ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] Vice-Chancellor and Chief Executive of the University of South Wales Group; and [redacted], Director of Student Services, University of South Wales
1	**CORONER** I am Dr. Sarah-Jane Richards, HM Assistant Coroner, for the Coroner area of South Wales Central.
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 16 December 2019, I commenced an investigation into the death of Daniel HALL. The investigation concluded at Inquest on 2 November 2021. The medical cause of death provided by pathologist, Dr. [redacted], Royal Glamorgan Hospital was: [redacted] and [redacted] The Coroner's short-form conclusion was that of "suicide". The family's concern at inquest related to the University's long waiting list for Mental Health Adviser support; a failure to expedite Daniel for mental health support knowing that he had expressed suicidal ideation and suffered ASD; and the lack of safeguarding by the University.
4	**CIRCUMSTANCES OF THE DEATH** These were recorded as :- Daniel Hall 20 years was a 2nd year student at the University of South Wales studying a BSc in Computer Gamer Development. He suffered from Autistic Spectrum Disorder (previously k/a Asperger's Syndrome) and had successfully completed his 1st year studies. Fellow student, [redacted] was his good friend and with whom he shared accommodation. Together they had travelled throughout Europe. He was aware of Daniel's depression and kept a watchful eye over him. Upon commencing his 2nd year, Daniel had made enquiries about benefiting from the Disabled Student Allowance (DSA) and his application was being progressed by the University. On 29 September 2019 and 23 October 2019 Daniel had face to face meetings with

	Nurse Adviser, [redacted] as a part of his DSA Needs Assessment. On both occasions he expressed suicidal thoughts. [redacted] signposted Daniel to the 'Request for Support' form and the Samaritans. Following completion of these forms Daniel received confirmation on 17 and 22 October 2019 that his name had been placed on a waiting list to see a Mental Health Adviser. Due to ill-health and absences of the University's three Mental Health Advisers, there were ~200 students awaiting mental health support. Daniel was 16th on the waiting list to be seen. Daniel was prescribed antidepressant medication by his GP on 30 October 2019 but failed to attend his follow-up appointment on 27 November 2019. [redacted], noting this failed appointment arranged for Daniel to be seen by the GP on 29 November 2019 and again on 11 December 2019. His antidepressant was providing little 'mood elevating' cover. On 15 November 2019 a referral was made for Specialist Mentor support and [redacted] was allocated to support Daniel on 21 November 2019 and she introduced herself to him at a meeting on 3 December 2019. There is no attendance note of this meeting or arrangements made for further contact. On 18th November 2019, Daniel purchased a [redacted]. In spite of continued support from his sister and friends, Daniel [redacted] 9 December 2019 at his student accommodation. During the 7-week period between expressing suicidal thoughts to Nurse Adviser, [redacted] and completing his suicide plan, Daniel had contact with a number of University administrative, teaching, nursing and medical staff yet he lacked receipt of any meaningful mental health support or any 'one to one' safeguarding.
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 – Lengthy delays for students at the University of South Wales to access mental health support services even when suicidal ideation has been expressed on more than one occasion and when risk factors (ASD) are known.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your organisation have the power to take such action. • Provide a rapid response counselling/support service when being made aware of an expression of suicide by a vulnerable student. • Antidepressant prescription should not be seen as the resolution to suicidal ideation. Pharmaceutical efficacy may take some time to develop and drug titration may be required. Throughout this time an individual may still be vulnerable to suicidal planning and plan execution. • Information was provided by [redacted], Director of Student Services, at Inquest who explained the University had, in response to Daniel's death, recruited more Mental Health Advisers and had successfully reduced waiting times for support. Nevertheless, I remained concerned that support needed to be more proactively delivered whilst forms requesting support were being processed, especially as during this time Daniel was not attending his course and his well-being was neither being systematically monitored nor checked i.e.

	someone undertaking a home visit to ensure he was safe.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 10 January 2022, allowing for statutory holidays. I may extend this period upon request. 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 His Honour Judge Thomas Teague QC; [redacted] (mother of the deceased); and [redacted] Deputy Minister for Mental Health and Wellbeing. 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. 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	Dated - 10 November 2021 **SIGNED:**  Dr. Sarah - Jane Richards, HM Assistant Coroner for South Wales Central