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Dr Elizabeth A Earland, MB.Ch.B.,D.A.,Dip.Law,L.P.C,Hon.LLD
HM Senior Coroner for the County of Devon
Room 226
County Hall
Topsham Road
Exeter
EX2 4QD

4th February 2016

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Dear Dr Earland

Re: William Jeffrey Maskell Deceased, Regulation 28 report

Thank you for sending us a copy of your report following the inquest into the death of Mr William Maskell in September 2013.

The University fully respects the Inquest process and appreciates the considerable time and attention of the Senior Coroner and Interested Persons in considering the facts surrounding Mr Maskell's death. The University also recognises that the death of Mr Maskell and the subsequent investigation will have been incredibly traumatic and stressful for Mr Maskell's parents and we offer our deepest condolences again to his family.

In your report dated 14 December 2015, you specifically highlight the following matters of concern and request that the University respond to these concerns:

1. *The decision to go to William's room was hampered by the lack of a clear protocol for the involvement of the relevant agencies and the Police.*

2. *The respect for the autonomy of the student in running his/her private life appeared to take precedence over a real concern for welfare, resulting in delays in attendance at the scene and a reluctance to take the decision to force entry.*
   It appears that the Students' Union's opposition to any erosion of the students' human rights (to privacy) was a factor.

3. *There is a real risk of future deaths of students in distress for lack of timeous intervention because of the current restraints.*

The University, in line with your recommendations, has conducted a full review of its processes and procedures in respect of students in crisis, and in particular how the Wellbeing Service decides whether (and how) emergency entry should be gained to a student's room. The review

has focussed solely on those students residing within University students' accommodation and does not deal with those living off campus.

The most relevant policy in place at the University is the 'Management of students at risk' policy which sets out the actions to be taken in the event that a student is classified 'at risk' following engagement with the Wellbeing Service. When a student is classified 'at risk' (as opposed to no, or low risk), the policy details appropriate next steps to be followed by the Wellbeing advisor. The University's review has shown that this policy is sufficient in safeguarding students at risk and is in line with practice at other higher education institutions.

As a result of this review, we can however see a benefit to all in further clarifying our current practices to staff, students and parents to aid their understanding as to the remit of the Wellbeing Service. We will therefore work to make more explicit and transparent all of our current procedures and practices around student welfare support. These actions will include:

- Publishing and disseminating the University's standards of practice in relation to missed Wellbeing Service appointments and Wellbeing Service support generally;

- Publishing and disseminating the normal standards of practice in relation to a reported imminent high-risk to life, including engagement with the emergency services;

- Consulting with statutory bodies on the development of a procedure governing potential deterioration in mental health status or wellbeing which is not confirmed as high risk to self or others.

- Clarifying the University's accommodation agreement with students with respect to emergency entry following consultation with the Students' Guild.

The University anticipates that these actions will be completed by March 2016.

Having conducted the above referenced review the University does not agree that the decision to enter Mr Maskell's room was hampered either by lack of protocols with partner agencies or by a consideration that personal privacy should take precedence over a concern for welfare. Whilst the latter was a consideration, this was because Mr Maskell was classified as being at low risk of self-harm. As the Coroner rightly identified, students often miss appointments with the Wellbeing Service and it is not reasonable to have an escalation policy in place for those classed as being at low risk of self-harm. Had Mr Maskell been classed as being at risk to himself, the Management of students at risk policy and procedure would have been followed.

As evidenced during the inquest, the Wellbeing Service felt throughout 25 September and 26 September that the welfare risk to Mr Maskell was low. They did not therefore have serious concern of self-harm or risk to life. This was echoed by the medical professionals involved in Mr Maskell's care at the time. The Wellbeing Service followed standard practice and regular clinical discussions took place on 26 September. Consultation continued to take place throughout the course of the day in order to review Mr Maskell's potential needs as additional information was received. This included contacting community health teams as part of partnership working. The decision to enter Mr Maskell's room was therefore based on his perceived needs regarding Mr Maskell's anxiety and general wellbeing, and not his risk of harm to self. In the absence of an assessment raising his risk classification or specific knowledge of information which would place him in a higher risk category, immediately seeking entry to the room would have been acting beyond normal practice in the higher education sector. Furthermore, we believe that to have

done so in the context of a situation evaluated to be low risk would have been inappropriate, as well as acting outside of our responsibilities in law and our duty of care to our students. This is contrasted with situations where we are aware of a high risk of harm (i.e. for students with a reported or confirmed imminent risk to life or self-harm) where our protocol would always be for our staff to take immediate steps to intervene physically where reasonably possible, and to engage the emergency services as statutory rescue bodies where necessary.

The University of Exeter Students' Guild is always involved in any major policy or practice development, acting as a voice for students and an important conduit for consultation. Following consultation with the Students' Guild, the University is aware that the Students' Guild had no direct involvement with this case but, if any change in policy for monitoring of students' welfare was to be considered, the Guild would have a very active role. The Students' Guild and the University are aligned in terms of balancing students' rights with welfare concerns and welfare is always the primary consideration in cases where a significant risk of harm to self or others is reported or identified.

The University is deeply saddened by the tragic circumstances of Mr Maskell's death and having reflected on both our legal duty of care and the risk evaluations made by the Wellbeing Service, it supports the actions and judgement of its staff in respect of their involvement with Mr Maskell. The University's review has found that Wellbeing Services employees contributed their best professional assessment given the available information and recent indicators of behaviour. The Wellbeing Service assessment mirrored that of the external assessment conducted by the NHS STEP team who were charged with the primary mental health care of Mr Maskell. The University found that the action taken by the Wellbeing Service was appropriate and within the limitations of the University's authority. Unfortunately, this action could not prevent Mr Maskell's death. Our review has concluded that no reasonable changes to our policies or procedures would have prevented this.

Separately to the review conducted following receipt of the Regulation 28 Report, the University had already undertaken to engage an independent third party to review its practices around out-of-hours welfare support and crisis management, taking into consideration the University's duty of care and legal responsibilities as well as resourcing and infrastructure requirements. This review forms part of the University's ongoing commitment to ensuring best practice in the industry. We anticipate this external review will be completed by May 2016.

We trust that the information offered provides assurance that the areas you have highlighted have received our full consideration and that the University is taking action to both formalise current practice as well as investigating the potential for clarification of appropriate standards and duty of care practices across the full remit of wellbeing support that the University offers.

Yours sincerely

Professor Sir Steve Smith
Vice-Chancellor and Chief Executive