 43.1. The location where Ms James died is not in doubt. Ms James was lying just within the treeline to the right of the gate looking outwards from the camp. Her body was approximately 11 metres from the perimeter fence line and 19 metres from the kerb. That area was lightly wooded with relatively limited ground vegetation. The body was on the margins of the wooded area.
- 43.2. One subject matter of proper inquiry is a contemporaneous police log entry from November 27 1995 of a report that “*this female was meant to be on guard duty at the rear of the barracks [sic], she was reported missing, on checking a room at the rear she has been found, believed a foxtrot*” (a fatality). This message has all the dangers of multiple hearsay and misunderstanding. Any suggestion that it reflects Ms James being found dead in the rear room in the portacabin at the guard post and her body moved is unsupported by evidence. I find this message of no probative value.
- 43.3. A number of witnesses at the scene confirmed that Ms James’ body was visible from the road and gate if one knew where to look. As she was found wearing camouflaged clothing her body would not have been immediately obvious once on the ground. She was not, however, hidden from view. Anyone standing where her body was found would have been plainly visible from the gate and the road.
- 43.4. There is no evidence that Ms James’ body was moved by those initially at the scene, other than for the legitimate purposes of checking for a pulse and identifying her. Photographs were taken before and after removal of the weapon, a task dictated by requirements of safety.
- 43.5. The magazine was fitted to Ms James’ SA80 rifle when she was found, and the evidence of those first on the scene is consistent with the position of the rifle shown in the initial scene photographs. It was by Ms James’s side, muzzle pointing to her head, her hands left above the right, with the back of her right hand lying on the weapon. There is no evidence from eye-witnesses or photographs to suggest her clothing was unusually disturbed or her pockets torn (indeed the scene photographs show her left breast pocket to be open and untorn).
- 43.6. Ms James had a large wound to the front right hand side of her face, just to the right of the bridge of her nose and in the right orbit. It was obvious that she was dead.

44. Attendees at the scene

- 44.1. CAD records show emergency services called by Cpl Corbett from the guard room at 08.44. The camp doctor and nurse also attended.
- 44.2. Nurse Catherine Smith was a civilian nursing sister at the medical centre. She had made no statement at the time of Ms James' death but came forward to Surrey Police in 2002 after speaking to a journalist. She arrived at the scene with her emergency equipment but was told she would not need it, as this was a fatality. She was the first healthcare professional at the scene and it was clear that Ms James was dead. She told the soldiers to await the doctor and then returned to the Medical Centre. She was told the body had been found a quarter of an hour earlier and she described everyone in shock.
- 44.3. Surrey Ambulance Service received an emergency call at 08.48. The first paramedic recorded his arrival on scene at 08.55 and a second vehicle arrived about 09.00. Information about the incident was recorded on both ambulance crews' report forms as 'query suicide'. There was no role for the ambulance service who were stood down by the attending Police Inspector, and so left.
- 44.4. Dr McClenahan arrived at 09.00. She only touched Ms James to check for a pulse. The ambulance log recorded her confirming Ms James' death at 09.00.
- 44.5. Dr McClenahan said she only had a very brief look at Ms James. In a statement made at 12.14 on November 27 1995 she recorded that she did not notice any soiling at the wound site. It seems that either her view of the wound was very cursory or her recollection of the wound immediately impoverished, as in that same statement she also recorded, inaccurately, that the wound was to Ms James' right temple.
- 44.6. Dr McClenahan did not recognise Ms James. A formal identification was made over an hour later by Sgt McEleavey.

45. Surrey Police arrival

- 45.1. PC Anne Pheby was one of the first civilian police officers to arrive. With a colleague at the guard room before 09.00 she was informed the body had been by found by LCpl Vousden. With blue police tape, as the photographs show,

they made a cordon and created an access route to the body. The RP staff posted male trainees on the road to stop traffic approaching the gate.

- 45.2. PC Pheby started a scene log, later maintained by her colleague PC Rowan-Smith. In contrast to the retrospective RP staff log, this meticulous contemporaneous record is likely to be accurate, and is to be preferred where there is any discrepancy.
- 45.3. At 09.01 Mr Robert Rumbold the Surrey Coroner's Officer was notified of the death and the police log records his arrival at 09.48. Others from Surrey Police and the RMP were also arriving.
- 45.4. Inspector Michael Day was the Police Duty Inspector. A uniformed officer of twenty-five years standing, he had no experience of a suspicious death. He arrived at 09.04, met PC Pheby and PC Rowan-Smith, went to the location and stayed outside the cordon so as not to contaminate the scene.
- 45.5. PC Hawkes and PC Paul Davidson of the MOD Police based at Pirbright arrived. Surrey Police and numerous army personnel were already present.
- 45.6. In his first statement in 2002, PC Hawkes recorded that he walked to within three to four feet of the body. He recognised Ms James as a recruit from Pirbright and noted "powder burns to the right side of her face". Asked for more detail in a statement seven months later he said: "the black mark round her eye was black powdery substance that gave the appearance of being powder burn". PC Davidson who was with him had no recall of seeing any wound.
- 45.7. PC Hawkes, courtesy of a discussion between RMP and Surrey Police, knew it was thought that Ms James had taken her life. As she was a soldier and the death was at the camp, RMP would deal with the enquiries. The MOD police officers left at about 09.16.
- 45.8. PC Pheby and a colleague went to Ms James' accommodation block about 09.35. PC Pheby looked unsuccessfully for a suicide note although she found a bag containing personal letters which have been made available to the Inquest.

46. The SIB

- 46.1. At 09.22 Sgt Michael Harrison and his colleagues arrived from the Special Investigations Branch (the SIB) of the Royal Military Police at Aldershot. Sgt

Harrison spoke to Inspector Day and offered his services as they awaited the arrival of the CID and the Coroner's Officer. Sgt Harrison was a qualified Scenes of Crime Officer and investigator. He had his camera and so although Inspector Day had requested a civil police photographer this request was cancelled at 09.46 because a military photographer was at the scene.

- 46.2. Sgt Harrison was assisted in giving his evidence by his contemporaneous notes and diary report, and he had a reasonable recollection of Ms James' case. He recalled a general conversation at the scene with the civil police and the Coroner's Officer regarding the circumstances not seeming suspicious. Mr Rumbold was an extremely experienced Coroner's Officer, and the scene did not appear suspicious to him.
- 46.3. Sgt Harrison did not challenge the idea of self-inflicted death, as there was nothing suspicious about the scene or anything that jumped out at him. To him "it was the opposite of contrived". He saw no sign of a struggle and nothing to suggest Ms James had died elsewhere. The outcome of the combined discussions was agreement that Surrey Police would not take any further action, and the SIB would lead the investigation. At 10.30 Sgt Harrison recorded in his notes "*jurisdiction handed over to us by the civilian police and Coroner.*"
- 46.4. Inspector Day confirmed there was no dissent from the view that it was not a suspicious scene, and told me as a result he made a decision that the civilian police would not take primacy. He left matters as a Coronial investigation with the support of the Military Police and army staff, who would have better access for the follow up investigations.
- 46.5. Sgt Harrison appreciated that Surrey Police had subsequently apologized for not taking primacy, and accepted that he should have ensured a full scientific examination, but said he was ready and willing to assist and he did his best to record and investigate impartially on behalf of the Coroner.
- 46.6. Sgt Harrison photographed the scene and drew a sketch plan with measurements. As far as he knew no one had touched the weapon and he presumed that it was live.
- 46.7. His photograph of Ms James' left hand shows a linear mark. He had no recollection of thinking about any need to photograph gunshot residue as there was already an assumption about the type of inquiry. He said he was probably more focused on recording the scene. Sgt Harrison had received gunshot residue himself when firing weapons, so was aware of it. He thought the wound a classic close contact shot with a flash eliminator to the skin with

charring, and looking back he thought there was gunshot residue because of the blacking and dark colouration around the wound.

- 46.8. The Armourer, LCpl Michael Burrows, arrived at 09.55 but had to wait until the first round of photography was finished. At 10.17 he approached Ms James' body, lying on its right. Although more concerned with making safe the weapon, he believed there were black markings around her right eye socket. His 2002 statement said "there appeared to be powder burns around the right side of her nose by the right eye socket" but he acknowledged that he was not a gunshot residue or ballistics expert.
- 46.9. LCpl Burrows could see the safety catch of the SA80 was on 'fire', the magazine fitted and the selector lever was on repetition. This was consistent with a round having been fired and meant that the weapon was ready to fire again without re-cocking. He removed the magazine, finding eight rounds and ejected a ninth round in the chamber. He handed these to Sgt Harrison. He noted the weapon had the correct webbing attached which enabled it to be slung across the chest leaving both hands free.
- 46.10. LCpl Burrows later thoroughly checked the weapon, finding no faults with it and recorded its unique serial number. In due course it was stripped, cleaned and reconditioned.
- 46.11. Sgt David Norton was an ammunition technician in the Explosive Ordnance Disposal Regiment. One of his roles was to check and report any ammunition accidents or failures and suggest measures that might prevent any recurrence. He was very familiar with the SA80 and its use. He arrived about 10.14 hours by which time there were a significant number of vehicles and people at the scene. He was briefed by the SIB and the Surrey Police and escorted to the body.
- 46.12. He said he looked closely at the weapon, noted the location of the wound to the head and blackening around the wound, which to him looked like powder, although whether from powder burns from the gun or bruising he did not know. Nothing raised his suspicions that the incident was other than self-infliction. He believed he saw the weapon in its original position and nothing struck him as strange. What did, was that there was no exit wound, although later an experienced senior NCO colleague explained how this might be given the tendency of the 5.56 round to fragment.

47. The search for the cartridge

- 47.1. The search for a spent cartridge was not easy given the type of undergrowth. In Sgt Norton's considerable experience of having fired more than 10,000 rounds from an SA80 and watched others, the ejection range when the shooter was standing was typically between 2.5 and 5 metres.
- 47.2. At 10.44 undertakers arrived to remove Ms James' body and after this the cartridge case was found. Sgt Harrison photographed the finding place, which was two metres from where the body had lain, uphill and to the right of where Ms James' feet had been.
- 47.3. Cpl Steven Davies of the SIB was a trainee. He described people moving the undergrowth like looking for a lost ball. Sgt Harrison described the moving of bracken with feet or hands. Those involved generally accepted that the spent cartridge could have been moved, but not any significant distance given the nature of the wooded ground.
- 47.4. Sgt Norton found the identification marks on the cartridge showed it to be from the same batch as the rounds in the magazine, and in the guard room, although a number given to many thousands of rounds. It was operations stock and different from that used for training.
- 47.5. Sgt Norton also noted the 'witness mark' caused by the firing pin resting against the base of the round within the chamber as expected. What was not expected was one of the other eight rounds also having a witness mark which meant that a weapon had been 'made ready' with that round. To chamber a round would go against standing orders and procedures unless under threat, and if discovered without reason or recording in the occurrence book, should have been dealt with very firmly. This led Sgt Norton to check all 210 rounds available for issue in the guard room. He found twelve exhibited witness marks. This was a concern as there was no good explanation, and the witness marks had not been picked up by the guard staff. There appeared to him no system to prevent or detect inappropriate making ready of weapons.
- 47.6. On November 30 1995 Sgt Norton's report recorded the thirteen examples of chambering. His recommendation was that each sentry post where ammunition was issued should be double-manned or, where possible, no ammunition issued unless absolutely necessary.
- 47.7. Sgt Harrison exhibited the SA80 rifle, an SA80 magazine, eight 5.56 rounds, a single round, a spent 5.56 empty case, and a blue beret. In due course he

received from the civil police a bag of personal correspondence recovered from Ms James' room.

48. Absence of scientific analysis of the scene

- 48.1. It is clear that although some steps were taken to limit disturbance at the scene, it was not treated as a scene of a crime might be. It was not preserved or subject to any scientific testing.
- 48.2. Almost from the outset the assumption by members of the Army and the public services who attended was that this was a self-inflicted injury. This assumption clearly coloured the subsequent approach to the collection of evidence.
- 48.3. Inspector Day acknowledged that his finding that Ms James's death was 'non-suspicious' was based on assumption and on information from others, not on his independent investigation. He and Sgt Harrison frankly accepted that there should have been a full scientific examination. As Inspector Day said: "Hindsight is a wonderful thing. Had it been, or had I had to make that decision again, I would without doubt have taken a different course of action."

PART 7: INVESTIGATIONS AFTER EVENTS

49. Introduction

49.1. The adequacy of the previous investigations is not within the scope of the Inquest. Nevertheless, I mention them briefly because they generated the vast majority of the evidence upon which this Inquest, twenty years after Ms James' death, has had to rely. The evidence I heard has to be assessed bearing in mind the context of how it came into existence.

50. The post-mortem examination

50.1. The post-mortem examination was on November 28 1995 carried out at Frimley Park Hospital in Surrey by Dr Christopher Smith, MA MBBS MRC Path, consultant histopathologist. In attendance were Sgt Harrison, Mr Rumbold, Cpl Davies, LCpl Lisa Dean of the SIB, RSM Gerald Kelly, and the mortuary technician, Mr John Robinson. All gave statements to the Surrey Police reinvestigation and in addition to Dr Smith's post-mortem report which he dictated at the time, Sgt Harrison made and kept his own contemporaneous notes.

50.2. The examination, which took about an hour, was a standard coroner's autopsy. Dr Smith asked both the Coroner's Officer and the members of the military police present to clarify why he, rather than a forensic pathologist, was being asked to conduct the autopsy, as he felt a forensic examination might be appropriate. He was told the investigation at the scene had led investigators to believe this was suicide without evidence to suggest that anybody else had been involved.

50.3. It was very thorough. Both Dr Cary and Prof Pounder, forensic pathologists commenting twenty years later, considered it well above the standard of a routine coroner's autopsy. No criticism can be made of Dr Smith who did what he was instructed to do professionally and properly. However, this was his first autopsy of a person killed by discharge of a rifle and he had little experience of gunshot wounds. It is regrettable that a more detailed forensic autopsy was not requested.

50.4. Dr Smith recorded no signs of assault by a third party, and no evidence of significant natural disease. A large gaping wound in the centre of the head involved the root of the nose inferiorly, the medial aspects of both orbits and the frontal bones. The wound measured 6.5 x 5.5 cm in breadth.

- 50.5. Internally there was extensive disruption of the calvarium and base of the skull, with burst fractures of most sutures and irregular fractures through both parietal and occipital bones. The brain was extensively disrupted. There was no exit wound apparent on examination or visible on the four photographs taken during the autopsy.
- 50.6. A magnetic metal head of a bullet was embedded in the posterior portion of the right cerebral hemisphere and multiple irregular fragments of metal bullet component were distributed within the posterior fossa. The bullet fragments were not retained, Sgt Harrison could not now recall why, but suspected it was because it was assumed they were from a 5.56 round. Certainly no one thought this needed direct scientific confirmation. Sgt Harrison agreed, in hindsight, that they should have been kept.
- 50.7. The cause of death was recorded by Dr Smith as “1(a) Gunshot wound to the head”.
- 50.8. Blood samples taken at autopsy were later reported as negative for alcohol and commonly abused drugs. Mr Humphrey, the forensic scientist who examined the samples later explained, in his 2002 statement, that depending upon tolerance, about nine hours between last consumption of alcohol and death would be sufficient for alcohol to have been broken down and eliminated. Hence it was possible for Ms James to have appeared drunk the evening before yet have a zero blood alcohol level at her death.
- 50.9. Dr Smith did not record the presence of soot, propellant, black charring or dark markings on the body. As his memory of the examination was not fresh, he initially suggested to this Inquest that no inference could be drawn from the fact that soot was not mentioned. He later stated, however, that if he had seen something he was confident was soot then it would have found its way into his report, although he could not say he would have mentioned searing of the skin.
- 50.10. In his contemporaneous notes, Sgt Harrison recorded under ‘external observations’ “*Black charring or make up below right eye*”. He could not now recall whether Dr Smith dictated this, as his written notes were a combination of Dr Smith’s dictation and his own observation. He stated that this record was consistent with his recollection of charring on Ms James’s body at the scene.

- 50.11. Cpl Davies remembered LCpl Dean pointing out powder that looked similar to mascara on Ms James' eyelashes and a line of powder round her cheekbones like mascara which had run. He said this they could all see. He did not recall the term 'gunshot residue' used and he could not say that it was residue or not as no chemical testing of the black powder was done. There was discussion of the topic back at Aldershot, and in hindsight Cpl Davies thought it gunshot residue.
- 50.12. The Coroner's Officer Mr Rumbold had no real recollection of the autopsy. He could not recall considering gunshot residue but it was not his expertise and would have relied on others. He did not recall mascara being mentioned.
- 50.13. During the autopsy Cpl Davies searched Ms James' clothing and found nothing of significance. Sgt Harrison's note recorded that some items were left at the hospital for incineration and other items were retained as personal effects. No testing was done on any of Ms James' clothing.

51. SIB investigation and photographs

- 51.1. On November 29 the SIB RMP Initial Case Report submitted by Major Wooldridge recorded Ms James' death a 'suspected suicide' and indicated that 'foul play is not suspected'. The investigation of the death continued by the SIB was not aimed at establishing whether there had been the commission of any offence. The SIB's role was seen as to assist the Coroner by recording witness statements from unit personnel to be submitted to the Coroner. The assumption remained that Ms James' death was self-inflicted and non-suspicious. Sgt Harrison said: "We were not dealing with a full criminal inquiry, it was more coronial and I suppose unfortunately it was based on assumptions of what had happened."
- 51.2. Sgt Harrison continued his enquiries as main investigator and kept rough notes of the information that was gathered. Those notes were available to this inquest. Sgt Harrison took statements from those he understood to be primary witnesses. Fourteen witness statements were obtained in addition to those of the RMP investigators and sent with the photographs to the Coroner's Office on December 14 1995. On December 18 the SIB was given the indication that no further evidence was required by the Coroner.

51.3. As a result of the assumption that this was self-harm and the approach adopted, basic and important steps to protect or preserve evidence were not taken. Most significantly:

- neither the scene nor Ms James' body was scientifically investigated on discovery of the death;
- no ballistics testing was undertaken to establish whether the cartridge recovered had been fired by Ms James' rifle;
- there was no forensic post mortem;
- there was no detailed recording of the observed presence or absence of gunshot residue;
- there was no testing for gunshot residue;
- recovered bullet fragments from the post-mortem were not preserved;
- Ms James' clothes were left to be incinerated without testing;
- no documents were seized from the guard room;
- there was no immediate attempt to draw up a comprehensive time line of sightings of Ms James and the passage of people through the gate whilst that evidence was fresh in people's minds.

51.4. This has left unanswered questions, which has understandably fuelled speculation as to how Ms James died. In the absence of direct scientific evidence on key matters experts have had to form their opinions without all the information they would normally expect to have had available to them. I have kept this disadvantage at the forefront of my mind.

52. The Inquest

52.1. A Coroner's Inquest on December 21 1995, less than a month after Ms James' death, heard oral evidence from Mr James, Pte Miller, Pte Wilkinson, LCpl Vousden, Major Gascoigne and Sgt Harrison. After a brief hearing the Coroner concluded there was no evidence that any other person caused the death and did not find accident was a likely explanation. However, he did not find suicide proved to the criminal standard and returned an open verdict.

52.2. This present Inquest follows the quashing by the High Court in 2014 of the first Inquest on the grounds of insufficiency of inquiry.¹

¹ *James v HM Coroner Surrey* [2014] Inquest LR 207.

53. Army investigations

- 53.1. In the aftermath of Ms James' death there were two investigations by the Army.
- 53.2. Brigadier Evans' review of Phase 2 training at Deepcut, was aimed at identifying any underlying reasons for the suicides of Ms James and Pte Benton. It reported on December 14 1995 and focused on shortcomings in the regime at Deepcut and the management of Phase 2 trainees rather than the facts of Pte Benton's or Ms James' death. It generated no new factual evidence relevant to events of November 27 1995, although several shortcomings were identified by Brigadier Evans who made recommendations for change.
- 53.3. The only other contemporary investigation featuring live evidence from witnesses was the Army's BOI in January 1996. Evidence was heard from eleven witnesses including all those army witnesses who had given evidence at the Inquest. Although no transcript was made, the short notes of the evidence were available to this Inquest. The BOI report recommended a radical review of Phase 2 training and concluded that Ms James had shot herself.

54. Surrey Police

- 54.1. In 2002 following two further deaths of trainees at Deepcut, Surrey Police opened an investigation into all four deaths. This lasted from July 2002 to September 2003. The vast majority of evidence heard at this Inquest arises from material then gathered and generated.
- 54.2. The passage of time between the Surrey Police investigation and the death precluded remedying the limitations of the original investigations. An unusual feature of this case is that much of the evidence gathered long after events was in the shadow of assurance or assumption that Ms James had committed suicide.
- 54.3. As Mr and Mrs James remind me, material consistent with a preconceived notion of suicide has taken greater prominence. The requirement for witnesses to recall events over twenty years ago in oral evidence led to a heavy reliance on witness statements, but the accuracy and reliability of those statements – many not made until seven years after the events - cannot be presumed. This and the extent to

which preconceptions may have tainted the evidence are risks that I have in mind when assessing the evidence.

54.4. The pathology and ballistics experts consulted by Surrey Police have been available to assist me alongside the two experts instructed afresh.

54.5. Mr David Pryor had 44 years' relevant ballistic experience derived in part from Iraq and Afghanistan. Dr Rouse has been a Home Office pathologist for 28 years. In the mid-1990s, he was seeing a shooting case a day. He also has valuable Gulf War experience with high velocity weapons.

54.6. Surrey Police also commissioned reports from the Bundeskriminalamt (BKA), the German Federal Police's Investigatory body, addressing ballistics issues in respect of all four Deepcut trainees' deaths.

54.7. The BKA reports and correspondence were co-authored by their team including Dr Bernd Salziger and Dr Ruprecht Nennsteil. The BKA also sought expert forensic pathology assistance from Professor Urban.

54.8. Whilst there has been some criticism on behalf of Mr and Mrs James of how Surrey Police's instructions to BKA developed, I am satisfied the scientists at BKA were acting independently and objectively in conducting their experimentation and reporting. I am extremely grateful to Dr Salziger and his colleagues Dr Thomas Liebscher and Dr Ludwig Niewoehner for agreeing to provide oral evidence and for the assistance that they have given me.

55. The Blake Review

55.1. Following the conclusion of the Surrey Police re-investigation the government appointed Nicholas Blake QC, now Mr Justice Blake, to investigate the circumstances of all four deaths at Deepcut in his *Deepcut Review* published in March 2006. This review was comprehensive and wide-ranging and identified very many of the concerns and shortcomings in the operation of Deepcut Barracks about which I have already spoken. It also generated further evidence used at this Inquest in the form of interviews with the chain of command.

56. New evidence at this Inquest

- 56.1. Whilst the majority of the witnesses I heard were identified through the Surrey Police investigation, a number of additional people have come forward to the Inquest with general information about Deepcut and their own experiences. I am very grateful to all who have offered their help. In most cases the information offered fell outside the scope of this inquest and there was agreement that these potential witnesses need not be called. Four of those new witnesses had information relevant to the facts of Ms James' death which fell within the scope of the inquest, and their evidence has been heard. Only one witness of fact declined to give oral evidence, so that evidence was read.
- 56.2. For my investigation and Inquest two further experts were commissioned to report. Dr Nat Cary MA MD MBBS FRCPath DMJ(Path) FFFLM has been a Home Office forensic pathologist for 23 years. He has longstanding firearms expertise, including recently examination of the terrorist shootings in Sousse, Tunisia and at In Amenas, Algeria. He oversaw the exhumation of Ms James in August 2015 and conducted the exhumation autopsy.
- 56.3. Ms Ann Kiernan BSc (Hons) MSc has been a forensic scientist since 2001, specialising in firearms since 2003. She has extensive experience with military rifles and ammunition, and has attended many post-mortems following deaths from high-velocity rifles. She has been involved in the investigation of a number of cases of gunshot wounds to the head from 5.56 rounds. Although ballistics testing had already been carried out by BKA she conducted further experimentation at my request. Each of her reports has been peer reviewed by Dr Mark Robinson.
- 56.4. From a booklet of photographs by Sgt Harrison at the scene and the post-mortem in 1995 some of the original negatives were used by specialist medical photographers to produce the best possible digital enhancements and obtain the clearest image.
- 56.5. I heard the evidence of the experts at the conclusion of the inquest (with the exception of the German BKA experts who were heard via video link at a time convenient to them). This had the advantage of my hearing the views of the various experts against a background of tested factual evidence. The experts included Professor Derrick Pounder MB ChB FRCPA, a forensic pathologist

instructed on behalf of Mr and Mrs James. Prof Pounder is Professor Emeritus of Forensic Medicine with extensive international experience. He was given access to all materials and attended the site visit to Deepcut which I undertook, with all the legal teams, in December 2015.

56.6. That site visit helped me understand the layout of Deepcut camp and in particular that the Royal Way gate was not remote or a secluded place, but was visible and accessible from the camp within direct sight of the trainees' accommodation and the parade ground.

56.7. Shortly before the inquest hearings in February Ms Kiernan conducted follow up experiments. The German experts were asked by me to provide a report commenting in more detail on projectile deflection after their oral evidence had been concluded. Some criticism was levelled by Mr and Mrs James at Ms Kiernan (although not at BKA) for conducting these clarifying tests without direct instructions to do so, but I am satisfied this was a reasonable step and provided useful material in a specialised area. Those further findings helped me in considering what could be observed in the photographs of the face, as well as with the explanation of the failure of the projectile to exit from the back of Ms James' head.

56.8. A joint expert meeting on January 27 2016 between Dr Cary, Prof Pounder and Ms Kiernan clarified areas of agreement and dispute. Ms Kiernan had not been able to view the enhanced photographs and Prof Pounder and Dr Cary had not had proper opportunity to consider her most recent testing, so some aspects of their opinions could only be clarified after that meeting.

PART 8: CONCLUSION AS TO THE DEATH

57. The medical cause of death

- 57.1. There is no question as to the medical cause of Ms James' death. Naturally occurring disease was ruled out and the evidence of a gunshot having disrupted the brain and caused widespread fragmentation of the skull is indisputable.
- 57.2. If further confirmation were needed, Dr Cary and Prof Pounder agreed that their findings at the post exhumation autopsy were consistent with death from a single high velocity gunshot wound with entry in the upper face. Their re-examination confirmed there was no identifiable gun shot entry wound to the back of the head, nor any identifiable exit wound. The inference was that the bullet's trajectory was front to back.
- 57.3. I find that the cause of Ms James' death was: 1(a) gunshot wound to the head.
- 57.4. I have not adopted the more descriptive formulation suggested by Prof Pounder of 'a high velocity gunshot wound to the head' because my findings in box 3 of the Record of Inquest will make clear the type of weapon that I find was used.

58. The law regarding conclusions as to the death

- 58.1. Whilst there is no statutory requirement to reach any short form conclusion at an inquest, the Chief Coroner's Guidance Number 17 on Conclusions is clear that:
- "Wherever possible coroners should conclude with a short-form conclusion. This has the advantage of being simple, accessible for bereaved families and public alike, and also clear for statistical purposes" [§26]**
- 58.2. I agree. Furthermore, that advice is particularly apposite where, as here, the wider public interest sits within the context of intense media focus upon Deepcut. Such a case requires a comprehensive, clear auditable conclusion not only for the bereaved, but also as a matter of public record.

- 58.3. I have been reminded by counsel for the interested persons that a short form conclusion can be combined with a narrative conclusion. I agree, and shall do so. Those representing Mr and Mrs James also urge me to return a short form within a narrative which also addresses systemic failings.
- 58.4. There are three contexts in which a traditional short form conclusion might be returned following death from a gunshot wound: killing by another, self-infliction and following an accident in either scenario. I have therefore considered all the evidence with those three contexts in mind.
- 58.5. Before coming to my conclusion I have reminded myself of the law which has been so helpfully set out in the comprehensive oral and written submissions on behalf of all the interested persons and by Counsel to the Inquest. There is very little difference between the interested persons as to the legal position in respect of short form conclusions; it is regarding the application of the law to the facts where the submissions differ. In the light of the agreement on the core legal principles, I need only set out the legal framework in outline.
- 58.6. Conclusions requiring the highest standard of proof, unlawful killing and suicide, must be considered before others.
- 58.7. A short form conclusion of unlawful killing by another person must be proved to the higher criminal standard. No interested person has suggested that there is evidence upon which I could find beyond reasonable doubt that Ms James was unlawfully killed. I agree.
- 58.8. The principles to be applied to sufficiency of evidence were formulated in *R v Galbraith*¹ with a later coronial gloss put on the *Galbraith* test in *Douglas-Williams*.² When I ask myself whether there is sufficient evidence on which I could properly reach a conclusion of unlawful killing and in addition, whether I am satisfied it would be safe to return such a conclusion, the only answer on the evidence I have heard is 'No'. Whilst there is no dissent from that proposition by any interested person, those acting on behalf of Mr and Mrs James still urge me to accept that Ms James was not killed by a near contact shot. That I consider in some detail later.
- 58.9. To return a conclusion of suicide the act and the intent must be established beyond reasonable doubt. I must be satisfied so that I am sure that the

¹ (1981) 73 Cr App R 124, CA

² *R v Inner South London Coroner, ex parte Douglas-Williams* [1999] 1 All ER 344

deceased deliberately and voluntarily did the act which caused her death and did so with the intent of taking her own life. Suicide can only be the conclusion after other possible alternatives have been excluded. It must not be presumed simply because it seems a likely, or the most likely, explanation. The case of *Jenkins v HM Coroner for Bridgend and Glamorgan Valleys*³ reminds me that a Coroner must:

'be sure that every other alternative had been excluded by the evidence; in a circumstantial case, ... [it is] not permissible to fill in gaps in the evidence...

and:

... [there is] an important difference between speculation and the drawing of an inference which excluded all other reasonable possibilities.'

58.10. A Coroner must exclude the possibility that the death was a result of some unexplained accident. *Per* Lord Widgery CJ in *Ex Parte Barber*.⁴

"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."

58.11. Whilst intent to die must be established to the required standard there is no requirement for a Coroner to determine why a person killed herself. Evidence of motive (in particular where notes are left) might assist in determining intent, but the Coroner is not obliged to discern (still less be sure of) reason or motive underlying the deceased's action and intention. I agree with the submission from the MOD that, on appropriate facts, a Coroner can be sure the death was self-inflicted and sure the deceased intended to take her life, but less than sure (or even unclear) what had led her to do so.

58.12. Evidence of intention to die can lie within the circumstances of and leading up to the death as well as by the means of achieving it. For deaths self-inflicted, the more obviously lethal the means, the more the circumstances may support the inference of an intention to take life. I accept the submissions of Surrey

³ [2012] Inquest LR 97 at §29.

⁴ [1975] 1 WLR 1310 at §1313.

Police, drawing on authorities from the criminal jurisdiction, that where specific intention must be found:

- Foresight of consequences can be evidence of intent, but no more;
- Probability of result can be critical in determining whether the result were intended: the greater the probability of the consequence the more likely it was foreseen; and if it was foreseen, the more likely it was intended.⁵

58.13. There is, however, no presumption within the criminal law that a person intended or foresaw the natural consequences of her act.⁶ A Coroner should approach the decision as to whether a deceased intended or foresaw a fatal outcome by reference to all the evidence, drawing such inferences from the evidence as appear proper in the circumstances.

58.14. If I am satisfied of the elements of suicide on the balance of probabilities but not to the required standard of proof, an open conclusion must follow. The Chief Coroner's guidance suggests reasoned explanation of why suicide was not proved.

58.15. The standard of proof for a finding of accidental death is the lower civil standard, the balance of probabilities. It is common ground between all interested persons that Counsel to the Inquest is correct in submitting that it would be unsafe on a *Galbraith* plus basis to return a conclusion suggesting accident.⁷ While suggesting that accident could not be excluded as a possibility, leading counsel for Mr and Mrs James accepted in her oral closing submissions that there is insufficient evidence for me properly to conclude on the balance of probabilities, that this death was an accident. I agree.

58.16. However, whether this death were possibly accidental must form part of my consideration of suicide, a conclusion open to me only after the exclusion of all reasonable alternatives.

58.17. Finally, an open conclusion is the only short-form conclusion open to me if no other is proved to the appropriate standard.

⁵ *R v Hancock & Shankland* [1986] AC 455, although foresight is not to be equated with intention: *R v Nedrick* [1986] 1 WLR 1025.

⁶ See *DPP v Smith* [1961] AC 290, and s. 8 Criminal Justice Act 1967.

⁷ Ms Dolan QC's written advice, 19 April 2016, §38

59. Evidence going to the Conclusion

Relevance of the distance at which the fatal shot was fired

- 59.1. A central issue has been the distance from which the shot which killed Ms James was fired. Distance is a key factor in determining the plausibility of self-injury.
- 59.2. It is not in dispute that a person can turn a SA80 rifle towards herself and depress the trigger causing a fatal head injury. Ms Kiernan analysed the distance from which this might be achieved. Using a woman of similar height to Ms James, Ms Kiernan established that the maximum distance from a SA80 muzzle to the head at which one could depress the trigger and self-inflict injury was about 26cm. Whilst this measurement cannot be exact, if the fatal shot were fired from a distance greater than 30cm it could not have been fired by Ms James and another person must be implicated in her death.
- 59.3. At the time of the death no steps were taken to explore the likely distance at which the fatal shot was fired. Had there been testing of Ms James' face or hands for any gunshot residue many of the subsequent questions that have arisen about her death could have been answered.
- 59.4. Scientific expertise was first canvassed during the Surrey Police investigation in 2002. Consequently, all ballistics specialists and pathologists have since worked with impoverished information in coming to their opinions as to whether or not the wound to Ms James' head was a contact shot or a near contact shot, or was a shot from a greater distance.
- 59.5. A serious and greater disadvantage for the experts is that much of their opinions have had to be based upon the 1995 photographs taken by Sgt Harrison at the scene, rather than their personal observations. Although the original negatives were used by specialist medical photographers to produce the best possible digital enhancements, there is a high degree of subjectivity in assessing even good quality photographs. They do not provide the same information as contemporaneous viewing of the subject in three dimensions.

The shape of the entry wound

- 59.6. The shape of the entry wound generated considerable debate. All experts agreed that the wound is 'stellate' with tears of the skin radiating out from the point of impact.
- 59.7. The BKA reported that this pattern of tearing was typical of shots at close range or contact. The regions round the eyes and the root of the nose were especially susceptible to the type of tearing seen here. Dr Salziger's team saw nothing inconsistent with a near contact shot.
- 59.8. Mr Pryor, the ballistics expert instructed by Surrey Police in 2002 and highly experienced in the examination of gunshot injuries, said his "strong opinion" was that this arose from muzzle contact, as to him the photographs showed stellate tearing caused by the expanding gases from a muzzle in intimate contact with skin causing the tissue to split radially.
- 59.9. Dr Rouse, a forensic pathologist who reviewed Dr Smith's original post-mortem report, as part of the Surrey Police 2002 investigation considered the appearance entirely consistent with contact, typical of what he had seen in self-inflicted shootings. He described this type of splitting as a result of large volumes of gas being forced into the skin on discharge. This in his view was the likely explanation. However, he accepted that stellate tearing could be caused by a distance shot and could not rule that out on wound shape alone.
- 59.10. Ms Kiernan agreed that stellate tearing typical of a near contact wound could also be caused by a distance shot. But she maintained that this wound was one of contact or near contact. She relied on a crescent defect between the left eye and nose associated with the discharge of gas independent of stellate tearing.
- 59.11. Prof Pounder accepted that the stellate tearing could be by way of a contact shot but he was of the view that such tearing was equally consistent with a distance shot and so the shape of the wound was not probative. In his opinion the wound shape could be accounted for by a distance shot to tight skin over a bone such as the orbital ridge, or the bullet entering the head and giving up its energy, causing temporary cavity formation within the skull. He believed it unnecessary to invoke a mechanism other than temporary cavity formation to explain the feature.
- 59.12. Dr Cary did not agree that what he saw as a typical stellate wound from a contact or near contact shot was equally consistent with a distance shot. He had never seen similar destruction immediately adjacent to the wound, from a

distance shot. He said at the expert meeting that the majority of high velocity entry wounds from a distance produced a neat round hole. To me, he said the most obvious finding in Ms James' case is of a typical contact wound with the consequences of a contact wound, namely massive destruction inside the head. He accepted possible causes of a stellate wound associated with massive destruction included an intermediate target destabilising the bullet. He noted that it was possible the first bone struck by the bullet at the front of the face could cause destabilisation. Dr Cary did not go as far as saying that a stellate tear from a distance shot was impossible. Although he had never seen such a phenomenon from a distance shot in his personal experience, even if not the norm, it was possible to achieve a wound of a stellate nature from a distance shot.

59.13. Professor Pounder's proposition, that the stellate shape of the wound taken alone is not determinative of distance must therefore be correct, given it is accepted by the other two forensic pathologists. Ms Kiernan agrees that the phenomenon of stellate tearing is not exclusive to contact or near contact.

59.14. Although I accept the opinions of Dr Cary and Dr Rouse, supported by all the ballistics specialists that the pattern is far more typical of a near, or contact injury, other physical features, and in particular the presence or absence of gunshot residue, must be considered before any conclusion might be reached as to the distance of this shot.

Absence of exit wound

59.15. From the earliest stages the absence of an exit wound was a matter of note and concern, and to the casual observer, a problem. Some non-expert witnesses found it strange that a shot from a high velocity rifle should not pass right through the head.

59.16. At the joint expert meeting all experts participating agreed it was common for high velocity 5.56 NATO rounds to fragment in the skull. However, whilst Dr Cary and Ms Kiernan both said a finding of no exit was within the range of possible outcomes, Prof Pounder felt the finding "anomalous".

59.17. A ballistics explanation for the fragmentation and non-exit was given at the inquest by Mr Pryor. He described how the 5.56 round's design was such that if a bullet hit the bony structures of the head at an angle it would tend to break up. The bullet would invariably break at its cannelure (a constriction half way down its side) and separate into smaller fragments acting as individual missiles. Each would have its own kinetic energy. Being small the fragments would give

up their energy very quickly and so greatly lessen the chance of an exit wound. If the projectile were only just emerging from a rifle it would also have a small degree of yaw or instability, which might contribute to this phenomenon.

59.18. To replicate experimentally the complex properties of a human skull and the exact conditions for entry and non-exit of a projectile is impossible. Experiments by the BKA in 2002 and Ms Kiernan in 2015 could demonstrate instability and fragmentation of a 5.56 round after hitting an intermediate target but could not replicate non-exit from a skull. However the BKA's later experimentation in 2016, which they reported at my request during the inquest, calculated the likely residual kinetic energy within the skull by measuring pieces of projectile as they passed through ballistic gelatin. The BKA deflected a round off a synthetic bone plate placed at an angle to replicate the orbit. The plausibility of non-exit was experimentally supported by their calculations.

59.19. It was well within Dr Cary's experience that the 5.56 NATO round had a particular tendency to break up. He said this was well recognised. He had previously spoken with Mr Tom Warlow, the author of the standard textbook on ballistics⁸ who cited a number close range fatal shootings involving an SA80. Warlow wrote:

"In almost every instance, which included head and chest shots, the bullets broke up inside the bodies, thus resulting in zero exits."

59.20. Warlow states it is likely that the tendency for 5.56 NATO rounds to fragment and be retained would be greatly reduced in longer ranges where the bullet has obtained a great degree of stability.

59.21. Prof Pounder, was aware of the textbook, but had not cited the relevant passage in his report since it did not explicitly distinguish head from skull. Prof Pounder acknowledged in oral evidence that he had been involved in only four or five cases involving a SA80 rifle and had relatively limited experience in cases involving 5.56 rounds fired at hard contact or close range. He said he omitted to mention this lack of experience as he did not consider it relevant. I disagree. An expert's experience of a key matter is relevant to the weight I give to his opinion.

⁸ Firearms, the Law and Forensic Ballistics. T A Warlow. CRC Press, chapter 7 'High Velocity wound effects'

59.22. I need not, however, weigh up the differing views as to whether non-exit is anomalous, as Professor Pounder withdrew his earlier contention that it was.

59.23. Professor Pounder initially suggested his view had changed because of information in the latest BKA report. But he accepted that the material parts of that information (in particular an experimental demonstration of temporary cavity formation early in the bullet's flight path), had already been available to him from the 2003 BKA report. He acknowledged that his reading of the more recent BKA report had been an error on his part.

59.24. All experts now agree that the lack of an exit wound after a contact or near contact shot is plausible. Whilst the lack of an exit wound does not militate against this being a contact or near contact shot, this factor alone does not help me determine the range of shot, nor can it assist in determining whether it were self-inflicted or inflicted by another.

The sound of the shot

59.25. Mr Pryor told me the characteristic supersonic crack and high notes of a rifle are lost in a contact shot when the signature sound is a muffled thud. A number of witnesses record having heard a shot, some from inside an accommodation block or the guard room. Mr and Mrs James submit that as none described it as a muffled shot that militates against near contact.

59.26. I cannot agree. This topic was not raised until final submissions and none of the witnesses who recalled hearing a shot had been asked to describe precisely its quality. No witness spontaneously described hearing a supersonic crack. There is likely to be a number of variables in play and in any event aural memory is not likely to be reliable after twenty years.

59.27. The evidence of those who heard a shot is not sufficiently detailed to be probative of distance or of a contact shot and, save to note that all reported hearing only one shot, I do not give it weight.

The presence or absence of gunshot residue

59.28. Experts were unanimous in the joint meeting that the definitive finding as to range of shot was the presence or absence of soot. The BKA also supported that view.

59.29. Soot residue is an almost inevitable consequence of a contact or near contact firing. The experimentation by the BKA and by Ms Kiernan demonstrated that at close range soot would be deposited upon the skin surface, but as the range increased less and less soot was deposited until at 50cm from muzzle to the target there would be very little visible soot or propellant. At an intermediate distance tattooing with individual grains of propellant can be observed but no one has suggested that such a phenomena was present in this case.

59.30. In summary, if soot were not present on Ms James' face, the range from which the shot was fired must be beyond that achievable with self-infliction and another person must have been involved in her death. The stark issue for me is whether the darker areas all the experts agree are present on the photographs of Ms James' face and left hand are soot/residue or some other phenomena, such as bruising, blood, dirt, or smudged make-up.

Facial marks

59.31. Prof Pounder proposed a medical cause for each of the several areas of darkening seen on the 1995 photographs of Ms James' face. He suggested that the area on the right cheek was sub-cutaneous bruising after outward bursting of the facial structure. The mark down the left cheek he thought associated with blood flow. Within the left eye socket he attributed marks to bruising. The dark area at the bridge of the nose and the blackening between the eyebrow he attributed to sub-cutaneous bruising associated with bursting lacerations. The dark areas round the wound margins he thought were either minor bruising, tissue drying, or blood.

59.32. The more extensive blackening on the face of 'Soldier A' (an undisputed close contact case, with some different factors) Prof Pounder thought worthy of comparative scrutiny. No other witness agreed. Dr Salziger said the lesser blackening on Ms James' face suggested the muzzle was very close to the skin.

59.33. Prof Pounder described how from the photographs of Ms James he visualized a 'virtual reconstruction' of the facial tissue. He suggested that from this he was able to conclude that there was no inward tissue loss and he could also identify an absence of any muzzle imprint on the facial skin which might arise on hard contact. The Professor had not mentioned these matters potentially so important to his overall opinion in any interim or final report nor at the joint expert meeting. There appeared a particularly high degree of subjectivity in this aspect of his opinion. The explanation, particularly as to muzzle imprint, was unconvincing.

- 59.34. A forensic post mortem in 1995 would have reconstructed the wound by aligning the edges of torn tissue. But although the Professor was trying to assist me I am not persuaded that the deficiencies in the original post-mortem can now be compensated by his virtual reconstruction which he agreed was a subjective task reliant, as he put it, on the observer's "mind's eye".
- 59.35. Dr Cary, properly, declined to adopt such a subjective technique, instead, warning of the need for caution when interpreting these images.
- 59.36. Prof Pounder did not feel so hampered by the limitations of the material. His opinion is that the quality of the photographs enabled him to be "satisfied" of the absence of soot. This is in stark contrast to comments by the other experts. The BKA made clear that it was not possible to give an unequivocal interpretation of the evidence. Dr Cary and Ms Kiernan told the joint expert meeting that the poor quality of the photographs restricted their ability to comment definitively upon the presence or absence of soot.
- 59.37. As Dr Cary told me it was apparent these photographs were not directed to record possible soot deposition, they were not carefully scaled and there was no attempt to get the right angles. One needs due caution before basing any opinion purely on photographs. I agree.
- 59.38. Prof Pounder described two dark areas, on the bridge of the nose and eyebrows, as "...areas which I would have I think greatest difficulty in persuading people." In his written evidence Prof Pounder had not acknowledged the possibility of debate or of a range of opinion about what these areas represented. It would have been helpful had he done so.
- 59.39. The BKA reported seeing blackish deposits on the unenhanced photographs in the two particular regions singled out by Prof Pounder as requiring his greatest persuasion of others. The BKA suggested the deposits could be gunshot residue and found unsurprising the absence of a substantial amount of visible gunshot residue. Skin at the point of entry was 'missing' and there might be blood masking. BKA experiments on pigskin in 2003, showed that with a shot from an SA80 at contact, the soot deposits mostly fell within a diameter of 6cm. Ms James' gaping facial wound measured at the original post-mortem 6.5 x 5.5 cm. Although recognizing that only chemical testing is definitive of gunshot residue, and not ruling out a firing by another, the BKA found no grounds which would contradict self-inflicted injury. It could say no more about what the blackish deposits might be.

- 59.40. Ms Kiernan emphasized that chemical testing is the sole definitive test. She deferred to pathology expertise regarding the mechanism of bruising and its characteristics, but had sufficient experience in gunshot residue and interpreting photographs to assess what appeared to her to be blackening on the photographs. She marked on an enhanced photograph the areas on Ms James' face that she regarded as not just consistent with soot deposition, but more consistent with soot than with other explanations when the overall picture was considered. These were the edges of the wound, the bridge of the nose, Ms James' forehead and left eyebrow and in the orbit of her left eyelid.
- 59.41. Whilst her experimentation had shown that the flash hider on a SA80 could produce a classic five pointed petal shaped soot deposition on a flat surface, her other test firings showed the absence of an obvious petal pattern could be indicative of hard or near contact or of the flash hider angled to the surface.
- 59.42. Her earlier tests on silicone mannequins demonstrated that soot deposition could be affected and reduced by the contours of the face, the left side being shadowed from soot by the nose. I accept her account that the amount of deposit that could be seen to remain on the silicone surface of the mannequins was a misleading comparator for human skin. Her tests on pigskin produced residue results similar to those produced by BKA in 2003 on a surface more comparable to human skin.
- 59.43. Dr Rouse after examining the original photographs reported seeing deposits of soot from the lower border of the right eye, a short length on the nose below the entry wound and a further length down the left cheek. He agreed that it was difficult to distinguish such marks from blood or bruising, but believed them to be soot.
- 59.44. Mr Pryor had not been shown the enhanced photographs and had not considered the facial marks in his 2002 report. From the photographs alone he could not say what the marks were. The most he could say was that there appeared to be blackening associated with the stellate tearing as he would expect to see in a contact wound of this type.
- 59.45. Dr Cary emphasized the limitations of opinions based on photographs. Despite his considerable experience he declined to give a view on the presence of soot or other causes of blackening. He saw nothing to suggest that the wound was other than from a contact or a near contact shot. His evidence was clear. The amount of soot deposited in a contact shot can be variable, and could explain the darkening shown on the photographs, since if pressure were applied with a contact shot less soot might escape. Hard contact limits the

potential for sooty gases emerging from the muzzle which may reduce blackening around the entrance wound. The muzzle soot could get caught in the wound and be difficult to see externally or soot from the flash hider might produce only a light dusting which might not stick to the skin.

59.46. Dr Cary agreed with Prof Pounder that “if there was compelling scientific evidence of a distance shot that would speak for itself”, but he added, “but of course there isn’t. From my point of view the compelling evidence in this is contact or near contact.”

59.47. Those representing Mr and Mrs James submit that whether soot is or is present is pre-eminently is an issue of medical science to be determined by the pathologists. I do not agree. Ballistic opinion is also relevant, but in any event Dr Cary is correct: the science and related expertise are only one part of the evidence. Opinions twenty years after events, based on two-dimensional photographs, must be weighed alongside the evidence of those witnesses who observed Ms James at the time.

59.48. Dr Smith’s 1995 post-mortem report did not refer to blackening or facial bruising. He had very little experience of death from firearms and all he had seen involved shotguns, not high velocity rifles. He told me he interpreted the discharge as very close, consistent with self-infliction. At this distance in time he chose not to comment on the presence or absence of residue.

59.49. Dr Smith now thought that if he had seen what he was confident was soot it would have featured in his report, although he might not have mentioned searing of the skin. Given Dr Smith’s lack of experience of this area, I must give less weight to this evidence than that of a forensic pathologist used to seeing and recording gunshot wounds. As a witness of fact his memory is, after twenty years, too limited. I respect his scrupulously professional caution in that and in all his evidence.

59.50. At the autopsy, Sgt Harrison recorded “*Black charring or make up below right eye*” which was consistent with his recollection from the scene. This note is the only contemporaneous documentary record made by any person of charring or anything that might be soot. I remind myself that it was written in the context of assumed self-infliction.

59.51. The only other medically qualified person viewing the body *in situ* and who made a near contemporaneous statement was Dr McClenahan. She told me she did not notice soiling round the wound, just as she recorded this in her 1995 statement. However, I can put little weight on these matters given her

admitted cursory observation of Ms James. Her contemporaneous statement was not intended to be, nor was it, a careful logging of the nature of the injuries she saw in her “quick look”. It included a fundamental error as to the location of the wound which she recorded as at Ms James’ temple.

59.52. All other non-expert or non-contemporaneous observations similarly need to be weighed carefully, with the additional caveat that in most cases it was seven years before witness statements were taken. Whilst many who viewed Ms James’ body at the scene have no recollection either way which assists as to deposition, none positively looked for gunshot residue but failed to find it.

59.53. Four eye-witnesses, however, do have a positive recollection of what they believed was dark powder or powder burns. PC Hawkes, an early arrival, said in 2002 that he had noted powder burns to the right side of the face. He confirmed his observation in a later statement saying “the black mark round her eye was black powdery substance that gave the appearance of being powder burn”.

59.54. LCpl Burrows in 2002 said he saw what appeared to be powder burns round the right of Ms James’ nose by the right eye socket. His purpose at the scene was to make the weapon safe and he tried not to look at the face. He could not say exactly what the black markings were.

59.55. Sgt Norton, the ammunition technician, said that he noted the location of the wound to the head and noticed blackening around the wound, which to him looked like powder. He could not say whether it were due to powder burns or bruising, nothing raised his suspicions of anything other than self-infliction. Sgt Norton said he examined Ms James’ injury closely enough to note there was no exit wound which he had thought unusual until another colleague later explained to him how this was possible if the round fragmented.

59.56. Cpl Davies recalled how, at the initial autopsy, LCpl Dean had drawn to others’ attention some powder resembling mascara on Ms James’ eyelashes and a line of powder round her cheekbone. That there was discussion about this powder is confirmed by Sgt Harrison’s post-mortem note of “black charring or makeup”. Cpl Davies said that after discussions he came to the view this was gunshot residue. Ms Kiernan agreed soot could resemble black mascara to a layman, or even to a ballistics expert.

59.57. This significant body of first impression evidence adds much weight to the conclusion that at least some areas of blackening on the photographs were caused by a near contact or contact shot and resulting deposition of soot. I

have borne in mind Prof Pounder's warning that a non-medical person might mistake a bruise for a dark area of soot, but as he reminded me, subjectivity is enhanced when viewing photographs because in a real life situation one can observe from multiple angles and, even without anything other than observation, an eye-witness to Ms James' face would be more reliable for drawing of inferences than those looking at photographs.

59.58. Three of those four eye-witnesses who recall seeing something of note on Ms James' face commented not by simply describing its colour or it being a dark area, but used a description that implies they also noted its consistency – describing “powder”. Were there only one eye-witness claiming for the first time in 2002 to have seen powder the possibility of mistake or hindsight bias might be high, but there were three. Sgt Norton, an ammunition technician, was specifically tasked with investigating this ammunition incident had reason to be observant and took a close interest in the nature of the wound.

59.59. This eye-witness evidence must be considered with the contemporaneous record by Sgt Harrison at post-mortem. Whatever was present on the face was noted by LCpl Dean. Despite the substance being a matter of discussion between some observers, no-one contemporaneously suggested it was bruising. Powder clearly has a different consistency from that of a bruise.

59.60. These eye-witness accounts, when taken with the preponderance of scientific evidence, fortify my conclusion that there was soot on Ms James' face.

Marks on the hand

59.61. The other dark areas of interest on the scene photographs are on the inner aspect of the web of the thumb and index finger and the inner aspect of the thumb near the knuckle joint of Ms James' left hand.

59.62. If those areas are soot markings it would indicate that the hand was placed on the rifle barrel behind the flash hider, another indicator of a close range shot. It would be consistent with steadying the muzzle on shooting oneself, or grasping the muzzle to fend off a close range shot by another person.

59.63. Prof. Pounder confirmed that the two dark areas on the left hand were where one would expect soot if a person held the muzzle on firing. His subjective view was that they were dirt from the left webbing coming into contact with mud/soil, and the left inner thumb separately coming into contact with a fern stem. At the expert meeting he “could not conceive how the mark could be soot”. He told me that on the enhanced photographs he saw irregularity

within the dark area and absent a ballistics explanation as to why you might get that irregularity his view was that there was no explanation for it. He therefore could not see how it could be soot.

59.64. Prof Pounder also laid some store on his suggestion that the tissue splatter seen on photographs indicated the right hand must have been more exposed to the wound than the left. The photographs, however, were not taken to record tissue splatter and hence were incomplete images. Given the limitations, I can attach little weight to this suggestion.

59.65. Ms Kiernan's resting position was that the dark areas on the hand were entirely characteristic of soot deposition. She went on to state that from her experience she was able to say that the marks were indistinguishable from what she expected to be produced on the surface of the skin by discharge residue sooting. When asked about the irregularity with some areas being darker than others she stated these were "entirely consistent with how soot is deposited". She had seen numerous images of hands holding a weapon at near contact with the muzzle, all consistent with what she had seen.

59.66. She acknowledged, absent of chemical testing, that dirt or mud could not be excluded. But the colour, depth, location and the lack of mud at the scene militated against either as candidates for the dark area.

59.67. Mr Pryor in 2002 noted these marks as being consistent with deposits from the hand being near the muzzle, but told me he could not tell from the unenhanced photograph whether they were residue or dirt. Dr Niewohner from BKA agreed.

59.68. Dr Cary initially favoured dirt. The left hand had been in contact with the ground and this, or transfer of dirt from a person moving the body, could provide an explanation for its presence. He subsequently deferred, however, to Ms. Kiernan based on her considerable experience. He said one could not possibly rule this out as soot merely from photographs as Prof Pounder had claimed.

59.69. As this mark is not related to a wound, pathologists bring no specialist expertise, although their opinions are valuable. Prof Pounder's explanation of how the inner web of the hand could have come into contact with the ground and how, separately, the thumb could have picked up dirt via a fern stem is unconvincing. It was also at odds with what he said was his own approach of applying Occam's razor – the simplest explanation is often true.

59.70. Ms Kiernan is the more appropriate expert to help me on this particular aspect. She was clear that the appearance was entirely consistent with soot. The location of the marks, all agreed, is where one would expect soot after a muzzle was held. I find Ms James' left hand was in contact with the rifle muzzle when the fatal shot was fired.

59.71. Soot on the hand taken with soot on the face, in the absence of any other circumstantial evidence inconsistent with the rifle being fired at near contact, puts the matter beyond doubt: this shot was fired at contact or near contact.

59.72. Stellate tearing and the absence of an exit wound, whilst not probative of near contact are consistent with it and, to that extent, supportive of my finding.

59.73. I acknowledge the constraints under which the experts laboured. Very few scientists will rule something out, and it has been my task to weigh the contrary views and to assess the fit within the larger evidential framework.

59.74. Prof Pounder made it clear that if the finding was that there was soot present on the face, then he did not intend his report to be understood as positively proposing that there had been infliction by another. But, as Dr Cary stated, "just because the deceased could have fired the shot does not mean that she did".

59.75. The pathology and science cannot without more resolve this. There was soot on the face and hand, and hence a contact or near contact shot, but as to who fired it science cannot help and I look to other evidence to reach a conclusion.

60. Circumstantial evidence

60.1. The interested persons have pointed to a number of factors that they suggest have emerged from the evidence and might have a bearing on the sufficiency of evidence going to a potential finding of self-infliction.

Possible earlier absences from the guard post

60.2. The possibility of as many as two absences from the gate before Ms James' final absence is raised by the recollections of Pte Michelle Burgoyne and Sgt Robert Collard who say they saw the gate unattended about 07.00 to 07.10; and by Cpl. Martin Barrow and Ms Loftus' evidence, which at face value might suggest it was also unguarded between 08.00-08.15 hours. The conversation

related in 1995 by Pte Wilkinson that Ms James had said she was “going to sit in the woods and let all the cars go in without checking the IDs” might also have some relevance.

- 60.3. I agree with the MOD submission that it would be fanciful to suggest that Ms James walked into the woods on two occasions against her will. But, it seems to me that there is no evidence that can lead me to determine that Ms James did actually leave the gate on more than one occasion. Rather the diversity of accounts and timings may well reflect these four witnesses first seeking to recall their timings some seven years after the events and simply being mistaken about when the events they were trying to recall actually happened.
- 60.4. I therefore attach no weight to the suggestion of an earlier period when the gate was unattended as a relevant factor to my conclusions.

The abandoned radio

- 60.5. Most trainees regarded the radio kit as bulky and an encumbrance, and it was common practice to remove it and put it down in or at the entrance of the cabin. Ms James’ radio was found there. Whilst its presence does not assist me to weigh up whether it were left behind voluntarily or under duress, it might provide very limited assistance with whether the death were an accident. If Ms James were going into the woods for an innocuous purpose, intending to return, it would have been a sensible precaution on leaving her post for any time in dereliction of duty to take it with her. This would reduce the risk of discovery of a planned temporary absence from the guard post by not answering.
- 60.6. However, I find the presence of the radio at the portacabin of no assistance in determining whether or not the shot was self-inflicted or inflicted by another.

The allocated SA80 rifle and rounds

- 60.7. The serial number of the SA80 rifle issued to Ms James that morning was recorded. She was also issued with ten 5.56 NATO rounds from the guardroom stock. No tests were done on the fragments of bullet found at the first post mortem and they were not preserved. The two fragments recovered at the exhumation autopsy have been examined by Ms Kiernan and confirmed to be consistent with a 5.56 round.

- 60.8. Whilst it cannot be scientifically determined if the gun recovered at the scene fired the fatal shot, circumstantial evidence precludes reasonable doubt that it did.
- 60.9. The systems of allocation and security of weapons from and in the guard room were conventional and examined. Records showed each trainee on the 07.00 stag had signed for his/her weapon and save for Ms James signed it back in. Standard procedure was ten rounds issued to each guard, and counted back in on their return. The only trainees with weapons at about 08.30 were the four posted to the other gates. There is no evidence any left their post and there were no prowler guards operating.
- 60.10. Only one shot was heard. There is clear contemporaneous documentary evidence that eight rounds were in the magazine fitted to the rifle beside Ms James' body and one round in the breach. That rifle bore the same serial number as that issued to Ms James that morning. The spent cartridge recovered at the scene was shown by its batch number to be from the same (albeit large) batch from which the ten rounds had been issued to Ms James that morning in the guardroom. This batch was from operational stock and so was a different batch of rounds from those that would have been issued to trainees for use on the firing range.
- 60.11. If an assailant killed Ms James with another SA80 then removed it from the scene he/she must have obtained it, in circumstances where there is no evidence that any other SA80 weapon was missing from the guard room or the armoury; then have, unnoticed and unrecorded, obtained a round from the same batch as in the guard room or from the magazine in her pocket without any resistance, then shot her with the second weapon and set up hers to look as if it had fired one round.
- 60.12. No credible evidence supports such a chain of events: it is speculation.

Absence of evidence of a struggle

- 60.13. There was no evidence of any struggle in or around the guard post and no evidence of force to, or defensive injury upon, Ms. James' body observed at the scene. No defence injuries were found at the 1995 post-mortem.
- 60.14. Nothing observed by eye-witnesses or observable in the photographs suggests that Ms James' clothing was unusually disturbed or her pockets torn (indeed the scene photographs show her left breast pocket to be open and untorn).

Damage to her outer pockets or clothing would be expected if she were resisting the forceful taking of her magazine, let alone her weapon. Moreover, she had recently demonstrated that she was prepared to take effective physical action when necessary.

Position of the spent cartridge

- 60.15. Making any positive determination from where the spent cartridge was found is problematic. Given so many variables including the possible degrees of rotation of one's head described by Prof Pounder, and the nature of the search, its position does not help me as to whether the injury were self-inflicted or inflicted by another.
- 60.16. It is possible the cartridge could have been kicked or moved in the search. It is unlikely to have gone far given the search actions and the foliage and undergrowth. A much greater distance could have ruled out self-infliction, but cannot rule it in. Its only relevance, therefore, is that the cartridge was from the same batch as the issued ammunition and found close enough to be consistent with ejection from a close range shot.

The location

- 60.17. The death occurred at a time of regular gate use, traffic coming to and from the camp as people began their day's work. Ms James' prone body in camouflaged combat clothing was not obvious from the roadway until it was pointed out. But, as the photographs show, it was visible if one knew where to look. The area is easily visible from the guard post and the approach road and any standing activity would have been easily noticeable to any drivers or passers by. The event was at the beginning of the day and people passed through the gate frequently that morning coming to work. The location of the body would have been a foolish choice for an assailant particularly as few more yards into the tree line provided far better cover. I agree with the submission on behalf of the MOD that it would have been folly to choose this as a location for a murder-dressed-as-suicide, the post-death staging certain to be in plain sight.
- 60.18. The location is not implausible if one chose to sit down and shoot oneself. The agreed pathology evidence of Prof Pounder and Dr Cary supports Ms James having been sitting when she was shot. Based upon the scene photographs and their knowledge of her immediately becoming limp and collapsing on being shot, both pathologists were of the view that Ms James was not standing

and was probably not kneeling at the time of the bullet's impact, but was seated or in a seated and reclining position.

Absence of opportunity

- 60.19. There is no visual evidence of any attacker, or of an attack. No one can speak of the vital moments. Mr and Mrs James argue that given the absence of reliable evidence in the period immediately before Ms James death, there is insufficient to draw any inference. I do not agree.
- 60.20. The recollections of those entering the camp near the crucial time have been set out earlier. Within two minutes of Ms James being seen by Cpl Ian Wilkinson he was joined as he parked his car by his colleague Sgt Wood, who had come through the gate after him on his pushbike and had found the gate unattended.
- 60.21. Capt Dixon, having found the guard absent at approximately 08.25 investigated the hut and surrounding area and saw nothing. Sgt. Townsend was coming down the hill towards the gate on his bicycle when he heard what he was fairly certain was a single shot, and arrived at the unattended gate within thirty seconds. His quick search revealed nothing.
- 60.22. This evidence fixes the possible window for another to take command of Ms James and effect her death without being seen. It is very small.
- 60.23. The concept that some unknown assailant was able in the brief time between Cpl Ian Wilkinson and Sgt Wood passing through the gate to put Ms James under duress such that she did not resist, kill her and then set up a staged suicide and leave the scene, or conceal themselves whilst waiting opportunity to do that staging, seems to me to be implausible.
- 60.24. It is equally implausible that in the thirty seconds or so between the shot and Sgt. Townsend reaching the gate a killer might have had the presence of mind and exercised the commensurate skill to set up all the elements of a staged suicide and leave the scene.

Absence of evidence of staging

- 60.25. The descriptions of those first on the scene as to the position of Ms James and the weapon match the photographs and are consistent with her having held the weapon towards herself, muzzle pointing towards her head, steadying the barrel with her left hand and depressing the trigger with her right. Sgt McEleavey's suggestion that the lie of the weapon looked "odd" to him is of no relevance given he viewed the scene after the armourer had moved the weapon to make it safe.
- 60.26. Professor Pounder's written report suggested the lie of the weapon on the ground as shown in the scene photographs was, as he put it, "potentially problematic" on the basis of his subjective interpretation of the position of vegetation under the weapon near the magazine and pistol grip as suggesting it had moved forward along the ground. He initially suggested it was "improbable" that it might fall as shown as he expected recoil to provide momentum in the opposite direction. On this basis he raised the possibility of the scene being staged.
- 60.27. How a SA80 weapon might recoil and fall is not within Prof Pounder's expertise. In his oral evidence it was clear that in coming to his written opinion, which he finalised after the joint meeting, he had, at very least, overlooked the opinion of Ms Kiernan expressed at that meeting. Her evidence was that the SA80 has very little recoil and the movement of the rifle on the ground if falling would be highly variable and unpredictable.
- 60.28. Professor Pounder told me he retracted his written opinion as to staging. That was clearly right. There is no evidence that this scene of death was staged.

Position of the wound

- 60.29. Dr Rouse considered the wound was in a position typical of self-infliction. He thought that if another person held a gun to Ms James' head an amount of moving away of the head or twisting might be expected. However he agreed that the wound position did not rule out shooting by another.
- 60.30. This concession accords with the minutes of the experts' meeting, when Dr Cary, Prof Pounder and Ms Kiernan all agreed the location of the entry wound had no probative value. It seems to me that as a factor taken on its own this logically this must be right. One can be shot in the centre of the head just as much as one can shoot oneself there.

60.31. In conjunction with my finding that Ms James had her left hand on the rifle, however, it could support an inference of self-infliction. Prof Pounder explained the head can be rotated 70 to 80 degrees in either direction. It seems implausible that, threatened by an assailant holding a rifle muzzle close to the forehead, a victim who had time to take hold of the barrel would not also, simultaneously, move her head away by a significant amount.

Absence of motive

60.32. If there were a possibility that another fired this near contact shot I must consider who it might have been and with what motive. In their application to the High Court seeking this fresh inquest Mr and Mrs James suggested that Spr Carr-Minns had a potential motive to harm Ms James and that Spr Carr-Minns' relationship with Ms James could have been a motive for Pte Wilkinson, or others, to harm her.

60.33. Those allegations were not pursued before me. There is no evidence to support them. As was accepted on behalf of Mr and Mrs James before Spr Carr-Minns and Pte Wilkinson gave evidence, neither could be considered as a suspect.

60.34. It was clear to me that there is no evidence that either had displayed any threat or violence towards Ms James or even bore her ill will. To the contrary, Spr Carr-Minns demonstrated his care of and commitment to her. I accept his evidence that he was at Gibraltar Barracks at the relevant time.

60.35. Pte Wilkinson, seventeen and smitten with Ms James was anxious to continue the new found relationship. That he was also keen to sort things out with her on the day of her death is not evidence of animosity towards her. It would be wrong to suggest that being part of a teenage love triangle gives either boyfriend any motive to wish for this death. There is no evidence linking either young man to the death. Mr and Mrs James have confirmed that they do not suggest that I can or should find that Mr Wilkinson caused or contributed to Ms James' death. They submit that such a finding would be inappropriate and unlawful. I agree.

60.36. There is no credible evidence to support a motive on anyone else's part to harm Ms James. The account of Pte Beards and his allegations regarding Ms James being ordered to have sex I find to have no foundation in reality. That

this death might have been the act of some random stranger would also be speculation and not a realistic possibility on the evidence.

61. Conclusion as to self-infliction

- 61.1. Neither the science nor any one of the above factors taken individually would satisfy me to the criminal standard that Ms James shot herself. I must consider whether they can be viewed cumulatively and weigh up the presence or absence of evidence to support any other explanation.
- 61.2. The factors I have considered vary in quality. Putting the pieces together, however, adds considerably to the picture. Overall, the preponderant scientific view combined with the other positive factors, as well as the absence of any evidence to support any other conclusion, satisfies me to the criminal standard that Ms. James shot herself.
- 61.3. The first element required for a suicide conclusion is made out. Suicide, however, may not be returned unless intent to die is also established beyond reasonable doubt and I may not find suicide to the requisite standard unless satisfied that other possibilities have been excluded. I have rejected a staged suicide as a possible explanation. I turn my attention to whether the self-inflicted shot could have been an accidental discharge.

62. Possibility of accidental discharge

- 62.1. The arming state required that the magazine was not fitted when on guard duty unless under threat. Although there was suggestion of possible confusion in the minds of some as to the arming state in November 1995, it is be explained by the passage of time. The preponderance of evidence is that the rules were understood by trainees and careful attention was given to ensuring that the magazine remained separate.
- 62.2. Those on guard should have kept the loaded magazine in a pocket or pouch until times of immediate threat. Had the magazine been fitted at the guard room, or while at the gate, such a serious and inherently risky deviation from duty would have been noticed immediately by the officers and NCOs passing through. Pte Wilkinson described an amount of cuddling in the portacabin. Had the magazine been fitted he also could not have missed it.

- 62.3. The inescapable conclusion is that Ms James did not have the magazine fitted to her weapon when on duty at the gate. It must have been fitted later and intentionally.
- 62.4. That point alone does not answer whether the firing of a shot could have been an accident. Witness marks on other rounds in the batch used for guard duty showed that magazines must have been fitted and some rounds must have been chambered by those previously on guard duty on other occasions. Pte Fawcett said she had done this on guard duty because she was “bored” and it may be trainees had chambered rounds while messing about. This is a serious matter, although there is no evidence that Ms. James had ever done it.
- 62.5. Even if Ms James had fitted the magazine so as to chamber a round for some reason not involving lethal intent, the progressive steps needed to discharge the round at one’s head are: (i) removing the rifle’s safety catch; (ii) releasing the webbing strap and turning the rifle round; (iii) aiming the muzzle at one’s head; and (iv) depressing the trigger with the rifle still in that position.
- 62.6. It is important that, as BKA makes clear, the force required to depress the trigger of Ms James’ rifle was some 47.5 Newtons with a trigger weight of about 4.8 kg. It is difficult to conceive how that last step of depressing the trigger with the muzzle pointing at one’s head might be unintentional. I note the evidence of LCpl Burrows that there were no malfunctions in this weapon when it was carefully examined by him shortly after the events. There is no evidence this rifle could have fired other than by the purposeful depression of the trigger. I conclude that accident can be safely ruled out. This was an intentional discharge by Ms James.

63. Intent

- 63.1. A finding of purposeful firing does not without more establish the intent required for suicide. It must still be established that Ms James fired the fatal shot intending thus to end her life.
- 63.2. Mr and Mrs James argue that Ms. James had no reason to take her own life. She was happy, loved by her family, popular and successful in the Army and her new posting, away from Deepcut, was imminent. Although a writer she left no suicide note. I also note, however, that the picture of her personality as seen by her parents is more complex viewed from the perspectives of others who saw differing sides of Ms James. Her parents were unaware that she was writing to a friend from home that she hated the army and wanted to leave

planning a pseudo-migraine to get discharged, as evidenced in her own letters written a few days before her death.

- 63.3. Interested persons other than Mr and Mrs James pointed to a number of potential stressors in Ms James' earlier life and related to her complex relationship position in late November 1995 which might have deepened through the previous night and the early parts of the guard tour of November 27 1995.
- 63.4. I have been reminded of the adolescent Ms James's somewhat unusual preoccupation with death and the creation of the guest list at her funeral; adverse events in her pre Army life of a sexual assault and the loss of a much loved cousin to suicide; a mild overdose; possible self cutting as an adolescent; her impulsive traits; that some who knew Ms James better recognized a darker side of her personality; etc.
- 63.5. None of these factors helps me determine Ms James' intent on the morning of November 27 1995. None is probative of any suicidal intent. Several potential stressors, even cumulatively, cannot establish a pervading suicidal intent. This is particularly so where Ms James was making tentative future arrangements to see Pte Barnett later that day and the picture that remains of the last thirty minutes in the guardroom is one of public normality and giggling, even if Ms James was also being criticised for how she was running her relationships.
- 63.6. Despite Ms James' clear disillusionment with and a wish to leave the Army and her possible concerns about her relationship predicament, the evidence does not reveal any clear motive for her to wish to kill herself.
- 63.7. Intent to die is, however, different from motive or desire and hence it is not always necessary (and sometimes impossible) to identify any motive before intent can be established.
- 63.8. Surrey Police suggest that Ms James volunteering for the duty on the rear gate is evidence of planning and preparation to self-harm. There is mixed evidence about whether she was allocated or she volunteered. I have found that on balance it is more likely she volunteered, this does not assist me to determine intent to self-harm being already formed. There could be many reasons for seeking a first posting to that gate and it would be speculation to conclude that she was already planning a quiet place to kill herself.

- 63.9. I have dismissed the possibility of Ms James acting under the influence of alcohol in light of the post mortem blood tests which showed no alcohol in her body at the relevant time.
- 63.10. Foresight of death is a crucial consideration when addressing intent. The lethality of a shot from a high velocity weapon would be apparent to any young soldier who had successfully completed her basic training and several sessions of guard duty. A shot to the head differs from other potentially lethal acts (such as an overdose) in that there is little likelihood of another discovering the act once done and intervening effectively to save life. The consequences of pulling the trigger are irreversible.
- 63.11. That Ms James could have been in no doubt about the consequences of a shot to the head from a SA80 rifle is supported by her references to Pte Benton's death and the ease of shooting oneself, and by her light hearted discussion with an electrician a few days before about getting out of the army by shooting oneself in the head. Surrey Police suggested that these are evidence of pre-meditation, planning and preparation to take her own life. I do not agree that they demonstrate any suicidal mindset *per se* on November 27 given the manner and circumstances in which they were made. They do, however, support the proposition that Ms James was well aware of the inevitable outcome of a rifle shot to the head.
- 63.12. I find that Ms James must have appreciated the virtual certainty of death from her actions and I infer that she foresaw death as a consequence of firing the rifle. This along with the several steps required to make ready and fire a rifle, in particular the final step of depressing a trigger of 4.8kg weighting when the rifle was pointed backwards and aimed at the forehead establishes her intent. There can be no reasonable doubt that Ms James carried out an intended and deliberate action well aware that its consequence would be her death. I am therefore satisfied so that I am sure that Ms James inflicted the fatal shot intending to die.

64. Contribution of the Deepcut regime to the death

- 64.1. The closing submissions on behalf of Mr and Mrs James urge me to make findings that a number of the clear shortcomings in the Deepcut regime and culture that I have outlined were causative, in the sense that they made a more than minimal contribution to Ms James' death. They suggest that trainees were left in an "inadequately supervised" and "deleterious environment which fostered a sexualised and alcohol fuelled culture."

- 64.2. Those submissions do not, however, set out the purported causal connection between the Deepcut regime and Ms James' death beyond the broad assertion that because the regime was flawed this must have had a negative influence and been destructive of the morale of those living in that environment. Without knowing the reason for her actions, it is of course difficult to identify their cause.
- 64.3. Ms James' morale may have been lowered by the general regime in which she lived. In the last week of her life she wrote of her wish to leave the Army and her plans to feign migraines to achieve this. There is, however, no evidential basis to establish that Ms James' disillusionment with the Army or any dislike of the Deepcut regime was, on the balance of probabilities, such as to cause her to wish to die.
- 64.4. Furthermore, whatever adverse events befell others at Deepcut, the evidence does not reveal that Ms James was subject to any unwanted sexual harassment, abuse or bullying by any person at the Barracks. None of her close friends have identified any improper conduct by others, or any feature of the Deepcut regime and culture that might have distressed Ms James to the point of contemplating serious self-harm. Without an evidential foundation I cannot find that any particular aspect of the regime, on the balance of probabilities, more than minimally contributed to Ms James taking her own life.
- 64.5. Mr and Mrs James also suggest that opportunities were missed when something could have been done to locate and or protect Ms James had those at the guard room reacted promptly to the reports of the gate being unattended on the morning of November 27 1995. It is not possible to establish how long it was after her leaving her post that Ms James died. Although I accept the response of the guard room to the first reports of Ms James' absence was inadequate, without more precise timings of events it would be speculative to suggest that had there been an adequate response her life would have been saved.
- 64.6. However section 5(2) Coroners and Justice Act 2009 requires me to ascertain not just how, but in what circumstances Ms James came by her death. There is an aspect of the system in operation at Deepcut that, in my view, is relevant to the circumstances of her death in so far as it created a dangerous situation and provided the opportunity for her to take her life. That is lone armed guard duty.

64.7. The acknowledged failure by those in the relevant chain of command to recognize and implement the UKLF ATSM 'Rules for the Carriage of Arms' created the opportunity for Ms James to be left unsupervised with a rifle and ammunition that morning. Ms James should not have been on armed guard duty alone. Moreover, the failure to implement these Rules sits within the wider context of the Army at that time neither recognising nor taking any steps to reduce the potential risk of trainees using their service weapons against themselves.

64.8. I shall be reflecting these shortcomings as part of the circumstances of the death within my narrative conclusion.

65. Report to prevent future deaths

65.1. Finally I have considered whether any matters identified in the evidence require me to write a report under regulation 28 of the Coroners (Investigations) Regulations 2013 to prevent future deaths ('a PFD report'). If I believe that action should be taken to prevent future deaths I have a duty to make such a report to the person, organisation, or government department who can take that action.

65.2. It is a feature of inquests held so long after the death that the systems and processes under investigation have often moved on and many shortcomings already identified and addressed. I heard from Brigadier Donnelly of the several and wholesale changes in training policies and practices in the Army Recruiting and Training Division over the past 20 years. Guard duty is no longer conducted by trainees and OFSTED now scrutinise the Army training organisations.

65.3. There have also been many initiatives in the wider Army. Since 1995, the unacceptably high rate of suicide in the armed forces has reduced from twice the national rate such that it is now lower than society at large.

65.4. I have noted how the most recent surveys demonstrate that the Army has not yet successfully tackled the issue of sexualized behaviour and levels of sexual harassment remain unacceptably high. I am satisfied however after hearing the Brigadier's evidence that the Army Chain of Command recognises this issue, albeit late in the day, and are giving the matter significant priority in seeking to tackle this problem.

65.5. In the circumstances, although the Army has still some way to go in changing attitudes and culture, I shall not be making a PFD report given I am assured that relevant action is already being taken.

65.6. I end therefore by formally announcing that my conclusions on the Record of Inquest are as follows:

1. Name of the deceased:

Cheryl Marie James

2. Medical cause of death:

1(a) Gunshot wound to the head

3: How, when and where and in what circumstances the deceased came by her death:

At about 08.25 on November 27 1995, whilst on lone guard duty, Ms James shot herself with a high velocity SA80 rifle in woodland adjacent to the Royal Way gate at Princess Royal Barracks, Deepcut, Surrey.

4: Conclusion of the Coroner as to the death:

Ms Cheryl James died as a result of suicide. The circumstances were that: Ms James had been posted as a lone female armed guard contrary to army policy; the risk of self-harm to trainees during lone armed guard duty had not been adequately recognised nor had adequate steps been taken to reduce that risk.

5. The further particulars for registration are:

- Ms James was born on 22 October 1977 at Deeside and Alyn, Wales.
- She died on 27 November 1995 at Princess Royal Barracks, Deepcut, Surrey.
- Her occupation was Army Private.
- Her usual address will be given as her parents' home address in 1995.

INTERESTED PERSONS

Mr and Mrs James

Represented by
Alison Foster QC
Peter Mant
Katherine Hardcastle
Instructed by Liberty

**The Ministry of Defence
Mr Carr-Minns
Mr Atkinson**

Represented by
Nicholas Moss
Emma Price
Instructed by the Government Legal Service

Mr Wilkinson

Represented by
Francesca Whitelaw
Instructed by the Government Legal Service

Surrey Police

Represented by
John Beggs QC
Cecily White

COUNSEL TO THE INQUEST

Bridget Dolan QC
Jamie Mathieson