Regulation 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1. His Majesty's Chief Inspector for Ofsted, [redacted]** **2. Secretary of State for Education, the Rt Hon Gillian Keegan** **3. Chief executive of Reading Borough Council, [redacted]**
1	**CORONER** I am Heidi Connor, Senior Coroner for the coroner area of Berkshire.
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. It is important to note the case of *R (Dr Siddiqui and Dr Paeprer-Rohricht) v Assistant Coroner for East London*. This case clarifies that the issuing and receipt of a Regulation 28 report entails no more than the coroner bringing some information regarding a public safety concern to the attention of the recipient. The report is not punitive in nature and engages no civil or criminal right or obligation on the part of the recipient, other than the obligation to respond to the report in writing within 56 days.
3	**INVESTIGATION and INQUEST** The family requested me to refer to the deceased as Ruth. I will reflect that in this report. I conducted an inquest into the death of Ruth Carla Perry which concluded on 7th of December 2023. I recorded a narrative conclusion as follows: Suicide, contributed to by an Ofsted inspection carried out in November 2022.
4	**CIRCUMSTANCES OF THE DEATH** This was the first Ofsted inspection that Caversham Primary School ('CPS') had had for 13 years. There was previously a policy which meant that schools which had been rated outstanding were not inspected in line with usual timescales. There was a policy change in 2021, and CPS was therefore due an inspection. This was the reason for the inspection in November 2022. CPS underwent an Ofsted inspection on the 15th and 16th of November 2022, after receiving a phone call to notify them of this at 1pm on 14th November 2022. Ruth's mental health deteriorated significantly during and after the inspection. She displayed suicidal ideation and planning a few days after the inspection. She sought mental health support, but felt unable to discuss the likely outcome of the inspection in any detail. Ruth had no relevant past mental health history. The records and evidence set out very clearly what the cause of her mental health deterioration was. She took her own life on 8th January 2023. Other findings which I made in this case included:

	1. I referred in questioning to hypothetical schools A and B. Hypothetical school A is good in all areas, but there are safeguarding concerns which can be remedied quickly. Hypothetical school B is dreadful in all respects. The system as it currently stands will mean that these 2 hypothetical schools will receive the same overall label of 'inadequate'. For maintained schools, both would face possible academisation and job losses. 2. The lead inspector told the chair of governors that CPS had a robust safeguarding culture and that all children felt safe. We heard different estimates for how long the inspection team believed the safeguarding issues identified would take to remedy. The longest of these was 30 working days. 3. Parts of the Ofsted inspection were conducted in a manner which lacked fairness, respect and sensitivity (these are the terms used in Ofsted's Code of Conduct). This likely had an effect on Ruth's ability to deal fully with the inspection process. It is very important to stress here that, although I necessarily had to consider the conduct of the inspectors in this matter, the focus should not be on any individual inspector, but more on the system, policies and training. 4. There is very little training by Ofsted, and no written policy, regarding management of school leader anxiety during inspections. 5. The suggestion that an inspection could be paused for reason of school leader distress was not part of Ofsted's policy or training. 6. Ofsted's confidentiality requirements (between inspection and final publication of the report) was a significant issue for Ruth. 7. Ruth's employer, Reading Borough Council, clearly felt that Ofsted's decision was wrong and unfair, but did not provide any comment on the draft report, despite asking for the opportunity to do so. 8. The legal test I have to apply is whether I consider it is likely that the Ofsted inspection contributed more than minimally to Ruth's mental health deterioration and death. I found that it did contribute. 9. An unfavourable inspection outcome in itself would be distressing to a headteacher. However, whilst the outcome of the inspection was a part of Ruth's distress, it was not the only cause. I remain concerned about: a. The conduct of the inspection itself. b. The current Ofsted system which allows for the single word judgement of 'inadequate' to be applied equally to a school rated otherwise good, but with issues that could be remedied by the time the report was published, as to a school which is dreadful in all respects. c. The confidentiality requirement at the time. d. The length of time between the inspection and final report, thus lengthening the period of the confidentiality requirement.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. I appreciate that some of the issues of concern are outside the gift of Ofsted, and that is part of the reason for including the Department for Education as a recipient of this report. The **MATTERS OF CONCERN** are as follows: (brief summary of matters of concern) **In relation to Ofsted and/or the Department for Education** **1.** The first of these relates to my hypothetical schools A and B point, referred to above. I am concerned about the impact on school leader welfare that this system may continue to have. Transparency and ease of message to parents is not currently weighed against teacher welfare. The current system allows a school which is inadequate in all areas to receive the same overall label as a school which is good in all areas, but with some safeguarding issues which can be repaired by the time the report is published.

	2. There is an almost complete absence of Ofsted training or published policy in the following areas: **a.** Signs of distress in school leaders during an inspection (this will be obvious to some, but not to all). **b.** Practical steps to deal with such distress. **c.** Pausing an inspection by reason of the distress of a school leader. **d.** Who can attend meetings with the inspectors during the inspection process. **3.** Absence of a clear path to raise concerns during an inspection if these cannot be resolved directly with the lead inspector. **4.** The confidentiality requirement after an inspection. Some changes have been made already, but this is not yet written into policy. Given how long this policy has been in place, school leaders may fear discussing outcomes with colleagues outside of the school, and mental health professionals, unless this is expressly dealt with in written policy. **5.** Timescales for report publication. **6.** No learning review of these matters was conducted by Ofsted. There is no policy requiring this to be done. **7.** In an Ofsted publication dated 12th of June 2023, the Secretary of State for Education was quoted as follows: "We must ensure our school leaders have the support they need, which is why today we are significantly expanding our wellbeing support. This expansion will help make sure headteachers have access to support whenever they need it". The Ofsted witness was not able to clarify what form this additional support has taken. **Reading Borough Council** 1. Reading Borough Council indicated an intention to adopt a much more robust and proactive approach to dealing with Ofsted, particularly where there are concerns about an inspection. This is not in written policy or guidance – which may go some way towards reassuring school leaders that their employer 'has their back' – both now and in future years. 2. Reading Borough Council also did not carry out any form of internal review. I was not made aware of any policy setting out when such an internal review should take place. 3. We heard in evidence that school leaders have received correspondence from Reading Borough Council about what mental health support options are available. I am concerned to know whether there is now written policy or guidance about communicating this, so that this continues to happen in future years.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I 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 **7th February 2024.** 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 Ruth's family, via their legal representative. I have also sent this report to the following recipients, who have an interest in this matter: 1. Legal representative for Ruth's GP. 2. Legal representative for Berkshire Healthcare NHS Foundation Trust

	I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**Dated: 12/12/2023**  **Heidi Connor** **Senior Coroner for** **Berkshire**