	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: **1. The Rt. Hon Damian Hinds, Secretary of State for Education, 145-157 St. John St, London EC1V 4PY**
1	CORONER I am Andrew Harris, Senior Coroner, London Inner South jurisdiction
2	CORONER'S LEGAL POWERS I make this report under paragraph 7, Schedule 5, Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	INQUEST On 15th December 2016, I opened an inquest into the death of **Master Abdul-Jamal Ottun, who died on 12.07.15 (01962-15) (JW) in British Columbia, Canada.** The delay in holding the inquest was due to difficulties in securing disclosure from the police investigation, which necessitated an application in a higher court in Canada. It was concluded on 15th December 2017. The medical cause of death was 1a Drowning The Conclusion of the Coroner was Accident.
4	CIRCUMSTANCES OF THE DEATH The circumstances of death were recorded as follows:

	Master Jamal Ottun was a 17 year old school student who arrived on a school rugby tour in British Columbia, Canada, on 11th July 2015. On the 12th July, he was in a group of students who went swimming in Shawnigan Lake. His absence was noted a short time after he entered the water and searching began almost immediately. They were hampered by poor visibility underwater. He was found by emergency services about 15 minutes after going missing. Advanced life support was stopped after 40 minutes at about 17:35 hours. Autopsy confirmed he had drowned. This was due to his not being a strong swimmer and being unacclimatised to the cold water (about 16 ° at the surface) which risks were not known to the trip leader. He either had cold water shock or cramp, or both, which rendered him immobile. He did not struggle and his plight was not spotted by his teachers or peers in the water, nor by a volunteer supervisor who was taking photographs from the jetty. Entering the water from the jetty rather than a tarmac beach also contributed to his death.
5	**CORONER'S CONCERNS** During the course of the inquest, the evidence revealed a matter giving rise to concern that in my opinion means that there is still a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTER OF CONCERN** is as follows. – Evidence was heard from an expert [redacted] who has worked in water accident prevention for many years and is currently educational advisor for 36 schools. He reported that 50 children drown in the UK annually and the rate is particularly high in the teenage years, because of ignorance of dangers and bravado and peer pressure. He was critical of the adequacy of the risk assessment conducted in planning the trip and at the scene. There was no consideration of the need for a lifeguard and inadequate supervision, which prevented proper consideration of the safest site of entry to water, of the risks of unacclimatised swimmers entering cold open natural waters, the necessary equipment, and the way to conduct the rescue. He said that in this country schools do not teach children to swim to a

	sufficiently high standard to be safe. Children are often expected to swim 25m in a heated pool, which gives no skills to save oneself in deep cold open waters. This compares with New Zealand, where 400m is the target used in education. Swimming is not in British schools' curricula: there is no requirement for any swimming at secondary school and access to pools is limited. He said that child deaths will continue to occur unless there is a fundamental change in the curriculum and in the pre-assessment of swimming ability before school trips and occasions when swimming outdoors. In this case, parents indicated on a form the swimming ability of their children in one of three boxes (strong/ moderate/ weak) This he said was wholly inadequate, as they often have no accurate idea of the adequacy of their children's swimming. Wellington County Grammar have taken a wide range of steps to reduce risk in the future. However the Headteacher said he was reluctant to introduce formal pre-trip assessment of swimming ability without central guidance. The expert gave specific recommendations of actions that should be taken to reduce deaths.
6	**ACTION SHOULD BE TAKEN** I send this report to the Secretary of State for Education (whom the expert stressed was the appropriate body, rather than the Secretary of sate for Sport), to draw your attention to this reported risk, as I believe that the minister is in a position to take action. The expert recommends that the minister considers these actions which he believes will reduce deaths: 1. To review the curriculum and introduce appropriate swimming instruction, with an ambitious target of competence. 2. To include in DoE guidance to schools the risks of inexperienced or weaker swimmers swimming in open and cold waters and the need for young people to know their swimming ability 3. To promote the adoption by schools as routine, prior to school trips and water events (including rowing), a proper test of swimming ability of each participant and using that in the risk assessments of the activity.

7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 15th March 2018. I, 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. If you require any further information or assistance about the case, please contact the case officer, [redacted]
8	**COPIES and PUBLICATION** I have sent a copy of my report to the following Interested Persons: [redacted] (uncle) for the family [redacted] The headmaster of Wallington County Grammar School ~~Headmaster~~ [redacted] The headmaster of Shawnigan Lake School I am also sending this report to the following, who may have an interest: Ms Karen Bradley, The Secretary of State for Media Culture and Sport [redacted] Principal Consultant, The Royal Society For The Prevention Of Accidents (ROSPA) [redacted] Water Safety Consultant 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	[DATE] 18-1-18 [SIGNED BY CORONER]