IN THE SURREY CORONER'S COURT PFD ref 2022-0386

On behalf of the University of Surrey

Response to Prevention of Future Deaths report for Sarah Clarke

Introduction

On 21 April 2021, HM Assistant Coroner Karen Henderson ("Assistant Coroner") commenced an inquest into the death of Sarah Margaret Clarke. Sarah died at the University of Surrey ("University") on 21 November 2019. Following the conclusion of the inquest the Assistant Coroner issued a Prevention of Future Deaths ("PFD") report to the University and other organisations. That PFD report was received from the Assistant Coroner's Service on 24 October 2022. This report was subsequently withdrawn and re-issued on 29 November 2022. This is the University's response to the PFD report issued on 29 November 2022. Guidance issued by the Chief Coroner notes that PFD reports should be sent out within 10 working days of the end of the inquest *(Chief Coroner's guidance sheet no.5, revised 14 January 2016, paragraph 36)*.

Set out below are the concerns cited by the Assistant Coroner in the PFD report issued on 29 November 2022 and the University's response to those concerns.

Corrections to box 4 "Circumstances of the Death"

At box 4 within the PFD report issued on 29 November 2022, the Assistant Coroner sets out her findings of fact from her investigation and the evidence presented in the inquest for Sarah Margaret Clarke. Set out below are a number of factual corrections:

a) **Care worker**: There are multiple references to Sarah speaking with a "care worker" from the Centre for Wellbeing ("CWB") at the University on 19 November 2019 *("…She [Sarah Clarke] completed an electronic proforma and a <u>care worker</u> (qualified social worker with mental health experience) from the CWB contacted her by telephone at or around 11.00 am").*

   So far as the University is aware, no evidence was given to the Assistant Coroner during the inquest that attributed the description "care worker" to the individual concerned. In evidence before the inquest, this individual described themselves as a "wellbeing advisor" at the CWB, not a care worker. In addition to the instance already identified, the Assistant Coroner goes on to use the term "care worker" at least five further times in reference to this individual. It is not clear why the Assistant Coroner chose to attribute the title

"care worker" to this individual. For clarity, on the day in question, the role undertaken by the individual concerned was "duty advisor" at the CWB.

b) As far as the University is concerned, the only evidence that Sarah had had contact with the CWB in the academic year 2019/20 was on 19 November 2019.

c) It is not clear that Sarah herself considered on 19 November 2019 that she needed more immediate support than was being offered. The exact reason for her dissatisfaction with the call on 19 November 2019 remains unclear.

d) There is no evidence that Sarah expressed an intention immediately to end her life on 19 November 2019. At least 42 hours elapsed between the telephone call on 19 November 2019 and her taking her own life. Sarah's friend, [redacted], gave evidence to the inquest saying that Sarah had sent her an SMS expressing dissatisfaction with the telephone contact with CWB. The following day there was further text message contact with Sarah which did not contain any indication that she intended self-harm.

e) The Assistant Coroner considered it was not possible to say that a more proactive approach by the CWB on 19 or 20 November 2019 would have altered the outcome and, furthermore, was satisfied that any delay in summoning assistance following receipt of the email on 21 November 2019 did not contribute to the death.

University's responses to the concerns cited by HM Assistant Coroner Henderson

Set out below are each of the concerns cited by the Assistant Coroner in the PFD issued on 29 November 2022. Below each concern is the University's response.

1. **I heard evidence that students have a higher incidence of mental health difficulties, self-harm and suicide exacerbated by multifactorial issues such as being effectively itinerant with work and other social pressures.**

   Response:

   So far as the University is concerned, no expert evidence was placed before the Assistant Coroner either during her investigation or in evidence at the inquest confirming this assertion that students have a greater incidence of mental health difficulties when compared with the general population.

   It is the University's understanding that the statistics available at the time of the inquest showed that between the academic year ending 2017 and the academic year ending 2020, higher education students in England and Wales had a significantly lower suicide rate compared with the general population of a

similar age (Office for National Statistics, *Estimating suicide among higher education students, England and Wales: Experimental Statistics: 2017 to 2020* (2022)).

Furthermore, the suicide rate for higher education students in the academic year ending 2020 in England and Wales was 3 deaths per 100,000 students (64 suicide deaths). This is the lowest rate observed over the last four years (Office for National Statistics, *Estimating suicide among higher education students, England and Wales: Experimental Statistics: 2017 to 2020* (2022)).

The Suicide-Safer Universities report produced by Universities UK and PAPYRUS in 2018 states "*the suicide rate is even higher outside universities*" (p.5).

2. **Sarah was known to have significant mental health difficulties exacerbated by a recent bereavement and other personal difficulties. On 19 November 2019 after Sarah hung up on the administrator and was knowingly extremely distressed, CWB staff did not take steps to reassure themselves that Sarah was safe from self-harm.**

Response:

The University does not accept that the CWB staff did not take steps to reassure themselves that Sarah was safe from self-harm. The team followed all internal processes which were in place at the time, which included a Duty Advisor phone call, a follow up email signposting to external support services and arranged an appointment for Sarah to see a Counsellor within two working days.

It is important to note that CWB is not an emergency service provision and should not be considered as replicating or replacing formal NHS and local mental health care services. For emergencies, students are informed and expected to contact the emergency services via 999, or the University's Security team. Members of the Security team are available 24/7 and can contact the local mental health crisis line, escort the student to a place of safety such as the local hospital A&E or Safe Haven, signpost to external sources of support such as Samaritans, PAPYRUS and other mental health charities.

A number of significant changes have been made to the CWB and wider mental health support at the University since November 2019:

a. Safeguarding is a theme running through all of the CWB's actions, and wider wellbeing and welfare department, underpinned by the safeguarding policy

b. Staff who are concerned about students can now expect a smoother process and a robust follow up. They can submit a new 'report a concern' or 'safeguarding concern' form, and for

more immediate issues, can directly contact CWB duty advisors. Out of hours support has also been increased for when the CWB is closed

c. All students seeking support from the CWB also have a new procedure to follow. They are required to complete an online self-assessment form which is then reviewed by a duty advisor. A robust follow-up process now sees three attempts to contact the student, and if no contact is made, then escalation occurs. This may be a GP referral, advice from the NHS mental health crisis service, a check by the security team or the Police

d. Students at risk are now supported with a personalised action plan to help them understand and manage their own risk. This action plan is student-led and is designed to support a student's individual safety needs whilst encouraging autonomy

e. In the CWB, closer case-load monitoring, daily check-ins with all advisors and structured handovers between duty advisors has improved case management and coordination, especially for 'high risk' cases. Information about students at risk is also now shared across key services at the University (Disability, CWB, Security and Residential Life) to ensure a joined-up approach to students of concern. Where consent is provided, information is also shared with trusted adults, such as family or friends. All information about individual students is sensitively managed.

Since Sarah's death there have also been changes at the CWB in respect of assessing the risk that students pose to themselves. This includes:

a. A clear process to promptly and robustly follow up any students who state risk to themselves. This includes the duty advisor utilising all contact points and escalation to statutory services (or to the security team for those not contactable)

b. Students at risk who do not attend for their planned appointment or disengage from the service are followed up in a similar manner as above

c. Although risk assessments in their basic form are not supported by NICE guidelines, the CWB has changed its use of risk assessments. They are now used as a working document between advisor and student to try, where possible, to mitigate risk and ensure that an action plan is in place. This helps to make sure that support is being received and any escalation can be actioned appropriately. It also provides a lower threshold for sharing of information and robust follow up, sooner.

3. **The organisation and systems at the CWB were insufficiently robust to appropriately manage, treat and safeguard students known to have mental health problems and be at high risk to themselves on**

a background of a lack of national guidance of what are the basic requirements for universities to provide such services.

Response:

It is not the case that the University should be judged by the same criteria as statutory mental health service providers, like NHS Trusts or Community Mental Health Recovery Services. The CWB is not a care provider, such as a care home or hospital or GP Practice, requiring registration with a regulatory oversight body such as the Care Quality Commission ("CQC"). It is a stand-alone discreet service provided by the University to support students in a pastoral way to help them to succeed at university. It is not designed or authorised to provide diagnosis or treatment and because of this any regulatory processes or policies in this regard will inevitably be absent. The CWB does not provide medical services and it is important that this distinction is made clear so that mandated services that do provide medical care - such as NHS Trusts or Community Mental Health Recovery Services - understand the boundaries between the care and treatment they provide and the signposting offered by the CWB.

With regards to safeguarding, since 2019 the University has updated its safeguarding policy, which all staff are required to follow. In addition, the University has improved access to safeguarding training, considers all students in the service as potential safeguarding concerns, and refers to the safeguarding policy if required. The CWB team's experience and that of the Designated Safeguarding Lead is called upon to ensure referrals and follow ups are robust.

The University agrees with the Assistant Coroner, when commenting that there is a "*lack of national guidance of what are the basic requirements for universities to provide such services*". While guidance is offered by UUK and there is a Student Minds Mental Health Charter, there is no regulatory framework setting service levels nor quality standards to which universities may be held accountable.

The University welcomes a response from central Government and its regulator, the Office for Students ("OfS"), on the expectations and legal responsibilities on higher-education institutions to provide mental health and wellbeing support to their students.

4. **National guidance issued in September 2018 to reduce the incidence of suicide in the student population had not been implemented by CWB at the time of Sarah's death.**

Response:

At the time of Sarah's death, the University did have a suicide safety policy which was approved by the Executive Board in September 2019. The University can confirm that all the recommendations in the UUK Suicide-Safer Universities report of 2018 have been adopted except for the University hosting a

mental health round-table event. This will take place in the Summer of 2023 and will reinforce and strengthen relationships in place with other local mental health support services.

5. **There was no internal (by CWB) or external regulatory (by the University of Surrey) oversight as to the service provision at CWB before Sarah's death or indeed after her death.**

   Response:

   The University agrees that there is no external regulatory oversight of the CWB for the reasons set out in response to item 3 above. To reiterate, the CWB is not a care provider, statutory health-care provider nor is it a statutory mental health service provider. This means its services are not monitored by any external regulatory body, such as the CQC.

   The University does not accept that there was no internal oversight of the service provision by the CWB. Significant detail of the policies and procedures applied specifically by the CWB and more generally by the University was provided to the Assistant Coroner during the course of her investigation and in evidence at the inquest.

   The University oversees and monitors the services provided by the CWB through the following:

   a) The Chief Student Officer ("CSO") chairs both the Wellbeing Strategy Group ("WSG") and the Prevent and Safeguarding Group. The latter is a reporting group for statistics and issues arising in wellbeing and safeguarding

   b) Regular reviews and updates of key policies, overseen by Head of Wellbeing and Welfare, CSO, Governance and Risk Assurance, and Executive Board as appropriate

   c) A full and comprehensive risk register for CWB that captures the risks relating to student well-being, as part of the University's risk management framework

   d) Key performance indicators have been developed to support robust follow ups and contact with the service, these are reported to WSG and the University's Health and Safety Executive Committee

   e) Reporting at the Health and Safety Executive Committee and consultative committee.

6. **There was little communication or learning between and a lack of involvement sought or offered by local NHS mental health services to ensure the service provided by CWB was within an acceptable standard.**

So far as the University is aware, there are no "*acceptable standards*" to which the CWB must be held to account. The support services provided by the CWB are not statutory mental health provision, such as those provided by local NHS mental health services. Instead, they are stand-alone services provided by the University to support students in a pastoral way to help them to succeed at university.

The University would welcome clarity and guidance from the Government and our regulator, the OfS, as to the nature and level of support services that should be provided by universities to students in relation to wellbeing and mental health. It is hoped that any regulations and/or conditions of registration produced can help prevent confusion between the services provided by local NHS mental health service-providers and universities.

Since Sarah's death, the University has taken considerable steps to improve links with local mental health services e.g., Community Mental Health Recovery Services, NHS Trusts and General Practitioner ("GP") practices. These steps include:

a) Regular contact with all services; all advisors have links to services such as Community Mental Health Recovery Service, Early Intervention in Psychosis, Eating Disorder Unit, Mental Health Single Point of Access, Psychiatric Liaison at Royal Surrey County Hospital

b) Weekly meetings with the GP practice on campus about cases and concerns

c) High level meetings with the Care Commissioning Groups ("CCG") and Practice Commissioner Networks ("PCN"); improved relationships with PCN leads; discussions about student mental health needs with the CCG and PCN

d) The University has a working relationship with the Surrey Suicide Prevention Partnership ("SSP"), which involves Surrey County Council, the Police and NHS Trust, working together. The SSP team is supporting the University to improve awareness and mental health training for University student-facing staff. In addition, the CWB is providing direct input into the SSP's own policy and guidance on suicide safety

e) A written responsibilities document which outlines the working relationships with external local partnerships

f) A new General Practice Integrated Mental Health Service is now available at GP practices in Surrey and the University has fed into the development and requirements for this.

7. **There was no serious incident report completed by US as to the working practices of the CWB and no reflection has taken place and no steps have been taken to put into place by CWB to provide more robust systems to confirm the safety of students such as Sarah.**

Response:

A *"serious incident report"* is the kind of report produced by a healthcare service provider, such as an NHS Trust, GP Practice or Community Mental Health Recovery Service. The University is not a regulated healthcare service provider and is not required to produce a serious incident report.

Even so, a full internal investigation report was prepared and shared with the Assistant Coroner during her investigation. This report included a detailed commentary on Sarah's interactions with the CWB and compiled an action plan setting out several recommendations in respect of further action that needed to be taken. Good progress has been made in implementing the recommendations and many of the actions are referred to in this response. However, immediately after the review the University was significantly impacted by the Covid-19 pandemic and resources across the University were re-directed. This meant there were delays in delivering training to staff members. In addition, Covid-19 saw a significant uplift in the number of students accessing services, therefore resources had been redirected to managing crisis and those with mental health issues.

In December 2022 Universities UK released new recommendations and these are currently being reviewed in readiness for implementation. This demonstrates our on-going and continuous commitment in this area.

Additional information relevant to the concerns raised by the Assistant Coroner

In addition to the responses to the specific concerns cited by the Assistant Coroner, the University can confirm the following additional relevant information:

1. **Information sharing within the University**

   Since Sarah's death, there have been changes in the mechanisms for, and quality of, information sharing between departments within the University and the CWB regarding student safety and mental health, specifically:

   a) Information is shared much more openly between key departments such as Security, Disability and Neurodiversity

   b) Through the new 'report a concern' form, a higher level of detail is requested when staff refer a student into the department, this allows for both a clear and reliable information trail as well as a detailed report of the concerns outlined

   c) A new student engagement platform has been rolled out, which tracks student engagement in key touch points of student life and allows us to identify students who are disengaging earlier than before. This information is being utilised by academic departments and professional services to

share information quicker and more easily improving communication between the personal tutors and CWB as well as other teams within the University

d) Any information shared by departments or via the new 'students of concern' form is documented on the CORE documentation system to ensure all information is available to all staff within the CWB.

2. Information sharing with other universities and beyond

There are ongoing mechanisms for sharing information with other universities and sector institutions, specifically:

a) Through the local authority, a meeting is held every two months with other universities within Surrey, and ideas and initiatives are shared

b) All CWB staff attend national conferences in improving mental health and wellbeing, sharing initiatives and learnings. Topics include working with NHS partners in mental health and wellbeing, information sharing, safeguarding in Higher Education, suicide safety and improving mental health in universities

c) The Head of Wellbeing and Welfare continues to be a board member of Advance HE's Mental Health and Wellbeing in Higher Education Expert Group to inform sector practice

d) The University has a working relationship with the Surrey Suicide Partnership team, which is working to review our University campus, including a review of suicide hot spots, the opportunity to place support information plaques in those areas and raise any issues which may increase the risk of suicide on campus. The team is also supporting the University with mental health training and provision to students, including contributing to their own policy/guidance on suicide safety

e) Contact with the local GP services has increased and the advice team meet the GP on campus each week to discuss any concerns affecting both services. Where there is a concern for a student's wellbeing and it reaches a threshold of 'vital interest', information may be shared with the GP.

3. **Further local initiatives**

Since Sarah's death, the University has undertaken steps at a local level to improve awareness of student mental health through the following means:

a) Improving our communications around mental health and wellbeing issues and signposting support services in regular communications to students

b) The University's peer support team of dedicated student volunteers have an overarching approach to wellbeing in their communications with peers on their social media channels

c) A bespoke communications campaign called "Let's talk" is being developed that will help signpost sources of support and reflect people's real-life experiences of managing their wellbeing

d) We have hosted multiple events that raise awareness and signpost students to services, such as at the Freshers' Fairs, during the mental health awareness weeks, and by hosting Samaritans on campus regularly (especially throughout exam period), and representatives of the Lucy Rayner Foundation who have attended campus events. PAPYRUS have also run events on campus for our students

e) Improving and clarifying the information on the University website, including a clear expression of the services provided by the CWB

f) A focus on training: Mental Health First Aid is now a substantial recommendation for all student-facing staff in professional and academic departments. The Applied Suicide Intervention Skills Training (ASIST) course is undertaken by key staff particularly in security roles. Mental health awareness, distressed student and safeguarding awareness training for all Personal Tutors is in hand.

4. **Set out below is a summary of the actions taken by the University in response to Sarah's death:**

a) Procedures and processes have been improved in CWB, in particular around risk management in CWB and the wider University, follow ups with students of concern and safeguarding

b) Training has improved across the University and within CWB on safeguarding, mental health, suicide awareness, distressed students and suicidal student support

c) External relationships continue to be developed with NHS and tertiary services

d) Information sharing internally and externally has improved

e) Data collection has improved to identify areas where improvements in service provision can be achieved

f) Internal reviews after any future suicides will now be standard procedure

g) A postvention team is now in place should there be any more suicides.

Conclusion

The University of Surrey strives to be a welcoming and caring community for its students and staff. Sarah's tragic death prompted a period of reflection and reform. There are necessary limitations to the support that any university's wellbeing services can provide students. They do not and cannot replicate the services of the NHS and other professional mental health services that have regulatory oversight from the Care Quality Commission. We will champion the need for greater clarity from Government and the Office for Students on this point so that there is no more confusion about the role of universities in supporting students' wellbeing. It is the responsibility of services within the NHS to actively diagnose and treat students' mental health. Meanwhile, and as a result of the findings of this inquest, we have and will continue to improve the pastoral care provided to our students, in line with any guidance for higher education institutions.

FOR AND ON BEHALF OF THE UNIVERSITY OF SURREY

24 January 2023