REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:

1. Rt Hon Mr Philip Hammond MP Secretary of State for Defence House of Commons London SW1A 0AA

1 CORONER

I am Rachel Redman, Senior Coroner, for the Coroner area of Central and South East Kent.

2 CORONER'S LEGAL POWERS

I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.

3 INVESTIGATION and INQUEST

On 11th November 2013 I commenced an investigation into the death of Dean Griffiths aged 21. The investigation concluded the following day when the inquest ended. The jury found that the cause of Dean's death was:

1a. Hypovolaemic shock

1b.Gunshot wound to the neck

and reached a narrative conclusion which is as follows:-

The incident occurred after two soldiers entered the compound and one engaged an enemy target in the right hand corner of the compound. Two shots were fired, one of which passed through the target and perimeter wall hitting the deceased.

We, the jury, conclude that Fusilier Dean Griffiths died as a result of an accident as the consequence of an unintended occurrence, act or omission during a live fire training exercise.

4 CIRCUMSTANCES OF THE DEATH

Dean Griffiths was training with 1st Royal Welsh regiment on Lydd Ranges in September 2011, prior to deployment to Afghanistan, in a live firing exercise. Due to an incorrectly placed target, he received a single shot gun wound which caused his death.

5 CORONER'S CONCERNS

During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur without action being taken. I was

made aware that such action had already been taken but nevertheless announced at the inquest that I would be writing to you in these terms in accordance with my statutory duty.

The MATTERS OF CONCERN are as follows:-

There were time pressures of completing the exercises within the allocated time available to the Range Conducting Officer. I believe that the Exercise Director must ensure that the Planning Officer allows sufficient time for the RCO to complete his final assurance check.

6 ACTION SHOULD BE TAKEN

A final sweep is carried out after refurbishment between signals to ensure that targets are correctly placed and only planned targets are presented.

Targetry should not be used for any other purpose than as targetry, and in particular, not as debris.

7 YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by 9th January 2014. I, the Coroner, may extend the period.

Your response must contain details of action which has been taken or why no action is proposed.

8 COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:-

- HM Inspector of Health and Safety

- TSOL Treasury Solicitors Department

Bolt Burden Kemp Solicitors

- Kent & Essex Serious Crime Directorate

I am under a duty to send the Chief Coroner a copy of your response and I shall be forwarding a copy to those I have listed above.

The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.

9 Date: 14th November 2013 Signed:

H M Coroner