VERONICA HAMILTON-DEELEY DL,
LL.B.
Her Majesty's Senior Coroner
for the City of Brighton & Hove

Assistant Coroners
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CORONERS SOCIETY OF ENGLAND AND WALES

ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	THIS REPORT IS BEING SENT TO: 1. [redacted], **Vice Chancellor, University of Sussex, Sussex House, Brighton, BN1 9RH** 2. [redacted], **Deputy Director of Student Experience, University of Sussex, Sussex House, Brighton, BN1 9RH**
1	**CORONER** I am Veronica HAMILTON-DEELEY, Senior Coroner, for the City of Brighton and Hove
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 26th September, 2018 I commenced an investigation into the death of Daniel Alexander Jeremiah BOWEN. The investigation concluded at the end of the inquest on 30th January, 2019.The conclusion of the inquest was HE TOOK HIS OWN LIFE.
4	**CIRCUMSTANCES OF THE DEATH** See Record of Inquest
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) Academic Advisor – Better use should be made of the person in this post for each school. There was a wasted opportunity for the academic advisor to be

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	involved in face to face meetings with Daniel and help him when he was struggling to get his work in on time and to deal with his academic pressures. In the circumstances I heard that if work was late a penalty would be imposed. This seems ridiculous; why hit a man when he is already down? (2) With regard to communication – this appeared to be deeply flawed amongst the huge number of University departments and units. The health clinic incorporating amongst other things a pharmacy and the counselling service, was excellent offering free access to students. The system failed – Daniel was not in the link between his GP/counsellor and the student support unit. If this link had been complete I do not believe Daniel would have died when he did.
	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.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 22nd April 2019. 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 1. [redacted] - Mother 2. [redacted] – Father 3. [redacted] – Sussex University Health Centre, For information 4. [redacted] – Head of Campus and Residential Support 5. [redacted] – Acting Head of University Counselling Service 6. Secretary of State for Health, Department of Health 7. [redacted], Chief Executive, NHS England 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 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	**Date: 1st February 2019** **SIGNED BY:** V. Hamilton Deeley **Senior Coroner Brighton and Hove**