Scouts

Ben Leonard Inquest
Prevention of Future Deaths Report
Response from The Scout Association

April 2024

Contents

Introduction ... 3
Section 1: Culture of Candour and Independent Inspection ... 5
Section 2: Fatal Accident Inquiry Panel Investigation Report (FAIP) now termed “Learning Review” ... 8
Section 3: Safety Training ... 13
Section 4: Restricted Duties ... 16
Section 5: Absence of Safeguarding and Safety Compliance ... 18
Section 6: Monitoring, Auditing and Reliance on Volunteer Line and the need for paid Trainers ... 21
Section 7: Delays in Training ... 24
Section 8: First Aid Kits ... 26
Section 9: First Aid Self Certification to meet Module 10 First Response requirement. ... 27
Section 10: Autonomous Charities ... 28
Section 11: Permit/ Licencing Schemes ... 31
Appendices ... 33
- Appendix A – Planned actions & delivery dates ... 33
- Appendix B – Fatal Accident Investigation Term of Reference ... 36
- Appendix C – Safety changes since 2018 ... 40
- Appendix D – ‘Growing Roots’ Overview ... 42

Introduction

On behalf of The Scout Association, we would like to express our wholehearted apology to the Leonard family – both for the death of Ben and for the anguish they have experienced over the past five and a half years. It was not the intention of anyone at Scouts to contribute towards any further pain, but we recognise that we have caused further distress and for that we are truly sorry.

This inquest and HM Coroner's Prevention of Future Deaths report has led to significant soul searching and reflection, with extensive discussions taking place within our Board and with wider stakeholders. It has rightly dominated our thinking and we pledge that it will continue to do so. As a result, we are proposing fundamental changes to our approach to safety throughout the Scout movement.

Throughout this report, we have addressed the concerns of HM Coroner using the same sub-headings in his Prevention of Future Deaths notice. In each section, we outline our response to these concerns and the actions we have taken since the inquest, the actions we will take from this point forwards, as well as capturing actions that have been taken since Ben's tragic death in 2018. This response further builds on the work we have undertaken after receiving the Prevention of Future Deaths notice in February 2020, and the further update provided in February 2021 to HM Coroner[1].

There are 25 key actions we will be undertaking, but we highlight the following:

1. A **Fatal Accident Investigation Panel for Ben's death** with an external chair and independent panel members was initiated within 48 hours of the conclusion of the inquest and is due for completion in June.
2. A **Critical Incident and Investigation Policy** and a **Duty of Candour Policy** will be agreed by the Board in July 2024 (with these principles implemented immediately). This will provide a consistent framework in how we respond in future to serious incidents, emphasising the need for transparency and to quickly capture learning.
3. We are commissioning a **new strategic partnership with a nationally recognised organisation that is a leader in safety** to review our current safety practices, and this party will act as a Third-Party reviewer. We anticipate that this partnership will be in place by May, with an initial review completed by October 2024.
4. We are currently commissioning **enhanced supplementary safety training and validation for all 145,000 volunteers** (the new training will be available by September 2024 with a target completion within 6 months thereafter). This is designed to further support volunteers and assure us that they understand what is required of them in terms of safety, and have the required competencies and knowledge in relation to risk assessments, terrain definitions, and requirements within our Policy Organisation & Rules (POR).
5. We are investing in several new systems and resources that will transform access to information and monitoring.

[1] Responses to this PFD Report were provided from The Scout Association dated 1.4.20 and then an updated response dated 12.2.21.

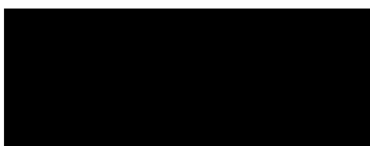
These include:

- **A new, movement-wide assurance framework** to support local leaders, and monitor and audit compliance, including in relation to safety.
- **Additional staffing resource** to support areas of safety, adventurous activities, training support, and local compliance.
- The implementation of a **new approach to the auditing of adult training, including the provision delivered by County Training Managers** under our new Audit & Assurance approach.
- We are **undertaking a full review of Permitting.**
- A **new Learner Management System and training packages**, which will provide significantly enhanced role specific training, including compliance data for volunteers and volunteer management roles across the movement.
- A **new Adult Membership System** that will provide far greater access to key information and transform how we assess, approve, and audit our Nights Away Application processes.

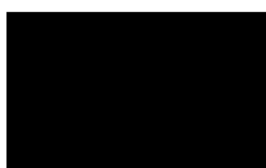
We have attached our delivery plan in Appendix A to ensure our response to Ben's death is more than words, and that the changes already undertaken, along with those planned, will enable the thousands of volunteers who deliver Scouting to continue to do so safely.

We will publish our progress against the plan on a quarterly basis in 2024 as part of our commitment to transparency and accountability. We will then include ongoing updates on progress as part of our new annual Safety Report. We understand our response must be more than simply a plan; it has to be a comprehensive response to this tragedy, and a significant moment in our history which leads to an overhaul of our culture and systems.

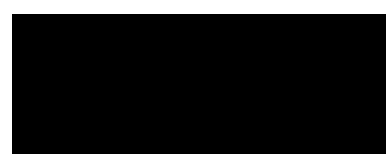
As leaders of the Scout movement, we want to state our commitment to ensuring that this is a transformative moment for Scouting at all levels. We are committed to learning, being honest and transparent, and building the trust of parents, young people, and wider stakeholders so that we remain true to our values of integrity, respect, care, belief, and co-operation.



Chair of the Board



Chief Executive



UK Chief Volunteer

Section 1: Culture of Candour and Independent Inspection

Concerns 1–2 (and Concern 39)

1. *I am concerned that there is not a culture of candour within The Scout Association ('TSA') and the impact that this has on safety and safeguarding.*

2. *I am also concerned that, whilst the Charity Commission has regulatory oversight, there is no robust regulator who independently and periodically audits and inspects the systems, processes and training of The Scout Association or the granting of permits for adventurous activities, hill walking and Nights Away permits. Further, The Scout Association permit scheme for adventurous activities is exempt from regulation by the Health and Safety Executive ('HSE').*

39. *The Scout Association press release within moments of the jury's conclusion demonstrates a failure of The Scout Association to accept any accountability and understanding any proper learning from Ben's death. The Scout Association is institutionally defensive.*

Culture of Candour

The Scout Association is committed to learning from Ben's tragic death. We know we can and must do better. We have carefully considered the Coroner's concerns in detail and will act with greater openness and transparency.

We agree with the Coroner that a culture of candour is essential in relation to safety and safeguarding, and we recognise there is more we must do in this respect. We have therefore agreed to put in place concrete measures to adopt an enhanced culture of candour. These include new policies and training in respect of how we respond to critical incidents. This will ensure we are clear with parents when things go wrong, we work with them, so they know the actions we are taking, and publish learning to ensure transparency and accountability.

We wholeheartedly apologise for any lack of candour in the past. Across Scouts, we strive to have an open and transparent culture and we accept improvement is needed.

Regulation & Audit

We are mindful that any decision on regulatory oversight is not a matter for The Scout Association but is for HM Government to determine. We will abide by their decision and stand ready to actively participate in any such discussions and/or proposals. There are a number of regulatory frameworks which we now work within, including the Charity Commission, Office of the Scottish Charity Regulator, Health & Safety Executive, ICO, DBS, AccessNI & PVG and our Primary Authority relationship.

We have significantly reflected on the Coroner's concerns and, irrespective of any government proposals, we are going further in terms of seeking Third Party external review, inspection, advice,

and assurance. In the actions section below, we outline the work we are now undertaking to engage in external strategic reviews and identify learning from **National Governing Bodies** (NGBs) that would enable a strengthened model for Scouting.

Finally, with regards to Concern 39 specifically, we wholeheartedly apologise to the Leonard family for the timing of our press release. While we stand by the commitment that we made to learning in the statement, we accept that it was released too soon. We hope the details in this response demonstrate our commitment to ensuring clear accountability.

Actions

Culture of Candour

1. To underpin our commitment to transparency, the Board have agreed to develop and adopt a new **Duty of Candour Policy** to be approved in our July Board 2024 (with these principles implemented immediately).

2. Starting in 2025, each year we will **publish a new annual Safety Report** that outlines our in-year learning reviews, lessons learned, and actions taken, further building a culture of candour in relation to Safety & Safeguarding (first publication April 2025).

Audit & Inspection

3. We are in discussions to **commission a new strategic partnership with a nationally recognised organisation that is a leader in safety to review our current safety practices, and this party will act as a Third-Party reviewer[2].** We anticipate this partnership will be in place by May 2024 and will initially cover four core areas:
    - A comprehensive independent review of our current safety practices (including the risk assessment process – identification, mitigation, change, review and sign-off) to assess if learning is successfully delivered, appropriate and effective.
    - A review of the required competencies and skills to inform our syllabus and approach to safety training and best practice.
    - The development of a revised safety framework and associated standards.
    - A yearly independent review of all safety policies and processes, along with review of these safety practices to align to internal and external learning and best practices. This is similar to the work already undertaken by the NSPCC on our safeguarding policies and procedures. (first review September 2024)

    The Board has agreed to invest in the required resources, including additional staffing, based on the findings of this review. This initial strategic review will report within six months (October 2024) with planned recommendations and proposed action.

4. Learning from external expert bodies is central to how The Scout Association operates. We already have membership and relationships with several **National Governing Bodies** (NGBs) within adventurous activities and sport. We will focus our engagement on relevant areas, such as hillwalking and adventurous activities permitting, and to understand how

[2] Third Party Reviewer – an independent organisation or body providing services in areas such as inspection, investigation, audit, and assurance.

better external scrutiny and oversight can address the concerns raised by the Coroner and support the external review outlined above. This will be initiated by June 2024.

Other key areas of work

5. In October 2023, The Scout Association agreed to make a **significant investment into a new and permanent internal Audit & Assurance staff team** which we are currently building. This new team, working in partnership with volunteer leadership, will look to audit and monitor all of our 8,000 charities at local level and provide reporting nationally to the Board. The **new Audit & Assurance team will initially look at training compliance, permitting compliance, the quality and effectiveness of risk assessment against proposed activities, implementation, and management of the Nights Away Permit approval process and wider permitting**. Furthermore, it will ensure that robust action plans are built, any issues are addressed, and if required, stop an activity from happening in partnership with local volunteer leadership. It will also support local Scouts charity Trustees in their responsibilities.

6. We are also investing significantly in a **new Adult Membership System** (AMS), due to be rolled out from December 2024, which will provide the following benefits:
   i. Enable volunteers to undertake key safety tasks more efficiently (including suspensions, permitting, Nights Away applications and approvals). In particular, it will transform how we approve and monitor Nights Away and Permitting by moving all applications and approvals online with a mandated requirement to upload all required paperwork, including risk assessments. The approver (Senior Volunteer) will be able to see all volunteers attending the trip, their training and disclosure status and assess all documentation when deciding whether to approve or decline the trip. The system will enable a full audit trail of all processes.
   ii. It will allow the integrated production and visibility of real time reporting at local and national levels for all training and wider compliance data.
   iii. It will integrate with our recruitment, onboarding and learning tools, as well as existing tools including disclosure checking, so local managers have access to all volunteer automated data and can validate compliance and safety vetting.

Section 2: Fatal Accident Inquiry Panel Investigation Report (FAIP) now termed “Learning Review”

Concerns 3–11

3. *Following Ben’s death, as indicated by Chapter 7 of The Scouts’ Policy, Organisation and Rules (Rule 7.2 version May 2018), at that time required the Charity and Company Secretary of the Association to establish an enquiry on behalf of the Board of Trustees. This should have detailed authorisation, training, equipment, briefing and leadership of the party involved together with their observation of the sequence of events and possible causes of the fatality.*

4. *As of 22.2.24, over 5 years since Ben’s death, there is still no Fatal Accident Inquiry Panel Report in existence. Further still, even the prospective panel members for this investigation have not been identified. A document I have received entitled ‘BL Great Orme Learning and Actions Update’ dated 30.9.19 is inadequate when considering the root and branch type of review needed following a child fatality to identify and address issues of safety and safeguarding – particularly these having been identified as significant issues on the day of Ben’s death and despite this fact – no investigation followed - with The Scout Association maintaining this was due to a live police investigation initially, and latterly due to this inquest.*

5. *Without a timely internal Fatal Accident Inquiry Panel Investigation Report (FAIP), this gives me great concern that issues of safety and safeguarding are not properly considered, transparently engaged with and then addressed formally in respect of a child fatality.*

6. *The evidence provided by The Scout Association has been inconsistent as to when it is said a FAIP report is commissioned and completed in circumstances where there is an inquest.*

7. *An FAIP investigation initiated by the Charity and Company Secretary, should have engaged with the early identification by the District Commissioner, County Commissioner, and The Scout Association Headquarters staff who had concerns and noted failings relating to the planning, risk assessment, supervision and approval for the trip including the absence and non-attendance of the identified and necessary first aider, the presence of over 18 year olds on trip which had not been disclosed or approved by the District Commissioner and concerns around the competence of the leaders.*

8. *The Scout Association reconstruction trip to the Great Orme after Ben’s death on 9.10.18 attended by The Scout Association Senior Scouting leadership and lawyers with the actual leaders from the trip indicates a desire by The Scout Association headquarters staff to control the narrative, especially surrounding dynamic risk assessment. Any investigation by County or District level was prevented by headquarters at Gilwell. The District and County Commissioners had identified failings and concerns relating to safety*

and safeguarding on the day Ben died and the extent of the failings were known and many identified further, following the trip to the Great Orme on the 9.10.2018.

9. *In this investigation, the evidence I have heard leads me to a concern as to a general reluctance by The Scout Association to engage in a meaningful learning exercise to prevent a recurrence of the issues pertaining to Ben's death. This inquest was stated as the reason preventing a FAIP report.*

10. *However, a FAIP relating to another death in Scouting of a 21-year-old leader was considered in evidence. This FAIP and recommendations were completed before that Inquest. However, it is not clear as to whether this report and recommendations was shared with the relevant Coroner. It is also not clear if, even when FAIP reports have been completed, whether they are provided to the relevant Coroner.*

11. *I therefore have concerns that not all matters regarding deaths connected with the Scouting Movement and Association are being communicated, even by provision of draft report and recommendations, to His Majesty's Coroners of England and Wales to inform PFD issues and a Coroner's PFD reporting duties.*

Fatal Accident Investigation

We wholeheartedly apologise for not completing a Fatal Accident Investigation (FAI) prior to this inquest and accept that our decision to not do so was wrong. This will not happen again.

We recognise that the lack of a FAI report into Ben's death has added to the distress experienced by the Leonard family and to the challenges within the inquest process. While we followed legal advice regarding the timing of the FAI after Ben's death, we accept it was wrong not to initiate a FAI in advance of the inquest. We recognise that undertaking an FAI would have allowed greater information to be available earlier in relation to Safety and Safeguarding matters and would have prompted quicker action in key areas.

Critical Incident Response & Learning

Learning from any incident is central to our commitment to continuous and cultural improvement. As such, we are fully reviewing our approach to Critical Incidents. This will now include a new approach that we will call a Fatal Incident Investigation[3].

We are reviewing current policies and creating a new Critical Incident & Investigation Policy and procedure, which will form part of our wider learning review process for any incidents. This will make sure any future critical incidents are immediately and robustly investigated, and learning is gathered quickly. Should a fatality occur again, all investigation findings will be provided to His Majesty's Coroners of England and Wales (and devolved nation equivalents) ahead of any inquest proceedings.

We acknowledge the concerns raised by HM Coroner with regard to the perception that members of The Scout Association tried to control the narrative. To the best of our knowledge, it was not the

[3] Moving forwards, and after discussion with external experts, we have agreed to remove the term 'accident' from Fatal Accident Investigation and use the term 'Incident' instead. This recognises that using the term 'accident' may reduce the importance of how an incident is seen and hinder the ability to identify the root causes.

intent of any individual within The Scout Association to attempt to do so, however we have learned from this. As detailed in point 2 below, we will now appoint a member of the Executive Leadership Team, who will report into the Board to ensure full transparency and accountability.

Our new Critical Incident & Investigation Policy will also set clear rules regarding site visits and how information is gathered. The policy will include a commitment to share all relevant information with statutory agencies in a fully transparent manner.

We recognise the concerns raised about poor communication with local leadership. We are committed to changing and learning from this. In future, we will ensure there is greater clarity about the roles and responsibilities of different parties, especially where any fatality has occurred. We will ensure that guidance is clear and update POR where a national policy, such as the new Critical Incident & Investigation policy, is implemented.

With regards to Concern 10 specifically, we would like to add some information regarding the tragic death in Scouting of a 21-year-old leader that was considered in evidence. We would like to clarify that The Scout Association did provide a copy of the fatal accident inquiry panel report to inquest investigators before the inquest commenced. Specifically, the report was shared with the Senior Environmental Health Officer (EHO) at Preston City Council, who the Coroner had instructed to provide a report to the inquest. Learning from this and in future, the new Critical Incident & Investigation Policy will ensure we have a consistent approach to the provision of such information.

Actions

Learning from Ben’s Tragic Death

1. The **Scout Association has now commissioned the Fatal Accident Investigation (FAI) into Ben’s death** with Terms of Reference, completed within 48 hours of the inquest concluding. Please see TORs attached for reference at Appendix B. As we highlight, we apologise for not doing this sooner. The initial FAI report is due to be completed by June 2024 and its findings and actions will be shared with the Leonard family and HM Coroner in accordance with our commitment at the inquest. We have also asked the FAI panel to undertake a detailed review into actions by The Scout Association after Ben’s death and our response. This is to ensure learning and to better understand the changes we need to make. This will also be shared with the Leonard family and as part of our annual Safety Report.
   As part of our commitment to transparency, the findings will also:
   - Be shared across the wider charitable and youth sector to enable wider learning. This will form part of our new Safety Report.
   - Be provided to the organisation we appoint to undertake our external strategic safety review to ensure that the learnings from this FAI are embedded in future ways of working.

   To lead the FAI panel, we have **appointed an independent Chair** with a robust senior health care background in the NHS and **two independent panel members with significant safety expertise**, along with two internal senior volunteers who are unconnected to any matters relating to this tragedy (see Appendix B)

Future Critical Incidents & Learning

2. **The Scout Association is creating a new Critical Incident & Investigation Policy** (using a root cause analysis approach) which will be formally approved by the Board in July 2024 (with the principles of the policy being implemented immediately). While the Board approval process is in train, the Board has agreed that the key requirements within this new policy are implemented immediately.

   The new policy will ensure a consistent approach that is founded in learning and the need to robustly investigate, act on, and learn from critical Incidents, including fatalities.

   Specifically, in relation to fatalities, it will include the requirement to initiate a Fatal Incident Investigation (FII) as soon as practically possible after a fatality has occurred, the need for independence within the process and, where appropriate, use external experts and chairs. The Critical Incident and Investigation Policy will set out in detail how any process is to be conducted. When this policy is produced and shared publicly, we would welcome feedback from any interested party.

   In terms of the governance of the Critical Incident process:
   - As is the current procedure, any **Critical Incident is overseen by the Safety Committee** (a sub-committee of the Board of Trustees, which includes additional expert and external members). The full report is presented to the Board with a list of recommended actions.
   - In the event of a fatality, a **senior level staff member (Executive Director level) will be designated as the senior accountable person** for leading the process and for collating information and liaising with relevant statutory agencies. That staff member will report directly to the Board.
   - The **Critical Incident & Investigation process will be commissioned by Safety Committee on behalf of the Board within 72 hours** of any future incidents, which will ensure the timely capture of all required information in one central location, and its findings will be presented to any statutory agencies on an open disclosure basis. This will be accompanied by an overall learning review for all critical incidents.

Other key areas of work

3. We will be developing **bespoke training packages to support our new approach to Critical Incidents** to build competency and ensure this approach is clearly understood by all key stakeholders.

4. We will **conduct an annual Critical Incident scenario exercise** to ensure the policy remains live and institutional knowledge is not lost. This will be **independently reviewed and assessed** to ensure learning is objectively identified and applied. (first scenario exercise December 2024)

5. Since Ben's tragic death in 2018, **Scouts have made over 50 changes to our policies, systems, processes, and ways of working**. These include changes to our Policy Organisation and Rules (POR), updated guidance and policy on risk assessments, Terrain

definitions, improvements in training and auditing compliance (see appendix C for a full list of these changes).

6. Over the past five years, we have undertaken five key learning reviews for critical incidents and a range of reviews for other accidents. We will now review our approaches aligned to the new Critical Incident and Investigation policy to ensure we capture learning for any incident.

7. Safety & Safeguarding reports have been reviewed by the Board of Trustees at each of their quarterly meetings since 2020. There are Safety & Safeguarding Committees in place, as sub-committees of the Trustee Board, with independent chairs (who are Trustees with professional roles external to Scouting, meaning they have relevant expertise) and additional expert members to contribute knowledge of outside trends and learning.

Section 3: Safety Training

Concerns 12–13

12. *Safety training is predominantly done online. Having seen and forensically within the hearing, undertaken an exercise to complete the current Safety Module, I am concerned that the course is superficial at best and fundamentally basic. It can be completed in 12 minutes. It is unsurprising that the current pass rate is now correspondingly high. This causes concern as an introductory module needed to equip thousands of leaders with an understanding of how to complete a risk assessment in order to keep Scouts safe. It does not embed the fundamental principles of safety and safe Scouting.*

13. *While reference material is available in the course, it is not mandatory reading and not required in order to complete the click through course.*

Online Safety Training

The Scout Association made the decision to bring its safety training exclusively online in 2020. This was to ensure volunteers were appropriately trained and there was consistency, including in terms of validation. In light of the concerns expressed by HM Coroner in the PFD report, we are now reviewing the balance of online training versus face-to-face training, and this will form part of our external strategic safety review (Section 1, point 3). This will ensure we are focusing even more on assessing competence, suitability and building a prevailing culture of safety.

We think it is important to highlight that safety training is just one component of our initial training suite, which also includes Safeguarding and First Response training, with the latter including an in-person practical component. We also provide clear guidance, further resources, and tools on our website which are available at all times and updated regularly. However, we recognise we must do more to support volunteers, so we can assure they have the right capabilities and better validate, evidence and audit delivery.

We accept the HM Coroner's concern that, if individuals chose to do so, they could complete our current training in 12 minutes. We have now acted on this, so the course cannot be undertaken in such a manner, which is explained below in point 1. As before these changes, at the end of the training module, the person being trained also needs to answer all safety questions to the pass mark of 100% to achieve completion and certification.

Actions

1. The Scout Association has **urgently reviewed the safety training provided online**, so a candidate cannot simply 'click through' the material and made the reading of the materials mandatory. Individuals are required to complete a self-declaration stating they have read all required materials, and they still need to achieve 100% in the final test.

2. We are **currently commissioning enhanced supplementary safety training and validation for all 145,000 volunteers**. The new training will be available by September 2024 with a target completion within 6 months thereafter. We will focus initially on

volunteers who will be delivering nights away or adventurous activities as our priority. For any volunteer who does not complete the training in the agreed time frames we will introduce agreed restrictions or suspension in line with the detail provided within Section 7 (Compliance & Suspensions). This new training is designed to further support volunteers, assuring us that they understand what is required of them in terms of safety, and they have the required competencies in the following four core areas:

- How to conduct and complete risk assessments (written and dynamic)
- Terrain definitions
- The related requirements within our Policy Organisation & Rules (POR)
- Permitting

3. As detailed in Section 1, point 3, we are **commissioning an independent strategic review of all new proposed safety training** as part of our strategic partnership. This will specifically address the issues and concerns identified by HM Coroner with the intention that all future training is fit for purpose. It will provide volunteers at every level, including our managers and senior volunteers, with the required competencies and skills suited to their role, including ongoing learning and development. Where possible, we will be seeking external accreditation for this training.

Other key areas of work

4. **The Scout Association is also investing in a new Learner Management System (LMS)** which will be rolled out to all 145,000 volunteers in late 2024. The LMS will enable the delivery of new, redesigned and enhanced safety training. It will enable all volunteers to easily access training that suits their role and builds their individual competency throughout the year, instead of being trained every three years. The system will:
   i. Mitigate the risk that only individuals with the correct access can undertake specific training programmes (lessening the risk of training being undertaken by one person on behalf of another).
   ii. Validate and assess volunteers for competency after undertaking relevant courses.
   iii. Enable full auditing of training compliance and check training is undertaken in a timely manner. It will drive greater consistency and will ensure that only nationally endorsed and up-to-date materials are being used.

5. As outlined in Section 1(point 6), we have **significantly invested in a new Adult Membership System (AMS)**.

6. The new AMS will also enable **all Nights Away Applications and associated Permitting to be done online**, including the submission and verification of all required paperwork in line with POR. There will be the ability to approve or decline any application by the relevant line manager or approver and to check for appropriate training and disclosures, as well as a full audit capability that will form part of our new national Audit & Assurance framework.

7. As part of our volunteer transformation programme which started the design work in 2018 and launched at the start of 2023, we are developing a new approach to how we manage and equip volunteers. **We have devised a completely new approach to training across the UK**, replacing the requirement to undertake Wood Badge training. Instead, the most important elements from the Wood Badge training will now form part of our mandatory training to be completed within six months of becoming a volunteer. This includes a requirement to undertake Safeguarding and Safety training within the first month of becoming a volunteer. Without up-to-date Safeguarding or Safety training, volunteers will not be allowed to lead or plan activities and will be supervised at all times. If a volunteer has not undertaken their training (within a one-month window), they will be suspended until this has occurred.
   (For a full overview of all training areas above, please refer to Appendix D).

Section 4: Restricted Duties

Concerns 14–15

14. *There was a plain reluctance to prioritise the safety of young people following Ben's death in that, the leaders Sean Glaister, Mary Carr and Gareth Williams were not subjected to "Restricted Duties" until 17.10.18 when Ben had died on 26.8.18 and in the time from Ben's death, Sean Glaister and Gareth Williams had taken part in a camp called "Deep Heat". POR (Policy, Organisation and Rules) indicated the neutral act of suspension should have been imposed as a minimum for Sean Glaister. Once the restricted duties were issued, there was confusion as to whether these related to individuals or specific activities and at least one of the leaders continued in their Scouting obligations with no restrictions as it related to "Scouts" rather than "Explorer Scouts" and so the restrictions were ineffective.*

15. *Suspension of Sean Glaister and Group Scout Leader Brian Garraway was only imposed in November 2022, four years after Ben's death, following the second inquest that needed to be adjourned due to non-disclosure. Suspension exists to ensure the safety and safeguarding of children until the investigation to establish facts has been undertaken.*

Compliance & Suspensions

We acknowledge that Ben's death was initially treated as a tragic accident. In hindsight, we were wrong to take that approach and we apologise for it. We also recognise than a timely FAI would have identified concerns. We followed legal advice at the time that informed our approach to implementing restricted duties on the leaders. Again, we made the wrong decision and should have suspended those involved. We have now changed our practices to underpin a culture of transparency and learning, making several immediate changes to ensure this will not happen again.

Actions

1. For any future incidents where there are significant near misses, injuries and/or a fatality, all relevant **individuals will be automatically suspended** (as a neutral act) to enable a full and frank investigation. This will be supported by changes in our polices and safety suspension powers, learning from how we currently operate within our Safeguarding team.

2. As set out in Section 2, we have agreed a **new approach to Critical Incident Investigation**. While the full policy is being finalised, the Board has agreed to enact the key requirements immediately. The new process will identify the key facts and enable robust and swift action where issues are identified within a framework of Root Cause Analysis to capture learning promptly.

3. In the event of a fatality, a senior level staff member **(Executive Director level) will be designated as the senior accountable person** for collating information and liaising

with relevant statutory agencies. They will report directly to the Board, ensuring clarity and communication at all levels.

4. We will **review our assessment criteria for Safeguarding** to ensure that any future critical incidents are automatically seen within a Safeguarding framework and can be assessed as such; by identifying any safeguarding concerns, and putting appropriate actions in place.

Section 5: Absence of Safeguarding and Safety Compliance

Concerns 16–19

16. *The nominal Explorer Scout Leader Sean Glaister in place when Ben Leonard died was subsequently appointed on Compass as a "District Section Leader Reddish Unit at Stockport" in November 2019. The formal interview to appoint Sean Glaister to the role the Reddish Explorer Scout Leader took place in 2020 after his appointment on Compass. It concerns me that notwithstanding the known failures in the planning and execution of the trip, and it having been identified by the County Commissioner, the District Commissioner, the Head of Safeguarding and Head of Safety at The Scout Association headquarters that Sean Glaister had lied in the planning for the trip at which Ben died.*

17. *Over 18-year-olds were allowed on this trip, by Sean Glaister, having not been listed on the Nights Away Notification ('NAN') form as adults, nor registered on the Scouts' Compass system or having undergone Disclosure Barring Service ('DBS') safeguarding checks.*

18. *In addition, the inquest has identified the limited knowledge and understanding of Sean Glaister of any of his training undertaken throughout his time acting as a volunteer leader for the Scouts. The lack of understanding of training was a similar picture for the other Leaders on the trip at which Ben died and for other Scouting witnesses.*

19. *This gives rise to a concern that there are other appointed Leaders in post who are not suitably competent or qualified in respect of the fundamental issues of safety and safeguarding.*

Competent and trained volunteers

Competent and effectively trained volunteers are vitally important to ensure the safety of all children and young people. We understand this must be underpinned by an effective culture of safety and prevention, and we recognise we have more to do to further improve both areas to enable consistency.

We accept the concerns raised by the Coroner. There was clearly a breakdown in our internal systems that enabled Sean Glaister to be fully appointed to a role supervising young people, for which we take full accountability and have acted to prevent a similar situation being repeated.

As part of our volunteer transformation programme (highlighted in section 3, point 7), we have also introduced key changes and new ways of working. We are continuing to invest in new approaches so that we can make sure everyone is fit and proper to undertake their roles with a culture of safety at the foundation. When volunteers apply for any role within Scouts, there is a local appointment process to assess suitability for each role including full references and appropriate disclosure and vetting checks conducted nationally. The recruitment process is overseen by our Regional and County Commissioners (senior volunteers). In addition, our strategic portfolio includes significant investment in a new adult membership system (AMS),

learning management system (LMS), and associated processes that will make appointing, tracking, and monitoring the competency of our volunteers more effective (detailed in Section 1, point 6, and Section 3 point 4).

To assure ourselves that all our individual volunteers have the skills and knowledge to keep young people safe, we are urgently undertaking a process to provide enhanced supplementary training and validation to support and ensure the competency of our 145,000 volunteers. Furthermore, we are working alongside the volunteer leadership to assure ourselves that other local appointments have been made in line with our policies and rules.

It was wrong for Sean Glaister to be appointed to the role of Explorer Leader in 2020, and we accept that anyone over the age of 18 should not have been on this trip without the correct planning and permissions.

We accept that Sean Glaister and others said they had limited knowledge of our training. In Section 3 (points 2 and 3), we have described the movement-wide review we are undertaking of our training to ensure these issues are robustly addressed.

As highlighted during this inquest, we are continuing to build robust approaches to Safeguarding practices and culture. We are committed to doing all that is practical to ensure all young people are always safe, and building a clear and ever-present safety culture. In response to this inquest and the concerns expressed by HM Coroner, we are now making a further investment to increase the size of our safety staff team and building a volunteer pool of experts to respond to and support the issues identified. This will increase capacity and offer additional support to our volunteers, including training support.

Actions

1. **The Scout Association Board have agreed to invest in and recruit sufficient safety and training focused staff** to deliver the commitments within this document, which will be informed by the external strategic safety review. However, **we are already taking action**. The Scout Association has already started to recruit to new roles into our safety team, and we are currently designing a new structure. A permanent structure with additional staff in the areas of safety and training support will be agreed at the October 2024 Board meeting.

2. The Scout Association are currently commissioning **enhanced supplementary safety training and validation for all 145,000 volunteers** with the new course available by September 2024 (detailed in Section 3, point 2).

3. We have **updated our safeguarding suspension system to include safety cases**. This will ensure any individuals who are appointed to volunteer roles during a safety suspension period are automatically flagged in our centralised case management system, which will prevent them from being appointed to another role while the suspension is active. This follows what we are doing in Safeguarding.

4. We have agreed to fully **review our new approach to training delivery and training content** in light of the findings from this inquest. This will be undertaken as part of our external strategic partnership. As in point 1 above, the Board have agreed to invest in and recruit the required staffing levels to support this commitment.

5. As set out in Sections 4 (point 1), **we have made changes to our systems and approach to enable suspensions for serious safety matters**. This will include the flagging and pausing of any changes to appointment for a volunteer role during any suspension and thorough investigation.

6. We will create **new, additional mandatory training and support** that is focused for our senior leaders (**District and County levels) so they are clear on their safety responsibilities.** This will further support the skills for their roles and will be underpinned by ongoing learning. We are planning this training to be externally validated and we are currently discussing this with potential providers. Learning from the inquest initial learning will be delivered by July 2024, then full ongoing training will roll out by October 2024 with completion within 6 months.

7. We will provide further training to all District and County Commissioners on the issues of over 18-year-olds and update the relevant guidance. This will be cascaded to all our volunteer leaders.

Other key areas of work

8. We have **made changes to our systems for those who turn 18, so they do not automatically become Network Members**. This addresses the safeguarding concern raised by HM Coroner in Concern 17 above.
    a. This will safeguard that:
        i. If anyone wishes to attend camp and they are over 18, they will need to have the correct membership level within our systems.
        ii. If they are assisting in the running of the camp, the relevant disclosure check has occurred prior to camp.
        iii. If they wish to participate in a camp with under 18s present, then the correct applications, staffing ratios, supervision and camp set up has been agreed prior with the District Commissioner (or approver) as part of the Nights Away Notification process.
        (This will also form part of our new Audit & Assurance review process (as detailed in Section 1, point 5).

9. We have **substantially changed our approach to Nights Away Notification** to ensure there is clarity on all documentation required, including the submission of risk assessments and all related planning documentation. As detailed in Section 1 (point 6), we are making further changes to this as we fully digitise the process within the new Adult Membership System. A recent staff supported review of Nights Away applications within the Greater Manchester East area found the correct paperwork to be in order, although we provided guidance on areas of improvement and offered best practice guidance on collating medical information.

Section 6: Monitoring, Auditing and Reliance on Volunteer Line and the need for paid Trainers

Concerns 20–25

20. *I have heard evidence that The Scout Association headquarters maintain that it is for the County and District as autonomous charities to monitor and audit training compliance. I am concerned that there are not robust systems of analysis, reporting and clarity as to the responsibilities of the County and District and what The Scout Association require from the County and District in respect of:*

    i. *Training compliance;*
    ii. *Completion of induction training within 5 months;*
    iii. *Completion of the full adult training scheme/ wood beads within 2 years;*
    iv. *Appointment to roles – both pre provisional, provisional, and full appointment;*
    v. *Granting of permits.*

21. *I heard evidence from the County Training Manager ('CTM') for Greater Manchester East- a volunteer role and he himself accepted that he had historically delivered training based on out-of-date factsheets and volunteered that he needed to update his own knowledge. I have been told that an urgent audit of the CTM occurred after his evidence to the inquest.*

22. *I have a concern therefore as to the general audit and inspection of County Training Managers nationally.*

23. *For Local Training Managers ('LTM') a process for validation exists whereby a training adviser interprets the Training Advisers Guide and has a broad scope within which they can validate a learner's training. This creates a risk of the approval of superficial and inadequate learning.*

24. *The provision of training relies heavily on the goodwill of volunteers and is time consuming. The expert to the inquest Mr Rosser recommended – as exists for other organisation and Charities – that there should be a paid regional individual with a responsibility for training who would serve as a point of contact for local volunteers should they require any support with their training and to ensure quality training and compliance.*

25. *Mr Rosser identified that this required a paid individual that was missing in the current chain between the volunteer line and The Scout Association necessary for training and delivery of activities.*

Monitoring, auditing, and supporting the volunteer line management

We agree with HM Coroner that we need to do more to ensure that, across Scouts, there is absolute clarity for Counties and Districts on the areas identified. This includes providing more support to local volunteers and to volunteer leadership.

We have already changed our approach:

- In 2023, we launched a new volunteer transformation programme, which has introduced changes to volunteer roles and leadership, training, systems and provided far greater clarity on expectations, including guidance and responsibilities.
- We changed existing Executive Committees (those running the 8,000 charities) to Trustee Boards, with greater clarity on expectations and their responsibilities.
- Since 2020, training compliance is monitored at local (89 counties), regional and national levels, including by The Scout Association Board.
- Local compliance data is produced monthly with swift action, including in relation to those not compliant (detailed Section 7 – Compliance & Suspensions).

Additionally, as highlighted in Section 5, point 1, The Scout Association Board have agreed to invest in further staff resources to support our safety work, adventurous activities, and training support, which responds to the recommendations made by Mr Rosser in concerns 24 and 25.

We accept that the County Training Manager for Greater Manchester East was using an out-of-date fact sheet in 2014, and that he needed to update his knowledge. We have undertaken an independent local review to provide assurance and to implement swift corrective actions.

Finally, as we outline below, we will keep investing in many areas to ensure we continue to build a culture that has safety, assurance, and accountability at its core.

Actions

1. In response to concerns 20–23, **we are investing in key new systems and resources** that will transform access to information and monitoring these including. These include:
    a. A **new Learner Management System**, which will provide significantly enhanced information and data for volunteers and volunteer management roles across the movement (detailed in Section 3, point 4).
    b. A **new Adult Membership System**, that will provide far great access to key information (detailed in Section 1, point 6).
    c. **A new movement-wide assurance framework** to support local leaders, monitor and audit compliance, including in relation to safety (detailed in Section 1, point 5).
    d. **Additional staffing resource** to support areas of safety, adventurous activities, training support, and local compliance (detailed in Section 5, point 1).
    e. **A strategic partnership that will review future safety training** and ensure we have identified the correct competencies and skills required to inform future training design, delivery, and validation (detailed in Section,1 point 3).
    f. The implementation of a **new approach to the auditing of adult training including the provision delivered by County Training Managers** under our new Audit & Assurance approach (detailed in Section 1, point 5).
    g. As we detail in Section 11 below, we are **undertaking a full review of permitting.**

Other key areas of work

2. While training non-compliance is already **monitored at The Scout Association Board level,** we will now also review **safety suspension data** to assure ourselves that preventative and corrective action is being embedded.

3. **The Scout Association Board will receive regular UK-wide heat mapping**[4], showing data in relation to training, safety, suspensions, and complaints.

4. In **Greater Manchester East, we have undertaken a full review of training provision** and put in place a volunteer and staff supported robust plan to enable the ongoing consistency and quality of provision. The plan includes changes to support, peer review, moderation, and leadership.

5. Since **2020, we have implemented new suspension protocols for any volunteer who has not completed their training**. This includes notification at 60 and 30 days prior to the expiry of any certification (usually three years), as highlighted in Section 7 (Suspensions & Compliance).

6. **All training guidance, fact sheets and materials are available from our website**. We have removed the ability to download fact sheets, so individuals must access the most up-to-date versions. We will continue to make sure our communications are clear on all relevant updates and changes.

[4] Heat Mapping uses data from various agreed sources to provide a coloured visual map. The colours, usually red, amber, and green, highlight where there may be issues or concerns within a specific geographic location after analysing all available data and identifying trends for further investigation.

Section 7: Delays in Training

Concerns 26–31

26. *Gareth Williams and Mary Carr had not completed their mandatory training within the 5-month period: Gareth Williams' training was 3 years and 9 months' late; Mary Carr's was 2 years and 1 month late.*

27. *Sean Glaister had not completed his wood beads training within the 2-year period; it was completed 2 years and 9 months late. There was no apparent sanction for having missed deadlines for training.*

28. *I was then provided with the following statistics, provided by Mr Kidd, the former UK Chief Commissioner of The Scout Association:*

    i. *"On 7 September 2018, there were 373 open roles in Stockport District that were in scope for Getting Started and Wood Badge training. The 373 roles were held by 318 volunteers.*
    ii. *There were 180 roles (48%) overdue for completing their Getting Started training.*
    iii. *There were 94 roles (25%) overdue for their Wood Badge training.*
    iv. *There were 318 volunteers in Stockport District that were in scope for first aid training. Of those 318 people, there were 57 (18%) who were overdue their first aid training. The rules at that time did not require first aid to be up to date at all times"*

29. *These statistics lead to the clear conclusion that there were widespread and significant gaps in training being completed in a timely manner, with concerns surrounding the training provision in the Stockport District.*

30. *Whilst the training statistics have notably improved, this is based on what I have considered on superficial and basic training which raises concerns around whether the core underlying principles such as risk assessments are being adequately understood.*

31. *I am concerned by evidence at the inquest that, presently, Stockport only has 6 Local Training Managers in post where 9 are required. The remaining 3 are "awaiting appointment".*

Training delays (please also see Section 3 – Safety Training)

We accept the above concerns expressed by HM Coroner, regarding delays in training and wider compliance issues across the movement in 2018. We have made significant progress since then, and there is now 98% compliance for Safety and Safeguarding training. However, we acknowledge the concerns raised by HM Coroner with regards to the training compliance statistics today, and as detailed in Section 3 (point 2), we are currently commissioning enhanced supplementary safety training and validation for all 145,000 volunteers to make certain that key issues, such as risk assessments and underlying principles, are understood.

We recognise that the effective delivery, quality, and governance of training is vital, and as detailed in Section 5, point 1, we are investing in additional paid training staff to ensure we respond to the concerns raised and issues identified.

Compliance & Suspensions

Since 2020, we have monitored training compliance at local and national levels across the movement. We have introduced new local powers to suspend volunteers significantly reducing non-compliance across Scouting. We are now going further and introducing a system whereby any volunteer who is not compliant with our mandatory Safeguarding and/or Safety training requirement will not be allowed to lead or plan activities and will be supervised at all times (to not be alone with children or young people).

We accept it was wrong that the three volunteer leaders had not completed the requisite training in the correct time. It was a failing in our systems to adequately identify this.

We accept the concerns of the HM Coroner with regards to the local training manager and have taken prompt action. This includes a full review into local practices and ways of working in relation to training. The result of this process is a bespoke action plan for Greater Manchester East to respond to the issues identified.

Actions

1. As outlined in Section 5, point 1, **The Scout Association Board have agreed to invest the necessary staff resources in order to ensure effective oversight of local delivery.** This will include a team of both new staff and senior volunteers. We are currently reviewing the requirements and future structure, which will be informed by our external strategic review, but will require significant investment into additional staffing.

2. Since 2020, **we have implemented new suspension protocols for any volunteer who has not completed their training**. This includes notification at 60 and 30 days prior to the expiry of any certification (usually three years).

3. As we highlight in Section 6 (but detail here for ease of reference), we are also investing in:
    a. A **new Learner Management System,** which will provide significantly enhanced information and data for volunteers and volunteer management roles across the movement as highlighted in Section 3, point 4.
    b. A **new Adult Membership System,** that will provide far great access to key information as highlighted in Section 1, point 6.
    c. **A new movement wide assurance framework** to support local leaders, monitor and audit compliance as highlighted in Section 1, point 5.

4. We would like to **confirm we are actively working with Greater Manchester East and Stockport to ensure they have sufficient training managers.** We are also **providing additional staffing and volunteer support** to make sure all issues are responded to.

Section 8: First Aid Kits

Findings 32–33

32. *I did not receive any evidence to suggest that, following an appropriate risk assessment for the Great Orme trip, there was a plan as to what type of first aid kit was required. None of the leaders had a first aid kit with them when they embarked on the walk up the Great Orme or on a 3-hour hike on the Saturday.*

33. *The Scout Association guidance on the website about first aid kit requirements is basic and the evidence I heard from Mr Killick gives me a concern that more should be done to ensure on every scouting trip and at scout huts there are appropriate first aid kits and contents including tourniquets to enable, if necessary, immediate life-saving treatment to be provided.*

First Aid Kits

We accept the concerns raised by HM Coroner. All leaders should have had a first aid kit suitable for the nature of the activity they were undertaking. As a result of the Coroner's concern, we have now reviewed this approach and our guidance.

Actions

1. We have **confirmed that the current information is fully in line with current Health & Safety Executive advice** and updated our guidance in line with industry standards (action completed).

2. We are **revising our guidance to make clear to all volunteers that first aid kit requirements are directly linked to the type of activity** (including terrain) and that they must also be informed by risk assessments. We will also provide example risk assessment to support this (to be completed by May 2024).

3. We will **enhance our online training to provide specific guidance on first aid kit suitability** and specifically to support the issues identified around terrain guidance (to be completed by September 2024).

4. **We will review our governance approach** and ensure that our First Aid Working Group has a review of the guidance relating to first aid kits as part of its annual review cycle. Our First Aid Working Group has a remit to provide a single focal point for all national level first aid decisions and actions, and to seek ways to improve the relevance and quality of first aid support and training across Scouts (to be completed by May 2024).

Section 9: First Aid Self Certification to meet Module 10 First Response requirement.

Findings 34–35

34. *There was a system in place whereby if a learner had a first aid at work certificate, they could self-certify that they had undertaken further learning, for Child CPR, hypothermia and meningitis to comply with Module 10 First Response. There were no checks to ensure that this further learning had been done, nor was it assessed.*

35. *I have heard evidence as to improvements that have been made to the learning gap and training to supplement a First aid at Work certificate as First Response Module 10 compliant, however, I am still concerned that the system lacks robustness.*

First Aid certification to meet module 10 requirement

We accept that the system in place at the time was not suitable and our guidance was not clear. At the time, we also acknowledge that our Policy, Organisation and Rules (POR) was not explicit on the nature of additional validation for child-specific elements that were not within most First Aid at Work qualifications (FAW), such as hypothermia, meningitis and child CPR.

Over the past five years, we have made several changes to our approach to our First Response training, and this is overseen by our First Aid Working Group.

In order to address HM Coroner's concerns, we have taken action to provide consistency across the movement and enable the robustness required.

Actions

1. All **volunteers who use FAW as a basis for First Response must subsequently meet with a First Aid Accredited trainer to demonstrate the specific child elements as part of a face-to-face practical element.** Only on passing this validation process will their accreditation be added to our training system.

2. **Any volunteer who has already used a FAW as the basis for First Response** within the past two years is **now required to undertake a validation meeting with a First Aid accredited trainer** if they have not already done so. (to be completed by November 2024)

3. Moving forwards, we will **monitor and track at Safety Committee (a sub-committee of the Board) all First Aid at Work conversion within The Scout Association** and ensure, as part of our ongoing audit cycle, that conversions and associated requirements are monitored and assessed through the appropriate audit process.

Section 10: Autonomous Charities

Findings 36–37

36. *The Scout Association is distant from its membership through its federated branches of 8000 charities and layers of hierarchy meaning that it cannot know how health and safety is executed at ground level. Training and POR are generated centrally, yet The Scout Association defer accountability for safeguarding and safety to the individual charities.*

37. *The centralised safeguarding team and safety team are not on par with each other in terms of resources and reach to local level. Safety is not prioritised in the same way as safeguarding has been. Safeguarding is reacted to more quickly than safety by The Scout Association.*

Federated model of the Scout movement

The issues identified by HM Coroner in concern 36 of the PFD notice have caused us to reflect hard on our structures and the challenges inherent in the scale of our activity. In particular, we have reflected on how we can strengthen relationships, support, communication and accountability, and introduce Third Party inspection and assurance within the movement.

We recognise that, in some cases, local charity governance has not been consistently well delivered and in some instances we have not provided sufficient support to local Scout Trustees. We are taking steps to address this as part of our transformation work that commenced at the start of 2023, which includes additional support and training to local Trustees, with support on safety responsibilities, good governance and building local accountability.

We know good governance underpins a culture of safety and accountability, rather than hindering it. However, if our federated structure presents barriers to the future safety of young people as we make the changes set out in this response, we are prepared to act and will propose to our Council (our most senior governing body) any changes we think are needed.

We accept that The Scout Association has a clear responsibility to ensure that it is not distant from its membership and that we learn from the issues and concerns raised during the inquest and by HM Coroner.

We have outlined a number of steps in this response which underpin our commitment to ensuring health and safety is consistently and reliably executed at ground level. This includes new systems for auditing and support of training, additional staff resources from working in partnership with our volunteer leadership, and clear powers for both staff and volunteer senior leaders so that volunteers do not supervise activities unless they have received the relevant training and/or Permits.

During the inquest, it became clear that knowledge at certain levels of our Policy, Organisation and Rules (POR) was not robust or clear. It is incumbent on us to change our systems and communication, so everyone in Scouts knows what is required of them and they have the

information they need. We will now review our approach and improve the clarity we provide to the charities within our federation and all our volunteers.

While local Scouts charities are responsible for the governance and decisions within their own separate charity, we take overall responsibility and accountability for safeguarding and safety within The Scout Association. Our central Safeguarding staff team and central Safety staff team, accountable to the Executive Director of Operations, hold the responsibility that all safeguarding and safety concerns are investigated and supported. Everyone in Scouting has a personal responsibility and accountability to ensure they uphold our safeguarding and safety requirements as outlined in our Yellow and Purple Cards. We would not expect this responsibility to be abdicated to local groups (even though they clearly do have a responsibility for safety within their group).

We also acknowledge the observation by HM Coroner that our Safeguarding team and Safety team in terms of resource and reach are not on par with each other, and that safety has a different structure and approach. While there are historical reasons for this, we have listened carefully to the concerns raised. As outlined in Section 5, point 1, we are investing in and designing a new structure with significantly increased staff resources. This new staff team will work in partnership with a team of senior volunteers with appropriate skills and experience.

Actions

1. As outlined within previous sections of our response, we are:
    a. **Further reviewing the support we need to provide to County and District leadership, including Trustees, so they have the right tools and support** in place to deliver the safest of provision. This is part of our volunteer transformation work.
    b. **Investing in new staffing resources** to significantly bolster our safety, adventurous activities, and training teams to work in partnership with our volunteer leadership. The new structure is to be agreed by the October 2024 Board meeting (with additional resources being recruited now).
    c. **Creating new safety suspension powers** as part of how we operate.
    d. **Reviewing our approach to training at all levels**, so we provide the right competencies, access to information and are clear on our rules with particular focus on safety requirements (linked to our external safety review)
    e. The Scout Association Board have **invested in a new Assurance & Audit staff team** that is already starting to be built.

2. Additionally, to underpin our approach moving forwards, we are in the process of **commissioning a new external strategic safety review**. As outlined in Section 1 (point 3), this will lead to:
    a. A comprehensive independent review of our current safety practices (including the risk assessment process – identification, mitigation, change, review and sign-off) to assess if learning is successfully delivered, appropriate and effective.
    b. A review of our safety training and required competencies and skills and future approaches and syllabus.
    c. The development of a revised safety framework and associated standards.
    d. A yearly independent review of all safety policies and processes, similar to the work already undertaken by NSPCC on our safeguarding policies and procedures.

3. Since 2018, we have held all-member calls, open to all volunteers with attendance of the entire volunteer leadership Team and Executive (staff) Leadership Team. We have a range of other communication methods so we can provide relevant and accurate information, and open communication.

Section 11: Permit/ Licencing Schemes

Finding 38

The example of Sean Glaister having been granted his Nights Away permit simply by providing a list of camps he had been on, demonstrates that there was no robust system in place to ensure that a permit holder responsible for children's safety was suitably qualified. There is no evidence he had the necessary skills and competencies to be granted such a permit. There was also a lack of clarity on where permits would be required for activities outside of the ordinary Scouts meeting place.

Permit Scheme

We accept that Sean Glaister should not have been granted a Nights Away permit based on the information he provided.

Permitting is a fundamental component to how Scouting operates and has a vital part to play in keeping people safe, especially in higher risk activities. To provide further assurance, many permit holders hold an externally recognised accreditation, which is used to assist with permit granting. This includes an external validation in areas such as mountaineering, water sports and adventurous activities.

We accept the Coroner's concerns regarding the Nights Away permit system and the circumstances when a permit is required. We will address them through the improvements in our permitting system outlined in detail in Section 3, point 6, as part of our new Adult Membership System. This will include the ability for all permitting to be fully digitised and auditable through the new online system. The new system will improve oversight, evidence, and approvals, so we have a consistent approach across Scouting.

As we have detailed in Section 1, point 5, our new Audit & Assurance work has Permitting as one of the initial areas of focus. It will continue to make sure we deliver the safest of provision and that it is effectively monitored at UK, County and District level. However, we have taken immediate steps to undertake a full UK-wide review of permit holders to confirm they have been issued in line with our policies and rules.

Finally, we are committed to externally reviewing our permitting scheme, working both with other NGBs and as part of our externally led strategic safety review. This will identify key issues and we will commit to any required changes.

Actions

1. **We have in train a process** whereby counties are assuring us **that permits have been issued appropriately in line with our Policy, Organisation and Rules (POR)**, and we are taking action where there are concerns or gaps. The Assurance and Audit team will subsequently spot check adherence (due for completion by August 2024, then ongoing).

2. Our **planned strategic partnership with an external expert body will include a full review of our permitting system**. We are also identifying other organisations who can add relevant expertise, such as NGOs and subject matter experts, to support this focused work. This will be completed within six months and the required actions implemented (due for completion by October 2024).

Appendices

Appendix A – Planned actions & delivery dates

As detailed within Section 2, page 10, we are currently undertaking a Fatal Accident Investigation into the Bens death. This will provide clear learning and recommendations shared with the family and HM Coroner including other relevant internal and external stakeholders. The main report is due in June 2024

Below are the other key actions we are undertaking.

No.	Action	Delivery date	Page
1.	Develop and adopt a new Duty of Candour Policy which will be published by July 2024.	July 2024	6
2.	Publish a new annual Safety Report that outlines our in-year learning reviews, lessons learnt, and actions taken.	Annual – intended first report April 2025	6
3.	Commission a new strategic partnership with a nationally recognised organisation that is a leader in safety to review our current safety practices, and act as a Third Party reviewer.	May 2024	6
4.	Working with our strategic partner, we have undertaken a comprehensive independent review of our current safety practices with clear recommendations for action. - Review all existing and proposed safety training and seek external accreditation.	Initial review by October 2024	6
5.	Working with our strategic partner to undertake a yearly review and audit of all safety policies and processes at The Scouts, similar to the work already undertaken by the NSPCC on our safeguarding policies and procedures. *For 2024, this review will form part of the comprehensive independent review above and be repeated annually*.	Annually – first review September 2024	6
6.	We will engage with National Governing Bodies (NGBs) and other relevant partner organisations to understand how they exercise external oversight and apply standards to their subject areas. We will use this research to develop an improved approach to external oversight in Scouting.	Initiated by June 2024	6
7.	Introduce a new internal assurance function consisting of staff and volunteers, to monitor and audit at local level all our 8,000 charities and provide reporting nationally to the Board.	April to November 2024	7

8.	Introduce the new Adult Membership System and associated improvements to managing safety compliance.	December 2024 to April 2025	7
9.	Introduce a new Critical Incident & Investigation Policy, that includes - Automatic neutral suspensions - Viewing incidents through the safeguarding framework	July 2024	11
10.	Develop training packages to support our new approach to Critical Incidents.	July 2024	11
11.	Conduct a yearly Critical Incident scenario exercise (independently reviewed and assessed).	December 2024	11
12.	Commission enhanced supplementary training and validation process for all 145,000 volunteers.	Training programme available by September 2024, and target completion of all volunteers within 6 months	13
13.	Introduce new Learning Management System to improve management and oversight of safety training.	December 2024	14
14.	Create new automatic suspension powers for those involved in Critical Incidents or significant near misses.	April 2024	16
15.	Increase the capacity of the safety team immediately and propose a new permanent structure to introduce additional staff in the areas of safety and training support.	April to October 2024	19
16.	Create new additional mandatory safety training and support that is level/role specific and appropriate for our senior District and County volunteer levels.	Urgent inquest learning by July 2024 – full training programme by October 2024 (completion within 6 months thereafter)	20
17.	The Board of Trustees will receive the first of regular reports on safety suspension data alongside heat maps of UK-wide compliance data relating to training completion, safety and safeguarding suspensions and complaints.	July 2024 meeting	23
18.	Ongoing support to ensure Greater Manchester East has the correct volunteers and support in place to deliver effective training.	Ongoing, target completion September 2024	24
19.	We will enhance our online training for volunteers to provide specific guidance on first aid kit suitability and terrain guidance.	September 2024	26

20.	Ensure that the reviewing of first aid kit guidance & contents is part of the annual review cycle for The First Aid Working Group.	May 2024	26
21.	Change our processes so volunteers who use a First Aid at Work certificate as the basis for their First Response accreditation must meet with a qualified trainer and demonstrate practical skills face-to-face.	June 2024	27
22.	Ask any volunteer who has already used a First Aid at Work certificate as the basis for their First Response accreditation to undertake a face-to-face re-validation meeting with a qualified First Aid Trainer.	Process starting May 2024	27
23.	County assurance process confirming that that permits have been issued appropriately in line with our Policy, Organisation and Rules (POR),	August 2024 (ongoing as part of new Audit & Assurance process)	31
24.	Undertake a full independent led review of our Permit Scheme.	October 2024	32

Appendix B – Fatal Accident Investigation Term of Reference

Purpose of the FAI

The Scouts Safety Committee has commissioned a Safe Scouting FAI into the circumstances relating to the incident where Ben Leonard, an Explorer Scout, suffered fatal injuries following a fall from the Great Orme in North Wales on 26th August 2018 and following the coroner inquest conclusion.

Owing to the nature of two previous failed inquests, significant document disclosure, and two Prevention of Future Death reports by HM Coroner, the FAIP must look at all available information, and only where absolutely necessary (to allow the FAIP to achieve its aims and objectives) speak to those relevant individuals. However, the FAIP must also be mindful of the ongoing and/or potential Police investigation(s) and the limitations that this may present on the ability to meet with those directly involved. It is envisaged that the considerable witness statements, evidence, and testimony should enable most areas to be robustly explored.

This FAI seeks to:

a) Undertake a systems-based investigation that explores the circumstances that led to the incident (what?), the contributing factor(s) to such circumstances (how?), and the root cause(s)/fundamental issues (why?)

b) Understand the risk control measures that should or could have avoided the incident. Understand the role, organisational and human factors that may have resulted in, or contributed to, actions and the underlying reasons for those actions and decisions that may have caused or contributed to this incident.

c) Make use of relevant research/previous Learning Review recommendations or FAIP reports to inform findings.

d) The FAIP and recommendations should be delivered by describing the outcome of what needs to be achieved rather than the output of what needs to happen in order to get to the outcome. This will allow for the Safety Committee to link with any previous learning and ensure the report truly reflects on any learning rather than a task list.

Aims and Objectives of the FAI

This FAI seeks to fully understand the factors that lead to Ben’s death, including the following objectives, to:

a) Assess the circumstances surrounding the incident, taking into account any external reports (such as police and coronial investigations) to establish the nature of the incident;

b) Assess the systems, processes and governance associated with the incident;

c) Identify any procedures adopted locally (including in respect of safeguarding and safety) at the time of the incident;

d) Assess the basis on which the Policy, Organisation and Rules (POR) of The Scout Association and associated guidance were followed and/or assisted or detracted from any

decision making process;

e) Understanding actions, the role and organisational factors and/or conditions, including the contribution of historic organisational changes, that led to a person(s) to act in the way they did;

f) Assess and understand the decisions and reasons why actions were taken by local Scouting members in the management of the activity/incident;

g) Assess adequacy and robustness of relevant assurance processes and whether those processes are sufficiently independent;

h) Understand the rationale for the decisions relating to suspension of leaders as opposed to placing them on restricted duties and the factors that led to this decision, including making future recommendations;

i) Assess why an FAIP was not undertaken directly after Ben's death; and

j) Assess the effectiveness of changes in risk control measures that have been implemented since the incident in 2018, in mitigating or preventing the system failures which contributed to or caused the incident.

Learning Points

The FAI will identify learning points for action that the Association, at any level, should undertake/implement to assure the future safety of young people, the effective response to such incidents and to maintain the confidence in Scouting's safety arrangements. These should include;

- culture,
- the impact, if any, of the Federated Structure,
- reporting issues,
- system and process changes,
- learning, changes to POR and guidance,
- training requirements,
- developments in good practice and
- any other learning points deemed relevant in the circumstances.

Learning points must focus on the outcome (and not the deliverables) which will be needed to achieve this outcome. The review group must indicate priorities where they feel there is significant importance, including the time scales appropriate for such recommendations. However, the responsibility for agreeing timescales and resource to achieve the approved learnings/requirements shall be a matter for the Safety Committee and be approved by the Board of The Scout Association.

Membership

- The review group will be made up of a minimum of five people.
- It will have an independent Chair to Scouting.
- The review group will consist of members of the Safe Scouting FAI Group, but may also seek membership from those with specific expertise relating to the incident or case.
- Members of the commissioning committee may not participate in a FAI.
- All those appointed to undertake a learning review must sign Scouts' confidentiality agreement and return to headquarters ahead of the review commencing.

FAI Members:	• Chair – Karen Thomas • [redacted] – External consultant • [redacted] – External consultant • [redacted] – Scout Volunteer Berkshire • [redacted] – consulting as required to panel on Youth Scouting experience
Safe Scouting Support:	• [redacted] – Safe Scouting Programme Sponsor
Senior Staff Support:	• [redacted] (Executive Director for Operations) • [redacted] (legal support) • [redacted] (Interim Head of Safety)

Timescales

Date FAI approved:		28th February 2024
Date ToR approved:	• Chair of Safety Committee • UK Chief Commissioner Executive Director of Operations	27th February 2024
	• Safety Committee	28th February 2024
Formally commissioned:		28th February 2024
Target date for report submission:	• TSA Safety Committee	June 2024
Report received:		

Generic ways of working/requirements

a) The FAIP should produce a clear, actionable report to be presented to the Safety Committee for review and agreement prior to being presented to the Board of Trustees.
b) Initial meeting to be set up within two weeks of identifying the FAIP membership to fully understand Terms of Reference (ToR) and internal support needed. This will be attended by a member of the Safe Scouting Management Team.
c) If during the FAIP there is information that indicates a child may be at risk of non-compliance with safety processes, procedures and rules, it must be flagged immediately with a member of the Safe Scouting Management Team (preferably on the day or as soon as is practically possible).
d) The FAIP will seek to conclude all interviews within six weeks from the date of the initial set up meeting (as per point 1). It is important to ensure the quality of the review, so extensions will be considered in the learning review keeping in touch meetings.
e) The Executive Director will set up a meeting within ten days of receipt of the report to be briefed and consider the learning points to be recommended to the Safety Committee. The report will be considered at the next face-to-face meeting of the Safety Committee.
f) The FAIP group should explore the existing information and research the evidence or statements provided as part of the inquest hearings. It should also include the impact on the other young people in the group and the volunteers. For clarity, this does not mean interviewing, but asking the group to keep the young person and their family at the centre of the review. This information can come from records.
g) It is recognised that the impact of the past five and a half years and recent inquest has impacted on individuals in different ways. An ongoing check by line managers of their staff members should be undertaken to ensure their welfare is of paramount focus. The UK Chief Commissioner will also work within the volunteer line to ensure the same approach. Should any individual need additional support, this will be provided as far as practically possible.

Version: 6.3

Appendix C – Safety changes since 2018

Area	Change	Date
Policy	POR Approval of activities 9.1. POR updated to be clear on the documenting of risk assessments.	February 2021
	Safety Policy now reviewed annually.	May 2021
	Change to approval processes for activities.	January 2022
	Documented risk assessment required as mandatory.	December 2022
	Activity and Nights Away Permit holders have to evidence their competency in risk assessment with 100% compliance rate. Assessors all have to have external accreditation (National Governing Body for XX) for chosen activity.	2020
Guidance	Change to Approval processes for Commissioners.	April 2020
	Terrain Definitions updated and clarified (Terrain zero specific).	April 2020
	Terrain Definition – review 2020, resources launched.	2021
	New safety checklists.	August 2020
	Approving activities guidance updated.	May 2020 Revised January 2022
	Risk assessment guidance updated.	August 2020
	Risk assessment examples launched and constantly expanded on Socuts.org.uk.	August 2020
	Review and update of website guidance on premises safety and web pages covering types of asbestos updated.	2021
	Guidance on talking to young people about safety.	July 2021
	Updates to risk assessment guidance – focus on reshaping narrative to look at safety to enable safe and enjoyable programmes.	February 2022
	Additional guidance for local managers, Group Scout Leaders and other local volunteers – how you make sure things are happening locally, including risk assessments.	February 2022
	Risk assessment guidance update – specific focus on contingency planning and ongoing dynamic decision making.	February 2023
Processes:	Mandate risk assessment being provided with Nights Away Notifications (NAN) form.	April 2020 and June 2020
	Review and improvement of HQ (The Scout Association) Safety Management System, The Scout Association Health and Safety website launched.	2021
	Launch new safety incident reporting tool (Eclipse).	2020–22
	NAN process and form updated to including contingency planning.	February 2023
Training	Mandatory Safety training changed and updated with learnings from 2018 and Inquest 1.	2020 updated 2024
	Launch of the updated first response training programme in partnership with Girlguiding.	November 2020
	First Aid compliance – significant programme to drive first aid training compliance (as of March 2024 – 97%).	2020 onwards
	First Aid – who needs it guidance amended.	2024
	Line manager safety induction workshops updated.	September 2022
	Safety role specific induction content is being pulled into role specific training and mandated from the start of transformation.	

Area	Change	Date
	safety and safeguarding training modules – Module 1 (Essential Information) and Module 1E (trustee induction) rolled out.	September 2020
	Risk assessment videos launched.	2020
	Managers and Trustees committee training updated and mandated.	September 2020
	Safety training 100% pass mark required and taken fully online and managed by The Scout Association central, clarified assessment and learning relating to the safety policy.	August 2020
	Launch of two new webinars – one including premises safety and one on asbestos management underpinning focus on risk and risk management.	2021
	Governance webinars on supporting Trustees on managing and supporting risk.	July 2021
	Support for World Scouting Jamboree on using dynamic risk assessment processes.	April/May 2023
	Communications to members – informing of all changes.	Ongoing
Comms	Local Trustees – Health & Safety focus.	Yearly update
	Board meetings – Nations Boards.	Yearly update
	Hill walking resources.	2022
Resources	DC confidence survey.	2022
Assurance	Bank of risk assessment guidance and support videos.	2021
	COVID-19 restart risk assessment – good data and evidence provided, including dip sampling.	2020–21
	RAAC – underpinning needs for risk assessment processes.	2023
	Adult membership– NAN & NAP processes – new multi-million pound membership system, bringing key processes fully online for approval and audit.	Build through 2023, fully rolled out by November 24
	New Assurance framework investment agreed at Board Level.	October 2023
	Ongoing updates to Data & Insights focusing on Training Compliance and suspensions for non-compliance.	2021
	Assurance policy.	May 2022
	Central safety function established and Head of Safety role created with associated investment.	April 2021
	Safety team enlarged with additional movement facing Safety and Compliance Officers Allows for more: • Planned site visits across UK • Reactive visits • Requests for visits • Post incident reviews and active visits to concerns sites • Face to face County and District Commissioner support	January/ February 2022
	Safety team KPIs.	2023
	Central safety team has done 100% sample activity Permit moderation (annually, every County is required to do a self-assessment).	2022

Appendix D – 'Growing Roots' Overview

The modules outlined below are part of our upcoming changes to training.

a. **Safe Scouting** (including)
    i. Understanding safety
    ii. Assessing and managing risk
    iii. Managing and reporting incidents
    iv. Safeguarding – why it is important
    v. Recognising concerns

b. **Creating Inclusion** – how we make Scouts a welcoming space for everybody.
    i. How to challenge assumptions
    ii. Practical ways to be more inclusive in everything we do
    iii. How to respond when people need reasonable adjustments
    iv. How to challenge discrimination

c. **Data Protection** – how we take care of people's personal data.
    i. What data protection and personal data is
    ii. How to gather personal data in Scouts
    iii. How to use, share and store personal data in Scouts
    iv. How to delete or archive personal data securely
    v. How to respond in case of a data breach or subject access request

d. **Who we are and what we do** – what Scouts is and how we help young people develop skills for life.
    i. Our purpose, Promise and values as Scouts
    ii. The support that's available to you
    iii. How our different teams work together
    iv. How Scouts create impact

Volunteers leading and running youth sections will also be required to complete:

e. **Delivering a great programme** – an introduction to how to run and deliver safe programmes.
    i. The Scout Method and how we create impact
    ii. How to involve young people and be youth led
    iii. How to promote positive behaviour when working with young people
    iv. How to plan and run our programmes, so young people can achieve their top awards
    v. How to work with parents and carers of our young people

f. First Response
    i. Managing a first aid incident
    ii. Offering emergency life support such as CPR
    iii. Helping in situations where a person is unconscious
    iv. Dealing with common Scouting injuries, including bleeding, sprains and head injuries
    v. A basic understanding of some of the major illnesses: asthma, stoke, diabetes, and so on