Confidential
Psychiatric Court Report

Prepared on Alexander Wayne Blackman

By

Professor Neil Greenberg

BSc BM MMedSc DOccMed MFMLM FHEA MInstLM MEWI MFFLM MD FRCPsych

Approved under Section 12 (2) of the Mental Health Act 1983

Fellow of the Royal College of Psychiatrists Number - 12455

Member of the Expert Witness Institute Registration Number - 1549

General Medical Council Specialist Registration Number - 4020682

ADMMH
Weston Education Centre
Cutcombe Road, London. SE5 9RJ

Biography (my full CV is at Appendix B)

Professor Neil Greenberg
BM, BSc, MMedSc, FHEA, MFMLM, DOccMed, MEWI, MInstLM, MFFLM, MD, FRCPsych
Professor of Defence Mental Health

I am an academic psychiatrist based at King's College London UK and an accredited specialist in adult, liaison and forensic psychiatry. I served in the Royal Navy for more than 23 years leaving in the rank of Surgeon Captain in the role of the Defence Professor of Mental Health. I have deployed to a number of hostile environments including Afghanistan and Iraq. I also run March on Stress (www.marchonstress.com) which is a company that provides a range of psychological health consultancy for companies that predictably place their personnel in harm's way. I conduct more than 50 medico-legal and occupational mental health reports each year covering a range of forensic issues including personal injury and criminal matters. I also provide clinical care for patients who have a range of mental health disorders. I am approved under Section 12(2) of the Mental Health Act 1983.

I studied medicine at Southampton University; I graduated in 1993. Whilst at University I joined the Royal Navy and after University I served as a general duties doctor in a variety of Warships, Submarines and with two Royal Marines Commando units. During my time with the Royal Marines I achieved my arctic warfare qualification and completed the all arms commando course, earning the coveted Green Beret.

I have completed a Master's Degree in Clinical Psychiatry, a Doctorate in Mental Health and am a Fellow of the Royal College of Psychiatrists. I am also a Member of the Faculty of Forensic and Legal Medicine, the Expert Witness Institute, the Faculty of Medical Leadership and Management and the Institute of Leadership and Management.

Since 1997 I have been at the forefront of developing a peer led traumatic stress support package (TRiM) now widely used by military and civilian organisation. I have provided psychological input for Foreign Office personnel after the events of September 11th 2001 and in Bali after 12th October 2002 bombings. I regularly advise organisations about how best to manage the aftermath of significant incidents including the London Ambulance Service after the London Bombings of 2005. Over recent years I have also provided mental health input into the psychological repatriation of a number of hostages and have advised the UK government about the psychological management of British nationals caught up in global terrorism. I am a [pro-bono] medical advisor for Hostage UK.

In 2008 I was awarded the Gilbert Blane Medal by the Royal Navy for my research work in supporting the health of Naval personnel. In 2013 my research team won a Military - Civilian Partnership award our deployment related research work. In 2015 I was shortlisted for psychiatrist of the year which is a prestigious award given by the Royal College of Psychiatrists.

I have published more than 180 scientific papers, book chapters and have presented to national and international audiences on matters concerning the psychological health of the UK Armed Forces, organisational management of traumatic stress and occupational mental health. I have been the Secretary of the European Society for Traumatic Stress Studies and I am the current President of the UK Psychological Trauma Society as well as being the current Royal College of Psychiatrists' Lead for military and Veterans Health. I am also a trustee with Walking for the Wounded, an independent director of the Forces in Mind Trust and regularly provide advice for Help for Heroes.

Date:	15th November 2015
Name:	Alexander Wayne Blackman
Date of Birth:	3rd July 1974; 41 years old
Current Placement:	HMP Erlestoke
GP:	Prison Medical Services HMP Erlestoke
Date of Interview:	15th October 2015
Instructed By:	Claire Warner as advised by Jonathan Goldberg QC and his legal team
Charges:	Murder
Status:	Convicted

Introduction

Mr Blackman is a 41 year old married man who is currently serving a life sentence with an eight year tariff for murder. He was convicted of Murder in 2013 at a Court Martial whilst serving in the Royal Marines. He is currently located at HMP Erlestoke. I have been asked to prepare a confidential Psychiatric Report in order to assist his legal team headed by Jonathan Goldberg QC who intends to ask the Criminal Cases Review Commission (CCRC) to review Mr Blackman's case in the near future with a view to referring the case back to Court Martial Appeal Court (CMAC) for rehearing. I have been asked to address, as far as I can, Mr Blackman's state of mind around the time that he shot a Taliban insurgent in Afghanistan in 2011. I have also been asked to specifically address the following questions:

I. On 15th September 2011 was Blackman suffering from any abnormality of mental functioning?
II. If so, did it arise from a recognised medical condition?
III. If so, which one(s)?
IV. Did that condition / those conditions substantially impair Blackman's ability to do one or more of the following (and if so, which):
    a. Understand the nature of his own conduct
    b. Form a rational judgment
    c. Exercise self-control
V. If so, do those condition(s) provide an explanation for Blackman's acts and omissions in doing or being a party to the killing? (in that regard the abnormality of mental functioning provides an explanation for Blackman's conduct if it causes, or is a significant contributory factor in causing him to carry out that conduct)
VI. Given the passage of time (over 4 years now from the shooting) to what extent is it possible today to answer these questions?

VII. What evidence was there or might there have been of Blackman's mental state at the or around the time this case was being prepared for trial (November 2012 to October 2013) which is no longer available today because of lapse of time?

VIII. What new evidence relevant to the psychiatric diagnosis has become available since then?

IX. If the answer to question II above is yes, to what extent if any is Blackman in denial about his mental condition in your opinion? (For example, by affecting a "tough Marine" image.)

X. If the answer to question II above is yes, to what extent if any may it have affected his perception whether the body was dead or alive when he shot it.

XI. If the answer to question II above is yes, please exhibit the relevant World Health Organisation classification(s) as an appendix.

In the preparation of this report I used the following sources of information:

1. A face to face interview with Mr Blackman at HMP Erlestoke, on 15th October 2015.
2. A face to face interview with Claire Warner, Mr Blackman's wife, on 15th October 2015.
3. A telephone interview with John Blackman, Mr Blackman's brother, on 9th October 2015.
4. A telephone interview with Grant Whitehead, Lance Corporal, serving at CP Omar, on 12th October 2015.
5. A telephone interview with Jack Hammond, Marine, serving at CP Omar during HERRICK 14, on 16th October 2015.
6. A telephone discussion with Warrant Officer Jim Wright, Royal Marines, on 29th October 2015
7. A telephone discussion with Corporal Murphy, Royal Marines, on 27th October 2015
8. A telephone discussion with Craig Rea, ex-Royal Marines, on 31st October 2015
9. A face to face interview with Colonel (retired) Oliver Lee, on 20th October 2015.
10. A copy of the Appeal Judgement from the Court of Appeal Criminal Division dated 22nd May 2014.
11. A series of Performance Appraisals (including reports known as SJARs) from the time that Mr Blackman served in the Royal Marines.
12. The charge sheet.
13. A copy of statements by Colonel (retired) Oliver Lee.
14. Submission Colonel (retired) Oliver Lee to Peter Glenser, dated 17th April 2014.
15. Meeting with Colonel (retired) Oliver Lee in London on 21st October 2015.
16. A formal letter of Instruction from Claire Warner-Blackman, dated 24th September 2015.
17. A transcript of an interview with Sergeant Blackman carried out by the service Police, dated 22nd September 2012.
18. Prepared Statements by Mr Blackman, dated 11th October 2012 and 12th October 2012.
19. Prosecution Outline of the Facts of the Case, dated 23rd October 2013.
20. Extracts from Telemeter Report [official Naval Service enquiry into the reasons for the shooting], Brigadier Huntley Royal Marines, March 2015
21. Report by Dr Michael Orr, Consultant Psychiatrist, on Marine A [Sergeant Blackman], dated 27th November 2013.
22. Transcript of the Summing Up Part 1, dated 6th November 2013.
23. Transcript of the Summing Up Part 2, dated 7th November 2013.

24. Transcript of the Mitigation by Berry QC and Sentencing remarks by JAG, dated 6th December 2013.
25. Transcript of videos 4 and 5.
26. DVD of five headcam footage videos
27. Conference Notes of Mr Blackman and his previous legal team dated 10th June 2013.
28. Sequence of Events document prepared by Mr Blackman.
29. Medical notes from Somerset Partnership NHS trust
30. DMICP medical files from Ministry of Defence for Sergeant Blackman

I explained to Mr Blackman that the nature and purpose of the interview was to provide a report for the Courts. I explained to Mr Blackman that the meeting was not therefore confidential as would normally be expected within the confines of the doctor/patient relationship.

1. Background History

1.1. Mr Blackman told me he was born in Brighton. As a child he lived at home with his mother, father and a brother who was six years older than him as well as two sisters, one of whom was three years older and another six years younger than him. His mother worked as a hairdresser and his father worked as a long distance lorry driver. His father was unemployed quite frequently. He told me their household was a busy one and the children were all well looked after and loved. He felt he had a good relationship with his siblings and with his parents as he grew up.

1.2. He got on well at primary school however in secondary school he suffered from a mild degree of bullying. He thinks this was probably related to the fact that he came from a reasonably poor family. He also thought that it did not help that he was not particularly interested in team sports such as football. Aged 15 or 16 he was assaulted just after leaving school one day. The assault was carried out by other pupils from his school and they were subsequently expelled. However, whilst at school he made some friends and he felt he got on reasonably with his teachers. He was very good at canoeing and practiced it frequently. He only got a few C grades in his GCSE's [subsequently, since becoming an adult, he has obtained more GCSE's].

1.3. Between 16 and 18 he attended Sixth Form College but did not pass re-sits of his maths and English; he did however get one more GCSE. He enjoyed college a lot more and in particular liked the 'grown up' attitude there. He was still very focused on his canoeing. He had a car accident whilst at college which prevented him from doing well enough at canoe trials to be able to represent the UK in the sport.

1.4. After leaving college, aged 18, he worked on a local farm initially as an odd jobs person. He ended up working at the farm for between five and six years in a range of roles including helping to run the dairy processes at the farm. His daily routine at work would commence at 0300hrs and run until 1200hrs each day. Overall, he told me that he enjoyed his time there and he said the environment there had been a very friendly one.

1.5. Aged 23 he decided to join the Royal Marines. This happened after he had been walking past a military careers centre and on a whim he decided to go in to see what they had to offer. He then attended the brief Potential Royal Marines Course (PRMC) and enjoyed the physical activity and challenges on the course.

1.6. He performed well during his basic Royal Marines training but was 'back-trooped'[1] as he became sufficiently ill for a while that he had to spend some time in hospital. After finishing his basic training he went to join 40 Commando [a Royal Marines 'battalion' sized (~600 personnel) unit] and he soon developed an interest in heavy weapons and passed the relevant courses to become a heavy weapon specialist.

1.7. Within his first few years of service, he deployed to Northern Ireland. After being in the service for about four years he attended and passed his Junior Command Course (JCC)[2] and took up various positions within 40 Commando. He was a Section Commander [in charge of an eight person team] in TELIC[3] 1 [the invasion of Iraq in 2003]. Whilst he was in Iraq a vehicle he was travelling in was hit by a number of rocket propelled grenades which led to him and other members of his team being in a highly dangerous situation for a while; he described this as having been quite frightening. He said he also found it frustrating, at times, being in Iraq because after being injured in the vehicle incident he did not get any re-supply of his operational equipment until he got home.

1.8. He then was drafted to Protection Group Royal Marines (PGRM) (based in Scotland) for two and a half years and during his time there he went to Iraq for a second time as an Acting Sergeant. He said this was a frustrating time for him as the unit that he was with was again under-equipped. He then completed his Senior Command Course (SCC) after being in service for about seven and a half years[4]. After passing his SCC he went to 40 Commando as a 'spare Sergeant' and then deployed to Iraq again to a more organised location. After coming back from Iraq he moved into a role as a Troop Sergeant at 40 Commando and began preparing to go to Afghanistan on HERRICK 7.

1.9. During HERRICK 7 (2007) he was based in the Sangin Valley in a Patrol Base (PB) called PB Inkerman. He said this was a hard tour and he and his troop [a Royal Marines unit with about 30 personnel] were under no illusions that it was going to be hard when the tour commenced. The unit suffered a lot of casualties. During the tour he had a junior officer with him who he said was not particularly effective. Because of

[1] The term back-trooped refers to becoming injured or ill during basic training to such a degree that the individual has to miss such a considerable period of training that they are required to re-join training with another troop of trainees to catch up on the training they have missed. This is very common for many Marines in training.
[2] The JCC is an arduous promotion course which, if passed, entitles an individual to take up the rank of Corporal. Passing this within four years of initial training is a sign of a successful and motivated marine.
[3] The names of UK military operations do not have any particular significance – they are selected from a predesignated list of potential names.
[4] The SCC is an arduous promotion course which, if passed, entitles an individual to take up the rank of Sergeant. Passing within seven and a half years is again an indicator of a successful career.

the lacklustre leadership skills of the troop officer, the burden of command at PB Inkerman effectively fell to him. However, whilst the tour was tough he felt that he and his men made a difference and he felt, and he told me that his appraisals reflected, that he did well.

1.10. After coming back from Afghanistan he was drafted to CTCRM Lympstone [this is the Royal Marines unit which carries out all basic, and much of the continuation, training for the Royal Marines] for two years. At CTCRM, he worked in the training office and he said although the job was initially reasonably quiet he managed to do well at the job and gained recognition, from his seniors, as having done well there. He said that when he started at CTCRM he had felt "worn down" by the numerous operational tours that he had been on during his service.

1.11. After his tour of duty at CTCRM he was asked to join 42 Commando and go to Afghanistan as a Troop Sergeant once again in 2011. He said this was a task that he had not particularly looked forward to as he had already done this role in the same environment [in HERRICK 7; which had been a difficult tour for him] but he knew the needs of the service were such that he would do as he was asked.

2. Family History

2.1. His mother is in her 70's. She is still in reasonable health and lives in the Brighton area. His father died shortly before he went on HERRICK 14. He was in his 70's and he had been ill for a while as a result of him being involved in a chemical accident during his working life. However, he was taken into hospital before Christmas in 2010 and seemed to improve but then, rather unexpectedly, he died in early 2011. When he had died the whole family had thought that he was improving. He attended his father's funeral shortly before completing his pre-deployment training for Afghanistan and scattered his ashes during his Rest and Recuperation (R&R) leave during the tour in July 2011; this was some two months before the incident.

2.2. He told me that his father had suffered from depression as a result of the chemical accident that he had at work and the medical consequences. As a result he had tried to take his life on a couple of occasions. His brother had been a heavy drinker. He is not aware of any family history of criminality.

3. Relationship History

3.1. Mr Blackman told me he had a number of short term relationships when he was in his 20's. However, he told me that his wife was the first person that he had met whom he felt he really got on well with. He had not had any serious relationships before meeting her. He met her in 2006 and they were married in 2009. His wife works for the National Health Service in a senior public relations role. He feels that they have a good relationship. He told me that he is quite content that she makes most of the important decisions relating to how they conduct their lives together. They do not have any children.

4. Past Medical History

4.1. Mr Blackman had a hernia operation as a result of being blown up in a vehicle in 2008 whilst in Afghanistan. He has occasional aches and pains but does not take any regular medication.

5. Past Psychiatric History

5.1. Mr Blackman did not have any history of contact with psychiatric services prior to being arrested. He reports that he has not been TRiMed [TRiM is a peer support programme initiated by the Royal Marines in the late 1990's and has been a standard operating procedure for the UK Armed Forces to deal with psychological trauma – it has been used widely by the Armed Forces since 2007/2008[5]]. He said that after being arrested for the second time, in October 2012, he was advised to spend some time, as an inpatient, at a mental health unit in Taunton. He was an inpatient there for a few days and did not like being in an environment with people who had serious mental health problems. Subsequent to this he was provided with some psychiatric support by Mr Ray Dixon from DCMH Plymouth for a while.

6. Substance Misuse History

6.1. Mr Blackman told me he had enjoyed drinking beer. He accepts that after coming back from TELIC 1 in 2003 he probably drank a bit too much alcohol. He said this was most probably because he had a long period of leave and he had been socialising heavily with other people. He thinks that otherwise during his adult life he has been a social drinker although he can drink up to ten pints of beer in social settings. He told me however that he regularly consumed no alcohol at all and he did not consider that alcohol had ever impaired his ability to perform his job.

7. Personality

7.1. Mr Blackman told me that other people would describe him as a quiet but friendly individual. He has no difficulty spending time by himself but he can also feel comfortable with others. He said he is the sort of person who would not feel the need to say something unless there was something to be said. He said that this aspect of his personality may lead to him coming across as quiet in some social situations. He has not had any particular problems with his self-esteem throughout his life.

7.2. Mr Blackman used to very much enjoy canoeing. More recently, prior to being imprisoned, he had enjoyed playing golf. He also enjoyed a range of individual sports.

[5] For a comprehensive review of evidence supporting the use of TRiM see - Whybrow D, Jones N and Greenberg N [the present author]. Promoting organizational well-being: a comprehensive review of Trauma Risk Management. Occupational Medicine 2015; doi: 10.1093/occmed/kqv024

7.3. Mr Blackman told me he has never had any problems with his seniors. He said he had been promoted quite quickly whilst he was in the Royal Marines as he was seen to be an individual who was able to work well within a structured environment. He feels that he was a good leader of others; ordinarily he would not shout at people but he could be firm when he needed to be. Mr Blackman told me that he has friends whom he has known for many years but he is generally a private person and does not share emotional material with others readily.

7.4. Mr Blackman told me that his mood is generally steady. He is not the sort of person to tell other people things that he does not need to. He said for example that he would be happy to speak to his wife about most things but not about events which he thought might worry her. For instance, he had not told her about being blown up in Afghanistan on Op HERRICK 7 in 2007 as he did not want to worry her. He said he often feels the need to try and insulate other people from his emotions as he does not like to worry other people.

7.5. In the past he noted that he has become stressed or frustrated when there has been a lack of support for him and his troops and also when he has felt that there was a lack of essential equipment he needed to get the job done. He said when he gets stressed he can find it harder to concentrate at times and he also sleeps less well.

8. Past Forensic History

8.1. Nil of note.

9. Social History

9.1. Mr Blackman told me that financially he and his wife were "ok off". He does not like having debts and he tends to pay off loans as soon as he can.

10. History Around Index Offence

10.1. Mr Blackman told me that during Op HERRICK 14 he had been charged with leading a Royal Marine detachment to Command Post (CP) Omar. He said when he joined his team prior to deployment he did not have a lot of time to prepare with them. He said his time [before deployment] with his unit was also disrupted by his father becoming seriously ill and subsequently dying. As such he was away for substantial periods of time during the unit's pre-deployment training in the UK.

10.2. When his unit arrived in Afghanistan, he went forward to CP Omar before the rest of his team so that he could get a handover from the unit who had been there during the previous tour. He noted that the team of 16 people that he was due to lead was replacing a team of 26 people who had been there before. He told me that his Troop Officer [Lieutenant Ollie Augustine] had been a good individual but he was located a few kilometres away from CP Omar [until he was killed early on during the tour].

10.3. He said whilst initially the situation at CP Omar was quiet, it very rapidly became more challenging and then stayed challenging for the rest of the tour. He said there were a lot of improvised explosive devices [IEDs] planted by the insurgents in the areas that his team were required to patrol. He said that a number of his close associates were injured or killed. He said his Troop Officer [Lieutenant Ollie Augustine] was killed and his Company Commander [Steve McCully] was seriously injured. He said he found injuries being suffered by people that he knew well were very upsetting for him; he told me that he regarded 'his team' as being as emotionally important to him as his own family were.

10.4. When I asked him about specific incidents of a traumatic nature he had experienced during the tour, he told me of one that happened in August 2011. Just before the incident, he and his team had been talking to local civilians. A fire fight [gun battle] ensued and grenades were thrown at him and the members of his team who were in his immediate vicinity. He told me that the only reason that he survived was that the grenades fell into a ditch that was behind him by chance. He told me he had worked hard throughout the tour. His role, as the location Commander, had been to lead his team which included him going out on patrols 'on the ground'. He told me that he and his two corporals [who effectively formed the senior management team at CP Omar] had also spent a considerable period of time in the operations room. He said that the three of them had to do a radio watch each and every night; therefore his sleep was always broken. He said he felt his team was consistently too small to be truly effective which had been a significant frustration for him. Additionally, he regularly was frustrated by having to ask for what he considered to be essential equipment, which was often not forthcoming. Such equipment was often needed, in his view, to improve the security of his location which would have been better if he had had more personnel at CP Omar.

10.5. He had been able to speak to his wife on a satellite phone and also use the text link [similar to a mobile phone SMS messaging service] service to text her at times. He had his Rest and Recuperation (R&R)[6] leave at the end of July 2011. During this time he went to Weymouth and scattered his father's ashes. He thinks he slept a bit better when he was at home but was consistently sleeping poorly whilst in Afghanistan.

10.6. He said whilst he was on R&R his wife noted that he had been spending considerable time looking at the ground when they went for walks. This behaviour was indicative of him being very alert in case there might be dangers to himself, or his wife, from IEDs. He recognised that this behaviour had been very similar to the way he had been whilst in Afghanistan where he had needed to be very alert to spotting similar dangers (such as IED's) that might injure or kill him or his men. He feels that he was probably a bit more irritable whilst he was on leave than would have been normal for him. He remembers being very aware that R&R was only a short period of time and when it ended he would return to the challenges of being back in theatre.

[6] R&R is usually 14 days in total, which with time required for travel usually leads a service person having about 10 days at home

10.7. He said when he got back to Afghanistan he plunged straight back into a challenging environment where he continued to feel frustrated that he was not being supported by his chain of command. He said that he felt that his base was often ignored by his commanders. He felt that when he, and his troops, had been pinned down by enemy action whilst out on patrol there was often no readily available support either from ground troops or from helicopters. He told me that the nearest helicopters had been 20-30 minutes' flying time away. He felt that the enemy always had the advantage and he was frequently fearful that he and his men would be seriously injured. He said he spent a lot of time worrying about 'the next patrol' and he had experienced feelings of dread each time he had to lead his troops outside of the relative safety of the checkpoint.

10.8. He also told me that he became increasingly concerned that the enemy had been specifically targeting him. He said when patrols deployed outside of CP Omar without him they were much less frequently attacked than were the patrols he led. He said that he was much taller [he is six foot three inches] than the rest of his team and he had also introduced himself as the team Commander to many of the locals when they were going about their 'hearts and minds work'. He said when his team were out on the ground other members of the team often appeared able to move around without being specifically shot at. However, when he patrolled he felt the enemy were looking to 'take him out' because he had been in charge. He told me that towards the end of the tour he had begun to do more than his fair share of patrols because he had been acutely aware that his two corporals (who had also been out on patrols regularly) had children. Whilst he did not want to die, he was even more concerned that his corporals should not be seriously injured or killed because of the impact this would have on their children. He said that he felt that he continued to perform well during the tour but he struggled to do so. As mentioned above his sleep was poor and he felt that his concentration was less than ideal for much of the time. He had often thought about difficult events that had occurred and he had felt that there were ever present serious dangers to him and his team during the tour. He felt that the tour had been relatively futile in that he and his team had not managed to achieve anything useful; as such at times he had come to doubt the purpose of their mission.

10.9. Mr Blackman told me that the unit Padre did not visit the location at all. He said he started the tour with a medic who had a leg blown off and then he was sent two female medics who could not cope with the challenges of being at CP Omar. Eventually he was assigned a female medic whom he said was good medically although she was not particularly confident in moving tactically around the area of operations. He told me that his Regimental Sergeant Major, Warrant Officer Phil Gilby, only visited a couple of times and his Commanding Officer [Lieutenant Colonel Ewen Murchison] visited the location only once early on during the tour. He told me that the more senior personnel from his unit were based elsewhere in the area of operations but he did not speak to them regularly other than for tactical reasons over the radio net.

10.10. He felt that, as time went on, the patrolling became increasingly less safe. On the day of the killing he had gone out in the morning on a patrol which had gone ok. A nearby

location [CP Talaanda] had been attacked and he had been asked to search a nearby building because of the attack. He said as his team were moving away from the search area the insurgent who had carried out the attack had been spotted. He told me that he had offered to stop the insurgent using his team but was told that an Apache Helicopter was going to deal with him. He and his team saw lots of rounds being fired by the Apache and they were then asked to go out and assess the impact. He said there were eight people in his team and after the Apache attack they saw the insurgent's body in a field. He said he and one other person moved forward and located the insurgent who appeared dead. Mr Blackman said he went to search him and as he did so the insurgent opened his eyes. He told me that he then got onto the radio and told his chain of command that the insurgent was alive; during the search he had found a grenade and spare ammunition for the insurgent's rifle.

10.11. He admits that he had hoped that the insurgent would simply die but nonetheless he told me that he and other Marines moved the man, tactically, from the middle of the field back to the treeline as it was not safe for them to be out in the field as they were exposed. He told me that he did not like being in the view of the surveillance cameras because he always felt that the camera operators would comment on what he was doing which he did not feel was usually helpful. He said he had not moved the insurgent out of the field because of a desire to avoid being seen because of his subsequent actions (the shooting of the insurgent). He told me that he had moved the injured insurgent because he did not want to be out in the middle of the field and would rather not have his actions carefully scrutinised by a camera which could then lead to him being criticised whether fairly or unfairly.

10.12. He said he asked his team members who wanted to give medical aid and no one said they did. However one of the team did eventually give medical aid. Sergeant Blackman told me that one of the team members had suggested that someone should put a round in the insurgent's head and he had responded by saying that this should not be done as it would be too obvious. He said that this comment had essentially been 'dark humour' which was a mechanism that he and his team used regularly in order to cope. Dark humour was a way they tried to lighten the nature of the intense situations they got into. Sergeant Blackman told me that he had then started to 'radio through' a medical report, called a 9 liner, to ask for medical help for the insurgent but as he was doing so, in his view he honestly thought the insurgent had died. As such he told the people on the radio that the insurgent had passed away. He said he had thought that the insurgent was dead as, having been clearly very seriously injured, the insurgent had appeared to have stopped breathing. He told me that given the nature of the insurgent's injuries, his dying had not been at all surprising to Sergeant Blackman. Having come to the view that the insurgent was dead, he told his team to stop wasting first aid materials on the [dead] insurgent.

10.13. Once the insurgent had, in his view, died, for reasons that he cannot quite understand himself, he drew his side arm and shot the insurgent in the chest. He told me that he has subsequent formed the view that his frustration and anger were a significant part of the reasons for his actions [in shooting the dead insurgent]. He said he realised

straight away that he had made a mistake and that it was wrong to shoot a dead body. He told me that he had gone on to say the "shuffle off this mortal coil" phrase in order again to lighten the mood of the situation. He told me that he fully knew that he had done wrong in having shot a dead body and it was not something he was proud of. However, he was also clear that he had not shot someone who was alive; he told me that his honest belief at the time was that the insurgent had been dead.

10.14. He said after he had been arrested he had been told by his legal team that PTSD was not a defence to murder and he did not see any reason why he should have requested that a psychiatric report be carried out. He said that as he had never been someone accused of a serious crime, he very much put his case into the hands of his legal team.

10.15. He told me that he had seen Dr Orr, a Consultant Psychiatrist, after being convicted whilst he had been at MCTC (Military Corrective Training Centre) in Colchester. He said he found Dr Orr had been okay to talk to but he had not seemed to particularly understand much about military life or what life on deployment was like.

10.16. He said that since being arrested he had sometimes thought about ending his life. He said he has not made any particular plans to do so but he had thought he could use a razor blade on his wrist if he had to. He said when looking back on his HERRICK 7 tour [which was his first deployment to Afghanistan in 2007] he had felt a sense of achievement. Whilst that tour had been difficult, and many of his team had been injured, he felt that they had succeeded in making the part of Afghanistan they had been deployed to safer. After HERRICK 14 he said he felt the situation was in fact worse than when they had started. He gave the example that during the last part of the tour his team had arrested two Taliban fighters who were then picked up from CP Omar but were subsequently released. He said this sort of occurrence epitomised the futility that he felt about all the highly dangerous work that his team had done.

10.17. He admitted that he had been jumpy and skittish when he had been in theatre during HERRICK 14; that was particularly so during the latter part of the tour. He said this continued for a while after he came home. He gave me an example of this sort of behaviour which had happened during a holiday to America with his wife in the latter part of 2011. Whilst there, they had gone to the theatre and when he had heard a loud bang which was part of the play he had jumped under his seat. However, his jumpiness had resolved well before he was arrested in 2012.

10.18. He said during the latter part of the tour he often felt as if somehow his life was going to end because of the danger he was in. Sergeant Blackman also told me that he had made a conscious effort to keep himself separate from the lads as he felt that he needed to be in charge and he also realised that they also needed their own space away from their boss. He said he was probably more short and "tetchy" with other people outside of CP Omar than he should have been. He gave the example that when he spoke to the stores Colour Sergeant to make logistical requests he was often sarcastic which he accepts was not his normal way of interacting with people who are more senior than him. He said normally he would have been able to use humour in such

situations but as the tour went on he became increasingly frustrated at the precarious position that he and his team were in. As such he no longer found the situation he was in to be funny and he therefore behaved in a somewhat sarcastic manner which was unusual for him.

10.19. Sergeant Blackman also told me that he was very well aware that if any of his team had been captured they would have been tortured before being killed. He said they had heard of another service person whom had been captured by the Taliban and it had been clear to him that this service person had been treated very badly by the enemy. He also told me that the support they received from their chain of command was frequently lacking and he said that despite his requests for resupply at times the situation got so bad they had gone down to just having a couple of days of water left in the camp. This had meant they had to stop patrolling altogether because it was not safe to use up all of their limited water supplies on a patrol.

10.20. He told me that at the time he was arrested he had been part of the military team that prepares individuals for deployment. He said when he was charged with murder he became quite depressed. He told me that this was both because of his situation and also because whilst he had tried so hard to protect his team when they were in Afghanistan, nonetheless it was apparent to him that his actions had led to other members of his team being arrested. This situation upset him greatly. He told me that he felt responsible for them. He said that he had felt similarly responsible for them during the tour itself.

10.21. Since being in custody he has started an Open University course which is focussing on social sciences and geography. He has at least six years of his tariff left to serve. He is pleased that his wife is sticking by him and he tries to see the positive elements of being in custody. He feels that he is treated quite well by prison officers and inmates and he has made a strong effort to continue to behave well whilst in custody in order to be in a good position to get out as soon as he is able to. He wants to get out of custody as much for his wife as he does for himself.

11. Mental State Examination at Interview on 15th October 2015

11.1. Appearance and Behaviour

Mr Blackman was polite and cooperative. He understood why I was speaking to him and he made reasonable eye contact during the interview. He was not distracted and I felt we had established a reasonable degree of rapport.

11.2. Speech

Mr Blackman spoke clearly. There was no evidence of any formal thought disorder.

11.3. Mood

Mr Blackman appeared to be mildly despondent. He was a very matter of fact gentleman. There were no clear signs of depression or significant anxiety.

11.4. Thoughts

Mr Blackman felt that it was strange to be in a situation where his case was being heard again. He maintains that he had never set out to murder anybody and that when he shot the body he then very quickly recognised that what he had done was wrong but he had honestly thought that the body was dead before he shot at it. He felt that as the tour had gone on he had become increasingly frustrated and concerned for the safety of the team and also for his own life. He felt that he had been targeted by the enemy specifically and he accepts that he was more jumpy and that he was sleeping poorly. His concentration was somewhat impaired and he was more irritable with people outside of the base than was normal for him. He said he had continued to be aware of threats when he was on leave during R&R when he had been looking for IEDs in the UK in the same way as he had whilst he had been in Afghanistan. He also told me that the pressures of being away in Afghanistan had continued to affect him for some time after coming back from the tour (he gave me the example of him having been jumpy when at the theatre in New York in late 2011).

He told me that when he had been arrested he had felt that he had wrecked his relationship with his wife. However, he has been pleased since that she has stayed with him. He was currently trying to look at being in custody as positively as possible and hence he was doing an Open University course. There was no evidence of him intending to harm himself or others although he had contemplated ending his life at times during the early part of his prison sentence. He had not made any specific plans about how to do so.

Mr Blackman told me he had not known that believing the person was dead was a defence to murder when he was interviewed by the Police. He had merely told the story as it was. He also had not known that he was being videoed at the time he had shot the insurgent; he told me that the camera on a colleague's helmet had been extremely small and was fitted to an already existing bracket. He said he had not been trying to set up an environment in which he could kill a wounded Taliban at all. He said he had also been told during his RSOI[7] training that if a coalition force member was seriously injured then he was not allowed to make a decision as to whether the injured person may or may not be dead; this decision would have to be made by a trained medic. However, he had been clearly told that the situation was very different in the case of a wounded enemy. In such cases he had been told that he could make a judgement call about which enemy were dead and which were not. He said this approach was in place in order to prevent British forces from having to get a medic to attend every incident in which enemy forces had been seriously injured and also because if British forces were going to take enemy forces who they considered to be dead to a location where there were medical staff who could confirm that death then it would be necessary to subsequently bring that person back to the location that they had been found. This would have been in order to ensure that their religious needs

[7] RSOI training is the training that all UK service personnel get once they arrived in theatre. It covered the specific challenges of being in Afghanistan at that time.

were met [since local needs required individuals to be buried very rapidly after being killed].

11.5. Perceptions
Mr Blackman did not display any abnormal perceptions, preoccupations or beliefs that would have been indicative of a serious mental illness.

11.6. Cognitive Function
Although I did not test his IQ formally he appeared to fall within the normal range. There was no evidence to suggest that there were deficits in terms of memory, orientation or concentration.

11.7. Insight
Mr Blackman did not feel that he was currently ill. He said at the time he had been on tour he had not thought of himself as being ill. He had recognised that he was suffering a number of symptoms [e.g. poor sleep, poor concentration and being highly alert to potential threats] and that his behaviour was somewhat different from normal; however at the time he felt this his situation was "*just the way that things were*".

12. Evidence from R. v Blackman, The Court Martial Court of Appeal Judgement dated 22nd May 2014

12.1. Within the Judgement it states that Mr Blackman joined the Royal Marines some five years after leaving school. By 2013 he had spent 15 years in the Royal Marines and his Commanding Officer set out in the letter to the Court Martial that he had risen to the rank of Sergeant because of his exceptional qualities. He had completed six operational tours in Northern Ireland, Iraq and Afghanistan. He had won a reputation as a talented and capable soldier and non-commissioned Officer in the Royal Marines. Service records written after he returned from Afghanistan and before September 2012 indicated that he had been regarded as having been an outstanding Commander of his post. As a consequence he was recommended for promotion to Colour Sergeant and his Commanding Officer was confident that he would have been promoted to Company Sergeant Major (Warrant Officer class 2) and perhaps further had he had stayed within the services.

12.2. The Judgement also said that no psychiatric evidence was put before the Court Martial prior to conviction. However, Dr Michael Orr, who was an experienced Consultant Psychiatrist, provided a report for the purpose of sentence. He had examined Mr Blackman on 22nd November 2013 which was around two years after the incident. He concluded, despite the time interval, that there was evidence of an accumulated frustration with some aspects of his past and recent military experience. Secondly he concluded that it was likely that his resilience had been compromised first by reactivation of his bereavement reaction following his father's death and second by the emergence of some symptoms of a combat stress disorder characterised by paranoid interpretations of combat situations whilst on patrol and the increasing intensity that he had taken these as a personal matter. He had thought that the insurgents were "gunning specifically" for him.

12.3. Dr Orr had pointed out that combat stress disorder could result in misconduct stress behaviour. He said that this sort of behaviour could be committed by good or heroic soldiers under significant combat stress. The Appeal Court had made its own enquires of the Armed Forces and it was told that other than being briefed about stress during his pre-deployment training he would not have received any further training on this topic during the time he was deployed to CP Omar. It was noted that it was his Commander's responsibility to check on his mental welfare however given the remote and austere nature of the terrain contact with his Commander had been limited. The Appeal Court suggests that this was "a very unfortunate circumstance". The Appeal Court also said that it was not possible two years after the killing to diagnose whether Mr Blackman was in fact suffering from a combat stress disorder and it was possible that any combat stress disorder went undetected.

12.4. The Judgement goes on to state that the cumulative effect of the lethal military action had had an obvious effect. Mr Blackman was also affected by reports that the Taliban had hung a British serviceman's severed limb in a tree. He was also in no doubt that the victim was an insurgent who had been firing at a checkpoint before he was wounded. The Judgement also states that Mr Blackman had been subject to the stress of operations. This was his sixth operational tour and his second to Afghanistan in less than 14 years of service. The constant pressure was enhanced by the reduction of available men and so he often had to undertake more patrols and place his men in danger more often. The Court Martial had accepted the psychiatric evidence that he was suffering to some degree from combat stress disorder. However, it was noted that thousands of other service personnel had experienced the same or similar stresses and yet they had exercised self-discipline when Mr Blackman had not. The Court also states that he had previously been of good character, had an excellent service record and that his father had died recently.

12.5. The Judgement also considered that whilst training to deal with stresses was important it was difficult to see how such training could be sufficient in the absence of regular visits by seniors and his commanding officer to talk face-to-face and observe the effects on those whom they command. His mental welfare had not thus been properly monitored by his commanders and the report noted that he had become somewhat paranoid about the Taliban "gunning for him".

13. Appraisal Commissioning Report for Mr Blackman, dated January 2012 – 31st August 2012

13.1. Sergeant Blackman had reported that he wanted to be promoted as soon as he could and also he would like to get a commission as an Officer in the Royal Marines.

13.2. This report, at which point he is an Acting Colour Sergeant, suggests that he is an excellent candidate for commissioning to become an Officer. He had received an excellent report and was noted to consistently perform above the standard required of his rank. He is bright, robust and engaging with impeccable moral courage. It is

noted that no challenge is too great for him and that every action is based upon sound, tactical acumen and his equally important ability to accurately judge second and third order effects. It is noted that his briefings are clear and unambiguous and he had demonstrated a real desire to gain a commission.

14. **Annual Appraisal Report, for Appraisal Year 2011 – 2012**

14.1. The report says that Acting Colour Sergeant Blackman is intelligent and able to engage and connect with all ranks remaining respectful but highly authoritative with his delivery. Whether speaking with Marines or officers commanding (OC's meaning officers in charge of reasonable sized units) he is effective and always listened to. It is noted that this mentorship of those under training is strong and he is always fair and produces extremely valid observations which are delivered in a clear and concise manner.

15. **Annual Appraisal Report, for Appraisal Year August 2009 – 30th June 2010**

15.1. The annual appraisal suggests that he is a quiet, effective leader who was respected by his peers and subordinates. His briefing style is comprehensive and informative and built on unequivocal direction. He was expected to be successful at the Admiralty Interview Board (the AIB is the interview panel that decides whether someone is deemed suitable to receive a commission as an officer within the Naval services (which includes the Royal Marines)). He was thought to be ready for promotion "now". He was rated in the top five per cent of the sergeants in the unit and his reporting officer states, "*He has nothing else to prove as a sergeant and should be promoted at the earliest opportunity*".

15.2. The second reporting officer (Lieutenant Colonel Ward) stated that, "*He demonstrates strong potential for commissioning and should compete ahead of his peers in challenging for AIB selection*". He was noted to be rated highly as being ready for commission.

16. **Appraisal Commissioning Report for Period 29th November 2010 – 31st August 2011 [written whilst he was on HERRICK 14]**

16.1. He was noted to have done well during the Op HERRICK 14 tour so far but was noted to be developing his potential to hold a commission or more senior non-commissioned rank. He was noted to need more time to develop his personal qualities and demonstrate a greater breadth to his portfolio. It was also noted that before he receives a positive recommendation for an AIB he will need to refine his relaxed manner and develop a more consistently authoritative and dynamic persona.

16.2. The second reporting officer (Lt Col Ewen Murchison) noted that at present he lacked the necessary spark and bite to be a credible contender for a commission. He needed to work to be more pro-active around the unit accepting greater responsibility to demonstrate his personal qualities and professional competencies. It was noted that

promotion to Colour Sergeant may well act as a natural stepping stone to allow him to take on greater responsibilities.

16.3. The second reporting officer ends by saying, "*At this stage I do not envisage reach beyond OF2 (Lieutenant)*".

17. **Annual Appraisal Report, for Appraisal Year 1st September 2007 – 30th August 2008**

17.1. It was noted that Sergeant Blackman had performed very well during HERRICK 7. He had shown tenacity and fulfilled his position with vigour and energy. He had stepped up as Troop Commander at times and showed a capacity to adapt his leadership style to suit the situation in which he found himself. He was viewed to have produced a consistently dependable performance of a sound quality during a demanding reporting period. He was thought to be ready for promotion to Colour Sergeant immediately and had the capability to become a Warrant Officer and indeed a commissioned officer once he had improved his educational qualifications [which military regulations require for someone to take up a commission as an officer].

18. My meeting with Colonel (retired) Oliver Lee, ex Royal Marines, in London on 21st October 2015

18.1. Colonel Lee told me that he had taken over command of CP Omar six days before the incident in which Sergeant Blackman shot the insurgent. Prior to this he had been in command of the area of operations (AO) which was next to the one that CP Omar was located in. He told me that he had serious concerns about the quality of the leadership in the AO that CP Omar was located in and had in fact approached a senior British officer in Helmand (who was a Brigadier) and expressed his concerns about this. He had written about this in some detail in witness statements that he had provided to Sergeant Blackman's legal teams both at trial and the new team preparing the case for the CCRC.

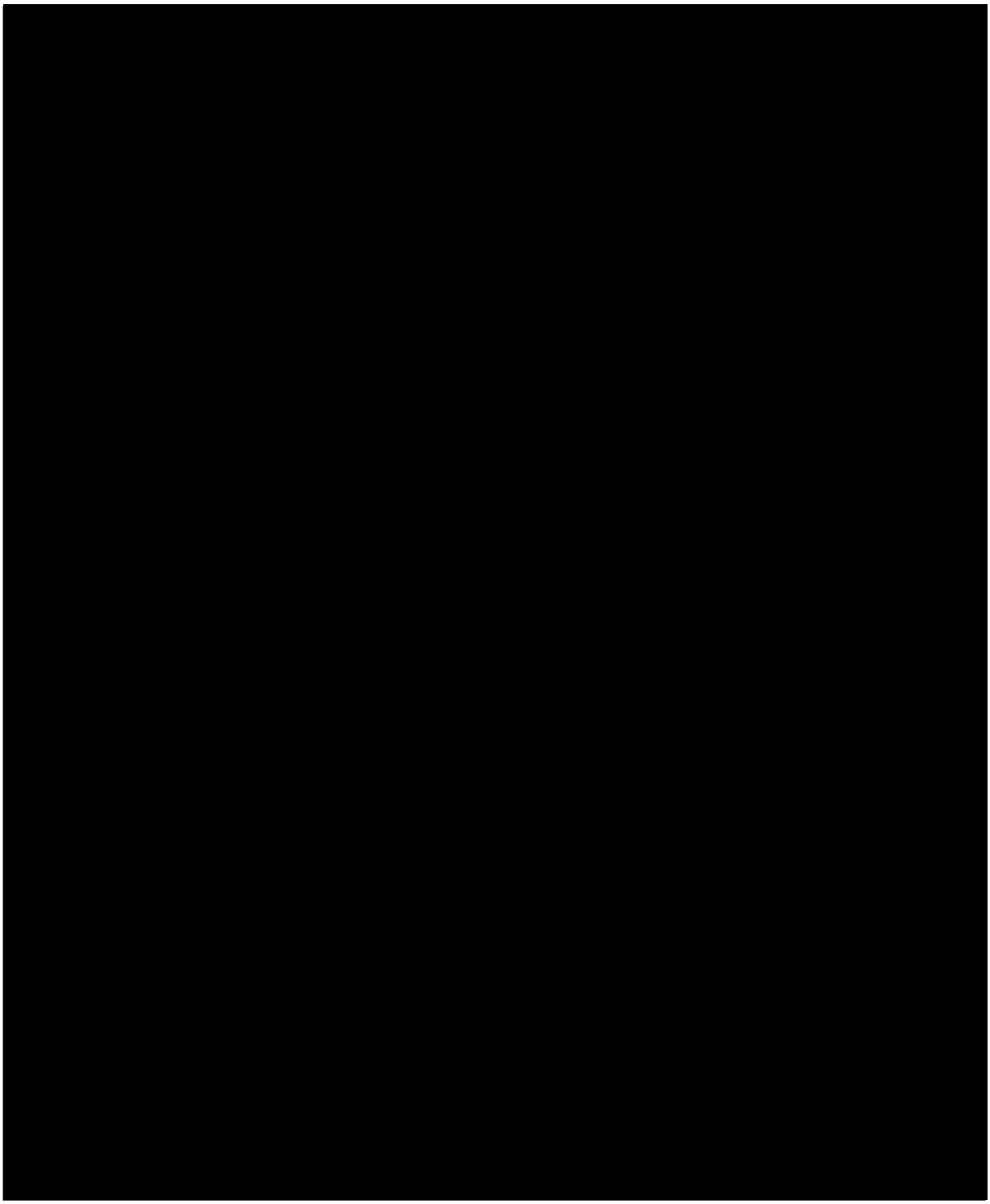
18.2. Colonel Lee also told me that he visited all of the bases in his AO every two weeks[8] in order to speak with those under his command and provide them with an opportunity to vent any concerns. He also always ensured that one of the team with whom he visited the bases under his command was TRiM trained in order that they could check on the mental health of personnel at the location who had been involved in serious incidents.

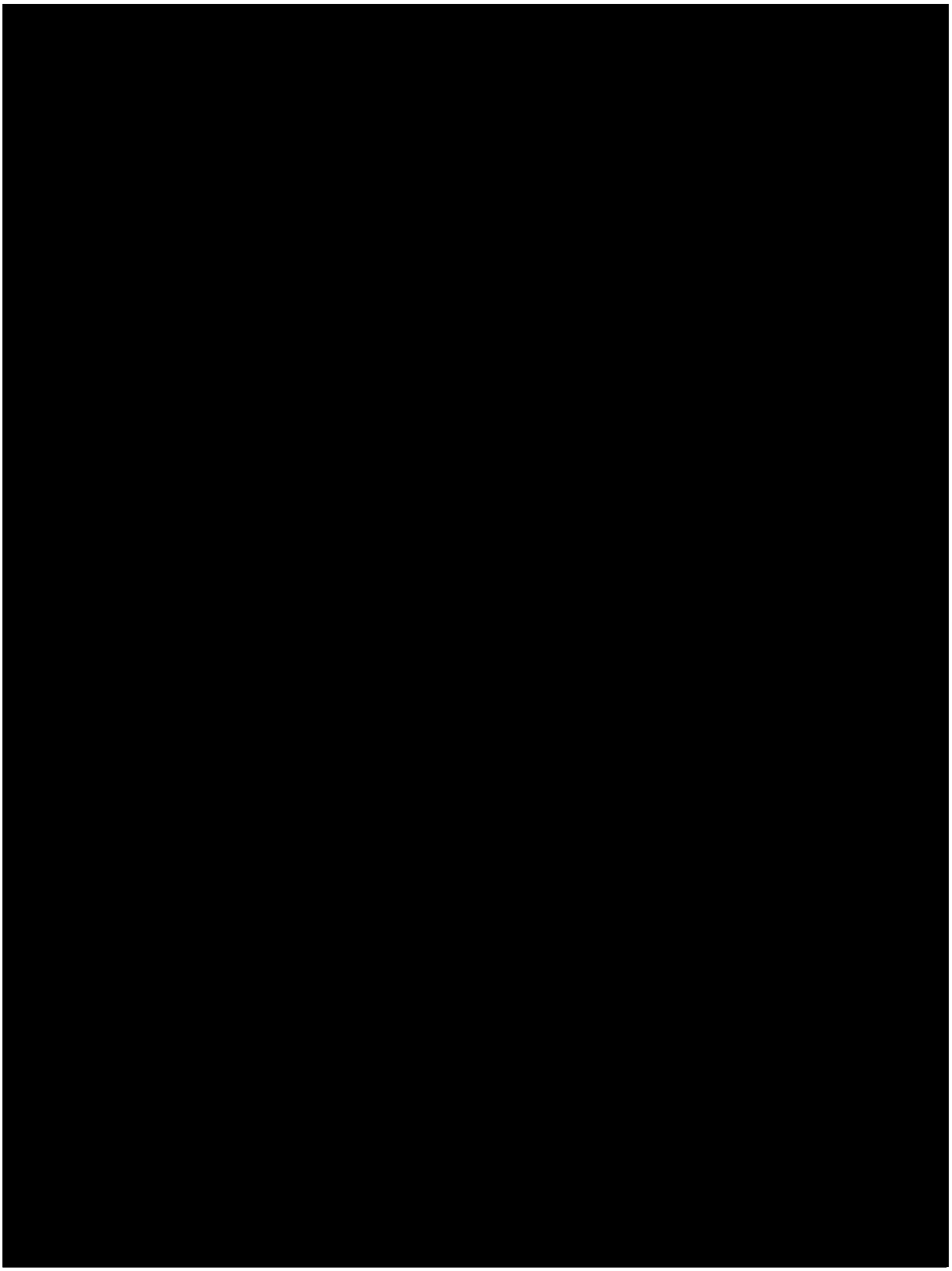
19. Statement by Colonel (retired) Oliver Lee, dated 16th August 2015.

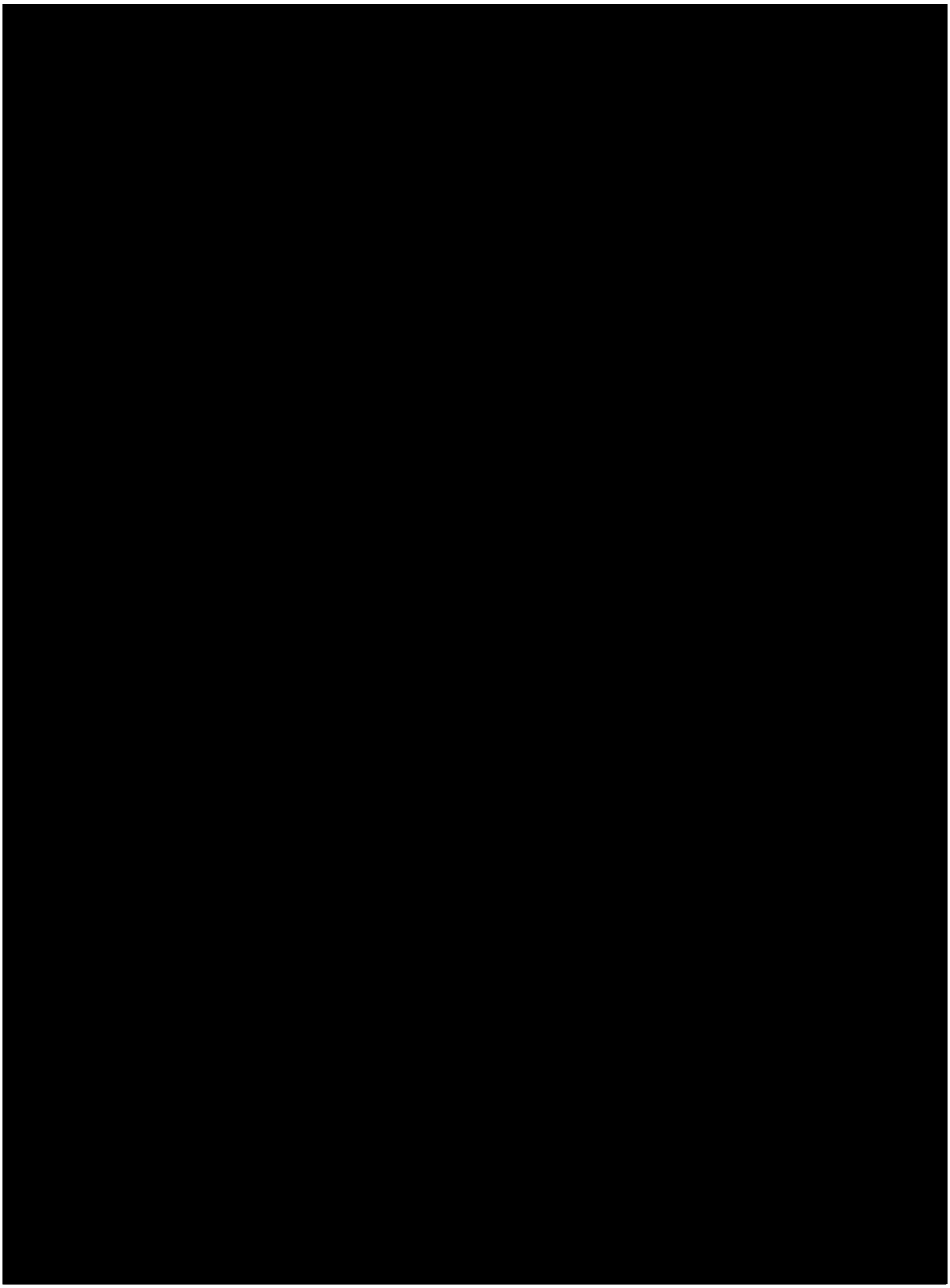
19.1. Colonel Lee's statement expresses, in considerable detail, his concerns about the quality of leadership in Nad-e-Ali North (the AO that CP Omar was located in). In his summary he states "*at the heart of these factors is my view that the leadership and oversight of Sergeant Blackman from Lieutenant Colonel Murchison and Major Fisher was shockingly bad and directly causal to Sergeant Blackman's conduct.*"

[8] This is in contrast to the report by Sergeant Blackman that his commanders almost never visited his location and he was not offered any TRiM support at all during HERRICK 14.

Colonel Lee believes that "*leadership is the key to enabling subordinates to navigate the very difficult moral tightrope on operations such as those in Helmand*".







[redacted]

21. **Service Police Record of Interview with Mr Blackman, dated 22nd September 2012**

21.1. In the interview he told the interviewing officers that he did not know there had been a headcam on during the incident which led to the insurgent being killed.

22. **Prosecution Summary of the Facts of The Case**

22.1. The Prosecution stated that the murder of the insurgent took place on 15th September 2011. It involved Marine A (Sergeant Blackman) using a pistol. It was claimed that he deliberately shot and killed an injured man. The man had been detained following an earlier incident in which he had been wounded by gunfire from an Apache attack helicopter. The document states that Marine A fired his pistol at close range into the injured man's chest. The Prosecutor goes on to say that the murder was captured on a video which was being recorded by Marine B (a second defendant; who was subsequently found not guilty). The Prosecution states that the victim had been seriously injured and he was under the control of and in the custody of the defendants.

22.2. The Prosecution's case is that what Sergeant Blackman did was to execute a man who had been wholly entitled to be treated with dignity and respect in the same way that any British service man or women would be entitled and would expect to be treated if they were in a similar position. In the case it is said that a PGSS (Persistent Ground Surveillance System) provides an overview of the local area and that Marine A is heard to say "*move him to a place where we can't be seen by the PGSS*". It is alleged that this move was asked for because Marine A knew full well what he was going to do. The team had apparently applied a first field dressing to the injured man. There is also a photograph of Marine A appearing to be looking up into the sky and the Prosecution suggests that when the shooting took place, Marine A had received assurance from Marine B that the Apache helicopter had gone and that they were waiting for the Apache to leave before they shot the injured man. One of the team had said "*Shall I shoot him in the head?*" to Marine A; Marine A had replied "*No, that would be too obvious*".

22.3. It goes on to say that the killing occurred about a month before Sergeant Blackman returned to the United Kingdom. He had been the commander of CP Omar at the time. He said that Marine A and Marine C had gone into the field to see the man who had been engaged by the Apache helicopter. When Sergeant Blackman had insisted in moving the injured man to a less exposed area he had said, "*Move him to a position where we can't be seen by the PGSS*". Sergeant Blackman had then used his radio to inform the operation base that the injured man was still alive. A short time later it is alleged that he used his pistol at close range, bending down to shoot the man in the chest at close range. After shooting the man he had said "*There you are shuffle off this mortal coil you cunt. It's nothing you wouldn't do to us*". He had gone on to say that, "*Obviously this doesn't go anywhere fellas, I have just broken the Geneva*

Convection". Before the shooting, but after the insurgent was taken into cover Marine A had said to his team, "*Anyone want to do first aid for this idiot?*" One of the other Marines is said to have said, "*I'll put one in his head if you want*" which provoked some laughter and then Marine A says, "*No not in the head because that would be too fucking obvious*". One of the other Marines had said, "*Gonna switch this fucker off*" (meaning the video cam) and Marine A says, "*I don't know where that Apache helicopter is mate*".

22.4. The Prosecution state that although some first aid was given, it was in fact a pretence and Marine A had said, "*He is over there and he can fucking see us"* (in reference to the Apache helicopter). One of the Marines then suggests that they ask for medical evacuation. There continues to be some laughter with references to strangling him at which point Marine A says, "*Yes he has passed, fuck it he has passed*". The Prosecution alleged that this was a pretence. One of the other Marines also says, "*He is dead*". Marine A then gets onto the radio and says, "*He's dead*". Marine A has said over the radio before, "*I hate to say it, administering first aid to this individual*" before then saying that, "*He has passed on from this world, over*". He then says he will take biometric samples [this is routine practice] Marine A had also said, "*Oh he is dead, don't waste your fucking FFD's [First Field Dressing] on the geezer take it off him. Right, get the HIIDE [forensic] camera and see if you can get a picture of him*".

22.5. The Prosecution then go on to say that when Marine A was questioned he admitted saying to his team, "*Anyone want to do first aid on this idiot?*" which would have had a negative impact on young serviceman. It was also mentioned that Marine A had claimed that he had personally administered first aid however the video evidence is clear that he did not do this. When further interviewed by the police he had said, "*All joking aside, no one killed him he died of his injuries*". It continues that in a prepared statement Sergeant Blackman had said, that following return to theatre from R&R in mid-august and up until the incident, his team was subject to numerous contacts. On the majority of occasions that he went out as Commander there was some form of incident. During the tour there were a number of casualties and fatalities. By the time of the shooting incident his Troop Commander had been killed; he had previously been highly respected. He had also witnessed how badly affected other members of the team were by deaths and life changing injuries. He was upset by the loss of his Troop Commander and worried for the welfare of his lads. He said it had been a very stressful time.

22.6. Returning to the incident he regretted to say that following the death of the insurgent his stress and anger took over and he discharged his firearm. The comments that he is heard to make during the video are a demonstration of his anger at the time. He accepts that he should not have reacted in this way. However he wished to emphasise that at the time he discharged his side arm he was firmly of the view that the insurgent was already dead. The Prosecution goes on to state that the Jury will have to decide whether Sergeant Blackman did or may have generally believed that the injured man was dead and he was firing into a man that he could not murder because he was dead. The Prosecution state that whatever the stresses and strains of those engaged in

combat, the video footage and comments made speak for themselves. That is to say that the Prosecution state that the killing of the insurgent was a deliberate intentional act by Sergeant Blackman. It is notable that one of the other Marines who the Prosecution refers to, who was present at the shooting, had said that he did not expect Sergeant Blackman to shoot or harm the prisoner. He said that after the shooting had occurred he was "*stunned*". One of the other Marines who had gone forward with Sergeant Blackman, to examine the insurgent in the middle of the field after the Apache had attacked him, made a statement to say that he had wanted to kill the insurgent if he had any excuse. He said Sergeant Blackman had said no because the PGSS feed went directly to Camp Bastion (a headquarters location). It was this Marine's view that the insurgent was dead but his brain had not caught up with his body. He said whilst he had been waiting to, "*pop*" him with a 9mm he had thought that the team were going to provide treatment for the casualty.

22.7. The Prosecution end by saying Marine A shot the injured man when he was still alive and at the time of the shooting Marine A had the intention to kill. They suggest that his words, and deeds, immediately before and after the killing were evidence that killing was his intention and he was aware that the man was still alive. In this respect they said that moving the man out of the sight of the PGSS was relevant as was his concern to know the whereabouts of the Apache helicopter. They suggest the comment, "*Anyone want to do first aid on this idiot*" and the exchange with the other Marines about not putting a bullet into the injured man's head because it would be too obvious also suggest his intent. They suggested the message relayed over the radio that the injured man had died was untrue and that his comments, "*Shuffle off....*" and "*It's nothing you wouldn't do to us*" and the comment about the Geneva Convention all add to the fact that he had intent to kill. Finally the comment about the insurgent being "*fully dead*" also suggest that Marine A had intent. The Prosecution also goes on to discuss the fact that the camera which recorded the killing had an automatic mode which Sergeant Blackman and indeed the Marine who wore the video cam, had been unaware of.

23. Judge Advocate General's Sentencing Remarks

23.1. The Sentencing Remarks state that having searched the insurgent found in the field, Sergeant Blackman purposely moved the insurgent to a place that his actions could not be seen. He failed to give appropriate medical treatment and ordered those giving first aid to stop. The Judge said that when the Apache helicopter was out of sight Sergeant Blackman calmly discharged a 9mm round into his chest. The suggestion that Sergeant Blackman thought the insurgent was dead lacks any credibility and was clearly made up in order to concoct a defence to murder. The Judge said that it was not an action taken in the heat of battle or immediately after he had engaged in a firefight nor was he under any immediate threat. He states that Sergeant Blackman had failed to demonstrate the self-discipline and restraint that is required of service personnel on operations which set British troops apart from the enemy they fight.

24. Medical Report by Dr Michael Orr, dated 27th November 2013

24.1. Dr Orr had seen Marine A for just under two hours. He had also seen the DVD of the killing but does not indicate that he had sight of any other materials relevant to the case. Marine A mentioned that he was a very private person and had pursued a range of individual sports. He had also spoken about the death of his father shortly before the deployment. He said during his period of R&R in July 2011 he had scattered his father's ashes which had reignited a grief process which had been suspended due to him having to prepare for deployment earlier that year.

24.2. Sergeant Blackman had talked about his tour in Afghanistan in 2007. He described the fighting he had been involved in as being fairly intense. He remembers some of his colleagues being badly injured. Another colleague died in an explosion caused by an IED. He said that the second tour to Afghanistan started off quietly and for a while the role was not particularly dangerous. He said after coming back from R&R things began to "*get a bit silly*". He explained about the patrols that he had done and he felt that the patrols that he had led had invariably experienced enemy contacts during which he was shot at. He stated that he felt that the insurgents were, "*gunning specifically for me*". He remembers feeling apprehensive as he was coming towards the end of his tour.

24.3. He also said his sleep had been poor for most of the six months mostly because of the very high temperatures at night. He had said that the insurgents were not nice people and that they shot children.

24.4. He said that he had been under the impression that the insurgent was dying when he first found him but he did not really care. He said he remembers seeing that the insurgent was dead and he then spread his lads out and approached the insurgent and discharged his firearm. Immediately afterwards he felt he had made a mistake and he describes his mind spinning and then making silly comments. He said he and his team had been frustrated that the Apache had not killed the insurgent. He remembers feeling the nature of the insurgent's injuries were such that first aid would be for nothing. He also mentioned that he was aware that if he or his team had been captured by the insurgent this would be followed by the insurgent "*chopping heads off and doing despicable things*".

24.5. Sergeant Blackman had, in the course of their conversation, expressed frustration about problems that had been avoidable during past tours as well as sadness and frustration about some aspects of his father's treatment in hospital before he died. He became distressed and close to tears when talking about his father's death despite making efforts to contain these feelings. Dr Orr also noted that the incident leading to the death of the insurgent included a description of the team's frustration at the failure of the Apache helicopter to kill the insurgent as they had been expecting. Dr Orr notes that frustration can be associated with irritability which can be an early symptom of a depressive episode. It was also noted that Sergeant Blackman's mood had been affected by the reactivation of the grieving process following his father's death. Whilst he had reported the scattering of his father's ashes in July 2011 as a good thing

it is possible that his low tolerance for frustration, irritability and the feeling of not being able to care for the injured insurgent may have been at least in part due to an ongoing bereavement reaction.

24.6. Dr Orr felt that, at examination, on 22nd November 2013, Sergeant Blackman had been suffering from mild to moderate depressive symptoms consistent with his current circumstances. Dr Orr formed the impression that Marine A was a very private man with a strong sense of professionalism and responsibility who prefers plain speaking and a straight forward professional fuss-free approach to his work. He had said he had always found it difficult to express feelings which Dr Orr felt made him more vulnerable to feelings of frustration and possibly irritability or unhappiness when things went wrong and circumstances at work, or his personal life, were out of control. It is not uncommon for people who are private to become progressively less tolerant of what they see as unnecessary frustrations or unreasonable demands.

24.7. He also noted that Sergeant Blackman had described himself as becoming paranoid. He kept these feelings to himself and it was Dr Orr's view that it might have assisted him if he had been able to discuss these feelings with a superior officer. Dr Orr also felt that it was likely that his visit to join his family in late July 2011 to scatter his father's ashes may have increased his vulnerability to his sense of exposure and to his emerging tendency to experience frustration. Dr Orr went on to discuss whether Sergeant Blackman may have suffered from any combat/operational stress injury. He goes on to state that combat and operational stress injuries include traumatic stress injury, fatigue stress injury and grief. These can precede significant and potentially disabling post-traumatic stress symptoms. He noted that Sergeant Blackman had experienced fatigue and poor sleep, grief related to reactivation of his father dying and what he described as paranoid feelings about being targeted by the enemy.

24.8. Dr Orr states that combat stress even under heroic combat conditions is no defence for criminal misconduct [it is not clear to me whether Dr Orr had considered whether this disorder might have amounted to the defence of diminished responsibility]. It could however be considered as an extenuating factor and determine the consequences of an offence. Dr Orr felt there was emergence of some symptoms of a combat stress disorder characterised by paranoid interpretations of combat situations and the increasing intensity with which Sergeant Blackman took this as a personal matter. Dr Orr stated that his presentation was similar to what is known as "burnout" particularly evidenced by his view that he did not, and could not, care anymore.

24.9. Dr Orr also attaches to his report two appendices which discuss combat stress behaviours and fatigue, stress injury and combat/operational stress injury [the sources of these are not however referenced].

25. **Notes from Somerset Partnership NHS Foundation trust**

25.1. Sergeant Blackman had been admitted to Rydon Ward in Taunton on 22nd October 2012 and subsequently discharged to the care of DCMH (Department of Community

Mental Health) Plymouth on 29th October. He was noted to have had suicidal thoughts the previous week and also reported having similar thoughts some nine years previously. He had been transferred from Colchester Prison (having been charged with murder) with increasingly low mood and suicidal ideation. He felt that he had let everyone down. He had not described flashbacks or other symptoms of PTSD (Post Traumatic Stress Disorder) but found that he had not been able to watch TV programs about Afghanistan since he came back as it triggered difficult memories.

25.2. He was noted to be someone who had longstanding difficulties with emotionally opening up to others and has found it difficult to discuss traumatic experiences with his wife. He was prescribed an antidepressant (called Mirtazapine) whilst in hospital. On discharge (to the care of Mr Ray Dixon, a community mental health nurse (CMHN) at DCMH Plymouth) he was thought to need help with problem solving, medication compliance and longer term psychotherapy as previous traumatic experiences were thought to have predisposed him to his current depression. He was thought to have possible unresolved issues from his experience of life threatening events and death of colleagues. As well as his current situation (his arrest) he was thought to have experienced traumatic situations in Iraq and Afghanistan which had impacted upon his mental health. Prior to being admitted, he was also noted to have been drinking alcohol to try and cope with his distress; he had been drinking three bottles of cider and several shots of spirits to try and help him sleep. His colleagues had noticed that he had become quiet and withdrawn. He also reported that his sleep had become disturbed and he had lost his appetite.

25.3. During his time on the ward he had spoken to staff about traumatic experiences he had had in Iraq and had become tearful about these. He said that he had become depressed after coming back from Iraq and drunk excess alcohol to cope; this was compounded by a relationship breakup. He also spoke about how difficult he continued to find his father's death. He had been tearful when speaking about this topic. He had felt that he had to go back to work immediately after his father had died as he felt responsible for the junior Marines under his command. He also reported finding the scattering of his father's ashes during his R&R to have been very difficult. He was noted to be significantly depressed and to be someone who used work as a way of dealing with feelings and tended to take care of others, particularly younger service personnel, at the expense of himself.

25.4. At the point he was discharged he was noted to be have a somewhat improved mood and had been eating well on the ward. He was due to return to a military base and take up a training position although he was not sure of the details. He told staff that he was looking forward to this.

26. Information from the Ministry of Defence DMICP medical files for Sergeant Blackman

26.1. Sergeant Blackman had been seen by Surgeon Commander Harrison, consultant psychiatrist, on 7th November 2012 after he had been discharged from hospital in Taunton. He had reported finding being an inpatient at Taunton to be unsettling

because of the mental health problems that the other patients had. He was thought to be suffering with a depressive adjustment disorder and the plan was for him to stay on his antidepressant medication and have some cognitive behavioural therapy with Ray Dixon. He was noted to be looking forward to getting back to work. His concentration was not ideal but was sufficient to be able to drive although not to handle weapons.

26.2. Over the next few months he saw Ray Dixon (a CMHN) a number of times and he appeared to improve and to benefit from having a routine to his life and being able to spend time with his wife. His dose of antidepressant was reduced relatively quickly without any recurrence of distress symptoms.

26.3. In June 2013 there is a medical record entry by a doctor [Surgeon Lieutenant Commander Lisa Stevens] reporting that Sergeant Blackman had been discharged from mental health follow up as he was doing well and he had been off of his antidepressants for a number of months. He was "back to normal" and enjoying everyday life

27. A face to face interview with Claire Warner, Mr Blackman's wife, on 15th October 2015

27.1. Ms Warner told me that it was usual that her husband did not discuss things with her which might worry her. She told me that she had, for instance, found out about him being blown up on HERRICK 7 only when she had overhead her husband, who had had a "*few beers*" at a barbeque speaking to a colleague about it. As such, whilst their relationship has always been a close one, she is used to him not speaking about such matters with her. She reported noticing that during his R&R on HERRICK 14, when they had gone for a country walk he had been obviously looking at the ground a lot and when she asked him why he had spoken about having to be very alert for threats (e.g. IEDs) whilst in Afghanistan. She also told me that she had seen her husband "jump under his seat" when they had been at the theatre during a holiday to the USA at the end of 2011 when there had been a loud noise in the show. She had not otherwise noticed that her husband was different or changed when she had communicated with him whilst he was deployed (e.g. over the phone or by text messaging).

28. Telephone discussion with Warrant Officer (WO) Jim Wright, Royal Marines, on 29th October 2015[9]

28.1. WO Wright told me that he knew Sergeant Blackman very well. They would regularly meet up in a friendly way and rank differences were not an issue in terms of their

[9] I place considerable weight on WO Wright's evidence as he was someone who knew Sergeant Blackman well enough that Sergeant Blackman might speak to him openly. He described their relationship as being one of professional friendship. WO Wright is also an experienced Royal Marine who understands the deployed environment and also, as a function of his experience and his TRiM training, has a good understanding of how Royal Marines respond to challenging experiences whilst on deployment.

comradeship. WO Wright is also TRiM trained [and thus has some understanding of mental health conditions that may result from exposure to challenging situations].

28.2. He told me that when he had met Sergeant Blackman prior to him going on HERRICK 14, they would often play golf and chat about topics related to their work. Whilst in his view Sergeant Blackman was never someone who would be open about his emotions, he was usually very keen to speak about his work and what had happened on operational tours and his views on these matters. He had met Sergeant Blackman during his R&R on HERRICK 14. He said that it was quickly apparent to him that Sergeant Blackman was not his usual self. He had lost a considerable amount of weight and his mood was flat. Unusually he did not want to speak about what was going on during the tour which WO Wright felt was highly unusual. He noticed that his friend was vacant and in his view he was "*a husk of his usual self*". WO Wright did not want to pry into what was wrong as he thought that his friend was going to have to go back to complete his tour so he got on and completed the game of golf (they were together for about four and half hours).

29. **Telephone discussion with Marine Jack Hammond, Royal Marines, on 15th October 2015**

29.1. He had met Sergeant Blackman about three months before the deployment; Mr Hammond felt that Sergeant Blackman had demonstrated a pretty good balance of being relaxed with the lads and being a highly professional leader. Mr Hammond had been based at CP Omar during HERRICK 14.

29.2. When asked, Mr Hammond told me that he noticed some changes in Sergeant Blackman's behaviour during the tour. He felt that Sergeant Blackman had become more tired and slowly worn down over the tour which he had thought were a result of, fierce and unremitting heat, and the pressure of work. Also, as the tour progressed, the manpower available to Sergeant Blackman had declined which he was aware had been a considerable frustration for him. Sergeant Blackman had worked in the operations room at CP Omar a lot and Mr Hammond felt that Sergeant Blackman did many extra hours in the ops room; it was his view that Sergeant Blackman was "*always*" in the operations room.

29.3. When I asked Mr Hammond about how Sergeant Blackman had been with the team at CP Omar, he told me that whilst he was somewhat withdrawn from general interaction with the other team members he could still "*have a laugh with the lads*". He was a good boss; for example he would make cups of tea for guys who were located in the hot and sweaty sangers [these are elevated observation positions within a secure location]. Whilst Mr Hammond does not remember him being irritable with the lads, he certainly had been frustrated and irritable with people he spoke to on the radio. Mr Hammond knew about this because his personal "*chill out spot*" was right next to the ops room which allowed him to hear the sort of interactions that Sergeant Blackman had with other people on the radio; these were often [in his view] heated.

29.4. Mr Hammond was also aware of various traumatic incidents that Sergeant Blackman had been involved in during the tour. Mr Hammond told me that Sergeant Blackman had been in command of a patrol which had been told to hold a position at a check point in August 2011. Whilst there the patrol had had a "*couple of grenades*" thrown into their position and these landed behind Sergeant Blackman and luckily they went into a ditch. This was, in his view, one of the scariest moments of the tour. Mr Hammond told me that Sergeant Blackman had been involved in "*every serious incident during the tour*" and in his view he had been "*out with the lads*" on almost every patrol.

29.5. On the day of the shooting the team had been on a standard patrol which was uneventful. However, one of the other nearby CPs had been engaged and Sergeant Blackman's team was asked to search a compound but could not find anything. They were asked to "*go firm*" and wait for further instructions. Mr Hammond told me that when the patrol turned from being routine to chasing the enemy, the situation had been fast and furious from the moment the other CP was attacked. Mr Hammond told me that the team's reaction to the other CP being attacked was, in his view, all pretty rushed and Sergeant Blackman had been talking on the radio a lot and the team reacted to whatever Sergeant Blackman had been told and the team's plans had rapidly changed many times.

29.6. Mr Hammond had felt that life in the CP was never safe and there was an underlying stress in the team which prevented anyone from ever really switching off. However, within the CP people got on well. Mr Hammond felt that there was a lot of hesitation from the unit's seniors about what to do with the enemy; he thought it often felt that they were trying to "*do things with their hands tied behind their back*". He also noted that the team did not really see any positive effect of their work, on the local population. HERRICK 14 had been his first tour.

30. Telephone discussion with Corporal Mark Murphy, Royal Marines, on 27th October 2015

30.1. Corporal Murphy told me that he felt that Sergeant Blackman had been a good boss. He was based at CP Omar with him during HERRICK 14. He did not know him before he joined the unit before the tour but he recognised that Sergeant Blackman was not the sort of person who would have opened up about how he was feeling or what he was thinking to his team.

30.2. Corporal Murphy was one of the senior personnel at CP Omar under the command of Sergeant Blackman. He told me that the location was very austere and there were lots of frustrations during tour for everyone at the CP. He told me that he would not have known about Sergeant Blackman's sleep or whether he was irritable with anyone outside of the CP. He told me that Sergeant Blackman did at least if not more than his fair share of dangerous duties during the tour.

31. **Telephone discussion with Craig Rea, ex-Royal Marines, on 31st October 2015**

31.1. Mr Rea was a Marine based at CP Omar during Herrick 14. It was his second tour of duty in Afghanistan. He had generally found Sergeant Blackman to be a helpful person and a good boss. He was however someone who kept himself to himself and when not on patrol or in the ops room he would spend time in his own tent watching films or at times reading books.

31.2. Mr Rea noted that the CP team had adopted a local cat which "the lads" liked having around. He noted that whilst Sergeant Blackman had been wholly ok with the cat being in the CP during the initial part of the tour, as the tour progressed he became increasingly irritated with the cat and kept trying to throw it out of the CP. Mr Rea does not know why he became irritated with the cat which [in his view] had been helpfully killing mice and would sit with the lads in the sangers; he noted that the cat seemed to "do his [Sergeant Blackman's] head in". He also noted that as the tour went on, whilst Sergeant Blackman tended to do just what needed to be done; he did not do anything more than he was asked to. He did not push the boundaries or, in his view, take any risks other than those which were wholly necessary.

31.3. He did not have any idea of what Sergeant Blackman's sleep was like but he noted that no one at the CP slept well as it was so hot and uncomfortable there. Mr Rea noted that a number of the personnel at the CP have since suffered with mental health problems including himself.

32. **Telephone discussion with Grant Whitehead, ex-Royal Marines Reserves (RMR), on 12th October 2015**

32.1. Mr Whitehead has been a firefighter for 20 years and served with the RMR between 2006-2013. He told me that his tour on HERRICK 14 was incredibly tough and the impact it had upon him wrecked his marriage. He had been with Sergeant Blackman on HERRICK 14 until shortly before the incident that led to Sergeant Blackman being found guilty of murder. On HERRICK 14 he had been a Lance Corporal and shared a tent with Sergeant Blackman. Mr Whitehead had met Sergeant Blackman just before the deployment commenced. He felt that he had a good relationship with him but he was always quite distant from the rest of the team. As he was quite a bit older [approaching his 40s] than other members of the team, he felt that Sergeant Blackman had been more likely to speak to him than other team members. However, he noted that Sergeant Blackman was not someone who was apt to open up much. He also thought there was a lot of pressure on Sergeant Blackman because he was new to the team and the Corporals in the team were also new.

32.2. He described CP Omar as being awful; in his view it was very badly built and as it was below road level people driving past could just look in. It was also very hard to put defences around; the sanger was not a good observation point and there was no practical front gate; there was just barbed wire.

32.3. Mr Whitehead said that Sergeant Blackman was quite a hard task master. He was strict on the lads wearing the right kit and he wanted them to do "the job" to a high standard. Sergeant Blackman had got rid of "one lad" part-way through the tour who he felt was useless. In Mr Whitehead's view this person had indeed been a liability.

32.4. Mr Whitehead felt that as the tour went on, in his view Sergeant Blackman became increasingly withdrawn. He had no one to talk to about matters [other than superficial ones] and whilst he shared a tent with him, Sergeant Blackman did not speak to him about anything of real substance. Mr Whitehead also said that he was aware of an incident on 10th August when two grenades had gone off very near to Sergeant Blackman. In his view, something 'went' in Sergeant Blackman at that point [by 'went' Mr Whitehead meant that it was as if some sort of 'emotional switch' had been flipped inside of Sergeant Blackman's head]. He had been more frequently in the operations room [a metal container] by himself than before the grenade attack and he also isolated himself in their tent more frequently. Sergeant Blackman often used to do the night shift so Mr Whitehead did not see him much but what he did see of him suggested that he was not sleeping well.

32.5. Mr Whitehead felt that the unit had lost a number of personnel with injuries and other difficulties throughout the tour and CP Omar had been "short of personnel the whole time". He also felt that Sergeant Blackman became more jumpy as the tour progressed; this was especially so after the 10th August grenade attacks. Mr Whitehead felt that Sergeant Blackman was also somewhat distracted when he was talking to other people at times [suggesting that he was finding it difficult to concentrate]; at other times however he was full of bravado [suggesting he was putting on a brave face in front of his team].

32.6. Mr Whitehead also noted that they all were on rations and they all lost weight. He felt it had been hard for Sergeant Blackman to "*keep the morale of the lads up*". He also was aware that as well as Sergeant Blackman not having enough people to carry out the required tasks properly, he was also highly frustrated by not having sufficient resources to make the location safe and to thus keep "*his people*" safe. He thought that Sergeant Blackman felt that they were fighting with both hands tied behind their backs and they were not allowed to engage people who they knew were enemy[10]. Mr Whitehead told me that he had left theatre before the incident happened. He said the impact of that tour on his psychological health led to him leaving the RMR.

33. Opinion

33.1. **In my opinion, there is good evidence that, at the time of the killing, Sergeant Blackman was suffering from symptoms consistent with an adjustment disorder. An adjustment disorder is a diagnosis within the International Classification of Diseases Volume 10 (ICD 10) (see Appendix C) which is a very widely used**

[10] My MD thesis (King's College London, 2008) examined data from UK military personnel who were engaged on peace-support operations in the Balkans. I found that operating under restricted rules of engagement are particularly psychologically toxic in terms of their effects on psychological health.

diagnostic classification system published by the World Health Organisation. Adjustment disorders follow the experiencing of psycho-social stressors, which do not have to be of a highly unusual or catastrophic type, within the month before the onset of symptoms. The emotional symptoms and or behavioural disturbances associated with this diagnosis can be highly variable in their form [e.g. anger, irritability, being withdrawn etc] and severity. It is my view Sergeant Blackman experienced a substantial disturbance of both emotions and conduct as a result of his adjustment disorder. It is notable that adjustment disorders do not ordinarily persist for more than six months after the cessation of the stressor. In this case the relevant stressors included the challenging nature of the deployment itself, the logistical and manpower frustrations he experienced and the reports he and his team had received about the inhumane behaviour of the insurgents (e.g. hanging limbs in trees).

33.2. **In my view Sergeant Blackman displayed many of the characteristic symptoms of an adjustment disorder during HERRICK 14 and for a period afterwards. He described poor sleep which was supported by evidence from a number of the witnesses I interviewed. Whilst poor sleep can increase an individual's propensity to suffer with mental health problems, it can also be a consequence of someone suffering with mental health difficulties[11]. Sergeant Blackman also described a disturbance in his ability to concentrate; again this was supported by witnesses I interviewed. It is not possible to determine to what degree this disturbance in his concentration impaired his ability to function but it is notable that Mr Whitehead reported that at times Sergeant Blackman would appear not to be concentrating on what his team were saying to him. Sergeant Blackman also described that he was irritable during the tour which is not a usual characteristic personality trait for him. His irritability was evident during his interactions with his seniors (such as the stores Colour Sergeant) and he reported to me that he had been highly frustrated with his chain of command who, in his view, had failed to provide him and his team with adequate support during the tour. However, I am not aware of any evidence that he was ever rude or disobedient with those who were in command of him during HERRICK 14. It is however notable that the appraisal report that he received from his chain of command during HERRICK 14 was much less positive than those he had received before and those he received after the tour. The non-HERRICK 14 appraisal reports regularly described Sergeant Blackman's performance in superlative terms. His mediocre HERRICK 14 report may have resulted from the impact of the symptoms of his adjustment disorder (e.g. poor concentration and motivation) or it may have been that his commanders felt that his attitude towards them was not particularly respectful [because in fact he felt that they had let him and his team down]. Sergeant Blackman also described having frequent thoughts about being specifically targeted by the enemy which, whether or not they were based in fact, accentuated the stress that he was feeling and the threat that he perceived himself to be under.**

[11] My team at King's College London have just submitted a scientific paper on sleep and mental health in service personnel to a peer-reviewed journal; this paper shows that poor sleep is a consequence of poor mental health and a risk factor for the development of poor mental health.

These were described by Dr Orr as paranoid ideas and the Telemeter reported noted that Sergeant Blackman was likely to have experienced an increased stress reaction from being contacted on patrols, especially if he felt he was being specifically targeted. Sergeant Blackman also reported being more jumpy whilst in theatre as the tour progressed and also experiencing feelings of dread as he was about to lead a patrol which he knew he had to do as the welfare of the team depended on him remaining resolute and strong during the deployment. In spite of him also feeling as if he did not really care about how well his team carried out their duties as the tour progressed [he described that he had thought his team's mission was essential futile] he felt the need to try and appear strong in front of his team.

33.3. **A number of personnel I interviewed who had contact with Sergeant Blackman during his time on HERRICK 14 also reported that he had displayed emotions and behaviours that were consistent with him suffering from an adjustment disorder during the tour. Other personnel located at CP Omar reported that whilst he was never someone who was open with others about his emotions, as the tour progressed he became increasingly avoidant of other people. He was also noted to be irritable with people to whom he communicated on the radio net and he became increasingly irritable with the cat that the other personnel at the CP had adopted; his irritability with the cat got to the point that he wanted to get rid of it. As mentioned above he was also noted to be sleeping poorly by his tent partner. A number of the personnel at the CP noted that he appeared to be particularly affected (including being more jumpy subsequently) by the incident on 10th August 2011 in which he fortuitously avoided being seriously injured or killed in a grenade attack. Furthermore, when he met with Warrant Officer Wright, who was his friend, during R&R he appeared to behave very differently to how he did normally. Warrant Officer Wright, an experienced Royal Marine and a TRiM practitioner, described Sergeant Blackman [on R&R] as being vacant and a "*husk of his former self*". His wife also noticed that he continued to remain vigilant for non-existent threats during R&R (e.g. looking for signs of IEDs on a country walk in the UK). He and his wife also reported that his jumpiness was still present a few months after the tour when they had been in the USA on holiday and he had "*jumped under his seat*" whilst at the theatre in response to loud noises in the show.**

33.4. **His situation during HERRICK 14 was likely to have been especially challenging, from a psychological stressor viewpoint, as a result of a number of traumatic incidents in which he was directly involved. As mentioned above, the incident on 10th August 2011 in which he was lucky not to have been killed by grenades thrown at him seems to have been particularly difficult for him. During the tour he was also coming to terms with his father's death and relatively early on during the tour he had been upset by the death of members of his troop including his troop officer who was someone he very much respected. Additionally, whilst in my view he was becoming increasingly distressed as the tour progressed, he nonetheless altered his own behaviour to put himself at risk more often by going**

out on extra patrols in order that he could protect his juniors who had young children and who he felt would therefore be "*missed*" more than he would if they died. Thus in taking his responsibilities as a leader seriously he caused himself to face more challenging situations at a time when he was less able to deal with them.

33.5. **In my view it is hard to be specific about the onset of the adjustment disorder however there is good evidence that it was clearly present during his R&R in July 2011 as evidenced by the interview I had with Warrant Officer Wright [who had noticed that his friend unusually did not want to speak about what was happening on tour, appeared vacant and was "*a husk of his former self*"] and with Sergeant Blackman's wife [who had noticed her husband spending considerable time looking at the ground whilst on a country walk because he was looking for threats such as IEDs which were evidently not likely to be there]. After his R&R these symptoms persisted, and in all likelihood became more intense throughout the tour. The effects of the disorder then waned over the months after he returned home. For example his wife reported that he was highly jumpy a few months after returning home when they were at a theatre. However, his appraisal reports from the unit he worked at after HERRICK 14 were good suggesting he was performing well and was thus not likely to be significantly affected by a mental disorder at that time.**

33.6. **In my view the onset of the disorder was made more likely by a number of factors including Sergeant Blackman's grief reaction to the loss of his father, the relative lack of preparation for his deployment to Operation HERRICK 14, to a lesser degree his trepidation about returning to Afghanistan in the same role that he had been in previously in which he had been blown up and had had to "endure" six months of very challenging experiences. In my view the main precipitating stressors were the high level of threat he and his team faced, the persistently poor logistical resources he was provided with in spite of his requests for these to be improved, poor support in his view from his leaders and an inadequate number of personnel of whom he was wholly responsible for the safety, and for whom he cared for very much. As the tour went on he felt that whilst he and his men continued to do their duty their mission was in essence futile. I have summarised the salient evidence about why, in my opinion, Sergeant Blackman developed the adjustment disorder in Appendix A attached to this report.**

33.7. **The impact of his adjustment disorder would have been to make him less able to make properly judged decisions particularly ones which he was being asked to do in quick time with limited time to think through the consequences of his actions. It is notable that he was described in one of his appraisal reports as being a man who is capable of judging not just the direct impact of his behaviour but also second and third order impacts. It therefore seems to be somewhat unusual that he shot the insurgent in front of numerous witnesses; if he had been clearly intent on murdering the insurgent, as he has been found guilty of having done, then someone who is able to think about second and third order impacts should have**

been able to think more 'cunningly' about committing the murder than appears to have happened. In my view one of the effects of the adjustment disorder was to make him less inclined to care about what he did which is described in Dr Orr's report as being akin to 'burnout'. This is a term used to describe exhaustion, lack of enthusiasm and motivation, feelings of ineffectiveness which also may have the dimension of frustration or cynicism, and as a result reduced efficacy within the workplace[12]. In my view his poor state of mental health led to him experiencing many of the symptoms of burnout [which whilst a commonly used term is not a medical diagnosis]. Whilst burnout is not a diagnostic term, in essence I agree with Dr Orr's view that this descriptive label can be appropriately applied to Sergeant Blackman's state of mind during HERRICK 14.

33.8. **In my view his adjustment disorder would have made him less likely to pay due care and attention to possible signs of life in an individual who had clearly been seriously injured and whom he continues to report that he thought was dead at the time he shot him. In my view it was unfortunate that the Court Martial, by reason of having no psychiatric report before conviction, did not have the opportunity to consider the impact of his state of mind at the time of the killing in relation to his ability to judge whether the insurgent was truly dead or not. Whilst it is apparent that he did not particularly desire to help the injured insurgent, in my view it is more likely than not that his adjustment disorder would have significantly impacted on his assessment of whether the insurgent was alive or dead. The impact of the adjustment disorder is relevant to both how diligently he carried out the assessment as well as his competence to do so.**

33.9. **In my view the negative impact of the adjustment disorder is evident elsewhere during the incident as well. For instance the way that he asked his team about whether anyone wanted to give first aid to the insurgent was clearly weak and ambiguous which, with hindsight, he accepts was down to his poor leadership at that time. This approach to leading his troops is markedly different to way his appraisal reports describe his usual leadership style. For instance the appraisal he received from the unit he was with when he was arrested had stated that *"his briefings are clear and unambiguous"*. In my view, his behaviour on the day of the shooting clearly lacked the usual dynamic and inspirational leadership qualities which are consistently described in his non-HERRICK 14 appraisals. His non-HERRICK 14 appraisals consistently describe someone who strives to maintain very high professional standards of leadership. It is these very qualities which had led to him being so rapidly promoted during his military service and made it likely that he would have been further promoted had he remained in service.**

33.10. **In answering the specific questions put to me by Sergeant Blackman's legal team I reminded myself of the requirements of Section 2 of the Homicide Act 1957 as amended by s52 of Coroners and Justice Act 2009 which provides:**

---

[12] Ruotsalainen JH, Verbeek JH, Mariné A, Serra C (2014). "Preventing occupational stress in healthcare workers". *The Cochrane Database of Systematic Reviews* **12**: CD002892. doi:10.1002/14651858.CD002892.pub4. PMID 25482522.

Persons suffering from diminished responsibility:

(1) A person ("D") who kills or is a party to the killing of another is not to be convicted of murder if D was suffering from an abnormality of mental functioning which—

(a) arose from a recognised medical condition,

(b) substantially impaired D's ability to do one or more of the things mentioned in subsection (1A), and

(c) provides an explanation for D's acts and omissions in doing or being a party to the killing.

(1A) Those things are—

(a) to understand the nature of D's conduct;

(b) to form a rational judgment;

(c) to exercise self-control.

(1B) For the purposes of subsection (1)(c), an abnormality of mental functioning provides an explanation for D's conduct if it causes, or is a significant contributory factor in causing, D to carry out that conduct.

(2) On a charge of murder, it shall be for the defence to prove that the person charged is by virtue of this section not liable to be convicted of murder.

I note that the burden of proof is upon on Sergeant Blackman to prove this on the balance of probabilities.

33.11. **In my opinion, in relation to the shooting on the 15th September 2011, there is good evidence, as highlighted above, that Sergeant Blackman was suffering from an abnormality of mental functioning. It is my opinion that this abnormality of mental functioning arose from a recognised medical condition, which as described above, was an adjustment disorder. This is a medical condition described within the International Classification of Diseases Volume 10 (see Appendix C for the specific diagnostic criteria for this condition).**

33.12. **It is my opinion that, on the balance of probabilities, whilst the adjustment disorder did not impair Sergeant Blackman's ability to understand the nature of his conduct, it did substantially impair his ability to form a rational judgement about what he was going to do in the moments before he shot the insurgent. Whilst I discussed his rationale for the shooting with him at some length he was not able to form any clear view about why in fact he had shot the body of the dead insurgent. He felt, with hindsight, that he had done so out of anger and frustration at the ongoing, difficult and futile situation in which he and his team were operating in. Whilst he may of course have been hiding his true intentions from me when I interviewed him, having considered the various evidence documented in this report, it is my opinion that he had not formed any rational judgement about the shooting; instead he just acted and then regretted his decision immediately once he had carried out the shooting.**

33.13. **In my opinion, on the balance of probabilities, his abnormality of mental functioning, arising because of his adjustment disorder, substantially impaired his ability to exercise self-control at the time he shot the insurgent. In my view the adjustment disorder was a significant contributory factor to him failing to exercise self-control. It is evident that Sergeant Blackman had been highly disgruntled that the Apache attack had not killed the insurgent. It is notable that the Telemeter report commented that the finding of a grenade upon the insurgent when he was first searched may have been particularly distressing for Sergeant Blackman because of him having been nearly killed by the 10th August grenade attack. He was also upset that having discovered, during the initial examination of the insurgent, that he was still alive, he then had a duty, which he accepts he did not want to carry out, to provide first aid to the insurgent. It is my view that the adjustment disorder had affected his ability to clearly think about what he was required to do and what he actually did. At this point of the tour, he really did not care about maintaining high professional standards nor did he think through the impact of not behaving in a highly ethical manner [which British troops are required to do]. Instead, in my view, his ongoing frustration and anger 'got the better of him' and he failed to exercise control of his contempt for the insurgent and instead he shot him.**

33.14. **In my view, whilst it is ideal to carry out a mental state examination on an individual who has committed, or alleged to have committed, a crime as soon after the incident as is possible it is also feasible to gain an understanding of someone's mental state by asking the individual about their actions, and reasons for them, at a later date. It is quite usual that forensic psychiatric reports are compiled long after a possible crime has been committed. Clearly with the passage of time it becomes more difficult for individuals to remember specific details clearly but there will always be a delay of some sort before people are asked to provide formal statements. Thus whilst it is ideal to speak with the accused, and with witnesses, soon after a possible crime has been committed, not being able to do so is no barrier necessarily to forming a balanced view on an individual's state of mind at the time of an alleged offence. Furthermore, through examining evidence from witnesses [which in themselves will also be subject to recall difficulties and bias] and other sources of information [such as video or available written material] around the time of the offence, it is indeed possible to form a retrospective view of what someone's state of mind would have been like at the time of an alleged offence.**

33.15. **The new evidence available to me, which was not available to the Court Martial, results from a number of sources including from my interviews with various witnesses included in the body of this report and the medical files which I obtained and report on above. In my view this new evidence has allowed me to form a balanced view on Sergeant Blackman's mental state during HERRICK 14 and in particular at the time of the incident.**

33.16. **Additionally the information I was provided with from the Telemeter report was useful in confirming the austere nature of CP Omar which the report describes as having been perceived as being a 'heart of darkness'. The Telemeter report is also helpful in confirming that the quality of leadership experienced by the personnel at CP Omar was less than ideal by stating "leadership requirements appear to have come second to other necessities judged more pressing in the AO" [evidence of the impact of leadership on mental health is presented in Appendix A]. The Telemeter report also provides some support for Sergeant Blackman's explanation for why he wanted to move the injured insurgent away from the PGSS.**

33.17. **In my view, Sergeant Blackman's personality is one which does not lend itself to self-disclosure of emotional material or indeed to speaking openly about fears or concerns with those he worked with directly. His lack of openness has been commented on by other medical practitioners including Dr Orr and staff at Somerset NHS partnership trust and was also known to his wife and was noticed by those with whom he served at CP Omar. He had, for instance, previously withheld information from his wife about being blown up on HERRICK 7 and she had not been at all surprised to have only found out about that information fortuitously. Sergeant Blackman reported to me that he does not try and dwell on any difficulties he might be experiencing and indeed whilst he had acknowledged that he was experiencing a number of psychological symptoms during HERRICK 14 he did not consider that they were indicative of him suffering from a mental health disorder. As such he did not ask for any help at the time nor did he ask that the legal team on whom he relied during his trial should have paid particular attention to his mental health status.**

33.18. **I have also been asked to comment about Dr Orr's report which was prepared for sentencing purposes. Whilst the report does helpfully comment on Sergeant Blackman's exposure to a number of stressors prior to the killing (such as the various logistical frustrations he experienced during deployment, his grief and his feeling that the insurgents were out to get him) I am not clear that the report properly appreciated the stressors that Mr Blackman had been under whilst in command of CP Omar and the responsibility that fell to him as location commander. I also note that whilst Dr Orr used terms such as *"Combat Stress disorder"*[13] and *"Burnout"* these are not diagnostic terms; that is to say they do not appear in the International Classification of Diseases Volume 10. It may have been that if Dr Orr was asked to comment on whether he had considered that**

[13] I also note that the classification of combat and operational stress injuries to which Dr Orr's report refers, comes from the US Marine Corps Combat Operational Stress Guidance. Whilst this does have relevance to the way the US military provide support to their personnel, it has no direct relevance to how the Royal Marines, or indeed any other element of the British Armed Forces, are provided with mental health support or how UK clinicians who provide care for individuals who suffer with mental health problems would think about mental health problems in UK service personnel. The term Combat Stress disorder is not a diagnostic term, rather it is a descriptive label that, in US military settings at least, can be applied to troops who may be found to suffer from one of a number of medical conditions or indeed may be ordinarily distressed but not formally medically unwell.

Sergeant Blackman was suffering from an abnormality of mental functioning arising from a recognised medical condition at the time of the shooting he might have formed the view that Sergeant Blackman's symptoms were consistent with him having suffered from an adjustment disorder.

33.19. **I also note that Dr Orr did not have the opportunity to speak to the various witnesses I was able to, nor did he have access to the medical files I managed to obtain. Additionally Dr Orr had not been provided with information about how operational stress management is carried out in the UK Armed Forces (for instance the use of TRiM) and he did not appear to have had sight of any of Sergeant Blackman's annual appraisals. In my view, had Dr Orr had access to this information he might have been able to comment further on Sergeant Blackman's state of mind at the time he shot the insurgent.**

33.20. **One final matter which I consider of relevance is that a number of witnesses I spoke to commented on the negative impact of their deployment on HERRICK 14 on the mental health of the personnel located at CP Omar. One witness [Mr Rea] mentioned that, because of the tour, he had developed mental health difficulties himself and he knew of other team members who had also done so. Another [Mr Whitehead] mentioned that the tour had wrecked his marriage. The Telemeter report also stated that one of the Marines at CP Omar had apparently developed PTSD. Whilst is not in any way possible to confirm how many personnel based at CP Omar actually developed diagnosable mental health difficulties, there is considerable published evidence that Royal Marines are especially unlikely to suffer with significant mental health problems compared to most other troops who operate in an infantry role[14]. As such if it is true that a significant number of the personnel based at CP Omar did develop diagnosable mental health conditions, it would suggest that the pressures of working from that location were indeed exceptionally 'toxic' to mental health which is of relevance to the understanding of why Sergeant Blackman developed an adjustment disorder during HERRICK 14.**

Statement of Truth

I understand that my primary duty in preparing this report and giving evidence is to help the Court, and that this duty overrides any obligation to the party engaging me. I confirm I have complied with that duty and have endeavoured to be as objective as possible throughout and I will continue to do so.

I will notify those instructing me in writing immediately if for any reason prior to giving evidence my report requires any correction or qualification.

I confirm that where facts stated in my report are within my own knowledge I have made it clear, and where matters are not within my own knowledge I have made that clear also. The opinions I

[14] Sundin J, Jones N, Greenberg N, Rona RJ, Hotopf M, Wessely S, Fear NT. Mental health among commando, airborne and other UK infantry personnel. Occup Med (Lond). 2010 Sep 6

have expressed herein represent my true and complete professional opinions. Whenever I may not have been able to give my opinion without qualification I have stated that qualification.

I have no interest pecuniary or otherwise in the outcome of this case.

Professor Neil Greenberg
BSc (Hons) BM MMedSc MFMLM FHEA DOccMed MInstLM MEWI MFFLM MD FRCPsych
Consultant Psychiatrist and Specialist in Forensic Psychiatry
Approved under Section 12 (2) of the Mental Health Act 1983

Appendix A to Confidential Psychiatric Court Report dated 15th November 2015 by Professor Neil Greenberg – summary of the scientific evidence about psychological vulnerability on deployment.

In trying to understand why it might be that an experienced and previously highly regarded non-commissioned officer in the Royal Marines might become psychologically unwell, during Op HERRICK 14, it is important to take account of published scientific literature about how mental resilience is maintained during arduous deployments. There are a number of peer-reviewed scientific papers on this topic[15,16] and I will highlight the salient points below. Many of the references referred to in this Appendix are scientific papers that I have co-authored.

First, probably the most important mechanism that the military have for maintaining psychological resilience in the face of adversity is ensuring that the quality of leadership provided to deployed troops is well above average and ideally high to exceptional. Studies of UK personnel carried out in Afghanistan have shown that troops who perceive experiencing high quality leadership have around one tenth of the rate of traumatic stress problems compared to troops who report poor leadership[17]. The direct relationship between the perceived quality of leadership and mental health has also been demonstrated in many other studies of military forces carrying out arduous duties[18] many of which date back fifty or more years. Thus the link between poor leadership and poor mental health is very well established. This is important because, as referred to elsewhere in this report, there appears to be good evidence that the leadership experienced by Sergeant Blackman was far from ideal. As an example of this is Colonel (rtd) Oliver Lee's comments in his statement that "*At the heart of these factors is my view that the leadership and oversight of Sergeant Blackman from Lieutenant Colonel Murchison and Major Fisher was shockingly bad and directly causal to Sergeant Blackman's conduct.*" The Telemeter report extracts made available to me also commented on the less than ideal standard of leadership during the tour.

Good quality leadership is not only directly protective of troops' mental health but high quality leaders may be able to detect mental health problems in subordinates which they have otherwise managed to mask from their colleagues and subordinates. Troops in leadership positions, such as Sergeant Blackman during HERRICK 14, may well not discuss fears or concerns they have with their team because of they do not want to appear 'weak' in front of those with whom they are directly working.[19,20]. In my view had Sergeant Blackman had opportunities to sit down, face to face, with seniors he trusted then he might have spoken about his growing concerns about him being targeted by the insurgents. He may also have talked about some of his other out of character behaviours such as being more irritable than usual with people outside his immediate

[15] Macmanus D, Jones N, Wessely S, Fear NT, Jones E, Greenberg N. The mental health of the UK Armed Forces in the 21st century: resilience in the face of adversity. J R Army Med Corps. 2014 Feb 26
[16] Greenberg N, Jones E, Jones N, Fear NT and Wessely S. The injured mind in the UK Armed Forces. Phil. Trans. R. Soc. B January 27, 2011 366:261-267
[17] Jones N, Seddon R, Fear NT, McAllister P, Wessely S, Greenberg N. Leadership, Cohesion, Morale, and the Mental Health of UK Armed Forces in Afghanistan. Psychiatry 2012; 75 (1): 49-59
[18] Wessely,S. (2006) Twentieth-century Theories on Combat Motivation and Breakdown. Journal of Contemporary History, 41, 269-286.
[19] Larson, G.E., Highfill-McRoy, R.M., & Booth-Kewley, S. (2008). Psychiatric diagnoses in historic and contemporary military cohorts: combat deployment and the healthy warrior effect. *American Journal of Epidemiology, 167*(11), 1269-1276
[20] Gould M, Adler A, Zamorski M, Castro C, Hanily N, Steele N, Kearney S, Greenberg N. Do stigma and other perceived barriers to mental health care differ across Armed Forces? J R Soc 148 Med 2010: 103: 148–156

team. Commanders who had taken time to get to know his 'usual' character (which would have been available from previous appraisals) should have been able to detect 'out of character' behaviour which might have been indicative of deteriorating mental health.

Secondly, because of a growing understanding of the potential for exposure to traumatic experiences to impact upon mental health, in the late 1990's the Royal Marines established a process called TRiM (Trauma Risk Management) which is a way of delivering 'psychological first aid' (PFA; this term refers to a range of supportive tasks (e.g. listening, problem solving, mentoring etc) to personnel who have been exposed to highly traumatic situations. The TRiM process is delivered by non-medical staff (peers and/or more senior staff) called TRiM practitioners. Where PFA does not assist someone to cope with/recover from the traumatic exposure, a TRiM practitioner will assist that person to speak with an appropriately experienced person who can help them [such as a healthcare professional, mental health nurse, Padre, understanding senior person]. It is therefore, most unfortunate that Sergeant Blackman was not encouraged to speak with a TRiM practitioner at all during the whole of the HERRICK 14 tour. This view is supported by the Telemeter extracts. During my discussion with Colonel (rtd) Lee he told me that one of his team, with whom he visited the locations under his command, was TRiM trained. Therefore, during his regular (every two weeks) visits to locations which he commanded, the TRiM trained member of his team would be able to sit down with personnel who had been through especially difficult situations (such as for instance the incident on 10th August 2011 in which Sergeant Blackman and colleagues came under grenade attack) and assess the impact of such events on mental health. This contrasts starkly with what appears to have been the regime in J Coy 42 Commando and applicable to Sgt Blackman at the time.

One of the key aspects of TRiM is that it is purposefully proactive. There is considerable evidence that the majority of people (military or not) with mental health problems do not seek any help for them. Sergeant Blackman has never been a person who would ordinarily have sought emotional support on a day to day basis and the TRiM process is one way [alongside being asked appropriate questions by a credible and caring leader] of encouraging people to speak about events that have impacted upon them.

Thirdly, another important vulnerability factor is the death of Sergeant Blackman's father [which was somewhat unexpected] shortly before he deployed and the consequential scattering of his father's ashes during his R&R time. The death of a father would be expected to be a difficult time for anyone, but his father's illness and death came at a time when he was supposed to be preparing for deployment to a highly threatening environment. One consequence of the time he spent with his father before he died, and in attending the funeral, was to prevent him from being fully prepared for the tour from a practical viewpoint [which may well have raised his anxieties about how he would perform]. The lack of time with his team before deployment would also have disturbed him forming close bonds with the troops he was going to lead and, perhaps more importantly given the known impact of poor leadership on mental health, those who were going to be in command of him.

Furthermore, most people find that being able to talk about their loss with people they are close to [including friends and family] can be helpful but for Sergeant Blackman having these sorts of discussions would have been more difficult because of his need to prepare for the impending tour

and then him being away on the tour. As mentioned by many witnesses and also by mental health providers who have spent time with Sergeant Blackman, he does not 'open up' readily and thus was highly unlikely to discuss his grief with members of the unit that he had just joined. Additionally, whilst he was able to get on with his team at CP Omar, he had no regular access to anyone who was either not in command of or who was not command of to speak to informally. I understand that the Padre did not visit CP Omar which is again unfortunate since his was a role which could have been particularly useful in terms of talking about his grief. It is perhaps of relevance that the reason stated, in the Telemeter report, that the Padre did not visit CP Omar was that it was viewed as being too dangerous. I also note that it was Dr Orr's view that the scattering of his father's ashes during his mid-tour leave whilst potentially producing some helpful 'closure' also served to reactivate his symptoms of grief. Thus whilst grief in itself is not pathological it is another stressor which in my view added to Sergeant Blackman's vulnerability. Although there is no specific time limit for how long the normal distressing symptoms of grief go on for; six months to a year is quite 'normal'[21].

And lastly, it is worth noting that Sergeant Blackman was not merely someone who had been asked to serve in the arduous environment of a conflict zone; he was also required to be a leader. Whilst, as mentioned elsewhere in this report, he did not always display the highest standards of leadership [in my view this was to a great degree an effect of his adjustment disorder] he clearly cared about the safety and wellbeing of the team he led. There has been research carried out which suggests that the burden of leadership, in war zones, itself is an additional stressor[22] and given the high levels of threat faced by, in his view, the under-supported and under-resourced team he led it is likely that this too led to him being particularly vulnerable to developing mental health problems.

[21] Kleinman A. Culture, bereavement, and psychiatry. Lancet. Volume 379, No. 9816, p608–609, 18 February 2012
[22] Bourne PG, Rose RM and Mason JW. 17-OHCS Levels in Combat Special Forces "A" Team Under Threat of Attack. Arch Gen Psychiatry. 1968;19(2):135-140. doi:10.1001/archpsyc.1968.01740080007002

Appendix B: CV for Professor Neil Greenberg

Curriculum Vitae

Professor Neil Greenberg

BM, BSc(Hons), MMedSc, FHEA, DOccMed, MFMLM, MInstLM, MEWI, MD, MFFLM FRCPsych

Oct 2015

1. Personal Details

Current main work address:	King's College London. Weston Education Centre, Cutcombe Road. London. SE5 9RJ.
Telephone:	Work: 0207 848 5351 Mobile: 07775 677859
Email:	neil.greenberg@kcl.ac.uk
Date of Birth:	06 December 1968
National Insurance No:	NR627558C
Defence Society:	A&M Insurance (MedSurance) No: MSD01087860
General Medical Council	Full Registration. On specialist register for Adult, Forensic & Liaison Psychiatry No: 4020682
Section 12(2) Approval	Until 12 Jan 2020
Member of the Faculty of Medical Leadership and Management	Since 2011
Member of Faculty of Forensic & Legal Medicine	Since 2009
Member of the Expert Witness Institute	Since 2004
Member of the Institute of Leadership and Management	Since 2015
Fellow of the Higher Education Academy	Since 2000
Fellow of the Royal College of Psychiatrists	Since 2011 (Member since 1999)
President of the UK Psychological Trauma Society	Since April 2014
Royal College of Psychiatrist's lead on Military And Veterans Health	Since July 2013

2. Education

Atholl Grammar School, London	1980-1985
Lowlands Sixth form College, London	1985-1987
Southampton Medical School	1987-1993
Leeds University (part time)	1997-2001
London University (part time)	2003-2008

3. Qualifications

BSc. 1st Class Honours in Biomedical Sciences	Southampton University, 1992
BM. Medical Degree	Southampton University, 1993
MRCPsych.	Royal College of Psychiatrists, 1999
MMedSc. (with merit) in Psychiatry	Leeds University, 2001
Certificate in Psychopharmacology.	Br. Ass. Psychopharmacology, 2002
DOccMed.	Fac Occupational Med, 2004
MD.	London University, 2008
MFFLM	Fac Forensic & Legal Med, 2009

MFMLM Fac Med Ldership & Mangmnt 2011

4. Career

07.2013 – current *Professor of Defence Mental Health at King's College London and Independent Clinical Practice*
Since leaving the Armed Forces I have taken up the post of Professor of Defence Mental Health at King's College London. I work as part of a military health research team but also have roles in supervising crisis management (as it relates to mental health) studies too. I also run March on Stress Ltd which is a traumatic stress consultancy and training organisation and provide a range of occupational, clinical and forensic mental health reports and case management through an allied company called Psych Health Solutions Ltd.

I also provide mental health advice to a variety of government organisations. I am the President of the UK Psychological Trauma Society (UKPTS) and have previously been the secretary of the European Society for Traumatic Stress Studies (ESTSS). I am also one of the board members of the Royal College of Psychiatrist's occupational mental health special interest group. I regularly present at national and international conferences on matters relating to military and occupational mental health and organisational management of traumatic situations. I am also the Royal College of Psychiatrists Lead on Military and Veterans Health. My role is therefore one of strategic influence allied to directing academic research and clinical activity focused on occupational mental health and the psychological management of traumatic stress.

12.2009 – 07.2013 *Co-Director – Academic Centre for Defence Mental Health and Defence Professor of Mental Health*
I was the Defence Professor of Mental Health. I coordinated and supervised the mental health research strategy for the United Kingdom Armed Forces. Much of the department's research focused on the effects of exposure to workplace trauma, occupational mental health impacts/outcomes and social psychiatry (stigma, social support etc) and my research efforts spanned a wide range of occupational groups including the military, media professionals, emergency services and security contractors. This busy role necessitated a highly flexible and responsible style of working. I co-directed the Academic Centre for Defence Mental Health (ACDMH) which is the UK Armed Forces in-house mental health research facility. My role spanned the personnel and health domains of MOD for all matters relating to mental health particularly that related to information gathering, research, occupational mental health and strategic direction. My ACDMH role required a range of skills including personnel and financial management, research and education. In 2010, I also took up the additional role of Consultant Advisor in Psychiatry to the Medical Director General (Naval) which is the head of the Royal Navy mental health cadre which is an occupational mental health service. This role also carries a significant personnel management burden but also involves wide liaison within the Royal Navy in support of improving the mental health of service personnel and their families.

I also provide mental health advice to a variety of government organisations. I was a board member of the UK Psychological Trauma Society (UKPTS) and have previously been the secretary of the European Society for Traumatic Stress Studies (ESTSS). I am also one of the board members of the Royal College of Psychiatrist's occupational mental health special interest

group. I regularly present at national and international conferences on matters relating to military and occupational mental health and organisational management of traumatic situations. My role is therefore one of strategic influence allied to directing academic research and clinical activity focused on occupational mental health and the psychological management of traumatic stress.

5.2007-12.2009 *Departmental Lead and Senior Lecturer in Military Psychiatry*
I worked as the uniformed lead for mental health research for the UK Armed Forces and the Forensic and General Consultant Psychiatrist for the Royal Navy. In the absence of a military professor, I led the military multidisciplinary research team at King's College London at the Academic Centre for Defence Mental Health; I also provided clinical sessions (mental health) for service personnel in two naval bases as well as dealing with the majority of the forensic cases for the Royal Navy. I was the principal investigator for two randomised controlled trials of mental health interventions in the UK Armed Forces as well as providing specialist mental health advice and training for the United Kingdom Special Forces and numerous governmental agencies including the Foreign and Commonwealth Office.

5.2005-5.2007 *Consultant in Psychiatry/Honorary Senior Lecturer in Military Psychiatry*
I ran a department of community mental health with 25 staff from a variety of professional backgrounds (including medical and nursing staff). My day to day work involved seeing a wide variety of psychiatric patients as well as being a clinical manager and the head of department. I was also an Honorary Senior Lecturer at the Institute of Psychiatry in London. I actively engaged in numerous research projects, including setting up a Randomised Controlled Trial examining the use of a novel system of post incident management for use within organisations.

8.2000-5.2005 Specialist Registrar Posts in General, Forensic and Liaison Psychiatry
These posts were all higher specialist training posts and were based in the South West (Dawlish), London and Portsmouth. These posts provided me with plenty of clinical management experience leading multidisciplinary teams caring for a wide variety of psychiatric patients including those with impulsive and aggressive tendencies. I have gained extensive experience of giving evidence at tribunals and in Courts. I also attended units which dealt with adolescents with behavioural difficulties and offenders who had mild learning disabilities. I provided an occupational mental health service both to the military but also to a NHS occupational health unit.

Outside of my mainstream clinical work, I led a team of military personnel to the South Pacific to provide psychological support to the crew of a badly damaged warship. I also provided psychological support and advice to UK nationals after a number of major, international terrorist attacks including travelling to New York after the 9/11 and Bali after the 2002 bombings. I also helped the Foreign Office to learn lessons from the Istanbul bombings of 2003 and have provided them with both training and advice in relation to psychological trauma since 2002. I also have assisted the London Ambulance Service in the aftermath of the 2005 July bombings in London.

General professional medical training *Senior House Officer Grade*
8.1997 - 7.2000 North Yorkshire Psychiatric Training Scheme

1994-1997 Royal Navy Medical Officer - Ships, Submarines and Royal Marines
During my general duties time I worked as a medical officer in Warships, submarines and with the Royal Marines. I gained my green beret, arctic warfare qualification and my submarine qualification. I spent extensive periods away providing medical care for large numbers of service men and civilians attached to our units (e.g. Royal Fleet Auxiliary staff). I frequently led medical and non-medical teams, making managerial and medical decisions independently was required, often in adverse climatic conditions away from easy access to supervision and support.

1993-1994 Professorial PRHO Posts Haslar & Royal Bournemouth Hospitals

5. Continuing Professional Development

I have remained up to date with my continuing professional development and am in good standing with the Royal College of Psychiatrists in that respect. I have attended and completed a range of psychotherapy skills courses (including Brief Solution Focussed Therapy Course in 2002, level 1/2 EMDR course in 2003, CBT training at King's College London 2003-2005; CBT refresher course 2013) as well as psychometric assessment courses (including Hare Psychopathy Checklist Revised (PCL-R) course in 2002, Historical, Clinical, Risk Management-20 (HCR-20) course in 2005) and completed medical appraiser accreditation in 2006 and 2012. I have also completed an ASIST suicide intervention skills course in 2009. Additionally I have regularly attended national and international meetings about occupational mental health, traumatic stress and military mental health matters including the ISTSS and ESTSS meetings.

6. Management experience

I have extensive experience of leading teams, in support of psychological health needs, in hostile environments as well as teams of researchers and running my own company (March on Stress – see above). I have also provided supervision and management advice to medical and nursing staff both in hospitals, community medical centres and in field conditions. Within the services my credentials, in terms of management legitimacy, was enhanced by gaining my Green Beret (commando training) and Dolphins (submariner qualification).

I have attended, been a member of and led a wide variety of local, national and international committees including setting up the Armed Forces Mental Healthcare Faculty in 2009 and chairing the UK Psychological Trauma Society board meetings as President. I have been involved in Service Development of both military and non-military protocols. Attendance at these committees, working groups and steering groups has allowed me to observe, participate and lead discussions which have led to the development of policy for both NHS and military organisations. I am a trustee/independent director of a number of military charities and lead the Royal College of Psychiatrist's in terms of military and Veteran's health.

I have also provided operational mental health supervision for operational military personnel by travelling to Afghanistan and liaising with medical and command personnel in theatre and conducting research in situ.

7. Teaching/Lecturing Experience

Military
As a Royal Naval Medical Officer I trained a wide range of military personnel including medical and non-medical staff on aspects of both psychological and emergency medical care. I regularly presented to numerous high ranking officers, ministers and Royalty in relation to mental health matters and have been a key advisor in the development of UK military policy on operational stress management.

Psychiatric
During my day to day work I have taught medical and allied health professionals about all elements of psychological health. I have regularly supervised the clinical work of both junior doctors and mental health nurses. I present on a number of Master's courses at King's College London and provide input to the military health special study module for medical students at King's College London. I regularly speak at mental health conferences about military mental health, organisational mental health and traumatic stress.

Higher Degree Supervisor/Assessor Experience
I have regularly supervised DClinPsych, and MSc, MDRes and PhD students. All the students I have supervised over the past ten years have completed their higher degrees on time and complied with the relevant trainee course requirements (eg. completion of monitoring forms). I have also been an examiner for PhD and MD students. I have previously been an examiner for the Diploma in Medical Care in Catastrophes.

Traumatic Stress
I helped develop the Armed Forces critical incident stress management package (TRiM – Trauma Risk Management). As Managing Director of March on Stress Ltd, I have been privileged to provide training for many trauma-exposed organisations including the Foreign and Commonwealth Office, various Police, Fire and Ambulance services, the BBC and other non-military organisations. I have lectured on this subject on numerous occasions nationally and internationally including at conferences organised by the International Society for Traumatic Stress Studies, the European Society for Traumatic Stress Studies and the UK Psychological Trauma Society.

Practical Organisational Traumatic Stress Management
I have garnered extensive experience in the management of psychological trauma since 1997. I have facilitated the post incident psychological management strategy for the Foreign and Commonwealth office both in the aftermath of 11th September 2001 and in Bali 2002. I lead a team of 4 military personnel to provide psychological support for HMS NOTTINGHAM, which grounded off the coast of Australia in 2002. As such I have developed both a theoretical understanding of psychological trauma and a practical "hands on" approach to post incident management. I have also advised the London Ambulance Service after the 2005 July bombings and assisted central government and commercial companies in dealing with personnel who have been detained as hostages. In 2013 I also provided direct assistance to a major oil company in the aftermath of the In Amenas incident.

I have advised numerous other organisations in how best to respond to specific traumatic events including the London Ambulance Service, Department for International Development, the British Council and various companies that operate staff in high threat areas including the BBC. I have also assisted in planning for and managing the psychological aspects of the repatriation of hostages for a variety of organisations and have undertaken specific training in counter-interrogation methods whilst in the military. I have also assisted some elements of the UK police and Foreign and Commonwealth Office develop their post-captivity psychological management plan. I am also a medical advisor for Hostage UK. More recently, I have been a key psychological health advisor for a number of large media organisations going through crises related to traumatic experiences and other periods of significant change.

8. Medico-legal/Forensic experience

I have carried out a wide range of medico-legal assessments for more than 10 years. These have included compiling more than 50 reports per year covering cases involving criminal charges as well as a large number of civil reports detailing whether individuals who have been exposed to traumatic stress in the course of their work have developed psychological injuries or not. I have worked for a range of companies based in the UK, and other nations, in compiling occupational mental health reports (including Australian emergency services and private security companies including maritime security companies) which have been used to both direct treatment and to aide in decision making in complex cases of causation and psychiatric disablement. I am a member of the UK Expert Witness Institute and a Member of the Faculty of Forensic and Legal Medicine.

9 Publications

Research Published

1. Banwell E, Greenberg N, Smith P, Jones N and Fertout M. What happens to the mental health of UK service personnel after they return home from Afghanistan? J R Army Med Corps. 2015 Oct 27. pii: jramc-2015-000425. doi: 10.1136/jramc-2015-000425. [Epub ahead of print]
2. Sage CA, Brooks SK, Jones N, Greenberg N. Attitudes towards mental health and help-seeking in railway workers. Occup Med (Lond). 2015 Oct 8. pii: kqv165. [Epub ahead of print] PubMed PMID: 26449493.
3. Brooks SK, Dunn R, Sage CA, Amlôt R, Greenberg N, Rubin GJ. Risk and resilience factors affecting the psychological wellbeing of individuals deployed in humanitarian relief roles after a disaster. J Ment Health. 2015 Oct 9:1-29. [Epub ahead of print] PubMed PMID: 26452755.
4. Thandi G, Sundin J, Knight T, Jones M, Hull L, Jones N, Greenberg N, Rona RJ, Wessely S, Fear NT. Alcohol misuse in the United Kingdom Armed Forces: A longitudinal study. Drug Alcohol Depend. (2015), http://dx.doi.org/10.1016/j.drugalcdep.2015.08.033
5. Sheriff RJ, Forbes HJ, Wessely SC, Greenberg N, Jones N, Fertout

M, Harrison K, Fear NT.Risky driving among UK regular armed forces personnel: changes over time. BMJ Open. 2015 Sep 23;5(9):e008434. doi: 10.1136/bmjopen-2015-008434.
6. Jones N and Greenberg N. The use of Threshold Assessment Grid triage (TAG-triage) in mental health assessment.J R Army Med Corps. 2015 Sep 18. pii: jramc-2015-000447. doi:10.1136/jramc-2015-000447. [Epub ahead of print]
7. Jones N, Keeling M, Thandi G, Greenberg N.Stigmatisation, perceived barriers to care, help seeking and the mental health of British Military personnel. Soc Psychiatry Psychiatr Epidemiol. 2015 Sep 15. [Epub ahead of print]
8. Whybrow D, Jones N, Evans C, Minshall D, Smith S and Greenberg N. The mental health of deployed UK maritime forces. Occup Environ Med doi:10.1136/oemed-2015-102961
9. Thandi G, Sundin J, Dandeker C, Jones N, Greenberg N, Wessely S, Fear NT. Risk-taking behaviours among UK military reservists. Occup Med (Lond). 2015 Jul;65(5):413-6. doi: 10.1093/occmed/kqv057
10. Dunn R, Brooks S, Rubin J and Greenberg N. Psychological impact of traumatic events: Guidance for trauma-exposed organisations. Occupational Health at Work 2015; 12(1): 17–21
11. Greenberg Neil; Brooks Samantha; Dunn Rebecca. Latest developments in post-traumatic stress disorder: diagnosis and treatment. British Medical Bulletin 2015;doi: 10.1093/bmb/ldv014
12. Whybrow D, Jones N and Greenberg N. Promoting organizational well-being: a comprehensive review of Trauma Risk Management. Occupational Medicine 2015; doi: 10.1093/occmed/kqv024
13. Greenberg, N., 2015. Military and Disaster Psychiatry. In: James D. Wright (editor-in-chief), International Encyclopedia of the Social & Behavioral Sciences, 2nd edition, Vol 15. Oxford: Elsevier. pp. 495–500.
14. Gould M, Meek D, Gibbs T, Sawford H, Wessely S, Greenberg N. What are the psychological effects of delivering and receiving "high-risk" survival resistance training? Mil Med. 2015 Feb;180(2):168-77
15. Sharp ML, Fear NT, Rona RJ, Wessely S, Greenberg N, Jones N, Goodwin L. Stigma as a Barrier to Seeking Health Care Among Military Personnel With Mental Health Problems. Epidemiol Rev. 2015 Jan 16. pii: mxu012. [Epub ahead of print]
16. Greenberg N, Wessely S and Wykes T. Potential mental health consequences for workers in the Ebola regions of West Africa – a lesson for all challenging environments. J Ment Health, 2015; 24(1): 1–3.
17. Bakhshi S, Lynn-Nicholson R, Jones B, Amlôt R, Greenberg N, Rubin GJ. Responding to a Radiological Crisis: Experiences of British Foreign Office Staff in Japan After the Fukushima Nuclear Meltdown. Disaster Med Public Health Prep. 2014 Oct 10:1-7. [Epub ahead of print]
18. Dunn R, Williams R, Kemp V, Patel D, Greenberg N. Systematic review: deployment length and the mental health of diplomats. Occup Med (Lond). 2014 Oct 18. pii: kqu142. [Epub ahead of print]
19. Greenberg N. What's so special about military veterans? International Psychiatry: 11;2;79-80. 2014

20. Burdett H, Greenberg N, Fear NT and Jones N. The mental health of military veterans in the UK. International Psychiatry: 11;4;86-87. 2014
21. Bergman BP, Burdett HJ & Greenberg N. Service Life and Beyond – Institution or Culture? RUSI Journal. Published online: 04 Nov 2014.
22. Parsloe L, Jones N, Fertout M, Luzon O, Greenberg N. Rest and recuperation in the UK Armed Forces Occupational Medicine 2014;doi:10.1093/occmed/kqu119
23. Vermetten E, Greenberg N, Boeschoten MA, Delahaije R, Jetly R, Castro CA and McFarlane AC. Deployment-related mental health support: comparative analysis of NATO and allied ISAF partners. European Journal of Psychotraumatology 2014, 5: 23732 - http://dx.doi.org/10.3402/ejpt.v5.23732.
24. Hunt EJF, Wessely S, Jones N, Rona RJ and Greenberg N. The mental health of the UK Armed Forces: where facts meet fiction. European Journal of Psychotraumatology 2014, 5: 23617.
25. Jones N, Fear NT, Rona R, Fertout M, Thandi G, Wessely S, Greenberg N. Mild traumatic brain injury (mTBI) among UK military personnel whilst deployed in Afghanistan in 2011. Brain Inj. 2014;28(7):896-9.
26. Macmanus D, Jones N, Wessely S, Fear NT, Jones E, Greenberg N. The mental health of the UK Armed Forces in the 21st century: resilience in the face of adversity. J R Army Med Corps. 2014 Feb 26. doi: 10.1136/jramc-2013-000213. [Epub ahead of print] PubMed PMID: 24574105.
27. Jones N, Twardzicki M, Ryan J, Jackson T, Fertout M, Henderson C and Greenberg N. Modifying attitudes to mental health using comedy as a delivery medium. Social Psychiatry and Psychiatric Epidemiology. April 2014
28. Sundin J, Herrell RK, Hoge CW, Fear NT, Adler AB, Greenberg N, Riviere LA, Thomas JL, Wessely S, Bliese PD. Mental health outcomes in US and UK military personnel returning from Iraq. Br J Psychiatry. 2014 Mar;204:200-7. doi: 10.1192/bjp.bp.113.129569. Epub 2014 Jan 16.
29. Debell F, Fear NT, Head M, Batt-Rawden S, Greenberg N, Wessely S, Goodwin L. A systematic review of the comorbidity between PTSD and alcohol misuse. Social Psychiatry and Psychiatric Epidemiology. March 2014
30. Murphy D, Hunt E, Luzon O, Greenberg N. Exploring positive pathways to care for members of the UK Armed Forces receiving treatment for PTSD: a qualitative study. European Journal of Psychotraumatology 2014, 5: 21759 http://dx.doi.org/10.3402/ejpt.v5.21759
31. Jones N, Thandi G, Fear NT, Wessely S, Greenberg N. The psychological effects of improvised explosive devices (IEDs) on UK military personnel in Afghanistan. Occup Environ Med. 2014 Jan 16. doi: 10.1136/oemed-2013-101903
32. Borschmann R, Greenberg N, Jones N, Henderson RC. Campaigns to reduce mental illness stigma in Europe: a scoping review. Die Psychiatrie 2014 11 1: 43-50
33. Jones N, Mitchell P, Clack J, Fertout M, Fear NT, Wessely S, Greenberg N. Mental health and psychological support in UK armed forces personnel deployed to Afghanistan in 2010 and 2011. Br J Psychiatry. 2014 Feb;204:157-62. doi: 10.1192/bjp.bp.113.131433
34. Hunt E, Jones N, Hastings V and Greenberg N. TRiM: an organizational response to traumatic events in Cumbria Constabulary. Occup Med (Lond) 2013 Dec;63(8):549-55.

35. Forbes HJ, Boyd CF, Jones N, Greenberg N, Jones E, Wessely S, Iversen AC, Fear NT. Attitudes to mental illness in the U.K. military: a comparison with the general population. Mil Med. 2013 Sep;178(9):957-65. doi: 10.7205/MILMED-D-12-00436
36. Aguirre M, Greenberg N, Sharpley J, Simpson R, Wall C. Alcohol consumption in the UK armed forces: are we drinking too much? J R Army Med Corps. 2013 Jun 17. doi: 10.1136/jramc-2013-000059. [Epub ahead of print]
37. MacManus D, Dean K, Jones M, Rona R, Greenberg N, Wessely S, Fear N. Violent offending by UK veterans - Authors' reply. Lancet. 2013 Jun 29;381(9885):2252. doi: 10.1016/S0140-6736(13)61480-4.
38. Jones N, Twardzicki M, Fertout M, Jackson T, Greenberg N (2013) Mental Health, Stigmatising Beliefs, Barriers to Care and Help-Seeking in a Non-Deployed Sample of UK Army Personnel. J Psychol Psychother 3: 129. doi: 10.4172/2161-0487.1000129
39. Greenberg N. Fostering Resilience Across the Deployment Cycle. In Building psychological resilience in military personnel : theory and practice. Authors: Robert R Sinclair; Thomas W Britt. American Psychological Association. 2013.
40. Osório C, Jones N, Fertout M, Greenberg N. Changes in stigma and barriers to care over time in UK Armed forces deployed to Afghanistan and Iraq between 2008 and 2011. Mil Med. 2013 Aug;178(8):846-53. doi: 10.7205/MILMED-D-13-00079.
41. Jones N, Fertout M, Parsloe L, Greenberg N. An evaluation of the psychological impact of operational rest and recuperation in United Kingdom Armed Forces personnel: a post-intervention survey. J R Soc Med. 2013 Jul 3. [Epub ahead of print]
42. Greenberg N. Stress and war: the limits of neuropsychiatry. J Neurol Neurosurg Psychiatry. 2013 Sep;84(9):e1. doi: 10.1136/jnnp-2013-306103.6.
43. Hicks T, Banks R, Fear NT, and Greenberg N. Acceptability of anxiety management within UK armed forces. Occup Med (Lond) (2013) 63 (6): 439-441 doi:10.1093/occmed/kqt083
44. Aguirre M, Greenberg N, Sharpley J, Simpson R & Wall C. A pilot study of an Enhanced Mental Health Assessment during routine and discharge medicals in the British Armed Forces. J R Army Med Corps 2013;0:1–5. doi:10.1136/jramc-2013-000058
45. Foran HM, Garber BG, Zamorski MA, Wray M, Mulligan K, Greenberg N, Castro CA, Adler AB. Postdeployment military mental health training: Cross-national evaluations. Psychol Serv. 2013 May;10(2):152-60. doi: 10.1037/a0032609.
46. Wesson M, Whybrow D, Gould M, Greenberg N. An Initial Evaluation of the Clinical and Fitness for Work Outcomes of a Military Group Behavioural Activation Programme. Behav Cogn Psychother. 2013 May 29:1-5.
47. MacManus D, Dean K, Jones M, Rona RJ, Greenberg N, Hull L, Fahy T, Wessely S, Fear NT. Violent offending by UK military personnel deployed to Iraq and Afghanistan: a data linkage cohort study. The Lancet, Volume 381, Issue 9870, Pages 907 - 917, 16 March 2013.
48. Wesson MI, Whybrow D, Greenberg N, Gould M. Clinical supervision in a UK military Department of Community Mental Health J R Army Med Corps. Published Online First: May 28, 2013 doi:10.1136/jramc-2013-000079
49. van Hoorn LA, Jones N, Busuttil W, Fear NT, Wessely S, Hunt E, Greenberg N. Iraq and Afghanistan veteran presentations to combat stress, since 2003. Occup Med (Lond). 2013 Apr;63(3):238-41. doi: 10.1093/occmed/kqt017. Epub 2013 Mar 11.

50. Jones N, Jones M, Fear NT, Fertout M, Wessely S & Greenberg N. Can mental health and readjustment be improved in UK military personnel by a brief period of structured post deployment rest (third location decompression)? Occup Environ Med 2013;0:17. doi:10.1136/oemed-2012-101229
51. Keeling M, Knight T, Sharp D, Fertout M, Greenberg N, Chesnokov M &Rona RJ. Contrasting beliefs about screening for mental disorders among UK military personnel returning from deployment to Afghanistan. J Med Screen 2012:16 DOI: 10.1258/jms.2012.012054
52. Heron R and Greenberg N. Occupational Mental Health in "Fitness for Work: The Medical Aspects" 5th Edition edited by Keith Palmer, Ian Brown and Jon Hobson. Faculty of Occupational Medicine. 2013
53. Whybrow D, Jones N & Greenberg N. Corporate Knowledge of Psychiatric Services Available in a Combat Zone . Military Medicine, 178, 2:e241, 201
54. Hatch SL, Harvey S, Dandeker C, Burdett H, Greenberg N, Fear NT & Wessely S. Life in and after the Armed Forces: social networks and mental health in the UK military Sociology of Health & Illness Vol No ; doi: 10.1111/1467-9566.1202
55. Harvey SB, Hatch SL, Jones M, Hull L, Jones N, Greenberg N, Dandeker C, Fear NT, Wessely S. The long-term consequences of military deployment: a 5-year cohort study of United kingdom reservists deployed to iraq in 2003. Am J Epidemiol. 2012 Dec 15;176(12):1177-84. doi: 10.1093/aje/kws248. Epub 2012 Nov 27. PubMed PMID: 23186749.
56. Fear NT, Seddon R, Jones N, Greenberg N, Wessely S. Does anonymity increase the reporting of mental health symptoms? BMC Public Health. 2012 Sep 17;12:797. doi: 10.1186/1471-2458-12-797. PubMed PMID: 22985427; PubMed Central PMCID: PMC3532328.
57. Rubin GJ, Amlôt R, Wessely S, Greenberg N. Anxiety, distress and anger among British nationals in Japan following the Fukushima nuclear accident. Br J Psychiatry. 2012 Nov;201(5):400-7. doi: 10.1192/bjp.bp.112.111575. Epub 2012 Sep 20. PubMed PMID: 22995630.
58. Forbes J Harriet, Jones Norman, Woodhead Charlotte, Greenberg Neil, Harrison Kate, White Sandra, Wessely Simon, Fear T Nicola. What are the effects of having an illness or injury whilst deployed on post deployment mental health? A population based record linkage study of UK Army personnel who have served in Iraq or Afghanistan. BMC Psychiatry.2012, 12:178. DOI: 10.1186/1471-244X-12-178
59. Sundin, J.; Fear, N. T.; Greenberg, N.; Riviere, L.; Herrell, R.; Adler, A.; Hoge, C.; Bliese, P.; Wessely, S. A Comparative Analysis Of Deployment Associated Mental Health Issues In United States And United Kingdom Armed Forces. In: Journal of Epidemiology and Community Health, Vol. 66, No. Suppl. 1, 09.2012, p. A8.
60. Osório C, Jones N, Fertout M, Greenberg N. Perceptions of stigma and barriers to care among UK military personnel deployed to Afghanistan and Iraq. Anxiety Stress Coping. 2013 Sep;26(5):539-57
61. Messenger K, Farquharson L, Stallworthy P, Cawkill P, Greenberg N. The experiences of security industry contractors working in iraq: an interpretative phenomenological analysis. J Occup Environ Med. 2012 Jul;54(7):859-67. PubMed PMID: 22796932.

62. Sundin J, Mulligan K, Henry S, Hull L, Jones N, Greenberg N, Wessely S, Fear NT. Impact on mental health of deploying as an individual augmentee in the UK Armed Forces. Mil Med. 2012 May;177(5):511-6. PubMed PMID: 22645876.
63. Mulligan K, Jones N, Davies M, McAllister P, Fear NT, Wessely S, Greenberg N. Effects of home on the mental health of British forces serving in Iraq and Afghanistan. Br J Psychiatry. 2012 Apr 26. [Epub ahead of print] PubMed PMID: 22539778.
64. Jones N, Seddon R, Fear NT, McAllister P, Wessely S, Greenberg N. Leadership, Cohesion, Morale, and the Mental Health of UK Armed Forces in Afghanistan. Psychiatry 2012; 75 (1): 49-59
65. Creamer MC, Varker T, Bisson J, Darte K, Greenberg N, Lau W, Moreton G, O'Donnell M, Richardson D, Ruzek J, Watson P, Forbes D. Guidelines for Peer Support in High-Risk Organizations: An International Consensus Study Using the Delphi Method. Journal of Traumatic Stress 2012; 25: 134141
66. Browne, T; Evangeli, M; Greenberg, N. Trauma-Related Guilt and Posttraumatic Stress Among Journalists. Journal of Traumatic Stress 2012; 25: 207-210
67. Buckman, E.J; Forbes, E.J; Clayton, T; Jones, M; Jones, N; Greenberg, N. Early Service leavers: a study of the factors associated with premature separation from the UK Armed Forces and the mental health of those that leave early. European Journal of Public Health 2012: doi:10.1093/eurpub/cks042
68. Mulligan, Kathleen; Fear, Nicola T.; Jones, Norman; Alvarez, Helen; Hull, Lisa; Naumann, Ulrike; Wessely, Simon; Greenberg, Neil. Post deployment Battlemind Training for the U.K. Armed Forces: A Cluster Randomized Controlled Trial. Journal of Consulting and Clinical Psychology, Mar 12 , 2012, 331-341. doi: 10.1037/a0027664
69. Rona RJ, Jones M, Fear NT, Hull L, Murphy D, Machell L, Coker B, Iversen AC, Jones N, David AS, Greenberg N, Hotopf M, Wessely S. Mild traumatic brain injury in UK military personnel returning from Afghanistan and Iraq: cohort and cross-sectional analyses. J Head Trauma Rehabil. 2012 Jan-Feb;27(1):33-44. doi: 10.1097/HTR.0b013e318212f814. PubMed PMID: 22241066.
70. Fertout M, Jones N, Greenberg N. Third location decompression for individual augmentees after a military deployment. Occup Med (Lond). 2012 Jan 12. [Epub ahead of print] PubMed PMID: 22247240.
71. Seddon, Rachel L; Jones, Edgar; Greenberg, Neil. Military Medicine, Volume 176, Number 12, December 2011, pp. 1357-1361(5)
72. Forbes, H. J., Jones, N., Woodhead, C., Greenberg, N., Harrison, K., White, S. Does attending an emergency department whilst deployed in Iraq or Afghanistan impact on the mental health of UK army personnel? 2011 Occupational and Environmental Medicine,Vol. 68, A99-A99
73. Harvey SB, Hatch SL, Jones M, Hull L, Jones N, Greenberg N, Dandeker C, Fear NT, Wessely S.Coming home: social functioning and the mental health of UK Reservists on return from deployment to Iraq or Afghanistan. Ann Epidemiol. 2011 Sep;21(9):666-72. Epub 2011 Jul 7.
74. McAllister P, Greenberg N and Henderson M. Occupational psychiatry in the armed forces: should depressed soldiers carry guns? APT 2011, 17:350-356.doi: 10.1192/apt.bp.107.004630

75. Pinder RJ*, Greenberg N*, Boyko EJ, Gackstetter GD, Hooper TI, Murphy D, Ryan MA, Smith B, Smith TC, Wells TS, Wessely S. Profile of two cohorts: UK and US prospective studies of military health. Int J Epidemiol. 2011 Jun 29. [Epub ahead of print]
76. Greenberg N, Langston V, Iversen AC, Wessely S. The acceptability of Trauma Risk Management within the UK Armed Forces. Occupational Medicine 2011; doi:10.1093/occmed/kqr022
77. Rona, Roberto J.; Jones, Margaret; Fear, Nicola T.; Hull, Lisa; Murphy, Dominic; Machell, Louise; Coker, Bolaji; Iversen, Amy C.; Jones, Norman; David, Anthony S.; Greenberg, Neil; Hotopf, Matthew; Wessely, Simon. Mild Traumatic Brain Injury in UK Military Personnel Returning From Afghanistan and Iraq: Cohort and Cross-sectional Analyses. Journal of Head Trauma Rehabilitation. 24 March 2011doi: 10.1097/HTR.0b013e318212f814
78. Hibberd J, Greenberg N. Coping with the impact of working in a conflict zone: a comparative study of diplomatic staff. Journal of Occupational and Environmental Medicine: doi: 10.1097/JOM.0b013e3182135973
79. Fertout M, Jones N, Greenberg N, Mulligan K, Knight T, Wessely S. A review of United Kingdom Armed Forces' approaches to prevent post-deployment mental health problems. International Review of Psychiatry 2011; DOI: 10.3109/09540261.2010.55777
80. Harvey SB, Hatch SL, Jones M, Hull L, Jones N, Greenberg N, Dandeker C, Fear NT, Wessely S. Coming Home: Social Functioning and the Mental Health of UK Reservists on Return From Deployment to Iraq or Afghanistan. Ann Epidemiol. 2011 Sep;21(9):666-72. Epub 2011 Jul 7. PubMed PMID: 21737306.
81. Fernando A, Hull L, Greenberg N, Fear NT, Hotopf M, Wessely S. "Warriors": impact of a powerful television drama on the psychological health of UK Bosnia peacekeepers. Ann Epidemiol. 2011 Sep;21(9):660-5. Epub 2011 Jun 17. PubMed PMID: 21684177.
82. Burdett H, Jones N, Fear NT, Wessely S, Greenberg N. Early psychosocial intervention following operational deployment: analysis of a free text questionnaire response. Mil Med. 2011 Jun;176(6):620-5. PubMed PMID: 21702377.
83. Iversen AC, van Staden L, Hughes JH, Greenberg N, Hotopf M, Rona RJ, Thornicroft G, Wessely S, Fear NT. The stigma of mental health problems and other barriers to care in the UK Armed Forces. BMC Health Serv Res. 2011 Feb 10;11:31. PubMed PMID: 21310027; PubMed Central PMCID: PMC3048487.
84. Dandeker C, Greenberg N and Orme G. The UK's Reserve Forces: Retrospect and Prospect. Armed Forces & Society published online 28 February 2011. DOI: 10.1177/0095327X11398332
85. Jones N, Wink P, Brown AB, Berrecloth D, Abson E, Doyle J, Fear NT, Wessely S, & Greenberg N. A clinical follow-up study of reserve forces personnel treated for mental health problems following demobilisation. Journal of Mental Health,2011; 1–10, iFirst article
86. Greenberg N. Managing traumatic stress at work. An organisational approach to the management of potentially traumatic events. Occupational Health at Work 2011; 7(5): 22–26
87. Greenberg N, Jones E, Jones N, Fear NT and Wessely S. The injured mind in the UK Armed Forces. Phil. Trans. R. Soc. B January 27, 2011 366:261-267.

88. Buckman JEJ, Sundin J, Greene T, Fear NT, Dandeker C, Greenberg N*, Wessely S*. The impact of deployment length on the health and well-being of military personnel: a systematic review of the literature. Occup Environ Med 68 (1): 69-76 Jan 2011
89. Jones N, Fear NT, Jones M, Wessely S & Greenberg N. Long-Term Military Work Outcomes in Soldiers Who Become Mental Health Casualties When Deployed on Operations. Psychiatry 73(4) Winter 2010 352
90. Greene T, Buckman J, Dandeker C, Greenberg N. The impact of culture clash on deployed troops. Mil Med. 2010 Dec;175(12):958-63
91. Jones N, Burdett H, Wessely S, Greenberg N. The subjective utility of early psychosocial interventions following combat deployment. Occupational Medicine 2010; doi: 10.1093/occmed/kqq182
92. Mulligan K, Jones N, Woodhead C, Davies M, Wessely S & Greenberg N. Mental health of UK military personnel while on deployment in Iraq. The British Journal of Psychiatry (2010) 197, 405–410.
93. Glozier N, Henderson M, Greenberg N. Work and psychiatric disorder in Hunter's Diseases of Occupations: Tenth Edition. Editors Peter Baxter, Tar-Ching Aw, Anne Cockcroft, Paul Durrington and Malcolm Harrington. Oxford University Press. 2010
94. Frappell-Cooke W, Gulina M, Green K, Hacker Hughes J, Greenberg N. Does trauma risk management reduce psychological distress in deployed troops? Occup Med (Lond). 2010 Occup Med (Lond). 2010; 60:8 645-650.
95. Greene, Talya; Buckman, Joshua; Dandeker, Christopher; Greenberg, Neil. How Communication With Families Can Both Help and Hinder Service Members' Mental Health and Occupational Effectiveness on Deployment. Military Medicine. Volume 175, Number 10, October 2010 750-758(9).
96. Greenberg N & Jones N. Optimizing Mental Health Support in the Military: The Role of Peers and Leaders. In Deployment Psychology: Evidence-Based Strategies to Promote Mental Health in the Military. Edited by Amy B. Adler, PhD; Paul D. Bliese, PhD; and Carl Andrew Castro, PhD. APA. October 2010.
97. Pinder, Richard J.; Fear, Nicola T.; Wessely, Simon; Reid, Geoffrey E.; Greenberg, Neil. Mental Health Care Provision in the U.K. Armed Forces. Military Medicine Volume 175, Number 10, October 2010 805-810(6)
98. Iversen AC, van Staden L, Hughes JH, Browne T, Greenberg N, Hotopf M, Wessely S, Fear NT. Help-seeking and receipt of treatment among UK service personnel. The British Journal of Psychiatry 2010 Aug 1;197(2):149-55.
99. Coetzee RH, Simpson RG, Greenberg N. Focus on Primary Health Care: A Practical Approach to Detecting Post-Deployment Mental Health Problems in Primary Care. Journal of the Royal Army Medical Corps. Volume 156; Number 3; Sep 10
100. Sundin J, Jones N, Greenberg N, Rona RJ, Hotopf M, Wessely S, Fear NT. Mental health among commando, airborne and other UK infantry personnel. Occup Med (Lond). 2010 Sep 6. [Epub ahead of print] PubMed PMID: 20819802.
101. Greenberg N, Langston V, Everitt B, Iversen A, Fear NT, Jones N, Wessely S. A cluster randomized controlled trial to determine the efficacy of Trauma Risk Management (TRiM) in a military population. J Trauma Stress. 2010 Aug;23(4):430-6. PubMed PMID: 20690168.

102. Mulligan K, Fear NT, Jones N, Wessely S and Greenberg N. Psycho-educational interventions designed to prevent deployment-related psychological ill-health in Armed Forces personnel: a review. Psychological Medicine, 2010, Jun 16:1-14
103. Fear NT, Jones M, Murphy D, Hull L, Iversen AC, Coker B, Machell L, Sundin J, Woodhead C, Jones N, Greenberg N, Landau S, Dandeker C, Rona RJ, Hotopf M, Wessely S. What are the consequences of deployment to Iraq and Afghanistan on the mental health of the UK armed forces? A cohort study. Lancet. 2010;375:1758-60
104. Gould M, Adler A, Zamorski M, Castro C, Hanily N, Steele N, Kearney S, Greenberg N. Do stigma and other perceived barriers to mental health care differ across Armed Forces? J R Soc 148 Med 2010: 103: 148–156. DOI 10.1258/jrsm.2010.090426
105. Langston V, Greenberg N, Fear NT, Iversen AC, French C, Wessely S. Stigma and mental health in the Royal Navy. Journal of Mental Health. 2010 Feb;19(1):8-16.
106. Azari J, Dandeker C & Greenberg N. Cultural Stress: How Interactions With and Among Foreign Populations Affect Military Personnel. Armed Forces & Society, January 19, 2010 as doi:10.1177/0095327X09358648
107. Woodhead C, Sloggett A, Bray I, Bradbury J, McManus S, Meltzer H, Brugha T, Jenkins R, Greenberg N, Wessely S, Fear N. An estimate of the veteran population in England: Based on data from the 2007 Adult Psychiatric Morbidity Survey. Population Trends. 2009:138, 50-54
108. Greenberg N, Gould M, Langston V, Brayne M. Journalists' and media professionals' attitudes to PTSD and help-seeking: A descriptive study. *Journal of Mental Health*, 18, 6, Dec 2009, 543 – 548. doi: 10.3109/09638230903191231
109. Greenberg N, Rubin, GJ and Wessely S. The Psychological Consequences of the London Bombings In: Mental Health and Disasters. Eds Yuval Neria, Sandro Galea & Fran H. Norris. Cambridge University Press.p 538-557. Published October 2009.
110. Iversen AC, van Staden L, Hughes JH, Browne T, Hull L, Hall J, Greenberg N, Rona RJ, Hotopf M, Wessely S, Fear NT. The prevalence of common mental disorders and PTSD in the UK military: using data from a clinical interview-based study. *BMC Psychiatry*. 2009 Oct 30;9:68
111. Dandeker C, Eversden-French C, Greenberg N, Hatch S, Riley P, van Staden L, & Wessely S. Laying Down Their Rifles: The Changing Influences on the Retention of Volunteer British Army Reservists Returning from Iraq, 2003–2006. *Armed Forces & Society*.2009; OnlineFirst, published on October 20, 2009 as doi:10.1177/0095327X09344068
112. Greenberg, N. Dow, C, Bland, D. Psychological Risk Assessment following the terrorist attacks in New York in 2001. *Journal of Mental Health*. 2009: 18: 3, 216 — 223
113. Jones N, Fear NT, Greenberg N, Hull L and Wessely S. Occupational outcomes in soldiers hospitalized with mental health problems. *Occup Med (Lond)*. 2009 Aug 10. [Epub ahead of print]
114. Misra M, Greenberg N, Hutchinson C, Brain A, Glozier N. Psychological impact upon London Ambulance Service of the 2005 bombings. *Occup Med (Lond)*. 2009 Sep;59(6):428-33. Epub 2009 Jul 28.
115. Greenberg N, Jones N & Fear NT. Medically unexplained symptoms in military personnel. *Psychiatry* 2009:8:5. 170-173
116. Murphy D, Greenberg N & Bland D. Health concerns in UK Armed Forces personnel. *J R Soc Med* 2009: 102: 143–147. DOI 10.1258/jrsm.2009.080387

117. Greenberg N & Wessely S. The dangers of inflation: memories of trauma and post-traumatic stress disorder. *The British Journal of Psychiatry* 2009;194, 1–2. doi: 10.1192/bjp.bp.109.063586
118. Iversen A, Greenberg N. Mental health of regular and reserve military veterans. *Advances in psychiatric treatment* 2009:15;100–106 doi: 10.1192/apt.bp.107.004713
119. Wessely S, Greenberg N, Woodhead C, Fear NT. Gulf War Illnesses. *Lancet.* 2009 Feb 7;373(9662):462.
120. Greenberg N & Wessely S. Gulf War syndrome: an emerging threat or a piece of history? *Emerging Health Threats Journal* 2008, **1**:e10. **doi**: 10.3134/ehtj.08.010.
121. Wessely S, Bryant RA, Greenberg N, Earnshaw M, Sharpley J, Hughes JH. Does psychoeducation help prevent post traumatic psychological distress? *Psychiatry.* 2008 Winter;71(4):287-302.
122. Henderson, A; Greenberg, N; Langston, V. Alcohol Misuse in the Royal Navy. Occupational Medicine. *Occupational Medicine (Lond).* Dec 2008. doi:10.1093/occmed/kqn152
123. Greenberg N, Langston V, Fear NT, Jones M, Wessely S. An evaluation of stress education in the Royal Navy. *Occup Med (Lond).* 2008 Nov 10.
124. Rona RJ, Jones M, Iversen A, Hull L, Greenberg N, Fear NT, Hotopf M, Wessely S. The impact of posttraumatic stress disorder on impairment in the UK military at the time of the Iraq war. *J Psychiatr Res.* 2008 Oct 22.
125. Hughes JG, Earnshaw NM, Greenberg N, Eldridge R, Fear NT, French C, Deahl MP, Wessely S. Use of psychological decompression in military operational environments. *Mil Med.* 2008 Jun;173(6):534-8.
126. Fear NT, Iversen AC, Chatterjee A, Jones M, Greenberg N, Hull L, Rona RJ, Hotopf M, Wessely S. Risky driving among regular armed forces personnel from the United Kingdom. *Am J Prev Med.* 2008 Sep;35(3):230-6.
127. Fear NT, Jones E, Groom M, Greenberg N, Hull L, Hodgetts TJ, Wessely S. Symptoms of post-concussional syndrome are non-specifically related to mild traumatic brain injury in UK Armed Forces personnel on return from deployment in Iraq: an analysis of self-reported data. *Psychol Med.* 2008 Oct 23:1-9.
128. Murphy D, Iversen A, Greenberg N. The mental health of veterans. *J R Army Med Corps.* 2008 Jun;154(2):136-9.
129. Greenberg N, Langston V, Jones N. Trauma risk management (TRiM) in the UK Armed Forces. *J R Army Med Corps.* 2008 Jun;154(2):124-7.
130. Pook A, Tarn M, Harrison J, McAllister P, Greenberg N. A career in military psychiatry. *J R Army Med Corps.* 2008 Jun;154(2):120-3.
131. Harrison J, Sharpley J, Greenberg N. The management of post traumatic stress reactions in the military. *J R Army Med Corps.* 2008 Jun;154(2):110-4.
132. Jones N, Greenberg N, Fear NT, Earnshaw M, McAllister P, Reid G, Wessely S. The operational mental health consequences of deployment to Iraq for UK Forces. *J R Army Med Corps.* 2008 Jun;154(2):102-6.
133. Jones M, Fear NT, Greenberg N, Jones N, Hull L, Hotopf M, Wessely S, Rona RJ. Do medical services personnel who deployed to the Iraq war have worse mental health than other deployed personnel? *The European Journal of Public Health* 2008; doi:10.1093/eurpub/ckn031
134. Tarn M, Greenberg N & Wessely S. Gulf War syndrome – has it gone away?

Advances in Psychiatric Treatment 2008 14: 414-422.

135. Gould, Matthew, Sharpley, John, Greenberg, Neil. Patient characteristics and clinical activities at a British military department of community mental health. *Psychiatr Bull* 2008 32: 99-102

136. Greenberg N, Iversen A, Hull L, Bland D, Wessely S. Getting a peace of the action: Measures of Post Traumatic Stress in UK military peacekeepers. *J Royal Soc Medicine* 2008: 101: 78-84

137. Iversen AC, Fear NT, Ehlers A, Hacker Hughes J, Hull L, Earnshaw M, Greenberg N, Rona R, Wessely S, Hotopf M. Risk factors for post-traumatic stress disorder among UK Armed Forces personnel. *Psychol Med.* 2008 Jan 29:1-12

138. Jones, N. Greenberg, N. Wessely, S. No plans survive first contact with the enemy: flexibility and improvisation in disaster mental health. *Psychiatry*, 70(4);361-365.

139. Browne TE, Iversen A, Hull L, Workman L, Barker C, Horn O, Jones M, Murphy D, Greenberg N, Rona R, Hotopf M, Wessely S, Fear N. How Do Experiences In Iraq Affect Alcohol Use Amongst Male UK Armed Forces Personnel? *Occup Environ Med.* 2008 Jan 4; [Epub ahead of print]

140. Greenberg, N. (2008) Studying the Psychological Effects of Conflict Zones. *Journal of international peace operations*:3:4:16.

141. Sharpley JG, Fear NT, Greenberg N, Jones M, Wessely S. Pre-deployment stress briefing: does it have an effect? *Occup Med (Lond)*. 2008 Jan;58(1):30-4.

142. Iversen AC, Fear NT, Simonoff E, Hull L, Horn O, Greenberg N, Hotopf M, Rona R, Wessely S. Influence of childhood adversity on health among male UK military personnel. *Br J Psychiatry*. 2007 Dec;191:506-11.

143. Jones, E. Greenberg, N. Long-term Psychological Consequences among Chemical Warfare Survivors of World War I and their Current Relevance. *Psychiatric Annals*; 37;11;724-723. 2007

144. Iversen A, Waterdrinker A, Fear N, Greenberg N, Barker C, Hotopf M, Hull L, Wessely S. Factors associated with heavy alcohol consumption in the U.K. armed forces: data from a health survey of Gulf, Bosnia, and era veterans. *Mil Med.* 2007 Sep;172(9):956-61.

145. Langston V, Gould M, Greenberg N. Culture: what is its effect on stress in the military? *Mil Med.* 2007 Sep;172(9):931-5. Review.

146. Fear NT, Iversen A, Meltzer H, Workman L, Hull L, Greenberg N, Barker C, Browne T, Earnshaw M, Horn O, Jones M, Murphy D, Rona RJ, Hotopf M, Wessely S. Patterns of drinking in the UK Armed Forces. *Addiction*. 2007 Nov;102(11):1749-59

147. Rona RJ, Fear NT, Hull L, Greenberg N, Earnshaw M, Hotopf M, Wessely S. Mental health consequences of overstretch in the UK armed forces: first phase of a cohort study. *BMJ*. 2007 Sep 22;335(7620):603. Epub 2007 Jul 30.

148. Greenberg N, Thomas S, Murphy D, Dandeker C. Occupational stress and job satisfaction in media personnel assigned to the Iraq war (2003): A qualitative study. *Journalism Practice*, Vol. 1, No 3, 2007

149. Gould M, Greenberg N, Hetherton J. Stigma and the military: Evaluation of a PTSD psycho educational program. *J Trauma Stress*. 2007 Aug;20(4):505-15.

150. Greenberg, N., Iversen, A., Morris, R., Wessely, S. Bridging the Gulf: 'Gulf War Syndrome' – What we know and what we don't. *Advances in Clinical Neuroscience & Rehabilitiation*. Vol 7. Iss 3. July/Aug 2007.

151. Bland DJ, Rona RJ, Coggon D, Anderson J, Greenberg N, Hull L, Wessely S. Urinary isotopic analysis in the UK Armed Forces: No evidence of depleted uranium absorption in combat and other personnel in Iraq. *Occup Environ Med.* 2007 Jul 3
152. Greenberg N, Langston V, Iversen A, Wessely S. Peer responses to perceived stress in the Royal Navy. *Occup Med (Lond).* 2007 Sep;57(6):424-9. Epub 2007 Jun 13
153. Browne T, Hull L, Horn O, Jones M, Murphy D, Fear NT, Greenberg N, French C, Rona RJ, Wessely S, Hotopf M. Explanations for the increase in mental health problems in UK reserve forces who have served in Iraq. *Br J Psychiatry.* 2007 Jun;190:484-9.
154. Greenberg N, Browne T, Langston V, McAllister P. Operational mental health: a user's guide for medical staff. *J R Nav Med Serv.* 2007;93(1):5-11.
155. Rubin GJ, Brewin CR, Greenberg N, Hughes JH, Simpson J, Wessely S. Enduring consequences of terrorism: 7-month follow-up survey of reactions to the bombings in London on 7 July 2005. *Br J Psychiatry.* 2007 Apr;190:350-6
156. Jones E, Greenberg N. Royal Naval Psychiatry: organisation, methods and outcomes 1900-1945, *Mariner's Mirror* 2006. 92: 190-203.
157. March C, Greenberg N. The Royal Marines approach to Psychological Trauma. In *Combat Stress Injury Theory, Research, and Management.* Edited by Charles R. Figley, William P. Nash Routledge Dec 2006.
158. Wessely S, Thomas S, Dandeker C, Greenberg N, Kelly V. "Serving in Bosnia made me appreciate living in Bristol": Stressful Experiences, Attitudes, and Psychological Needs of Members of the United Kingdom Armed Forces. *Mil Medicine* 2006: 171: 376-380
159. William V. Bobo, Richard M. Keller, Neil Greenberg, Christopher A. Alfonzo, Larry H. Pastor, and Thomas A. Grieger. Psychological Responses to Terrorism, In *Military life: the psychology of serving in peace and combat* /edited by Thomas W. Britt, Amy B. Adler, and Carl Andrew Castro. Praeger Security International. Westport, Connecticut. 2006.
160. Hotopf M, Hull L, Fear N, Browne T, Horn O, Iversen A, Jones M, Murphy D, Bland D, Earnshaw M, Greenberg N, Hacker-Hughes J, Tate R, Dandeker C, Rona R, Wessely S. The health of UK military personnel who deployed to the 2003 Iraq War. *Lancet* 2006: 367: 1731-1741
161. Rona RJ, Hooper R, Greenberg N, Jones M, Wessely S. Medical downgrading, self-perception of health, and psychological symptoms in the British Armed Forces. *Occup Environ Med.* 2006 Apr;63(4):250-4.
162. Greenberg, N. Book Review: Command at Sea: Naval Command and Control since the Sixteenth Century. *Armed Forces & Society, 2006, 32,* 335-33
163. Iversen, A., Nikolaou, V., Greenberg, N., Unwin, C., Hull, L., Hotopf, M. et al. What happens to British veterans when they leave the armed forces? *Eur J Public Health, 2005, 15,* 175-184.
164. Greenberg, N., Henderson, M., Karim, S., & Holland-Elliott, K. Does having an occupational mental health service make any difference? *Occup.Med.(Lond), 2005 55,* 549-551.
165. Greenberg, N., Cawkill, P., & Sharpley, J. How to TRiM away at post traumatic stress reactions: traumatic risk management--now and the future. *J R.Nav.Med.Serv. 2005, 91,* 26-31.

166. Greenberg, N. Gulf War illnesses...the story is still alive and well. *Occup.Environ.Med. 2005, 62,* 142-143.
167. Greenberg, N. & Wessely, S. Gulf War Syndrome-the story so far. *J R.Nav.Med.Serv. 2005, 91,* 4-11.
168. Hughes, J. H., Cameron, F., Eldridge, R., Devon, M., Wessely, S., & Greenberg, N. Going to war does not have to hurt: preliminary findings from the British deployment to Iraq. *Br.J Psychiatry, 2005, 186,* 536-537.
169. Iversen, A., Dyson, C., Smith, N., Greenberg, N., Walwyn, R., Unwin, C. et al. 'Goodbye and good luck': the mental health needs and treatment experiences of British ex-service personnel. *Br.J Psychiatry, 2005, 186,* 480-486.
170. Rubin, G. J., Brewin, C. R., Greenberg, N., Simpson, J., & Wessely, S. Psychological and behavioural reactions to the bombings in London on 7 July 2005: cross sectional survey of a representative sample of Londoners. *BMJ, 2005, 331,* 606.
171. Keller, R. T., Greenberg, N., Bobo, W. V., Roberts, P., Jones, N., & Orman, D. T. Soldier peer mentoring care and support: bringing psychological awareness to the front. *Mil.Med. 2005, 170,* 355-361.
172. Greenberg, N. Reconstructing early interventions after trauma: Innovations in the care of survivors. *Psychological Medicine, 2005, 35,* 454-455
173. Iversen, A. & Greenberg, N. Food for thought: Participating and managing the psychological aspects of food chain contamination and terrorism. *Psychiatric Annals, 2004, 34,* 720-+.
174. Greenberg, N., Iversen, A. C., Unwin, C., Hull, L., & Wessely, S. Screening for depleted uranium in the United Kingdom armed forces: who wants it and why? *J Epidemiol.Community Health, 2004, 58,* 558-561.
175. Greenberg, N. Thomas, S. Iversen, A. Unwin, C. Hull, L Wessely, S. Do military peacekeepers want to talk about their experiences? Perceived psychological support of UK military peacekeepers on return from deployment. J Ment Health 2003 12, 6, 561 ± 569
176. Jones, N., Roberts, P., & Greenberg, N. Peer-group risk assessment: a post-traumatic management strategy for hierarchical organizations. *Occup.Med.(Lond), 2003, 53,* 469-47.
177. Greenberg, N., Iversen, A., Hull, L., Unwin, C., Destrange, M., & Wessely, S. Vaccination records in Gulf War veterans. *J Occup.Environ.Med. 2003, 45,* 219.
178. Greenberg, N. & Haines, N. The use of Section 136 of the Mental Health Act 1983 in a family of rural English police forces. *Med.Sci.Law, 2003, 43,* 75-79.
179. Greenberg, N., Lloyd, K., O'Brien, C., McIver, S., Hessford, A., & Donovan, M. A prospective survey of section 136 in rural England (Devon and Cornwall). *Med.Sci.Law, 2002,42,* 129-134.
180. McAllister, P. D., Barker, C. T., Temple, M. J., & Greenberg, N. Preparing for the MRCPsych examinations. *J R.Army Med.Corps.* 2002:148;176-182.
181. Greenberg, N. Temple, M. Neal, L, Palmer, I. Military psychiatry: A unique national resource. *Psychiatric Bulletin* 2002 26: 227-229
182. Greenberg, N., Temple, M., & Palmer, I. A career in military psychiatry? *JRArmyMedCorps.* 2001:147; 339-342.
183. Temple, M. & Greenberg, N. Military psychiatry. *BMJ Career Focus*, 2001, 324, S161a.

184. Greenberg, N. A critical review of psychological debriefing: the management of psychological health after traumatic experiences. *J RNavMedServ* 2001:87:158-161.
185. Greenberg N. (2001). The interrater reliability of the Royal Marines Psychological Risk Assessment Tool. Masters Thesis. Leeds University Medical School.
186. Greenberg N. (1992). How do lymphocytes get out of the brain? A guinea pig model. Southampton University School of Medicine.

10. Awards

The Gilbert Blane Medal for my work on supporting the health of Royal Navy personnel through research (2008)

Military – Civilian Partnership Mental Health Award – for leading a team which conducted mental health research in a deployed setting (2013)

Help for Heroes "Hero" award – for providing pro-bono expert advice, support and input to Help for Heroes and the Wounded Injured and Sick personnel they support (2013).

Shortlisted for Royal College of Psychiatrist 'Psychiatrist of the Year' 2015

11. Grants Awarded (as Principal Investigator)

Trauma Risk Management RCT 2004-2007; MOD; £250,000
Battlemind post-deployment RCT 2007-2010; MOD; £400,000
Future military psychological health issues; SEA: £75,000
Post deployment screening study RCT; 2011-2015; US DOD; $3,000,000
Non-operational stress in the British Army; 2013; British Army; £100,000
Stigma and Barriers to Care in the UK Armed Forces; 2013; MOD; £110,000
Tour length for Diplomats; 2013; Foreign Office; £10,000
Counting the Cost study; 2014; Help for Heroes; £100,000
Organisational Trauma Management; 2014 NIHR; £4M grant (PI for one theme)
Psychosocial impact of Ebola in UK response workers; 2014 PHE; £60,000 (co-PI)
Psychosocial impact of Ebola in WHO response workers; 2015 PHE; £30,000 (co-PI)
Stigma in military Veterans; Forces in Mind Trust; 2015 £180,000
The potential for genetic screening in the UK military; 2015 DHCSTC/MoD/ £35,000

Appendix C. Extract from the International Classification of Diseases Volume 10

F43.2 Adjustment disorders

A. Experience of an identifiable psycho-social stressor, not of an unusual or catastrophic type, within one month of the onset of symptoms.

B. Symptoms or behaviour disturbance of types found in any of the affective disorders (except for delusions and hallucinations), any disorders in F4 (neurotic, stress related and somatoform disorders) and conduct disorders, so long as the criteria of an individual disorder are not fulfilled. Symptoms may be variable in both form and severity.

The predominant feature of the symptoms may be further specified by the use of a fifth character:

F43.20 Brief depressive reaction. A transient mild depressive state of a duration not exceeding one month.

F43.21 Prolonged depressive reaction. A mild depressive state occurring in response to a prolonged exposure to a stressful situation but of a duration not exceeding two years.

F43.22 Mixed anxiety and depressive reaction. Both anxiety and depressive symptoms are prominent, but at levels no greater than specified in mixed anxiety and depressive disorder (F41.2) or other mixed anxiety disorders (F41.3).

F43.23 With predominant disturbance of other emotions. The symptoms are usually of several types of emotion, such as anxiety, depression, worry, tensions and anger. Symptoms of anxiety and depression may meet the criteria for mixed anxiety and depressive disorder (F41.2) or other mixed anxiety disorders (F41.3), but they are not so predominant that other more specific depressive or anxiety disorders can be diagnosed. This category should also be used for reactions in children in which regressive behaviour such as bed-wetting or thumb-sucking are also present.

F43.24 With predominant disturbance of conduct. The main disturbance is one involving conduct, e.g. an adolescent grief reaction resulting in aggressive or dissocial behaviour.

F43.25 With mixed disturbance of emotions and conduct. Both emotional symptoms and disturbances of conduct are prominent features.

F43.28 With other specified predominant symptoms.

C. The symptoms do not persist for more than six months, except F43.21 prolonged depressive reaction, after the cessation of the stress or its consequences (but this criterion should not prevent a provisional diagnosis being made if it is not yet fulfilled).