Ofsted suicides: who is responsible for suicide prevention?

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Abstract

Purpose – The purpose of this paper is to discuss the response of the relevant authorities to evidence that female primary schoolteachers have an elevated suicide risk in the UK. The paper situates the recent tragic death of a primary school head teacher, following an Ofsted inspection at her school, within the wider context of teacher suicide deaths and asks what, if any, action the authorities have taken to prevent avoidable suicide deaths from occurring.

Design/methodology/approach – The paper examines a recent case of suicide by a primary head teacher within the wider context of statistical data on suicides by primary schoolteachers and in relation to previous cases of suicide linked to a school inspection.

Findings – The paper suggests that the relevant authorities have failed to act in relation to evidence of high suicide risk amongst female primary schoolteachers and to previous suicide deaths linked to the impact of a school inspection. Without learning from suicide deaths and acting on available evidence, there is a risk that preventable suicide deaths will continue to occur.

Originality/value – The paper draws together case study evidence and statistical data to make the case for regulatory reform to ensure that work-related suicides are investigated, monitored and prevented.

Keywords Suicide, Ofsted, Social justice, Teachers, Bereavement

Paper type Viewpoint

Seeking social justice

Bereaved family members are often powerful advocates for social justice in the aftermath of the suicide death of a loved one. Having a closer and more intimate knowledge of the person than anyone else, they can speak with authority and legitimacy on the circumstances surrounding their death. In the case of the tragic death of head teacher Ruth Perry on the 8th January 2023, it was the sheer determination of her sister, Julia Waters, to speak out against the profound injustice of her sister’s death, to challenge the indifference of responsible organisations and to call for truth and accountability, that triggered a nationwide campaign that culminated in the decision to launch a cross-parliamentary inquiry into Ofsted on the 13th of June [1]. We write this piece as members of Hazards Campaign who have spent many long years highlighting the dangerous consequences of a lack of recognition and regulation of work-related suicides [2]. Yet, the actions of Julia Waters in recent months have managed to achieve greater awareness of, and indeed, more substantial progress on this question than any of our campaigning activity over at least a decade or more.

Researchers are right to praise the determination and inspiring work of bereaved families in seeking accountability and meaningful change in the aftermath of a suicide death (McDonnell et al., 2020). Yet, the place of bereaved families at the forefront of campaigns for justice also signals a failure of the organisations which should be acting on their behalf. When a suicide takes place in a workplace or working conditions have been identified as a potential contributory cause, we would expect the suicide death to be fully investigated,
workplace practices to be reviewed and measures to be put in place to prevent further deaths. When bereaved family members shoulder the responsibility of leading a campaign, it is often because these basic conditions have not been met. They do so frequently at enormous cost to their own emotional and psychological well-being, especially as studies show that bereavement by the suicide of a relative or friend is a risk factor for suicide (Pitman et al., 2016).

Following Ruth Perry’s death, her family made clear from the outset that the school inspection had been critical to her predicament and pointed to factors such as a flawed inspection process, the impact of a single-word judgement, the long wait before publication of the inspection report and a confidentiality clause that prevented her from speaking about the inspection outcome to other teachers, peers or, officially, friends and family. Both the family and teaching unions urged Ofsted to pause inspections to allow time for an urgent enquiry to take place. However, in the face of these pleas, Ofsted continued with routine inspections. During the weeks following Ruth Perry’s death, the same Ofsted inspector who had downgraded Caversham Primary carried out two further inspections of primary schools in the local area. The chief inspector of schools in England publicly defended inspections, arguing that they were necessary for schools to improve and reiterated that the results of the inspection in Caversham Primary had been sound. Despite this, a new inspection of the school in July upgraded the school to “good”, while making no mention of Perry or the circumstances surrounding her death (Adams, 2023). Meanwhile, the Health and Safety Executive (HSE) whose core mission is to prevent work-related injury and death did not investigate the suicide or involve itself in the case.

It was this insistence by the relevant authorities to turn a blind eye, to apparently continue as normal, to refuse to investigate the death or take measures to prevent further deaths which galvanised Julia Waters to speak to the media, ultimately sparking a wave of deep-seated public outrage and a campaign for reform across the education sector. This campaign has become a catalyst for broader demands around work-related stress and a more humane school inspection system. On the 31st March, The National Association of Head Teachers (NAHT) took the first step in judicial review proceedings against Ofsted, citing the European Convention on Human Rights, which imposes obligations on public authorities to take reasonable steps where there is a real and immediate risk of a loss of life (Article 2). A former Ofsted inspector launched a Fair Judgement Campaign at the end of April raising over £45,000 to take legal action against Ofsted (NAHT, 2023). A social media spreadsheet launched by a primary schoolteacher received 3,000 responses by teachers describing devastating experiences of Ofsted inspections (Fazackerley, 2023). An opinion piece in the British Medical Journal called on Ofsted to accept that it has a duty of care for teachers and urged the HSE to investigate every work-related suicide (Waters and McKee, 2023). At the end of May, Julia Waters together with a parent and teacher from Caversham Primary took part in the first of three meetings with the education secretary, Gillian Keegan, who committed to improving the Ofsted inspection system (Almroth-Wright & PA Media, 2023).

The absence of any legal framework for monitoring or regulating work-related suicides in the UK means that it frequently falls on the shoulders of family members to take on the responsibility of leading a campaign at a time when they are experiencing immense personal grief. Yet, in countries such as France, the legal framework is designed partly to protect bereaved family members from the burden of undertaking litigation in a similar situation. When a suicide takes place in the workplace in France, it is presumed to be a work-related death and an investigation takes place automatically, so that family members are spared the necessity to pursue litigation themselves. Even where a suicide takes place outside of the workplace, but there is material evidence of a link to work, families can pursue justice in the courts and the death will be fully investigated as work-related where certain criteria are in place (Lerouge, 2014). According to French jurisprudence, a suicide is recognised as potentially work-related and may be subject to legal action where one of the
following criteria exists: the deceased was wearing a work uniform, a suicide note points to work-related factors or, critically, there is testimonial evidence by family members or documented work-related difficulties (Gigonzac et al., 2021). A legal framework that is protective of the mental health of employees and their families has meant that family members have been successful in taking legal action against large companies including France Telecom, La Poste and Renault, and this, in turn, has led to significant improvements in workplace safety in France (Waters, 2020).

The widespread campaign to reform Ofsted has been met with a backlash in parts of the media with some journalists expressing concern that an individual suicide was being used to legitimise calls for institutional reform. One piece warned that it was wrong to blame Ofsted for Ruth Perry's death and that "mental health is complicated" (Finkelstein, 2023). Meanwhile, BBC 4 radio panelists pointed to the risks of "oversimplifying the causes of suicide" or "weaponizing suicide" (BBC Radio 4, 2023). The complexity of the reasons behind suicide has never been questioned by campaigners, and more generally, it is considered as a fundamental tenet within suicide research. Theorists from Emile Durkheim, Maurice Halbwachs to Edwin Shneidman emphasise that suicide is a deeply human, singular and ultimately unknowable act. In his series of essays On Suicide, Holocaust survivor Jean Améry reminds us to avoid imposing a “bold description of the act” but instead strive for “a gentle and cautious approach to it” that starts with the perspective of the suicidal person themselves (Améry, 1999, p. 28) While the reasons behind an individual’s decision to take their own life are undoubtedly complex, the notion of complexity should not be used to close down discussion or prevent investigations from taking place. Studies have shown that “complexity” is a classic tactic used by companies in the food, beverage, alcohol and gambling industries to dispute their role in causing public harm and to deflect blame onto the individual (Petticrew et al., 2017). While recognising that the reasons behind suicide can be complex, this does not mean that causal factors are not present and that those causal factors should not be fully investigated in the interests of preventing further deaths. In response to a piece in The Times (“We can’t blame Ofsted for Ruth Perry’s death”), Julia Waters noted “staying silent about life-threatening risks, which confront thousands of head teachers, would be wrong” (Waters, 2023).

Suicide has long been regarded by epidemiologists as an alarm signal, with changes in suicide patterns considered to be a serious public health concern (Iskander and Crosby, 2021). For Christophe Dejours, a leading international expert on work-related suicide, the act of suicide is the tip of an iceberg: “a single suicide in the workplace represents a de facto risk that affects the entire workplace community to the extent that it signals a profound deterioration in the human and social fabric of work” (Dejours and Bégue, 2009, p. 14). Where no action takes place following a suicide and no lessons are learned in its aftermath, then others affected by similar working conditions may be at risk. It is for this reason that the notion of a suicide cluster is used in other contexts to identify rises in suicide during a specific period of time or within a given locality which may be linked to risk factors derived from the collective context (John et al., 2022).

Workplace health and safety

As the UK’s regulator for workplace health and safety, the HSE is responsible for ensuring that workplaces are safe and that employees’ physical and mental health is protected. However, suicide is explicitly excluded from the list of work-related deaths that need to be reported to the HSE for further investigation: “All deaths to workers and nonworkers, with the exception of suicides, must be reported if they arise from a work-related accident” [3]. Whereas an employer is legally obliged to report the fracture of an arm or leg, asthma or a skin rash caused by unsafe working conditions, a suicide occurring in the workplace or that has definitive links to work does not need to be reported. As a result, there are no requirements made on an employer to undertake an investigation following a suicide, to
review policies or practices or to put suicide prevention measures in place. Suicide is also excluded from the Work-related Deaths Protocol, which sets out the terms of cooperation between key organisations when investigating fatal incidents [4]. While the HSE recognises work-related stress and has introduced measures to tackle it, if someone in the face of extreme work-related stress takes their own life, this is then treated as a private matter with no links to work. A report on work-related suicide that was presented to the HSE two years ago warned that “the failure to recognise, monitor and regulate work-related suicides poses serious and ongoing risks to the health and safety of UK employees” (Waters and Palmer, 2021, p. 3).

Suicide is still treated by the public authorities as an individual mental health problem, and its connections to work and working conditions, even if extensively documented, are rarely recognised. In 2021, the HSE introduced much-needed guidance on suicide prevention on its website, signalling an acknowledgement that suicide and suicide prevention are matters that concern work and the workplace. While such guidance is vitally important, it frames suicide as an issue linked to personal, emotional, financial problems or pre-existing mental health conditions that originate outside of work. Suicide is conceptualised as a mental health problem that a person brings into the workplace, rather than as an act that could be shaped or determined by work-related experiences or conditions. Where work is recognised as having a role to play, it is in exacerbating an underlying mental health problem: “Many suicides are impulsive moments of crisis associated with significant life events. For example, people struggling with isolation, relationship breakdown, financial problems or work pressures. It can also be linked to pre-existing mental health conditions”.

While advising employers how to support someone who is struggling, it concludes by reaffirming that suicide is not a reportable work-related death: “Suicides in the workplace are not RIDDOR reportable as the regulations only require you to report a death from a workplace accident” [5].

**Teacher suicides**

The World Health Organisation makes clear that surveillance and monitoring of suicide are the foundation for effective suicide prevention, providing the means by which the relevant authorities can identify suicide patterns and provide targeted support for groups at elevated risk (WHO, 2021). Similarly, the UK government has emphasised the importance of producing accurate and timely data “to identify and implement targeted support to reduce suicide numbers” (HM Government, 2021, p. 4). It might be worthwhile to ask whether data is available on suicides affecting primary schoolteachers and if this data might be used to inform targeted suicide prevention. In its first analysis of suicide by occupation conducted in 2017, the Office for National Statistics (ONS) noted that during the period 2011–2015 there were 139 suicides among female teaching and educational professionals, and almost three-quarters (73%) of these, or 102 suicides, were for those recorded as primary and nursery schoolteachers. When focusing on female primary and nursery schoolteachers, the risk of suicide was 42% higher than the national average (ONS, 2017). A subsequent census of suicide by occupation shows that there were 198 suicides by primary and nursery education teaching professionals between 2011 and 2020, of which 188 were women and 10 men (ONS, 2021). It is worth noting that the teaching profession is predominantly female, and in the primary school sector in particular, over 82% of teachers are women (BESA, 2021). Yet, the high suicide risk amongst female primary teachers has not been a matter of statistical interest alone, but has been covered in the media, with newspapers reporting that primary schoolteachers’ suicide rate is nearly double the national average and teaching unions sounding the alarm about dangerous levels of work-related stress (Bulman, 2017).

Tragically, there have also been precedents of suicides by primary schoolteachers linked to the impact of a school inspection, and in some of these cases, the education
authorities were alerted to the risks of a harmful inspection system. One study pointed to at least 10 cases of suicide by primary schoolteachers (four of whom were head teachers), where a school inspection was cited as a contributory factor by an official source (coroner’s verdict, police investigation, GP report) (Waters and Palmer, 2021). In five of the cases, suicides were linked to fears about an upcoming inspection, and in the other five cases, the suicide followed an Ofsted inspection. In March 2006, a 50-year-old female senior teacher disappeared on her way to work on the day of an Ofsted inspection at her school and had written in her diary how much she was dreading it [6]. In the case of a 53-year-old male head teacher who killed himself in July 2007, the day before an Ofsted inspection, the coroner noted: “It was that impending inspection that triggered off the action he decided to take” (BBC News, 2007). In November 2012, a head teacher who had been in her post for less than six months and was concerned that her school would lose its outstanding rating took her own life (BBC News, 2013). Teachers have also taken their own life following a negative Ofsted inspection. In one case, an inquest reported that a 35-year-old male teacher who took his own life in July 2007 had felt “he was being pressured following a poor Ofsted inspection” and felt “bullied and victimised” (East Anglian Daily Times, 2007). Similarly, a fatal accidents inquiry into the suicide of 54-year-old female head teacher who was found dead days after a school inspection in the Scottish Borders in March 2008 noted that her death had been “inextricably linked” to the outcome of the inspection (The Scotsman, 2010). In a case that bears similarities with the tragic circumstances leading to Ruth Perry’s death, a head teacher took her own life on 29 July 2015 and had told her doctor that she had failed an Ofsted inspection and let everyone down. Both cases involved high-achieving schools led by successful school leaders which had recently been downgraded to inadequate (Adams, 2015).

In some cases, there was a direct exchange between teaching unions and Ofsted following the suicide. In the case of the suicide of a 57-year-old teacher in January 2000 who had left a handwritten note blaming job stress, the head of a teaching union accused the Chief inspector of Schools of contributing to the suicide by allowing inspectors to place too much pressure on teachers. Ofsted upheld a formal complaint lodged by the school about how the inspection was carried out and admitted that errors had been made (BBC News, 2000). There is evidence that Ofsted may have been aware that inspections were linked to previous suicide cases. Indeed, in 2015, in response to pressures from teaching unions, Ofsted released a clarification document for schools in 2015 to “dispel myths about inspection” that can generate unnecessary workloads in schools (Ofsted, 2018). One of the recommendations made in a recent report on work-related suicide was that “Alongside general initiatives to reduce teacher stress, Ofsted should incorporate specific suicide prevention measures to help better prepare teachers for inspections, improve mental health awareness, reduce pressure on individual teachers and provide counselling following an inspection” (Waters and Palmer, 2021, p. 23). However, there is little evidence that the processes or methods of school inspection have been modified to safeguard teachers from harm to their mental health.

Conclusion
The high suicide risk amongst female primary schoolteachers stems from an array of factors. Data shows that teaching professionals have higher rates of work-related stress, anxiety and depression than other occupational groups. The causes of heightened work-related stress and distress have been identified as excessive workload, lack of autonomy, poor salary, perceived lack of status, challenging student behaviour and difficult relationships with colleagues (HSE, 2020). Work-related stress may also be derived from pressure to “perform” in a context in which schools are increasingly judged against an array of externally determined targets (Ball, 2003). We have seen that the
extreme stress that leads to suicide may also be linked to the exceptional pressures placed on an individual teacher or head teacher in the context of an Ofsted inspection. While the extraordinary campaign led by Ruth Perry’s family has resulted in a cross-parliamentary inquiry into Ofsted, we have yet to see if this leads to substantive changes to the inspection process to reduce the harmful pressure placed on teachers. Meanwhile, the HSE whose core mission is to prevent work-related deaths has failed to act in response to this case or indeed to any other suicide case. Without taking responsibility for preventing suicide deaths and putting in place mechanisms to monitor, investigate and regulate work-related suicides, there is a risk that further avoidable suicide deaths will continue to occur.

Notes
2. www.hazardscampaign.org.uk/
3. www.hse.gov.uk/riddor/reportable-incidents.htm
5. RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013) is the regulatory framework for reporting work-related injuries or fatalities. www.hse.gov.uk/stress/suicide.htm
6. While the police concluded that suicide was the most likely cause of death in this case, the coroner recorded an open verdict. www.theguardian.com/g2/story/0,,1928883,00.html

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Further reading


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