David Pojur
Assistant Coroner for North Wales (East and Central)

BEN LEONARD INQUEST
PREVENTION OF FUTURE DEATH REPORT No.2

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1.** The Scouts Association, England, [redacted] **2.** Unity Insurance Services: Scouting and Scout Groups Insurance **3.** Secretary of State for Education, Gillian Keegan MP **4.** Minister of State for Children and Families, David Johnston MP **5.** Minister for Education, Wales, Jeremy Miles MS **6.** Children's Commissioner for England, [redacted] **7.** Children's Commissioner for Wales, [redacted] **8.** Charity Commission for England and Wales, [redacted] **9.** Health and Safety Executive, [redacted].
1	**CORONER** I am David Pojur Assistant Coroner for North Wales (East and Central), Sitting at the Manchester Civil Justice Centre.
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On the 28.8.18 the Court commenced an investigation into the death of Benjamin David Leonard (DOB 01.11.01). Ben died on 26.8.18.

	The investigation continued with a 5-day jury inquest from 3.2.20-7.2.20. Whilst the jury were in jury retirement, on hearing the PFD evidence it became apparent that the Court had been misled, resulting in the jury being discharged on 7.2.20. On 7.2.20, I issued a Report to Prevent Future Deaths ('PFD') with the following 20 points: 1. The arranging of the trip did not adhere to the Scouts Association's own safety policies. 2. Such policies were not adequately understood at grass roots level. 3. Safety policies exist but are not implemented. 4. There was no written risk assessment. 5. There was no dynamic risk assessment. 6. There is not a full understanding of what a risk assessment is. 7. There is not a full understanding on when to do written and/or dynamic risk assessments. 8. There had been no approval sought for the trip as required from the District Commissioner. 9. There was an absence of a permanent District Commissioner to give oversight to the leadership of the group. 10. There was no meaningful discussion between the scout leaders as to the plan for trip on the Great Orme. 11. The leaders did not have a participant list nor list of phone numbers for the boys. 12. There was no route planned for the Great Orme trip. 13. No instruction or briefing was given to the boys. 14. Each of the 3 leaders assumed the 3 boys were with one of the leaders when in fact they were not. They were on their own. 15. There was no effective leadership for the group. 16. The Scouts Association failed to provide the Court with full information about the action it had in fact taken concerning its leaders on the trip, post death. 17. The Scouts Association created a misleading impression in the evidence concerning its actions regarding its leaders on the trip post death.

	18. The Scouts Association is distant from its membership through its federated branches of 8,000 charities and layers of hierarchy meaning that it cannot know how health and safety is executed at ground level. 19. The health and safety training intervals for leaders are said to be every 3 years with no way of assessing their competencies. 20. The lives of young people are being put at risk by The Scouts Association's failure to recognise the inadequacies of their operational practice and the part this has played in the death of Ben. Responses to this PFD Report were provided from The Scouts Association dated 1.4.20 and then an updated response dated 12.2.21. The Second jury inquest was fixed for 4 weeks and was due to proceed on 2.11.22 but had to be aborted due to material non-disclosure to the court. The Third jury inquest began on 4.1.24 and concluded on 22.2.24. The Jury recorded their ultimate Conclusion in Section 4 was: **Unlawful killing by the Explorer Scout Leader and Assistant Explorer Scout Leader contributed to by the Neglect of the Scouts Association.**
4	**CIRCUMSTANCES OF THE DEATH** Ben (aged 16) was on a 3-day Explorer Scout trip in North Wales with 3 leaders and 8 other Explorer Scouts. Prior to the trip, Ben had undergone a circumcision. On the day of arrival, the Assistant Explorer Scout Leader took all the Explorer Scouts on a 3-hour unplanned hike without the other leaders. The next day's plan of going up Snowdon was rearranged due to poor weather conditions. They instead went to Llandudno. After breakfast, the Explorer Scout Leader and his son left to move his car. The two other leaders and remaining Scouts walked through the town towards the Great Orme. There was no brief, instructions or written risk assessment was done. The group then proceeded up the Orme led by the Assistant Explorer Scout Leader, with the Assistant Scout Leader at the rear.

	Ben and two of the other Explorer Scouts split off from the main group, taking a different path up the Orme. Part way up the Orme, the Assistant Scout Leader paused and broke away from the group. Near the top of the Orme, the Assistant Explorer Scout Leader saw Ben and the two other Scouts on the grassy tops. The Assistant Explorer Scout Leader did not give any instructions to regroup, or to stay on the safe path. Ben and the two other Scouts were left unsupervised and proceeded to walk to the cliff edge. Ben complained of discomfort due to circumcision. Ben thought he could see a quicker way down the Orme and attempted to follow animal tracks down the cliff edge. During his descent, Ben slipped and fell from the cliff. Paramedics attended the scene and performed medical interventions and CPR. Ben was pronounced dead at 14:45 on the 26th August 2018 due to head injury.
5	**CORONER'S CONCERNS** During the course of the inquest, the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. Public Inquiry As part of the submission received to me from the Leonard family, it is said such are the matters of concern in the Inquest of Ben Leonard as to system issues relating to safety and safeguarding, that there is an urgent need for the establishment of a Public Inquiry under the Inquiries Act 2005 into The Scouts Association (be that statutory or non-statutory), and asking me to write to the relevant minister to request the establishment of a Public Inquiry. I have only considered the inquest relating to Ben Leonard and not wider cases. However, the matters of concern are below, and the relevant minister is sent this report to consider the issues and the request of the family. The **MATTERS OF CONCERN** are as follows. –

Culture of Candour and Independent Inspection

1. I am concerned that there is not a culture of candour within The Scouts 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 Scouts Association or the granting of permits for adventurous activities, hill walking and Nights Away permits. Further, The Scouts Association permit scheme for adventurous activities is exempt from regulation by the Health and Safety Executive ('HSE').

Fatal Accident Inquiry Panel Investigation Report (FAIP) now termed "Learning Review"

3. Following Ben's death as indicated by Chapter 7 of The Scout's 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 Scouts 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 Scouts 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 Scouts 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 Scouts Association reconstruction trip to the Great Orme after Ben's death on 9.10.18 attended by The Scouts Association Senior Scouting leadership and lawyers with the actual leaders from the trip indicates a desire by the Scouts 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 Scouts 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.

Safety Training

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

Restricted Duties

14. There was a plain reluctance to prioritise the safety of young people following Ben's death in that, the leaders [redacted]

[redacted] 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, [redacted] 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 [redacted]. 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 [redacted] and Group Scout Leader [redacted] 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.

<u>Absence of Safeguarding and Safety Compliance</u>

16. The nominal Explorer Scout Leader [redacted] 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 [redacted] 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 Scouts Association headquarters that [redacted] had lied in the planning for the trip at which Ben died.

17. Over 18-year-olds were allowed on this trip, by [redacted], 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 [redacted] 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.

<u>Monitoring, Auditing and Reliance on Volunteer Line and the need for paid Trainers</u>

20. I have heard evidence that The Scouts 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 Scouts 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 [redacted] 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. [redacted] identified that this required a paid individual that was missing in the current chain between the volunteer line and The Scouts Association necessary for training and delivery of activities.

<u>Delays in Training</u>

26. [redacted] had not completed their mandatory training within the 5-month period: [redacted]' training was 3 years and 9 months' late; [redacted] was 2 years and 1 month late.

27. [redacted] 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 [redacted], the former UK Chief Commissioner of The Scouts 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".

<u>First Aid Kits</u>

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 Scouts Association guidance on the website about first aid kit requirements is basic and the evidence I heard from [redacted] 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 Self Certification to meet Module 10 First Response requirement

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.

Autonomous Charities

36. The Scouts 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 Scouts 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 Scouts Association. <u>Permit/ Licencing Schemes</u> 38. The example of [redacted] 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. 39. The Scouts Association press release within moments of the jury's conclusion demonstrates a failure of The Scouts Association to accept any accountability and understanding any proper learning from Ben's death. The Scouts Association is institutionally defensive.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely **18.04.2024.** I, David Pojur, Assistant Coroner, may extend the period.

	Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise, you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Family of the Deceased and to the Chief Coroner. I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner. Regulation 28(4) of the Coroners (Investigations) Regulations 2013, requires that a copy of this Report be sent to the Local Child Safeguarding Board as Ben was under 18 years of age when he died. It will be sent to the Board for the area where Ben lived as well as to the Board for the area where he died. Copies of this Report will be sent to: 1. Child Death Overview Panel (Tameside, Trafford and Stockport); 2. Child Death Review Team (Wales) 3. Scouts Scotland, [redacted] 4. Scouts Northern Ireland, [redacted] 5. World Organisation of Scout Movement, [redacted] 6. Mountain Rescue for England and Wales 7. All Tracks Academy, Whistler, Canada 8. Conwy Centres, Wales 9. HM Senior Coroner for North West Wales, Ms Kate Robertson

	10. HM Senior Coroner for Lancashire and Blackburn with Darwen, Dr James Adeley
9	Dated 22.2.24  Signature David Pojur Assistant Coroner for North Wales (East and Central) Sitting at the Manchester Civil Justice Centre