## P-06-1195 Conduct an independent inquiry into the death of Glyn Summers and the actions of Coleg y Cymoedd, Correspondence – Petitioner to Committee, 17.10.21

Dear Sir/Madam,

Thank you for allowing me to share my views and progress so far with my brother's case. As the education minister advises in his reply to the petition committee, my family have been fighting to find out the exact circumstances of my brother's tragic accident since his death in 2011. To our disbelief, we have found the systems of sharing information between Further Education colleges and Local Education Authority's to be inadequate, which resulted in multiple failures that led to my brother's accident not being properly investigated. In addition, my family has received no evidence that lessons have been learned at a FE and LEA level, from my brother's tragic accident and those who are responsible were not held to account.

To date, Ystrad Mynach College, now known as Coleg Y Cymoedd has refused to share the findings of an internal investigation they conducted into their staff members conduct whilst on the trip, and over the past ten years, my family have pieced together information and evidence which proves that the professionals responsible for Glyn's care acted inappropriately. The college's reason for not sharing this information is down to employment and data protection law. However, this has left my family with no closure from Glyn's tragic death. Quite frankly, it's highlighted a system that harbours failings behind data protection and employment law, which only results in putting children's safety at further risk.

The sad truth here is that my family isn't the only family who has had to fight public bodies to find out the circumstances of a child's serious accident or death. This is abhorrently wrong. No parent should have to enter legal battles to find out the events that surrounded their child's death. In my reply to the education minister in September this year, I cited over 50 examples of other families who are in the same position as my family: still no further in finding out what failings were made which contributed or resulted in their child's accident or death.

On page 3 of this document I have included examples and evidence of how tutors disregarded their responsibilities which resulted in my brother's tragic accident, and I also include a call recording of the college staff member [redacted], a tutor on the trip who advised my brother's private insurance company, that "he jumped from a 5th storey building" and committed suicide.

The overall aims of my family and the 834 people who signed this petition are to ensure that there is a thorough investigation into the failings made at College, Local Education Authority and Government level, so lessons can be learned from Glyn's tragic accident and legislation can be put in place to ensure education professionals are held to account when their safety responsibility is disregarded or misconduct occurs in Glyn's case granting a 17 year old to enter a strip bar club.

**These failures include:**

1. Gross misconduct from an educational professional responsible for children including fabricating the circumstance of a child's accident. This is not acceptable and has no place in our educational system.

2. Failure from senior members of college staff to adequately investigate these actions when it was brought to their attention is unacceptable.

3. Failure from college senior staff to share all the information of Glyn's accident with the Child Safeguarding Board regarding his accident is unacceptable. If [redacted] had continued to tell his lie regarding Glyn jumping, a Serious Case Review would've been conducted by the LEA immediately, however, the information the LEA received from the college about Glyn's accident "didn't meet the required threshold" for a Serious Case Review. The CSB hasn't provided a reason why the threshold wasn't met and exactly what information they received, this is because there was no record completed.

4. Failure to conduct a Child Practice Review (now known as a Serious Case Review) when Caerphilly Country Borough Council received further information regarding Glyn's accident is not acceptable.

5. Failure to adequately address the concerns raised about staff conduct by the PRUDIC review conducted is not acceptable. In our opinion, the PRUDIC review process was not appropriate.

6. Failure from Government ministers to investigate the above failings when evidence is provided, is not acceptable.

7. Failure of government ministers to adequately investigate and explore solutions to ensure no other family has to enter legal battles over data protection and employment laws to find out the circumstances of their child's death, is unacceptable.

8. Failure to ensure that all child deaths or serious accidents in an education setting are independently investigated, is unacceptable.

I have briefly given 8 key examples of how different child safeguarding systems have failed to adequately resolve the failings that led to my brother's accident and ensure that lessons are learned from his tragic death. To date, we have received no evidence to show that changes to processes and procedures to safeguard children are in place across the whole FE sector along with how serious accidents and fatalities are now handled.

The education minister does have the power to trigger an investigation into the system-wide failings of Coleg Y Cymoedd and the LEA, Caerphilly County Borough Council, however, has decided not to use that power. The minister advises that to sanction a public inquiry the case needs to be in the public interest and show system-wide failures. This petition should show the minister that there is indeed public interest he is seeking with 834 signatures and I have identified 8 key system failures above - none of which to our knowledge have been rectified.

An independent public inquiry will help my family gain closure from Glyn's tragic accident, and also ensure this doesn't happen to any other student or family again. We call the minister to investigate the college's handling of Glyn's accident, the failings from Caerphilly County Borough Council identified by the Public Services Ombudsman, and provide a solution to the legal constraints that withhold families from receiving the circumstances of their child's death.

I trust that the education minister will advise that an Estyn report was commissioned by Huw Lewis. Whilst I understand and welcome the Estyn report, this desk-based report only confirms that guidelines are in place for educational professionals to follow and don't explore how guidelines are used, interpreted and acted upon in the field by educational professionals responsible for the care of children. The issue in Glyn's case is that professionals at Coleg Y Cymoedd disregarded their guidelines and were not held accountable by the institution they worked for, the Local Education Authority, the Child Safe Guarding Board and the Welsh Government. This is unacceptable. No one learns lessons from tragedies by refusing to recognise failings, apologising for them, and making changes to ensure student safety. Poor individual conduct still allows system-wide failures to occur.

My family has provided a series of questions that provide an objective for the public inquiry we're seeking. However, If the education minister continues to exclude the option of a public inquiry then these key questions should still be his focus to solve the issue regarding information sharing and accountability of educational professionals misconduct.

- What measures have been put in place to prevent individuals from not adhering to safety policies?
- How do education bodies ensure that educational professionals are held accountable using an independent mechanism when safety misconduct occurs?
- What measures have been put in place and what lessons have been learned to ensure Child Safeguarding Boards employ the correct actions when dealing with child deaths? Are these the same in all local authorities?
- What actions have been taken to ensure that LEA's conduct Serious Case Reviews or Child Practice Reviews when serious accidents or deaths occur abroad - regardless of what information is received?
- Will the education minister ensure that all parties (including parents) have the opportunity to provide evidence to Child Practice Reviews?

- What measures have been put in place to ensure communication between FE colleges and Local Authorities is robust and ensures all information is shared?
- What measures have been put in place to ensure FE colleges are held accountable for student safety, especially those below the age of 18?
- What changes have been made as a result of the Public Services Ombudsman complaint in 2014?

**Further evidence Provided:**

College 2011 Student Safety Policy wording:

The responsibility for the safety of each student must be clearly defined at all times. This is particularly important when the responsibility is divided between college and centre during a residential course. Never assume that "someone else" is doing it. Under common law, it is the tutor who has the ultimate responsibility for acting 'in loco parentis'. A tutor may discharge this responsibility to a competent and highly qualified member of centre staff for say a high risk activity (caving, climbing, sailing etc.) which requires special skills. Bur for the rest of the visit, the responsibility remains with the tutor - even at night.

responsible for the group if there is down-time between activities;

ensure that all supervisors understand that their supervisory role continues in the evening – however hard a day it has been, that it is not a time to relax in the bar or in front of the TV;

Ratios in themselves do not guarantee safety. In all cases, the duty remains with the Department Head and leader to ensure adequate supervision for the particular group and for the particular activity.

Evidence of inappropriate actions from College Staff in a letter received in 2012 :

Staff made it clear to the learners that permission to visit the club was being granted on condition that the learners agreed to observe a curfew of 11:30pm; to stay in groups of no less than three; and to telephone the staff when leaving the club. All learners were also aware that staff were available to learners on a 24 hour basis via a dedicated mobile telephone and had been provided with the number for this phone.

***Question 8:*** *Where were the staff when Glyn was put to bed feeling unwell?*

As we have said, the staff did not accompany the learners to the Tropicana Club and remained for a period at the Aloha bar. The staff were at their hotel when they received the telephone call from one of the learners informing them of Glyn's accident.

Legal Constraints

Disclosure of College's Internal Report into the College Trip

Your letter of 28 August repeated your request for a copy of our client's report into the circumstances of Glyn Summers' death. Our letter of 9 August 2013 set out the reasoning why our client is not in a position to disclose to your clients the report which was prepared in the context of internal disciplinary proceedings arising from the College trip ("the College Report"). Our client owes a duty of confidentiality to its staff in relation to matters arising during their employment (including the content of the College Report), in addition to having obligations under the Data Protection Act 1998. The College has carefully considered your request for voluntary disclosure of the College Report in light of these obligations and of the fact that no proceedings have been issued at this stage. As a result, it has concluded that, in all the circumstances, it would not be appropriate to disclose the College Report at this stage. We appreciate that your clients might consider it a straightforward matter to disclose the College Report, but we trust that you will be able to explain to them the legal basis for our client's position.

CCBC confirming the threshold for Serious Case Reviews:

...House,
Tredomen Park,
Ystrad Mynach,
Hengoed CF82 7PG

Tŷ Penallta,
Parc Tredomen,
Ystrad Mynach,
Hengoed CF82 7PG

Corporate Director / Cyfarwyddwr Corfforaethol
**Dave Street**

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Duffryn Park
Pen-Pedair- Heol
Hengoed
CF82 8HD

Carol A Davies
01443 864745
CD/HJP
24th July 2014

Dear Mr & Mrs Summers

**Re: your late son Glyn Summers DOB 19/4/94 DOD 24.10.11**

Thank you for your email dated 11.6.14 which has been passed to me to respond on behalf of the Safeguarding and Review Team. Firstly may I offer you both my sincere condolences in relation to the tragic loss of your son Glyn, at such a young age.

Through my enquiries, I can confirm that the service manager with lead responsibility for safeguarding, responded to this matter, as they would on any matter, when the Department is informed of a child death. The Department's role was to consider any support required for fellow pupils and consider whether the serious case review process should be instigated.
Safeguarding children: working together under the Children Act 2004 (2006) Chapter 10 outlines that:
The Local Safeguarding Children Boards (Wales) Regulations 2005 require that where abuse or neglect of a child is known or suspected and:

- a child dies; or
- a child sustains a potentially life-threatening injury or serious and permanent impairment of health or development, this may include cases where a child has been subjected to particularly serious sexual abuse.

the Local Safeguarding Children Board for the area must conduct a serious case review.

Public Services Ombudsman Report Conclusion:

PRUDiC or AWCPP). I am also concerned about the impact that such a delay may have had on any subsequent review or investigation. The delay and failure to inform Mr and Mrs X of the decision caused an injustice to them. Additionally, it is my view that the failure to comply with CSM's recommendation to contact the College resulted in a missed opportunity for the Council, to not only ensure the future safety of the students at the College, but also to ensure that a thorough investigation had been undertaken. In view of the above I **partly uphold** this complaint.