ForThe100

Evaluation of September 2023 Proposal by Higher Education Mental Health Implementation Task Force for National Review of Higher Education Student Suicides

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Signed by Fifteen Bereaved Families

30 October 2023

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Evaluation of September 2023 Proposal by Higher Education Mental Health Implementation Task Force for National Review of Higher Education Student Suicides

The introduction of a National Review of Higher Education Student Suicides is undoubtedly a significant step in addressing the pressing issue of student suicide within the higher education sector. However, like any government initiative, such proposals should be subject to critical external evaluation in the form of an 'expert comment' from other interested parties with an alternative viewpoint such as ForThe100.

ForThe100 are a national group campaigning for higher education students to be owed a minimum standard of legal protection enshrined in a statutory duty of care. The group want a clear and transparent legal requirement for institutions to act reasonably and responsibly, so that students are not harmed by things institutions do (acts) and/or things institutions fail to do (omissions).

Our intention is to provide timely, pertinent and constructive submissions to enrich the debate by suggesting ways in which a more effective and cohesive overall solution can be achieved. We envisage that the following suggested improvements would deliver some rapid initial findings and strengthen the overall proposal for saving up to 100 plus student lives each and every year.

SUBMISSIONS

1. Flawed Methodology: The Government promised an independent review of student suicides. However instead of sourcing and collating original material, for comprehensive scrutiny by properly trained investigators with an open mindset, the proposed review will be limited to a meta-analysis of second-hand internal reports produced by the very organisations which are supposedly being investigated. Everything hinges on the quality of in-house material that is being created. A total reliance on nuanced, guarded and uncorroborated internal university investigations, in which institutions are in effect 'marking their own homework', is likely to deliver a heavily filtered, politically correct and watered-down set of final recommendations in which issues that were overlooked will continue to be missed or avoided. The credibility of any such post-processing of material should instead rely on the initial use of independent third-party serious incident investigations as standard practice across the sector.

2. Limited Historical Review: The initiative primarily focuses on incidents occurring in the 2023/24 academic year, and thereafter, with historical cases only being considered if lessons have been 'learned'. This limited time frame will miss important insights from past incidents that would meaningfully inform present strategies. Institutions should be looking to learn from the past, irrespective of whether or not previous lessons have been identified since it is equally important to discover what has been missed. The approach of this review effectively means current students are being used to test existing systems, which places them in a potentially very vulnerable situation. As Coroner's Inquests can take months or years to be concluded, the review should also be looking at all sudden, unexpected and self-neglect related deaths. The latter being indicative of a vulnerability akin to suicide. The Government proposed time frame is shortsighted and will not provide a comprehensive understanding of the issues, trends

and contributing factors which often develop over several years. To truly address the problem, a more extensive historical dataset is clearly required, irrespective of whether institutions are comfortable with this or not.

3. Unrealistic Expectations: The proposed analysis of individual reports, is relying on advice that was provided in optional sector-produced "postvention guidance". This guidance suggests that 'serious incident' reviews should be conducted by higher education providers, to identify whether changes to policies, procedures, or processes were required. The main problem with optional guidance is that institutions can just as easily opt-in as they can opt-out. There is also no accepted definition of what is meant by a 'serious incident', although the postvention guidance suggests it should be wide ranging in terms of what is covered. The proposed national review assumes that relevant internal institutional reviews are already being conducted across the sector. However it is unclear how many institutions currently do 'serious incident' reviews and the scope of the incidents that are covered. The standard to which internal reviews should be completed is also a problematic issue that has been disputed at inquests. Bereaved families' experiences show that many universities do not review suicides or non-fatal suicidal behaviour. Any attempt by a student to take their own life is a cause for concern. The scope and purpose of serious incident reviews should be clearly defined and sector wide implementation compulsory.

4. No Standardised Reporting: The quality and reliability of data collected from different institutions may vary significantly. Without standardised reporting mechanisms and rigorous quality control processes, the resulting dataset could be inconsistent and unreliable for drawing any meaningful conclusions. A poor initial investigation may fail to collect comprehensive information about the circumstances leading to a student's suicide. This can leave crucial gaps in understanding the contributing factors. An initial investigation that lacks depth may not uncover systemic issues within an institution which need addressing. Without this understanding, there will be missed opportunities to make meaningful policy and procedural changes. High priority must be given to establishing a comprehensive and robust approved data collecting mechanism which has transparent data quality control procedures at its heart and that must be followed on each occasion at every educational provider.

5. Failing to Build on Past Research: The effectiveness of the proposed approach hinges entirely on institutions acknowledging and rectifying their own shortcomings. However, institutions might lack the capacity to recognise their own deficiencies, and historical evidence suggests that comprehensive investigations are rarely conducted, with disputes remaining outstanding and/or struggling to be settled in court. Notably, a significant body of work, meticulously compiled by families, some of whom are skilled researchers, was recently and unjustly disregarded as 'anecdotal evidence'. In light of the known inadequacy and inconsistency of internal reviewing, it is imperative to make best use of existing alternative holistic case studies as part of a qualitative research agenda, and not wait until there are sufficient reviews to facilitate a statistically significant larger-scale quantitative analysis. It is crucial in all such undertakings to acknowledge the exhaustive efforts made by bereaved families in this regard. Their stories are key. Much of the detailed information and in-depth analysis that will be needed already exists, but it is not being accepted or acted upon. It is especially important to discover from such studies where to look for problems and any notion of institutional internal reviews being superior to parental investigations must end.

6. Conflict of Interest: It is essential to establish robust protocols to ensure the honesty and integrity of all institutional investigations, leaving no room for deliberate omissions or oversights. It is a common experience of many bereaved families that major organisations, including higher education providers, will default to denial when confronted with allegations of any wrongdoing. This defensive posture can prevent institutions from disclosing vital information and being held accountable for potential negligence or inadequate support that may have contributed to a student's death. Such resistance to accountability poses a significant obstacle to the enhancement of student safety and provision of appropriate support within higher education, which can place institutional reputation ahead of student wellbeing. To address concerns of potential cover-ups, it is imperative for institutions to involve external experts or organisations throughout all stages of any inquiry. Incorporating independent oversight can offer an impartial perspective and bolster the credibility of the investigation and its findings. If external investigators are not used, investigations will need to be monitored or policed. So who will be doing that?

7. Production of Annual Statistics: 'Harry's Law' called for universities to record and publish the number of student suicides each year at their institution which could be amalgamated into a national dataset. The current proposal offers a potential solution to the difficulty of having the scale of student suicides properly quantified and for high-risk institutions to be identified. The necessity to conduct a serious incident review is an obvious source of the required statistics (including attempted suicides) and would alleviate the problem of having to rely on ONS for producing delayed best-guess underestimates on an ad hoc basis. Five questions arise in such respects:

    - Is quantification of student suicides and attempted suicides together with identification of high-risk institutions within the scope of the current proposal?
    - Are sufficient measures included to ensure the collation, accuracy and regular publication of student suicide and attempted suicide statistics?
    - How would involvement of the judicial system be practically integrated into such a process?
    - Is limited anticipated engagement by the Ministry of Justice a significant obstacle to the success of this initiative, and are there alternative ways to compensate for this shortcoming?
    - Is there an existing framework to account for and include students who pass away shortly after graduation, or after having taken a break in their studies, or who died during the summer vacation period (i.e., when they are not actually registered)?

8. Compliance and Accountability: The present proposal solely focuses on identifying problematic issues that currently exist within individual higher education institutions or across the sector. Matters that require urgent attention. However, it remains uncertain who will assume responsibility for ensuring that any improvements pinpointed in the functioning of the sector will be effectively implemented and enforced. The intended review should be extended to encompass a consideration of different mechanisms for protecting future students in a rapidly changing world and provide recommendations on exactly how implementation of recognised existing shortcomings are to be resolved. It is imperative that the external body commissioned to do a review properly considers the delicate balance between student safety, institutional autonomy and the necessity for legislation. Essential to ensuring responsibility for implementation would be to have robust and direct accountability to students who have been wronged, harmed or have

died. Otherwise we are once again relying on vague directives, as with previous non-binding guidelines. The review also does not indicate a clear allocated time frame for institutions to comply with requests or recommendations.

9. Terminology and Transparency: In the 'Proposed Work Programme' a notification states "*To work with the selected provider to identify any developments to the existing template for HEPs when reviewing a suspected suicide or near-miss*". We consider the terminology "*near-miss*" as being an insensitive choice of words. Established research suggests such wording can be harmful because it frames suicide as being potentially inevitable and an eventual 'success'. In our document we have chosen to use the terms 'attempted suicide' and 'non-fatal suicidal behaviour' interchangeably.

   Taskforce minutes of an initial meeting held on 18th July 2023 state that it will be a 'transparent forum'. Given that there is strong public interest in addressing the important issue of higher education student suicides, the government should also publish the membership of any subgroup responsible for the development of proposals, details of their decision-making process, the discussions and arguments behind their reasoning and any recommendations arising.

Having reviewed the current proposal for a national review of student suicides, it's clear that there are significant shortcomings. We urge the Government and the Task Force to thoroughly reevaluate their proposal and put in the necessary effort to rectify its considerable shortcomings. It is crucial that such issues are addressed effectively, and we expect a more comprehensive and diligent approach in the upcoming revisions. We all owe this to those students who have already been harmed or died and to current and future generations of students.

The focus needs to shift from blaming students for struggling, to addressing the underlying systems which leave them vulnerable. Rather than merely praising resilience, there should be a concerted effort to bring about systemic changes in the higher education landscape. By broadening the scope of involvement in developing an improved proposal, the aim would be to encourage a more inclusive approach that reflects the varied experiences and insights crucial to comprehensive problem-solving.

To make our country's higher education system better, we should focus on making people proud of it. We can do this by planning and launching initiatives that highlight the importance of a top-notch education system which takes good care of students, properly supports them in their hour of need, and delivers more efficacious overall outcomes centred on maximising student success. By setting high standards, we aim to create a system that not only works well now but also builds a strong foundation for the future, so our national higher education system can remain a world leader.

Robert Abrahart
Balwant Kaur

30th October 2023

Signed by Fifteen Bereaved Families

Robert and Margaret Abrahart
Parents of Natasha Abrahart, died April 2018, aged 20, University of Bristol.

Balwant Kaur and Kuljit Chuhan
Parents of Naseeb Chuhan, died May 2016, aged 21, Leeds Beckett University.

Maxine Carrick and Gary Potts
Parents of Oskar Carrick, died June 2021, aged 21, Sheffield Hallam University.

Liz de Oliveira
Mother of Lucy de Oliveira, died February 2017, aged 22, Liverpool John Moores University.

Vivian Long
Mother of Kim Long, died November 2016, aged 18, University of Bristol.

Esther Brennan
Mother of Theo Jude Brennan-Hulme, died March 2019, aged 21, University of East Anglia.

Mark and Becky Winfield
Parents of Jos Winfield, died June 2023, aged 21, Brunel University London.

Andrew and Valerie Hayter
Parents of Alex Hayter, died September 2020, aged 21, Nottingham Trent University.

Hilary Mullen
Mother of Carl Mullen, died April 2018, aged 20, University of Nottingham.

Iain Thacker
Father of Ceara Thacker, died May 2018, aged 19, University of Liverpool.

Rupert and Alice Armstrong Evans
Parents of Harry Armstrong Evans, died June 2021, aged 21, University of Exeter.

Nic Hart
Father of Averil Hart, died December 2012, aged 19, University of East Anglia.

Hilary Grime
Mother of Phoebe Grime, died June 2021, aged 20, Newcastle University.

Amar and Sonia Abraham
Parents of Anugrah Abraham, died March 2023, aged 21, Leeds Trinity University.

Kirstie Pelling and Stuart Wickes
Parents of Matthew Wickes, died June 2022, aged 21, University of Southampton.

APPENDIX 1

National Review of Higher Education Student Suicides

Higher Education Mental Health Implementation Task Force

September 2023

Department for Education

National Review of Higher Education Student Suicides

Introduction

Each student death is a tragic loss. Where a student dies by suicide or attempts to take their own life, UUK guidance is explicit that HEPs should examine the relevant context and interactions with the institution, fellow students, relatives and staff in partner organisations (e.g. NHS services). This internal review should evaluate whether changes to policies, procedures, or processes could be made to reduce future suicides.

There is potentially huge benefit in HEPs learning the collective lessons from these reviews. To this end, Robert Halfon has announced the commissioning of an independent organisation to conduct a national analysis of these local reviews of serious incidents. HEPs will be expected to submit their reviews as part of this initiative. This will enable the publication of an anonymous meta-analysis of student suicides and near-misses, focusing on lessons learnt and areas for improvement. Unlike other work strands, this is an area where relative size or capacity of an HEP regulated by the Office for Students does not suggest an alternative approach should be pursued.

Taskforce Objective

- To enable broad lessons around addressing serious mental illness and preventing suicide in HEPs to be shared more widely across the sector such that HEPs can enhance processes and policies.
- To encourage HEPs to engage with the current Postvention Guidance, including submission of internal reviews for external analysis, and discuss with the selected provider any further developments of the current suicide review template that good practice in other sectors may suggest.
- To ensure there is a robust method of collecting data on student suicides.

Proposed Work Programme

- Consultation (July-November)
    - To start consultation with IHE, AoC, GuildHE and UUK on the methods for and safeguards around submission of internal reviews for analysis.
    - To consider any specific approaches that will support smaller HEPs and FECs.

Published September 2023

- Notification (November-May)
    - To notify HEPs of the agreed process to submit a review to the national organisation.
    - To work with the selected provider to identify any developments to the existing template for HEPs when reviewing a suspected suicide or near-miss.
    - To consider progress towards a robust data collection approach.

A procurement process is currently taking place and these timescales may be subject to change.

This will determine when the independent organisation can commence work and when it will publish its report. Only student suicides and near-misses occurring in the 2023/24 academic year will be reviewed in the first instance but the report will consider how and whether lessons have been learnt from historic cases.

Under the direction of HEMHIT, a sub-group of relevant colleagues and organisations may be formed to oversee the consultation and develop the review template.


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