Jury finds Scout was unlawfully killed whilst on a Scout Expedition[1]

The purpose of a Coroner's Inquest is to answer the following: Who died? When? Where? And, in what circumstances?

Conclusions (previously called Verdicts) are often short, such as 'accident' or 'misadventure' but it is possible to have a finding of 'unlawful killing'. The latter means that the Coroner (or Jury) is satisfied that the requisite elements of a homicide offence (such as manslaughter) are made out 'on the balance of probabilities' (a lesser standard of proof than in the criminal courts, which requires such a finding to be made 'beyond all reasonable doubt). A finding of 'neglect' refers to a failure to meet basic or physical needs.

If a Coroner believes that action should be taken to prevent further deaths, he or she may issue a Prevention of Future Deaths Report.

What happened?

Benjamin Leonard died on 26 August 2018, aged 16. The Jury at the Inquest (ending on 22 February 2024) found that he had been **unlawfully killed** by the Explorer Scout Leader and Assistant Explorer Scout Leader, contributed to by the **Neglect** of The Scouts Association.

Benjamin had been attending a 3-day Explorer Scout trip in North Wales. A hike up Snowden was planned but had to be cancelled due to bad weather. The group hiked up Great Orme instead. There was no brief, no instructions and no written risk assessments.

The group was led by the Assistant Explorer Scout Leader, with the Assistant Scout Leader at the rear. Ben and two other Scouts split off from the main group to take a different path up the Orme. Close to the top of the Orme, the Assistant Explorer Scout Leader saw Ben and his two fellow Scouts on the grassy tops, but provided them with no instructions nor asked them to regroup. They were left unsupervised to descend.

Ben was feeling uncomfortable and wanted a quicker way down the Orme, so he attempted to follow animal tracks down the cliff edge. He slipped and fell from the cliff, suffering a fatal head injury.

News reports suggest the three boys were given no instructions about areas to avoid, or safe routes to take, and that no qualified first aiders were present.

Coroner's Concerns – Prevention of Future Deaths Report

Candour

The Coroner is concerned that there is not a culture of candour within the Scouts Association, and this impacts on safety and safeguarding. This is because within the Scout's Policy, Organisation and Rules, there should have been an enquiry by the Trustees into the possible causes of the fatality. At the time of the Inquest, that still had not been done. The Scouts Association confirmed that its absence was due to the Police investigation and then the Inquest but the Coroner considered it due to a general reluctance to engage in a meaningful learning exercise to prevent a recurrence of issues which led to Benjamin's death. He considered the approach of The Scouts Association to the Inquest to have been 'institutionally defensive', showing a failure to accept any accountability or understand learnings from the death.

Safety Training

The Coroner is concerned that the safety training for Leaders, which is designed to equip Leaders with an understanding of completing risk assessments, and which is an online course, is 'superficial at best', being capable of being completed within 12 minutes. Reference material is not mandatory reading.

Restricted Duties

Those involved were not subjected to restricted duties or suspended after the incident, yet these mechanisms are designed to ensure the safety and safeguarding of children whilst investigations are carried out.

Absence of Safeguarding and Safety Compliance

The Leaders on the trip had a lack of understanding of their training (presumably in relation to safeguarding and safety compliance).

Monitoring, Auditing and Reliance on Volunteers for training

The provision of training relies heavily on the goodwill of volunteers and there were delays and gaps in training of the Leaders as well as more widely. There should be a paid individual with responsibility for training to act as liaison between the volunteers and the Association.

First Aid Kits

None of the leaders carried with them a first aid kit. The system around first aid training is not robust enough.

Permit/Licencing Schemes

The Coroner expressed concerns about a Nights Away permit system lacking robustness.

What next?

The Scouts Association is required to respond to the Coroner by 18 April 2024 (can be extended by agreement) setting out details of action taken or proposed, along with a timetable for action. If no action is proposed, the Association must explain why.

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1 In the Inquest touching upon the death of Benjamin Leonard before Coroner David Pajour: Report 22 February 2024