ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:

- 1. The Secretary of State for Education The Right Honourable Mr Gavin Williamson
- 2. The Chief Executive of UCAS
- 3. The Chief Executive of The Sixth Form Colleges Association

1 CORONER

I am Mary Burke, Assistant Coroner, for the Coroner area of West Yorkshire – Western Division.

2 CORONER'S LEGAL POWERS

I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.

3 INVESTIGATION and INQUEST

On the 20th August 2018 an investigation was commenced into the death of Owen Arron Wynne Williams.

The investigation concluded at the end of the inquest on the 2nd May 2019

The inquest determined that the medical cause of Owens death was due to hanging and a conclusion of suicide was made.

4 CIRCUMSTANCES OF THE DEATH

Owen Williams attended Greenhead Sixth Form College in Huddersfield West Yorkshire to undertake various A levels, sitting all relevant exams in May / June 2018.

He was described as a high performing student by the principal of the college who gave evidence at the inquest.

He was described by teaching staff and his tutor as a reliable, cheerful and fully engaged young man.

Owen was expected to achieve the grades required to be accepted on the university course he had set his mind upon attending.

None of his teachers or tutor had any cause for concern for his health and wellbeing.

Owen stayed with his sister and her family in Elland the night before his A level results were released.

There was nothing in Owens presentation which gave his sister and her family cause for concern.

At 6.00am on the 16th August 2018 Greenhead College released A level results electronically which was accessible to all students. The college was open from 8.00am to provide student support and result sheets were available from the college from 9.00am.

At 6.30 am on the 16th August 2018 Owens brother in law got up for work and noted Owen was not in the house, his laptop was open, all of Owens personal possessions including his phone and wallet were still present.

Over the ensuing hours his sister and brother in law immediately undertook checks and searches to try and locate Owen, all to no gain.

They therefore contacted West Yorkshire Police, who immediately commenced a missing persons investigation.

Later that day Owen was found unresponsive suspended by a rope tied to a tree in a secluded wooded area near to his sisters home.

Owens death was confirmed by attendant paramedics a short time later.

Subsequent enquiries revealed that Owen had accessed his results and had not achieved his expected grades required for the university course he wished to attend.

Owen's father expressed deep concerns at the way in which Owen had access to his results and stated that if Owen had been required to personally attend the college, an approach adopted by other educational institutions, and expressed the view that Owen would have been able to immediately access support and guidance and that the tragic events which occurred would have been avoided.

5 During the course of the inquest the evidence revealed matters giving rise for concern.

In my opinion there is a risk that future deaths may occur unless action is taken. In the circumstances it is my statutory duty to report to you.

The MATTERS OF CONCERN are as follows:-

I heard evidence from the Principal of the college that Owen attended that there is wide variance both locally and nationally of the timing and way in which colleges release A level results, some release results electronically as early as 6.00 am and later the same morning provide a facility within the school and college to provide support to students, some colleges / schools require the students to physically attend to obtain their results, when at the same time support by staff members is immediately on hand.

I understand UCAS is available from 8.00 am onwards, once again some hours after some students have obtained their results.

In particular, from the evidence presented to me it appears:-

- That there is no national agreement across all educational institutions to the timing and manner in which A level results are released.
- That there can be a significant time lag between results being released by some schools and colleges and the timing of when there is the availability of staff to provide support to those students that may have received unexpected results.
- That UCAS is presently available some hours after some educational institutions have released student results.

	4. That there is no national requirement for educational establishments to communicate directly to parents in advance of results day and explain the system in place for the release of the A level results at the educational establishment that their child is attending and to alert them to the potential that unexpected results can occur and to be alert to the impact that this may have upon their child.
6	ACTION SHOULD BE TAKEN
	In my opinion action should be taken to prevent future deaths and believe you [AND/OR your organisation] have the power to take such action.
7	YOUR RESPONSE
	You are under a duty to respond to this report within 56 days of the date of this report, namely by 20 th September 2019, the Coroner, may extend the period.
	Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	COPIES and PUBLICATION
	i have sent a copy of my report to the Chief Coroner and to the following Interested Persons – (Owen's Mother) and to Father).
	I am also under a duty to send the Chief Coroner a copy of your response.
	The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	[SIGNED BY ASSISTANT CORONER]
	25/7/2019