Report to Prevent Future Deaths

[[redacted], referred to as] 'Student A' (Date of death: 28 July 2024)

	Regulation 28 Report to Prevent Future Deaths
	THIS REPORT IS BEING SENT TO: 1. Chief Executive Officer The Unite Group plc Temple Back Bristol BS1 6FL
1	**CORONER** I am Ian Potter, assistant coroner for Inner North London.
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 6 August 2024, I commenced an investigation into the death of Student A, aged 21 years at the time of his death. An inquest was opened on 7 August 2024. The investigation concluded at the end of an inquest heard by me on 14 January 2025. The conclusion of the inquest was 'suicide'. The medical cause of death was: 1a asphyxiation [redacted]
4	**CIRCUMSTANCES OF DEATH** Student A lived in student accommodation at Somerset Court, Aldenham Street, London. He was last known to be alive on 27 July 2024, having spoken to his mother on the telephone and being seen returning to his address by staff at Somerset Court. The following morning, staff at the accommodation were requested to conduct a welfare check on Student A. At about 10:50 on 28 July 2024, staff noted Student A to be unresponsive (not responding to his name being shouted) in his room, but only saw his legs on the bed from the doorway to the room. Emergency services were called following a subsequent welfare check, at approximately 12:00, in which staff found Student A on his bed with [redacted]

	Paramedics verified the fact of Student A's death shortly thereafter. He died of asphyxiation having intended to end his own life.
5	**CORONER'S CONCERNS** During the course of my investigation and the inquest, the evidence 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: I received statements (taken by police officers) from three members of staff at Somerset Court, which is operated by Unite Students. 1. On 28 July 2024, the request for a welfare check was received by staff at Somerset Court, from the Emergency Control Centre (the ECC) for Unite Students, at approximately 07:00. The basis of the request was that Student A's mother had been unable to contact her son. The member of staff advised the ECC that they would try to 'call the student and if he did not answer I would then go to his room.' At approximately 10:15, the staff member called Student A's mobile telephone three times, 'but it did not ring it only beeped.' At approximately 10:50, the staff member went upstairs to Student A's room and received a call from the ECC but 'ignored the call' to go to Student A's room. While at the material time there was no way of knowing whether this was an emergency or not, the concern here is that it nevertheless took hours for the request for a welfare check to be actioned in any way. Further, on getting no response from attempts at contact by telephone, there was further delay in physically attending Student A's room. 2. When attending Student A's room at about 10:50 on 28 July 2024, the member of staff knocked repeatedly on the door and asked for Student A to come to the door. The staff member then used their staff pass to open the door, on account of getting no response. In their statement, the staff member sets out that they remained in the doorway and could see Student A's legs (from the knees down) on the bed within the room. The statement continues, 'I called out to the student and stated that it was reception and asked if they were okay. At this time I was scared so I closed the door and went to the stairwell.' The staff member spoke to the ECC and explained the circumstances to them and the ECC advised the staff member to call an ambulance 'and to also get someone from one of the other buildings that is run by the university.' Following the call with the ECC, the staff member sent a text message to their 'general manager' explaining the situation and requesting that

	a receptionist from another building be sent to assist. The staff member's statement then says, 'At approximately 1134 I called my manager and whilst on the phone returned to the room and knocked on the door repeatedly. I shouted out and knocked loudly. The student did not answer the door.' The staff member then returned to reception and telephoned for a colleague in another building to come and assist. Assistance from a colleague arrived at approximately 12 noon. Both members of staff then made their way to Student A's room where, upon entering they found Student A unresponsive on his bed in the manner already described at section 4 of this report. As a result, the staff left the room, returned to reception and 'called our managers and emergency services and we waited for their arrival.' The concerns here are numerous: • It was obvious to staff that Student A was, at the very least, unresponsive / difficult to rouse at about 10:50, which on any view would be regarded as a serious / emergency situation. However, it appears that no positive or definitive action was taken to assist for over an hour. • The ECC advised the staff member to call an ambulance at about 10:50, yet this was not done until approximately 12 noon. • The staff member who first checked on Student A at 10:50, went no further than threshold (seeing no more than his legs) and therefore did little, if anything, to satisfy themselves about the true welfare status of Student A. • The staff members who attended Student A's room at approximately 12 noon, did not attempt to render basic assistance or first aid to Student A. • In the particular circumstances of Student A's case, he was highly likely to have been deceased for hours prior to his death being verified by paramedics at 12:27. However, that fact was not known to staff at the material time and, therefore, they would have been expected to act in accordance with any protocols or policy in place at that time. Given these matters, I am concerned that there may be a lack of appropriate training in place for staff or, if there is such training in place, that it may not be effective. Nothing in the evidence available to me has suggested that the future risks posed by my concerns have been addressed.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that you 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 17 March 2025. 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: • The parents of Student A • The University at which Student A was studying 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 summary form. She may send a copy of this report to any person who she 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	**Ian Potter** HM Assistant Coroner, Inner North London 20 January 2025