CHIEF CORONER

HH Peter Rook QC
c/o Bridget Dolan QC
Counsel to the Inquest - inquest into the death of Private Geoff Gray
Serjeants Inn Chambers
85 Fleet Street
London EC4Y 1AE

6 September 2019

Dear Judge Rook,

Inquest into the death of Private Geoff Gray

This document is a response by the Chief Coroner of England and Wales to the Regulation 28 Report to Prevent Future Deaths following the fresh inquest in to the death of Private Geoff Gray. I understand that some of the issues raised were also aired during the fresh inquest in to the death of Private Sean Benton.

I have read the material provided about the circumstances of the death and the coroner's concerns carefully. I note the response of the Royal College of Pathologists dated 25 July.

You have asked me to consider the following action to be taken:

> *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*

I am very grateful for you for bringing these important issues to my attention. First, it is important for me to make clear that as Chief Coroner I cannot direct coroners on their independent judicial decisions in individual cases, whether in Guidance or elsewhere. Ultimately coroners must make their own decisions, including on whether (and in what form) to order a post-mortem examination. Much depends on the circumstances of each case.

Secondly, it is important to point out that as Chief Coroner the purpose of any Guidance I publish is to assist coroners with the law and their legal duties, and to provide commentary and advice on policy and practice. It is not possible for my Guidance to direct coroners prescriptively or to fetter their judicial discretion.

It is also, I believe, important to emphasise that practices ought to have moved on significantly since the tragic deaths at Deepcut barracks in the 1990s and early 2000s.

Nevertheless, I recognise the force of your concerns and I am grateful to you for bringing these important learning points to my attention. In response to your concerns I will take the following action.

I have included the following text in the forthcoming Guidance on second post-mortems (and post-mortems more generally), which will be published this Autumn:

> "*deaths resulting from the inflicting of stab injuries or gun shot injuries which may or may not be self-inflicted may be cases where the coroner will wish to give particular thought to the need for or scope of a PM examination*".

I should make clear that this is the first Guidance on the use of post-mortem examinations and second post-mortem examinations in 20 years. This Guidance will supersede previous Home Office Guidance (Home Office Circular (No 30/1999) that was addressed to Chief Constables and coroners. At the time that circular was issued the Home Office had responsibility for coroner law and practice.

There is also a general encouragement in the Guidance for coroners to consider the possible value of CT scans in forensic cases and to consider the value of other recording, such as video or photography as part of evidence capture at the first examination.

The following developments, outside of my remit as Chief Coroner, may be relevant to the issues raised because they have served to reinforce the message to others (particularly the police) about not making assumptions about a cause of death.

1. In September 2013 the National Policing Lead for Pathology wrote to all Chief Constables following concerns raised by the Forensic Science Regulator. It reminded Chief Constables that the use of non-forensic pathologists can, in certain cases, create risks.

2. The Homicide Manual, as it was then called, was re-written and became Practice Advice Dealing with Sudden and Unexpected Death issued by the Home Office. A key paragraph says:

   "The two disciplines of normal non–forensic post mortems and forensic post mortems are very different. Therefore if the outcome of that initial police investigation is flawed and the decision by the police is that the case is not suspicious, there will be no forensic examination of the body and a potential homicide could be missed."

Yours sincerely,

HHJ Mark Lucraft QC
Chief Coroner of England and Wales