

**Regulation 28: Prevention of Future Deaths report**

**Julius Jake Little died 7th June 2019**

	<p><b>THIS REPORT IS BEING SENT TO:</b></p> <p><b>1.</b> <b>Dean of Students</b> [REDACTED] <b>University of the Arts London</b> <b>272 High Holborn</b> <b>London WC1V 7EY</b> <b>United Kingdom</b></p> <p><b>2.</b> <b>Chief Executive - Claire Marchant</b> <b>UCAS</b> <b>Rosehill</b> <b>New Barn Lane</b> <b>Cheltenham</b> <b>Gloucestershire</b> <b>GL52 3LZ</b></p>
<b>1</b>	<p><b>CORONER</b></p> <p>I am: Mr Graeme Irvine Assistant Coroner Inner North London St Pancras Coroner's Court Camley Street London N1C 4PP</p>
<b>2</b>	<p><b>CORONER'S LEGAL POWERS</b></p> <p>I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.</p>

3	<p><b>INVESTIGATION and INQUEST</b></p> <p>On 12th June 2019 I commenced an investigation into the death of Julius Jake Little aged 20. The investigation concluded at the end of the inquest on 9th October 2019. I made a determination at inquest of suicide, recording that;</p> <p><i>"At 1.03 am on 7th June 2019 Julius Jake little was found unresponsive in his room in student halls of residence. A self applied ligature secured to a wardrobe clothes rail was tied around his neck. Despite efforts to resuscitate him, life was pronounced extinct at 02.03."</i></p> <p>The medical cause of death was recorded as;</p> <p><i>"1.a suspension by ligature"</i></p>
4	<p><b>CIRCUMSTANCES OF THE DEATH</b></p> <p>Mr Little was a first year undergraduate at UAL living in halls of residence. On 7th June 2019 he was found hanging from a belt attached to a clothes rail in his wardrobe. Mr Little had a history of depression and was receiving treatment in the form of psychotherapy and medication overseen by a psychiatrist</p>
5	<p><b>CORONER'S CONCERNS</b></p> <p>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.</p> <p>The <b>MATTERS OF CONCERN</b> are as follows.</p> <p>In the course of hearing an inquest at Poplar Coroner's Court on 9/10/19 into the death of Julius Jake Little, evidence was considered in relation to available support services offered to undergraduates at UAL who have a history of mental health problems.</p> <p>The Dean of Students at UAL [REDACTED], gave</p>

	<p>evidence that applicants to UAL make an online application to the admissions organisation UCAS. The application invites them to disclose any history they have of mental health problems, upon being accepted on a course of study this information is provided to the admitting university.</p> <p>■■■■■ indicated that the mental health disclosure information is used to target students that may require support, and at UAL emails are sent to undergraduates, inviting them to register with the university's support services.</p> <p>Regrettably, it would appear that of UAL's cohort of students that disclosed mental health problems to UCAS, only 66% of undergraduates responded to the email invitation offering mental health support. The remaining 33%, a total of some 200 students, did not respond to the offer.</p> <p>I asked ■■■■■ whether the identity of students who had made a mental health disclosure in their UCAS application was communicated to tutors and halls of residence staff at the university. I was informed that this information was not so disseminated as it would be breach of data protection legislation, this appears to be a missed opportunity.</p> <p>I cannot suggest a solution to this problem, however it does appear to be a lost opportunity to secure this valuable information but not to utilise it effectively.</p>
6	<p><b>ACTION SHOULD BE TAKEN</b></p> <p>In my opinion, action should be taken to prevent future deaths and I believe that your organisation have the power to take such action.</p>
7	<p><b>YOUR RESPONSE</b></p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 23rd December 2019. I, the coroner, may extend the period.</p> <p>Your response must contain details of action taken or</p>

	<p>proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.</p>
<p>8</p>	<p><b>COPIES and PUBLICATION</b></p> <p>I have sent a copy of my report to the following.</p> <ul style="list-style-type: none"> <li>• The Office for Students, Nicholson House, Lime Kiln Close, Stoke Gifford, BRISTOL BS34 8SR</li> <li>• University Mental Health Advisers Network (UMHAN). c/o Impact Hub, Walker Building, 58 Oxford Street, Birmingham, B5 5NR</li> </ul> <p>I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>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.</p>
<p>9</p>	<p><b>DATE 28th October 2019</b></p> <p><b>SIGNED BY ASSISTANT CORONER GRAEME IRVINE</b></p>