ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. [redacted] President and Vice-Chancellor, Cardiff University 2. [redacted] Director of Student Support & Wellbeing, Cardiff University
1	**CORONER** I am Rachel Knight, Assistant Coroner for the coroner area of South Wales Central.
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 the 7th November 2018 an inquest was opened in to the death of Mr Jack Liam May. The investigation concluded at the end of the inquest on 27th February 2019. The conclusion of the inquest was suicide.
4	**CIRCUMSTANCES OF THE DEATH** • Jack May, aged 20, died in the River Taff on 25th October 2018. • He was a nursing student at Cardiff University, with a longstanding history of mental health problems and was part of the LGBT society and community. He had recently been prescribed Sertraline by his GP, but the drug had not yet had time to take effect.
5	**CORONER'S CONCERNS** During the course of the inquest, and the investigation leading up to it, 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. –

	(1) Provision of sufficient services within Cardiff University to provide emergency help and support for students. Evidence suggested that there may be inadequate provision of counselling and wellbeing services, with long waits being experienced by attendees, also that after 4 appointments, students must reapply. This presents obvious difficulties for students with longer term needs; and (2) Patchy provision of pastoral support by Personal Tutors. Evidence suggested that Personal Tutors receive only 3 hours of training (per annum) in relation to identifying and signposting students in need of additional help with mental health or other personal difficulties. Also, that some Personal Tutors do not contact their tutees to initiate contact, and some tutees do not respond. Therefore, students can, and do slip through the net.
6	**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. You may wish to consider the following points: (a) The resourcing, provision and aim of counselling and wellbeing services within the University; (b) The training of Personal Tutors in relation to identifying real concerns with students; and (c) The accountability of Personal Tutors for contacting students and vice versa, and the frequency with which meetings take place.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 26th 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: 1. [redacted], The Medical Centre, Cardiff Road, Taffs Well 2. The family 3. The Chief Coroner who may find it useful or of interest. 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	1st March 2019	SIGNED:  Miss Rachel Knight Assistant Coroner