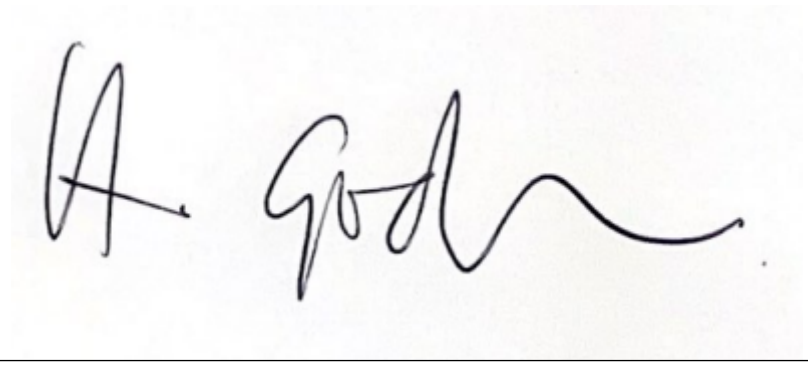
Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 Reading University** **2 Universities UK**
1	**CORONER** I am Hannah GODFREY, Area Coroner for the coroner area of Berkshire
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. A prevention of future deaths report raises issues and is a recommendation that action should be taken but does not recommend what that action should be. That is a matter for the recipient. It is important to note the case of R (Dr Siddiqui and Dr Paeprer-Rohricht) v Assistant Coroner for East London. This case clarifies that the issuing and receipt of a Regulation 28 report entails no more than the coroner bringing some information regarding a public safety concern to the attention of the recipient. The report is not punitive in nature and engages no civil or criminal right or obligation on the part of the recipient, other than the obligation to respond to the report in writing within 56 days.
3	**INVESTIGATION and INQUEST** On 3 October 2023 I opened an inquest into the death of Benjamin Faux on 5 August 2023, aged 21. The inquest concluded on 26 June 2024. The conclusion of the inquest was suicide, and the medical cause of death was 1a Hanging. The family requested that I refer to Benjamin as Ben, I will reflect that in this report.
4	**CIRCUMSTANCES OF THE DEATH** Ben graduated from Cambridge University in Summer 2022 and started a taught research Masters in the Chemistry School at Reading University in the autumn term of 2022. From October 2022 Ben had a diagnosis of mixed anxiety and depressive disorder on a background of chronic social anxiety since the Covid pandemic. Ben's attendance fell drastically from Christmas 2022. From then on Ben missed lectures, hardly attended labs and missed deadlines repeatedly. In early 2023 he developed acute mental health issues probably triggered by the stress of managing academic work and deadlines and he reported suicidal thoughts to student welfare counsellors, his GP and NHS secondary mental health services. Ben had capacity and was adamant he did not want his parents to know about his mental health problems, or his difficulties with his studies. Ben's academic tutor and department director of academic tutoring (DDAT) were

	unaware of Ben's difficulties until he wrote to them in March 2023 explaining that he had severe mental health problems that were interfering with his work. They met with him twice and at the second and last meeting on 24 April 2023 proposed that he formally indefinitely suspend his studies and concentrate on his health. Ben was provided with paperwork to formally take this step. Ben's academic tutor thought that Ben was going to do it. Ben in fact did not. On 17 May 2023 Ben told a member of staff at the Student Support Centre who contacted him that he no longer wanted to suspend and would contact his academic school to produce an academic plan of action. However he did not contact his school and they did not contact him. Academic staff became aware that Ben had not suspended his studies in late June 2023. No-one from the University took any other steps to contact or check on Ben, or to ask anyone else to contact or check on him. Ben did not re-engage with any academic work but continued living in his student accommodation where he took his own life on or around 5 August 2023.
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: (brief summary of matters of concern) The evidence heard at the inquest touching Ben's death was specific to students on taught graduate research courses at the University of Reading, and my concerns set out below are specific to that group. I am copying this report to Universities UK as I consider there may be a wider application to comparable student groups in other universities nationally. (1) About 5 years ago, following concerns from academic staff that they were not equipped to support students with welfare issues, Reading University stripped out the pastoral care function from the academic supervisor role, leaving only 'academic advisors/tutors'. There is alternative provision made for welfare but it is not part of the tutor role and students on taught research courses do not have named pastoral tutors; (2) The nature of taught research courses (largely independent work) makes it more challenging to monitor students' engagement and identify issues at an early stage. Ben's difficulties with his academic work started after Christmas 2022 but were not addressed by the department until he raised them himself in March 2023 by which point he was at a crisis point; (3) Ben was appropriately encouraged to use University procedures such as 'exceptional circumstances' applications through to a conclusion, however there was no process for ensuring that after being offered the option to suspend his studies Ben was supported through to a conclusion of that process one way or another, and that remains the case for students in that position now; (4) There is an established process for enforced suspension of studies and the University agreed that with hindsight Ben was clearly not fit to study and should have been identified as such and put on that pathway instead of leaving it to Ben to decide and take action to suspend his studies; (5) By March 2023 Ben's department at Reading University knew that Ben was a student

	with severe mental health concerns linked to management of his academic work, who had not taken any exam and had not completed sufficient research to file a dissertation and by late June they also knew that he had not completed paperwork to suspend his studies and yet: a. The University staff who knew this did not appear to appreciate what it meant for Ben and his continuing risk of vulnerability; and b. There was no individual who was given or took responsibility for what should happen next with regard to resolving Ben's academic situation; and c. Apart from brief further contact from the Student Support Centre re the suspension forms, no-one from the University contacted Ben between 24 April 2023 and when he took his life on or around 5 August 2023; (6) The primary responsibility to meet acute mental health needs when they arise lies with mental health care services. I acknowledge that Reading University have engaged with and are continuing to implement a lessons learned process since Ben's death. However I consider that circumstances at Reading University continue to present a risk to vulnerable graduate students on taught research courses who struggle with their work and develop mental health issues. The risk is of being overlooked until a crisis is reached, or becoming isolated, or of being left in academic limbo, as Ben was, with tragic results.
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 September 04, 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 Ben's family and Berkshire Healthcare NHS Foundation Trust (the other interested persons in the inquest). 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, 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: 10/07/2024** 

	Hannah GODFREY **Area Coroner for** **Berkshire**