

ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	<p>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</p> <p>THIS REPORT IS BEING SENT TO:</p> <p>1. The Scouting Association</p>
1	<p>CORONER</p> <p>I am James Newman , who at the time of the inquest touching upon the death of Jack Saunders was the area coroner, for the coroner area of Lancashire and Blackburn with Darwen</p>
2	<p>CORONER'S LEGAL POWERS</p> <p>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.</p>
3	<p>INVESTIGATION and INQUEST</p> <p>On 14th August 2017 I commenced an investigation into the death of Jack William Saunders, 21. The investigation concluded at the end of the inquest on 10th January 2020. The conclusion of the inquest was that Jack Saunders died of carbon monoxide poisoning within 24-hours of arrival at Waddecar Scout Centre on 29th March 2017. The jury recorded that Jack, who had medical diagnoses of ASD and dyslexia which affected his learning stye. As a jury they were unanimous as to him having no training and instruction regarding the dangers of carbon monoxide, resulting from the use of fuel burning appliances in tents, received by Jack as he learnt from example, the evidence leading to Jack having seen these practices being undertaken at previous camps, including Linnet Clough in 2017, and show lack of understanding to the dangers of that risk. They further found that Jack attended Waddecar Scout Camp on 29th March 2017, alone and probable time of his death was within 24-hours of his returning to site after going to the supermarket.</p>
4	<p>CIRCUMSTANCES OF THE DEATH</p> <p>The evidence heard was that Jack Saunders had been a cub from the age of 8-years-old, joining the 8th Solihull Group, and progressed through cubs to scouts, achieving awards and merits, including the Chief Scout's Coral Award, but at around the age of 16 left as there was no available Explorer Scout Troup. It was set out that in adulthood Jack returned as an adult volunteer, during which he was provided with an adult training booklet and a training assessor, who would prepare a personal learning plan. There was no evidence of a personal learning plan available at the inquest or evidence of any certificates of completion of training.</p> <p>The evidence set out identified that Jack had travelled to Waddecar Scout Camp, as a scout, and in adulthood, sought to replicate this experience, and booked to travel up from his home to Waddecar on 29th March 2017. There is conflicting evidence as to whether it was his intention to camp with friends, or not, although there is no evidence to suggest that anyone either travelled up with him or visited him once he was there. The evidence did indicate that in preparing to camp, he had borrowed a gas cooker and a Landman outdoor heater from the 8th Solihull Scout Group, with the knowledge of at</p>

	<p>least one other scout leader, his training assessor.</p> <p>The available evidence confirmed that Jack arrived at the camp site on 29th March 2017, and signed in, before erecting his camp and then leaving to go to a supermarket to buy provision. Jack was not seen again until on 3rd April 2017, the day after he was due to have left, when a site staff went to check on him and found him deceased in his tent.</p> <p>Postmortem, and in particular toxicology, identified a carboxyhaemoglobin level of 54% and the pathologist advanced a cause of death of 1a Carbon Monoxide poisoning, and whilst extensive examination of the time of death, this could not be clarified. Evidence was available to confirm that Jack had been alive as at 22:35 on the night of 29th March 2017 from the sending of a text message, and the pathologist suggested that it was possible that he had passed away within 24-hours of being found, there was inconsistencies given the lack of provisions consumed and no further telephone activity.</p> <p>Investigations found the two gas burning pieces of equipment inside the tent, turned off, but still connected to the gas bottles. Extensive testing identified that whilst both pieces of equipment functioned appropriately, the Landman Outdoor heater generated high levels of carbon monoxide over a short period of time. The expert investigation concluded, as heard by the inquest, that this was the source of the carbon monoxide that led to Jack's death. This was accepted by the jury.</p> <p>The evidence, and findings of the jury, was that the training that Jack received was limited in respect of the risks of carbon monoxide was limited, particularly given his learning style, brought about by his dyslexia and autistic spectrum disorder, and that it was likely that he had observed adult leaders using such heaters and gas hobs inside mess tents on previous camping expeditions.</p> <p>The jury found that Jack had received no training or instruction regarding the dangers of carbon monoxide resulting from the use of fuel burning appliances in tents, as he learnt by example, and had observed such practices on previous camps. They further found that he passed away within 24-hours or returning to the campsite after visiting the supermarket on 29th March 2017.</p>
5	<p><u>CORONER'S CONCERNS</u></p> <p>During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you.</p> <p>The MATTERS OF CONCERN are as follows. –</p> <ol style="list-style-type: none"> (1) The equipment that had been borrowed had no instructions available as to their use, and although there were illustrations/instructions on the equipment itself warning against use in enclosed spaces, these were small and could have been clearer. (2) That on the finding of the jury, whilst knowledge around the risks of carbon monoxide poisoning was known and training had been prepared nationally, this had not reached the trainers within individual troops. (3) That Jack, even if informed of the risks, had observed other adult leaders using gas fuelled equipment in tents, particularly mess tents, on previous camps, and due to his visual learning style, would have placed greater reliance on the same.
6	<p>ACTION SHOULD BE TAKEN</p> <p>In my opinion action should be taken to prevent future deaths and I believe you and your organisation have the power to take such action.</p>

7	<p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 27th May 2026. I, the coroner, may extend the period.</p> <p>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.</p>
8	<p>COPIES and PUBLICATION</p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:</p> <p>████████████████████ Preston City Council</p> <p>I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>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.</p>
9	<p style="text-align: right;">31st March 2026</p> <p>James Newman</p>