REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1.** [redacted] Chief of the General Staff Army Headquarters Blenheim Building Marlborough Lines ANDOVER SP11 8HJ
1	**CORONER** I am Mrs Heidi J. Connor, senior coroner, for the coroner area of Berkshire.
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** I conducted an inquest into the death of Joel Robinson at Reading Town Hall between 9th and 11th November 2021. I returned a conclusion of suicide.
4	**CIRCUMSTANCES OF THE DEATH** The family asked me to refer to the deceased as Joel during the inquest. I will respect that wish in this report. Joel Robinson was born on 9th July 1994. He had no previous recorded mental health history, apart from a brief period of time in 2016 when he sought medical advice following the death of his father the previous year. He was posted to the Equestrian Centre in Paderborn in Germany in June 2017. It was not within the scope of the inquest to determine whether the allegations Joel made about his time in Germany were accurate or not. It was clear however that, at the very least, there was tension between Joel and another officer. Joel described this as bullying. He wrote a service complaint, which was shown to his Commanding Officer. The army appears to have kept no record of this letter. The only reason we have seen it is because he sent a draft of it to his mother. Joel described himself as being lonely and depressed in his letter. Informal attempts to resolve the issues were not successful, and a senior officer brought forward a trip to Germany to deal with this. One of the senior officers who gave evidence stated that he believed that the formal service complaint process had begun, but it is clear from correspondence between Joel and his mother that, after a period of time, even Joel did not expect a formal response, and thought it not worth proceeding with. Joel was clear that he did not wish his colleague to be the subject of disciplinary proceedings. He did not know, and his superior officers did not advise him, that that was not necessarily always the outcome of a service complaint. It was clear that the officers dealing with Joel's complaint at the time were fully or partially unaware of the service complaint procedure.

	Joel took his own life by [redacted] on 25 March 2019. I did not conclude on the balance of probabilities, that this tragedy would have been avoided had his service complaint been dealt with differently. Coroners have to consider whether there is evidence of a risk of future deaths, and it is our duty to address these. We heard in evidence that the army has the highest suicide rate of the armed forces generally. We also heard evidence about studies that have been undertaken around suicide in the army and in the wider armed forces. These studies were published in July 2017 and November 2018. The impression I was left with, after reviewing these reports and hearing evidence in court, was that the investigations have not gone much further than acknowledging the problem. A Suicide Prevention Group has been set up, but is still in its infancy. It is due to meet again this year. I am conscious that we heard a relatively small amount of evidence about the work that is being done by the Suicide Prevention Group. It may be that they have already considered these matters, and can answer this letter in those terms. I am concerned that, although awareness of available services, such as helplines etc, is important, the approach appears on the face of it to be a passive one. By this I mean that a soldier would need to raise his or her hand to say that s/he is struggling rather than having a process which actively looks at risk factors to identify soldiers who may be vulnerable. We regularly screen for physical disease, such as cancer or heart disease, and perhaps mental health should be viewed in the same way. Some work around identifying risk factors should be considered, with the input of mental health professionals, and consideration should be given to regular review of soldiers with these risk factors in mind. As set out in the case of R (Dr Siddiqui and Dr Paeprer-Rohricht) -v- Assistant Coroner for East London, the issuing of a Regulation 28 Report entails no more than the coroner bringing some information regarding a public safety concern to the attention of the recipient. The report is not punitive in nature.
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 could 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. Consideration should be given to having a clear timeline for the setting up of the Suicide Prevention Group, in terms of not just collecting data, but also analysing it and putting new strategies in place. I am aware that work has begun on this, but in my view, consideration should be given to doing this more quickly, and certainly within a realistic but clear timeframe. 2. Consideration should be given to identifying key risk factors, and how (in very practical terms) that information can be used to reduce suicide risk. 3. Consideration should be given to regular review of individual soldiers, to screen their mental as well as physical health. It may be that that would be something which would sit better outside of their chain of command. 4. Consideration should be given to increasing awareness of how to handle service complaints within the army. Service complaints are made when, by definition, things are not going well, and this could be viewed as a risk factor.
6	**ACTION SHOULD BE TAKEN**

	In my opinion action should be taken to prevent future deaths and I believe you and your organisation have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 20 January 2022. 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, to [redacted] 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	**25 November 2021**  **Mrs Heidi J. Connor** **Senior Coroner for Berkshire**