ACPNS LEGAL CASE REPORTS SERIES

This series compiles short summaries of significant cases involving charitable, philanthropic, nonprofit and social enterprise organisations in Australia and overseas.

Benjamin Leonard: Prevention of future deaths report

Coroner's Report, Assistant Coroner for North Wales David Pojur, 26 February 2024

A report concerning the death of a minor while engaged in scouting activities.

Key words: Scouting, England and Wales, Death of a Child, Unlawful Killing, Safety, Safeguarding, Training, Volunteers

1. This was a prevention of future deaths (PFD) report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.

2. Benjamin Leonard (Ben) died on 26 August 2018 while engaged on a scouting trip in Wales.

3. There were three jury inquests in the Coroner's Court related to the case. The first was in February 2020. However, whilst the jury were in jury retirement, it became apparent that the Court had been misled, resulting in the jury being discharged.

4. The second inquest was due in November 2022, but had to be aborted due to material non-disclosure to the Court.

5. The third was in January 2024 with the jury's conclusion being that there had been an unlawful killing by the Explorer Scout Leader and Assistant Explorer Scout Leader contributed to by the neglect of The Scouts Association (TSA).

6. The facts of the case were that Ben attended a three day Explorer Scout trip, together with 3 leaders and 8 other scouts.

7. On the first day there was an unplanned three hour hike accompanied only by the Assistant Explorer Scout Leader. On the second day, a hike up Snowden was cancelled due to bad weather. The scouts instead went to Llandudno.

8. After breakfast, the Explorer Scout Leader and his son left to move his car. The two assistant scout leaders and remaining scouts walked through the town towards the Great Orme, northwest of Llandudno. The group then proceeded up the Orme led by the Assistant Explorer Scout Leader, with the Assistant Scout Leader at the rear.

9. For this excursion, there was no brief, instructions, or written risk assessment undertaken.

10. Ben and two other scouts separated from the main group onto a different path. Having been seen to be apart, there was no instruction given to regroup, or to stay on a safe path.

11. Ben felt unwell, and sought a quicker way down the slope via some animal tracks, but slipped and fell, dying from head injuries.

12. The Coroner expressed serious concerns about the safety measures taken by the leaders involved, and by the Scouts Association.

13. The matters of concern were:

Culture of Candour and Independent Inspection

14. The Coroner was concerned that there is not a culture of candour within TSA and the impact that this failing had on safety and safeguarding.

15. There was also concern that, whilst the Charity Commission had regulatory oversight, there was no robust regulator who independently and periodically audits and inspects the systems, processes and training of TSA, or the granting of permits for adventurous activities, hill walking and Nights Away permits. Further, the Association's permit scheme for adventurous activities was exempt from regulation by the Health and Safety Executive (HSE).

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

16. Following Ben's death 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 TSA 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.

17. The Coroner noted that as of 22 February 2024, there was still no Fatal Accident Inquiry Panel Report (FAIP) in existence. Further, even the prospective panel members for the investigation had not been identified. He had received a document entitled 'BL Great Orme Learning and Actions Update' dated 30 September 2019, which he characterised as 'inadequate when considering the root and branch type of review needed following a child fatality to identify and address issues of safety and safeguarding'. TSA stated that there had been no investigation because of the police investigation, and then because of the inquests.

18. Without a timely internal FAIP the Coroner had 'great concern' that issues of safety and safeguarding were not properly considered, transparently engaged with, and then addressed formally in respect of a child fatality.

19. The evidence provided by The Scouts Association had been inconsistent as to when it is said a FAIP report was commissioned and completed in circumstances where there was an inquest.

20. A FAIP investigation, initiated by the charity and company secretary, should have engaged with the early identification by the District Commissioner, County Commissioner, and TSA 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.

21. In the Coroner's view, a TSA reconstruction trip to Great Orme after Ben's death on 9 October 2018 attended by TSA Senior Scouting leadership and lawyers, together with the actual leaders from the trip, indicated a desire by TSA headquarters staff to control the narrative, especially surrounding dynamic risk assessment.

22. The Coroner noted that any investigation at County or District level was prevented by TSA headquarters. The District and County Commissioners had identified failings and concerns relating to safety and safeguarding on the day Ben died. The extent of the failings was known, and many others were identified following the trip to Great Orme on 9 October 2018.

23. Thus, the Coroner stated that the evidence he had heard led him to have a concern as to a general reluctance by TSA to engage in a meaningful learning exercise to prevent a recurrence of the issues pertaining to Ben's death. Further, a previous recent FAIP report concerning the death of a 21 year old leader had not been communicated to the relevant Coroner. The Coroner in this case was of the view that this non-provision was standard practice.

24. The Coroner thus had concerns that not all matters regarding deaths connected with the Scouting Movement and Association were being communicated, even by provision of draft reports and recommendations, to His Majesty's Coroners of England and Wales to inform PFD issues and a Coroner's PFD reporting duties.

Safety Training

25. Safety training was predominantly done online. The Coroner, having undertaken the course himself, was concerned that the course was superficial at best and fundamentally basic. It could be completed in 12 minutes. It was unsurprising that the current pass rate was correspondingly high. This caused 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 did not embed the fundamental principles of safety and safe scouting.

Restricted Duties

26. The Coroner raised a concern that the leaders in question were not subjected to "Restricted Duties" immediately after Ben's death. POR (Policy, Organisation and Rules) indicated the neutral act of suspension should have been imposed as a minimum. When the restricted duties were eventually applied, 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', making the restrictions ineffective.

Absence of Safeguarding and Safety Compliance

27. The nominal Explorer Scout Leader in place when Ben died was subsequently appointed as a District Section Leader in November 2019. The Coroner was concerned that this was notwithstanding the known failures in the planning and execution of the trip where Ben died, as identified by the County Commissioner, the District Commissioner, the Head of Safeguarding, and Head of Safety at TSA headquarters.

28. In addition, the inquest identified the limited knowledge and understanding of any of the main leader's training undertaken throughout his time acting as a volunteer leader for the Scouts. The lack of understanding of training was similar for the other leaders on the trip on which Ben died, and for other scouting witnesses appearing at the inquest.

29. This gave rise to a concern that there were other appointed leaders in post who were not suitably competent or qualified in respect of the fundamental issues concerning safety and safeguarding.

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

30. TSA headquarters maintained that it was for the County and District as autonomous charities to monitor and audit training compliance. The Coroner was concerned that there were not robust systems of analysis, reporting and clarity as to the responsibilities of the County and District, and what TSA required 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 appointments;
    v. Granting of permits.

31. The evidence from the County Training Manager for Greater Manchester East (a volunteer role) was that he had historically delivered training based on out-of-date factsheets and that he needed to update his own knowledge.

32. The Coroner had a concern therefore as to the general audit and inspection of County Training Managers nationally, and indicated that an urgent audit was required because of the risk of superficial and inadequate learning.

33. The provision of training relied heavily on the goodwill of volunteers and was time consuming. The expert to the inquest recommended that, as exists for other organisation and charities, there should be a paid regional individual with 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.

Delays in Training

34. The relevant leaders on Ben's trip had not completed their mandatory training within the required 5 month period. Their training was up to 3 years and 9 months late. There was no apparent sanction for missing deadlines for training.

35. Evidence indicated that late training amongst leaders was commonplace, with the statistics leading to 'the clear conclusion that there were widespread and significant gaps in training being completed in a timely manner', with concerns surrounding training provision generally.

36. Moreover, the training was what the Coroner considered to be superficial and basic which raised concerns around whether the core underlying principles such as risk assessments were being adequately understood.

First Aid Kits

37. None of the leaders had a first aid kit with them when they embarked on the walk up Great Orme, or on the 3 hour hike on the Saturday. TSA website guidance about first aid kit requirements was basic, and the Coroner had a concern that more should be done to ensure that on every scouting trip and at scout huts generally there were appropriate first aid kits and contents including tourniquets to enable, if necessary, immediate life-saving treatment to be provided.

Autonomous Charities

38. Because of its structure, TSA 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 the local level. Training and

POR are generated centrally, yet TSA defers accountability for safeguarding and safety to the individual local charities.

39. The centralised safeguarding team and safety team were not adequately resourced to reach all the local charities that formed TSA. Therefore, safety was not prioritised in the same way as safeguarding has been. Safeguarding was reacted to more quickly than safety by TSA.

Permit/ Licencing Schemes

40. There was no robust system in place to ensure that a permit holder responsible for children's safety was suitably qualified. There was no evidence that the scout leaders in question had the necessary skills and competencies to be granted such a permit. There was also a lack of clarity on when permits would be required for activities outside of the ordinary scouts meeting place.

Accountability

41. The Coroner concluded his report by saying that TSA's press release within moments of the jury's conclusion demonstrated a failure by TSA to accept any accountability, or understand any proper learning from Ben's death. The Coroner's final remark was that 'The Scouts Association is institutionally defensive'.

Public Inquiry

42. As a separate issue, the Coroner noted that such are the matters of concern raised by this inquest as to system issues relating to safety and safeguarding, that the family of Ben submitted that there was an urgent need for the establishment of a Public Inquiry under the Inquiries Act 2005 into The Scouts Association (either statutory or non-statutory). He had therefore written to the relevant minister to request the establishment of a Public Inquiry.

COMMENT

The outcome of this inquest signals to charities that compliance with safety and safeguarding issues is of major importance to maintain public trust.

In all matters, charities should have legal compliance in mind as a daily part of their work. Moreover, the Charity Commission of England and Wales's definition of 'safeguarding' is much wider than any legislative one because it involves keeping from harm anyone who comes into contact with a charity.

The Charity Commission published its new five year strategy on 26 February 2024, underpinned by five key priorities, the second of which is to support charities 'to get it right but to take robust action where it sees wrongdoing and harm'. The implication is that the Commission will place equal emphasis on being a source of support to trustees and on enforcement. Therefore, compliance is increasingly a central requirement for charities. This is underlined by the latest version of the Commission's annual return, which asks registered charities to indicate the policies and procedures they have in place from a list provided (at section 8), and has a separate section on safeguarding and risk that charities must comply with (at section 9).

In an increasingly complex regulatory environment, it is critical for charities not only to have appropriate written policies in place, but for all staff and volunteers to be properly trained in them, and for those policies to be implemented in practice and their proper implementation monitored.

In this case, the Assistant Coroner noted an important issue relating to effective management of health and safety which appeared to be inbuilt into the structure of TSA. TSA is at the apex of a federated structure of many smaller scout groups (which are also charities) around the UK. Sections are organised into groups, which in turn are organised into districts, all managed within counties. All these sits within overarching regional and national structures that make up TSA.

Each group, district and county are a separate charity, each with their own trustee board, but within a federation of charities operating under the auspices of a Royal Charter. All groups must follow The Association's Policy, Organisation and Rules (POR).

In his report, the Assistant Coroner observed that TSA was distant from its membership because of its federated structure of '8,000 charities and layers and hierarchy', meaning that it is difficult for TSA to know how health and safety is being managed at the local level. However, as the Coroner's report emphasised, difficulty does not preclude responsibility.

While most charities are not part of a federated structure, nevertheless there are hierarchies of authority within all but the smallest of charities, with boards retaining responsibility for oversight of their charity's work even if they delegate its day-to-day operation to paid staff and volunteers. Therefore, the Coroner's remarks are of general application i.e. all connected with a charity (or a group of charities) have their part to play in ensuring a culture of compliance to avoid serious civil, criminal or other consequences.

The coroner noted that there were volunteers involved in this case. It is possible that these volunteers may face criminal proceedings following the inquest's findings. However, although it can be a heavy burden, volunteers must comply with all aspects of the policy requirements of their charity, such as training in their own time. The coroner was shocked in this case that so many of TSA's volunteers were many years behind schedule in training compliance, and that there was no penalty for not doing necessary safety training. The learning from these remarks is that volunteers must be managed and audited closely. The Charity Commission for England and Wales acknowledges the obvious difficulty that arises. There are many charities in the UK where work is hampered by board vacancies and volunteer deficits. The way to amend this situation is not obvious, with the Commission saying only that it sought to attract 'people who are currently underrepresented into the fold of trusteeship'.

VIEW THE CASE

This report may be viewed at: https://www.judiciary.uk/prevention-of-future-death-reports/benjamin-leonard-prevention-of-future-deaths-report/

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