Ministry of Defence

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FLOOR 5 ZONE B MAIN BUILDING
WHITEHALL LONDON SW1A 2HB

[redacted]

THE LORD COAKER
MINISTER FOR THE HOUSE OF LORDS

[redacted]

27 November 2025

Dear Ms Cundy,

Thank you for your report of 15 October 2025 to the Defence Secretary following your Inquest into the death of AS1 Malik Bunton. First and foremost, I would like to offer my sincere condolences to AS1 Bunton's family, friends and colleagues.

You have raised concerns regarding the welfare support provided to and oversight of AS1 Bunton, the clinical care review process, and the recovery of evidence. I take the health and wellbeing of our Armed Forces personnel extremely seriously and wholly share your desire to prevent future deaths. I have considered each of your concerns below.

<u>The Chain of Command's management of AS1 Bunton's welfare.</u>

I have sought assurance that the Chain of Command at RAF stations are equipped and trained to respond to welfare concerns and that effective welfare training is provided to them. I am assured that the training and processes in place enables managers to safeguard the welfare of their personnel, and I am aware that the RAF has reiterated the importance of ensuring it is continually developed. I will continue to ensure that Defence does all it can to care for its personnel.

It is of course unfortunate that the full details of the River Ouse incident were not known to the Chain of Command in the immediate aftermath of the incident. I am assured that the Chain of Command acted properly based on the information available to them at the time and having had no prior concerns regarding AS1 Bunton's mental health or welfare.

<u>The Clinical Care Review (CCR) Process</u>

On receipt of your report, the Defence Medical Services (DMS) conducted a review of the CCR undertaken after AS1 Bunton's death. I can confirm that the CCR was shared by the Senior Medical Officer with the GP. Unfortunately, due to the passage of time, the GP was unable to recall this fact at the inquest. However, I am assured that the correct process was followed in relation to the CCR, and that independent scrutiny was applied to ensure early recommendations for learning were identified and implementation plans were put in place.
Defence Primary Health Care regularly review their policies and processes, and recent and separate work has focused on enhancing the approach to clinical reviews of serious healthcare incidents. A key development is the introduction of an early

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review by an experienced and independent Learning Event Review Panel, which will supplement the individual review conducted by a local clinician. Additionally, a new Significant Event Reporting system is being developed in partnership with the DMS Healthcare Assurance team to improve recording of reviews and the ability to implement lessons. This will also include a specific requirement to share CCRs with the clinicians involved in the case. These developments build on the existing process to ensure that the CCR process remains a robust mechanism to identify concerns and mitigate the risk of recurrence.

Recovery of Evidence

The loss of AS1 Bunton was and remains a deeply profound tragedy for those who knew him within the RAF. I fully recognise and appreciate the challenging and unprecedented circumstances faced by station personnel at RAF Leeming in the latter half of 2023 to manage wider welfare concerns and safeguard the duty of care to those service personnel most impacted by AS1 Bunton's death.

Nevertheless, we acknowledge the need for a more robust post incident process within the RAF that gathers relevant material in the immediate hours and days following an event. To address this, the Head People and Families Support, as the RAF lead for personnel welfare, has directed that all suspected suicides within the RAF will now be subject to an immediate fact-finding investigation. This process is designed to ensure timely, compassionate, and thorough understanding of the circumstances surrounding such incidents. Responsibility for gathering this evidence and conducting an initial investigation will rest with the Station Commander and will be formally brought into the RAF Postvention Suicide Response policy as a matter of urgency.

Regarding the delay in providing statements to the Service Inquiry panel, I understand that the statements in question were prepared for the inquest, and I am assured that the delay arose from a desire to adhere to the appropriate disclosure processes. However, further direction and guidance has been issued to ensure such delays are avoided in the future. Furthermore, the Defence Inquests Unit is working to implement a process to retain, where appropriate, the email accounts of deceased service personnel. This will allow for the retrieval of relevant data, should it be required for inquests.

Once again, my deepest condolences go out to AS1 Bunton's family and all those impacted by his passing. Thank you for bringing these important matters to my attention. I hope my response has assured you that the MOD is committed to ensuring that our processes and policies are robust, transparent and effective and

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that we are able to truly learn lessons so we can improve the support provided to our personnel.

Yours sincerely,

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