Mr DAVID POJUR
Assistant Coroner for North Wales (East and Central)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** The Scout Association Gilwell Park, Chingford, London, E4 7QW.
1	**CORONER** I am David Pojur, Assistant Coroner for North Wales (East and Central)
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 28th of August 2018 the Court commenced an investigation into the death of Benjamin David Leonard (DOB 01.11.01 DOD 26.8.18). The investigation continued with a 5 day jury inquest from 3rd to 7th February 2020. Whilst the jury were in jury retirement a matter of law arose resulting in the jury being discharged. They were discharged on 7.2.20. A new inquest will be heard.
4	**CIRCUMSTANCES OF THE DEATH** Ben Leonard, age 16, was on an arranged Scout trip to go up Mount Snowdon with an option to go on the Great Orme at Llandudno on 26.8.18. The Snowdon expedition had an external qualified leader in addition to the 3 scout leaders. There were 9 scouts. Snowdon was cancelled due to bad weather and so the external leader was not engaged. The group went up the Orme. Ben was with 2 other friends when they went on a different path and split off out of sight from the rest of the group. One leader was aware of this. Ben wandered around the cliff tops and thought there was an alternative path down the cliff side of the Orme, on the Marine Drive side. He followed a narrow path and moved across a ledge. He tried to climb down. He slipped and fell approximately 200 feet. He died at the scene from a head injury according to the post mortem report.
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. The **MATTERS OF CONCERN** are as follows. – 1. The arranging of the trip did not adhere to the Scout 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.

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	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 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 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 Scout 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 Scout Association created a misleading impression in the evidence concerning its actions regarding its leaders on the trip, post death. 18. 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. 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 Scout Association's failure to recognise the inadequacies of their operational practice and the part this has played in the death of Ben.
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 by 3.4..20. I, the 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 Chief Coroner and to the Family of the Deceased 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.
9	Dated 7th February 2020 Signature_____ Assistant Coroner for North Wales (East and Central)

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