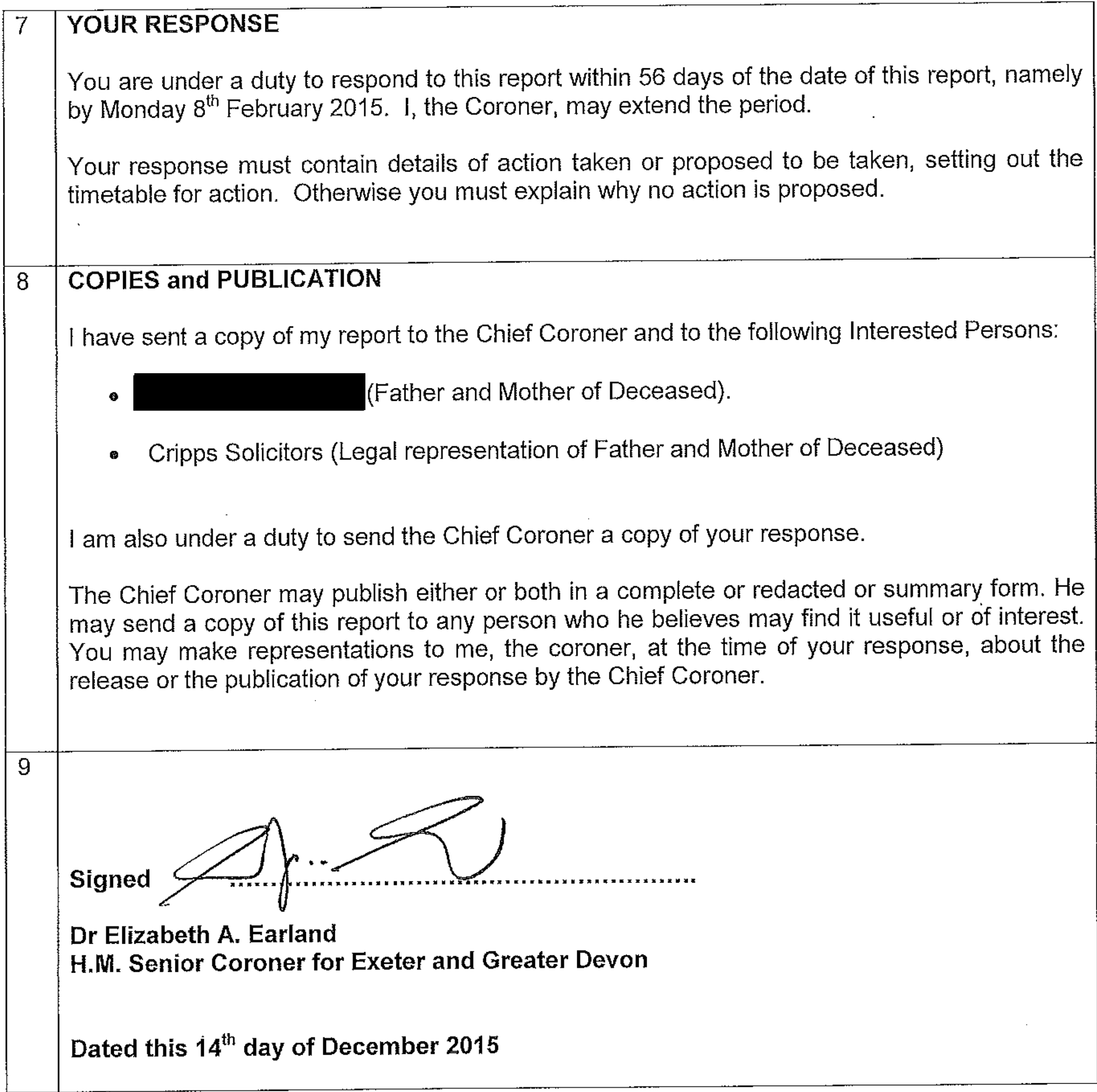
ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Professor Sir Steve Smith** **Vice-Chancellor and Chief Executive Officer, University of Exeter** Streatham Campus Northcote House The Queens Drive Exeter EX4 4QJ **2. Melanie Walker** **Chief Executive Officer, Devon Partnership NHS Trust** Wonford House Dryden Road Exeter EX2 5AF **3.** [redacted] **Guild President of Students Union, University of Exeter** Streatham Campus Devonshire House Exeter EX4
1	**CORONER** I am Dr Elizabeth Ann Earland, Senior Coroner for the coroner area of Exeter and Greater Devon.
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 30 September 2013 I commenced an investigation into the death of William Jeffrey MASKELL. The investigation concluded at the end of the Inquest on 3rd December 2015. The details of how the death occurred were: Sometime after 21.18 hours on the 25 September 2013 the Deceased, who suffered from Bipolar mental illness, ingested a fatal quantity of Venlafaxine and Lamotrigine in Room H53, Birks Grange Village, Exeter University. The conclusion of the Inquest was Mr MASKELL "Took his own life while the balance of his mind was disturbed".

4	**CIRCUMSTANCES OF THE DEATH** William Jeffrey MASKELL had a history of ongoing Bipolar Disorder. He had previously had to withdraw from University courses because of his mental health problems and on arrival at Exeter on 12 September 2013 (for the second time), he had a large support network including the University Wellbeing Team and Community Mental Health Services (STEP and CRISIS) and his family who had moved to be close by in the initial six weeks. We were told he was assessed as Low risk for self-harm. Despite this, concerns were raised for his welfare by Rachel Bragg, University Care Coordinator and Wellbeing Consultant, when he did not attend a planned appointment at 12:00 hours on 26 September 2013. The Community Mental Health STEP and CRISIS teams (Devon Partnership NHS Trust) were informed and attempts made to contact William without success. Eventually [redacted] (Head of Wellbeing) notified Elizabeth Murphy (Head of Student Support Services) at 17:30 hours on 26 September 2015 and having evaluated the situation (it is common for students to miss appointments) Estates Control were contacted between 18:00 – 18:15 hours and they went to William's room at Birks Grange. The door was locked on the inside so another updated monitor key/fob had to be obtained to enter the room. William was found breathing, but collapsed on the bed. Despite immediate resuscitation attempts, attendance of emergency services (called at 18:24 hours, arrived 18:34 hours) and transfer to hospital, he was declared Deceased. The Cause of Death was Ia. Venlafaxine and Lamotrigine Overdose.
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. The decision to go to William's room was hampered by the lack of a clear protocol for the involvement of the relevant agencies and the Police. 2. The respect for the autonomy of the student in running his/her private life appeared to take precedence over a real concern for welfare, resulting in delays in attendance at the scene and a reluctance to take the decision to force entry. It appears that the Students Union's opposition to any erosion of the students' human rights (to privacy) was a factor. 3. There is a real risk of future deaths of students in distress for lack of timeous intervention because of the current restraints.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that Exeter University Wellbeing Services, Devon Partnership NHS Trust (for STEP and CRISIS teams) and Students Union have the power to take such action. It is accepted that if a student is not on campus it may not be possible for "rescues" to be effected but this does not preclude a review of systems within the University Halls of Residence.



7 YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by Monday 8th February 2015. 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:

- (Father and Mother of Deceased).
- Cripps Solicitors (Legal representation of Father and Mother of Deceased)

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.

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Signed ....

Dr Elizabeth A. Earland
H.M. Senior Coroner for Exeter and Greater Devon

Dated this 14th day of December 2015