



M. E. Voisin
Her Majesty's Senior Coroner
Area of Avon

2nd May 2019

REF: 10743


	<p>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</p> <p>THIS REPORT IS BEING SENT TO:</p> <p>Bristol University The Department of Education The Minister for Suicide Prevention UCAS</p>
1	<p>CORONER</p> <p>I am M E Voisin Senior Coroner for Area of Avon</p>
2	<p>CORONER'S LEGAL POWERS</p> <p>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.</p> <p>http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made</p>
3	<p>INVESTIGATION and INQUEST</p> <p>On 30/05/2018 I commenced an investigation into the death of Benjamin James Charles MURRAY. The investigation concluded at the end of the inquest.</p> <p>The conclusion of the inquest was: suicide</p>
4	<p>CIRCUMSTANCES OF THE DEATH</p> <p>On 5th May 2018 Ben had lunch with his father and left him shortly before 2pm. His father's statement stated that: "he seemed somewhat down and I was concerned because he was sensitive but the thought that he would take his own life never crossed my mind"</p> <p>At 3pm Ben was found beneath the Clifton suspension bridge on the canopy area, the police officer reviewed the CCTV footage from the bridge, he described what he saw - that Ben walked unaccompanied onto the bridge, he walked to the buttress wall, climbed up onto it and without hesitation propelled himself forward.</p> <p>It was clear from the investigation that there were a number of matters going on in Ben's personal life including: that Bristol was not Ben's first choice of university to study at; that he never seemed to fully engage with University studies; that his place at University had been withdrawn; that there was a significant debt owed to the University for tuition and accommodation; that Ben had disclosed that he</p>

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	<p>was suffering illness and anxiety and it appears that he may have been confused about his status with the University.</p>
<p>5</p>	<p><u>CORONER'S CONCERNS</u></p> <p>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.</p> <p>The MATTERS OF CONCERN are as follows. –</p> <ol style="list-style-type: none"> 1. For Bristol University, The Department of Education and The Minister for Suicide Prevention <p>Bristol University have clearly made many fundamental changes to their practices to support students wellbeing and it may be that their current practices can be shared throughout the Higher Education sector to assist with suicide prevention.</p> 2. For UCAS, The Department of Education and The Minister for Suicide Prevention <p>The concern over mental health disclosure either on the UCAS application form or indeed to a prospective University.</p> <p>I am told that currently such disclosure is at 37%. There needs to be a move towards de-stigmatising mental health and ensuring that students are made aware that by disclosing mental health problems on their UCAS form or to their prospective University that it will not affect getting a place at University.</p> 3. For Bristol University, The Department of Education and The Minister for Suicide Prevention <p>The transition from home to University can be a challenging time for some students and Universities clearly have the primary role of education however this inquest has demonstrated they also carry out an important pastoral role.</p> <p>It is not the role of the Coroner to investigate Ben's journey through University in light of the circumstances of his tragic death and the limited scope. That said as a Coroner has a duty to consider prevention of future deaths it was appropriate in this case that aspects of Ben's progress were investigated by me.</p> <p>In addition currently the University sector does not carry out an investigation report (such as a root cause analysis or sudden untoward investigation) after a death of a student. Such a written report usually affords an opportunity to review what happened; what was done well/the good practice points; areas of concern, if there are any, and importantly what lessons can be learned often with a formal written action plan. Such a document is also very helpful to the Coroner when considering and discharging this duty. Such a formal process and document most importantly assists in preventing future deaths.</p>

6	<p>ACTION SHOULD BE TAKEN</p> <p>In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.</p>
7	<p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 12th July 2019. I, the coroner, may extend the period.</p> <p>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:</p>
8	<p>COPIES and PUBLICATION</p> <p>I have sent a copy of my report to the chief coroner and to the following interested persons – the family of the deceased. I have also sent it to the following who may find it useful or of interest.</p> <ul style="list-style-type: none"> • Universities UK • Student Minds • Chris Skidmore, MP, Minister of State for Universities, Science, Research and Innovation • Duncan Selbie, Chief Executive of Public Health England • [REDACTED] President of Universities UKL <p>I am also under a duty to send the chief coroner a copy of your response.</p> <p>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.</p>
9	<p>16/05/2019</p> <p>Signature </p> <p>M E Voisin Senior Coroner Area of Avon</p>