ForcesWatch

NOTES ON ATTENDING THE INQUEST INTO SEAN BENTON'S DEATH AT DEEPCUT BARRACKS

ForcesWatch, July 2018

INTRODUCTION

Referenced here is an earlier copy of the full verdict, or the Coroner's factual findings, which will be available here very soon: https://news.surreycc.gov.uk/inquest-into-the-death-of-sean-benton/

Last week the Coroner at Working Coroner's Court delivered the findings into the circumstances of Sean Benton's death at Deepcut Barracks in June 1995. Sean was the first of four soldiers to die there between 1995 and 2002. ForcesWatch have been monitoring the inquest; this article shares our records from the inquest and notes on the final findings.

It was only on certain days of the inquest – for example, when Sergeant Andrew Gavaghan took the stand, and for the verdict, that the small room at Woking Coroner's Court was full. On most days, other than lawyers for Sean's family, for the Ministry of Defence and for Surrey Police, there were few attendees: members of Sean's family, their legal representatives from Liberty, an independent journalist dedicated to covering Deepcut, and the mother of Geoff Gray, another young person who died there.

Diane Gray was there without fail, listening like the Coroner to evidence from former Deepcut recruits and military personnel who knew Sean. The inquest into her own son's death will begin next year; the second pre-inquest hearing also took place last week.

Speaking with Diane showed her to be a person with an extraordinary capacity for strength and resilience, fighting to get justice for her son and for others who suffered like him. There was frustration from years of fighting, the failure to get a jury, and the disappointing probability that the inquests will not go to a criminal court. The overwhelming sense was of the exceptionalism of the military with regards to justice and human rights, the feeling of powerlessness and the immense impact of the Deepcut abuse and deaths on individuals and families.

The evidence heard during the inquest included testimonies of abuse impacting many recruits other than Sean. While lengthy and thorough the inquest was far from all-encompassing. Only evidence of physical and mental bullying was heard; evidence of sexual abuse at Deepcut was not included in the remit of the inquest.[1] It is also important to note that this inquest, while vital for uncovering and sifting through the evidence relevant to Sean's death, was not a criminal investigation nor was it a public inquiry. The Coroner noted in his factual findings:

'This is not a public inquiry into the training of RLC soldiers at Pirbright and Deepcut in the mid-1990s, let alone an inquiry into the wider state of the army at the time. It is not within the scope of my statutory powers to consider or address every alleged adverse event or shortcoming at Deepcut or to make detailed findings about responsibility for any identified or admitted failings in the systems and structures in place. Nonetheless, it is within the scope of this inquest to consider how army policies and systems operated for those entering the RLC in 1995 in so far as consideration of this wider background is relevant to my investigation into the circumstances by which Sean Benton came by his death.' (p.9)

1 https://medium.com/@barrykeevins/reprehensible-sexual-misconduct-at-deepcut-73a94c2e352b

It was tragically clear that over twenty years later, many people are deeply affected by what they experienced as teenagers or young people in army training. One former recruit said during the Inquest:

'I sometimes dream about not finding my uniform… once I didn't have it and I borrowed someone else's. It didn't fit me and I didn't have any tights. I still dream about it sometimes – the fear. It's never gone away, I'll never forget it… Not just the night [when Sean died] but the whole time there will stay with me forever. I think of it when I'm with my son, my daughter…they want to join the Army and I won't let them.' (ForcesWatch, notes from attending the inquest)

Sean himself, besides his disappointment and shame upon hearing he was going to be discharged, expressed discontent with his treatment in the Army in his final suicide letters. His letter addressed to his parents ended:

'For ages I been trying to apply for a week's leave but they wouldn't let me have it… & they all knew that I needed a break from blackdown and that I was cracking up but they just said I wasn't entitled to it, so can you see Gill Barwick & ask her if she could see a lawyer to see if you can get anything out of this, ask her to get the lawyer to have a look at my Army Medical reports, thanks. Love, Sean xxx' (p.92)

OVERALL

The picture that emerged in Sean Benton's inquest was of a young person with psychological issues which may have been exacerbated by severe bullying from other recruits and from at least one of his commanders, and which were not responded to appropriately by the Army chain of command.

His mental state deteriorated visibly over many months until the point when he died, a deterioration which was visibly 'chronic' to his fellow trainees, although the NCOs were not monitoring Sean closely enough to appreciate the scale of his deterioration.

A post-mortem psychiatric diagnosis undertaken as part of this inquest concluded Sean to be likely to have had an evolving/emerging Emotionally Unstable Personality Disorder. Attention Deficit and Hyperactivity Disorder (ADHD) was also put forward as another potential retrospective diagnosis. (pp. 62-64)

The second inquest, like the original inquest which was held within a month of Sean's death, reached a verdict of suicide. However, the second inquest examined the circumstances of Sean's death in ways that were not explored in any of the initial investigations.

The second inquest found that if the Army had not missed opportunities to safeguard Sean's welfare, there could *possibly* have been a different outcome (p.99).

It found that if there had been appropriate safeguarding policies and measures in place – namely a clear instruction that Sean should not have been given a weapon, then he *probably* would not have killed himself in the way he did, when he did.

It found that the fact that Sean 'was being subject to legitimate but, in his case, excessive disciplinary sanctions from NCOs, whilst having to endure targeted bullying in the form of verbal aggression and humiliation and unpredictable use of physical violence by Sgt Gavaghan during the day, as well as manage the fear of assault by other trainees at night', '*could possibly*' have been a contributory factor in his death. (pp.104-105) The Coroner said:

'On the balance of probabilities [Sean] and others were mistreated at Deepcut in 1995. Although the evidence does not establish that those actions probably caused or contributed to Sean's decision to take his own life, I acknowledge that such conduct could destabilise an individual, sapping their resilience. It may bring about feelings of depression and worse sometimes lead to a sense of despair and hopelessness. Its impact is likely to be greater if the victim is young and vulnerable. A constant theme in the evidence was that young trainees at Deepcut felt unable to complain through the chain of command for fear of becoming a target of reprisal. I accept that in 1995 it would have appeared that there was no realistic channel for complaint.' (p.111)

The Coroner also noted that given Sean's emerging personality disorder, it seems he *'was not suited to life in the services, and crisis points were likely to have been reached regardless of whether or not Sean was ill-treated.'* (p.106)

The critical factor in Sean taking his own life was hearing that he was soon to be discharged from the Army – his emerging personality disorder would have made it very difficult for him to deal with 'significant disappointments and stressful life events.' (p.106)

FLAWS IN THE ORIGINAL INVESTIGATION

The original investigation was severely flawed. The Coroner wrote in his factual findings:

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

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

SAFEGUARDING FAILURES

1. Lack of adequate response to mental needs or adequate system for safeguarding mental wellbeing

It is clear that the failure of the Army chain of command to safeguard Sean's welfare - even when it was evident that he was particularly vulnerable - were factors in the deterioration of his mental state and in him taking his own life in the way he did, when he did. It also seems likely that the culture of abuse may have contributed to his mental deterioration.

The Coroner wrote: *'with the benefit of hindsight it is clear that opportunities were missed which could have led to an early appreciation by the army of Sean's psychological condition and the nature and scale of his vulnerability.'* He also criticised the army recruitment process at that time for not involving a mandatory requirement of disclosure of Sean's medical records (95), while also stating that '*even without the benefit of evidence of significant self-harm in Sean's pre-army life, there was ample evidence available to those responsible for Sean's welfare at Deepcut that Sean was vulnerable and would require significant support.'*

A former Sergeant described Sean as being *'someone who used to look right through you, as though things weren't registering'*, being very *'up one day and down the next.'* (Notes from attending the inquest, ForcesWatch) The Coroner's factual findings described Sean's visible deterioration following his second driver training failure and Pioneer allocation:

'The standard of his kit, which had never been immaculate, dropped further and his tendency to answer back increased, making him a larger target for discipline…Pte Pankhurst who was at Deepcut from November 1994 described Sean as initially being happy and often laughing but that as time drew on he laughed less and "towards the end he started closing in on himself, his kit started to suffer. He just stopped caring.'

A former soldier who knew Sean said he was someone who was evidently *'under pressure'*, carrying injuries from beatings – *'you could tell he was hurting and struggling*.' (Notes from attending the inquest, ForcesWatch).

On 8 February 1995, not long after failing his driver training, Sean kicked through a glass panel in the accommodation block and injured himself by walking through the broken frame, after having drunk heavily. Sgt Stevens recalls being on duty then, going to see him and finding him drunk, angry, bleeding from his neck and saying that he *'did not want to live if he could not be a driver in the army and he had 'had enough.'* (27) Consequent psychiatric assessments did not detect any psychiatric illness, but it appears that he was then not permitted access to a weapon for a short period of time. (p.28).

Since in 1994 a recruit's GP records were not obtained and scrutinised as a matter of course during the recruitment process, the psychiatrist who saw Sean following the 8 February incident, Lt Col Adrian Gillham, was not aware that Sean had taken two overdoses and seen a psychiatrist previously, nor did Sean tell him; and Sean declined to give him permission to write to his GP to get more details of previous medical records. (p.57)

On 11 April 1995, one month into his three month warning order, Sean took an Anadin overdose and was admitted to hospital. The psychiatrist's opinion was that Sean had an immature personality and that he was *'unsure as to whether [Sean] would be able to continue with army life'*, however the Coroner said: *'It is notable that despite Sean also being on the warning order, this psychiatric assessment did not appear to have triggered a full review of Sean's position by the chain of command.'* (32) Furthermore, although there was a visible deterioration in Sean's mental state over the next eight weeks, nothing was reported back to the camp GP, Dr McClenahan. (pp.60-61).

The military chain of command had access to Sean's psychiatric report but it was badly interpreted by them. A former lieutenant said that after Sean's psychiatric evaluation, since there was no psychiatric diagnosis, it was communicated back to the camp that Sean was 'perfectly sound' and could go back in as normal. (Notes from attending the inquest, ForcesWatch). The Coroner wrote:

'When the advice came that Sean had no formal psychiatric diagnosis and should return to normal Deepcut trainee life, it should have been clear to the chain of command that this did not mean Sean had no problems….Sean simply returned "into the mix" and was subject to normal military discipline at a point when a well-considered strategy to support him to succeed was required.' (pp.96-97)

Upon returning to the camp, rather than being treated with greater empathy and consideration for his mental wellbeing, Sean was subject to further discipline. The Coroner wrote:

'Cpl Barrow recalled Sean as someone who "lacked discipline, he was late for parades, poorly turned out and his sleeping area was generally in bad order and he had emotional problems". He explained in court that there were reports from troop staff that Sean had been crying, self-harming, and had been referred for psychiatric assessment He agreed that it was clear that the NCOs were aware that Sean was in tears more often than other recruits. Cpl Barrow commented that in his view the NCO's demeanour showed a "lack of empathy" to Sean, from individuals and from the "system in general." Cpl Barrow agreed that what Sean needed was support, but what he received was NCOs complaining about his appearance and his bed inspections.' (p.34)

Sean's troop commander during his three month warning period (the period in which Sean died) had to do weekly reports on him. Sean was the only recruit he ever had on this warning period. Yet he claimed to have no memory of Sean overdosing during this time or of any support he was given, nor did he know if Sean was on an 'at risk' register which he says he never saw despite asking. He said that not all information pertinent to particular individuals was passed down to the people responsible for them. He did however remember Sean being treated harshly. (Notes from attending the inquest, ForcesWatch).

The Coroner disputed in his factual findings whether these weekly reports were actually ever written, saying *'it seems remarkable that such important documents would not have been preserved and placed in his personnel file. Given the informality of every other welfare structure I am not persuaded that there ever was a weekly written assessment of Sean.'* (p.33)

The Coroner also stated: *'Beyond his review, neither Lt Radford nor any other witness from within the chain of command could explain to me what methods, structures or plan were put in place to assist Sean to succeed, save for the use of normal disciplinary sanctions.'* (p/33)

Wider welfare issues beyond Sean Benton were evident, with multiple reports of an abusive, frightening culture, a lack of a functioning safeguarding structure, and an atmosphere of submission to authority and silence in the face of abuse. Recruits were also said to have been bored and frustrated. The coroner emphasised the unsafe and unwise ratio of recruits to instructors – there were so many recruits that it was hard to maintain discipline and look after individual recruits' welfare.

While the Coroner noted that welfare was understood to be 'part of an inherent command responsibility within the army' (p.16), he also pointed out that there was no dedicated welfare officer despite concerns that there should be:

'Major Gascoigne said during his evidence that the first task of any welfare system was to be able to identify those soldiers with welfare issues at an early stage and the camp needed such a system. In 1995 Deepcut did not have a designated Officer with responsibility for welfare issues. Col Josling told me that he had asked RLC headquarters for a Unit Welfare Officer to be provided but he understood that, at that time, unless a unit was deployable, there was "no case for these welfare people" and so to provide one would be contrary to army policy. He accepted that had there been such a role this would have given welfare of trainees a clearer and more structured focus.' (p.16)

There was no formal welfare policy in place. The Coroner noted:

'There was… no formal induction or training for the NCOs and neither NCOs nor Officers were given any specific training in looking after the wellbeing of teenagers and young adults. It is telling that when Brigadier Evans conducted a review of systems at Deepcut following the death of Cheryl James in September 1995 he noted a "lack of awareness amongst staff, particularly junior NCOs and SNCOs of the role of welfare agencies" and he commented that the instructors were often perceived to treat welfare support as an "unnecessary irritation.'

He also said: *'While during that era there was no formal welfare system and no dedicated welfare officer at Deepcut, this did not absolve the chain of command from identifying the need for a better understanding of Sean's problems and devising an approach to meet Sean's vulnerabilities. The solution to managing Sean was seen to lie in discipline but as Prof Fahy told me "it would be preferable if the discipline is offered within the context of enquiry, sensitivity and support, and that it is not just pursued in a rigid way that isn't interested in the individual's particular circumstances". To deliver this "doesn't require professional qualifications". (p.97)*

2. Lack of adequate policy around weaponry

Despite the short period following the broken window incident when Sean was not allowed a weapon, there was no clear policy in place for safeguarding vulnerable recruits from handling weaponry. On the night Sean died, no clear instruction had been given that he shouldn't have a weapon even though the chain of command knew he was particularly vulnerable that night and should not have one. The Coroner said:

'There was no policy requirement for a soldier, who had committed acts of self-harm but who had not been medically downgraded, to be formally risk assessed in terms of their access to a weapon. While such action could have been taken in the absence of medical downgrading, it was a matter for the discretion of the chain of command. The MOD has accepted that the issue of access to weapons amongst those at risk of self-harm should have been formally clarified as a matter of policy, and that there should have been a codified process that would be followed.' (p.28)

On 8 June, Sean heard that he was going to be discharged after swearing at and threatening to shoot an NCO on 2 June. The Coroner wrote:

'Major Gascoigne was aware that the discharge application would have a significant impact on Sean. He said he "knew full well that we would have a very, very upset soldier on our hands and as a result we needed to take one or two extra precautions."' (p.70)

Lt Radford similarly agreed that he too knew Sean would be disappointed and there was a possible risk of self-harm, however he could not recollect what measures were put in place to protect Sean from that risk.' (p.70)

Sergeant Gavaghan was the guard commander that night and sought out Captain Cammack to discuss whether Sean continuing as part of the guard that evening was the right thing to do. Sergeant Gavaghan knew that Sean had self-harmed and had undergone psychiatric assessments, and knew that he never wanted to be discharged from the army. He thought Sean's risk of self-harm was directly connected to being drunk, and did not know that about the overdose in April which had not involved alcohol. Captain Cammack did, however, know about this overdose. (pp.70-71)

The two decided that Sean would continue to assist Sergeant Gavaghan in his guard commander role but should not be used on a stag rota, would not have access to a rifle and ammunition, but would be kept occupied. Sergeant Gavaghan briefed the trainees that Sean would not be doing stags, but the trainees were not specifically told that Sean should not have access to a rifle and ammunition. There was no explicit order or instruction that they must not hand over their allocated weapon to another guard. (p.71)

As the evening progressed Sean did not show signs of being overly upset and seems to have been pacified by Sergeant Gavaghan who was attempting to reassure him. (p.72). Several of the guard recalled seeing Sean writing letters after dark at the back of the guard accommodation and asking for stamps, and that he seemed calm and matter of fact. (p.72)

Sean attempted to get a weapon from several other recruits, saying he would 'love to do a stag' and that it might be the last one he would ever do. There appears to have been a rumour going round that Sean should not be allowed near weapons but no clear instruction. (p.73)

At around 05.30, Sean approached two recruits on guard duty, and told one of them that he had been told to relieve her because Sergeant Gavaghan wanted to speak to her at the guardroom. She did not know that he was not part of the guard rota, nor that he was about to be discharged, nor had she heard that he ought not to have a weapon. She handed him her rifle and magazine and left to find Sergeant Gavaghan. Sean said he was going to do a 'prowler' patrol and walked away parallel to the perimeter fence, he shortly took his own life. (p.76)

The Coroner wrote: *'It is overwhelmingly likely that had Ptes Embleton and Garratt been specifically told that Sean should not have been allowed a rifle, they would not have allowed him to acquire one.'* (p.77) The Coroner's factual findings say that:

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

He described the lack of a simple instruction to all trainees that Sean should not have a weapon as a 'failure.' (p.101). He found it probable that Sean would not have *'killed himself when he did in the way he did'* (p.102) had *'adequate precautions been taken and the guard been given adequate instructions regarding Sean being banned from weapons handling.'*

3. **Army Discipline**

Another issue emphasized by the Coroner in his factual findings was the lack of a clear policy on standardised punishments. *While 'as a matter of policy, bullying and the abuse of physical strength… were clearly prohibited in the army;'* (p.18) *'the MoD accept that in the absence of clear policy setting out a list of standardised punishments and with considerable latitude afforded to NCOs with little interference from their troop commanders, the system was open to NCOs administering physically excessive or overly repetitive punishments that went beyond legitimate sanctions.' (p.19)*

4**. Young age**

Vulnerability associated with young age and inexperience came up regularly; one former recruit said *'looking back now it's horrendous. But at 18 I didn't know any better. I knew that the Army was a tough environment and just shut up and took whatever came my way.'* (Notes from attending the inquest, ForcesWatch)

Many of the recruits at Deepcut would have been younger than 18.

Another former young recruit, who was also 18 at the time, said *'I was young, it was a scary place. Now, I'd stand up – but when you're young you don't feel you have a voice.'* (Notes from attending the inquest, ForcesWatch) Others similarly said:

'I think about how when Sean was on the floor [being punched in the leg] and none of us did anything, none of us stopped it when we were too scared. I'd never just let something like that happen now.'

'Gavaghan [one of the key figures alleged to have abused recruits] was 'confusing and frightening, he had two personalities… bear in mind we were teenagers, many of us were away from home for the first time.'

'Gavaghan was a sadistic bully – he was your best mate one minute and tearing your head off the next. Quite worrying if you're a teenager, and that's what we were – we were teenagers' and 'we were all young adults or teenagers… we weren't equipped to deal with it.'

In his factual findings, the Coroner said:

'Phase 2 trainees were invariably adolescents or young adults, some as young as 17, many of whom were away from home for the first time. The army, then as now, recruits from a diverse pool of the population some of whom bring with them vulnerability to welfare problems.' (p.16)

Gavaghan himself said that it surprised him how many teen recruits had previous issues. He agreed that in the Army 'a lot of people from similar backgrounds come in for escape', with a history of behavioural difficulties and emotional vulnerability.

Yet the Army was evidently not deemed to be a place where these young people could get the support they needed or indeed avoid treatment that might exacerbate their issues – Gavaghan said: 'but they were in the Army, I needed to maintain standards.' (Notes from attending the inquest, ForcesWatch)

Having worked with young people previously in his career, Sergeant Gavaghan said: *'the difference between Deepcut and other areas of your work is you were responsible for vulnerable teenagers away from home for the first time.'* Rather than acknowledging that perhaps this meant they should be treated with more care, he said 'to older, more experienced soldiers I wouldn't have had to show my nasty side.' (Notes from attending the inquest, ForcesWatch)

5**. Army structure and Chain of Command**

The way in which the military hierarchy can enable abuse of power was also a thread throughout the inquest; one witness, still in the military, said: *'Giving young NCOs such a level of power and control quite often makes it go to their head. I still witness it today just not on the same violent scale. As for tolerating it, I just assumed that this was how the Army made people more robust.'* (Notes from attending the inquest, ForcesWatch)

It appeared that communications broke down within the hierarchy, with less senior members of staff and recruits feeling unable to report issues, or not being listened to when they did.

The Coroner acknowledged this is in his Factual Findings report*: 'clearly I need to consider the immaturity of some witnesses at the time events occurred as well as whether there existed fears that reporting might lead to reprisals. A recurring theme was the difficulty in raising matters through the chain of command when it would involve reporting to those perpetuating the misconduct*.' (pp.3-4)

He further said: *'Major Gascoigne stated that, together with the issue concerning young trainees undertaking guard duty, the instructor-to-trainee ration was a constant concern to him. However his*

efforts to raise the issue of the need for more properly trained instructors up the chain of command did not meet with success.'

and

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

Members of staff claimed to have been poorly trained, prepared and supported. One former lieutenant who had responsibility for recruits' welfare, claimed not to have witnessed any bullying at Deepcut, but himself was accused by multiple former recruits of 'crossing the line.'

He blamed this on lack of experience, knowledge and support from above, and said: *'I had responsibility for 350 soldiers, for all their welfare needs, across three different training establishments in the UK.'* This responsibility was 'overwhelming' and the former Lieutenant said things may have fallen through the cracks because of the sheer number of recruits they had – it was 'not possible' to properly monitor their welfare. He agreed to having lacked sufficient training and experience in welfare although he was responsible for it. (Notes from attending the inquest, ForcesWatch)

Indeed despite having had overarching responsibility for recruits' welfare, the former Lieutenant claimed ignorance about the welfare situation at Deepcut. He said he didn't realise NCOs were giving recruits guard duty as punishment and that they should not have been doing so, and that he never saw any bullying at Deepcut - despite how widespread and extreme it was according to countless testimonies from former recruits. (Notes from attending the inquest, ForcesWatch)

The former Lieutenant admitted he had heard stories of Sergeant Gavaghan and his 'twin brother' (his Jekyll & Hyde-esque, overly aggressive alter-ego), and said that he had no authority to do anything about it, but he did pass it up his chain of command. (Notes from attending the inquest, ForcesWatch)

He agreed that despite his overarching responsibility for welfare, welfare issues would usually be reported to the NCO rather than to him in the first instance – and so if the problem was with the NCO, this would be a serious issue with the system. (Notes from attending the inquest, ForcesWatch)

A sense of being expected to defer to and trust superiors facilitated the abuse. A former Lieutenant said he was taught at Sandhurst to rely on and trust senior NCOs. When asked if his colleague, another Lieutenant, would have deferred to Sergeant Gavaghan and left her troop to him to run, he said that while he didn't know if this were the case, she certainly would have trusted Gavaghan's 'superior expertise.' (Notes from attending the inquest, ForcesWatch)

6. Bullying of Sean and other recruits

Witnesses spoke of how Sean was repeatedly singled out by people in positions of authority in the military structure. One particular focus was Sergeant Gavaghan, who gained a reputation as a 'monster' and a 'sadistic bully'. He was nonetheless informally responsible for the welfare of recruits, and indeed went on to work for the Army Welfare Service after Deepcut. The Coroner wrote in his factual findings:

'The scope of this inquest.. has not been limited to allegations made regarding Sgt Gavaghan. However when applying the civil standard of proof, that is on the balance of probabilities, the scant evidence in support of the very few specific allegations made against another other named NCOs and officers is, in my view, insufficiently probative to make any factual findings. The same cannot be said in respect of Sgt Gavaghan.'

He bears in mind that the 'great deal of factual and opinion evidence' existing in particular about Sergeant Gavaghan could be in part because of Surrey Police probing for evidence in particular about him

in a way they did not with other NCOs in their 2002-2003 investigation, as well as the media attention and focus around him.

Gavaghan denied allegations that he repeatedly abused Sean (and others) from many witnesses. He was said to have regularly picked Sean out of the parade and humiliated him in front of other trainees. The lawyer for Sean's family told him in one heated moment:

*'You made him lie on the floor while another NCO shouted 'arm or leg arm or leg' and you punched him while he pleaded. You made him do press-ups on top of a female officer [etc] you treated him like s***. Many have described how you constantly singled him out.'* (Notes from attending the inquest, ForcesWatch)

Others testified to Sean being given punitive parading – putting a broom stick through his sleeves and walking him past the troop to humiliate him; of Gavaghan making him kiss his boots, throwing Sean's mail at him or onto the floor, and regularly shouting at and beasting him. Gavaghan was said to have 'enjoyed' humiliating people and to have done so to Sean more than to anyone else. (Notes from attending the inquest, ForcesWatch)

Beasting involved the 'b****** position' – back against a wall, knees at right angles to thighs, holding out arms in a stress position – former recruits said it was 'absolute torture.' It could also involve holding a very heavy object up in the air for as long as you could before doing push ups and sit ups while being screamed and shouted at in your face. (Notes from attending the inquest, ForcesWatch)

One witness remembered a time *when, 'Gavaghan had gone up to Sean, pushed his whole face into his while shouting which was regular. Sean seemed ready to snap – next thing his belt and beret were taken off which meant he was going to be taken to the guardroom and beasted. I didn't see him the rest of the day.'* (Notes from attending the inquest, ForcesWatch)

Another said:

'All the trainees were scared of Gavaghan. He regularly punished people for no reason, especially Benton. Deepcut was truly dreadful and terrifying. Gavaghan was one of the main reasons why. It's my opinion he was a bully. He destroyed Sean for no reason and was a factor in his death.' (Notes from attending the inquest, ForcesWatch)

One former recruit said that Gavaghan and other instructors saw Sean as a challenge because he wouldn't back down - '*he didn't like that so he bullied him. After a time Sean wasn't his jokey self, he still tried to stand up but he wasn't as strong. People like Sean were a challenge, they wanted to break him down.'*

The Coroner similarly discussed in his factual findings how Sean stood out as a character and did not get on well with Army discipline. He wrote:

'Many trainees felt the best way to get through Deepcut generally was by keeping their heads down and attracted as little attention as possible from the NCOs: becoming a "grey" person to avoid getting into trouble. Sean was anything but grey: many witnesses commented that Sean failed to follow advise from fellow privates "to keep his head down".

While the Coroner agreed that the evidence shows Sean was treated badly in terms of physical and verbal abuse by Sergeant Gavaghan in particular as well as a group of recruits, other former young recruits also testified to being severely bullied.

One woman coming into the court to testify against Gavaghan said the she 'froze' and felt deeply affected by seeing her abuser. When asked 'what did you do to that woman to make her feel that way?' Gavaghan denied that anything had happened. (Notes from attending the inquest, ForcesWatch)

Numerous allegations of physical abuse were accepted by the Coroner in his factual findings: these can be found on pages 47-50.

One woman testified to being given the choice of being punched in the arm or given a formal charge. An anonymous source who is still serving and joined 'in 96 before being Deepcut in 97' age 18, told ForcesWatch: 'The statement where the soldier was given a choice of a punch or formal charge was common place. I was often offered Top, Middle or Bottom as a punishment for minor infractions.'

Gavaghan did admit to his infamous 'twin brother' – the aggressive, bullish alter-ego he is said to have brought out to intimidate recruits, which he called a 'management strategy' and said had been exaggerated. The Coroner wrote in his factual findings:

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

While Gavagahan accepted that in retrospect his twin brother strategy was 'not a good idea' and that he did not appreciate how people might have been distressed by his conduct, the Coroner wrote: *'His apparent lack of insight into the impact of his behaviour at the time is remarkable, particularly when, at its worst, his loss of temper could involve physical violence.'* (p,47)

Gavaghan claimed to have lacked knowledge and experience. He said that, despite having had experience and training in youth work and counselling outside the Army, he had not learnt the effect on young people of repeatedly being shouted at and frightened – he said that this was just a normal part of his role as an Army Sergeant. (Notes from attending the inquest, ForcesWatch) The Coroner wrote:

'It is striking that Sgt Gavaghan had the self-belief and confidence to perform in this way without apparent fear of reprimand from those senior to him in the chain of command… Stretched resources may have contributed to the failure of the chain of command to appreciate the full nature of what Sgt Gavaghan was doing. In the circumstances, I am not in a position to say that any member of the chain of command was aware that Sgt Gavaghan was regularly abusing his authority. However, on any view, a closer check should have been kept on Sgt Gavaghan's management of the trainees including use of the twin brother technique… It is clear that this lack of appropriate monitoring contributed to his abuse of authority. Furthermore, it is clear that the existence of an independent welfare officer outside the chain of command might have facilitated reporting and brought Sgt Gavaghan's conduct to a timely halt' (pp.52-53)

While Gavaghan was a focus, according to many witnesses other instructors were abusive too. (Notes from attending the inquest, ForcesWatch) One witness commented: *'It's not normal or acceptable is it, to scream at, belittle and bully young people, humiliate them in front of their peers, strangle them.'* (Notes from attending the inquest, ForcesWatch)

There also appears to have been a group of trainees who targeted underperforming trainees for beatings. The Coroner stated: *'I do accept that there probably was a group of trainees at Deepcut who would hide their identity and assault other trainees, they assaulted Pte Cave and on at least one occasion such a group assaulted Sean.'* (p.39)

He continued to say, *'that any trainee could act in this unchecked way is, in my view, attributable to the low ratio of staff to trainees and the lack of adequate night-time supervision provided by NCOs. This was wholly unacceptable behaviour by trainees that should have come to the attention of staff and been stopped. That trainees who received these serious beatings seem to have been reluctant to complain is yet another reflection of the inadequate welfare provision at Deepcut at that time.' (p.40)*

IMMEDIATE AFTERMATH OF SEAN'S DEATH

After Sean's death, former recruits say names were pulled randomly out of a hat to go to the funeral. One said that although she was a close friend of Sean and wanted to pay her respects to his family, her name wasn't picked so she could not go. She said that Gavaghan was 'cold' when he told them Sean was dead:

*'I heard: 'Benton shot himself, we need to go' so we all went and paraded. A girl standing behind me was crying and asked 'is he alright', Gavaghan said 'no, stop f****** crying, he's dead and he was a s*** soldier, he won't be getting a f****** funeral… It seemed to me nobody really cared. I was upset, I was close to Sean. But you weren't allowed to cry'.* (Notes from attending the inquest, ForcesWatch)

Another said: *'We weren't allowed to talk to anyone else or to each other at breakfast afterwards'.* (Notes from attending the inquest, ForcesWatch)

Another former recruit said: *'I saw the staff turn purple with rage… Fear controlled the place. I felt unsafe and paranoid the whole time I was there. I was afraid something terrible would happen to me. After Sean died being on duty was really distressing, especially the same gate where he died.'* (Notes from attending the inquest, ForcesWatch)

Another said that seeing the bloodstain and damage on the fence where Sean died weeks after has caused him mental health problems. The inquest heard allegations that fellow soldiers were asked to clean bits off the fence. (Notes from attending the inquest, ForcesWatch)

The Coroner noted in his factual findings report that simple requests in Sean's suicide letters were not adhered to, nor were all the letters given to those to whom they were addressed:

'Pte Williams did not learn that Sean had left him a letter until informed of this by Surrey Police in 2002. He never was given the Spurs shirt that Sean wished him to have. Similarly, Sgt Pike and Sgt Russell knew nothing of the thanks Sean wished to be conveyed to them until they too were interviewed during the Surrey Police investigation. As a matter of principle, when letters from a deceased are found, not only should they be delivered to those for whom they were intended, but any wishes expressed in the letters should be respected if possible. Even if the original letters are required for other purposes, copies can be provided to the intended recipient. There would have to be a very good reason for departing from this practice.' (p.106)

CORONER'S REPORT TO PREVENT FUTURE DEATHS

The Coroner was satisfied that the Army has made sufficient welfare changes since Sean's death. He wrote:

'During the 23 years that have elapsed since Sean's death, many of the shortcomings and systemic failings that have been examined in the course of the inquest have already been identified and major efforts made to address them. There has been a sea change in attitude towards suicide and deliberate self-harm within the army since 1995 with recognition of the importance of continued research in this area.. I note that Ofsted now scrutinise the army training organisations, and their recent reports have been brought to my attention.' (p.109)

He also noted that Ofsted's welfare and duty of care inspections in late 2016 generated 'critical comment about soldiers awaiting training' and said that the army must '*urgently improve the effectiveness of the training pipeline management to reduce the number of service personnel awaiting training, the length of time trainees are service personnel awaiting training and to optimise training throughout.'* However, he noted that the *''Headquarters of the Army Recruiting and Training Division has launched a comprehensive view of holdover in response to Ofsted's observations in July 2017 and has introduced measures to minimise holdover, manage holdover soldiers effectively, and monitor holdover trends more closely.'* He is 'satisfied that Ofsted already have under review' this area of fundamental importance.

He noted that in the immediate aftermath of Sean's death, the army Board of Inquiry ensured specific reference to preventing the handover a weapon from one trainee to another whenever trainees were paraded for guard. (pp.109-110)

He also noted that although it took some years, the army eventually came to resource a separate guard force so that inexperienced young people were not undertaking guard duty, although two young privates died while conducting guard duty before this change happened. He wrote: '*Only in certain limited field training contexts is armed guarding now undertaken by trainees. They are not issued with ammunition.*' (p.110)

The coroner also noted that: *'The practice that allowed Sean to be recruited without reference to his GP records has been discontinued.'* Current practice enables the army to *'identify many applicants who, on account of their medical, psychological and social history, would be unsuited to army life' and that 'in the event of subsequent medical and psychological issues arising, those responsible for a trainee's medical and pastoral care have the fullest possible information to enable proper diagnosis and devise any necessary care plan.' (p111)*

He also said: *'Brigadier Coles explained that between 1995 and today there has been a real change of army culture and mindset which ensures commanders understand their obligations and very much empowers the individual to use the mechanisms at their disposal to complain about what they believe is a wrong, be it criminality or poor behaviour. For instance, the army now runs a bullying, harassment and discrimination 'speakout' helpline with trained counsellors fielding calls. These trained individuals can distinguish between ill-founded petty grievances and criminal activity, and can signpost the caller in all cases to the right organisation which might include the chain of command, the service complaints ombudsman or straight to the service or civilian police. Now an army sergeant major, the senior army soldier, plays the role of champion on the soldier's behalf for the army leadership code ensuring soldiers understand their ability to come forward and speak out. I am satisfied that the army does now have a significant array of helplines and literature available to its troops about redress where a crime has been committed against them, including a 'Victims of Crime' leaflet.'*

He added that Brigadier Coles told him: *'The army accepts that there is no difficulty with adding a direct report to the civilian police as a further outlet that is available if the complaint is to criminal misconduct. Accordingly, an instruction will be sent to the training establishment in the next induction rounds, and when handouts for induction programmes are next updated, the civilian police will be added to the list of those to whom trainees can take complaints of criminal misconduct.' (pp.111-112)*

The Coroner reported that this has already been actioned at Deepcut where the Squadron Sergeant Major will inform trainees during his induction talk that they can take complaints directly to civil police in addition to other outlets for complaints. (p.112)

The welfare system itself has improved greatly according to the Coroner, who says the welfare policies today are 'far more developed and comprehensive' and that the 'clear systemic failing has now been properly addressed' (p.113)

Further, the Coroner stated that: *'measures have now been taken to increase awareness of the Service Complaints Ombudsman, including the contact details of the SCO appearing on every army payslip in October 2017. In 2019 the army will adopt a new Command, Leadership and Management package containing formal training on the SCO and the Service Complaints System.'*

The Coroner stated that Sean's family had brought to his attention, *'issues that persist concerning the resources and powers, including investigatory powers, granted to the Ombudsman'* but that '*matters such as the extent of the powers of the Ombudsman lie well outside the scope of my inquiry and so will not be the subject of a PFD report.'* (p.114)

Ultimately the Coroner did not make a Prevent Future Deaths report because he was satisfied that *'relevant action has already been taken or is going to be taken' and that 'the army chain of command has, albeit on occasions relatively late in the day, recognised and addressed matters which would otherwise have led me to make a PFD report.'* (p.114)

CONCERNS AND CRITIQUE

1. **We need a public inquiry into Deepcut**

While the inquest revealed important information about the circumstances by which Sean Benton came by his death, and in doing so has uncovered and sifted through significant evidence about structural failings, abuse and welfare concerns at Deepcut in the 1990s, it has nonetheless been limited in many ways. The Coroner was clear that he was not mandated to inquire into the 'wider state of the army at that time' (9) nor was it a public inquiry in which every 'alleged adverse event or shortcoming at Deepcut' (9) would be addressed.

We believe that given the volume of serious allegations made regarding bullying, sexual and physical abuse and systemic failures at Deepcut which have affected many people's lives, a public inquiry is needed.

2. The military should not be able to investigate serious crimes internally and, as it stands, the military police must be better trained and resourced.

Liberty, an advocacy group which campaigns to protect civil liberties and to promote human rights, is representing Sean Benton's family along with other families impacted by the deaths of young people at Deepcut. In their statement following the Coroner's verdict, they noted that the brief investigation which followed Sean's death was undertaken by the military's internal police, and was 'rushed and grossly inadequate.'[2]

While it is a welcome and important step that the Army has agreed that recruits should be able to report criminal misconduct to the civilian police, and that this information will be made available to them when handouts for induction programmes are next updated (and in induction talks at Deepcut), it is nonetheless still the case that the Army's internal police (the RMP) can investigate serious allegations, such as sexual assault, themselves – and are under no obligation to refer them to the civilian police.

Following the Deepcut deaths, the Ministry of Defence and civilian police forces confirmed that sudden deaths on military property must always be investigated by civilian police – but rape, sexual and physical assault, child sexual abuse and other serious crimes can still be investigated by the military police themselves.[3] While recruits will now clearly have recourse to report crimes to the civilian police, if they do not do so then serious cases can still be investigated internally, and by a system that has proved itself to be severely lacking.

The RMP, which decades ago conducted a woefully lacking investigation into Sean Benton's death, still according to Liberty lacks the 'training and independence necessary to deal with such serious cases.'[4]

This year, a criminal case being held in the military justice system collapsed. It involved allegations of serious assaults on junior recruits (under 18, legally children) at the Army Foundation College in Harrogate. The Judge ruled that the trial could not continue as it would not be a fair trial for the accused, because of serious failings by the RMP. Key witnesses were not interviewed, important evidence was not obtained, and the accused training instructors were not arrested or interviewed for more than two years after the initial allegations. The RMP stated that they struggled because of 'staff shortages, positions being gapped, personnel posted away on career courses and the pressure from other more urgent enquiries.'[5]

We agree with Liberty that there should not be two justice systems in the UK – the military's own system, and the civilian court system for everyone else, nor as it stands should the military police be so badly under-trained and under-resourced that it cannot do its job properly.

3. While significant improvements have been made to Army safeguarding and welfare structures and culture, serious problems persist.

The Coroner was reassured that the Army has improved its systematic understanding of and approach to safeguarding and welfare including bullying and abuse. Yet while welcome measures have been put in place, bullying still impacts the lives of many people in the Army.

In the 2018 Armed Forces Continuous Attitude Survey, 12% of said they had experienced bullying, harassment or discrimination in the last year.[6] Female junior ranking officers have been found to be most at risk of sexual harassment out of everyone in the Army.[7]

In 2015, 1 in 8 women in the army (about 1000) said they had had a 'particularly upsetting experience of sexual bullying.' Women are twice as likely to be sexually bullied in the army as in other jobs.[8]

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2 https://www.libertyhumanrights.org.uk/news/press-releases-and-statements/liberty-calls-civilian-police-investigate-all-military-crimes-0

3 https://www.libertyhumanrights.org.uk/news/blog/our-soldiers-deserve-first-rate-justice

4 https://www.libertyhumanrights.org.uk/news/press-releases-and-statements/government-scrap-archaic-loophole-lets-armed-forces-commanding

5 See 3.

6 https://www.gov.uk/government/statistics/armed-forces-continuous-attitude-survey-2018

7 https://www.telegraph.co.uk/women/womens-life/11751718/Sexual-harassment-in-the-UK-Armed-Forces-The-dark-truth.html

8 http://beforeyousignup.info/army-bullying

Research into sexual harassment in the Army published in 2015 led the chief of general staff General Sir Nick Carter to conclude that the Army has 'an overly sexualised culture in which inappropriate behaviour is deemed acceptable.'[9]

Although only 11% of all service personnel are women, they make up 22% of complainants to the Service Complaints Ombudsman. Of these complaints made by women, 43 percent relate to allegations of bullying, discrimination and harassment. 61 percent of complaints made by BAME personnel relate to such allegations.[10]

Liberty wrote in 2017: 'Our experience helping women who have suffered sexual harassment or sexual assault to navigate the service complaints system is that the process can be drawn-out, insensitive and, in some cases, re-traumatising.'[11]

Bolt Burdon Kemp, one of the UK's leading military claims firms, have talked about sexual harassment and rape going unreported, how emotional commitment to the services, and the strict hierarchical military chain of command can make it harder for people to come forward. They wrote in 2015.

'To look at statistics, between 2009 and 2014, there were 100 allegations of rape, of which 20 were followed by courts martial, and none by convictions. With sexual assault, there were 250 reported allegations, of which 60 were prosecuted by Court martial and there were 20 convictions. But these don't show the whole picture. The real problem here is the sexual assaults and rapes that go unreported. This is not down to poor record keeping or alleged cover ups. The problem goes deeper than this, to the atmosphere and culture which is rooted deeply in the military, across all ranks and all barracks which so often encourages the motto, 'shut up and put up'.'[12]

Emma Norton, Head of Legal Casework at Liberty and solicitor for the Benton family, said following the Coroner's verdict that soldiers are still 'failed by a closed-ranks military culture that resents outsight oversight.'[13]

The Coroner said: *'A constant theme in the evidence was that young trainees at Deepcut felt unable to complain through the chain of command for fear of becoming a target of reprisal.'* While satisfied that the army has done enough to ensure that 'commanders understand their obligations' and to empower individuals to come forward, he also cited the 2017 findings of the Annual Report of the Service Complaints Commissioner which said that Service personnel report limited knowledge of the system and awareness of the Service Complaints Ombudsman, and *'continued reports from personnel that they were discouraged from making a Service complaint or advised that it was not in the best interest of their career to do so.'* (111, 112) However, he was assured by Brigadier Coles that the Army will soon be providing new formal training on the SCO and the Service Complaints System within a Command, Leadership and Management Package, and including the contact details of the SCO on every army payslip.

We are not convinced that this new package and more available contact details address the scale of the problem. In the Armed Forces Continuous Attitude Survey 2018, 12% of personnel reported that they had experienced bullying, discrimination or harassment – and only 6% of those who had experienced it made a formal written complaint.[14]

The top three reasons why the 94% of personnel who had experienced bullying, discrimination or harassment did not make a formal written complaint were not believing anything would be done if a complaint was made (63%), a belief that it might adversely affect their career (50%), and not wanting to go through the complaints procedure (30%).[15]

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9 https://www.telegraph.co.uk/women/womens-life/11751718/Sexual-harassment-in-the-UK-Armed-Forces-The-dark-truth.html

10 https://www.libertyhumanrights.org.uk/news/blog/bullying-and-discrimination-persist-armed-forces-%E2%80%93-mod-must-act

11 https://www.libertyhumanrights.org.uk/news/blog/bullying-and-discrimination-persist-armed-forces-%E2%80%93-mod-must-act

12 https://www.boltburdonkemp.co.uk/news-blogs/military-claims-blog/sexual-assault-and-bullying-in-the-forces/

13 https://www.libertyhumanrights.org.uk/news/press-releases-and-statements/liberty-calls-civilian-police-investigate-all-military-crimes-0

14 https://www.gov.uk/government/statistics/armed-forces-continuous-attitude-survey-2018

15 https://www.gov.uk/government/statistics/armed-forces-continuous-attitude-survey-2018

Time will tell over the coming years as to whether or not the measures Brigadier Coles assured the Coroner that the Army is taking to improve complaints procedure are sufficiently effective. However we are concerned that the view of a senior Army officer, who appears to have been the key person providing insight to the Coroner into the Army's current complaints system and welfare provision, is naturally biased and seeks to circumvent criticism.

The Coroner also mentioned that Sean's family had brought to his attention 'issues that persist concerning the resources and powers, including investigatory powers, granted to the Ombudsman' – however this was not addressed as it was outside the scope of his inquiry. (112)

The Coroner noted that Ofsted now scrutinise army training organisations, and was satisfied that the Army is adequately responding to concerns from Ofsted around delays in personnel awaiting training, and that overall effectiveness has been 'at least good' in recent reports. (113) He was also assured by Brigadier Coles that the practice that allowed Sean to be recruited without reference to his GP records has been discontinued – now following enlistment there is a pre-service medical screening and a second assessment in which a recruit's Primary Health Care Records are obtained and scrutinised. (110)

While this is undoubtedly an improvement, it is regrettable that a young person can enlist – which is likely to entail leaving school or college – and be all set to go into training, before these screenings take place. The disappointment and disruption that could be caused to potentially vulnerable young people could be mitigated by undertaking these screenings before they have been enlisted.

Furthermore, the most recent Harrogate inspection (undertaken in November 2017), noted that not enough information is given to instructors about care leavers and looked after children, and that redeployment of a medical officer affects detailed oversight of the service.[16] This jars with the assurance from Brigadier Coles to the Coroner that 'those responsible for a trainee's medical and pastoral care have the fullest possible information to enable proper diagnosis and devise any necessary care plan' (111)

4. The suitability of Army discipline and culture for young and vulnerable recruits

The Coroner wrote:

'As Brigadier Coles agreed and common sense dictates, discipline is an essential aspect of army life for good reason. Soldiers need to react immediately and instinctively to orders, and not to backchat or question instructions. Units of soldiers all need to work together as a team and it is reasonable to engender collective responsibility for keeping up standards with the life of all could depend upon the actions of one team member.' (18)

In this way, collective punishment was deemed justifiable: the Coroner later wrote in his factual findings:

'On occasion at Deepcut all trainees would be punished for the shortcoming of one trainee, with the entire troop completing a sanction together, such as extra PT runs or parades… I acknowledge that when training young soldiers, the sense of collective responsibility instilled in trainees by team discipline and collective punishment could lead to constructive and supportive behaviour. Whilst such techniques were aimed to generate collective responsibility it also risked individuals being disliked by those who had punishments unfairly vested upon them.' (37)

While the Coroner accepts the necessity of discipline, following orders without question and no 'backchat', we counter that this necessary part of Army culture is problematic particularly when recruiting vulnerable young people. We argue that adolescence is a vital time for learning to critique and question authority, make your own choices and feel safe and able to do so, albeit perhaps within a guided and informative structure. Indeed this is part of the adaptive developmental process an adolescent brain goes through.

We question the ethics of training teenagers as soldiers in such a way and consider that this should not simply be accepted as normal and correct, particularly given that the UN Committee on the Rights of the Child and prominent child rights organisations have considered it inappropriate to recruit under 18 year olds into Army training

16 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/708775/Welfare_and_duty_of_care_in_Armed_Forces_initial_training_2017-18.pdf

The Coroner further said: *'Brigadier Coles told me that when he joined the army, he assumed he was going to get shouted at. It would be unrealistic to expect otherwise. I am alive to the possibility that the reports of some ex-trainees of their shock and even disgust at aspects of army discipline may reflect their own discomfort with army life and the required standards rather than being evidence of inappropriate training and discipline methods.' (18)*

This leads to a further point. While the culture and welfare structure in Army training has undoubtedly changed for the better since the series of deaths and reports of abuse in Army training in the nineties, the reality is that Army training is still an inevitably tough environment which is supposed to instil instant obedience to orders, endurance, a willingness to do things that would be unnatural in a civilian environment (such as kill), etc. The youngest recruits are far more likely than adult recruits to drop out of Army training, perhaps because their experiences do not tally with their expectations or hopes of Army life. Army recruitment marketing campaigns target young people and of course do not emphasize the harder aspects of Army life.

It is often suggested that Army culture can 'sort out' young people who have problems with discipline – indeed this is one of the justifications for the military ethos in schools agenda, and for the recruitment of under 18 year olds. Perhaps this is the case for some. However, Sean Benton's former lieutenant told the inquest that while the Army relies on obedience to orders and subservience to authority, someone like Sean who had issues with authority could never do well in army culture. (Notes from attending the inquest, ForcesWatch)

The young age of recruits at Deepcut came up during the inquiry many times, in reference to their particular vulnerability, the fact that many were away from home for the first time, lack of confidence in reporting or responding to abuse – particularly given the hierarchical chain of command. This is still the case today; the UK has the lowest enlistment age in Europe.

The Coroner was not mandated to examine the UK's heavily criticised policy of recruiting under 18 year olds into Army training. However, given commonsensical understanding of the particular welfare and safeguarding needs of under 18 year olds, criticism from the UN Committee on the Rights of the Child and other child rights organisations on military recruitment of minors in the UK, and evidence showing that young age at enlistment – combined with childhood adversity – are risk factors for long-term mental and physical ill-health resulting from a military career, it is time that the Defence Select Committee undertook a review of this policy.

Indeed ,an independent review of the policy was recommended by Parliament's Defence Committee in its post-Deepcut report in 2005, but have never been carried out.[17] In 2005, the Committee were concerned that the Army was failing to act *in loco parentis*, overlooking moral obligations around the welfare of young people in its care and focusing too rigidly on its legal duties as an employer. The army continue to take this position today.[18]

The Committee also expressed concern about the appropriate balance between welfare and the army's training and operational needs. Today, difficulties meeting recruitment targets continue to prevent the armed forces from reviewing their position on enlisting under-18s.

Ourselves and other organisations have been campaigning for this policy to change for many years because we believe an all-adult force is more ethical and would be far better for the mental and physical health of personnel, and for would-be recruits who enlist too young and subsequently drop out. The Army, which recruits more under 18 year olds than any other service, is dragging its feet on this issue as it has around many of the issues brought up by the Deepcut cases. We hope that this will soon change, though 'late in the day' as the Coroner put it in reference to addressing shortcomings implicated in Sean's death. Those in a position to recommend or advise a raise in recruitment age must do their part in pushing the military forward on this matter.

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17 See the *Duty of Care* report list here: https://publications.parliament.uk/pa/cm200405/cmselect/cmdfence/cmdfence.htm

18 The MoD's training guidance (2014) states that, 'A CO does not have the rights and obligations imposed on a parent or guardian (such as a local authority looking after a child in care) in respect of a Service person who is U18. *JSP 898 DEFENCE DIRECTION AND GUIDANCE ON TRAINING, EDUCATION AND SKILLS* (2014), p.12. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/433762/20141126-JSP_898_Part2_Guidance_v1_1.pdf