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

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

The examining pathologist, who was a forensic pathologist, told me that generally photographs and x-rays would not be taken at a routine post mortem and that he would never do so.

Other investigative inadequacies in the investigation of Geoff Gray's death were added to by the absence of either a forensic post-mortem, or at least additional steps being taken within a 'routine' coronial post-mortem and the retention of Geoff's clothes.

Two earlier deaths of young trainees from gunshot wounds at the same barracks in 1995 (Private Sean Benton and Ms Cheryl James), were also both investigated with 'routine' coronial post-mortems. In Sean Benton's case I have earlier heard the fresh inquest into his death, which concluded in July 2018. His post-mortem was carried out by a general histopathologist, who had no experience of performing an autopsy after a death from high velocity gunshot wounds.

At the inquest into the death of Sean Benton two expert Forensic Pathologists, [redacted] and [redacted] produced a joint report in which they agreed that much potentially useful evidence had been lost due to *inter alia* the absence of post-mortem photographs and the lack of adequate post-mortem description in relation to both the external and internal features of the gunshot wounds.

5 **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 unless action is taken. In the circumstances it is my statutory duty to report to you.

The **MATTERS OF CONCERN** are as follows. –

1. I instructed [redacted] as an independent expert in forensic pathology. He told me that the practice in Northern Ireland is that every firearms death, whatever the circumstances, will be subject to a forensic post-mortem.

2. Both [redacted] and [redacted], the forensic pathologist who conducted the post-mortem told me that that there is no specific guidance to either pathologists, and as I understand it to coroners, that urges them to give particular consideration to the nature of the post-mortem examination in cases of death by firearms, even when that death is of a child.

3. It is of concern that where assumptions of suicide lead to cursory post-mortem investigations this creates a risk that homicides will go undetected. The higher the possibility that homicides will be distinguished from self-inflicted deaths, the greater the deterrence to those who might have reason to try to make a murder look like a suicide.

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

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