REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Secretary of State for Educations - Department of Education 2. 3.
1	**CORONER** I am Ms Joanne Kearsley, Senior Coroner for the Coroner area of Manchester North
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroner's and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013
3	**INVESTIGATION and INQUEST** On the 19th November 2018 I concluded an Inquest into the death of Ben Walmsley date of birth 21.09.2002 who died on the 04.02.2018 aged 15 years old.
4	**CIRCUMSTANCES OF DEATH** The circumstances of the death are that on the 4th February 2018 Ben Walmsley committed suicide at his home address by hanging. Ben had little involvement with any services at the time of his death. Bury Safeguarding Childrens Board have undertaken a Serious Case review into previous contact and a number of learning points arise from this. However during the course of the Inquest evidence was heard on one specific issue which I am of the opinion needs to be addressed in order to prevent future deaths. Details of this are set out below.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows:- During the course of the investigation into Bens death it emerged that on a number of days in the month prior to his death he had searched on the school (St Phillips Secondary school) computers "how to kill myself ", "how to tie a noose" and " why I shouldn't commit suicide". It was explained to the Court that the school filters are accessed via Smoothwall which provides age appropriate filtered content. Whilst Ben could not access these pages as they were blocked , there was no mechanism in place at the time for the school to be made aware that a pupil may have attempted to search for such pages. The Court heard evidence that at the time of Ben's death the only monitoring was in lessons and was solely reliant on the teacher trying to watch what students were doing. The school has 900 pupils and the Court heard in any one day there can be 12,000 attempts by pupils to access blocked content. Not all of these would be as concerning as the content Ben was trying to access, some may relate to social media pages which the school does not allow. Evidence was provided to the Court that since Ben's death, Smoothwall have now upgraded functionality and

	staff now receive notifications when blocked high risk safeguarding categories are attempting to be accessed. These alerts are "real time" notifications and go to three identified members of staff. Since this installation staff have been notified of two other children attempting to access similar sites to Ben and have taken action to speak to them and also to speak to their parents to offer support. However it is not known if this functionality is mandatory for all schools or indeed whether other software providers who are used by schools have this option. If schools do not have this facility you may wish to consider disseminating this information, this is of course a matter for yourself.
6	**ACTION SHOULD BE TAKEN** **In my opinion action should be taken to prevent future deaths and I believe each of you respectively 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 16th January 2019. 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.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons namely:- the parents of Ben Walmsley 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 from. 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.
-	Date: 21st November 2018 Signed: