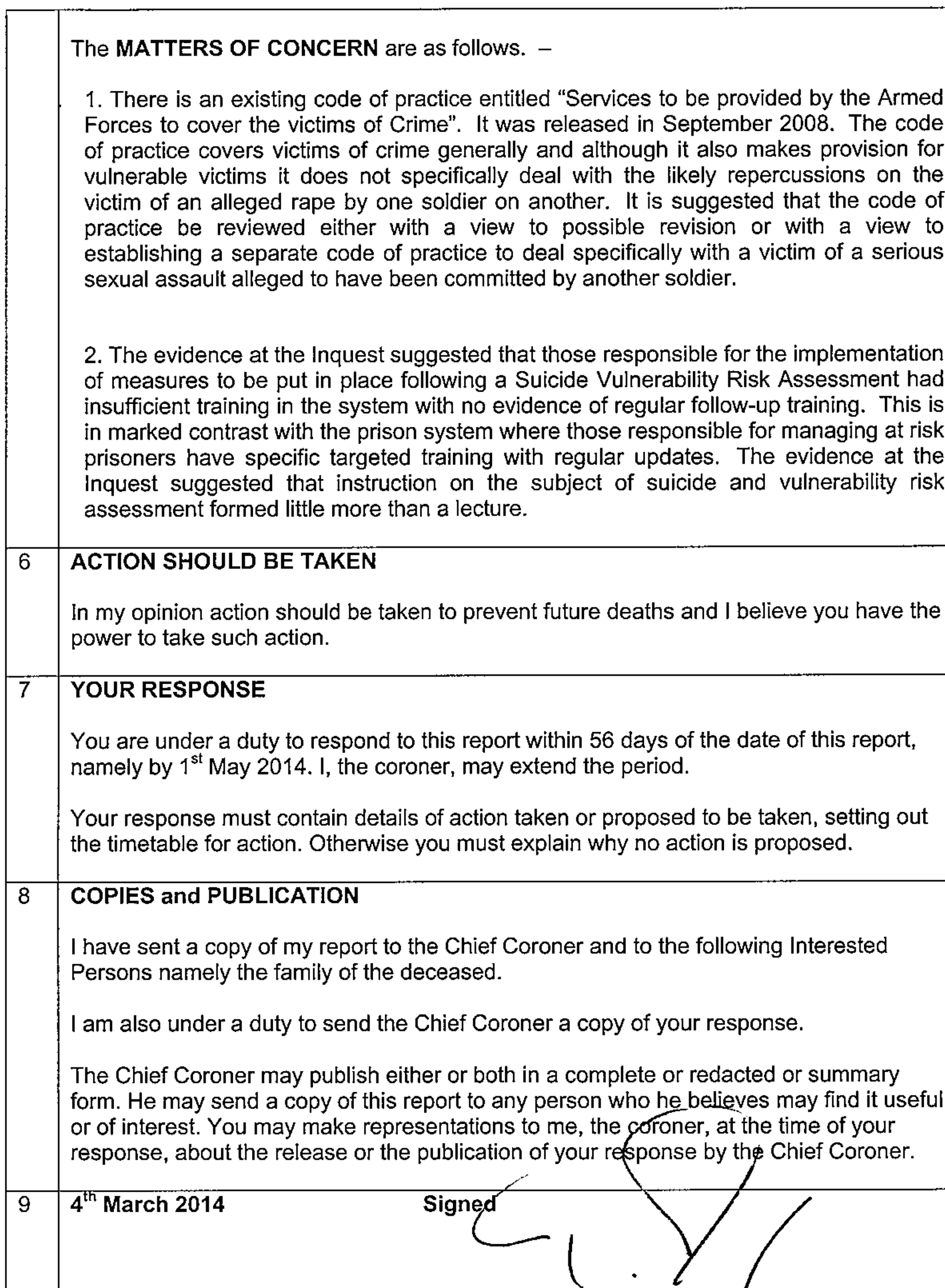
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Armed Forces Minister** 2. **Provost Marshall (Army)** 3. [redacted]
1	**CORONER** I am Nicholas Leslie Rheinberg assistant coroner, for the coroner area of Wiltshire and Swindon
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 3rd February 2014 I commenced an investigation into the death of Corporal Anne-Marie Katherine Ellement aged 30. The investigation concluded at the end of the inquest on 3rd March 2014. The conclusion of the inquest was as follows: At some time around 8 pm on Sunday 9th October 2011 the deceased attached one end of a ligature formed from a scarf to the fire escape outside her room at Flat 1, Block 609, Kiwi Barracks, Bulford, Wiltshire. Having attached the other end of the ligature around her neck the deceased hanged herself, subsequently being pronounced dead at Salisbury District Hospital, Salisbury, Wiltshire. Anne-Marie Ellement took her own life. The following matters contributed to her death: (1) The lingering mental effects of an act of alleged rape during the night of 19th/20th November 2009. (2) Bullying in the work place. (3) Work related despair (4) The effects of a break-up of a romantic relationship
4	**CIRCUMSTANCES OF THE DEATH** Anne-Marie Katherine Ellement ("Anne-Marie") died outside her accommodation block at Kiwi Barracks in Wiltshire. She died by her own hand. One of the matters that weighed heavily on her mind at the time of her death was an alleged rape by two fellow soldiers at an army base in Senelager on 19th/20th November 2009. Although the response to the incident by the chain of command was compassionate and well-intentioned, lack of clear guidance meant that the response was haphazard and less than adequate. Subsequently Anne-Marie was made the subject of a Suicide Vulnerability Risk Assessment. The officer responsible for implementation of the SVRA after the assessment had taken place, lacked knowledge and adequate training in respect of the system.
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. There is an existing code of practice entitled "Services to be provided by the Armed Forces to cover the victims of Crime". It was released in September 2008. The code of practice covers victims of crime generally and although it also makes provision for vulnerable victims it does not specifically deal with the likely repercussions on the victim of an alleged rape by one soldier on another. It is suggested that the code of practice be reviewed either with a view to possible revision or with a view to establishing a separate code of practice to deal specifically with a victim of a serious sexual assault alleged to have been committed by another soldier. 2. The evidence at the Inquest suggested that those responsible for the implementation of measures to be put in place following a Suicide Vulnerability Risk Assessment had insufficient training in the system with no evidence of regular follow-up training. This is in marked contrast with the prison system where those responsible for managing at risk prisoners have specific targeted training with regular updates. The evidence at the Inquest suggested that instruction on the subject of suicide and vulnerability risk assessment formed little more than a lecture.
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.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 1st May 2014. 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 namely the family of the deceased. 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	**4th March 2014** **Signed**