Regulation 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1 [redacted], Vice-President of Education, University of Southampton** **2 [redacted], Associate Director, Student Support, Student and Education Services, University of Southampton**
1	**CORONER** I am Christopher Campbell Wilkinson, Senior Coroner for the coroner area of Hampshire, Portsmouth and Southampton.
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 30 June 2022 I commenced an investigation into the death of Matthew George WICKES aged 21. The investigation concluded at the end of the inquest on 4 August 2023. The conclusion of the inquest was that the Deceased impulsively took his own life (by jumping from a bridge) whilst suffering an acute anxiety crisis.
4	**CIRCUMSTANCES OF THE DEATH** The Deceased died in hospital care at 06.35 on the morning of 30 June 2022 after falling from a road bridge across Thomas Lewis Way in Southampton at approximately 05.30 that morning. Despite emergency medical attention he was unable to be resuscitated and died as a result of his injuries. No drugs or alcohol were involved in the death. The Deceased was a third-year student at university and was neurodiverse. He had been struggling with the pressures of his third year of study, following irregularities created and imposed on his otherwise established study routine and rhythm of daily living as a result of successive lockdowns. He had also fallen ill with Covid-19 in March 2022 and was believed to have been suffering long covid symptoms in the subsequent months. His illness had impacted on his concentration and his ability to perform, as well as causing chronic fatigue and insomnia. As a result, he had fallen behind in his third-year project and, it is believed, had determined that he was going to be unable to successfully pass his year of study, thereby preventing his ability to proceed at university and halting his ambition to pursue his academic career. It is believed that these factors had had an overwhelming effect on him, leading, on 30 June 2022 - the day of the publication of his exam results - to an acute anxiety crisis out of which he was unable to see a path. Although he had left no clear explanation of his feelings or reason for his actions, the evidence established that it was more likely than not that he had jumped from the bridge in a moment of acute distress in the early hours of the morning. There was no evidence to suggest that he had accidentally fallen to his death and no evidence of any third-party involvement. It was found that his actions were impulsive yet deliberate in their intent to take his own life, whilst suffering an acute anxiety crisis.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries revealed matters giving rise to concern. In my opinion there is a risk that future deaths could 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. Matthew was neurodiverse. It was accepted that this condition was not known by the university at the relevant time, as he was diagnosed after his commencement on his course and did not disclose his condition to the university. In the circumstances, appropriate actions and case specific assistance which might otherwise have been availble to and assisted Matthew were neither implemented in response nor accessed by him. Notwithstanding Matthew's neurodiverity – which of itself was a barrier to him being able to reach out or to seek help - I am concerned about the level of awareness, understanding and curiosity of accademic staff around the mental health of students, particularly in the post-pandemic climate, where interruptions to their study and dysregulated student life have had a significant impact on their mental health.

   Whilst it was explained to me that all staff are offered training on mental health management and are provided with guidance on how to support students, I am concerned that aspects of this are not made compulsory for accademic staff. Where a myriad of training options are made availble to staff and often required of them, with very little practical time availble in which to do it, there is a risk that modules and aids with regard to mental health will not be prioritised, followed through or addressed. There is as I understand it no evident monitoring in respect of which staff have viewed or undertaken what training or indeed in respect of who has completed the modules on offer. It remains unclear as to who or how many staff have actually viewed or undertaken the online training around student mental health.

   Although the process of 'raising a concern' by accademic staff is a means by which such matters can be considered and is a process set up and encouraged through the student hubs, I am concerned that in not ensuring that accademic staff are at least armed with the ability to spot or to know when to make initial enquiries of students or are clearly guided on how best to do so (particularly with regard to an understanding of the needs and skills required to liaise with students with neurodiversity), there is a risk that an over-focus on accademic policies and procedures will endure and that those students who are struggling to adhere to them will be missed or overlooked.

2. It was evident to the Court that very positive steps have already been undertaken in planning towards an 'early warning system' for students in the accademic year 2023/24. This will allow triggers to be identified and set for accademic absence and changes in study or support behaviours (as is to be trialled in 2023/24). Such steps are to be commended and I hope will proceed at pace. However, I do have concerns that there is and remains an evident gap between the accademic assessment of students and the pastoral support that they receive. I hope this will be addressed and filled – in part in the development of staff training and understanding around mental health and in what circumstances concerns should be raised (as above).

   Where accademic absence or performance issues are identified, I am not convinced, on the evidence heard at this inquest, that enough has yet been done to also consider how 'reaching out' to such students can be most effectively achieved. It was evident that much of the group-focused approaches offered by the universtity or the initaitves where the onus is placed on the student to come forward, may not work. Practically, how best can students – especially those with neurodiverse needs – be compassionately and empathetically approached and engaged with to ensure they receive the help and validation that they probably desperately require?

	3. The evidence at this inquest raised concerns over the existance, frequency and accuracy of the recording and minueting of accademic meetings with students, especially those between the student and Personal Accademic Tutor and the Project Supervisor in the third year of study. It was of concern to me that the University was unable to locate or provide clear minutes of supervisory catch ups, progress checks or agreed guidance or actions for Matthew. It was of further concern that the accademic staff supporting and mentoring him in his third year had not provided written evidence of his progress or agreed minutes of actions etc to him. Whilst it is recognised, particularly in a third year of study, that there must be a balance between independence and appropriate support, it would in my view be important for any student and university accademic team to have a clear record of achievement or progress. This must be able to be reflected back to the student and recorded in such a way as to ensure that both student and tutor are clear and agreed as to progress that has been achieved and as to what needs to be done to move forward. The absence of such information and appropriate support, which can lead to feelings of isolation and desperation, must be avoided at all costs.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you (and/or your organisation) have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 15 March 2024. I, the coroner, may extend the period. 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 and to the following Interested Persons [redacted]**, Head of Electronics and Computer Science, Chair of ECS Exam Boards, University of Southampton.** who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest. 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	**Dated: 19.1.24** **His Majesty's Senior Coroner, Hampshire, Portsmouth and Southampton**