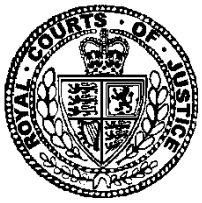

Neutral Citation Number: [2025] EWHC 167 (Admin)

AC-2024-MAN-000187
AC-2024-MAN-000186

IN THE HIGH COURT OF JUSTICE
KING'S BENCH DIVISION
ADMINISTRATIVE COURT
SITTING IN MANCHESTER

Thursday, 30th January 2025

Before:
FORDHAM J

- -

Between:

THE KING (on the applications of (1) SEAN GLAISTER (2) MARY CARR)	**Claimants**
- and –	
HM ASSISTANT CORONER FOR NORTH WALES (EAST AND CENTRAL)	**Defendant**
– and–	
(1) THE FAMILY OF BENJAMIN DAVID LEONARD (2) THE SCOUT ASSOCIATION (3) GARETH WILLIAMS (4) BRIAN GARRAWAY (5) ROSS MALONEY (6) JESS KELLY (7) TINA WILSON (8) STEVEN HOLLOWAY	**Interested Parties**

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Oliver Campbell KC (instructed by DAC Beachcroft) for the **First Claimant**
Noel Dilworth (Weightmans LLP) for the **Second Claimant**
Sophie Cartwright KC & **Anna Chestnutt** (Denbighshire County Council) for the **Defendant**
Bernard Richmond KC & **Nick McCall** (Fieldfisher) for the **First Interested Party**
Jamas Hodivala KC & **James Ageros KC** (Kennedys) for the **Second Interested Party**

- -

Hearing dates: 17-18.12.24
Draft judgment: 20.1.25

- -

Approved Judgment

- -

FORDHAM J

This judgment was handed down virtually at 10am on 30.1.25
by being circulated to the parties and uploaded to the National Archives.

FORDHAM J:

Introduction

1. This case is about a coroner's inquest which arrived at conclusions of unlawful killing. Benjamin David Leonard was born on 1 November 2001. Ben died on 26 August 2018 at Great Orme in North Wales. The medical cause of Ben's death was a head injury. All of this was recorded by the jury in Sections 1, 2 and 5 of the Record of Inquest (ROI). The jury's unanimous conclusions of unlawful killing were delivered on 22 February 2024 and contained in Section 4.

2. The Coroner issued a Prevention of Future Deaths Report, dated 22 February 2024, pursuant to the Coroners and Justice Act 2009 Act Sch 5 §7 and reg.28 of the Coroners (Investigations) Regulations 2013. That Report was published on the Courts and Tribunals Judiciary website (reference 2024-0106). It sets out the contents of Sections 3 and 4 of the ROI. It also explains the passage of time. The inquest investigation had commenced on 26 August 2018. There had been a 5-day hearing from 3 to 7 February 2020, at which it became apparent that the coroner's court had been misled, resulting in the jury being discharged. A second 4-week inquest hearing was due to proceed on 2 November 2022, but it was aborted due to material non-disclosure.

3. The inquest involved 32 hearing days (starting on 4.1.24). The Coroner gave the jury a list of 15 Topics. There was live evidence from some 20 witnesses, and evidence was read to the jury from another five. At the start of his two-day summing up (Monday 19.2.24), the Coroner provided the jury with written legal directions (WLDs) and a route to conclusion (RTC). He went through these documents orally, before turning to his summing up of the evidence.

4. After all the evidence had been heard there had been a hearing (Sunday 18.2.24) in the jury's absence, at which the Coroner had given an oral ruling ("the Ruling") to leave unlawful killing for the jury to consider, in respect of each of the Claimants. Written submissions on that question had been filed by all interested persons. No advocate sought to make oral submissions. In the Ruling, the Coroner identified and applied the Galbraith principle, by which (see R (Officer B50) v HM Assistant Coroner for East Riding of Yorkshire and Kingston Upon Hull [2023] EWHC 81 (Admin) at §54):

> ***if on one possible view of the facts there is evidence upon which a jury could properly come to the conclusion that the deceased was unlawfully killed, then the coroner should allow that issue to be tried by the jury***

The so-called "plus" aspect of Galbraith – which concerns "safety" as opposed to sufficiency of evidence – features in this case only in terms of the warning in R v Inner South London Coroner, ex p Douglas-Williams [1999] 1 All ER 344, 348-349 that "to leave all possible verdicts could in some situations merely confuse and overburden the jury" (Officer B50 at §41), so that (Officer B50 at §45):

> ***if the procedure adopted (eg. with regard to a large number of possible verdicts being left) is apt to confuse the jury so that there is a risk of them bringing in a wrong verdict because of confusion or misunderstanding, the wider interests of justice are not being served and steps must be taken to remedy the position.***

5. These judicial review proceedings involve two claims, heard together. The Claimants are the individuals described in the ROI as the "Explorer Scout Leader" (Mr Glaister) and the "Assistant Explorer Scout Leader" (Ms Carr). Ben's family appeared as a participating Interested Party, resisting the claim for judicial review. The Scout Association also appeared, raising points which – expressly and carefully – would arise for consideration only if the claim succeeded and the Court needed to consider the question of the appropriate remedy.

6. Ben was 16. He was on an explorer scout weekend away. It was the bank holiday weekend: Saturday 25 to Monday 27 August 2018. The explorer scouts were from the 1st/4th Reddish, based at a scout hut in Stockport. They were camping at Swallow Falls at Betws-y-Coed in the Eryri National Park (Snowdonia). As well as Ben, there were three other 16 year olds (Chris Gilbert, Child A and Child B both anonymised at the inquest). There were a 15 year old (Alex Jamieson); two 18 year olds (Mac Goodwin and Jack Glaister); one 19 year old (Aidan Burns); and one 20 year old (Joseph Hilditch). There were three leaders. All three were volunteers. Mr Glaister (the First Claimant) was aged 54 and was the Explorer Scout Leader. He was also Jack's father. He accepted at the inquest that he was leader for the weekend. The jury heard that he had joined scouting in June 2012; had undertaken 17 modules of leadership training between October 2014 and November 2017; and had attended a "hill-walking day" in April 2016. Ms Carr (the Second Claimant) and Gareth Williams, both aged 26, were Assistant Leaders on the weekend. Ms Carr accepted (Day 16) that she was "leading the walk" up the Great Orme. The jury heard that she had joined scouting in April 2016; and had undertaken a first three modules of leadership training in April 2018. Mr Williams was the Assistant Scout Leader, who had joined scouting in February 2014. He told the jury (Day 12) that he was "basically another car to use as transport". Nobody suggested that unlawful killing could be a proper conclusion in respect of Mr Williams and the Coroner left unlawful killing to the jury only in relation to Mr Glaister and Ms Carr.

Section 4 of the ROI

7. The jury recorded the following conclusion at Section 4:

> ***4. Conclusion of the jury as to the death. Unlawful killing by the Explorer Scout Leader and Assistant Explorer Scout Leader contributed to by the Neglect of the Scout Association.***

Section 3 of the ROI

8. The jury recorded the following findings in Section 3 (numbering in square brackets in quotations is mine):

> ***3. How, when and where … the deceased came by his death. [1] Ben 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. [2] 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. [3] 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 done. [4] 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 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. [5] 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. [6] Ben complained of discomfort due to circumcision. [7] 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. [8] 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.***

An Agreed Factual Foundation

9. Section 3 of the ROI stands as including the jury's "agreed … factual foundation" for Section 4. The Coroner had directed the jury that they were obliged to follow the WLDs. One of the WLDs, which nobody in this case has criticised, told the jury clearly that (emphasis added):

> ***you are required to record your ultimate conclusion in Section 4. This should not be considered until you have agreed the factual foundation for it in Section 3.***

I add these points, so far as the link between Sections 3 and 4 is concerned. The Chief Coroner's Guidance No.17 says at §18 that, even in a complex case, the "short-form conclusion" in Section 4 "in combination with" the answer to 'how' in Section 3 "will often be sufficient to 'seek out and record as many of the facts concerning the death as the public interest requires'". Guidance No.17 refers at §19 to "key questions of fact" which the jury may "decide" in Section 3. Jervis on Coroners §13-03 says it is "critical" that the facts found and recorded in Sections 1-3 should disclose a "factual basis" for the conclusion in Section 4. In Officer 1 and Officer 2 v HM Coroner for Gibraltar 2024/GCA/007 at §8 Sir Maurice Kay (as President of the Court of Appeal of Gibraltar, dealing with a judicial review claim) said that the coronial procedure can mean it is "difficult for a reviewing court to know precisely what factual findings were made by the jury beyond the brief formal findings required by [statute]". In this case, I am materially better informed as to key findings of fact which stand as the jury's agreed factual foundation for its short-form conclusion of unlawful killing.

The Coroner's Lists of Potential Breaches

10. In the Ruling, the WLDs and the RTC the Coroner used lists of "potential breaches". In the Ruling he reasoned that each of these passed the Galbraith test. I will set them out here, taken from the WLDs. First, regarding Mr Glaister. The WLDs (see too §46 below) included this:

> ***[46.2] Focus on the following in deciding whether there was a breach by Mr Glaister, did he: (1) Provide appropriate and accurate information to the District Commissioner to permit him to make a proper assessment about whether this was a safe trip and whether he should grant his permission? (2) Identify for himself the obvious risks to life present on the Orme? (3) Conduct any risk assessment? (4) Identify that there was terrain on the Orme which was not "Terrain 0" and assess the risks associated with such terrain? (5) Consider Ben's age and medical condition? (6) Warn Ben of the risks to life present on the Orme? (7) Give Ben any information about safe and unsafe routes? (8) Prevent Ben from avoiding any route which took him near the cliff edge? (9) Warn Ben about the possibility of "False" paths which were in fact animal tracks and which might lead him to the cliff edge? (10) Supervise Ben and/or his fellow Explorers and/or his assistant leaders? (11) Give his assistant leaders any information about risk assessment or programmes or to establish boundaries? (12) Prevent Mary Carr from taking Ben up the Orme without any proper risk assessment or preparation and without notifying him? (13) Prevent Mary Carr from taking Ben up the Orme without any proper risk assessment or preparation and without notifying him and allowing her to do so when she was neither properly qualified nor the***

> ***designated leader? (14) Require Mary Carr to stop the walk? (15) Ensure any adequate method was in place to be able to contact or warn Ben? (16) Appreciate, as a reasonable person engaged in taking a group including children in walks on cliff areas would have, that the nature of the terrain, any hazards which exist, & ensured that all those involved were warned of them?***

11. Second, regarding Mary Carr. The WLDs (see too §47 below) included this:

> ***[47.2] Focus on the following in deciding whether there was a breach by Mary Carr, did she: (1) Take over the leadership role in the walk up the Orme when she was neither authorised nor properly qualified? (2) Conduct any risk assessment or ascertain whether Sean Glaister had undertaken one? (3) Identify the obvious risks to life present on the Orme? (4) Consider Ben's age and medical condition? (5) Warn Ben of the risks to life present on the Orme? (6) Prevent Ben from avoiding any route which took him near the cliff edge? (7) Supervise Ben? (8) Prevent Ben from becoming separated from leaders and the main group? (9) Warn Ben when she saw him on the grassy tops and/or instruct him to return to the path? (10) Instruct Ben to return to the path when she was aware of the telephone call to Mac Goodwin? (11) Permit Ben to "wander around" the top of the Orme? (12) Recognise the risk to Ben being where he was without the presence of a leader to accompany them? (13) Recognise the risk to Ben of straying near the cliffs? (14) In having with her during the walk, those who were over 18 undertake, any supervisory role over those who were children? (15) Communicate with Gareth Williams to ensure Ben's safety?***

12. As can be seen, the Coroner used the phrase "focus on the following in deciding". This has an echo in what crown court judges are given in the Crown Court Compendium (July 2024 at p.19-31):

> ***the jury will need explicit guidance on which aspect of the defendant's conduct they must focus in deciding whether there was a breach.***

A related point, emphasised in Officer 1 (at §14), is that it is appropriate for the coroner to assist the jury "by directing their attention to specific alleged acts and omissions, which might separately or together establish a relevant breach of duty", to "specify acts or omissions which might amount to breaches of duty". Key points in this case are each Claimant's submissions that none of these potential breaches should have been left to the jury; or that they should not all have been left to the jury; and further that the Coroner did not give the jury legally adequate WLDs or RTC.

An Inquest is not a Criminal Trial

13. In R (Maughan) v Oxfordshire Senior Coroner [2020] UKSC 46 [2021] AC 454, Lady Arden said (at §93) that:

> ***the public are likely to understand that there is a difference between a finding at an inquest and one at a criminal trial where the accused has well-established rights to participate actively in the process.***

There are fundamental differences between coroner's inquests and crown court trials. Coroners are a type of court; with a jury; with legal directions; and a summing up. Some "criminal law concepts" are "applied" (Maughan §84). There are Galbraith rulings about what can be left. But there are very important differences. These include the absence of criminal due process, the "well-established rights" to which Lady Arden referred, some of which reflect Article 6 ECHR. There is – as decided in Maughan – no proof to the criminal standard, requiring the jury to be sure. The civil standard of the balance of probabilities applies. There is no defence advocate, cross-examining witnesses, and then making a final speech to the jury. The defendant does not call witnesses for the defence.

The rules of evidence are more relaxed. An inquest is inquisitorial. A coroner must discharge the duty to "conduct an investigation into" a person's death (2009 Act s.1) with the statutory purpose to "ascertain … how, when and where the deceased came by his or her death" (s.5(1)(b)) making a "determination" on those questions (s.10(1)(a)). In inquests governed by Article 2 ECHR, the purpose is to include ascertaining "the circumstances in which" the death occurred where that is necessary to satisfy Article 2. The coroner's jury itself can be encouraged to ask questions of a witness. The family of the deceased may be represented by an advocate. There is no indictment. There is no prosecutor. There is no defendant. The range of criminal law and human rights safeguards, which apply to protect a criminal accused, do not apply. In an inquest, nothing has to be proved beyond reasonable doubt. Nobody is being convicted or being acquitted. The word "conclusion" is preferred to "verdict". There is a statutory prohibition on the inquest determination being "framed in such a way as to appear to determine" any question of criminal liability on the part of a named person or any question of civil liability (2009 Act s.10(2)). Nobody is being convicted or a crime; or found liable in civil law.

14. The Chief Coroner's Law Sheet No.5 refers to the "well-known passage" explaining the duty and responsibility of the coroner" from R v HM Coroner for North Humberside and Scunthorpe, ex p Jamieson [1995] 1 QB 1 at 26:

> ***It is the duty of the coroner as the public official responsible for the conduct of inquests, whether … sitting with a jury or without, to ensure that the relevant facts are fully, fairly and fearlessly investigated … [and] ensure that the relevant facts are exposed to public scrutiny …***

This is from R v South London Coroner, ex p Thompson The Times 15 May 1982 (Maughan §141):

> ***an inquest is a fact-finding exercise and not a method of apportioning guilt. The procedure and rules of evidence which are suitable for one are unsuitable for the other. In an inquest … there are no parties, there is no indictment, there is no prosecution, there is no defence, there is no trial, simply an attempt to establish facts. It is an inquisitorial process, a process of investigation quite unlike a criminal trial where the prosecutor accuses and the accused defends, the judge holding the balance or the ring, whichever metaphor one chooses to use.***

R (Hambleton) v Coroner for the Birmingham Inquests (1974) [2018] EWCA Civ 2081 [2019] 1 WLR 3417 explained (at §46) that the inquest is:

> ***an inquisitorial process for which the coroner is entirely responsible. There are no parties to an inquest… The inquest is not an adversarial proceeding. A coroner is a judicial officer working within a statutory framework.***

Officer B50 explained (at §94) that the inquest:

> ***belongs to the coroner. In a criminal case, the prosecution decides whether to institute proceedings, what charges to bring and what evidence to adduce in support. The defendant decides whether to give evidence or call witnesses, and is perfectly entitled to do neither… The coroner's inquest is the culmination of an investigative process, not a dispute. The coroner has a wide discretion as to the form of the inquiry, which is never a trial between combatants…. [T]he Coroners (Inquests) Rules specifically prohibit an 'address to the facts' by an interested person.***

Gross Negligence Manslaughter

15. The species of "unlawful killing" whose criminal law concepts were being applied in the inquest in this case was once called "involuntary manslaughter by breach of duty" (R v Adomako [1995] 1 AC 171) and became known as "gross negligence manslaughter". The Coroner correctly identified the six elements and set them out in the Ruling, the WLDs and the RTC. This passage is from the WLDs (matching the Compendium at p.19-28):

> ***There are six elements of the offence of Gross Negligence Manslaughter, as follows: (1) The leader (ie. the individual you are considering) owed an existing duty of care to Ben. (2) The leader negligently breached that duty of care. (3) That breach of duty gave rise to an obvious and serious risk of death. (4) It was also reasonably foreseeable at the time of alleged breach that the breach of that duty gave rise to a serious and obvious risk of death. (5) The breach of that duty caused the death of Ben. (6) The circumstances of the breach were truly exceptionally bad and so reprehensible as to justify the conclusion that it amounted to gross negligence and required criminal sanction.***

This passage is from R v Broughton [2020] EWCA Crim 1093 [2021] 1 WLR 543 at §5:

> ***[S]ix elements have been identified that the prosecution must prove before a defendant can be convicted of gross negligence manslaughter: (i) The defendant owed an existing duty of care to the victim. (ii) The defendant negligently breached that duty of care. (iii) At the time of the breach there was a serious and obvious risk of death. Serious, in this context, qualifies the nature of the risk of death as something much more than minimal or remote. Risk of injury or illness, even serious injury or illness, is not enough. An obvious risk is one that is present, clear, and unambiguous. It is immediately apparent, striking and glaring rather than something that might become apparent on further investigation. (iv) It was reasonably foreseeable at the time of the breach of the duty that the breach gave rise to a serious and obvious risk of death. (v) The breach of the duty caused or made a significant (ie. more than minimal) contribution to the death of the victim. (vi) In the view of the jury, the circumstances of the breach were truly exceptionally bad and so reprehensible as to justify the conclusion that it amounted to gross negligence and required criminal sanction.***

This is from R v Rose [2017] EWCA Crim 1168 [2018] QB 328 at §77(3):

> ***The question of whether there is a serious and obvious risk of death must exist at, and is to be assessed with respect to, knowledge at the time of the breach of duty.***

The Broughton Threshold

16. Broughton was a criminal case where the defendant had supplied the class A drugs from which his girlfriend Louella had died. The prosecution alleged gross negligence manslaughter by reason of the defendant's inaction in not getting medical help for Louella, as her health deteriorated before his eyes. The gross negligence manslaughter conviction was overturned. The judge at the criminal trial had been wrong in the ruling which left gross negligence manslaughter to the jury. That was because, on the evidence even at its highest, a properly directed jury could not be satisfied that element (v) (causation) was proved at the point which could satisfy elements (iii) and (iv) (the reasonably foreseeable serious and obvious risk of death). As Mr Campbell KC and Mr Dilworth emphasise, the Court of Appeal said this in Broughton at §89 (emphasis added):

> ***To establish the guilt of the defendant the prosecution had to make the jury sure that at the time when Louella's condition was such that there was a serious and obvious risk of death the defendant was grossly negligent in failing to obtain medical assistance and that such assistance would have saved her life. That she was having a bad trip, or the time had come when medical***

> ***help was needed is not enough. In a case of this sort, as in medical cases involving health professionals, there needs to be a clear focus on when the condition of the deceased reached the threshold of serious and obvious risk of death, what the accused should have done then and the prospects of survival at that point.***

A key point in this judicial review case is each Claimant's contention that the evidence could not support a properly directed jury finding that this Broughton Threshold (the "threshold of serious and obvious risk of death") had been reached, at the time of any breach of any duty, assessed with respect to the Claimant's knowledge at that time, at which time Ben's death could have been prevented.

The Kuddus Chance of a Risk

17. R v Kuddus [2019] EWCA Crim 837 [2019] 1 WLR 5199 was a criminal case where the defendant – a restaurant-owning chef – had supplied a peanut-containing kebab from which the deceased had died, she having identified her allergy to the restaurant in her online order form. The gross negligence manslaughter conviction was overturned. The judge at the criminal trial had misdirected the jury that knowledge of the allergy (a) on the part of the restaurant business could be equated with knowledge (b) on the part of the defendant chef as business owner. As Mr Campbell KC and Mr Dilworth emphasise, the Court of Appeal said this in Kuddus at §79 (emphasis added)

> ***if a reasonable person possessed of the knowledge available to the defendant would have foreseen only a chance that the risk of death might arise, that is not enough to justify a conviction for gross negligence manslaughter. What is required is that the reasonable person would have foreseen an obvious and serious risk of death.***

In the present case the Coroner's WLDs directed the jury as follows:

> ***If a reasonable person possessed of the knowledge available to the Leader would have foreseen only a chance that the risk of death might arise from cliffs, that is not enough to justify gross negligence manslaughter determination. You must be satisfied that a reasonable person would have foreseen that, if they did not take the action in question, that failure would give rise to a serious and obvious risk of death.***

A key point in the claim for judicial review is each Claimant's contention that the evidence, taken at its highest, could only support a properly directed jury finding that a reasonable scout leader or assistant leader – possessed of the knowledge available to each Claimant at the time of alleged breach of duty – could have foreseen a Kuddus chance that the risk of death might arise; not an obvious and serious risk of death.

The Rose Trap

18. Broughton element (iii) excludes "something that might become apparent on further investigation". Rose says the serious and obvious risk of death "must … be assessed with respect to, knowledge at the time of the breach of duty". Kuddus refers to the "knowledge available to the defendant". The law of gross negligence manslaughter excludes information of which a defendant would have been aware, had they performed the very duty which they breached. Taking account of information of that kind was described by Mr Dilworth as "the Rose Trap". Rose was a criminal case where the defendant, a Boots optometrist, was said negligently to have failed to conduct a full eye examination, whether by (a) viewing retinal images or (b) doing an ophthalmoscopy. The gross negligence manslaughter conviction was overturned. The judge, in a ruling at the criminal

trial, had been wrong to leave gross negligence manslaughter to the crown court jury. On the evidence even at its highest, a properly directed jury could only be satisfied as to elements (iii) and (iv) (reasonably foreseeable serious and obvious risk of death) by reference to what the defendant optometrist would have known had she performed very duty which was breached (an examination involving viewing the retinal images or doing the ophthalmoscopy). As Mr Campbell KC and Mr Dilworth emphasise, the Court of Appeal said this in Rose at §94:

> ***in assessing reasonable foreseeability of serious and obvious risk of death in cases of gross negligence manslaughter, it is not appropriate to take into account what the defendant would have known but for his or her breach of duty.***

In the present case the Coroner's WLDs directed the jury as follows:

> ***Was there at the time of and arising from the breach, a serious and obvious, ie present, clear and unambiguous, risk of the occurrence of a fatal fall or put another way, an immediately apparent, striking and glaring risk. Risk of death is an objective question, not a question about whether the leader foresaw any such risk or something that might become apparent on further investigation.***
>
> ***The risk must be obvious to the reasonable person in the leader's shoes, who demonstrates the same level of negligence as the leader. The test is not whether the reasonable person who had not been negligent would have appreciated the existence of an obvious risk of death; the risk must be assessed with reference to the leader's negligent standard. The risk must therefore be obvious to the Leader on the basis of the information available to the Leader at the time of the breach.***

A key point in this claim for judicial review is each Claimant's contention that the evidence could not support a finding by a properly directed jury of reasonable foreseeability of serious and obvious risk of death without falling into the Rose Trap, of taking into account what they would have known had they performed the very duty which is said to have been breached.

'Flag' Cases

19. It does not follow from Rose that a failure to conduct an examination or assessment can never be a relevant breach of duty for the purposes of gross negligence manslaughter. Avoiding the Rose Trap means assessing reasonable foreseeability of serious and obvious risk of death by ignoring what the examination or assessment would have shown. Taking that approach, there may be reasonable foreseeability of serious and obvious risk of death. This is from Rose at §85, using the word "flag":

> ***The fact that an intra-ocular examination might reveal a serious abnormality, or even in some cases serious life-threatening problems, does not mean that there is a "serious and obvious risk of death" if such an examination is not carried out. It might be different if the patient presented with symptoms which themselves either pointed to the risk of a potentially life threatening condition or provided a flag that alerted a competent optometrist to that risk …***

So, at §94 the Court in Rose accepted that there could be circumstances where it is:

> ***reasonably foreseeable that failure to carry out such tests would carry an obvious and serious risk of death…***

Risk Assessment

20. Mr Campbell KC advanced this proposition: a failure to conduct a risk assessment can never, whether in principle or in practice, constitute a relevant breach of duty capable of

satisfying the six elements of gross negligence manslaughter. He gave two reasons. First, so far as concerns element (v) (causation), he submitted that the failure to conduct a risk assessment could never be the cause of a death. He cited Nicholls v Ladbrokes Betting & Gaming Ltd [2013] EWCA Civ 1963 at §§46-50. That passage recognised that a failure to carry out a sufficient and suitable risk assessment "is never the direct cause of an injury" and "can only ever be an indirect cause". It recognised that the failure to carry out a proper risk assessment was "not, on its own, sufficient to establish the claim". Secondly, so far as concerns elements (iii) and (iv) (reasonably foreseeable serious and obvious risk of death), Mr Campbell KC submitted that a failure to conduct a risk assessment will always fall short of gross negligence manslaughter, once the Rose Trap is avoided. That is because what will always be key is the information which the risk assessment would have brought to the knowledge of the person who breached the very duty to conduct it. I am unable to accept the rigidity of Mr Campbell KC's proposition. The causation element requires that the breach made a significant (more than minimal) contribution to the death of the victim. And in a 'Flag' Case, the failure to conduct the risk assessment could arise where there is a foreseeable serious and obvious risk of death, without falling into the Rose Trap. A risk assessment may operate, not to elicit unknown information, but as a discipline in thinking about already-available information, to focus on appropriate action. Cases will turn on their contexts, facts and circumstances.

Imminence

21. Element (iii) of gross negligence manslaughter uses the word "immediately", in the context of a serious and obvious risk of death. Mr Campbell KC and Mr Dilworth each accepted that there is no legal requirement of imminence: a risk of serious and obvious risk of imminent death. They were right, in my judgment, to do so. It would be very easy for the case-law on gross negligence manslaughter to have included a requirement of imminence, including in the discussion in Rose, Kuddus and Broughton. The word "immediately" is used, but that word attaches to the "obvious risk of death". The risk of death must be "immediately obvious". Broughton was about when a condition of visible health deterioration reached the threshold of "serious and obvious risk of death". Take the facts of Rose. There, the optometrist did not, during her February 2012 routine eye-check of 7 year old Vincent, look at retinal images which were available, and which would have shown information triggering the need for urgent referral (§13). Vincent's condition was treatable up until "the point of his acute deterioration and demise on 13 July 2012" (§10). That was five months later. The problem with the conviction in Rose was not about whether the threshold of serious and obvious risk of death could be crossed in February 2012. It could be. But only where an optometrist at that point in time saw the retinal images, which she did not. Take this example. A chef – knowing about peanut allergies – who packs up snacks for a future weekend trip for a group of children, one of whose parents has clearly communicated a serious peanut allergy. I think, in principle, the chef could be breaching a duty in circumstances of a "risk of death" which is "immediately obvious". No death is "imminent". The trip could be weeks or even months away. Mr Campbell KC says that in cases where there is a long lead-time between a breach and an event, elements (iv) and (vi) – foreseeability and causation – may not so readily be met. I agree. But that still does not mean that serious and obvious risk of death incorporates a test of imminence. Cases will turn on their contexts, facts and circumstances.

Non-Aggregation of Breaches

22. The Coroner directed the jury, at several points in the WLDs and RTC, that potential breaches had to be considered individually and not "aggregated". This was one of the Coroner's WLDs:

> ***Each of these [six] elements must be established on the balance of probabilities before you may return a conclusion of unlawful killing. All of the elements must relate to one identifiable person or persons (who must not be named) and may not be aggregated through the actions of a number of people, or the number of breaches. You will find below potential breaches of duty, raised during the course of the evidence, for you to consider. You must consider these allegations each separately and individually. You could only conclude that the conclusion has been established if all of the elements in the test apply in relation to a single alleged breach or breaches.***

Mr Campbell KC and Mr Dilworth submitted to the Coroner – and maintain – that there must be no aggregation of potential breaches. They rely on Broughton at §22, which refers to "a series of alleged failings, each of which needed to be judged by reference to the proper yardstick for gross negligence". That was a passage discussing causation: its purpose was to ensure that each aspect of conduct relied on for breach had occurred before the time when there became no chance of the victim's survival. Officer 1 (§24 below) speaks of directing the jury about "specific alleged acts and omissions, which might separately or together establish a relevant breach of duty". The Compendium says reliance can be placed "on the cumulative effect of breaches" (p.19-31). Mr Richmond KC and Mr McCall for the Leonard family had put forward for the Coroner a list of potential breaches which they said "individually and collectively" gave rise to an obvious and serious risk of death. The Coroner excluded the idea of "collectively". I have set out his direction. It was reinforced in answering questions in jury notes on Day 30 (20.2.24) and Day 32 (22.2.24). I can leave questions about aggregating breaches to a case where they matter. But I do need to identify an important related point about non-distortion of facts.

Non-Distortion of Facts

23. When the jury was looking at an individual alleged breach, they were doing so in the context of the other surrounding facts and circumstances. They were directed to consider potential breaches "separately and individually" with no aggregation of breaches. But the other facts were plainly relevant, as surrounding facts. Otherwise, the jury would have needed to make artificial assumptions which distorted the facts. Rightly, the Coroner did not tell the jury to ignore facts or make artificial assumptions about facts. I can illustrate this point by returning to the Rose case. There, the Boots optometrist did not view the retinal images and nor did she conduct an ophthalmoscopy. Suppose each of these were put forward as a potential breach. Suppose the jury were told not to "aggregate" them. Suppose the jury was considering the individual alleged breach of duty of not viewing the retinal images. In doing so, it would not distort the other facts. It would not treat the optometrist as having conducted an ophthalmoscopy. Focusing on an individual potential breach does not mean embracing a fiction as to other surrounding facts.

Officer 1

24. In Officer 1 the claimants were two police officers whose vessel had pursued a rigid hulled inflatable boat, during which there was a collision and two people under pursuit had died. The claim for judicial review succeeded because, although unlawful killing had

been properly left to the jury, the coroner had misdirected them. The duty of care was expressed for the jury in a way which was manifestly wrong in law, because the law applicable to a police pursuit was narrower (ie. such care and skill as is reasonable in all the circumstances) than the coroner's formulation (ie. not to expose those being pursued to the risk of harm): see §§12-14. The coroner had also failed to assist the jury "by directing their attention to specific alleged acts and omissions, which might separately or together establish a relevant breach of duty", and so failing to "specify acts or omissions which might amount to breaches of duty" (§14). The coroner had missed the elements (iii) and (iv) – the reasonably foreseeable serious and obvious risk of death – by relying on outdated guidance (§§15, 22); and failing to give a direction to "focus on what was objectively reasonably foreseeable at the time of the breach of duty" given the importance of the Kuddus Chance of a Risk (§16). The elements of gross negligence manslaughter needed to be "analysed in a properly structured way" (§17). The jury needed to be directed to consider "all the circumstances" and the coroner failed "to marshal the evidence so as to identify the relevant circumstances which the jury would need to evaluate and weigh", giving proper "guidance" (§21), with directions which were "properly marshalled and balanced" as well as "legally accurate" (§25). In the present case, in their challenge to the Coroner's WLDs, RTC and summing up, Mr Campbell KC and Mr Dilworth say some of these same legal flaws are present here too.

The Coroner and the Jury

25. A coroner can hold an inquest with a jury if the coroner thinks that there is sufficient reason for doing so" (2009 Act s.7(3)). There are important distinctions between the role of the coroner and the jury; between law and fact; and between interpretation and application. The Coroner had important functions: including to make legal rulings; to decide what conclusions should be left to the jury; to give legally correct and appropriate legal directions; and to assist the jury with a legally appropriate summing up. The jury had important functions: including to consider the evidence; to arrive at findings of fact; to apply the directions; and to make evaluative judgments in applying the directions. Here, the Coroner's WLDs told the jury: that they were the judges of the facts; they were responsible for weighing up the evidence and deciding the facts of the case; that it was entirely up to them to decide what evidence was reliable and what evidence was not; that they did not have to decide every disputed point that had been raised in the inquest, but only those that were necessary for them to reach their conclusion and to complete the ROI; that where there was conflicting evidence, they must decide how reliable, honest and accurate each witness was; that they may draw sensible conclusions from the evidence they had heard, but must not guess or speculate about anything that was not covered by the evidence; that it was for them to decide how important the various pieces of evidence were; and so on. There is no criticism of these directions.

What an Inquest Decides

26. By the 2009 Act s.5(1), the statutory purpose of the inquest was to ascertain how, when and where Ben Leonard came by his death. By s.10(1)(a) the jury was required to make a determination as to how, when and where Ben came by his death. By s.5(3), the jury was prohibited from expressing any opinion on any matter other than how, when and where Ben came by his death. By rule 34 of the Coroners (Inquests) Rules 2013, the jury was obliged to make its statutory determination and findings using the prescribed Sch 1 §1 form. That prescribed form contains "notes" which list "short-form conclusions" which may be adopted, including "lawful/ unlawful killing". The notes refer to the

possibility of "a brief narrative conclusion" as an alternative or in addition to one of the short-form conclusions. Guidance No.17 says at §18 the short-form conclusion should be one from the list in the notes to the prescribed form and that, although that list is not exclusive, "straying from the list will usually be unwise". By s.10(2) of the 2009 Act, there was a prohibition on the determination as to how, when and where Ben came by his death being framed in such a way as to appear to determine any question of (a) criminal liability on the part of a named person or (b) civil liability. Law Sheet No.1 at §10 says "no conclusion of unlawful killing may name the person responsible". In this case, in order to decide whether to arrive at the "short-form conclusion" of "unlawful killing" the jury had to decide whether – in relation to Mr Glaister and separately in relation to Ms Carr – the six elements of gross negligence manslaughter were satisfied. That means, "in the mind of the decision-maker", the jury were identifying recognised elements of civil and criminal liability in respect of identified individuals. Everyone agrees that this was necessary and appropriate, as does Law Sheet No.1 at §10. But a key question in this judicial review claim is each Claimant's contention that Section 4 of the ROI unlawfully included "by the Explorer Scout Leader and Assistant Explorer Scout Leader".

Judicial Review

27. As illustrated by cases like Broughton, Rose and Kuddus convictions for unlawful act manslaughter in crown court trials are appealable to the Court of Appeal Criminal Division. Conclusions in inquests are not appealable, including to the High Court. As illustrated by cases like Officer 1 and Officer B50, judicial review is available. The judicial review court operates under the "ordinary constraints of judicial review", meaning there is no general jurisdiction on the part of the judicial review court to intervene "on the basis that it considers that the coroner was 'wrong'": see Hambleton §§48-49. In Officer 1, the test for judicial review for materially misdirecting the jury was framed as whether "the directions were flawed in a material way or ways" (§6). So far as the application of Galbraith is concerned, "the coroner must make a judgment based on sufficiency of evidence" (Law Sheet No.2 §1), and whether there is sufficient evidence is a matter of judgment not discretion (Law Sheet No.5 §24). As to that, Officer B50 (at §§36 and 39) cited R v HM Coroner for Exeter and East Devon, ex p Palmer [2000] Inquest LR 78, where Lord Woolf MR and Mantell LJ, respectively, said:

> ***If there is no evidence that would entitle a Coroner's jury to come to the conclusion that the proper verdict was one of unlawful killing, as a matter of law the Coroner is not then entitled to leave that issue to the jury. If he does so, the position is that this court, or the [Administrative Court] judge on the initial application, is not only entitled but required to intervene.***
>
> ***The test of Wednesbury reasonableness will seldom have any application to a coroner's decision to leave or withdraw a particular verdict for or from the jury's consideration. There will either be evidence to support the verdict or there will not. Objectively viewed, the decision will either be right or it will be wrong.***

There is the Douglas-Williams question (Officer B50 §§41, 45): whether the "procedure adopted" as to conclusions being left to a jury was "apt to confuse the jury so that there [was] a risk of them bringing in a wrong [conclusion] because of confusion or misunderstanding". And there is the question whether claimed deficiency in the coroner's summing-up mean the summing up was "so deficient as to render unsafe the jury's conclusion on unlawful killing" (Officer B50 §§90, 93).

The Scouts

28. The Coroner and the jury had heard a lot of evidence across the first 28 hearing days before the Coroner made the Ruling. I was given the full transcripts and have been assisted by the parties as to parts that matter. For the purposes of this judgment, it will suffice to give an overview of some features of evidence heard by the jury. I am not making findings of fact, but describing aspects of evidence. I start with scouts and explorers. Within the structure of the Scout Association, scouts are ultimately organised by Group. There is a Group Scout Leader with assistant Group Leaders. For the 1st/4th Reddish scouts the Group Scout Leader was Brian Garraway and Gareth Williams was an Assistant Scout Leader. The Explorer Leader was Mr Glaister and Ms Carr was Assistant Explorer Leader. Mr Garraway was Training Adviser to Mr Glaister (until 2017) and to Ms Carr. Above Group level, there is District level with a District Commissioner (Craig Jones) and Deputy District Commissioner (Phil Santana-Reedy). Above District level there is then County level with a County Commissioner (Steven Holloway) and a Deputy County Commissioner (Mark Sackville-Ford). Above County level there is a Regional Commissioner (Andrew Corrie). Above that is the Chief Commissioner for England (Alexandra Peace-Gadsby). Among the witnesses from whom the jury heard evidence were Mr Garraway, Mr Glaister, Mr Williams, Ms Carr, Mr Jones, Mr Holloway and Ms Peace-Gadsby.

The POR

29. The Scout Association had a rule-book called POR (Policy Organisation and Rules). The relevant edition was published in May 2018. The rules stated that the District Commissioner was responsible for approving all activities for Explorer Scouts (POR9.1b); that the Leader must ensure prior approval (POR9.2a); that the Leader or another member of the party must hold a permit under the Adventurous Activity Permit Scheme (POR9.2a, 9.7), including hill walking "in Terrain One or Two" (POR9.7a); that the Leader holding the permit who must take all decisions for the duration of the activity (POR9.2a); that the Leader holding the permit must ensure that a risk assessment is carried out (POR9.2a, 9.4); that external centres and instructors must be suitably accredited and qualified (POR9.9); that a nights away permit must be obtained by means of a nights away notification (NAN), including for a campsite (POR9.57a) with all groups having immediate access to someone with a current First Aid qualification (POR 9.56d). A Factsheet on "Safety – Practical Tips" (August 2012) described the "Leader in charge", explaining that "Scouting safely is not just about ensuring that risk assessments and safety checks are conducted; all adults need to be clear on what they need to do and young people should be given clear instructions, guidance and rules"; and "It is extremely important that anyone who has been designated as the leader in charge fully understands their responsibilities. There should be no assumption that other adults are in charge. The leader in charge is responsible for overseeing the activity and all adults and young people." A Factsheet on "Activities – Risk Assessment" (August 2012) provided guidance for leaders on how to conduct a risk assessment both before and during an activity". A Safety Checklist (2017) had a heading "organise your programme" which referred to POR and said "complete a risk assessment" for a "scout-led" as opposed to an "externally-led" activity. Other headings described "leader in charge" and "risk assessment". Trainer's Notes for Ongoing Safety Training describe emphasising the difference between hazard and risk, where a hazard is anything that could harm and risk is the chance that someone will be harmed by the hazard. Mr Glaister told the jury (Day

18) that "we were never told to do any written risk assessments" and he had "never been trained on … risk assessments". Under the POR, Terrain Zero and Terrain One each "contains no element of mountainous steep ground" (POR9.28, 9.29). Terrain Two includes any terrain which "contains an element of mountainous steep ground" (POR9.30). A Factsheet (January 2018) provided information regarding activities taking place in Terrain Zero. The insurance incident report form which County Commissioner Holloway signed on 30.8.18 described the activity as "walking terrain 0 on the Great Orme". Mr Jones told the jury (Day 3) that a proposed trip that may take children into a terrain that could include aspects of terrain 1 or terrain 2 would have been referred to the County Activities Team.

Explorer Autonomy

30. Mr Garraway said (Day 11) that County Commissioner Holloway had said, after Ben's death, that explorer scouts often walked unsupervised. Mr Williams said (Day 13) Mr Holloway had said explorer scouts do not require constant supervision and often walk on their own; and that Mr Williams's own experience as an explorer scout was that it was normal for explorers to walk on their own. Ms Carr said (Day 16) that "boys of that age and experience and character" would be able "to assess those risks themselves", "undertaking walks in mountainous terrain unaccompanied" with "a certain level of doing your own risk assessment at that age". Mr Glaister said (Day 19) that explorers are "free to walk around", being "at the age group where they can walk in areas by themselves". Mr Holloway said (Day 22) that "certainly explorer scouts are more than capable generally of walking on their own, but there is a caveat to that and that is that where they are walking should always be assessed by the leaders". Mr Kidd (Day 24) said he would not have insisted on the participants being with a leader at all times on a Terrain Zero walk, but that he would suggest predetermined points where the group meets up again.

The NANs and the Designated First Aider

31. The 15 Topics included "the written applications in the Nights Away Notification (NAN) and approval for the weekend trip and the number of leaders who would be attending". The first NAN was emailed by Mr Glaister to both Mr Santana-Reedy and Mr Sackville-Ford (17.8.18), replaced with a second NAN (19.8.18) approved that same day by Mr Jones. The NAN Form states that it provides the information required by a Commissioner to approve an event, referring to POR9.1b and 9.1c. The NAN forms were filled in by Mr Glaister to say the Event was "summer camp". Nothing was entered by him in the box for "Special Activities". The NAN form said "menus, programmes and other paperwork are NOT required with this form". Mr Jones said (Day 3) that a hike up the Great Orme needed to be approved by him as a District Commissioner. The first NAN (17.8.18) said there would be (approx) "3 adults" and 9 explorer scouts on the summer camp. An email (19.8.18) from Mr Glaister told Mr Jones that "Gareth Williams and Mary Carr will be with me in Wales". Mr Williams had confirmed his attendance on 17.5.18 and Ms Carr on 18.5.18. An email from Mr Garraway (28.5.18) said he could not attend. Responding to the first NAN, Mr Jones wanted to know "who will be the First Aider on the camp" (19.8.18), noting that Mr Glaister's own first aid qualification had lapsed. Mr Glaister messaged Mr Garraway (19.8.18 19:48) "can I put you down" and Mr Garraway replied "no problem" (19:50). Mr Glaister then emailed Mr Jones to say "Brian Garraway has advised he will be attending the camp always handy as he is retired". The second NAN (19.8.24) now said there would be (approx) "4 adults" and 9

explorer scouts. The following day's email from Mr Glaister describing the weekend events (20.8.18 at 19:28) was sent by him to Ms Carr and Mr Williams; but not to Mr Garraway. Mr Garraway never attended the weekend. Nobody messaged to ask where he was. Mr Williams said (Day 12) he did not think he had expected Mr Garraway to go on the camp. Mr Glaister said (Day 19) he understood Mr Garraway to have confirmed "he was coming", he was "sure he was coming along", and he "presumed he was in Llandudno" at his holiday cottage. Mr Campbell KC submitted that none of Mr Glaister's conduct regarding the designated first aider could have any causative relevance. In my judgment, it was a topic whose exploration at the inquest was capable of illuminating the picture as to Mr Glaister and his conduct, including what he said he knew and did not know from training and about the POR and factsheets.

A Climb and a Hill Walk

32. The walk up the Great Orme was an activity envisaged by Mr Glaister for the weekend. It was going to be on the Bank Holiday Monday. His Facebook post accessible to parents described the camping weekend at Swallow Falls, with "the climb up Snowden" (Yr Wyddfa) for the Sunday, and the "Monday option" to go to Llandudno and "maybe hill walk up the Great Orme". An email from Mr Glaister to Ms Carr and Mr Williams (20.8.18 at 19:28) contained that same information "maybe hill walk up the Great Orme". For the planned climb up Yr Wyddfa (Snowden), there were communications from Mr Glaister to potential external guides, Youth Action Tameside and then the Conway Centre where a guide (Ben Eldon) was confirmed on 24.8.24. Mr Glaister had emailed District (Mr Sackville-Ford) and County (Mr Santana-Reedy) on 1.5.18, describing this "hike up Snowdon" and the intended use of an external guide because "our leaders do not have scout permits that cover Snowdon summiting". He was then told by District (Mr Sackville-Ford) on 9.5.18 that "POR includes the details of using external providers" and by County (Mr Santana-Reedy) on 10.5.18 that an external guide would need a suitable licence. Regarding the climb up Yr Wyddfa there were also text messages between Mr Glaister and Mr Garraway including on 16.5.18, giving the date as the August Bank Holiday. The insurance incident report form, which County Commissioner Holloway signed on 30.8.18, said that walking up Snowden with a guide who was an external provider had "negated" the need for additional permits. In the event, it was decided by Mr Glaister that the Sunday and Monday activities would be swapped. The Sunday climb up Yr Wyddfa was deferred – by texts between Mr Glaister and Mr Eldon at 15:49 on the Saturday afternoon – in the hope of doing it on the Monday instead. The deferral was on the advice of Mr Eldon because of the weather. So, Sunday became the day to go to Llandudno with the prospect of the hill walk up the Great Orme. The wet weather meant the group did not attempt breakfast on the camp barbeque at the camp-site in Swallow Falls, but went into Llandudno to a café booked by Ms Carr. The boys were in their walking clothes. Ms Carr said (Day 17) it was "slippery under foot". After breakfast, Mr Glaister went with Jack to move his car, while the others walked through the town. A text from Child A (12:30) to Mr Glaister said "meet at the back of the Grand Hotel", to which Mr Glaister replied (12:31) "On my way". A text from Ms Carr (12:41) to Mr Glaister said "walking up the hill". Mr Williams said (Day 13) that at the start of the walk he noticed that Ben, Chris and Alex were on a parallel path, 2-5 metres away.

The Great Orme

33. The jury's Section 3 findings refer to the Orme; to walking through the town of Llandudno towards the Great Orme; to proceeding up the Orme; to a different path up

the Orme; to the grassy tops; to the safe path; to animal tracks; and to the cliff edge. The jury saw maps and photos and heard evidence. Ms Carr had never been to the Orme. Mr Williams had been to the Orme but only as a child. Mr Glaister had been to the Orme, and was familiar with it and a circular walk up, around to the left and back down. DS Terry described the Great Orme as a place that would get busy with a wide variety of people including younger families; with fencing around Bishop's Quarry and around the Bronze Age mines; with walls and fencing associated with working farms; and with no barrier or fencing between the areas over which walkers walk and the cliffs at the perimeter of the park. Approaching the Great Orme from Llandudno, you pass the cable car station to your right, beyond which is the pier. You go through the entrance to Happy Valley, beyond which is the Ski Centre. Mr Glaister said (Day 19) that the Great Orme is "mountainous terrain". As you approach the Orme you can see that there are steep cliffs up and to the right. DS Terry was asked this by Mr Richmond KC (Day 2):

> ***Q. But as you are approaching the Orme, it is obviously a cliff, isn't it? A. Very much so.***

The route which Ms Carr took involved going up a tarmac road past a stone shelter to the right. After that is a gravelled area. There is then a gate in a dry stone wall, with a sign to dog walkers, ahead of which is an area of rocky territory. The path beyond the gate goes to the left of the rocky territory. DS Terry said the path which Ms Carr took is a safe, simple and well laid path. As you walk up the stepped path, up and to your right is what DS Terry called (Day 2) an area of "scrambling territory" with outcrops of rocks and grassy areas which "goes between walking and rock climbing" and "only 150 metres to the far right … you are definitely in high mountainous terrain" with the "steep cliffs". On the stepped path itself is a bench, with some steep rocks immediately to the right behind the bench. After the bench you then bear right and carry on up the path. The path has steps, every couple of paces, with a grassy area up to the right containing some rocks. Ms Carr said (Day 16) that she "must have known that the grassy tops would eventually reach the side of the cliffs". The stepped-path continues up to a plateau at the top. From the top, you can then turn left and go back down to Llandudno, completing a circular walk. That circular walk is about 1½ miles. It took Ms Carr about 40 minutes.

Brief, Instructions and Written Risk Assessment

34. The jury's Section 3 findings include, in the context of the group walking towards and then proceeding up the Orme, that:

> ***There was no brief, instructions or written risk assessment done***

The 15 Topics included "How the trip was organised and planned by … the leaders"; "consideration of any hazards or risks associated with the Great Orme"; "written risk assessments"; "dynamic risk assessments"; "communication between the leaders before the trip, in preparation for it"; "communication and instruction by the leaders to the boys in relation to Great Orme trip"; and "communication between the leaders during the trip". After Ben's death, Mr Holloway wrote an email (20.9.18) to Jess Kelly (National Safety Manager), after having a meeting with Mr Glaister. It included this:

> ***SG confirmed that there was no agreement regarding the supervision plan for the group as most of the explorers had their DofE or Chief-scout Gold and had enough experience for the day. As there were no planned activities there was no formal risk assessment carried out. The only pre-determined meeting point that was agreed was behind the Grand hotel and when SG arrived the group had gone on ahead. No timescales were set for the afternoon. No instructions were given***

> ***by SG to the young people or adults and MC was the leader who took them up the Orme. Normally a walk around the Orme takes about an hour so no set times were mentioned. Most of the explorers and leaders had mobile phones however the signal was really bad so contacting people was difficult and there were no formal plans as to what to do in an emergency… SG confirmed that there was no formal planning documents produced, no written Method statement, risk assessment or kit list was done. He did book a guide for the walk up Snowdon with Conway Centres …***

35. This is from DS Terry's evidence to the jury (Day 2):

> ***Q. Nobody has ever suggested that it was feasible or practical to fence off the Orme, have any? A. No. Q. And it is not practical, is it? A. No. Q. So even though there might be fences wherever there are, you are not going to be in a situation where it's practical to fence off the whole of the cliff side, are you? A. No. Q. And that depends on care being taken? A. Yes. Q. And people knowing where they are going? A. (Nods) Q. And what you have said to us before is your position that everything relates to planning? A. Yes. Q. Those three boys, had there been planning, should not have got anywhere near that edge, should they? A. I agree. Q. And the people who had responsibility for protecting them were those three leaders, weren't they? A. True. Q. And if they had done the planning, Ben would still be alive, wouldn't he? A. I believe that's the case.***

36. Mr Williams said (Day 12) that he did not recall any specific conversation about planning the trip; that in respect of the Great Orme in advance of the trip he had not been given any map, or route map or plan for that; and no written risk assessment had been provided. He said (Day 13) there was never any group briefing between the three leaders. Ms Carr said (Day 16) there was a "proper full briefing" the week before the weekend, at the scout hut, "talking mainly about Snowdon and the challenges that that would bring" and "discussions with the Explorers about the trip in general". She said she thought the Great Orme would have been discussed then "because it was an outlying plan for the Monday"; that "we certainly discussed going for a walk up the Orme", but she could not "recall the details of … specific information given about it". Ms Carr accepted that the Orme was a proposed activity which should have been the subject of a risk assessment; she accepted there was never a safety briefing between the three leaders; she did not "remember there being a specific briefing on the Saturday morning"; nor any "group information" on the Sunday; and she did not think there was a stage when everybody was grouped together with Mr Glaister and given a briefing about what was going to happen that day. Mr Glaister said (Day 19) that he thought an instruction he had given on the Wednesday night at the hut as a "full safety brief" which "pretty much covered everything" including "stay together" and "keep on the path".

<u>On the Grassy Tops</u>

37. The jury's Section 3 findings include:

> ***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.***

There was a photograph from a video which was identified by DS Terry as showing where he understood Ms Carr and the boys to have been when she had seen them. It showed the safe and simple and well laid path on which Ms Carr was standing. Then up to the right of the path – if walking uphill – it showed the outcrops of rocks with the grassy tops.

38. Ms Carr could see where they were. They were not on a path, but on the grassy tops. She could see no leader with them. She said they were "maybe twice the width of this court" away. Ms Carr said (Day 14):

> ***A little later on towards the tops, we then saw Ben, Chris and Alex on the side just above where the path had run. So they were -- if you are walking up the path, they were to the right and they were on a ground a little bit higher than us. So we waved to them. I think Child B shouted "hello", or some such. They were too far to have a conversation, but close enough to acknowledge. And then I continued walking with the five boys who were with me round towards the tram station and down the -- down round to town.***

Ms Carr's evidence included this (Day 14):

> ***Q. I want to understand, you described that you all waved to Ben, Chris and Alex from that point, why, at that stage, you didn't call them to re-group with your group rather than waving at them, and I think you describe, was it Child B, shouting "hello"? A. I think at that stage I had absolutely sort of no concerns or worries about where they were, or what direction they were heading in. They were on the grassy tops, they were very close to the main path. I was happy that they had seen us, acknowledged us. I was still believing that Gareth and Sean would be coming up to sweep them up as such, and I was happy with where they were and that they'd seen where we were, and I didn't have any concerns at that stage.***

And this (Day 16):

> ***Q. They have not been given any instructions before you all set out; do you agree? A. I didn't give any instructions on that particular day, no.***
>
> ***Q. That they weren't on the path. A. Uh-huh.***
>
> ***Q. And they weren't with a leader? A. Yes.***
>
> ***Q. And you yourself are saying that you had identified that there were cliffs? A. Yes.***
>
> ***Q. And so I want to understand, as part of that process that you are telling this jury that you were doing, as to why that didn't result in a request of the boys to come to you.***
>
> ***A. Yes, I can explain a bit more about my thought process if that would help. I think the first thing to note is that at that time on the tops, they weren't close to the cliffs and it wasn't at the forefront of my mind that they might go towards the cliffs. But that being said, having considered, I could see there were cliffs at the bottom, I knew it was a coastal area, when I think about hazards -- when I assess risks in my day-to-day and how I work, you've heard I'm an engineer, I am quite analytical, I do a lot of balancing things in my head, so when I considered the cliffs, and I considered the young people I had with them, I knew their ages, but I also knew their characters, their capabilities, their experience within Scouts, hill walking, et cetera. And so when it comes to looking at a hazard -- and in this case the cliffs -- my process for considering that was well, okay, it could be very severe, there could be really high consequences if you were to end up slipping or falling down a cliff. So that there is a high severity attached to them. But you also have to consider in my mind the likelihood or the probability that one of the young adults or the boys in the group would go close to the cliff edge, and slip, and not be able to regain their footings, and all of these things have to happen for there to be a severe consequence to the cliffs themselves. So knowing the boys as I did, their experience, their characters, for me I didn't see it as even a high possibility, even a slim possibility, that they would go very close to the cliff edge. So I didn't consider that I needed to give any further instruction along the lines of, you know, "Hi, don't – don't go really close to the cliff", because I considered the probability that they would do so to be very low. And that was sort of -- would have been my thoughts, was my thoughts, at the bottom, and seeing the cliffs and thinking about things like that, and then at the tops I hadn't really considered where they were, you know, they weren't in close proximity to the cliffs, I didn't see an increased risk there, so hopefully that explains a bit better. I didn't feel like I needed to give that instruction because -- because of their age, their experience, their characters …***

DS Terry

39. DS Terry gave evidence at the inquest on Day 2 (5.1.24) and Day 27 (15.2.24). He was the original investigating officer for North Wales Police. He also had 20 years of hillwalking experience, was a qualified mountain leader and was a trained mountain rescue team member. He had taken photos and produced a video of the Orme. Questioned by Mr Richmond KC for the family, DS Terry identified the best image which showed where he understood Ms Carr to have seen the three boys, and where they had each been. This evidence then followed (Day 2):

> ***Q. Right. Now, I want to substitute Mary Carr for you with all your training. If you had seen those three boys standing where you have just pointed you saw them, what would have been your first reaction? A. If it was three boys that were under my responsibility as a mountain leader, it would have been to stop what I was doing and to call to them to tell them to stop what they are doing.***
>
> ***Q. Why? A. Because they are under my responsibility to keep them safe. If they are not with me or with another leader, their safety cannot be guaranteed.***
>
> ***Q. And at that particular point, why can't their safety be guaranteed? A. Because at their age and level of experience in terrain like this, they cannot be thought to be able to make decisions for themselves if they find themselves in a dangerous situation.***
>
> ***Q. I want to imagine a scale of zero, which is perfectly safe, no risk at all, and 10 being imminent risk of serious harm; do you understand that scale? A. Yes.***
>
> ***Q. Where the boys were at that stage, in your view, where on the scale was that risk? A. If they were standing here right now?***
>
> ***Q. Yes. A. The risks to them standing there are fairly low as they stand there. There is a risk of slipping on wet grass and twisting an angle. You might be looking at a risk level of 3 at that point.***
>
> ***Q. What about the minute they start moving? A. The minute they start moving, the risk goes up and if they are moving in the direction they did, which is downhill, the risk goes up again.***
>
> ***Q. So in terms of lost opportunities, the best opportunity that anybody in this case had to save Ben's life was that point there, wasn't it? A. I would say that this opportunity was an opportunity to prevent what went on to happen next.***
>
> ***Q. And given your experience, it was an obvious risk, wasn't it? A. For me, it's a logically arrived at risk.***
>
> ***Q. If you are going to be responsible for taking young people on walks on terrain like that, it's exactly the sort of risk you should be aware of, isn't it? A. Yes.***

Mike Rosser

40. Mr Rosser was an expert witness with 50 years of experience of teaching, instructing and leading experience in walking, mountaineering and climbing. Part of his evidence was that he was asked (Day 26) about the position when Ms Carr described seeing the boys on the grassy tops.

> ***Q. Can I ask you about that? Mary Carr has given evidence to this jury about the time when she saw Ben, Chris and Alex not on a path, but on an area that was described. Can you recall that evidence? A. I can.***

> ***Q. Can I ask you, in terms of what is your evidence to this jury about what should have happened at that point? A. Well, from what I recall, Mary might have waved at the group. But what I would have been doing is waving them back towards me and saying "come back towards me".***
>
> ***Q. Why do you say that? A. Because they were heading in the direction of the steep and broken ground, and they were on their own. And they were the people in the group that were under 18.***

41. Ms Carr's representatives asked for this to be clarified, because of the reference to "heading in the direction of the steep and broken ground", which they said misrepresented Ms Carr's evidence. She had said: "I had absolutely sort of no concerns or worries about where they were or what direction they were heading in". On Day 27, Mr Rosser was reminded of Ms Carr's evidence:

> ***Q. Can I ask you also, some clarification is also sought to evidence that was given yesterday about Mary Carr… The clarification that is sought is linked to the evidence Mary Carr, in fact, gave. So I want to read that and then ask for your clarification, please. So the portion of evidence that's flagged is, the question that was asked of Mary was. "Question: I want to understand, you described that you all waved to Ben, Chris and Alex from that point, why at that stage you didn't call them to regroup with your group rather than waving at them and I think you described, was it, Child B shouting "hello". And Mary's answer was. "Answer: I think at that stage I had absolutely sort of no concerns or worries about where they were or what direction they were heading in. They were on the grassy tops, they were very close to the main path, I was happy that they had seen us, acknowledged us. I was still believing that Gareth and Sean would be coming up to sweep them up as such and I was happy with where they were and that they had seen where we were, and I didn't have any concerns at that stage". So that was the answer given by Mary.***

This was the request for clarification:

> ***So the clarification that's sought is: yesterday I asked the question: "Mary gave an answer about where she saw the boys on the tops. What is your evidence about what should have happened at that point?" And the answer you gave yesterday was: "From what I recall, she might have waved at them. What I would have done is waved them back towards me." And I asked the question: "Why?" And you said: "Because they were heading in the direction of steep broken ground on their own and they were under 18." The question that is posed is that that answer misrepresents Mary Carr's evidence, and so we are seeking clarification about -- your evidence about Mary's evidence about what occurred and the wave. So having heard now the full portion of Mary's answer, is there any additional information or comment you wish to make about the point of the wave?***

Mr Rosser responded:

> ***Well, I think all the points I have made about managing the group, managing the group safely, Mary in her evidence there has made an assumption that Gareth was going to sweep the group up. There had been no conversation about that. There had been no planning about where the group should be. As you hear, in my opinion the group within the terrain zero definition should all have been on the footpath. So the fact that the boys weren't on the footpath, they should have been waved back.***

There was this follow-up question:

> ***I think the other clarification that is sought is the position of Mary was there was no suggestion on the evidence that the boys were moving in the direction of steep broken ground at the point at which Mary saw them.***

Mr Rosser responded:

> ***Well, I guess you would need to stand and watch them for a while before you could actually say which direction they were moving in. You know, as you walk up grassy terrain, it's quite normal***

> ***to sort of zigzag and try and find the route of least resistance. So it may well have changed the walking direction many times. But certainly, you know, they eventually got to a place they should never have been in.***

Chris Gilbert's Call to Mac Goodwin

42. Chris Gilbert's police statement had described a phone call he had subsequently made to Mac Goodwin:

> ***I rang him and so I could ask him if it was all right if we stayed out and we just walked around a little bit and there wasn't like a place we were supposed to meet and there wasn't anywhere we were suppose to be … and [Mac Goodwin] asked the leader that was with him at the time, Mary, if it was all right if we just wandered around a little bit?... and he said 'Mary is it all right if they kind of just wander around a bit? Is there anywhere they are supposed to be? And she was like 'No just wander around' and it was very chilled out and just, you know, have a nice time at Llandudno.***

Alex Jamieson said he could not remember the phone call. Ms Carr said that Chris had called Mac, after Ms Carr and her group had "just gone round off the tops and had just started going down the path next to the road". What was relayed to her was "it's Chris on the phone, he wants to know what the plan is" and Ms Carr's response was "we're heading back down, let's meet at the tent on the prom", which was where Ms Carr and her group then arrived at about 13:15.

Mr Williams's Call to Ms Carr

43. Mr Williams said (Day 13) that he had been at the back of the group, and sat down on the bench. Mr Glaister caught up with him, after which he (Mr Williams) rang Ms Carr asking her whereabouts. She replied that she was "on the Orme" and had been to the summit and was "going to head back down now". Ms Carr had asked "are Ben, Chris and Alex with you?" and Mr Williams said "no, I thought they would have caught up with you". Mr Williams's statement (28.8.18) within the insurance incident report (30.8.18) had said "we … managed to get through. Mary said they were at the top and started to go back down, she asked had we bumped into Ben/Alex/Chris I said I thought they would have caught up with you". Mr Glaister's statement (28.8.18) within the same insurance incident report (30.8.18) had said: "Gareth advised he had a signal and we called Mary who advised she was on the beach. I asked Gareth to check if they were all there. Mary advised that 3 had gone a different route. So I used Jack's phone to contact Ben and left a voice mail. We carried on and we then did the same with Chris's phone". Ms Carr said (Day 16) that Mr Williams rang her at about 13:15, when she was already back at the tent on the prom. She said she thought she had asked "Is Alex, Ben and Chris with you?", and that Mr Williams had said "no" and that he (Mr Williams) was with Mr Glaister. The jury saw a text from Ms Carr to Mr Glaister (13:44): "At the music tent on promenade".

Admissions from the Scout Association

44. On Day 7 (12.1.24) the following list of admissions by the Scout Association was read to the jury and the document added to their Jury Bundle. These were the Scout Association's admissions. There is a disagreement as to whether these admissions were evidence that could be relied on against the Claimants, but nobody has said that anything turns on this.

> ***The Scout Association ("TSA") admits the following: (1) TSA owed Ben Leonard a duty of care. (2) TSA was in breach of its duty of care. (3) TSA was in breach of its duty of care as a result of the failings on the part of one or other of the leaders, in particular the matters listed below: (i) there was a lack of risk assessment; (ii) There was a lack of appropriate supervision; (iii) There was a lack of the provision of instructions; (iv) Ben and the two other Explorer Scouts were permitted to venture alone without any guidance into a potentially dangerous environment. (4) These breaches of duty caused Ben's death. (5) It makes no suggestion of contributory negligence. (6) It does not blame Ben Leonard for any of the circumstances surrounding his fall. (7) TSA accepts that aspects of the post-accident situation were poorly handled, in particular, there was at times a lack of sensitivity shown towards the Leonard family. (8) TSA accepts that during the first inquest in February 2020, the stance adopted by TSA and its legal team was overly defensive. (9) In February 2021 at a Pre-Inquest Review (i.e. a preliminary hearing) TSA apologised to the Leonard family in open court, for the matters in paragraphs (7) and (8). (10) It admitted its breach of duty, and the matters in points (7) and (8) above in a meeting with the Leonard family and by letter, both in November 2021. (11) On 4th January 2024, for the first time in the Coroner's Court, TSA made an acceptance of fault and responsibility for Ben Leonard's death and apologised.***

The Ruling

45. The Ruling to leave unlawful killing to the jury occupies 14 pages of transcript (18.2.24). The Coroner addressed the relevant law, as to gross negligence manslaughter and as to Galbraith test. He identified the lists of potential breaches (§10 above). He went through each of the six elements of gross negligence manslaughter in respect of Mr Glaister, and then Ms Carr. On each element he explained that he considered that the jury could conclude that each element was satisfied in respect of each of the potential breaches. His conclusions were:

> ***Accordingly, I am satisfied that each of the elements and the supporting evidence are matters upon which a jury properly directed could conclude on the balance of probabilities that unlawful killing is made out, in terms of the evidence relating to Sean Glaister. Furthermore, it is, in my judgment, safe to leave it to the jury and it is in the interests of justice to do so. So therefore, the jury will consider that as a possible conclusion relating to gross negligence manslaughter and Sean Glaister…***
>
> ***So, therefore, I am satisfied that each of the elements and supporting evidence are matters upon which a jury properly directed could conclude on the balance of probabilities that unlawful killing is made out in terms of the evidence relating to Mary Carr. Furthermore, it is safe to leave it to the jury and it is in the interests of justice to do so.***

The WLDs

46. The WLDs were a 15-page document, accompanied by the 5-page RTC. Unlawful killing by gross negligence manslaughter by the Claimants was addressed, by reference to the six stages, in the WLDs. The Claimants had each, through their Counsel, confirmed to the Coroner on Day 1 (4.1.24) that they owed a duty of care to Ben as leaders on the trip. First, regarding Mr Glaister (WLDs §46):

> ***[46.1] Did Mr Glaister owe an existing duty of care to Ben? The duty to is take reasonable care. It is not a duty to ensure his safety, nor a duty to take all reasonably practicable steps to ensure his safety. He accepts that he did owe a duty of care to Ben.***
>
> ***[46.2] Did Mr Glaister negligently breach that duty of care? You need to consider whether individual acts or omissions could amount to breaches of the duty owed to Ben. Potential breaches cannot be aggregated either as between interested persons or aggregated as breaches. Focus on the following in deciding whether there was a breach by Mr Glaister, did he: (1) Provide appropriate and accurate information to the District Commissioner to permit him to make a***

proper assessment about whether this was a safe trip and whether he should grant his permission? (2) Identify for himself the obvious risks to life present on the Orme? (3) Conduct any risk assessment? (4) Identify that there was terrain on the Orme which was not "Terrain 0" and assess the risks associated with such terrain? (5) Consider Ben's age and medical condition? (6) Warn Ben of the risks to life present on the Orme? (7) Give Ben any information about safe and unsafe routes? (8) Prevent Ben from avoiding any route which took him near the cliff edge? (9) Warn Ben about the possibility of "False" paths which were in fact animal tracks and which might lead him to the cliff edge? (10) Supervise Ben and/or his fellow Explorers and/or his assistant leaders? (11) Give his assistant leaders any information about risk assessment or programmes or to establish boundaries? (12) Prevent Mary Carr from taking Ben up the Orme without any proper risk assessment or preparation and without notifying him? (13) Prevent Mary Carr from taking Ben up the Orme without any proper risk assessment or preparation and without notifying him and allowing her to do so when she was neither properly qualified nor the designated leader? (14) Require Mary Carr to stop the walk? (15) Ensure any adequate method was in place to be able to contact or warn Ben? (16) Appreciate, as a reasonable person engaged in taking a group including children in walks on cliff areas would have, that the nature of the terrain, any hazards which exist, & ensured that all those involved were warned of them?

[46.3] Did that breach of duty give rise to an obvious and serious risk of death from cliffs? Was there at the time of and arising from the breach, a serious and obvious, ie. present, clear and unambiguous, risk of the occurrence of a fatal fall or put another way, an immediately apparent, striking and glaring risk. Risk of death is an objective question, not a question about whether the leader foresaw any such risk or something that might become apparent on further investigation. The risk must be obvious to the reasonable person in the leader's shoes, who demonstrates the same level of negligence as the leader. The test is not whether the reasonable person who had not been negligent would have appreciated the existence of an obvious risk of death; the risk must be assessed with reference to the leader's negligent standard. The risk must therefore be obvious to the Leader on the basis of the information available to the Leader at the time of the breach.

[46.4] Was Such a risk reasonably foreseeable at the time of alleged breach? The circumstances must be such that a reasonably prudent person would have foreseen a serious and obvious risk not merely of injury, even serious injury, but of death. Did Risk exist at the time? It is to be assessed with respect to the information available to the Leader at the time of the breach of duty. If a reasonable person possessed of the knowledge available to the Leader would have foreseen only a chance that the risk of death might arise from cliffs, that is not enough to justify gross negligence manslaughter determination. You must be satisfied that a reasonable person would have foreseen that, if they did not take the action in question, that failure would give rise to a serious and obvious risk of death.

[46.5] Did the breach of duty cause the death of Ben? Is there a direct link between one or more of the breaches and Ben falling from the cliff? The conduct need not be the sole or principal cause of death but you must be satisfied that breach was a significant cause of Ben's death as a substantial, that is more than minimal cause, and operative as a cause of death. The breach must be conduct which on a common sense view is regarded as instrumental in bringing about the death.

[46.6] Are the circumstances of the breach truly exceptionally bad and so reprehensible as to justify the conclusion that it amounted to gross negligence and required criminal sanction? You must be satisfied that the individual breach is sufficiently grave to be one deserving to be criminal and to constitute manslaughter. Very serious mistakes or very serious errors of judgement are not enough for a crime as serious as manslaughter to be committed. Are you satisfied on the balance of probabilities, that the breach or breaches fell so far below the standard to be expected of a reasonably competent and careful Leader that each of the breaches you rely on, are truly exceptionally bad, which showed such an indifference to an obviously serious risk to Ben's life, to amount a criminal act or omission. You are not considering whether the negligence was gross and whether it was additionally a crime. Rather you must consider was the behaviour grossly negligent and consequently criminal?

47. Second, regarding Mary Carr (WLDs §47):

[47.1] Did Mary Carr owe an existing duty of care to Ben? The duty to is take reasonable care. It is not a duty to ensure his safety, nor a duty to take all reasonably practicable steps to ensure his safety. She accepts that he did owe a duty of care to Ben.

[47.2] Did Mary Carr negligently breach that duty of care? You need to consider whether individual acts or omissions could amount to breaches of the duty owed to Ben. Potential breaches cannot be aggregated either as between interested persons or aggregated as breaches. Focus on the following in deciding whether there was a breach by Mary Carr, did she: (1) Take over the leadership role in the walk up the Orme when she was neither authorised nor properly qualified? (2) Conduct any risk assessment or ascertain whether Sean Glaister had undertaken one? (3) Identify the obvious risks to life present on the Orme? (4) Consider Ben's age and medical condition? (5) Warn Ben of the risks to life present on the Orme? (6) Prevent Ben from avoiding any route which took him near the cliff edge? (7) Supervise Ben? (8) Prevent Ben from becoming separated from leaders and the main group? (9) Warn Ben when she saw him on the grassy tops and/or instruct him to return to the path? (10) Instruct Ben to return to the path when she was aware of the telephone call to Mac Goodwin? (11) Permit Ben to "wander around" the top of the Orme? (12) Recognise the risk to Ben being where he was without the presence of a leader to accompany them? (13) Recognise the risk to Ben of straying near the cliffs? (14) In having with her during the walk, those who were over 18 undertake, any supervisory role over those who were children? (15) Communicate with Gareth Williams to ensure Ben's safety?

[47.3] Did that breach of duty gave rise to an obvious and serious risk of death from cliffs? Was there at the time of and arising from the breach, a serious and obvious, ie. present, clear and unambiguous, risk of the occurrence of a fatal fall or put another way, an immediately apparent, striking and glaring risk. Risk of death is an objective question, not a question about whether the leader foresaw any such risk or something that might become apparent on further investigation. The risk must be obvious to the reasonable person in the leader's shoes, who demonstrates the same level of negligence as the leader. The test is not whether the reasonable person who had not been negligent would have appreciated the existence of an obvious risk of death; the risk must be assessed with reference to the leader's negligent standard. The risk must therefore be obvious to the Leader on the basis of the information available to the Leader at the time of the breach.

[47.4] Was Such a risk reasonably foreseeable at the time of alleged breach? The circumstances must be such that a reasonably prudent person would have foreseen a serious and obvious risk not merely of injury, even serious injury, but of death. Did Risk exist at the time? It is to be assessed with respect to the information available to the Leader at the time of the breach of duty. If a reasonable person possessed of the knowledge available to the Leader would have foreseen only a chance that the risk of death might arise from cliffs, that is not enough to justify gross negligence manslaughter determination. You must be satisfied that a reasonable person would have foreseen that, if they did not take the action in question, that failure would give rise to a serious and obvious risk of death.

[47.5] Did the breach of duty cause the death of Ben? Is there a direct link between one or more of the breaches and Ben falling from the cliff? The conduct need not be the sole or principal cause of death but you must be satisfied that the breach was a significant cause of Ben's death as a substantial, that is more than minimal cause, and operative as a cause of death. The breach must be conduct which on a common sense view is regarded as instrumental in bringing about the death.

[47.6] Are the circumstances of the breach truly exceptionally bad and so reprehensible as to justify the conclusion that it amounted to gross negligence and required criminal sanction? You must be satisfied that the individual breach is sufficiently grave to be one deserving to be criminal and to constitute manslaughter. Very serious mistakes or very serious errors of judgement are not enough for a crime as serious as manslaughter to be committed on the balance of probabilities. Are you satisfied on the balance of probabilities, that the breach or breaches fell so far below the standard to be expected of a reasonably competent and careful Leader that each of the breaches you rely on, are truly exceptionally bad, which showed such an indifference to an obviously serious risk to Ben's life, to amount a criminal act or omission. You are not considering whether the negligence was gross and whether it was additionally a crime. Rather you must consider was the behaviour grossly negligent and consequently criminal?

48. The Coroner's explanation at [46.6] and [47.6] – that the jury would not be deciding whether the negligence was "additionally a crime" but whether it was grossly negligent in the sense directed "and *consequently* criminal" – is consistent with what coroners are told by Law Sheet No.1 at §22; and in line with R v Misra [2004] EWCA Crim 2375 [2005] 1 Cr App R 21 at §62.

Derivation

49. The Coroner's lists of potential breaches were largely derived from written submissions (10.2.24) of Mr Richmond KC and Mr McCall for the Leonard family. Those submissions included that there was "evidence from which the jury could (if they accepted the evidence) conclude that" each of the Claimants owed a duty of care to Ben which they breached by the following failures. In the case of Mr Glaister:

> ***[SG1] Failed to provide appropriate and accurate information to the District Commissioner to permit him to make a proper assessment about whether this was a safe trip and whether he should grant his permission. [SG2] Identify for himself the obvious risks (to life) present on the Orme. [SG3] Failed to conduct any risk assessment. [SG4] Failed to identify that there was terrain on the Orme which was not "Terrain 0" and assess the risks associated with such terrain. [SG5] Failed to consider Ben's age and medical condition. [SG6] Failed to warn Ben of the risks (to life) present on the Orme. [SG7] Failed to give Ben any information about safe and unsafe routes. [SG8] Failed to prevent Ben from avoiding any route which took him near the cliff edge. [SG9] Failed to warn Ben about the possibility of "False" paths which were in fact animal tracks and which might lead him to the cliff edge. [SG10] Failed to warn Ben of the danger of "foreshortening". [SG11] Failed to supervise Ben and/or his fellow Explorers and/or his assistant leaders. [SG12] Failed to give his assistant leaders any information about risk assessment or programmes or to establish boundaries. [SG13] Failed to prevent Mary Carr from taking Ben up the Orme without any proper risk assessment or preparation and without notifying him. [SG14] Further to [SG12] allowing her to do so when she was neither properly qualified nor the designated leader. [SG15] Failure to require Mary Carr to stop the walk? [SG16] Failure to ensure any adequate method was in place to be able to contact or warn Ben.***

In the case of Ms Carr:

> ***[MC1] Took over the leadership role in the walk up the Orme when she was neither authorised nor properly qualified. [MC2] Failed to conduct any risk assessment or ascertain whether Sean Glaister had undertaken one. [MC3] Failed to identify the obvious risks to life present on the Orme. [MC4] Failed to identify that there was terrain on the Orme which was not "Terrain 0" and assess the risks associated with such terrain. [MC5] Failed to consider Ben's age and medical condition. [MC6] Failed to warn Ben of the risks (to life) present on the Orme. [MC7] Failed to prevent Ben from avoiding any route which took him near the cliff edge. [MC8] Failed to warn Ben about the possibility of "False" paths which were in fact animal tracks and which might lead him to the cliff edge. [MC9] Failed to warn Ben of the danger of foreshortening. [MC10] Failed to supervise Ben. [MC11] Failed to prevent Ben from becoming separated from leaders and the main group. [MC12] Failed to warn Ben when she saw him on the grassy tops and/or instruct him to return to the path. [MC13] Failed to instruct Ben to return to the path when she was aware of the telephone call to Mac Goodwin. [MC14] Permitted him to "wander around". [MC15] Failed to recognise the risk to Ben being where he was without the presence of a leader to accompany them. [MC16] Failed to recognise the risk to Ben of straying near the cliffs. [MC17] Failed to communicate with Gareth Williams to ensure Ben's safety.***

50. Mr Campbell KC and Mr Dilworth submitted that the Coroner adopted these lists at [46.2] and [46.3] without independent careful thought. In particular, they draw attention to the inapt language of "failed to prevent Ben from avoiding" at [SG8] and [MC7], which the Coroner adopted in WLDs [46.2] at (8) and [47.2] at (6). I cannot accept that these are fair criticisms. Certainly, the Coroner accepted most of what the family had put

forward. But this was not a 'block and paste', as I will now demonstrate. Each potential breach which the Coroner accepted involved some textual change. The Coroner did not accept the family's suggested [SG10] on the subject of "foreshortening" (the difference in how a landscape looks from further and closer). The family's suggested breach [SG14] had a typo because it cross-referenced "further to [SG12]" when it meant "further to [SG13]", and the Coroner recognised this in his own drafting: see [46.2] at (13). Potential breach [46.2] at (16) originated from the Coroner. The Coroner did not accept the family's [MC4] about "Terrain 0", the family's [MC8] about "False paths", or the family's suggested [MC9] about foreshortening. Potential breaches [47.2] at (7) and (14) originated from the Coroner. It is true that there was a problem with the language of the family's [SG8] and [MC7], which the Coroner accepted in [46.2] at (8) and in [47.2] at (6). It was not picked up at any stage – by anybody – after it was first provided (10.2.24), including when Mr Campbell KC and Mr Dilworth each responded in writing to the family's lists (on 14.2.24), and again when WLDs were circulated in draft (on 18.2.24) and recirculated in draft (19.2.24) in preparation for the summing up; nor even when the Coroner went through the directions with the jury, orally. The idea being communicated is clear. Nobody was confused.

Mr Glaister's Core Point

51. Mr Campbell KC for Mr Glaister identified the following core point. Mr Glaister's evidence at the inquest was clear that he did not know, at a time when he could have intervened, that Ben or anyone else: (a) had left the path; (b) was unaccompanied by a leader; or (c) was near the cliffs. There was no evidence to the contrary, to say that Mr Glaister was aware of these things, at any time when Mr Glaister could have done anything at all about it. It was not put to Mr Glaister that he did know these things, at a time when he could have acted. On the evidence, he did not see any of it. He was behind the group with his son catching up. There could never have been a serious and obvious risk of death, at the time of any breach of the duty of care, based on what was known to Mr Glaister. This was squarely raised with the Coroner, and has been a central point ever since. Mr Glaister has never been given an answer. Not in the Ruling; nor in the Record of Inquest. Here is how this was put in Mr Campbell KC's written submissions (14.2.24):

> ***It is recognised that the Jury could conclude that Mr Glaister was guilty of failings. However, it is abundantly clear that no Jury could possibly conclude, on the basis of what Mr Glaister knew that at the time of any alleged breach, that there was an "immediately apparent, striking and glaring" risk of Ben falling from a cliff arising from any such breach. Mr Glaister did not know that Ben had gone anywhere near the cliffs. He did not even know that Ben, Chris and Alex had left the path and become separated until well after the time he could have done anything about it. He had no idea that they had gone into a position of danger. No doubt it will be said that he ought to have known, and that he ought to have controlled the situation better. However, that comes nowhere near satisfying the relevant test. In assessing whether Mr Glaister was aware of an immediately apparent, striking and glaring risk of death, the Jury could only take into what he actually knew, not what he ought to have known but for the breach. It is noteworthy that it was never put to Mr Glaister that he knew that Ben was in a position of danger. It was not even put to him that he ought to have been aware that Ben was in a position of danger. Even if that had been put, it would have been plainly wrong. This is not a case where the Court has to weigh the evidence or have particular regard to the second limb of the Galbraith plus test. It is absolutely clear on a proper understanding of the elements of the offence of gross negligence manslaughter that a Jury could not properly conclude that Mr Glaister was guilty of it.***

Ms Carr's Core Point

52. Mr Dilworth for Ms Carr identified the following core point. Ms Carr's evidence was that the last time she saw the three boys was when they were on the grassy tops, when she waved. They had proceeded in a parallel direction to the main group. She did not subsequently see them anywhere else. She did not see what direction they next took. There was no evidence that she did see them subsequently; nor that she did see the direction they took next. This means DS Terry's evidence (§39 above) necessarily provided a decisive answer in Ms Carr's favour. The risk described by DS Terry ("a risk level of 3 at that point") could not possibly constitute a serious and obvious risk of death. It was impossible to fashion a higher risk score, based on what the boys did next, or based on the boy's future intentions, because none of that was known to Ms Carr at the time of any breach. True, Ms Carr saw that the boys had left the main path, and saw that there was no leader with them on the grassy tops. But she did not see them anywhere near the cliffs. She did not know they were near the cliffs at any time when she could have intervened. This central point was squarely raised with the Coroner. Here is how it was put in Mr Dilworth's written submissions (14.2.24):

> ***It is alleged that Ms Carr should have warned Ben when she saw him on the grassy tops and/or instructed him to return to the path. It is apt, at this point, to apply[] Lord Burnett LCJ's foundational test in Broughton: "had Ben's condition (or position) by that time reached the threshold of serious and obvious risk of death?' The answer is, as a matter of fact and law, quite simply, 'no'…. Most importantly… in the context of the analysis of risk at the time of the wave… and the putative failure to summon the group of three to attend the immediate vicinity of the advance group, the relevant scene is that of a grassy plateau. When asked to imagine a scale of zero (perfectly safe, no risk at all) and 10 being imminent risk of serious harm and to rate the level of the risks of the boys at the point at which the wave was done, DS Terry replied: "the risks to them standing there are fairly low as they stand there. There is a risk of slipping on wet grass and twisting an ankle. You might be looking at risk level of 3 at that point". In other words, the risk profile at that point of the wave is both modest and was explicitly linked by DS Terry to a minor injury. It is comparable to the quotidian risks are likely to apply to everyday scenes of town pavements or marked country parts. At the point at which Ms Carr saw the boys there was no risk of death, and there was nothing to indicate that they were at or imminently at risk of death. No properly directed jury could reasonably conclude that the risks to which Ben was, at that point, subject was a serious and obvious risk of death. It is also clear that the risk generally, let alone the risk of death is not apparent, striking or glaring (let alone all 3). The allegations of breach and allowing the group of three to go out of sight of the leaders cannot provide a basis for imputing to any of the leaders the developments that subsequently happened. Those subsequent developments cannot be assumed to have been within the contemplation any of the leaders. Indeed, Mary Carr had assumed, at that point, that they were "heading the same general direction to us" … and that the other leaders, acting as sweepers would, as is the ordinary pattern, sweet the boys up in any event. However, more fundamentally, to embark on an exercise of what further knowledge could have been gleaned time as to the intentions of the group of three and their subsequent movements and what might therefore have been ascertained as result of further investigation as to where they would [go] or that Ben would not only go closer to [the] edge, but would alone go beyond the edge is irrelevant to the test. It would be to make the same mistake as vitiated the child judges error in Rose…***

A Central Unifying Point

53. At the substantive hearing of these judicial review proceedings a central unifying point came into sharp focus in the oral submissions of Mr Campbell KC and Mr Dilworth. Mr Campbell KC and Mr Dilworth each submitted that the only thing that gave rise to a legally relevant risk – the foreseeable serious and obvious risk of death required by elements (iii) and (iv) – was the action of Ben in going near to the steep cliffs. That was

the point at which the Broughton Threshold would be crossed. Prior to that point they could be nothing more than the Kuddus Chance of a Risk. Since there was no evidence that either of the Claimants were aware that Ben was going near to the cliff, at any time when they could have intervened, unlawful killing could not reasonably be left to the jury in the claim for judicial review should succeed.

54. I am unable to accept this analysis. As I see it, it introduces imminence into the threshold of the "obvious risk" of death which is "present, clear, and unambiguous", "immediately apparent, striking and glaring". Mr Dilworth's written submission (14.2.24) included "imminently" in this sentence:

> ***At the point at which Ms Carr saw the boys there was no risk of death, and there was nothing to indicate that they were at or imminently at risk of death.***

The law has not, in my judgment, required a risk of "imminent" death: §21 above. It could have done so. But if the test were an obvious risk of "imminent" death, only duties of care to act in the face of an obvious risk of "imminent" death would be legally relevant, and breaches could only be causative if performing the duty could have prevented an "imminent" death. This came into focus when Mr Dilworth addressed the situation of allowing a toddler to wander onto a train platform. His logic was that, only when the toddler crosses the yellow line and is close to the edge of the platform, would there be the "obvious risk" of death which is "present, clear, and unambiguous", "immediately apparent, striking and glaring". I cannot agree that this is the law.

The Lawfulness of the Ruling

55. The Coroner had to decide whether, on a possible view of the facts, there was evidence on which a properly-directed jury applying the civil standard could properly come to the conclusion that Ben was unlawfully killed. In the case of each of Mr Glaister and Ms Carr that would mean each of the six elements – which the Coroner correctly identified – being satisfied. I have to myself revisit the Palmer question of judgment: whether or not there was evidence entitling the jury to come to the conclusion of unlawful killing, so that the "issue" was lawfully and reasonably left to the jury. I apply other relevant conventional judicial review principles (the Hambleton "ordinary constraints"). And I ask the Douglas-Williams question whether the procedure adopted as to what was being left was apt to overburden and confuse the jury, with the risk of them bringing in a wrong verdict because of confusion or misunderstanding. See §§4 and 27 above.

56. Mr Campbell KC and Mr Dilworth each submit as follows. There was, within the Coroner's lists of potential breaches of duty, nothing which a properly directed jury could properly find satisfied each of the 6 elements of gross negligence manslaughter. Even if there was within the list any potential breach or breaches of duty which a properly directed jury could properly find satisfied each of the 6 elements of gross negligence manslaughter, the Coroner acted unlawfully or unreasonably or unfairly in deciding to leave the conclusion of unlawful killing to the jury. First, it was not the case that each of the 16 potential breaches in the case of Mr Glaister and each of the 15 potential breaches in the case of Ms Carr could properly be found by a properly directed jury to satisfy each of the 6 elements. Secondly, in finding that each of the potential breaches could properly be found by a properly directed jury to satisfy each of the 6 elements, the Coroner adopted a position which was unreasonable and failed to give legally adequate reasons, through failing to grapple with individual potential breaches and giving an unilluminating global

reasoned conclusion. Thirdly, it necessarily followed from the identification of 16 potential breaches in the case of Mr Glaister and 15 in the case of Ms Carr that the directions to the jury were bound to be confusing and overcomplicated, as indeed they were. In the light of these plain deficiencies in the coroner's decision-making, and even if unlawful killing could have been left to the jury, this decision to do so was vitiated by material public law error and must be quashed.

57. In my judgment, the correct legal analysis in this case is as follows. On a possible view of the facts, there was evidence on which a properly-directed jury applying the civil standard could properly come to a conclusion of unlawful killing applying the six elements of gross negligence manslaughter in relation to Mr Glaister. On a possible view of the facts, there was evidence on which a properly-directed jury applying the civil standard could properly come to a conclusion of unlawful killing applying the six elements of gross negligence manslaughter in relation to Ms Carr. It follows that the Coroner acted lawfully in leaving "the issue" of unlawful killing, in respect of each of them. I am unable to accept the submissions of Mr Campbell KC and Mr Dilworth to the contrary. The conduct of Mr Glaister, applying the six elements of gross negligence manslaughter, which – on a possible view of the facts – could lead a properly-directed jury applying the civil standard could properly come to a conclusion of unlawful killing was his conduct regarding planning and instruction. The conduct of Ms Carr, applying the six elements of gross negligence manslaughter, which – on a possible view of the facts – could lead a properly-directed jury applying the civil standard could properly come to a conclusion of unlawful killing was her conduct when she saw the boys on the grassy tops.

58. A possible view of the facts would include the following. Mr Glaister was the leader in charge of the weekend and activities on it. He envisaged a walk up the Great Orme. Mr Glaister was an experienced leader. He had done the walk up the Great Orme. He knew about the safe path. He knew about the "mountainous terrain". He knew about the "steep cliffs". He knew about "false paths". Ms Carr was an inexperienced leader, who had not done the walk up the Great Orme. Mr Glaister knew that. Mr Glaister knew about the Scout Association rules and standards including as to terrain and risk assessment. He knew that mountainous terrain was not "Terrain 0". He knew that explorer scout autonomy did not extend to walking unaccompanied in mountainous terrain, and did not obviate the need for instructions. Mr Glaister knew to take planning steps, and did so, in relation to Yr Wyddfa. He knew to take planning steps, and did so, in relation to camping; though the information he passed on about activities was incomplete; and the information about a First Aider attending was and remained inaccurate. There was no planning at all carried out by Mr Glaister for the walk up the Great Orme. There was no instruction at all given by Mr Glaister regarding the walk up the Great Orme. There was no intervention at all by Mr Glaister regarding the walk up the Great Orme, led by Ms Carr. The explorer scouts attending the weekend were at no stage – including the previous Wednesday evening at the hut – given an instruction in relation to the Great Orme, to "stay together" and "stay to the path". On the day, Mr Glaister knew that the group was going on ahead. He had the opportunity to give instructions. He had the opportunity halt the walk. None of these facts needed to be distorted by the jury when they were considering potential breaches of a duty, against the six elements of gross negligence manslaughter.

59. A possible view of the facts would also include the following. Ms Carr knew the explorer scouts had been given no instruction. She knew they had not been given a route for going

up the Orme and back down. She knew they had not been told to stay together; or to stay to the path. Ms Carr was not the leader for the weekend or its activities. But she was leading the walk up the Orme, having not waited for Mr Glaister. She was not an experienced leader and she did not have extensive training. Near the top, she saw that the three boys were on the grassy tops. She saw that they were not with a leader. She knew their ages were 15 and 16. She knew there were steep cliffs further in that direction, clearly visible to her when approaching the Orme. She knew the boys' direction had been across to the right, diverging from the safe path. She had no reason to think they were headed towards the safe path. She had every reason to think their direction would continue on the grassy tops, away from the safe path. They were in shouting distance. She was able to gesture to them. She did not beckon to them or shout to them. She waved to them. She was untroubled by the three boys being unaccompanied on the grassy tops. She was unconcerned about what direction they were heading in. She was content to leave them unsupervised on the grassy tops, at the top of the Orme, to explore, find their own paths, and find their own way down.

60. In my judgment, the following were capable of constituting breaches which, applying the six elements of gross negligence manslaughter – and on a possible and undistorted view of the other facts – could lead a properly-directed jury applying the civil standard properly to come to a conclusion of unlawful killing in respect of Mr Glaister as the leader for the weekend and its activities:

> ***(i) Mr Glaister's failure to carry out any planning for the walk up the Orme. (ii) Mr Glaister's failure to conduct any risk assessment for the walk up the Orme. (iii) Mr Glaister's failure to ensure that instructions were given to the explorer scouts about the walk up the Orme. (iv) Mr Glaister's failure to ensure that instructions were given to Ms Carr about the walk up the Orme. (v) Mr Glaister's failure to give an instruction to halt the walk up the Orme.***

In my judgment, a properly directed jury faithfully applying the legal elements as an evaluative judgment would not be bound to find it a good and sufficient answer that Mr Glaister's actions were at a time when he did not know that Ben or anyone else had left the path, was unaccompanied by a leader, or was near the cliffs.

61. In my judgment, the following were capable of constituting breaches which, applying the six elements of gross negligence manslaughter – and on a possible and undistorted view of the other facts – could lead a properly-directed jury applying the civil standard properly to come to a conclusion of unlawful killing in respect of Ms Carr as assistant leader who was leading the walk up the Orme.

> ***(i) Ms Carr's failure, by words or gestures, to instruct the three boys to join Ms Carr and the other explorer scouts on the safe path. (ii) Ms Carr's action in leaving the three boys to explore the grassy tops unsupervised and find their own path on the Orme and back down.***

In my judgment, a properly directed jury faithfully applying the legal elements as an evaluative judgment would not be bound to find it a good and sufficient answer that Ms Carr saw the boys on the grassy tops, did not see what direction they next took, did not know their intentions and did not see them anywhere near the cliffs.

62. I do not agree that these as possible breaches, applying the six elements on a possible and undistorted view of the other facts, would not be open by reason of the Broughton Threshold, the Kuddus Chance of a Risk or the Rose Trap. I have explained that an "immediately obvious" risk of death does not require "imminence" (§21 above). I do not

accept that planning, or risk assessment, nor the Coroner's phrases "identify for himself" and "identify that", fall into the Rose Trap. This was not a case about Mr Glaister obtaining information about the Great Orme. On a possible view of the evidence this was a Flag case, because Mr Glaister was familiar with the Great Orme, with its obviously visible steep cliffs, and himself described the Orme as mountainous terrain (Day 19). That was a basis on which he needed he needed to plan, and think, and be clear about what to do. But that is not attributing to him knowledge or information that he would derive only from performing a duty being breached. Nor, in my judgment, is this a case about attributing to Ms Carr knowledge which she would only have had by discharging a breached duty, by supposing that she had stayed and watched the direction in which the boys went next. A properly-directed jury would know to distinguish the Kuddus Chance of a Risk and the Rose Trap, and this jury needed to be expressly directed about both, as indeed they were.

63. Nor can I accept Mr Dilworth's submission that the decision to leave unlawful killing in respect of Mr Carr was undermined by the decision to leave to the jury a neglect rider on the part of the Scout Association. His essential point was that if the Scout Association training of Ms Carr had been neglectful in a causally relevant way, then Ms Carr must then stand exonerated. I was unpersuaded as to that logic, and as to its suggested consequence.

64. There must, in my judgment, be a degree of latitude as to the identification and articulation of these aspects. What matters most is substance and clarity. A balance needed to be struck as to what to include, and what to separate out. The formulation about planning and risk assessment could also include "so as to identify appropriate action", though mine does not. My formulation separates out planning and risk assessment; it separates out instructions to the leaders and instructions to the explorer scouts. My formulation in relation to Ms Carr includes "by words or gestures"; it includes "find their own path on the Orme and back down"; it separates out failing to instruct from leaving to explore unsupervised. I cannot accept that there is only one objectively correct list, or number of potential breaches, or form of wording by which to articulate them.

65. What follows from my analysis is that I think the Coroner's list of potential breaches was overinclusive. The Coroner had included in the list of potential breaches aspects which were factual matters, each of which the jury properly-directed could consider as part of the facts in deciding whether there was a breach which satisfied the six elements; but which could not in my judgment of themselves constitute breaches capable of meeting all six elements. Mr Richmond KC and Mr McCall for the family accept this. They concede that the failure to consider Ben's age and medical condition was not a potential breach of duty which could properly be found by a properly directed jury to meet all six elements. Revisiting the question of sufficiency of evidence as an objective standard for review, on a Palmer correctness basis, the list should have been materially shorter and simpler. What follows, in my judgment, is this. The Coroner's reasoning in the Ruling expressed satisfaction that each of the potential breaches in the identified list could meet the six elements. This reasoning was succinct. In my judgment, this reasoning was also clear. It does, however, reflect an objective judgment on sufficiency of evidence with whose breadth I do not agree.

66. But it does not follow that the claim for judicial review succeeds, so far as the challenge to the Ruling is concerned. I find that it does not. I find that there was no material unlawfulness, unreasonableness or unfairness. That is for three reasons. First, the "issue"

of unlawful killing (which is the focus in Officer B50 §54; and in Palmer) was – for the reasons I have given applying a Palmer objective standard – was an "issue" lawfully and properly left to the jury, in respect of each of Mr Glaister and Ms Carr. Secondly, the procedure adopted was not, in my judgment, such that conclusions were left to the jury in a way which was apt to confuse the jury so that there was a risk of them bringing in a wrong conclusion because of confusion or misunderstanding (Officer B50 §§41, 45). The Coroner was using a list, in a context where Mr Campbell KC and Mr Dilworth were urging that there could be no "aggregation" of breach (§22 above). The Coroner provided a menu of potential breaches, some of which clearly overlapped, but with a view to giving them very clear directions that they needed to consider potential breaches separately and individually and could only arrive at a conclusion of unlawful killing if in relation to a single alleged breach or more than one alleged breach each of the 6 elements of the test was met. I add here that I cannot agree with Mr Campbell KC that the adoption of the lists of potential breaches gave rise to a risk of subconscious aggregation; nor that they could only be left to the jury if there were a separate RTC in respect of each potential breach. The answer to both these points is that the coroner clearly and repeatedly directed the jury of the need to focus on an individual potential breach and apply all six of the elements to it. Thirdly, the jury identified their agreed factual foundation for their conclusions within Section 3 of the ROI, in accordance with a clear and lawful direction from the Coroner (§9 above). It falls squarely within the scope of what, in my judgment, was to be left to the jury. There is, in my judgment, no doubt about the basis on which the jury was satisfied as to unlawful killing, on an undistorted view of the surrounding facts and circumstances. So far as Mr Glaister's conduct is concerned the jury recorded within their agreed factual foundation:

> ***There was no brief, instructions or written risk assessment done.***

So far as Ms Carr's conduct is concerned the jury recorded with their agreed factual foundation:

> ***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.***

The Lawfulness of the Directions

67. I turn to the WLDs and RTC. The question is whether the directions were flawed in a material way or ways. In my judgment, they were not. I have dealt already with the inclusion of the lists of potential breaches. That leaves two further topics. The first concerns the duty of care. The WLDs told the jury that the first element of gross negligence manslaughter was whether the leader – whichever individual they were considering – owed an existing duty of care. This is how the duty was formulated in the Legal Directions:

> ***The duty to is take reasonable care. It is not a duty to ensure his safety, nor a duty to take all reasonably practicable steps to ensure his safety.***

This was derived from the written submissions of Mr Campbell KC for Mr Glaister on 18 February 2024, in response to the Coroner's draft WLDs. Mr Campbell KC had submitted, and the Coroner accepted, that:

> ***the jury should be told what the duty of care is: ie a duty to take reasonable care. It is not a duty to ensure his safety, nor a duty to take all reasonably practicable steps to ensure his safety.***

68. Mr Dilworth for Ms Carr had gone further. He had submitted, in response to the draft WLDs: that the Coroner should give "guidance on the scope of the duty"; that it was "necessary to define the scope of the duty of care, including by reference to the leader's volunteer status and Ben's age and character, in order to assess, for each alleged particular, whether or not the alleged particular of breach of the duty in fact constituted a breach". Joint written submissions by Mr Campbell KC and Mr Dilworth (joined by Angus Withington KC for Mr Williams) dated 9 February 2024 had included this:

> ***When viewed through the lens of the above principles, the following propositions can be deduced as to the scope of the duty: (a) A scout leader owes a duty of care to any person under 18 in his or her care. (b) Although not relevant here, there is always a positive duty not to take any positive action which might cause harm – physical or psychological – to a child to whom a duty is owed. (c) Beyond that, the nature and scope of that duty – analogous with that in Titchener v BRB 1984 SC (HL) 34 – will vary with the age, abilities, intelligence and/or competence of the relevant child. (d) As regards guidance required to be given to a child, there is unlikely to be a duty of care to provide advice or instructions to an older and/or more intelligent child in respect of risks or dangers of which they can reasonably be expected to be aware.***

69. Mr Dilworth submitted as follows. This joint formulation (9.2.24) met a need for precision within the WLDs. The Coroner needed to direct the jury that "reasonable" care was informed by all of these points: the fact that the scout leader is a volunteer; the age, abilities, intelligence and competence of the person under 18 in their care to whom the duty is owed; the culture of autonomy applicable to explorer scouts; and the standard to which the scout leader had been trained. Titchener was about safety of those entering railway premises and said (at 53 and 55) "what is reasonable care must depend on all the circumstances of the case" and "one of the circumstances is the age and intelligence of the entrant", and "the existence and of a duty to fence will depend on the circumstances of the case including the age and intelligence of the particular person entering upon the premises". Reference was also made to Cattley v St John's Ambulance Brigade (Judge Prosser QC, 25.11.88) which described "the standards of the ordinary skilled first-aider exercising and professing to have that special skill of a first-aider", and whether there has been "such failure as no first-aider of ordinary skill would be guilty of, if acting with ordinary care"; and Knight v Home Office [1990] 3 All ER 237 which found (at 243) "the standard of care in a prison hospital" was not "as high as the standard of care for all purposes in a psychiatric hospital outside prison".

70. I am unable to accept that the formulation of the duty of care required more of the Coroner than the statement that the duty was to take reasonable care, and the adoption of the two points which Mr Campbell KC had put forward. I do not accept that the Coroner was obliged in law to give a specific further direction about reasonableness nor to give specific further directions about the scope of the duty of care in the context of each or any of the potential breaches. The jury heard a lot of evidence about the leaders being volunteers, about the nature and extent of their training, about their roles and responsibilities, about different ages of different groups and about an appropriate degrees of autonomy and protection in the context of ages. The WLDs used the phrase "reasonable care". That duty was accepted. They jury had to apply "reasonable" in the context of the evidence they had heard. The importance of "reasonable" was then emphasised by distinguishing a duty "to ensure safety" or to take "all reasonably practicable steps to ensure safety". The WLDs went on to direct the jury by reference to

"the reasonable person in the leader's shoes"; "a reasonably prudent person"; "a reasonable person possessed of the knowledge available to the Leader"; and "a reasonable person". I cannot accept that the WLDs were, for this reason, flawed in a material way.

71. The next topic is about signalling to the jury. Mr Campbell KC and Mr Dilworth submitted that the lists of potential breaches as formulated in the WLDs were "signalling" by the Coroner to the jury that certain facts must be accepted to be breaches, or that certain breaches must be accepted, when these were matters for the jury to decide without any influence from the Coroner. I am unable to accept these submissions. The Coroner made clear that it was the jury's function to decide facts. He made it clear that it was the jury's function to decide what was a breach of a duty to take "reasonable care". He spelled out in relation to the first of the 6 elements that it was accepted by each of the Claimants – as had been confirmed to him on Day 1 – that they did owe the duty (the duty "to take reasonable care") as a duty of care owed to Ben. In relation to the second element, the Coroner was not signalling to the jury that there was any breach of a duty of care by either of the Claimants. On the contrary, the Coroner spelled out to the jury that they had to apply the six elements in relation to "potential breaches of duty, raised during the course of the evidence, for you to consider". The Coroner directed the jury that a conclusion of unlawful killing could only have been established if all of the elements in the test applied in relation to a single "alleged" breach or breaches. He was careful to use the word "alleged"; as he had been to use the word "potential". He directed the jury, in relation to the "breach" element:

> ***You need to consider whether individual acts or omissions could amount to breaches of the duty owed to Ben.***

He was not answering that question for them. He gave them his lists of potential breaches of duty, on which they should focus, when it came to "consider whether" there was any breach of the duty of care. He was not, for example, telling the jury that Mr Glaister failed to provide appropriate and accurate information to the district commissioner, but was telling them to consider whether or not he had done so, and if not whether that would constitute a breach of the duty to take reasonable care. He was not, for example, telling the jury to find that there were obvious risks to life present on the Orme; or that there was Terrain on the Orme which was not "Terrain 0"; or that Mr Glaister or Ms Carr was taking a group including children on a walk in a cliff area; or that Ms Carr lacked authorisation or proper qualification to take a leadership role in the walk up the Orme; or that Mr Glaister knew about the possibility of false paths; or that Mr Glaister ought to have prevented Mary Carr or required her to stop. He was telling the jury to consider all of these matters, decide the facts, decide what constituted a duty "to take reasonable care", and apply all of the other elements to anything that did constitute a breach. He did not signal how to answer the questions he posed. He did not signal that any answer to any factual question would constitute a breach.

72. There was, in my judgment, no procedure adopted – with regard to the conclusions which were left – which confused the jury and produced the risk of bringing in a wrong conclusion because of confusion or misunderstanding; still less any risk which materialised in the light of the jury's agreed factual foundation for its conclusions. The directions were not flawed in a material way.

The Lawfulness of the Summing Up

73. I turn to the question whether the summing up was so deficient as to render unsafe the jury's conclusions on unlawful killing. In my judgment, it was not. I have reminded myself of what Collins J said in R (Anderson) v HM Coroner for Inner Greater London [2004] EWHC 2729 (Admin) §22 (Officer B50 §44):

> ***The absence of any opening or closing speeches at inquests means that the need for clarity in a summing-up becomes all the more important. This is not to say that a summing-up should be subjected to a close analysis or that the absence of a particular form of words or indeed of particular directions will necessarily be fatal. But the jury must know clearly what they must find as facts in order to justify any verdict, especially one which decides that a criminal offence has caused the death.***

74. Mr Dilworth argued that there was a material deficiency in the way in which the Coroner summed up Mike Rosser's evidence (§§40-41). When he came to Mr Rosser's evidence in the summing up, the Coroner included this:

> ***When Mary Carr waved, I would have been waving them back because they were heading to steep, broken ground on their own and they were under 18.***

The Coroner later included this:

> ***Mary waving at the boys on the grassy tops: "I have no concerns or worries about where they were and what direction they were heading in. I was still believing that Gareth or Sean would be coming to sweep them up. I didn't have any concerns at that stage." And he [Mr Rosser] commented on that: "There was an assumption that Gareth was going to sweep the group up. There had been no planning about where the group should be. The group should have all been on the footpath and the boys should have been waved back towards the Leaders. I guess you would stand and watch them for a while to see the direction they were walking in. They eventually got to a place they should never have been in".***

75. Mr Dilworth submits that this part of the summing up was materially unfair or unlawfully prejudicial. The Coroner repeated and amplified a piece of expert evidence, which was clearly based on a misapprehension, when he should have "deleted" this part of the evidence, or alternatively should have reminded the jury that "they were heading to steep broken ground" was not Ms Carr's evidence. I am unable to accept these submissions. Mr Rosser's evidence was "I would be waving them back". He did not retract that view when Ms Carr's evidence was put back to him (§§40-41 above). Mr Rosser repeated his evidence: "the boys should have been waved back". The Coroner did not say "they were heading to steep broken ground" was Ms Carr's evidence. As to what Ms Carr's evidence was, it was that she had "no concerns or worries about … what direction they were heading in". That was what was put for clarification and the Coroner specifically included that, within this part of the summing up. He also included Mr Rosser's "I guess you would stand and watch them for a while to see the direction they were walking in". The jury was able to consider all of this evidence, and the other evidence, about the boys on the grassy tops and what Ms Carr saw and did, and did not do, including with a clear direction about the Rose Trap. The Coroner was not required to "delete" evidence or make further comments about evidence. The important point was that the expert, including when the point was put for clarification, was maintaining that he would have been beckoning the boys back to the path and he gave reasons why he maintained that opinion. The Coroner could have made more of the clarification, but it would have likely served to emphasise that the opinion remained the same, about beckoning the boys back to the path.

76. Next, I cannot agree with Mr Dilworth that it was a material deficiency that the summing up did not include the evidence of Child B's mother. Her statement (8.12.22) was read to the jury (Day 13), including:

> ***Child B told me that due to the weather the original location for the walk changed and they went to Llandudno to walk on the Great Orme. He said the leader Sean Glaister told him that due to the wet weather it would be quite slippery underfoot due to there being slate or stone under the grass in some areas and to go carefully and stick to the main pathways.***

Her further statement (30.1.24) was read to the jury (Day 28) which said:

> ***By way of clarification, I assumed that it was Sean who had said this due to him being the leader, but [Child B] never actually told me who had said this to them. I have no idea who did say this.***

The Coroner could have included a reference to this hearsay evidence, of something said on the day to Child B, which was not recalled by Mr Glaister nor by Ms Carr. There was no material deficiency in omitting it.

77. Next, the Coroner included in his summing up, this from Rev Rowles's evidence:

> ***At a separate meeting with Mary, in 2018 in my church in [Droylsden] we spent about half an hour talking, and she said, "It's all part of God's plan", and that shocked me.***

The Coroner had ruled (Day 14) against an objection on behalf of Ms Carr to this evidence being put before the jury. Mr Dilworth says two things. His logically prior point is that this evidence should never have been admitted in the first place: it was irrelevant, because a religious belief about "God's plan" could not inform a finding about how an individual would actually behave; it was prejudicial, because it ascribed to Ms Carr an unpopular and attractive religious belief likely to alienate her from the jury. In my judgment, the Coroner was not wrong to decline to exclude this part of the evidence. It was evidence, alongside what Ms Carr and Rev Rowles said about it, which the jury was entitled to consider when considering all of the evidence about what Ms Carr did, thought and recognised. Returning to the summing up, Mr Dilworth says that, if mentioning this in the summing up, the Coroner was obliged in fairness to remind the jury that Ms Carr denied saying it. In my judgment, there was no deficiency, still less to render unsafe the jury's conclusions on unlawful killing. The jury was well aware that Ms Carr disputed saying "it's all part of God's plan".

78. Since the point has been raised, I will record the key points which the jury had heard. Mr Richmond KC for the family asked Ms Carr about Rev Rowles's statement (Day 16):

> ***Q. What about the idea -- because you have seen her statement, haven't you --***
> ***A. I have.***
> ***Q. -- that what you said to her about Ben's death that it was all part of God's plan?***
> ***A. It's honestly absolutely nonsense.***
> ***Q. So that's a complete lie, is it?***
> ***A. It's a complete lie.***
> ***Q. Right. So just so we are clear –***
> ***A. Yes.***
> ***Q. -- she says you said it, you said you didn't --***
> ***A. I did not say that.***
> ***Q. -- one of you must be lying?***
> ***A. Correct. Or misremembering, but I did not say that.***

Mr Dilworth (for Ms Carr) asked Ms Carr (Day 17):

> ***Q. Would you ever use or have you ever used the phrase 'God's plan' to explain human acts or events even retrospectively?***
> ***A. No, absolutely not. I'm not the sort of Christian who believes in fate or pre-determined things. I mean, I'm an engineer and that's not how I consider it, or ever have considered it.***

Rev Rowles (Day 21):

> ***She talked a little bit about putting things in boxes and she said, "It's all part of God's plan." and -- and I was really -- well, that really shocked me and it challenged me from a kind of theological point of view. I sat there thinking, "Gosh" -- I didn't quite know what to make of that.***

Then, after Mr Richmond KC asked Rev Rowles about this (Day 21), Mr Dilworth returned to it with Rev Rowles (Day 22):

> ***Q. -- your response yesterday was "I can't say that she said this"?***
> ***A. Okay, so there was a misunderstanding and I apologise for that. I can't say that she said, "I did nothing wrong." I can say that she said, "It is all part of God's plan"***
> ***…***
> ***The Coroner: Mr Dilworth, at page 187 the witness said this: "She gave me the impression that -- and I can't say that she said this -- but she gave me the impression that she believed she herself had done nothing wrong and that it was God's plan."***
> ***Mr Dilworth: Yes.***
> ***The Coroner: So that is the full context twice on the transcript yesterday of what the witness is saying.***
> ***Mr Dilworth: Yes.***
> ***The Coroner: And just to clarify, are you still saying that you heard her say, "It's all God's plan"?***
> ***A. Absolutely.***

Mr Dilworth again (Day 22):

> ***Q. Reverend Rowles, we've heard evidence from Mary Carr herself, Day 17… "Question: Would you ever use or have you ever used the phrase 'God's plan' to explain human acts or events even retrospectively? "Answer: No, absolutely not. I'm not the sort of Christian who believes in fate or pre-determined things. I mean, I'm an engineer and that's not how I consider it, or ever have considered it."... Reverend Rowles, do you accept that you may have misheard what you now think were the words "God's plan" in that conversation?***
> ***A. No.***

The Lawfulness of ROI Section 4

79. I turn to the final issue raised by the Claimants. The question is whether it was lawful that the ROI Section 4 conclusion of "unlawful killing" should have been accompanied by an identification – albeit other than by name – of the persons against whom that finding was made.

80. Mr Campbell KC and Mr Dilworth submit that the answer is a clear no. They submit, in essence as I saw it, as follows. The applicable law (§26 above) includes the s.5(1) statutory purpose; the s.10(1)(a) requirement to make a determination (as to how, when and where); the s.5(3) prohibition on expressing any opinion on any other matter; the rule 34 obligation and the Sch 1 §1 prescribed form including its notes, supported by Guidance No.17 at §18; and the s.10(2) prohibition (on the determination as to how, when and where Ben came by his death being "framed" in such a way as to determine – or to "appear" to determine – any question of criminal liability on the part of a named person or civil liability). Compliance with these duties and prohibitions requires a coroner and jury to do "everything possible" to avoid "appearing" to arrive at any conclusion on criminal or civil liability on the part of any identified or identifiable individual. In R v

Inner South London Coroner, ex p Kendall [1988] 1 WLR 1186 – where a coroner's Section 4 conclusion of death by "acute abuse of a drug" was quashed because the Tippex solvent inhaled by the deceased was not a "drug" for the purposes of the Rules – the Court described a clearly established policy of "avoiding so far as possible" any unnecessary stigma to the memory of the deceased (1191H-1192A). There is a similar "avoiding so far as possible" duty when it comes to identifiability of an individual. True, where there is one known individual who is the sole person to whose actions or omissions a conclusion of unlawful killing could relate, the jury is not to be dissuaded from its findings of fact and a conclusion of unlawful killing. That is inescapable. True, "everything possible" does not carry a requirement of anonymity at an inquest, because that would derogate from the constitutional value of open justice. The duty to do "everything possible" to adhere to the statutory duties and prohibitions, and to promote and not frustrate their purposes, means a jury cannot in ROI Section 4 identify a person by reference to their role. It follows in the present case that, even if the judicial review claim fails in every other respect, the phrase "by the Explorer Scout Leader and Assistant Explorer Scout Leader" would need to be quashed and deleted from Section 4.

81. My attention was also invited to these cases. Jamieson, which said of the language in s.10(2) was "legitimating a [conclusion] of unlawful killing provided no one is named" (24C). Jordan v Lord Chancellor [2007] UKHL 14 [2007] 2 AC 226, where Lady Hale said at §49 that "the object is to avoid attributing blame to any individual or individuals, while being as precise as the evidence permits in answering the four factual questions posed by the legislation". R (Hambleton) v Coroner for the Birmingham Inquests (1974) [2018] EWCA Civ 2081 [2019] 1 WLR 3417, where the coroner's ruling on the scope of the resumed inquest into the Birmingham pub bombings – namely that they would not investigate "the identity of the true perpetrators of the bombings" – was upheld as lawful on judicial review. In describing "the identity of the true perpetrators" as not a central issue, the Court of Appeal invoked s.10(2) – as had the coroner – and explained why deciding not to investigate and call evidence to seek to answer a question "when the jury are disabled from reaching a conclusion on that matter" and "a distinct question which the jury is prohibited by statute from answering" (§§53, 56). Pausing there, the Court was careful to say that this was a fact-specific approach, which was "not a black and white issue which applies at every inquest"; that there are inquests "where the identity of the person or persons responsible for the death are known and in doubt, indeed such people may be interested persons at an inquest" and that often "the conduct of known individuals will usually be under scrutiny" with evidence "which implicates identified individuals"; and that the circumstances were "an inquest which follows a comprehensive police investigation which has been unable satisfactorily to identify those responsible" (§53). Maughan was about the standard of proof. Lady Arden recognised that findings by way of a narrative statement may "point a figure" a "person implicated in the conclusion of unlawful killing", meaning they are "liable to suffer prejudice" (§95). She recognised the "statutory protection" (§87), but acknowledged that there are cases where "the identity of the person whom the jury considered was responsible for the death may be obvious to persons familiar with the facts" (§91). She spoke of "public confidence" in an inquest being able to "lead to clear findings on the balance of probabilities" (§93); adding (see §13 above) that "the public are likely to understand that there is a difference between a finding at an inquest and one at a criminal trial where the accused has well-established rights to participate actively in the process" (§93).

82. I am unable to accept this part of the claim. Unlawful killing is a proper conclusion for a jury to reach, where that conclusion is justified on the evidence. The jury is not making a determination of any question of criminal liability on the part of anyone, named or otherwise. In the same way, although elements of gross negligence manslaughter would be sufficient ingredients for civil liability, and although they are evaluated on the civil standard, the jury is not making a determination of any question of civil liability. There is neither a s.10(2) determination, nor a s.10(2) apparent determination, of any question criminal or civil liability. That is so even though – as indeed anyone who attended the inquest will know – the jury has been directed by the coroner to apply elements of a crime or tort to an identifiable individual. That is part of the jury's required deliberation and reasoning, in "the mind of the decision-maker": Law Sheet No.1 §10. The reason there is no s.10(2) determination – or s.10(2) apparent determination – of any question criminal or civil liability is that the jury is performing its distinct statutory inquisitorial function of deciding how, when and where the deceased died.

83. The inquest is entitled to get to the bottom of the facts. There is a responsibility, and a public interest, in ensuring that the relevant facts are fully, fairly and fearlessly investigated and exposed to public scrutiny. There is a public interest, and a need for public confidence, in an inquest being able to lead to "clear findings" on the balance of probabilities, as Lady Arden explained. The ROI Section 3 findings of fact can appropriately identify actions and inactions of identifiable individuals, as in the present case. Section 3 can contain the jury's "agreed … factual foundation" for Section 4, as in the present case. The logic of the argument is that the coroner is obliged, by legislative provisions and/or public law duties, to ensure that the ROI leaves deliberate ambiguity, in any case where the jury reaches the conclusion of unlawful killing, where there is more than one identifiable individual as a person to whose actions or omissions a conclusion of unlawful killing could relate. I have not been persuaded that this is correct. In my judgment, a jury can lawfully include descriptions of different individuals, by reference to their role or actions, in the findings of fact in Section 3. In my judgment, it is not unlawful, unreasonable or unfair for a coroner to invite the jury to include descriptions – including role – within its conclusion in Section 4. The law does not mandate ambiguity. It allows clarity. If the jury had found unlawful killing in respect of one of the Claimants, but not the other, they would not by law be required to indicate both, or indicate that it was one but not say which. The jury was not required by law to indicate ambiguity as to Mr Williams the Assistant Scout Leader. This is not about implicating anyone. Enforced ambiguity can serve to undermine the public interest, full and fearless fact-finding of the inquest, to discern and record fact and truth. Withholding names does not undermine the full and fearless fact-finding of the inquest, to discern and record fact and truth. Withholding names does not mean ambiguity. There is, moreover, clear guidance in the Chief Coroner's Law Sheet No.1 at §10 that no conclusion of unlawful killing should "name" a person responsible. If, for example, there were a road death after collisions involving multiple vehicles, a coroner's jury could make findings and conclusions to identify which collision caused a death, and which driver of which car they mean when finding unlawful killing. Some individuals may prefer the elimination of ambiguity. Others may prefer the engendering of ambiguity. That preference may be linked to what it is that the jury is considering, or what it has in fact decided. The inquest has not determined criminal responsibility. Nor has it determined civil responsibility. The processes are different as are the outcomes. The public can be expected to understand that. This court will doubtless continue to repeat it.

Conclusion

84. In light of my conclusions on the various issues raised, the two claims for judicial review have not succeeded. The question of remedy does not arise. That includes the points which the Scout Association wished to raise if that question were reached. Having received this judgment in draft, the parties were agreed as to the appropriate order, which I make. There was no application for permission to appeal. I was initially told that Ms Carr did not "at this stage" seek permission to appeal. Points were made by reference to English v Emery Reimbold & Strick Ltd [2002] EWCA Civ 605 [2002] 1 WLR 2409 at §25, which applies where "an application for permission … is made". The position was helpfully clarified. The option was declined of the Court possibly allowing further time (Judicial Review Guide 2024 §26.6.2) in which to make any application for permission to appeal. My Order is that the claims are dismissed; with no orders as to costs.