**REGULATION 28: REPORT TO PREVENT FUTURE DEATHS**

**HARRY JOSEPH PENGELLY ARMSTRONG EVANS**

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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>THIS REPORT IS BEING SENT TO:<br><br>[redacted] Vice Chancellor, Exeter University |
| 1 | **CORONER**<br><br>My name is Guy Davies, I am His Majesty's Assistant Coroner for Cornwall & the Isles of Scilly. |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>On 24 June 2021 I commenced an investigation into the death of Harry Joseph Pengelly Armstrong Evans. The investigation concluded at the end of the inquest on 31 October 2022.<br><br>The conclusion of the inquest was Suicide.<br><br>The four questions - who, when, where and how – were answered as follows<br><br>*Harry Joseph Pengelly Armstrong Evans died on 24 June 2021 at Trecarrell Mill Trebullett Launceston Cornwall by hanging* [redacted] *against a background of an acute mental health crisis* |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>Harry was 21 years old at the date of his death, he lived in Cornwall with his parents and younger sister. He was a student at Exeter University, studying Physics and Astrophysics. At the time of his death, he was in his third year of a 3 year degree course. |

Harry had no relevant medical history. He had not consulted his GP about mental health problems

Harry took exams in January 2021; his exam results can be characterized as a disastrous failure. His results leading up to those exams indicated a high performing student.

Harry subsequently chose to defer the re-takes of both his January and May 2021 exams to August 2021. A total of 6 exams. Our academic witnesses indicated this was a huge amount of work for a difficult subject.

Harry resided at university continuously from 29 December 2020 to May 2021, during which time there was little or no contact with his parents and family.

On two occasions during May 2021 Harry's mother, [redacted] contacted by phone and email the University welfare services, raising concerns about Harry. [redacted] stated that Harry was not sharing information with the family. Due to a systems failure both of these safeguarding alerts were closed off without further action.

In late May 2021 his parents visited Harry and were concerned at his physical and mental condition. They brought back Harry back to Cornwall. [redacted] then emailed Harry's tutor, raising further concerns about Harry, and indicating that he was not sharing information with the family. These concerns were forwarded to Welfare Services who indicated that no information could be shared with parents without the consent of the student.

On 28 May Harry contacted his personal tutor and welfare services raising concerns about his mental health and expressly referring to the difficulties he had in communicating those concerns. He referred to the isolation that he had suffered during the pandemic and the mounting academic pressures he faced in undertaking the re-sits. These concerns were forwarded to Welfare Services who sent a number of emails to Harry inviting him to fill out an online form to access a telephone appointment.

There was no attempt to contact Harry by phone or in person by anyone at Exeter University. There was no consideration given to sharing information with Harry's parents without his consent. There was no attempt to speak to Harry to obtain that consent.

Only after Harry's death did his parents find out about the extent of Harry's exam failures.

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. –

**1) Training**

The evidence that indicated an absence of mandatory training for academic staff on suicide prevention and mental health awareness.

The University is invited to review the provision of training for academic staff upon information sharing [see below], mental health awareness and suicide prevention.

**2) Responding proactively**

The evidence indicated that nobody from the university attempted to speak to or visit Harry despite numerous concerns being raised regarding his wellbeing. There was a total absence of personal engagement.

The court heard that research has consistently shown that most students and staff who experience poor mental health do not access formal support.

The university response was entirely by email and can be characterized as reactive. The evidence indicated a marked reluctance to respond flexibly and proactively to concerns.

The university is invited to review their policy as regards their response to welfare concerns and whether the current approach is sufficiently flexible and proactive. Specifically, whether there is an over-reliance on email responses and students themselves completing online application forms to access support.

**3) Sharing information**

The university policy allows sharing of information with consent in circumstances involving a concern for wellbeing, and without consent in exceptional circumstances. This necessarily would have involved a conversation with Harry and failing that a consideration whether exceptional circumstances applied for sharing information with his parents.

The evidence revealed a lack of staff awareness regarding university policy on information sharing. There was evidence of a misunderstanding of policy which specifically allowed the sharing of information in cases of concern, subject to discussion with Harry, and then in exceptional circumstances

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| | without his consent. Witnesses referred to a blanket ban on sharing or alternatively to sharing only if they perceived imminent risk to life.<br><br>The evidence indicated that there was insufficient consideration given to notifying Harry's parents of the extent of his exam failure, in order to fully mobilize Harry's support network. There was no evidence of the 'Think Family' approach adopted by the university following previous suicides.<br><br>The University is invited to review the thresholds for sharing information and staff awareness of those thresholds, and the implementation and understanding across academic and welfare staff of the Think Family approach.<br><br>**4) Pastoral support**<br><br>The evidence indicated that if Harry's pastoral tutor had known Harry's mobile number, he may have called him. The court heard that there was no policy for pastoral tutors exchanging mobile numbers with students.<br><br>The university is invited to review whether pastoral tutors should offer to exchange mobile numbers with their students, and to consider whether pastoral tutors should have a work mobile to facilitate a proactive approach in the event that there are concerns for wellbeing.<br><br>**5) Welfare services case management system**<br><br>The court heard evidence that systems failures led to safeguarding alerts not being followed up and the case marked closed.<br><br>The university is invited to review whether the welfare case management system is fit for purpose, whether it is sufficient to capture and ensure actions on welfare concerns raised by students or third parties. |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>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. |
| 7 | **YOUR RESPONSE**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 30 December 2022. I, the coroner, may extend the period.<br><br>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. |

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| 8 | **COPIES and PUBLICATION**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons; [redacted]<br><br>I have also sent it to [redacted], His Majesty' Senior Coroner for Exeter, who may find it useful or of interest.<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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. |
| 9 | **04.11.2022** **Guy Davies** |