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CORONER FOR NORTHERN IRELAND

MR JOSEPH McCRISKEN

INQUEST INTO THE DEATH OF

LANCE CORPORAL JAMES ROSS

FACTUAL FINDINGS

27 February 2019

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Introduction.

[1] I was represented by Coroners Counsel Mr Philip Henry. My solicitor was Ms Dougan. Ms Karen Quinlivan QC and Ms Leona Askin appeared for the next of kin (NOK) instructed by Ms Emma Norton, Liberty. Mr Philip Aldworth QC and Mr Michael Egan appeared for the Ministry of Defence (MoD) instructed by Ms Gilmore, Ms Meegan, Ms Moore, Ms Armstrong, Crown Solicitors Office and also Lt Colonel Campbell.

[2] I want to thank those members of the Northern Ireland Court Service and Coroners Service who have worked tirelessly in preparation for and during these inquests. We have at times struggled with issues concerning technology but those difficulties are no way attributable to any of the staff who, in my view, have done their very best to help all of us. The fact that these lengthy inquests started and concluded in accordance to the schedule is a testament, in my opinion, to the hard work and dedication demonstrated by everyone involved.

[3] I want to formally recognise the patience and strength of the extended Mitchell and Ross families. Ms Ketcher and Ms Mitchell attended throughout the inquest hearing. They have waited too long for the findings which I am about to deliver, they have listened to evidence that no parent would wish to hear but they have waited and listened with respect and have shown respect for this process. They should be proud of themselves. Their sons were dedicated and brave soldiers. They were spoken of in the highest regard by everyone who knew them. I was particularly struck by how highly both men were thought of as men and as Riflemen.

[4] Throughout these findings I shall refer to as Lance Corporal Ross as 'James'. I shall also refer to all military personnel mentioned using the rank they held in 2012/2013. Abercorn Barracks, Ballykinlar, County Down, Northern Ireland shall be referred to as

Ballykinlar. I held joined inquests into the deaths of Lance Corporal Ross and Rifleman Darren Mitchell but I have prepared separate findings for each.

Relevant law and approach to the conclusions.

[5] Rule 15 of the Coroners (Practice and Procedure) Rules (Northern Ireland) 1963 governs the matters to which inquests shall be directed. This rule provides that:

> "The proceedings and evidence of an inquest shall be directed solely to ascertaining the following matters, namely:
>
> (a) Who the deceased was;
>
> (b) How, when and where the deceased came by his death;
>
> (c) … The particulars for the time being required by the Births and Deaths Registration (Northern Ireland) Order 1976 to be registered concerning the death."

[6] Rule 16 goes on to provide that:

> "Neither the Coroner nor the jury shall express any opinion on questions of civil or criminal liability …"

[7] I indicated at the conclusion of the evidence my view that my findings should comply with article 2 of the European Convention on Human Rights (art 2) so that the 'how' in Rule 15(2) is to be interpreted as meaning 'by what means and in what circumstances' each deceased came by their death. It has already been accepted that the inquests themselves complied with art 2. Neither the NOK nor the MoD objected to this

approach. I indicated that I did not require any interested person to address me on the facts, as is my discretion, but I allowed the interested persons an opportunity to address me on the relevant law. I also drafted questions relating to causation and allowed the interested persons to comment. The final decision, of course, as to which questions I pose, and then answer, rests with me.

[8] What should be included in article 2 narrative findings? Narratives can include; 'causes of death, defects in the system which contributed to death and any other factors relevant to the circumstances of the death'. According to the Chief Coroners Guidance in England and Wales (which does not bind me in any way) a narrative finding must culminate in an expression of my conclusions on the 'central issues'. A coroner has a power in an article 2 inquest, but not a duty, to consider for the purposes of a narrative conclusion, circumstances which are possible (i.e. more than speculative) but not probable causes of death. *(R (Lewis) v HM Coroner for the Mid and North Division of Shropshire [2010] 1 WLR 1836).* A narrative conclusion may also (but does not have to) include factual findings on matters which are possible but not probable causes of death where those findings will assist a coroner in producing a report to prevent future deaths pursuant to Rule 23(2)(b) of the Coroners Rules. A conclusion in an article 2 inquest may be a 'judgmental conclusion of a factual nature [on the core factual issues], directly relating to the circumstances of death' while avoiding questions of civil or criminal liability.

[9] The Chief Coroners Guidance suggests that permitted judgmental words include 'inadequate', 'inappropriate', 'insufficient', 'lacking', 'unsuitable', 'unsatisfactory', and 'failure'. On the other hand words which suggest civil liability such as 'negligence', 'breach of duty', breach of article 2' and 'careless' are not permitted as they may breach the Rules.

[10] I have framed my questions on causation so that an act or omission is identified. I then ask if this act or omission caused or contributed to the death. The correct standard of proof to be applied when considering an answer is the civil standard and I must be satisfied that the act or omission caused or contributed in more than a minimal or negligible way to the death.

[11] In relation to the standard of proof generally in an inquest, any fact has to be proved to the civil standard, that is, the balance of probabilities. The standard of proof to determine if the deceased died by their own hand is also the civil standard.

Personal Background.

[12] James Ross was born on 6 April 1982 in Leeds. His mother, Mrs Linda Ketcher, gave evidence at the inquest. James has three siblings, Helen Thomas, Laura and Sam. James' father, Paul Ross, separated from his mother when James was a young child. James' father did not keep contact with either James or his siblings as children, but he later resumed contact in 2012. I was told that James was positive about this contact and went to meet his father.

[13] After the break-up of this relationship Mrs Ketcher commenced another relationship. She told the inquest that this relationship deteriorated over time and that this man was an alcoholic. James was about eight years old when Mrs Ketcher got married to this man. I was told that the relationship was marked by psychological and physical abuse against Mrs Ketcher, Helen and James. Mrs Ketcher said that James felt very protective of his family but that in her view he was afraid of this man. Helen and James both moved out of the family home at a young age to get away from their step-father. Mrs Ketcher said that she supported this decision.

[14] Mrs Ketcher and Helen Thomas told the inquest that despite the issues with James' stepfather the children had very good support from James's paternal grandfather, Joseph Ross. He was very close to James and fulfilled the role of father. James also had a very close family friend called Aunty Winnie with whom he used to spend a lot of time. Mrs Ketcher said that these people provided a loving and stable source of support to James growing up.

[15] Mrs Ketcher described James as a healthy, normal child. She said he was generally very positive and outgoing. He tended to get on with everybody and never caused any problems as he was growing up. He was very active. He did not get into trouble at school and was popular. In her evidence, Mrs Ketcher called James 'transparent' and said he was never scared to ask questions or ask for help. James' sister Helen told the inquest that whilst they came from a broken home, she did not think his childhood would have affected him later in life. James always had girlfriends and he would tend to have one semi-serious relationship after another. His mother said that he was always popular with the girls. James gained 6 General Certificate of Secondary Education (GCSE) qualifications and a National Vocational Qualification (NVQ).

[16] Mrs Ketcher said that James was not a moody teenager and would always speak to her. She considered that they had a good relationship. When he left school James got a job as a holiday representative which he thought was great fun. He then got a job in sales and then in a recruitment agency. Mrs Ketcher said that she thought James joined the army because he could not really settle in these office jobs and found them boring. The nickname his family gave him was 'showtime James'. Before going onto consider his military career, what was abundantly clear to me as a result of the inquest process was that James had a close and loving family. He cared deeply for them – that was obvious from the evidence – and likewise, they cared deeply for him.

Military Career

[17] Mrs Ketcher told the inquest that, although James had never expressed any particular interest in joining the army, he joined the Territorial Army (TA) on 11 July 2006. She said that she supported this decision.

[18] The inquest heard evidence from Ms Emma Koczy. She was a friend of James who trained with him in the TA. Ms Koczy said that she got to know James because they had certain classes together and undertook some exercises together. They also studied defensive instructional techniques around the same time. She said that she was more academic than James but he was physically stronger and better at Physical Training (PT) than she was - so they supported each other. Their relationship was always completely platonic. Ms Koczy said that during her time as a reserve James was protective of her because, in her opinion, she was a young woman surrounded by a lot of guys and because James was a bit older than she was.

[19] They both lived in Leeds and, on occasion would go drinking and socialising in Leeds. She said they used to go to the Rifleman pub until it closed. She said that James enjoyed alcohol and as far as she was aware never did any drugs.

[20] At the time James was a reserve he was in a relationship with a girl called Gemma Isherwood. Ms Koczy recalled that on a couple of occasions, after there had been an argument between them James would become upset. She once saw him crying about this and he said something along the lines of, "I'm in love with her, mate". After he and Gemma split up Ms Koczy told the inquest that James was a bit of a 'player' with the ladies. Ms Koczy told the inquest that James could be a bit sulky at times as well as self-conscious about his body. He told her he used to be quite overweight. She said he also got teased (but was not ostracised) for being over sensitive and moody at times. She said it was what the Army would call 'banter' but that it was probably hurtful.

[21] James trained and deployed to Afghanistan with the TA on Operation HERRICK 10 (HERRICK 10). However, he suffered an injury after about one month and was brought back on 11 May 2009. Ms Koczy recalled that James was genuinely very positive and excited about going out to Afghanistan and that when he returned he was fine. She said he seemed more mature. HERRICK 10 was described as a 'brutal' tour and thirteen members of 2 Rifles lost their lives with many others sustaining serious injuries. Mrs Ketcher said that James told her about an incident, probably on HERRICK 10, when an armoured vehicle was attacked and all five men died or were badly injured. James said he felt dreadful and lonely because he could not speak about it to anyone. Mrs Ketcher said that she didn't think James was directly involved in that incident itself but he was affected by it.

[22] After returning from HERRICK 10 James decided to join the regular Army and started his initial training in Catterick on 2 May 2010. Mrs Ketcher told the inquest that James found his training challenging, given the age difference between himself and most of the new recruits who were much younger than him. However, she said he completely loved the training and was very happy. Mrs Ketcher went to his passing out parade and was extremely proud of him. James was posted to the Second Battalion, The Rifles (2 Rifles), who were stationed in Ballykinlar. Mrs Ketcher said that James was gutted to be posted there because he wanted to be closer to home. Mrs Ketcher said that James described Ballykinlar as 'isolated, cold with nothing to do there'.

[23] James was described as an excellent soldier by all of those who knew and trained with him in Ballykinlar. He was extremely fit and I was told by one of his friends, Lance Corporal McAtee, that James regularly 'beasted' him during beach runs, meaning that James was a very strong and physically fit, athletic soldier.

[24] As a single soldier James was allocated a single room in a communal block within the base. James' room was on the ground floor and contained a bed and some storage

for personal items. Communal toilet and shower facilities were available along a corridor. James' room was on the same floor as the cookhouse, which provided food etc. to soldiers.

[25] After a period of training in Ballykinlar with 2 Rifles James then deployed to Afghanistan on Operation HERRICK 15 (HERRICK 15) with C Company, 2 Rifles. I was told that his tour dates were 12 October 2011 to 25 April 2012. Mrs Ketcher said that James did not tell her very much about his time in Afghanistan during HERRICK 15. Communication was difficult at times but when James did call home he tell her about the weather and what he was doing in general terms but there was not much detail.

[26] Mrs Ketcher said that James did describe one incident to her from HERRICK 15. There had been some sort of explosion and she recalled James telling her about an Afghan man who came running towards him holding something in his arms in a blanket. James had to shout at him to stop and get down on the floor because he did not know what was in his arms. James approached the man and opened the blanket and saw that there was a little girl in there, still alive but obviously very badly injured with a head trauma. James told her that he had the medi-pack on his back and he put it on the girl's head. He then passed her over to the medics and they took her away. He said it was very distressing and that it stuck with him.

[27] Mrs Ketcher also recalled James telling her about an incident when he was out on patrol and his Sergeant was shot through the leg. He told her that it was a sniper attack and was unprovoked. James told her that he and his colleagues had to deal with it until a helicopter came and took the casualty away.

[28] None of the military witnesses who were stationed in Afghanistan either with James or in the same Company were able to tell the inquest about any significant

incidents involving James. No Trauma Risk Management (TRiM) entries exist for James during his HERRICK 15 deployment.

[29] During the inquest James's sister, Helen Thomas confirmed that James had only spoken to her about one incident in Afghanistan. She wasn't able to give a lot of detail but said that it involved children being taught or shown something. She told the Service Inquiry that there were no incidents that took place during HERRICK 15 involving James as far as she was aware.

Post HERRICK 15

[30] James returned from Afghanistan on 26 April 2012. It seems that the process for bringing soldiers home from HERRICK 15 included a two day stop in Cyprus for what has been described as 'decompression'. The soldiers then travelled to Ballykinlar where I was told a further 'normalisation' procedure took place. On 27 April 2012 James returned to Ballykinlar. One issue that the inquest examined was whether or not James had completed the full normalisation procedure. I will comment on this later. James had post operational tour leave from 17 May to 15 June 2012. During that time, he was based at home and his mother told the inquest that she saw quite a lot of him.

[31] When James returned from HERRICK 15 he resumed living with Gemma and they got engaged in June 2012. However, they broke up shortly afterwards in July 2012.

[32] In August 2012 James met Sharon Lemon. They met on-line and first met in person in a bar in Belfast. They began a relationship. Sharon Lemon described James as a brilliant boyfriend and she said they had a good relationship. James would stay over at Sharon Lemon's property during the week and at weekends. She would also use her vehicle to collect him from the base if they were travelling out to certain places. Sharon Lemon told the inquest that she never detected any sign of depression from James and

did not express any concerns about James during their relationship, apart from one incident when he had some alcohol taken. On this occasion he phoned her and she was concerned about him because of his demeanour on the telephone. James mentioned his tour in Afghanistan to her but he did not go into any detail. He showed her videos of the conflict on YouTube. He told her about an incident with a young girl who he was unable to save.

[33] When James re-joined the Battalion in about September 2012 his mother said that he was very busy doing courses and working to obtain his promotion to Lance Corporal which he achieved on 26 October 2012 when he successfully completed his Junior Non-Commissioned Officer (JNCO) Cadre. She said in her evidence that James was very pleased to have obtained that rank as he was very ambitious. James attended a mortar course at the end of November in Salisbury and after that he transferred to Mortar Platoon, I Company.

[34] Mrs Ketcher was introduced to Sharon Lemon in November 2012 and she said that he seemed very happy with Sharon and had mentioned that if they were still going steady the following summer, they were talking about getting a place together, so he could live off barracks with her. Mrs Ketcher told the inquest that they seemed very well-suited. Sharon Lemon told the inquest that they planned to travel to Paris in and around the New Year in 2013 and had planned to move in together into a property together in Ballynahinch associated with an elderly member of her family.

[35] James applied for a leave pass to come home over Christmas but then cancelled it. He told his mother that he wanted to stay on the base to train for a further promotion course. He said he would spend Christmas Day and Boxing Day with Sharon and her family but he seemed keen to return to England for New Year. He also told Mrs Ketcher that his friends Jackie and Nathan Abbott had asked him to be godparent to their child. He was planning to go with Sharon to the christening in England.

[36] The last communication between James and his mother was the Thursday 6 December. James was doing his driver's course and they had a general chat about it. Mrs Ketcher said that he seemed pleased to be doing the course and told her he still had the second part of the course to complete.

Demotion in rank?

[37] Two witnesses told the inquest about telephone calls with James in mid-November 2012 in which he told them that he thought he was going to lose his promotion. Ms Koczy, his friend from the TA, said she was at work when she received a phone call from James. He did not sound like his normal self, he was more serious. She said that he then told her he would be flying back soon and he then started ranting and became quite incoherent. He said, "fucking Army - I have been bumped" and "fucked over". She took this to mean that he had been demoted. She said he confirmed he had lost his rank. He said he had taken a load of "crows" or "NIGs" to a beach to "frag" them. "Crows" is a derogatory term for junior soldiers and "NIGs" stands for "new intake gunner". He said he had taken them for a run then made them swim in the sea and been "busted" and so had been demoted or "bumped" as a consequence. Ms Koczy said she did not think he sounded very well and she had no doubt that he genuinely believed he had been demoted. He sounded like he was crying. He was distraught at being demoted. Ms Koczy told the inquest that following this call she never heard from James again. She tried to call him on a number of occasions but he stopped taking her calls and blocked her from contacting him on social media.

[38] Around the same timeframe James also telephoned another friend from his time in the TA and told him a similar story about getting into trouble for taking junior soldiers to the beach at Ballykinler. James asked if they could meet to discuss, but the friend was unable because of family commitments.

[39] No other witness reported that an incident on the beach like that described by James occurred. None of his friends, senior officers or commanding officers had heard about this incident and it was confirmed that James had not been disciplined or lost his rank as a result of any such incident. It appears that, for some unknown reason, James fabricated this story.

The incident with Rifleman White.

[40] The inquest heard evidence about an incident which occurred between James and Rifleman Darren White. I was told that on the day that James received his promotion he found that Rifleman White, who was a member of his Company, had not completed what they referred to as a "block job" – each soldier on the block was given a task to do. White's was to clean the communal showers. James spoke to Rifleman White about this and there was a disagreement. James, as a Lance Corporal, then decided to discipline Rifleman White, by way of what is known as an AGAI. This meant that Rifleman White had to complete extra duties. Rifleman White told the inquest that there was no need for James to do this because Rifleman White had been at an appointment and therefore had been unable to complete the block job prior to his return from that appointment. White's view was that James was trying to show off his enhanced rank and 'lay down the law'. The two men did not speak for a period of time afterwards. Rifleman White said that on a ferry back from the course in Salisbury a few weeks later in November James made an effort to speak to him and they shook hands. Rifleman White explained that this conciliatory act made him respect James, for having made the first move to mend bridges.

[41] Although there was nothing of significance between James and Darren White between that ferry trip back to Northern Ireland in November and James' death in December. While White didn't consider himself one of James' friends, he described how

they would pass themselves with one another and he likened their disagreement over the AGAI to a "workplace fall out". White said they were both mature soldiers, they'd shaken hands, he didn't hold a grudge and they put it behind them.

[42] I don't think the incident between them was of any significance in terms of the issues I've to decide in this inquest. There was evidence that soldiers were often transferred to a different unit after promotion so that they didn't have to give orders to or discipline friends. That did not happen with James' promotion, but I don't think that was significant. The only issue raised in connection with this was with White and I am satisfied that after James' mature conciliatory move on the ferry, the two men put the incident behind them; and the fact that James wasn't moved to a different unit doesn't speak to the questions I have to determine.

The Driving Course

[43] William Reilly was a civilian driving instructor who took James for a driving course the week before his death at Kinnegar Barracks. The aim of the course was to teach participants how to drive a Heavy Goods Vehicle (HGV). The course commenced on 3 December 2012 and was to last a week and would involve a test with an external instructor. Mr Reilly told the inquest that from the minute James arrived he had an attitude problem and he didn't look like he wanted to be there. James complained and moaned throughout the course according to Mr Reilly. On Thursday 6 December Mr Reilly said that James told him 'I don't care if I pass out'. A verbal altercation then took place with a driving examiner while James was trying to carry out a manoeuvre. James mentioned to Mr Reilly that he had just been promoted and, according to Mr Reilly, James was looking forward to getting qualified in preparation for his next promotion.

[44] James did not pass the course within the time that was allocated and he was due to return the following week to complete the course. In Mr Reilly's opinion James was

upset at not being able to complete the course. I heard evidence from a number of military witnesses who suggested that there would, in all likelihood, not have been an issue with James' failure to pass the course.

[45] On Friday 7 December Sharon Lemon was in contact with James by text and Facebook. She did not see him that day but he told her that he had a fight with his driving instructor and a planned driving test was not going to take place. James also told Rifleman Stephen Holmes that he had physically grabbed the driving instructor by the throat during an altercation. Mr Reilly, who witnessed the argument between the instructor, Mr Walker, and James, was adamant that no physical altercation had taken place. I am satisfied that James did not grab him by the throat as he had suggested.

[46] According to Sharon Lemon James seemed to be disproportionately anxious about making it back to base in time for the mess dinner which was taking place on the Friday evening. According to Sharon Lemon he thought he would be reprimanded. Rifleman White also reported that James was concerned about making it back in time for the mess dinner that night. Ultimately the evidence suggested strongly that he did make it back to the barracks on time. Darren White described how James thanked the driver for "saving the day". Also, no one at the barracks described James being late for the function.

[47] The last contact between James and Sharon Lemon was on 7 December at around 6.30pm. James sent her a text saying that he had returned back to Ballykinlar. Sharon Lemon was not invited by James to attend the mess dinner with him. He told her that he was not able to arrange for her to attend, although that was not correct. Corporal McAtee, who was a friend of James and was principally responsible for organising the function, said she certainly could have come to the function, even at late notice, but it seems, that he did not want her to attend with him.

The Mess Christmas Dinner.

[48] Corporal McAtee, president of the Mess Committee at Ballykinlar, and a friend of James, told the inquest that one of his responsibilities as president was to organise the Christmas Dinner in the Mess. He considered James to have the 'gift of the gab' and thought he could assist in organising the function. The event was to take place in the cookhouse and only JNCO could attend. As James had just recently been promoted this was the first time he was able to attend this event.

[49] Corporal McAtee did not think that James had any personal problems. On the evening of 7 December 2012 James looked after Corporal McAtee's fiancé while he was looking after guests at the Christmas dinner. Sometime during the night Corporal McAtee, prompted by his fiancé, went to James room to retrieve his own room key which James had in his possession. Corporal McAtee was concerned that he would be unable to retrieve the key at a later stage because James was becoming more intoxicated. When James went to the room he had difficulty opening the door. Corporal McAtee described James as being drunk. At around 2am Corporal McAtee walked past James' room and nothing seemed untoward. Later in the morning Corporal McAtee walked past James's room as he was leaving the function and noticed that some damage had been done to the door frame near the door lock. However, the door was still locked.

[50] The inquest heard evidence from a number of people who were present at the dinner. Lance Corporal Leonard Maleiba, a friend of James, spoke to James at the event. He said that he had known James for about a year and when James told him he was staying at the base over Christmas he invited James to attend Midnight Mass with his family. Lance Corporal Maleiba had invited a former Leeds United footballer to his home and told the inquest that James, a fan of Leeds United, was very excited to meet this player on Christmas Eve. Lance Corporal Maleiba had no concerns about James during the function.

[51] Mrs Heather McAtee (formerly Kerr) provided a statement in which she said that she had been in James's company at the Christmas dinner. She described James as helpful and mild mannered. She recalled that at times during the evening James seemed distracted/melancholy. She last saw James between 1am and 2am on 8 December 2012 and he seemed happy and was intoxicated. She said she had no concerns.

[52] Corporal Toni Halliday was an acquaintance of James'. Apparently he had asked her out on a previous occasion and then nothing had come of it. At the Christmas dinner he made an arrangement to meet her the following Tuesday for a Chinese meal.

[53] Rifleman Andrew Fisher, a friend of James and a member of 2 Rifles, told the inquest about an incident which occurred during the night of the dinner. James was in Rifleman Fisher's room during the night bringing alcohol to the room from the dinner. Rifleman Fisher described James as being very drunk. Rifleman Fisher admitted that he was also very drunk. Rifleman Fisher and others were not eligible to attend the mess function because of their rank, although they were having their own Christmas celebrations in the accommodation block. At some stage James came to Rifleman Fisher's room with his iPad to play some music. James left at one point, he said, to phone Ms Lemon. Rifleman Fisher fell asleep. He last saw James at 4.30 am when James was helping him to get to his own room. During this encounter James burst into tears. Rifleman Fisher asked him what was wrong but James would not tell him. Rifleman Fisher describes how he tried to comfort James by giving him a hug. James then said he was going to bed and made his way to his own room. In his evidence Rifleman Fisher described how he followed James to James' door asking him, in terms, was he OK.

[54] This was the last time that Rifleman Fisher saw James alive. Rifleman Fisher didn't mention either of the two of them doing anything that could have caused any damage

to the door of James' room. Rifleman Fisher, in his evidence, agreed that James was 'out of his head' on drink, as was he.

Discovery of James' body

[55] Sharon Lemon told the inquest that she had not received any contact from James since the previous night of Friday 7 December. She texted him just after 10am on 8 December 2012 and she got no response. Ms Lemon was supposed to be meeting James on the afternoon of 8 December and it had been arranged that she would pick him up at the base. Ms Lemon tried to call James a number of times without response. About 4.00 pm she rang the guardhouse at Ballykinlar. She asked if someone could check on James. She rang the base on further occasions. Some of James's friends noticed that damage had been done to his door frame.

[56] Corporal McAtee noticed this just after 8.30am on 8 December. Sometime around 6pm two soldiers obtained the master key in order that they could open James' room. There was now a concern for his safety as he had not been seen for some time and his girlfriend had telephoned also expressing concern. Rifleman Hughes and Rifleman Thomas White used the master key to unlock James's room. They described the door as being locked from the inside and even when the door was unlocked using a key, considerable force was required to open the door. Rifleman Hughes looked in and could see James's body hanging behind the door. Rifleman Hughes said that he knew that James was dead and closed the door. White entered the room. He said he was the only soldier to physically enter the bedroom between the time James was discovered and the arrival of police. His recollection was that the office chair was on the bed and a ceiling tile was disturbed. I don't think the witness was dishonest, but I do not accept that the chair was on the bed and the ceiling tile was disturbed. The photos show the

chair on the floor, not the bed, and no one else noticed and roof tiles disturbed. I think those two factors are innocent by false memories.

[57] An ambulance was called. When paramedics arrived they gained entry by pushing the door open. This action caused part of the inner top frame to break off and James' body fell to the floor. He was facing the door and his feet were on the ground. A paramedic told the inquest that it was clear that James was dead and had been dead for some time. He was cold to touch, rigor mortis had set in and James's tongue was cyanosed. A black leather belt was secured around his neck. The belt was not attached to a ligature point at the other end.

[58] Dr Harrison, who was the attending forensic medical officer, told the inquest that when he examined the body of James he considered that he had been dead for in excess of 6 hours. He was unable to give an exact time of death based upon his observations only.

[59] Constable McConn was tasked to attend the scene at 6.35pm. On his arrival he was informed that James had been dead for a number of hours. He took steps to preserve the scene and seized a number of exhibits including James' mobile phone and laptop. A photographer was tasked to attend and arrived about an hour after police. His statement recorded that when he entered the room James' was behind the door on his knees facing up toward the back of the door. The door frame at the top was damaged and the metal door closer which was attached to both the frame and the door were damaged. Constable McConn believed that one end of the belt had been attached to the door closer and the other end to James's neck. A key for the room was not identified or seized. No note had been left and none was discovered on any electronic equipment.

[60] A post mortem examination concluded that James was physically healthy. There was no natural disease to cause or accelerate death. In the opinion of the Assistant State

Pathologist, Dr Peter Ingram, death was due to hanging. The pathologist explained that there was a ligature, a belt, encircling the neck and its position was such that when the belt tightened, under the partial weight of James' body, it would have interfered with breathing and the flow of blood to and from his head. The pathologist told the inquest that unconsciousness would probably have occurred quite rapidly with death supervening within a few minutes.

[61] Apart from the ligature mark there were no other recent marks of violence just a healing abrasion on the right knee. The pathologist did not consider that a third party had been involved. The pathologist was unable to give an exact time of death but said that James' could have been dead for a period up to 12 hours depending on conditions within the room.

[62] A report from Forensic Science Northern Ireland showed that at the time of his death there was some alcohol in James' body, 185mg per 100ml. The pathologist opined that this concentration would have caused at least a slight degree of intoxication and could possibly have upset James emotional stability. At inquest the pathologist considered, taking into account a urine concentration of 254mg per 100ml, that James had probably consumed much more alcohol before he died but that his body was in the process of eliminating alcohol, in other words he was in the process of 'sobering up' when he died.

Evidence from Professor Fazel.

[63] I instructed Professor Seena Fazel, a Specialist Forensic Psychiatrist at the University of Oxford to examine certain circumstances concerning James' death. Professor Fazel has extensive experience in psychiatry and has treated individuals who served in the army and who suffered from Post-Traumatic Stress Disorder (PTSD).

[64] Professor Fazel considered post-mortem reports, witness Statements, the Service Inquiry Report and List of Exhibits and selected Exhibits, medical records of the deceased, Service Inquiry transcripts (days 1-21), and relevant policy documents.

[65] He told the inquest that his report outlined that James had certain stressors in his life prior to his death. He noted that Mr Reilly reported that James 'hated' Northern Ireland, and a number of witnesses said that James had problems in his relationship with his girlfriend, Ms Lemon. James gave the impression that he was 'unhappy or unlucky in his love life' but at the same time, his girlfriend, who lived locally, did not describe any problems, stated that the 'last week, it was perfect' and explained that they had booked to go to Paris together over the Christmas period. James failed an HGV course in the week leading up to his death, although told his girlfriend that he was 'not bothered' about the course. He noted that Ms Lemon had reported James as 'getting more stressed' about being late during the afternoon. In addition, there was a delay in James officially receiving his rank, but there is no indication that this acted as a stressor to him.

[66] Despite the apparent stressors described above, however, James was reported to have been looking forward to a promotion, 'loved his job' and was planning to go to Paris with his girlfriend. Army colleagues did not report any symptoms consistent with PTSD or depression or any other mental illness, nor was his girlfriend. All of them were spending time with him in those last days, weeks and months. He did not have a history of mental health problems, self-harm or substance abuse.

[67] Professor Fazel further considered that there were slightly different accounts of James' mental state on the evening of the Christmas dinner. James was described as being in 'good spirits', 'on good form', and there was 'nothing out of the ordinary' and 'enjoying the night' by various witnesses. However, he was also reported as 'out of character' in that he was 'happier' than usual, 'hugging, kissing' and 'abnormally happy'

(as described by Darren White). James was described as drinking heavily and increasingly intoxicated as the evening proceeded. At 0430 hours, James visited a friend on the barracks, Rifleman Fisher, when he 'burst out crying'. When Rifleman Fisher asked what was wrong, James said 'nowt'. That appeared to be the last contact that James had with any individual before his death. Professor Fazel further noted that the post-mortem report stated that there was no medication detected, no suicide note found, no indication of violence, and that James was physically healthy.

[68] Professor Fazel concluded that James appeared to have had very few risk factors for suicide. There was no history of self-harm, mental health problems or substance abuse, and he appeared to have been content in his job with a recent promotion. Furthermore, he had plans for the future, including a trip to Paris and for future promotions. Professor Fazel told the inquest that future plans are typically considered protective factors.

[69] Professor Fazel did not think that the failed driving course or any relationship difficulties would have made James suicidal. He considered James to be an intelligent man who could overcome relationship difficulties and the course did not seem to be time limited.

[70] Professor Fazel did think there was a possibility that James' personality may have increased his risk. James was described as 'bottling' his emotions, and his last appraisal reported an inability to take criticism or setbacks. Thus, the Professor opined, it was possible that a longer-term dissatisfaction with the overall direction of his relationships may have weighed on James on occasion. Furthermore, on the night of his death, he was acutely intoxicated with alcohol, and this would have increased his impulsivity. Professor Fazel considered alcohol to be an important contributory factor to James death but did not think that alcohol intoxication was sufficient to explain James' death.

Professor Fazel thought that the manner of the hanging with the locked door did not suggest low intent.

[71] Professor Fazel explained that suicide is usually understood as being caused by a combination of historical (or vulnerability) factors and recent triggers (such as life events or psychiatric illness). However, in James' case, there was little evidence of any vulnerability factors (possibly some personality factors) and no strong recent triggers.

[72] In summary, it was Professor Fazel's view that the contributory factors leading to James' death were not known. In addition, Professor Fazel did not think that James displayed any warning signs for self-harm or suicide prior to his death.

[73] When questioned at inquest Professor Fazel outlined the usual symptoms of PTSD. He said that normally the condition was triggered by an exceptionally distressing or traumatic event. The condition can occur within weeks or months of the event and symptoms last for at least a month and can affect daily life. He was asked about sub-threshold PTSD and said that there were internationally recognised standards for diagnosis which set the threshold. When people describe sub-threshold they mean that not all of the symptoms for diagnosis are present. Whilst he described that the international standards refer to the number and type of symptoms required before a diagnosis, he also explained that there is also a degree of clinical judgement involved, and this might be based on a degree of impairment.

[74] Professor Fazel explained the difference between depression and PTSD. He said that to diagnose a clinical depression a persistent period of low mood, lasting at least two weeks is usually required, along with loss of interest or pleasure in normal interests/ hobbies. He emphasised the need for pervasiveness before he would diagnosis clinical depression and how normally the patient would be unable to derive pleasure from areas of their lives that previously provided them with pleasure. He said

that depression was different to PTSD. Professor Fazel said a core symptom of depression is fatigue without much physical activity but other symptoms include sleep problems (which can overlap with PTSD), poor appetite, weight loss, low libido, false beliefs.

[75] At inquest Professor Fazel discussed suicide and certain vulnerability factors. He said that certain types of personality are more likely to attempt suicide, those who are impulsive. Mental health problems increase the risk of suicide.

[76] He then discussed triggers to suicide and said that trigger risks that are well known are relationship problems, financial problems, bereavement, drugs or alcohol, social media reports but that every individual is different.

[77] Professor Fazel did not think that James Ross was suffering from either depression or PTSD in the time before his death.

Abercorn Barracks, Ballykinlar.

Regime and facilities.

[78] Abercorn Barracks, named after the Duke of Abercorn, was built in 1901. It was largely used as a military training establishment. 2 Rifles moved there in 2007 following the creation of The Rifles. Major renovations to the Barracks were carried out in 2008. 2 Rifles moved to Thiepval Barracks in Lisburn in June 2014. The Commanding Officer (CO) of 2 Rifles between June 2012 and April 2015 was Lt Col Gidlow-Jackson.

Medical facilities

[79] There was a medical centre on site which was manned by a Regimental Medical Officer (RMO), one Service Nurse, two civilian Registered Nurses and approximately six Combat Medical Technicians (CMTs). The Defence Community Mental Health (DCMH) team was based in Lisburn. During the relevant time the manager was Captain Connelly (now Major Priest) once assessed, personnel may be referred to the DCMH. Major Diacon was the RMO at the relevant time advised the inquest that if he considered that there was a serious mental health concern, then an appointment the following day, or sooner, could be arranged. Those with a less serious problem were offered an appointment within 28 days.

[80] The DCMH service was led by a Consultant Psychiatrist and supported by qualified Psychiatric Nurses. The DCMH team provided a service during business working hours and outside of these hours, Service personnel would be acutely cared for by the local health service and then ne followed up the next working day by the DCMH team. A visiting Psychiatric Nurse visited Abercorn Barracks to review Service personnel usually every one to two weeks.

[81] 2 Rifles had a Unit Welfare Office led by the Unit Welfare Officer and his deputy, the Unit Welfare Sergeant. They were responsible for the support, assistance and welfare advice given to Service personnel and their dependants and were a 24 hour service. In addition, 2 Rifles had a Padre attached to them. His role was to provide spiritual support and moral guidance. Finally, Abercorn barracks had access to the Army Welfare Service who provide confidential and specialist welfare services to soldiers and their families.

[82] Since 7th January 2013 there was a member of the Women's Royal Voluntary Service (WRVS) on camp. Lou McGhie was responsible for running the recreational centre. Her role was as a confidential adviser if any soldier had an issue from financial

problems to mental health issues. Ms McGhie assisted with any issues the soldiers did not want the chain of command or Padre or Unit Welfare Officer to deal with.

Incident with Rifleman Ingham and Soldiers D and G

[83] Following Darren's death, Nurse MacPherson in the Medical Centre referred his closest friends, Soldiers D, Soldier G and Rifleman Ingham to the DCMH under Captain Connelly. Captain Connelly arranged for the soldiers to participate in a horse-riding course for two weeks at Lisburn.

[84]Warrant Office Class Two (WO2) Webb held the post of Company Sergeant Major (CSM) B Company from February 2013 and took over from Sgt Major Bell. During evidence he told the inquest that as CSM he was accountable for all the Soldiers under his command whether in camp or outside it. He said he only joined the base after Darren Mitchell had died and his first task was to arrange his funeral. On one occasion not long after Darren died Soldiers D, G and Rifleman Ingham could not be accounted for and they were called to Sgt Major Webb's office. The soldiers in evidence alleged that Sgt Major Webb said 'if I ever find out you're bluffing and all this I'm gonna AGAI you up to your eyeballs'. During evidence Sgt Major Webb could not recall using this phrase.

[85]After Darren's death Soldier D self-harmed. When brought to the guardroom after Sgt Major Webb came to see him. Soldier D stated in evidence that Sgt Major Webb called him a 'dick for doing it' – meaning self-harming. Sgt Major Webb stated he could not recall using that terminology.

[86] It was also alleged that during parades Corporal Farragher made comments directed to Soldiers D and G and that other soldiers laughed. Corporal Farragher said that he was suspicious that D and G were not being truthful about how they felt following Darren's death and were reporting back to the other soldiers about the activities they were undertaking at Lisburn like horse riding and pizza parties. Corporal

Farragher asked for information about their treatment from Nurse MacPherson but she told him that he was not entitled to this information.

Soldier's views on Ballykinlar.

[87] Mrs Mitchell in her evidence said that her son described Ballykinlar as 'isolated, cold with nothing to do there'.

[88] Corporal Robin Hughes spent four years in Ballykinlar and when asked if he considered Ballykinlar was isolated he said 'it's your outlook on things, you've got to make the best of the situation. Got to be a bit proactive and make the best of the situation.' When asked about support in 2 RIFLES, Corporal Hughes said there was support if needed in the form of the chain of command, medical centre and padre as well as a Unit Welfare Officer. Rifleman Hughes said that his friends were the first point of contact for him. He said you could open up to them and they would understand because they have been through the same thing.

[89] Lance Corporal Maleiba lived in a house with his partner on camp. When asked if he had any concerns in relation to Ballykinlar he replied 'you either love it or hate it'. He said it was difficult and challenging at times but in terms of military training it was really good. When asked about support he said his own personal experience was good. He recalled on one occasion when his mother had a stroke he knocked on the Doctor's door for advice. He said they had a really good Padre on camp and he had an open door and was friendly.

[90] Corporal David McAtee told the inquest that there was a culture within the battalion where people did not feel comfortable going through the chain of command for help. He stated that he went out of the camp to seek help on one occasion. He took the view that an ambitious solider might not seek help because it may affect their promotion. Corporal McAtee was of the opinion that Lt Colonel Gidlow-Jackson's

policy was to provide support but that there were certain NCOs who were not approachable. During his evidence Corporal McAtee was pressed on the issue of available support, he admitted that he would feel comfortable going to the Sgt Major, Nurse MacPherson, the RMO and Captain Connelly. In effect he admitted that despite his previous view that there was little support in reality there was a lot of support.

[91] Rifleman Rodgers when asked about B Company said as a Company they got on well. Rifleman Rigby said that everyone was approachable and that Sgt Major Bell invested time in him and in the boxers and anyone in his company. He said Sgt Major Bell cared about his soldiers. It is worth noting that although Darren was working at the ATC, he still resided in B Company accommodation. Sgt Major Bell was responsible for B Company. Rifleman Ingham described Sgt Major Bell as an "awesome bloke", this was a theme throughout the evidence. I was also very impressed at how Sgt Major Bell gave evidence and how highly regarded he was within the Company.

[92] Rifleman Ingham said that Ballykinlar had amazing facilities but that it was isolated. Rifleman Ingham told the inquest that the facilities for help were there but that no one wanted to go and seek help. He took the view that it was put down on your record and would affect your career.

[93] Lt Colonel Bryan was the Commanding Officer for B Company. He frankly accepted that despite the excellent facilities, Ballykinlar was not suitable for the long term placement of a predominantly English regiment. Soldiers who were stationed in Ballykinlar received extra pay. They also received 12 free return tickets home each year.

[94] Lt Colonel Gidlow-Jackson, Commander Officer of the Battalion said that he thought the atmosphere on the base was friendly. He said the training and leisure facilities were some of the best available to the British Army. The base had a swimming pool, golf course, shooting range, access to a beach and the sea, proximity to the Mourne Mountains and many other facilities. He admitted that the base was isolated.

The chain of command did take steps to provide transport to soldiers but it was not popular.

[95] I could see the conundrum with Ballykinlar. When I visited the base I could see that it had real potential to be an excellent place to train soldiers. I could also see how isolated it was. Soldiers were not permitted, for security reasons apparently, to socialise in local towns and had to make a long journey to either Belfast or Lisburn. The base was effectively the soldier's home and yet they could not really treat it as a home. One Rifleman told me that he wanted to join a local sports club but could not because of security concerns. The army tried to make the base work until a decision had to be taken on its long term future. Lt Colonel Gidlow-Jackson said this was a difficult decision. The battalion moved to Thiepval Barracks in Lisburn. The facilities are not as good, I was told, but it is less isolated.

Conclusions

[96] If he did not receive TRiM, ought James Ross to have been provided with TRiM during HERRICK 15? If so, did this failure to provide James Ross with TRiM cause or contribute to his death?

[97] Trauma Risk Management (TRiM) was described by Captain Coltart, former Adjudant at Ballykinlar, as a peer delivered, evidence informed psychological support strategy. Although not a treatment itself, Captain Coltart said that TRiM endeavours to foster peer and organisational support in the short term and, where appropriate, direct individuals towards formal sources of help. Essentially one soldier, who had been TRiM trained, who speak with the subject soldier to attempt to identify if there were any concerns or issues and provide support and/or start the process getting the subject soldier to whoever was best placed to provide the help they needed.

[98] Captain Coltart said that the following events were sufficient to initiate the TRiM process:

1. When personnel experience or witness serious injury to others; particularly colleagues.

2. When personnel have been disabled or disfigured.

3. When the trauma involved death; particularly grotesque death.

4. When the trauma is complex, long lasting or multiple.

5. When personnel have been involved in a 'near miss'.

[99] Prior to HERRICK 15, 2 Rifles trained personnel so that there was a TRIM qualified individual working in each deployed force element. Following a traumatic incident a TRiM trained person would conduct an initial interview with the person at risk within 72 hours after the incident to create an Initial Risk Assessment. This interview enabled assessment and the signposting (if required) for additional medically trained support. lt also allowed for a baseline against which a second interview could be judged. A second interview was then conducted a month after the incident which enabled the identification of any changes with an understanding of the initial interview having the capacity to bring up issues after open discussion regarding the traumatic incident. The output of the second interview was the Second Risk Assessment. The process was not compulsory i.e. the soldier being TRiM'ed didn't have to go through with the process if he or she didn't want to.

[100]At inquest we examined the lack of TRiM records for James while he was deployed in Afghanistan. The NOK suggested that if James experienced the things he informed his family about then he should have received TRiM. The lack of records, say the NOK, suggest that he did not receive TRiM when he should have.

[101] I am satisfied, having considered all of the evidence that James did not receive TRiM during or after HERRICK 15 because he did not experience an event traumatic enough to warrant TRiM. The two experiences that James told his mother about have never been corroborated. Sharon Lemon told the inquest that she heard one story though a friend but James did not tell her directly. Indeed, Sharon Lemon reported that James used to watch 'funny' YouTube videos of the conflict in Afghanistan involving shootings and according to her 'all he wanted to do was to get back'. James did not seem to tell anyone else about the incidents he claimed to have experienced and no other soldiers confirmed that they were involved in these incidents. I am not satisfied that James experienced any incident traumatic enough to warrant TRiM, although I don't suggest for a second that James didn't face some truly difficulty and challenging experiences in Afghanistan.

[102] In conclusion I find as a fact that James did not go through TRIM during or after his HERRICK 15 tour of Afghanistan. I conclude that he did not experience anything that ought to have resulted in him being TRIM'ed. Therefore I conclude that there was no causal link between the fact that he didn't go through TRIM and his death.

[103] Was there a failure to complete POSM for James Ross? If there was did this failure cause or contribute to his death?

[104]At inquest I was shown the manual Post Operational Stress Management record for James.

- The entry for Stage 0 – 'Pre-deployment' was completed.
- The entry for Stage 1 – 'Decompression' was completed.
- No entries were made confirming that Stage 2 – 'Normalisation', Stage 3 – 'In service support', Stage 4 – 'Aftercare' or Stage 5 – 'JPA Entries Input' were completed.

[105] There was, therefore, no official confirmation that James had completed the full POSM process. In particular, there is no recorded confirmation that he completed the latter stages of the process. All soldiers, regardless of rank or unit, are meant to complete POSM after a combat tour.

[106] I was told that the normalisation part of the process included a flight back to Aldergrove Airport followed by a period of rest within the base during which the soldiers were given information and leaflets (FMED 1019 and 1020) about PTSD and other mental health issues. After this each soldier was given a period of post-deployment leave. The process was designed so that they were meant to remain as a unit in Ballykinlar before returning to their families. Since James' record for the rest of normalisation was not complete it is not possible to say if he received any of the information that other soldiers were given.

[107] Having heard evidence about the normalisation process it seems to me to be more likely than not that James did take part in some normalisation process in Ballykinlar and poor record keeping is to blame for the lack of official recording.

[108] Even if I am wrong about this and James did miss some of the steps in normalisation the temporal connection between his death and return from deployment is too remote for me to be satisfied that there is any causal connection between an incomplete normalisation process and James's death. At no time between May 2012

(when he should have received Stage 2 upon his return from Afghanistan and Cyprus) and December 2012 did James show any signs of mental illness nor any other red flags. At no time did James seek help for any issues which could have been missed during normalisation. Indeed, family members, friends and his girlfriend indicated that he was happy, looking forward to promotion and keen to return to Afghanistan. This makes his death all the more difficult to understand.

[109] I conclude on balance that James completed the POSM process, at least to stage 3. Whether or not he completed any of the unrecorded stages of POSM, I conclude that any failure to ensure POSM was completed would have had no causal link to his death because of how he was presenting at the material times.

[110] Was James Ross on the SVRM before his death? If not, should he have been included on the SVRM and did a failure to place him on the SVRM cause or contribute to his death?

[111] I was told about the Suicide and Vulnerability Risk Matrix (SVRM) during the inquest. The governing document for the management of personnel vulnerable to suicide and self-harm was Army General Administrative Instruction chapter 110, 'Army Suicide Vulnerability Risk Management (SVRM) Policy. Captain Coltart told me that this process was built around a 4 stage process: Stage 1 - risk identification; Stage 2 - risk conference; Stage 3 - Initiating Care Action Plans; and Stage 4 - review and closure.

[112] Stage 1 (Risk Identification) processes: The process 2 Rifles had to enable identifying those at risk and was for education of personnel and the chain of command and the creation of a climate of acceptability of mental health issues. This education included the Decompression and Normalisation briefings Chain of Command SVRM training and TRIM training of nominated personnel. I was told that all 2 Rifles personnel who had conducted Decompression and Normalisation were aware of the

risks, and indicators and warnings associated with mental distress. Individuals who were suffering could self-refer or the chain of command would assign individuals to see the medical staff and / or a CPN for assessment self-referral and medical confidence did in some instances result in the chain of command being blind-sided from a full understanding of the issues and risks that individuals had presented to healthcare professionals.

[113] Stage 2 (Risk Conference) process. Captain Coltart accepted that this aspect of the process was not formally in place until September 2012 when the Commanding Officer, Lt Col Gidlow-Jackson decided that SVRM should be deliberately discussed as part of the monthly 2 Rifles Unit Health Committee. Due to the sensitive nature of the Information the SVRM Risk Conference was conducted with a reduced forum. This forum included: (from the medical side) the Medical Officer, CPN, Physiotherapist (a civilian who in a number of cases was used by soldiers to voice issues); and (from the chain of command side) the Commanding Officer, the Adjutant, the Unit Welfare Officer, RSM and the Company Commander. The health committee worked through each of the five companies in the battalion. By this method company commanders presented personnel who had been identified as being at risk. The decision to raise an individual onto the SVRM was made by the Commanding Officer and direction for the Care Action Plan was given. For extraordinary cases, where waiting for the Health Committee was inappropriate, Company Commanders raised the issue directly with the Commanding Officer. This was generally resulted in referral to the medical chain and the inclusion on the SVRM with a Care. Individuals on the SVRM were reviewed at Unit Health Committee meetings.

[114] At inquest I heard how Captain Coltart had kept the SVRM database on his computer. It was kept in no other location. When he transferred from the base to another location in December 2012 the database, which had been stored on his desktop, was somehow lost. I accept that it did exist and that it was lost. It could not be

recovered in its original form the and the new Adjudant, Captain McCarthy had to rebuild the SVRM using Captain Coltart's memory as well as other documents.

[115] I conclude on balance that James was not on the SVRM before his death. I also conclude that given his presentation from May 2012 until December 2012 he did not need to be on this register. At no time prior to his death did James present as being suicidal or vulnerable so as to require entry onto the SVRM.

[116] Was there a culture in 2 Rifles, in terms of how soldiers experiencing mental health difficulties were treated, (in particular by their fellow soldiers and/or immediate chain of command) which operated to dissuade soldiers who were suffering from stress and/or mental health issues from seeking help? If so, did this culture, cause or contribute to James Ross' death?

[117] A number of Riflemen gave evidence about this. Although Corporal McAtee, was originally critical about the services provided by the army on the base he accepted that there were good facilities available if a soldier wanted help.

[118] Rifleman Wood was critical about his own personal experience when he sought help for a stress related problem. He thought that if a soldier was acting in a concerning manner that others would talk about him behind his back. Rifleman Woods did seek help for his own issues and said there was a subjective element in not wanting to get help sooner. He said that soldiers thought a record of getting help for a mental health problem would adversely affect their chances of promotion even if, objectively, this was not true.

[119] Rifleman Holmes told the inquest that he had been medically retired from the army because of a PTSD diagnosis. He said that there was help available within the base and there were regular briefings about mental health problems aimed at encouraging

soldiers to come forward and seek help. Rifleman Holmes was not critical of the service and help available, rather, he said his own pride prevented him from coming forward earlier. Like Rifleman Wood he said the army had taken steps to encourage soldiers like him to come forward and get help, he just didn't want to. He did not want to seem weak and he thought that receiving help might prevent progress in his career. He made it clear that this was his own view even though, objectively, this might not be true.

[120] Rifleman Ingham did get help after Darren Mitchell died. He was seen by CPN Captain Connolly and was referred to Lisburn and Aldergrove where he received treatment.

[121] Soldier G also received treatment from Captain Connolly following Darren's death. Despite feeling that he was singled out for abuse by Corporal Farragher after Darren's death Soldier G went and sought help again after he self-harmed a number of months later. He gave evidence to the service inquiry in which he said a relationship break up potentially acted a significant stressor.

[122] Soldier D also received treatment from Captain Connolly following Darren's death.

[123] The next of kin want me to draw an inference from the incidents involving Soldiers D, G and Ingham that there was a culture of bullying soldiers who were suffering from mental health problems or alternatively that there was a fear on the part of soldiers that they would be looked down upon if they did seek help, or that it might effect their career progression. The next of kin point to the behaviour of Sgt Major Webb and Corporal Farragher as evidence of a culture which belittles those with mental health problems. However, there are a number of problems with this.

[124] Corporal Farragher's behaviour toward D, G and to a lesser extent Ingham, while distasteful and wrong, did not indicate to me that a culture existed. It seems to me that for a culture to exist there must some consistent approach by the chain of command and/or other Riflemen. Corporal Farragher's approach was not even consistent with his own past behaviour. Soldier D told the inquest that when he had previously self-harmed prior to deployment to Kenya it was Corporal Farragher who had been sympathetic to him. Sgt Major Webb, who admitted to warning the three soldiers about trying to 'bluff' had only just been stationed on the base on the day after Darren Mitchell's death. His behaviour can hardly be consistent with a culture if he hadn't even been in Ballykinlar when James Ross and Darren Mitchell died. The most important point of all to understand is that all the events involving Soldier G, D and Ingham took place ***after*** Darren Mitchell's death and ***as a reaction to it***. That doesn't mean that inappropriate behaviour after a death can't be a continuation of a pre-existing culture, but on the evidence before me I find it impossible to draw an inference that such a culture existed, nor that it caused or contributed to either death in these circumstances.

[125] The overwhelming weight of the evidence was that there was no culture of bullying, nor was the battalion responsible for a culture whereby soldiers were dissuaded from seeking help. Quite the opposite in fact. 2 Rifles were regularly described as a family and I accept that as accurate.

[126] Sgt Dulake, a member of the Royal Military Police carried out an investigation specifically in relation to bullying at the request of the Service Inquiry. He found no evidence of bullying on the base.

[127] Rifleman Ingham described the Company Sgt Major for B Company as "an awesome bloke" and he wasn't the only person to have that opinion of Sgt Major Bell (he was the Sgt Major for B Company during the material times). James Ross wasn't in B Company, but this issue of requires consideration of all the evidence.

[128] I was conscious that a number of the witnesses I heard from were no longer serving and therefore won't have the same inclination to give evidence favourable to the army.

[129] Some soldiers like Rifleman Holmes said that they were dissuaded from seeking help for mental health issues but not because of anything done by the chain of command or fellow soldiers. Rifleman Holmes said that he knew where to get support, there were always lectures and briefings trying to encourage them to seek help. He just did not want to get help because he felt it would make him feel weak. He placed no blame on the army for this and I do not either.

[130] I have taken into account that bullying is not the only facet of culture potentially relevant here. There is also the issue of whether or not soldiers, particularly young and/or junior soldiers, felt there was a stigma associated with mental health in the army and that their progression through the army might be adversely effected if they reported any potential difficulties. There was evidence before me that historically this was a real issue and that soldiers would not report difficulties. All soldiers in the upper ranks told me this was no longer the case, however I did receive evidence from some of the more junior soldiers or former soldiers that they perceived that this type of stigma still existed to some extent. I have concluded that some individuals might perceive this, but I was not satisfied that there was a culture in 2 Rifles in terms of how soldiers were treated by their colleagues and/or chain of command that would dissuade soldiers from reporting potential mental health problems and/or seeking help.

[131] I have considered this question carefully after taking into account all of the evidence given to me about 2 Rifles by soldiers and former soldiers of all ranks, as well from those involved in the provision of care and support. Whilst there were anomalies, such as the incident on parade with Corporal Farragher, I was struck by the sense of

genuine willingness to support soldiers that ran consistently through the evidence. The soldiers themselves, both present and former, described it. The question is about the culture in 2 Rifles, rather than whether there were some individual instances of a stigma being perceived.

[132] I am therefore not satisfied that any culture existed in terms of how soldiers experiencing mental health difficulties were treated (in particular by their fellow soldiers and/or immediate chain of command) which operated to dissuade soldiers who were suffering from stress or mental health issues from coming forward for assistance.

[133] Rather, the issue is one which civil society also struggles with, young men are reluctant to come forward and seek help for mental health problems. The Government, health profession and others face a similar dilemma to the army in trying to encourage more young men to come forward.

[134] Was the Army doing enough to identify soldiers in 2 Rifles who were suffering from stress and / or mental health issues? If not, did it cause or contribute to James Ross' death?

[135] It is impossible to say if any further screening or proactive engagement would have identified any stressor or mental health issue in relation to James. I did not hear any evidence to suggest that he was suffering from an underlying illness which could have been treated if he had been screened on a regular basis, for example. No witness suggested that he could have had any issue for which treatment was not available. Therefore, in relation to James, lack of such a system did not cause or contribute to his death. However, the answer to the first of this question is 'yes' the army could carry out mandatory screening on a more regular basis. I was impressed with the evidence given by all of the Rifleman. In particular I was impressed by the evidence of Rifleman Wood

and Rifleman Holmes. Both these men are retired from the army. Both loved the army and their jobs. Rifleman Holmes was medically retired in 2018 after suffering from PTSD following HERRICK 10. Rifleman Wood retired recently having sought help for mental ill health while in the army. Rifleman Wood thought that regular mandatory screening for mental health problems might take the stigma out of seeking help since the onus would not be on the soldiers to actively seek it. In other words, never mind letting the horse come to water, why not, take some water to the horse every now and again and see if it wants to drink.

[136] I therefore conclude that the army could have done more to identify soldiers suffering from stress and related mental health problems but that there is no causal connection between this failing and the death of James.

[137] Did James Ross receive anti-malarial medication, and, if so, what medication did he receive? If he did, did this medication cause or contribute to his death?

[138] There is no evidence from any source that James received anti-malarial medication. Even if he did, no evidence was lead at inquest to suggest that this medication could have played any part in his death.

[139] Did the living conditions, including limitations placed upon soldiers in relation to where they could socialise, in Ballykinler, cause or contribute to James Ross' death?

[140] In the months before his death James was not lonely and had few limitations placed upon his ability to socialise. In August 2012 he met Sharon Lemon. I was told that he spent much of his free time with her, including staying at her address in Belfast. He socialised with her and she provided transport. Therefore, although at some stage James may have found the base lonely and isolating, and there was ample, indeed uniform evidence from every witness that the base was isolated, and this was confirmed

during the site visit, I am not satisfied that the living conditions at the base played any part in his death.

[141] Were there any other acts or omissions on the part of the MoD which caused or contributed to the death, which may include issues relating to:

- Welfare support
- Medical care/expertise/training
- Evidence of bullying or improper conduct in relation to soldiers with mental health issues
- The environment of Ballykinler camp

[142] I am unable to identify any failings on behalf of the MoD which caused or contributed to James's death.

Did James take his own life and intend to do so?

[143] To return a conclusion of suicide the act and the intent must be established on the balance of probabilities. I must be more satisfied than not so that James deliberately and voluntarily did the act which caused his death and did so with the intent of taking his own life. Suicide can only be the conclusion after other possible alternatives have been excluded. It must not be presumed simply because it seems a likely or the most likely explanation. A Coroner must exclude the possibility that the death was a result of some unexplained accident. Per Lord Widgery in *ex Parte Barber* [1975] 1 WLR 1310

> "lf a person dies a violent death, the possibility of suicide may be there for all to see, but it must not be presumed because it seems on the face of it to be a likely explanation. Suicide must be proved by evidence and, if it is not proved by evidence, it is the duty of the coroner not to find suicide…."

[144] Although intent to die must be established to the required standard there is no requirement for a coroner to determine 'why' a person killed themselves. Evidence of motive (in particular where notes are left) might assist in determining intent, but the coroner is not obliged to discern (still less be sure of) reason or motive for the deceased's action and intention. A coroner can be sure the death was self-inflicted and sure the deceased intended to take his life, but less than sure what had led him to do so.

[145] Evidence of intention to die can lie within the circumstances of and leading up to the death as well as by the means of achieving it, the more obviously lethal the means, the more the circumstances may support the inference of an intention to take life.

Evidence going to the conclusion

[146] It was never reported that James had expressed any suicidal thoughts or had even been treated for any mental health condition. Professor Fazel made it clear that a mental illness increases the risk for suicide. Therefore I consider the lack of a diagnosed mental illness makes it less likely that James intended to die.

[147] Locked door – Professor Fazel thought that James' door being locked demonstrated a higher intent than if the door had been left open. He said that, in his experience, when a person performs an act in order to seek the attention of others – 'a cry for help' – they usually make sure that someone else will find them in the act. In James' case the fact that his door was locked was suggestive of him not wanting to be disturbed during the act. I am satisfied that there was damage to the door close mechanism on the frame said of James door. I am also satisfied on balance that James damaged the door himself probably during an attempt to gain entry having lost his key. I note that Mrs McAtee was concerned about James continuing to consume alcohol at the mess dinner because he had custody of her room key. She asked Corporal McAtee

to retrieve the key. I am satisfied on balance that James lost his key at some point during the evening and then kicked his door to effect entry.

[148] None of James' last message or calls to his girlfriend are concerning and are not indicative of any intention to end his life at any point.

[149] Method of death – As I indicated above in certain circumstances the method of death can indicate intention. The more likely that death is going to occur, the higher the intention. James died by placing his own leather belt around his neck. I am satisfied that he inserted the other end of the belt into the metal door closer at the top of the door. He either had to open the door slightly to achieve this or he was able to jam the end of the belt into the door close mechanism. The belt caused his death when it was tightened. Some degree of planning was required to find a suitable sturdy ligature point within the room. James' feet were touching the ground when he attached the belt to the door and this position may at first blush indicate low intent. Dr Ingram made it clear that a person can die by hanging even if they maintain contact with the ground. What is required is for their body weight to drop. Dr Ingram also made it clear that it is possible for a person to tie a ligature around their neck with no intent to die but for the person to accidently become unconscious due to ischaemia (lack of blood supply to the brain). If the blood supply to head is cut off by a ligature around the neck, unconsciousness might occur within 10 seconds. Once a person is unconscious they are likely to die without assistance in a matter of minutes. I have considered the possibility that James placed the ligature around his neck not intending to die but with the intention of self-harming or for some other reason. Professor Fazel thought that self-harm using a ligature was unlikely.

[150] Protective factors – Professor Fazel indicated that family and future plans were protective factors for suicide. James had a supportive and loving family. At the time of his death he was not experiencing any particular relationship difficulties. However,

although he was making plans with Sharon Lemon he was also talking about "fucking her over" and had made plans to see another woman the following week.

[151] Alcohol consumption – General McAllister and Professor Fazel both indicated that alcohol can have an effect on impulsivity and mood. General McAllister said that high alcohol consumption can have an adverse effect on mental health and assist a person in performing risky behaviour which they might not perform while sober.

[152] I have considered all of the evidence and the factors above and I am not satisfied to the required standard, that is, on the balance of probabilities that James intended to end his life when he placed the ligature around his neck. I consider that it is a real possibility that James placed the belt around his neck for some other reason. I cannot be specific and I do not need to be. I consider James death to be an accident.