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Department for Education

National review of higher education student suicide deaths

National Confidential Inquiry into Suicide and Safety in Mental Health

2025

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We would like to thank the HE providers who participated in the national review and Universities UK (UUK), Guild HE, Independent HE and the Association of Colleges for their assistance with engagement. We are also grateful for the invaluable testimony of bereaved families, and for the Department of Education's and our expert advisory group's important contributions to our work. Our thanks also for the time and input contributed from sector-specific charities.

We are aware that the content of this report, which includes some detail of methods of death, may be distressing for some readers.

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Summary

Why did we carry out the national review?

The incidence of student suicide has increased per year since 2009/10 and rose to over 90 deaths per year prior to the COVID-19 pandemic. Although there has been a subsequent fall it is not known whether this represents a sustained changed or whether the upward trend will continue.

This national review of higher education student suicide deaths (and incidents of non-fatal self-harm) was commissioned by the Department for Education. We examined serious incident reports of suspected suicide deaths and incidents of non-fatal self-harm submitted by HE providers for the academic year 2023 to 2024. The main aim of the national review was to promote learning from these incidents to help prevent future deaths. Specifically, we aimed to:

- collate key findings identified within serious incident reports of suspected suicide (and non-fatal self-harm) in higher education students
- assess the quality of serious incident reports against sector-wide and NCISH guidance for investigating serious incidents
- identify (i) examples of good practice within the HE sector and (ii) areas needing improvement.

What did we do?

We worked with nominated contacts at all institutions registered in England offering higher education courses directly to students to provide information on whether their organisation had completed or planned to complete a serious incident investigation into a suspected suicide death or an incident of non-fatal self-harm in the 2023 to 2024 academic year.

If a serious incident investigation had been conducted (or was planned), we asked that the redacted final report be submitted to the national review. We also collated supplementary information from historical cases, including prevention of future death (PFD) reports, previous serious incident reports, and the testimony of bereaved families.

What are the key findings?

Sector-wide engagement

- We have found an excellent response from universities to this national review. On such a sensitive issue, this is a welcome sign for future prevention. Our evidence suggests also that the UUK/PAPYRUS/Samaritans guidance on investigating serious incidents, particularly incidents of suspected suicide, has been well received.

- We were informed of 107 suspected suicide deaths (i.e., deaths not yet confirmed as suicide by a coroner) and 62 incidents of non-fatal self-harm in higher education students during the 2023 to 2024 academic year. A total of 169 incidents from 73 HE providers. Serious incident reports were submitted for 104 (62%) of these, 79 (74%) reports of suspected suicide and 25 (40%) reports of incidents of non-fatal self-harm. This is the largest national study of detailed individual-level data of suicide in higher education students.

Student characteristics

- Almost three-quarters (60, 73%) of students were undergraduates; of these over a quarter (23, 27%) were in their first year of undergraduate studies.

- International students accounted for almost a quarter (21, 24%) of all submitted reports.

- Most (87, 83%) students were actively studying at the time of the incident; 13% (n=14) had interrupted their studies or withdrawn from university.

- A third (33, 32%) of reports identified evidence of non-attendance. The most common response to non-attendance was an email to the student from the programme administrator or course team.

- 70% (n=73) of reports referred to students who were known to university support services, most often wellbeing services. The support they received is an important indication of the problems they were facing, e.g., mental ill-health, financial problems, harassment.

- The most common method of suicide (where known) was hanging (10, 37%); most incidents of non-fatal self-harm (where known) were by self-poisoning (15, 60%).

- 23% (where known, n=15) of suspected suicide deaths or incidents of non-fatal self-harm occurred in university-managed accommodation. 3% (n=3) occurred on campus (but not in or not known if in student accommodation).

Key findings identified within serious incident reports

- Almost half (49, 47%) of reports identified mental health difficulties as a potential factor prior to the incident, and almost a third (32, 31%) of students had a mental health diagnosis, mainly depression and anxiety disorders (21, 20%). Almost a third (31, 30%) of reports described a diagnosis, or suspected diagnosis, of neurodiversity.
- 17% (n=17) of students had expressed suicidal ideation or intent at some time. 22% (n=23) had a known history of self-harm.
- Academic problems were often referred to in the reports (39, 38%), 10% (n=10) related to exams or exam results. A fifth (21, 20%) of students were, or had been, part of support to study procedures. The number of students subject to conduct or disciplinary procedures was small (less than three).
- 13% (n=13) of students were reported to have been victims of violence, including sexual or physical assault, harassment or threats of violence. Five victims of violence were female and five were male, in three the gender of the student was not reported.
- 12% (n=12) had reported social isolation.
- Many students had experienced adverse life events prior to the incident, including relationship problems (16, 15%), problems with housing (11, 11%), family relationships (11, 11%), peers (10, 10%), or finance (10, 10%).
- Six (6%) reports indicated potential suicide clusters due to proximity in time, place, or both, though no direct connection was identified between the students.
- Over two-thirds (53, 67%) of reports of suspected suicide detailed how the university responded to the death (postvention). Postvention support was most often offered to fellow students (32, 41%). There was less evidence for postvention support for staff impacted by the death (14, 18%) or for the student's family (7, 9%).

Learning identified within serious incident reports

- We found most reports identified points of learning to reduce the risk of further incidents. This learning centred around:
  - access to support
  - information sharing and communication (both internally within the HE institution and with the student, and other external agencies)
- risk recognition and management
- improving information systems, including the monitoring of attendance and engagement, record keeping and identifying vulnerable students
- pastoral support
- training and guidance for staff
- confidentiality and access to information about students.

Additional sources of information

- We found supplementary information from prevention of future death (PFD) reports, previous serious incident reports, and the testimony of bereaved families, identified similar stressors and themes to those listed above, indicating continuing risk from established causal factors. Families we spoke to provided moving accounts of feeling excluded from the process of finding out what happened to their loved ones, and some had a perception that the university was evasive and reluctant to answer important and painful questions.

- These additional sources also raised concern about stressors not identified in serious incident reports, including social ostracism by other students.

Extent to which serious incident reports followed UUK/PAPYRUS/ Samaritans guidance

- We found most serious incident reports were broadly in line with the underlying principles of the guidance on carrying out a serious incident review, though not with all parts. Most included points of learning and plans for follow-up actions. In most (57, 72%) reports into suspected suicide it was clear the family of the student were contacted by the HE provider in the days following the student's death to offer condolences and practical and emotional support.

- A crucial omission was the absence of family involvement in the serious incident review process; in three quarters (79, 76%) of all reports reviewed the family were not involved in any aspect of the investigation process.

- It was difficult for this national review to establish to what extent serious incident investigations were led by independent, senior members of staff. 13% (n=14) of reports explicitly stated that the lead reviewer had no prior involvement or knowledge of the student.

- The gathering of information did not generally extend to records and contributions from other agencies, such as primary care, secondary mental health care, and the criminal justice system. This was true even where the HE provider was aware that these agencies had played a critical role in the student's care.

- Almost a third (32, 31%) of reports included chronologies that began when the student enrolled at the HE provider and ended at the time of the incident. However, in other reports there were gaps in the chronology, variations in the timeline under investigation, and a lack of clarity on the period covered by the review process.

- Over three-quarters (82, 79%) of all serious incident reports identified learning to prevent the risk of recurrence of future incidents, with almost 300 recommendations in total.

- We found evidence for the consistent development of clear action plans, with over half (55, 53%) of reports identifying actions to be taken to reduce the risk of future incidents. However, attaching clear owners and timescales for delivery to agreed actions was less consistent.

- Many of the reports we reviewed appeared to have been written for internal purposes and referred to HE provider systems and structures, using associated acronyms. This suggests the reports were not intended for onward sharing.

Our recommendations

Our recommendations centre around (1) safety concerns, (2) suicide prevention within university systems, (3) amendments to the UUK/PAPYRUS/Samaritans guidance, and (4) safety messages for the wider system. Many support the work of other organisations, including the Higher Education Mental Health Implementation Taskforce, and build on changes HE providers may have already made. For added value they should be read alongside:

- The Taskforce's forthcoming Competency Framework
- The Taskforce's statement on Compassionate Communication in Higher Education
- Collective responsibility, collective action to prevent student suicide - guidance for the HE sector to reduce risk and restrict access to means of student suicide
- The Taskforce's ongoing work on promoting the identification of students at risk and case management approaches to coordinated support
- Suicide-Safer Universities: sharing information with trusted contacts
- Sharing information to support student wellbeing and safety
- The University Mental Health Charter Framework

Safety concerns

1. **Mental health awareness** and **suicide prevention training** should be available for **all staff** in student-facing roles and consideration given to mandatory training for all student-facing staff on identifying, raising and escalating concerns about a student.

2. This training should include areas highlighted in this report including **recognising and responding to risk** and **neurodiversity.**

3. Students who are **struggling academically** should be recognised as potentially at risk, with an enhanced focus on providing a **supportive response**.

4. **Awareness of support** at key points in the academic calendar should be increased, including exam times.

5. The **safety of university-managed accommodation** should be reviewed, including physical safety, high-risk locations, the criteria for welfare checks, and signposting for support, particularly out-of-hours.

6. **Suicide prevention activities** should be **enhanced** after a single death on the grounds that any suicide has the potential to lead to a **cluster**. Policies to respond to the aftermath of a suicide death should be reviewed to ensure they are in line with Public Health England guidance.

7. When a suicide takes place on or near the campus, universities should **review the safety of the location**, e.g., accessibility, and consider discouraging the placing of tributes to avoid drawing attention to the site as a suicide location.

8. Anyone affected by a student's death by suicide should be **offered or signposted to appropriate support**.

Suicide prevention within university systems

9. **Access to mental health and other support** should be reviewed, particularly for those at additional risk (e.g., students with problems with finance, accommodation, relationships, or who have been victims of violence or abuse) or likely to experience problems of access.

10. **Information sharing** internally and externally, including best practice in the use of IT systems, should be reviewed with a view to **encouraging** routine information sharing information, e.g., between academic and non-academic staff.

11. Universities should **review** how well **confidentiality arrangements** are working under recent UUK/PAPYRUS guidance on information sharing and guidance on sharing information with accommodation providers.

UUK/PAPYRUS/Samaritans guidance

12. **Input from bereaved families** should be a key part of the serious incident investigation process, and their questions should be answered as far as possible. This would allow HE providers to look for learning beyond the institutional response, including at the events and stressors students face.

13. A decision about the appropriate level of **independence** should be part of the initial setting up of an investigation, with consideration given to the perceptions of a bereaved family or the wider public, while serious incident reports should routinely record the degree of independence of the reviewer(s), recognising that this may vary according to circumstances of the death and practical considerations.

14. The serious incident review process should be granted sufficient status within an HE provider, ensuring it is conducted by people with the right skills and level of independence, who have the relevant training, experience and knowledge, as well as an **understanding suicide risks** specific to young people.

15. There should be an addition to the UUK/PAPYRUS/Samaritans guidance that all reports be **signed-off** by a member of the senior leadership team/senior executive board to demonstrate institutional acceptance of the recommendations, and a **commitment to implementation**. Identified actions should be reviewed biannually/annually to ensure they have been embedded and concerns have been addressed and if not, what further actions is required.

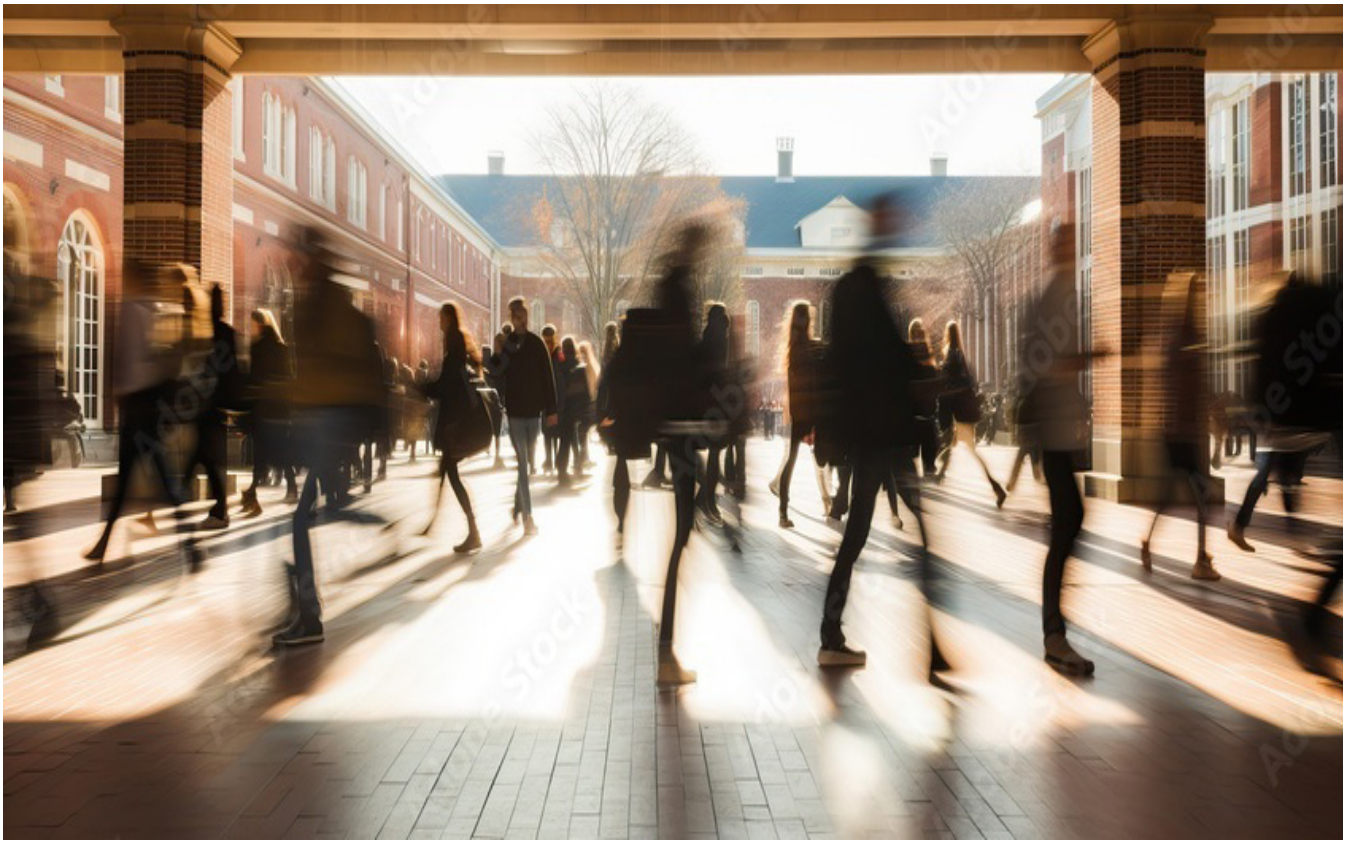
16. A **supplement to the guidance** in relation to investigating the most serious incidents of **self-harm** should include (a) eligibility for investigation, and (b) involvement of the student who self-harmed, including an offer of support.

Safety messages for the wider system

17. A **duty of candour** should be introduced to the HE sector, setting out organisational responsibilities to be **open and transparent with families** after a suspected suicide. It would include a duty to provide information on what happened, at the earliest point. It should be developed and shaped by the sector itself to ensure it is appropriate to the HE setting.

18. A **collaborative forum** should be established for **sharing of statistical data** relevant to the prevention of student suicide nationally.

19. This **national review** of higher education student suicide deaths should be established as a **long-term initiative**, across the UK. It should explore the inclusion of other providers (i.e., Further Education colleges) and include more precise guidance on the inclusion of the most serious incidents of non-fatal self-harm. Such an initiative would also allow for the monitoring of progress within the HE sector against the recommendations in this report, to ensure learning is occurring.



Introduction

In 2023, the Department for Education commissioned experts in suicide and self-harm prevention from the National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH), to conduct an independent national review of student suicide deaths (and incidents of non-fatal self-harm). The focus of the review was incidents that occurred during the 2023 to 2024 academic year, for which HE providers had conducted a serious incident investigation, in line with guidance published by Universities UK (UUK)/PAPYRUS/Samaritans (2022) or by other relevant guidance or frameworks. Our purpose was not to re-investigate student suicide deaths but to collate learning and evaluate serious incident reports against sector-wide guidance. Although the focus of the national review is HE providers in England, it is hoped the recommendations will also be relevant across the UK.

The main aim of the national review is to promote learning from these incidents and identify broad lessons around mental ill-health and suicide in higher education students to help prevent future deaths. The review was also designed to assess the quality of serious incident reports against sector-wide guidance published by UUK/PAPYRUS/Samaritans (2022). Submitted reports were assessed for information on factors such as pre-existing mental ill-health, the role of academic and non-academic factors, and the content and availability of mental health support. Reports were examined for evidence of good practice as well as areas for improvement.

It is important to stress that the figures and graphs in this report relate to real, often young, lives lost, and families devastated. The serious incident reports we examined are individual tragedies and demonstrate the need to improve prevention.

Background

Suicide is the leading cause of death in adolescents and young adults and suicide rates have increased over the last decade, particularly in women and girls under 25 (Office for National Statistics (ONS), 2024). Figures for mental ill-health (Lewis and Stiebahl, 2024) and suicide (ONS, 2018) among higher education students also rose during this time. Although the most recent figures are lower (ONS, 2022), this could be explained by delays to coroner inquests because of the early COVID-19 pandemic. It is not yet known whether the most recent lower figures represent a sustained change or whether the upward trend will resume.

Official statistics suggest that the suicide rate for higher education students is lower compared with the general population of the same age (Gunnell et al., 2020; ONS, 2022). However, the incidence of student suicide per year has increased since 2009/10 (Gunnell et al., 2020) and rose to over 90 deaths per year prior to the COVID-19 pandemic, with a subsequent fall. The unique risks and challenges associated with the transition into higher education highlight a need to offer dedicated mental health support and be vigilant about suicide risk. Social isolation, moving away from home, increased autonomy, alcohol and/or drug misuse, exam pressures, problems with studying or employment, financial problems, experiencing sexual violence, and in recent years the lasting effect of the COVID-19 pandemic have been reported as possible factors exacerbating mental health problems and increasing self-harm and suicide risk in students (Cleary et al, 2011; Gunnell et al., 2020; Lewis and Stiebahl, 2024; NCISH, 2018; NCISH, 2024; Office for Students, 2022; Steele et al., 2021).

The University Mental Health Charter Framework (Hughes and Spanner, 2018) provides a set of evidence-based principles of good practice to support universities to embed a whole-university approach to mental health and wellbeing in both students and staff, in line with UUK/PAPYRUS guidance on "Suicide Safer Universities" (2018). Strengthening links between universities and NHS services may prevent suicide in students, by promoting mental health in university settings and ensuring availability of support, especially at times of risk such as exam months (Clements et al., 2023; NCISH, 2018; NCISH, 2024; John et al., 2024). The Higher Education Mental Health Implementation Taskforce ("the Taskforce") was established in 2023 to promote the development and adoption of good practice in the HE sector to ultimately improve the mental health and wellbeing of students. The Taskforce has focused on four areas (i) supporting adoption of good practice, (ii) identification of students at risk, (iii) developing a HE Student Commitment, and (iv) a national review of higher education student suicide deaths.

The main aim of the national review is to promote learning from these incidents and identify broad lessons around mental ill-health and suicide in higher education students to help prevent future deaths. This is the largest national study to conduct a detailed examination of individual factors related to suicide in higher education students.

The National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) was commissioned by the Department for Education to conduct an independent national review of higher education student suicide deaths (and incidents of non-fatal self-harm) for the academic year 2023 to 2024, by examining serious incident reports submitted by HE providers.

How we carried out the national review

Overview

All institutions registered in England offering higher education courses directly to students (including universities, colleges, professional schools, and institutes of technology) were informed of the national review in January 2024 by the former Minister for Skills, Apprenticeships and Higher Education. In this initial contact, HE providers (including members of Universities UK (UUK), Guild HE, Independent HE (IHE) and the Association of Colleges (AOC)) were asked to nominate a lead contact within their organisation who would engage with NCISH directly regarding the national review. Further information and guidance were provided to UUK members at an engagement event held with NCISH in February 2024 and by email to Guild HE, IHE and AOC members. Data collection then took the following stages:

1. All nominated contacts were asked to provide information on whether their organisation had (a) completed or planned to complete a serious incident investigation into a suspected suicide death or an incident of non-fatal self-harm in the 2023 to 2024 academic year or (b) had no incidents to report.

2. If a serious incident investigation had been conducted (or was planned), HE providers were asked to submit the redacted final serious incident report to the national review without waiting for the coroner investigation or inquest.

3. Submitted serious incident reports were reviewed by senior NCISH researchers who (a) collated key findings identified within serious reports as potentially relevant to suicide and self-harm in higher education students, (b) assessed their quality against existing UUK guidance, and (c) identified lessons for the HE sector around good practice and areas for improvement in suicide prevention for students. This information was extracted using a proforma developed in collaboration with an expert advisory group.

It is important to note that the data presented in this report are not official statistics of confirmed suicide deaths in the HE sector. Our findings are based on suspected suicide deaths notified to us by HE providers. The most recent official statistics on suicide among higher education students have been published by the Office for National Statistics (ONS, 2022).

Aims of the national review

- Collate key findings identified within serious incident reports of suspected suicide (and non-fatal self-harm) in higher education students
- Assess the quality of serious incident reports against sector-wide and NCISH guidance for investigating serious incidents
- Identify (i) examples of good practice within the HE sector and (ii) areas needing improvement.

Review structure

The review consisted of three parts:

1. A thematic analysis of all submitted serious incident reports. We collated the key findings identified in serious incident reports and examined the reports for evidence of good practice and areas needing improvement within the HE sector. We reviewed the documents under three broad headings:
   - student characteristics, including demographic characteristics, details of study (i.e., course, fee status, year of study etc.), and method of suicide and self-harm
   - structure of the report, including key findings identified within the report
   - the HE provider's response in terms of the care and support provided to the student before the incident occurred.

2. A review of the quality of the reports against existing sector-wide guidance, including if and how the guidance could be improved. To do this we referred to the UUK/PAPYRUS/Samaritans guidance for carrying out a serious incident review, our own standards for investigating serious incidents in the NHS (modified for the HE sector; Appendix 3), and other agreed areas of focus. We also considered whether the UUK template can detect individual risk factors for suicide in higher education students, and its applicability to Further Education Colleges and small/specialist HE providers.

3. The examination of any relevant supplementary information sent to us from historical cases. Although this was not part of our core data collection, we also collated the key findings from serious incident reports from the 2022 to 2023 academic year, searched for prevention of future deaths (PFD) reports, and considered the testimony of bereaved families.

Our purpose was not to re-investigate the incidents of suspected suicide (or non-fatal self-harm). It was to draw out the safety lessons from the serious incident reports as well as collate the key findings they identified.

The members of the independent national review at NCISH were: Dr Cathryn Rodway (CR), Programme Manager and Research Fellow; Ms Su-Gwan Tham (SGT), Research Associate; Dr Pauline Turnbull (PT), Project Director & Academic Lead; Professor Nav Kapur (NK), Director, and Professor Louis Appleby (LA), Director. CR, who has over 20 years' experience in mental health and suicide prevention research, led the review. CR and SGT reviewed the serious incident reports against a specifically developed, structured proforma. CR, LA, PT and NK reviewed the findings and determined the recommendations and prevention measures, which were commented on by a wider expert advisory group (see Appendix 4).

Eligibility

Serious incident reports completed by HE providers were considered for inclusion in the national review if they met the following criteria:

- The report was conducted by a HE provider registered in England. International students and home students from Scotland, Northern Ireland and Wales were included if they attended an institution in England. The report investigated an incident of suspected suicide or an incident of non-fatal self-harm (see definitions in Appendix 1, page 47). HE providers determined whether an investigation was appropriate in relation to incidents of non-fatal self-harm. We reviewed all reports that HE providers submitted to the national review.
- The incident occurred during the 2023 to 2024 academic year (1 August 2023 to 31 July 2024).
- The student was in higher (not further) education. Recent graduates within six months of finishing their studies were also included.

Reports could be in any format (most were PDFs/Word documents) and did not have to follow the UUK/PAPYRUS/Samaritans postvention guidance and template. We also accepted serious incident reports and testimony outside these criteria, if considered relevant to the national review, such as historical reviews outside the 2023 to 2024 academic year, and feedback from HE providers on the serious incident review process.

Analysis

Information was extracted from serious incident reports into a proforma. We analysed reports related to suspected suicide or non-fatal self-harm separately and found no notable differences. Therefore we present combined findings for suspected suicide and non-fatal self-harm, with the exception of findings on method, postvention support and suicide clusters. Findings are presented as numbers and percentages. Currently, higher education student population figures for the academic year 2023 to 2024 are not available. To calculate the rate of suspected suicide deaths in higher education students we used regression analysis and linear prediction estimates based on the previous five years of student population data to project student population estimates for the academic year 2023 to 2024 (Higher Education Statistics Agency (HESA), 2024). We applied ONS guidance on disclosure control to protect confidentiality, and suppressed low numbers under three, including zero.

What we found

Sector engagement

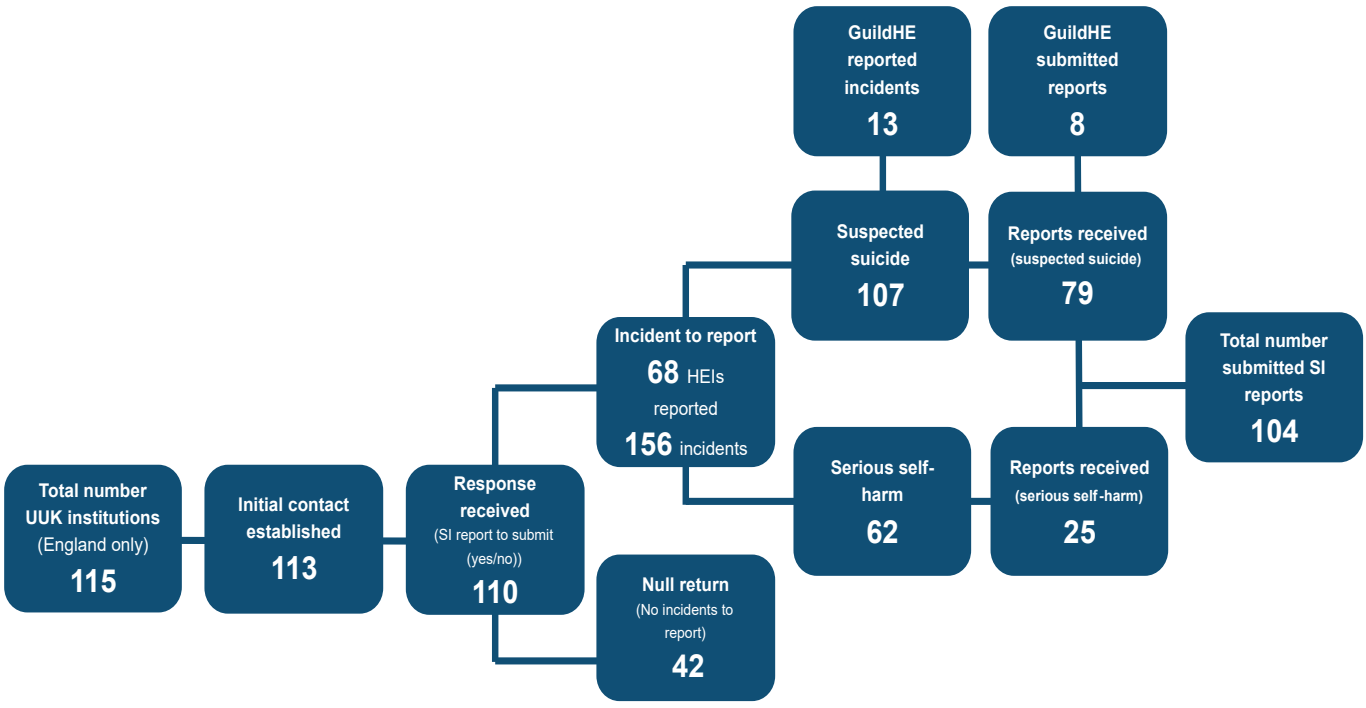
All HE providers registered in England were asked to participate in the national review. Participation was not mandatory.

Figure 1 details the level of engagement from UUK members in the national review. Guild HE, IHE, and AOC were also approached to participate. As UUK universities represent 96% of all HE students in the UK (UUK, 2024), our expectation was that engagement from Guild HE, IHE and AOC would be lower due to the comparatively smaller size of the higher education student population that they represent.

Of the 115 UUK universities, 113 (98%) provided a nominated contact and 110 (96%) responded with information on the number of serious incidents that had occurred in the 2023 to 2024 academic year. For three (3%) although initial contact was established, there was no further engagement. This may be because they had no suspected suicides or incidents of non-fatal self-harm to report, but this is unconfirmed. Overall, 68 (59%) UUK universities informed us of at least one serious incident; 42 (37%) reported no serious incidents (a null return). In total, we were informed of 156 serious incidents for the 2023 to 2024 academic year – 106 suspected suicide deaths and 50 incidents of non-fatal self-harm. Thirty-five (30%) UUK universities reported one suspected suicide or incident of non-fatal self-harm in the 2023 to 2024 academic year. Thirty-three (29%) reported more than one, with six reporting incidents of both suspected suicide and non-fatal self-harm.

Nominated contacts were provided by 54 Guild HE, IHE or AOC members. Of these, five informed us that at least one serious incident had occurred in the 2023 to 2024 academic year – reporting 13 suspected suicide deaths or incidents of non-fatal self-harm overall. Thirty-four reported a null return.

Figure 1: Universities UK (UUK) member engagement with this national review



Overall, we were informed of 107 suspected suicide deaths and 62 incidents of non-fatal self-harm in higher education students during the 2023 to 2024 academic year, a total of 169 incidents. The number of incidents of non-fatal self-harm is likely to be under-reported.

These figures correspond to an estimated prevalence in the 2023 to 2024 academic year of 3.5 (95% confidence interval: 2.9-4.2) suspected suicide deaths per 100,000 higher education students in England; taking into account differences in definition and time period, this is broadly comparable to the rate of 3.0 deaths per 100,000 students based on ONS data (ONS, 2022), and may be lower than 3.5 once coronial decisions about cause of death are made.

Serious incident reports submitted

Of the 169 suspected suicide deaths and incidents of non-fatal self-harm notified to us, 104 (62%) serious incident reports were submitted for review - 79 suspected suicide deaths and 25 incidents of non-fatal self-harm. Over half (57, 55%) were from the largest HE providers (by enrolment)[1] with a student population of over 20,000. There was no apparent difference in the number of submitted reports between HE provider regions. There were 65 serious incidents where no serious incident report was submitted within the study timeline[2]. The reasons for non-submission are shown in Table 1. The remainder of this report is based on the 104 serious incident reports that were submitted and reviewed.

Eight of the 104 serious incident reports were submitted by Guild HE members. These reports are included in our analysis, although we acknowledge the current UUK/PAPYRUS/Samaritans postvention guidance and template is less likely to have been followed by non-UUK HE providers when carrying out a serious incident review.

In 10 (13%) serious incident reports of suspected suicide, we were informed of the outcome of the coroner inquest – eight received a suicide conclusion. The two that did not receive a suicide conclusion remain included in our analysis.

Table 1: Reasons for non-submission to the national review

	Number = 65
No formal serious incident investigation conducted	24 (37%)
Serious incident report not finalised or signed-off	5 (8%)
Ongoing legal proceedings, or unwilling to submit before the coroner inquest had concluded or without the family's consent	6 (9%)
Report expected but not submitted before data collection closed	24 (37%)
Not known	6 (9%)

1. HE provider size is based on HE student enrolment data for the 2022 to 2023 academic year (HESA, 2024).
2. HE providers were asked to submit their serious incident report to the national review within three months of the incident, on the basis that this would enable sufficient time to conduct their investigation and produce a report. This would have taken some reports (i.e., those investigating incidents that occurred at the end of the 2023 to 2024 academic year) beyond the end of our data collection period (31 October 2024).

In addition, we received eight reports that related to incidents occurring in the 2022 to 2023 academic year. We collated the key findings identified in these reports, but did not review them for the extent to which they followed the UUK/PAPYRUS/Samaritans guidance, due to the timing in relation to the publication of the guidance (December 2023).

One hundred and four serious incident reports were submitted to the national review within the data collection timeline, 79 reports of suspected suicide and 25 reports of incidents of non-fatal self-harm in higher education students during the 2023 to 2024 academic year.

Student characteristics

The demographic characteristics and details of study sections below are based on the 104 submitted serious incident reports plus a further ten serious incidents (three suspected suicide deaths and seven incidents of non-fatal self-harm) where summary data on the student was submitted in the absence of a serious incident report. A total of 114. The remaining sections are based on a total of 104 submitted serious incident reports.

Demographic characteristics

The student's ethnicity was rarely reported. Ethnicity often reveals inequalities in suicide and suicide prevention.

Demographic characteristics are outlined in Table 2, with national data (where available) for comparison (HESA, 2024). This information was missing in many of the submitted reports; ethnicity was unknown for 90% of students, age for 75%, and gender for 10%. Men accounted for around three-quarters (52, 71%) of suspected suicide deaths, consistent with what we know about suicide in the general population (ONS, 2024). Five students identified as being part of the lesbian, gay, bisexual or transgender community, although information on sexual orientation and gender identity were not often provided (90%). In ten of the eleven serious incident reports where the ethnicity of the student was reported, the student was an international student, mostly of Chinese origin (n=8).

Table 2: Demographic characteristics

	Serious incidents (n = 114)	HESA (2022/23 AY)[3]
Aged under 20 years	7/29 (24%)	24%
20 to 24 years	15/29 (52%)	40%
25 to 29 years	3/29 (10%)	13%
30 years and over	4/29 (14%)	23%
Male	70/103 (68%)	43%
Female	31/103 (30%)	57%
Mature student	12/42 (29%)	56%

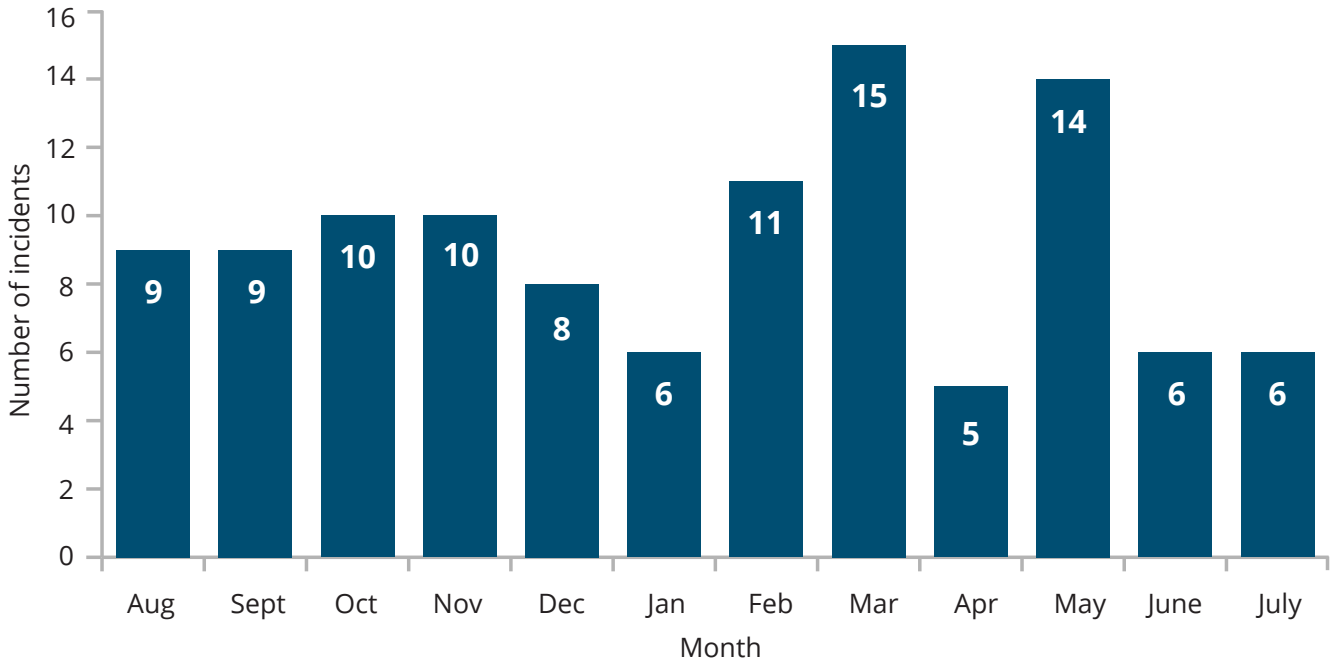
AY = academic year

3. Comparison data is from HESA, where the latest available data is for the 2022 to 2023 academic year.

Figure 2 shows the number of suspected suicides and incidents of non-fatal self-harm by month of occurrence. There were peaks in the number of serious incidents in March and May, coinciding with the assessment and exam period. The lowest numbers were in April, January, June and July, coinciding with the Easter break and the end of the academic year. Forty (36%) incidents were identified as occurring at a time of stress for the student, this included impending or missed assignment deadlines (n=11), the beginning of a new term or placement (n=11), exams (including resits, n=8), impending or recent exam or assignment results (n=5), or other issues (e.g., financial, personal; n=11).

The highest number of incidents were in March and May, the lowest in April.

Figure 2: Month of incident[4]



Details of study

Most (73%) students were undergraduates, over a fifth (22%) were postgraduates (Table 3). Over a quarter (27%) were in their first year of undergraduate studies, with the majority (73%) in other years. Almost a quarter (24%) were international students. Most (83%) students were actively studying at the time of the incident, although 13% had interrupted their studies or withdrawn from university. This was because of (mental) health concerns (n=6), or because of non- attendance, disengagement or misconduct (n=4). Nine students were on placement at the time of the incident.

Around one in four students were in their first year of undergraduate studies, one in five were international students and one in ten students had interrupted or withdrawn from their studies.

4. The month the incident occurred was not available in five serious incident reports.

Table 3: Details of study

	Serious incidents (n = 114)	HESA (2022/23 AY)
STEM course	26/66 (39%)	45%
Level of study: Foundation	4/82 (5%)	1%
Level of study: Undergraduate	60/82 (73%)	65%
Level of study: Postgraduate	18/82 (22%)	30%
Year of study: First year undergraduate	23/84 (27%)	--
Year of study: Other years	61/84 (73%)	--
Fee status: Home	66/87 (76%)	74%
Fee status: International	21/87 (24%)	26%
Status: Active	87/105 (83%)	--
Status: Interrupted	11/105 (10%)	--
Status: Withdrawn	3/105 (3%)	--
Status: Graduate	4/105 (4%)	--
On placement at time of incident	9/87 (10%)	--

AY = academic year

Non-attendance and/or non-engagement

Thirty-three (32%) serious incident reports identified evidence of academic non-attendance and/or non-engagement. In 26, there was information available on the HE provider's response. Most often (n=13), an attendance monitoring process was triggered, such as an email (sometimes automated), with an offer of support from programme administrators or the course team. Six students were contacted by and then discussed their non-attendance with a personal tutor or the programme team, which included signposting and referral to wellbeing support. In the remaining seven, the student's non-attendance did not meet the threshold to trigger engagement concerns or alerts. Ten (28%) of these 36 reports identified learning around monitoring student engagement and non-attendance.

A third of reports identified evidence of non-attendance in higher education students. The most common response was an email to the student from the programme administrator or course team.

Mitigating circumstances

Most (87, 84%) reports provided information on whether the student had made a request for mitigating circumstances affecting their studies. There were 32 (31%) students who had made such a request prior to the incident for personal reasons, anxiety about academic pressures and mental health concerns. Most (25, 24%) mitigating circumstances requests had been accepted; in the remaining seven this information was not detailed in the report. Fourteen (13%) reports identified evidence of both non-attendance and requests for mitigating circumstances.

> Almost a third of reports identified students who had made requests for mitigating circumstances affecting their studies. Most (78%) of these requests were known to have been accepted by the HE provider.

Contact with support services

There was information available in 73 (70%) reports of contact (at any time) with university support services prior to the incident[5]. This was most often with Student Wellbeing Services (Table 4). In 36 (35%) reports there was information on the student receiving university support to look after their mental health at the time of the incident. Overall, 26 (25%) were not known to any university support services. In five there was no information in the report on contact with university support services.

Information on whether the student was registered with and under the care of a local GP was available in 41 (39%) reports. In 37 (36%) of these, the student had a local GP. There was information on 19 (18%) students having previously attended A&E, mostly following self-harm (n=15). Five (5%) students had previous contact with the criminal justice system, including as a perpetrator of violence.

Table 4: Contact with university support services

	Contact at any time	Recent contact
Wellbeing/welfare	39 (38%)	16 (15%)
Mental health team/advisor	26 (25%)	12 (12%)
Disability/inclusion	24 (23%)	--
Counselling	16 (15%)	8 (8%)
Residential Life Team	13 (13%)	3 (3%)
Student support (unspecified)	11 (11%)	--
Financial guidance	5 (5%)	--
Campus security	6 (6%)	--
Harassment and violence support	4 (4%)	--
Crisis/out-of-hours/outreach support	4 (4%)	3 (3%)
Other (e.g., Occupational Health)	6 (6%)	--

5. Taking into account differences in methodology and time frame, this is higher (70% vs. 12%) than previous evidence of the proportion of 18-19-year-olds in further or higher education who were in contact with college or university support services prior to their death by suicide (NCISH, 2017).

Almost three-quarters of students were known to university support services prior to the incident. The support they received is an important indication of the problems they were facing, e.g., mental ill-health, financial problems, harassment etc.

Incident details and access to means

The method of suspected suicide or non-fatal self-harm was recorded, respectively, in 27 (34%) and 25 (78%) of the serious incident reports we reviewed. The most common method of suicide (where known) was hanging (10, 37%), followed by self-poisoning (8, 30%). Most incidents of non-fatal self-harm (where known) were by self-poisoning (15, 60%). Of the 23 incidents of self-poisoning overall, four (17%) were with over-the-counter medication (e.g., paracetamol) and three (13%) with medication prescribed to the student. Other methods of suicide and self-harm were rare.

Where known (n=66), 32 (48%) students died (or self-harmed) at their term-time address (i.e., away from home). Of these 32, 15 (23%) occurred in university-managed student accommodation (e.g., Halls of Residence), 11 (17%) in privately rented or privately managed student accommodation, and in six (9%) the report did not specify whether the student's term-time accommodation was university-managed or privately rented. Fourteen (21%) incidents occurred at the students' home address and 17 (27%) in a public place, most frequently parks or woodland (n=6). Three incidents of suicide or self-harm occurred on campus (but not in, or not known if in, student accommodation).

Fifteen incidents of suspected suicide or non-fatal self-harm occurred in university-managed student accommodation.

Nine (9%) reports specified that they did not have or had not requested information on the circumstances of the death or the incident of non-fatal self-harm, though the UUK/PAPYRUS/Samaritans guidance suggests that this be part of the final serious incident report structure. In other reports, there was no reference to the method (54, 52%) or the location (29, 28%), and these were recorded as unknown. This meant information on access to means of suicide was limited.

Area for improvement

Information about the circumstances of the incident should, where possible, be ascertained during the serious incident investigation, and consideration given to access to means, including the safety of university-managed accommodation. Guidance for the HE sector to reduce risk and restrict access to means of suicide was published in September 2024.

Key findings identified within serious incident reports

Ninety-four (90%) of the 104 submitted serious incident reports identified potential stressors and experiences that may have contributed to suicide risk. These factors were recorded if they were referred to as having been present in the student's life at any time. Many are common in young people who die by suicide in the general population (Rodway et al., 2020) and should be the target for prevention.

Suicide and self-harm in higher education students is rarely caused by one thing; it may follow a combination of vulnerabilities, both academic and non-academic.

The findings identified from the serious incident reports are common in young people particularly, most of whom overcome them without serious harm. For some, however, their experiences and the stressors they face are serious and the risks are real.

Mental ill-health, self-harm and suicidal ideas

Mental health difficulties (not necessarily a mental health diagnosis) were identified as a factor in the student's life in 49 (47%) reports. Twenty-three (22%) students had a history of self-harm and 17 (16%) had expressed thoughts of suicide.

Thirty-two (31%) serious incident reports described the student as having a diagnosed mental health condition, most commonly depression and anxiety disorders (21, 20%). Five students had a diagnosed eating disorder, three had been given a diagnosis of personality disorder, and three of post-traumatic stress disorder. In 18 (17%) reports reference was made to these conditions being disclosed pre-entry/upon entry to university either on the student's UCAS application form or upon registration. In 13 of these 18 reports, there was reference to the HE provider responding to these disclosures by putting in place adjustments (e.g., learning support/inclusion plans, arranging disabled student allowance, reasonable adjustments), assessing the student for further support, or offering support, which the student did not respond to. However, learning was also identified relating to learning contracts being delayed or not being issued when they should have been.

Good practice

Most mental health conditions which were disclosed pre-entry or upon registration were responded to and adjustments and/or support put in place.

Academic problems

Thirty-nine (38%) students were experiencing academic problems or pressures – for a minority (n=10) these were exam-related. Other problems included anxiety about falling behind or upcoming deadlines or perceived pressure to perform well by self or others (n=19), poor attendance/non-engagement or missed deadlines (n=8), being unhappy with a course or teaching staff (n=5), and misconduct charges (n=3). Eight had experienced problems related to a placement. Twenty-one (20%) students were, or had been, part of support to study procedures. The number of students subject to conduct or disciplinary procedures was small (less than three), although learning about better academic misconduct support for students was identified.

Neurodiversity

Thirty-one (30%) reports described a diagnosis of, or suspected, neurodiversity, including attention deficit hyperactivity disorder (ADHD; n=18), autism spectrum disorder (n=9), or dyslexia (n=7). Of these, 14 described reasonable adjustments or support/inclusion plans tailored to the needs of the student. Twelve (12%) neurodivergent students also had a mental health diagnosis.

Relationship problems, including breakup

Sixteen (15%) students had experienced relationship problems, including the breakdown of a relationship (n=7).

Victim of violence, harassment or threats of violence

Thirteen (13%) students were reported to have been victims of violence, including sexual (n=8) or physical assault (n=3), harassment or threats of violence (n=3). Five students had received support from specialist support services for violence or abuse. Five victims of violence were female and five were male – in the remaining three the gender of the student was not available in the report.

Social isolation

Twelve (12%) serious incident reports referred to the student as being socially isolated. This was mainly through the student's own account of feeling isolated or lonely.

Accommodation problems

Eleven (11%) reports referred to the student experiencing accommodation problems, i.e., recent changes or difficulty in securing accommodation, threat of eviction, or issues with a landlord or tenancy agreement. In a small minority (less than three) the problem was in university-managed accommodation.

Family problems

Eleven (11%) students had experienced family problems. These were often unspecified.

Problems with peers

Problems with peers, including friends, housemates, and other students from the same cohort, were reported in 10 (10%) serious incident reports. Problems included falling out with friends and difficulties getting on with housemates. A small number of reports mentioned bullying (n=3), but we found none which specifically referred to social ostracism. It may still have happened but was not identified in the reports we examined.

Financial problems

Ten (10%) students had experienced financial problems. This mainly included receiving or applying for financial support through a hardship fund (n=5). None of the serious incidents we examined referred to gambling.

Alcohol and drugs

Nine (9%) students had a reported history of alcohol and/or drug misuse or increased or excessive alcohol use.

Bereavement

Seven (7%) reports referred to the student having been bereaved, including by suicide. Three students had been bereaved by the death of a family member, and three by the death of a friend.

Physical ill-health

A physical health condition was recorded in seven (7%) reports.

COVID-19 pandemic

Five (5%) reports referred to disruption caused by the COVID-19 pandemic, i.e., starting University during the pandemic, or the impact on teaching, learning, and assessment etc.

Suicide clusters

Twenty (25% of suspected suicide reports) HE providers submitted more than one serious incident report into suspected suicide. These ranged from two (14 HE providers) to between three and five (six HE providers) suspected suicide deaths at a single HE provider during the 2023 to 2024 academic year. We considered whether there was any connection between these individual deaths by examining information (if available) on the location and date of death, age and gender, fee status, the course the student was on, their School within the university, year of study, and related welfare or safety concerns. We found six reports from three HE providers where there may have been evidence for a potential cluster, although the HE provider could not identify a direct connection between the deaths.

Six reports (6%) indicated potential suicide clusters due to proximity in time, place, or both, though no direct connection was identified between the students. Policies to respond to the aftermath of a suicide death should include the prevention of a cluster in line with Public Health England guidance.

Postvention support

In 32 (41%) serious incident reports relating to suspected suicide, there was evidence of postvention support following the death for those who were close to the deceased (i.e., flatmates, students in the same cohort, friends, partners). There was less evidence of postvention support for staff impacted by the death (14, 18%) or for the student's family (7, 9%). In six (8%) reports, postvention support was offered to staff and students via email or verbal signposting to support services. Five serious incident reports identified a need to improve, review or widen their postvention support for staff and/or students. There was less evidence of support for people asked to contribute to the serious incident review process, particularly those whose responsibility it was to conduct/lead the investigation.

Good practice

Postvention support was considered as part of the serious investigation process in over two-thirds (53, 67%) of reports of suspected suicide, particularly for those who were closest to the deceased.

Area for improvement

Postvention support for the student's family and for staff should be improved and/or widened, including for those contributing to the serious incident investigation.

Learning identified within serious incident reports

Most (79%) serious incident reports identified learning to reduce the risk of recurrence or of a similar incident. We collated this learning into the following themes.

Access to support

Thirty-four (33%) reports identified learning around access to student support. This included:

- Improving staff and student awareness of support, including out-of-hours support, specialist support (i.e., for sexual violence or substance misuse), and the provision of support information in languages other than English.
- Signposting students to support following disclosures of poor mental health in extenuating circumstances and related requests.
- Improving and revising processes so there is a move from signposting or providing students with support information to support services or course teams/tutors proactively contacting students known to be struggling or at potential risk (e.g., facing potential disciplinary action), or more actively following-up and identifying students who have missed appointments or not accessed support that was offered.
- Reviewing the level of support for specific groups of students including postgraduate research students, international students, students who have interrupted, and students returning to study after a leave of absence.

Area for improvement

HE providers should be proactive in identifying and responding to student need. We support the Department for Education HE Mental Health Implementation Taskforce's suggestion of a Competency Framework to aid staff to identify and proactively support students at risk.

Information sharing and communication

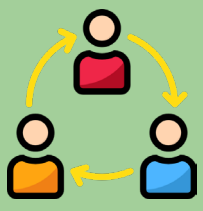
Inadequate information sharing was identified in 24 (23%) reports. This was in relation to internal systems including clinical, pastoral and academic staff, and Schools, Faculties and central support teams (including campus security and residential life teams). This was also identified as an issue between the HE provider and external agencies (e.g., GP, NHS), with reports acknowledging that being informed about a student's mental health may have led to better support, including reasonable adjustments.

Fourteen (13%) reports identified problems with communication both internally within the HE institutions and with the student, and other agencies. Issues identified included:

- Inadequate consideration of communications to the student, for example a reliance on automated emails in relation to non-completion of assessments or misconduct. A recommendation in these reports being to develop or refer to compassionate communication guidance[6].
- Inadequate communication between Schools and support teams, or with external support agencies.
- A need to develop and/or review out-of-hours communication arrangements, for example adjusting email signatures to include support numbers when staff are on leave.

Ten (10%) reports recognised approaches to collaborative working both internally and with other agencies (e.g., NHS, placement providers) needed to be improved to form a more comprehensive understanding of risk.

Good practice example - collaborative working



"Member of staff within Early Intervention Team acted as point of contact between [student] and the University". In this example, the serious incident report details emails, phone calls and updates between the support services of the University and the NHS provider. [HE086]

"The University's own mental health support is augmented by the [name of provider] Student Mental Health Hub. Based on the University's campus, this HS staffed service provides a direct route for students into the full range of NHS mental health services." [HE078, HE079]

6. In November 2024, guidance on compassionate communication in higher education was published.

Risk assessment and management

Fifteen (14%) reports identified learning around risk assessment and management. This included instances where cause for concern or fitness to study procedures had not been appropriately escalated, support services intake/triage procedures had not been comprehensive in considering students presenting with risk to self, and poor staff understanding of how to understand, assess, monitor and mitigate suicide risk.

Area for improvement

Access to means of suicide (e.g., medication, bodies of water, online purchasing, and accommodation safety) was rarely addressed. Only one of the eight reports that referred to access to means recommended addressing this to prevent future deaths. Guidance for the HE sector to reduce risk and restrict access to means of suicide was published in September 2024.

Improving information systems

There were 10 (10%) reports that identified a need to improve IT solutions for identifying students with multiple vulnerabilities and service contacts, or to centralise information on student history and health, including from the UCAS application.

Twelve (12%) serious incident reports identified a need for additional or more robust processes for monitoring student engagement and non-attendance. This included recommendations to review attendance triggers (i.e., the HE provider's criteria for determining when non-attendance or non-engagement has become a concern that, when reached, prompts a process to investigate further), the development of consistent approaches to responding to non-attendance, and earlier intervention when disengagement is identified.

Seven (7%) reports identified problems with record keeping. This included a lack of recording of interactions and missed appointments with Personal Academic Tutors, the inconsistent use of information management systems, and a need for staff development on the importance of updating students' academic and health records.

Pastoral support and training and guidance for staff

Nine (9%) reports identified a need to review pastoral policies and approaches to personal academic tutoring, including ensuring a sufficient scheduling of one-to-one contacts and follow-ups, and additional training for staff in pastoral roles.

Developing and/or reviewing staff (including academic, outreach and residential and security staff) training on student wellbeing, such as identifying signs and symptoms of distress, raising concerns, and signposting students to support were identified in nine (9%) reports. Information on whether academic staff had received mental health or suicide prevention training (or had been provided with guidance on student support) was not available in most of the serious incident reports examined.

Confidentiality

Nine (9%) reports identified a need to review arrangements for contacting parents or other emergency contacts when serious issues or concerns arise. A further five (5%) recognised the need to review the impact of staff restrictions on access to important information about a student, to ensure better staff understanding of the balance between safeguarding and maintaining confidentiality.

Good practice

Some HE providers recognise that restrictions in data sharing due to confidentiality may adversely affect their ability to support a student in need, and have committed to reviewing confidentiality in the context of safeguarding.

The extent to which serious incident reports followed Universities UK/PAPYRUS/Samaritans guidance

We examined how well submitted reports followed the UUK/PAPYRUS/Samaritans postvention guidance and associated template for carrying out a serious incident review (2022). We reviewed the reports against the principles set out in the guidance to support learning to help prevent future incidents (Box 1). These principles broadly aligned with NCISH's 10 standards for investigating serious incidents (Appendix 3).

We found most serious incident reports were in line with the underlying principles of the UUK/PAPYRUS/Samaritans postvention guidance and template to some degree, except for involving families in the serious incident investigation process. Most reports appeared to be based on the guidance or had used it as a "tool" in the investigation process and report structure. One HE provider told us:

"Although we used the UUK guidance as a tool to help guide us through the investigation, it rapidly became quite unwieldy as a document and a redacted version for reporting purposes would be quite hard to follow. We were also guided by the NCISH 10 Principles."

Family involvement and contact

[NCISH standard: Contacting family]

In 57 (72%) serious incident reports into suspected suicide it was clear the family of the student were contacted by the HE provider in the days following the student's death, in line with UUK postvention guidance (UUK, 2022). This contact was often from the Director or Head of Student Experience and Support/Student Services or the University Chaplain (n=22). Contact was most often to offer condolences (n=12), support with funeral and repatriation costs/arrangements or recovering the student's belongings (n=11) or other non-specified "offers of support" (n=10). Postvention support for families (n=7) included signposting to local support organisations or an offer of support from Student Support and Wellbeing Services. We noted this as good practice.

In 12 (48%) reports of incidents of non-fatal self-harm there was evidence of contact with the family (or trusted contact) following the incident.

Box 1: UUK/PAPYRUS/Samaritans review principles

Involve the family
Each review should ideally involve the student's family.

Timeliness
The review should be completed as soon after the incident as practical and information gathered within two weeks of the incident or as soon as possible thereafter.

Address specific questions
The review should be focused on addressing specific questions raised by those impacted by the incident.

Led by an independent, senior member of staff
Reviews should be led by a senior member of staff, who has had no prior involvement with the student.

Gather information from a range of different sources
Each review should consider gathering information from a range of different sources, such as staff involved in the incident or who provided support to the student, academic and professional service staff, fellow students, the family, and partner organisations.

Produce a chronology of events
There should be a chronology of events which summarises relevant context and interactions between the student and others prior to, during and after the incident. It should set out all aspects of the student's time at the higher education institution.

Convene a review group
A review group (of up to five people) should be convened to review all relevant documentation pertaining to the student, identify learnings and develop actions for improvement. It will usually be comprised of staff, but consideration should be given (where relevant) to input from others.

Identify knowledge gaps
The review should consider whether there are any outstanding questions or gaps in knowledge relating to the incident.

Identify learning
Reviews should identify any learnings or reflections that can be drawn from what has happened.

Develop a clear action plan and owners for improvement
Each review should include agreed actions aimed at minimising the risk of a recurrence or of a similar incident. Actions must have clear owners and timescales for delivery.

Good practice example - postvention support for bereaved families

"Student Support and Wellbeing has remained in touch with the family since the event to offer ongoing support". (HE008)

"The Programme team and Wellbeing team have reached out to [student's] sister and plans are in place to proactively support them in the future". (HE002)

Although contact with families was often made to offer condolences and advice on finding support, we found little evidence of them being invited to contribute to or be involved in the serious incident investigation. Overall, 11% of families contributed to (7, 7%) or were offered involvement in the investigation process (4, 4%). Ten (10%) reports considered information or questions/concerns that the family had raised, although the family had no direct involvement in the investigation process. In four incidents the family were not contacted, or it was deemed inappropriate to contact them. Six (6%) serious incident reports had been shared with the students' families[7].

In three-quarters (79, 76%) of serious incident reports reviewed, the family were not involved in any aspect of the investigation process.

Barriers to involving families in serious incident investigations may include:

Timing, current guidance may be prohibitive to ensuring family involvement. An underlying principle within the guidance is that a review should "be completed as soon after the incident as practical". In practice, staff responsible for conducting serious incident investigations told us they have been unable to complete a serious incident report within the first three months after the death of a student "whilst keeping at the forefront the emotional needs and wellbeing of the family", reporting that contacting a grieving family to participate in the investigation within this time frame "would not have been the right thing to do". During this national review, bereaved families have told us that they may not want to contribute to a serious incident investigation in the immediate weeks and months after the death of their loved one. They also told us that they should be offered the opportunity to do so if they wish, and there should be attempts to engage with them in a meaningful and compassionate way.

Apprehension about addressing concerns raised by families. HE providers told us that this is a concern about potential legal action or culpability; that any learning identified "may be seized on as having had the potential to have made a material difference to the outcome" – Anonymous HE provider.

Area for improvement

There is a clear need in the HE sector to improve transparency and involve families in serious incident investigations. This is in line with HE sector guidance on postvention and follows guidance for serious incidents in both the NHS and independent mental health provider organisations.

7. Most serious incident reports did not give any indication of who the finalised report was shared with. Five were shared with "those responsible for ensuring actions are implemented", three with senior leadership (e.g., the University Executive Board), and three with the coroner.

Area for improvement

The UUK/PAPYRUS/Samaritans guidance should encourage HE providers to maximise the opportunity for families to contribute as fully as they wish, acknowledging that a refusal to engage in the review process from the outset may not mean they do not wish to engage at all.

Good practice example - involving families

"Thanks to the open involvement of [student's] parents...we now have a better understanding of [student's] circumstances prior to their enrolment, including a fuller appreciation of the extent of their mental health difficulties which they did not fully disclose in their application or as they began their course". (HE072)

"...the approach is to be proactive in the first contact with families that this [the serious incident review] will happen and to assure them that they will be asked for their input and will receive a copy of the final report". (HE078, HE079)

Timeliness

In 49 (47%) reports, there was no information included on how soon the investigation process commenced after the incident occurred. For the 55 (53%) reports where this information was available, 15 (14%) serious incident investigations were initiated within a week of the student's death (or the incident of self-harm), with nine (9%) starting as soon as the HE provider became aware of the incident. A further 13 (13%) began within a month of the incident, 14 (13%) within 3 months, and 13 (13%) more than 3 months after the incident.

Good practice

Some HE providers initiated a serious incident investigation as soon as they became aware of an incident.

Information on when the serious incident investigation was completed and the final report signed off was available for 67 (64%) reports. Thirty-six (35%) were completed (i.e., signed off by the lead reviewer or, in some cases, other senior staff) within three months of the incident, 21 (20%) within six months, and ten (10%) more than six months after the incident. Some reviews and associated reports may have been completed in response to our request for reports to be submitted to the national review.

Address specific questions

[NCISH standard: Specific terms of reference]

Very few families (n=17) were involved in the serious incident review process, and so addressing questions raised by the student's family was rare. Five reports referred to questions or concerns raised by the family being considered in the review or to the family being assured that the HE provider was willing to answer any questions raised. Few (n=11) of the reports we examined included a statement of the scope of the investigation (i.e., Terms of Reference (ToR)), and these were often generic (e.g., to reflect on what happened, to identify any learnings or reflections, to develop an action plan; n=9) rather than specific to the student.

Area for improvement

The scope of an investigation should be clear, including the questions raised and issues to be addressed, with clarity about the purpose and report audience.

The scope of the review should extend beyond internal actions by inviting the family to raise questions and concerns and provide other information that may be pertinent to the review process.

Good practice example - address specific questions

"The review concentrates on three areas: (1) During [name] time as a student, what support was given to them? Were any opportunities to provide additional support missed? (2) Following [name] death, how did the university respond? Was the response coherent, coordinated & compassionate? (3) What lessons can be drawn to prevent or respond to any future incidents?". (HE050)

"There were two broad subjects to consider, which included [name] academic engagement and their interactions with the programme (including any disengagements); and the support services element and knowledge, which [name of university] services had, of [student's name]." (HE081)

Led by an independent, senior member of staff

[NCISH standard: Clearly independent investigators]

In 36 (35%) reports, information on the lead reviewer was not available, either because it had not been provided or it was redacted. It was difficult for this national review to establish to what extent serious incident investigations were led by independent, senior members of staff. Fourteen (13%) reports explicitly stated that the lead reviewer had no prior involvement or knowledge of the student. Sixty-eight (65%) were led by senior members of staff, most often the Director or Head of Student Services/Experience/Wellbeing (39, 38%), but it was unclear from the report if the lead reviewer was independent of the services that supported the student.

People responsible for conducting serious incident investigations have told us that there is often no training or institutional support for the review process. Often, completing a serious incident review is an additional strategic-level responsibility, with no status of its own within someone's job role.

We also examined whether there was any indication of senior executive sign-off of the final serious incident report and its learning, recommendations, and actions. Though this is not a principle in the guidance, we included this as an indication of senior accountability. In the majority of reports (74, 71%), it was unclear whether there had been any sign-off of the final report. Thirty (29%) had clear sign-off, 12 (12%) by the person also named as the lead reviewer, and nine (9%) by a member of the senior executive team. In a further nine (9%), the report had been signed-off, but the information was redacted.

Area for improvement

The review process should include an early decision about independence and clarity within the report about how this was decided. HE providers may consider convening an independent review group chaired by a senior member of staff of a neighbouring HE provider, possibly as part of a reciprocal arrangement.

Guidance for completing a serious incident investigation could be clarified to advise on who has the expertise to conduct a serious incident investigation.

The identify and role of the lead reviewer should be clear. They should sign off reports as a commitment to implement identified actions.

Good practice example - clearly independent investigators

"This report has been shared with an external review group comprising three Directors of Student Services. This external review is an important part of the process to ensure that the review does not embed rather than challenge any existing limitations in processes". (HE092)

Gather information from a range of different sources

[NCISH standard: Accessing full case records]

It was often difficult for this national review to determine, from the information available in the reports, whether there was access to all records relating to the student's time at the university. In some instances, records were unavailable due to restrictions on case management or record systems; this was noted as a learning point for the HE providers involved. Where stated, student support service records (n=15) and information from academic staff (n=15) were accessed most often, followed by information from other professional staff (i.e., accommodation, finance, security, n=9), and attendance data (n=6). The gathering of information did not generally extend to records and contributions from other agencies, such as primary care, secondary mental health care, and the criminal justice system. This was true even where the HE provider was aware that those agencies had played a critical role in the student's care. We found 62 (60%) reports with some indication that the student had contact with other agencies (including primary and secondary mental health care), but in only four (6%) of these did the partner organisation contribute to the review process. Sixty-three (61%) reports had no information on whether the student was registered with a GP, where known this based on student report. There appeared to be no GP contribution to the review process.

Testimony from one HE provider suggests the lack of information from other agencies in the serious incident report may, in part, be due to the UUK/PAPYRUS/Samaritans template and stated "The advice around the purpose and process of conducting a review is very helpful – but the serious incident review form itself is less so…some sections seemed over-inclusive…whilst other areas were phrased in a way that didn't seem to allow for the full picture to emerge (particularly around the support/contact the student had with NHS services)".

Area for improvement

Clarity on the information gathered for the review process, and which agencies contributed.

Reviews should gather information from partner organisations that were involved in the student's care.

The review process would benefit from gathering information directly from staff alongside records, as staff knowledge is likely to be more comprehensive. It was often unclear in the reports we reviewed whether this had happened.

Good practice example - gathering information

"To complete this review, meetings were held with colleagues internal and external [local NHS and Social Care Partnership Mental Health Trust] to the University in order to address the main terms of reference." (HE048)

Produce a chronology of events

[NCISH standard: Sufficient information for understanding what happened]

Sixty-two (60%) reports included a chronology of events with sufficient information for an understanding of the incident and the support and care the student had received. Chronologies varied in length from very brief summaries to more than 10 pages. However, in 40% (n=42) of reports, there was little or no information about circumstances prior to the incident, particularly for incidents of non-fatal self-harm. This may be because the student had only recently started university, were known to be fully engaged with studies, or had no contact with support services. Thirteen (13%) reports focused solely on events and follow-up action after the incident.

There were examples (n=9) of gaps in the chronology with little or no information between the student's last contact with the HE provider and the incident. We suggest this reflects a focus on internal vigilance. Gathering information from external sources, such as other agencies or the family, may have filled these knowledge gaps. There was also variation in the timeline under investigation. Thirty-two (31%) reports included chronologies that began when the student started at the HE institution and ended at the time of the incident. Other reports (n=16) were less clear on the period they covered or were limited to the day of or the day(s) before the incident.

Good practice

Almost a third of reports included chronologies that began when the student enrolled at the HE provider and ended at the time of the incident (or post-incident, if a consideration of postvention support is included in the review process).

Area for improvement

Reviews should provide sufficient information to enable a thorough understanding of what happened, to who, where and when.

Area for improvement

We recommend clarity in both serious incident reports and the UUK/PAPYRUS/ Samaritans guidance about whether the timeline under investigation should begin from when the student started at the University.

Convene a review group

Most reports (63, 60%) contained no information about how the investigation was conducted and whether a review group was convened. In 22 (21%) serious incident reports there was explicit reference to a review panel.

Area for improvement

Serious incident reports should include information about how the investigation was conducted and whether a review group was convened, including group membership.

Good practice example - convene a review group

"The Serious Incident Review panel was comprised of the Chair (a member of the University's Executive Board), one member of academic staff (from within the student's School) and three members of professional staff. The panel met on [date], [date] and [date]. Discussions with relevant employees were conducted and fed back to the panel.

The panel considered and reviewed this feedback along with all relevant documents and University records in order to produce the recommendations set out in this report". (HE005)

Identify knowledge gaps

Fifty-six (54%) serious incident reports included no information on whether they had considered any outstanding questions or gaps in knowledge relating to the incident. Of the 48 (46%) reports where this element was considered in the final report structure, 17 (35%) stated there were no knowledge gaps remaining and commented that they had a complete and full account of the student's time at university. Thirty-one (30%) reports identified remaining knowledge gaps. These focused on a lack of information about: the circumstances of death and access to means (n=10); the stressors or triggers contributing to the incident, including why the student had not engaged with offers of support (n=9); interactions with external agencies, such as the Police, NHS, or information from the family (n=9); the student's mental health history and related support (n=8), and attendance and engagement or contacts with academic staff (n=6).

Good practice

Recognition that a lack of information from external agencies or the family constitutes a knowledge gap.

Overall, most serious incident reports (70%) failed to consider or identify gaps in knowledge relating to the incident. This suggests a focus on internal vigilance. HE providers may not feel confident in identifying a knowledge gap, such as information from partner organisations, or a thorough understanding of the circumstances of the incident, and the activity of the services involved.

Area for improvement

The UUK/PAPYRUS/Samaritans guidance could provide clarity about what might constitute a knowledge gap. For example, we found several serious incident reports where there was not enough available information (including from partner organisations) for the review to fully understand the student's circumstances or potential stressors prior to the incident.

Good practice example - identify knowledge gaps

"It is unclear if [student name] had a history of poor mental health or if they accessed support outside of University". (HE028)

Identify learning

[NCISH standard: Learning]

Overall, 297 recommendations were identified in 82 (79%) serious incident reports – 238 (80%) were recommendations to reduce the risk of recurrence or of a similar incident, 53 (18%) focused on the postvention response to the incident. Six reports of incidents of non-fatal self-harm identified recommendations to provide support for the student. Twenty-two (21%) reports proposed no recommendations based on their review of the incident, though some (n=7) of these reports were submitted as interim documents as the review process was ongoing. Further information on identified learning is on pages 26 to 29.

Over three-quarters of all serious incident reports identified learning to help prevent the risk of recurrence of future incidents, with almost 300 recommendations in total.

Good practice

The scale of recommendations identified in the reports we reviewed indicates a commitment with the HE sector to implement change to prevent future incidents.

Develop a clear action plan and owners for improvement

[NCISH standard: Action plan]

Over half (55, 53%) of the reports we reviewed identified actions to be taken to reduce the risk of future incidents. However, clear owners and timescales for delivery were not always attached to each action. Of the 55 action plans, 10 (18%) were missing clear owners and 22 (40%) had no timescales for delivery.

Good practice

The consistent development of clear action plans.

Area for improvement

Ensure every action has a clear owner and a timescale for delivery.

Good practice example - develop a clear action plan

"The panel agrees the following actions to reduce the risk of a recurrence or of a similar incident:

Owner	*Delivery date*	*Action*
[Name of owner], reporting to [name]		

The panel agreed it would reconvene in [date] to review the progress of these recommendations and escalate any next steps or outstanding actions to relevant University committees". (HE005)

Additional NCISH standards for investigating serious incidents

NCISH standards for investigating serious incidents include three principles (contributory factors, report coherence and accessibility to a lay reader) that are not currently in the UUK/PAPYRUS/ Samaritans guidance for carrying out a serious incident review. We reviewed the serious incident reports against these three additional standards. We note that HE providers have not been provided with these as guiding principles, though the extent to which they followed them may be consistent with good practice.

Contributory factors

Most reports focused on the interactions between the student and the HE provider, but many (90%) also made reference to stressors and experiences reported by the student or other sources (e.g., support services, friends, academic staff). Reports that had a primary focus on the actions of the university appear to have missed other salient events particularly in those where there was a gap between the last contact with the university and the incident (9, 9%). Some of the factors we know to be commonly associated with suicide among young people, such as alcohol and drug misuse, were underrepresented in the reports we examined. This may be because the reports did not gather information from external agencies or the student's family. Personal circumstances that may have contributed to suicide risk are likely to have been underreported.

Area for improvement

HE providers could improve identification of stressors and/or experiences that may have contributed to suicide risk by examining wider problems and including information from external agencies and the family.

Report coherence

Almost half (49, 47%) of reports lacked clear continuity between sections, from the purpose and scope to the findings and actions. In 20 (19%) reports no recommendations were made to help prevent the recurrence of future incidents though some of these reports made reference to stressors or experiences that may have contributed to suicide risk. This may be affected by the number of summary or interim reports we reviewed as investigations were ongoing (n=7). In nine (10%) reports there was a lack of continuity between the information in the report and the recommendations and actions; some key findings were not reflected in the recommendations, and it was unclear why some recommendations had been reached. Four (4%) reports included insufficiently detailed recommendations to understand how they would prevent future incidents. We found three (3%) reports that were difficult to follow as information was inconsistent or spread across several documents.

Accessibility to a lay reader

Most reports partially met this principle and were of reasonable standard in terms of style and presentation. Length and structure were broadly consistent between HE providers, with many reports following headings and/or a structure similar to the UUK/PAPYRUS/Samaritans template. However, reports varied widely from in-depth, detailed documentation of the incident and the wider context to summaries of the incident with very little background information, seemingly reflecting a lack of detailed local investigation into the incident.

Many of the reports we reviewed appeared to have been written for internal purposes and referred to HE provider systems and structures, using associated acronyms. This suggests the reports were not intended for onward sharing and in only ten (10%) was there any indication that the report was to be shared externally with the family, the coroner, or external agencies or reviewer(s).

Area for improvement

There is a clear need to improve the accessibility of serious incident reports to lay readers, with consideration for bereaved families. Occasionally, we found the language used to be insensitive. The UUK/PAPYRUS/Samaritans guidance could include guidance on respectful language usage.

Historical cases and wider engagement

As part of this national review, we considered whether lessons from historic cases have been learnt by collating supplementary information from prevention of future death (PFD) reports, serious incident reports from the 2022 to 2023 academic year (n=8), and the testimony of bereaved families.

Using the Preventable Deaths Tracker (Richards, 2024), we found 21 PFD reports that matched our search criteria:

- *Category* of death: "Suicide", and/or
- *Sent to*: [name of] University, Department for Education, Universities UK
- *Date of report*: any (range: 2015 to 2024).

These reports related to deaths that occurred between 2013 and 2023 and included three deaths by suicide that occurred in the 2023 to 2024 academic year.

In addition, the testimony we have heard suggests bereaved families have felt excluded from and not listened to in the process of finding out what happened to their loved one. Some had a perception that universities can be evasive and reluctant to answer important and painful questions relevant to prevention. Some gave accounts of distressing experiences at inquest in finding themselves in opposition to a powerful organisation. Although we cannot comment on the prevalence of this, these are credible reports and it is essential that we respond.

Of the three PFDs of student suicide for the 2023 to 2024 academic year he concerns focused on:

- The potential negative impact of social ostracism on mental health.
- Access to means and ensuring "student accommodation not managed and controlled by educational establishments" meets standards.
- Gaps in pastoral support, a lack of monitoring of engagement, inadequate use of fitness to study procedures, and a lack of support all presenting a risk to vulnerable, postgraduate students who struggle with their work and develop mental health issues.

We identified stressors and themes from these historical cases and testimony of bereaved families that have also been identified in this current review, indicating a continuing risk from established causal factors. Specifically, these issues included:

- finance and student debt
- access to support (and follow-up by support services), including placing the responsibility on students to "reach-out" for support
- risk assessment and management
- staff training on identifying, supporting and signposting students who are struggling with their mental health
- information sharing
- monitoring attendance and disengagement
- engaging with families or trusted contacts
- communication within the HE institution and with the student, and other agencies.

What this review does not tell us

- The national review cannot tell us the exact number of suicide deaths by higher education students because it is based on suspected suicide deaths notified by HE providers, unconfirmed by coroner inquest. Official statistics on suicide among higher education students have been published by ONS.

- It may also not tell us the exact number of suspected suicides in higher education students. It is not mandatory for HE providers to conduct serious incident investigations or if they did, to submit them to the national review. However, the level of engagement from the sector, suggests we were notified of the majority.

- The findings are for England, and may not apply to Northern Ireland, Scotland and Wales.

- We may have under-estimated the true figure for some findings. They are based on the information that was available in the reports we examined. If a stressor or experience (e.g., alcohol and/or drug misuse) was not identified in the report, it may still have happened.

- The incident of non-fatal self-harm in higher education students is significantly underreported. It is likely that some HE providers do not have a system for monitoring known incidents of self-harm in their students; without a system the more serious of these incidents may not have been investigated.

- Our findings tell us about what was happening from the HE provider's perspective. Information from NHS, GP, and other third sector organisations did not generally inform the serious incident reports we examined.

- Our findings are based on a single academic year and will not provide an understanding of trends of suicide in higher education students.

- Demographic data, particularly in relation to ethnicity, age, and sexuality, were not well captured in our findings. Often this information was redacted from the submitted version of the serious incident report or had not been obtained as part of the serious incident investigation. We are therefore unable to comment on the prevalence of risk factors in specific student subgroups.

Conclusions and recommendations

We have found an excellent response from universities to this national review. On such a sensitive issue, this is a welcome sign for future prevention. Our evidence suggests also that the guidance on investigating student suicide has been well received. Our immediate aim has been to improve learning from these tragic incidents and to build on changes HE providers have already made, and help develop a safety culture, but we also want to contribute to all aspects of suicide prevention. We acknowledge that for bereaved families, these changes are too late. They are concerned that progress has been slow and would prefer changes to be mandatory and more immediate.

Our conclusions and recommendations are therefore set out as (1) safety concerns, (2) suicide prevention within university systems, (3) amendments to the UUK/PAPYRUS/Samaritans guidance, and (4) safety messages for the wider system. Many support the work of other organisations, including the Higher Education Mental Health Implementation Taskforce, and for added value they should be read alongside:

- The Taskforce's forthcoming Competency Framework
- The Taskforce's statement on Compassionate Communication in Higher Education
- Collective responsibility, collective action to prevent student suicide - guidance for the HE sector to reduce risk and restrict access to means of student suicide
- The Taskforce's ongoing work on promoting the identification of students at risk and case management approaches to coordinated support
- Suicide-Safer Universities: sharing information with trusted contacts
- Sharing information to support student wellbeing and safety
- The University Mental Health Charter Framework

Safety concerns

We found numerous factors that may have contributed to suicide and that should be the target of future prevention. Two factors stood out: mental ill-health and academic problems. Several other factors point to the need for targeted support.

- Mental ill-health had frequently been identified in the students who died. In some cases, the indications of risk were clear through mental illness or self-harm. However, others experienced apparently less severe problems of "mental wellbeing". Around three quarters of students had been in contact with support services of some kind. These factors together – lesser severity and previous contact – suggest a need for greater risk recognition.

Recommendations

1. **Mental health awareness and suicide prevention training** should be available for **all staff** in student-facing roles, and consideration given to mandatory training for all student-facing staff on identifying, raising and escalating concerns about a student.
2. This training should include areas highlighted in this report including **recognising and responding to risk** and **neurodiversity**.

- Over a third of the students were experiencing academic problems or pressures at the time of the suicide or self-harm incident. These included exam pressures but the majority showed students struggling with course requirements, such as deadlines. Our findings suggest time points through the academic year that HE providers could offer enhanced support, particularly for those already known to have problems of mental health or wellbeing.

Recommendations

3. Students who are **struggling academically** should be recognised as potentially at risk, with an enhanced focus on providing a **supportive response**.
4. **Awareness of support** at key points in the academic calendar should be increased, including exam times.

- One specific stress should be highlighted because it falls within the remit of the universities themselves: almost a quarter of incidents (where known) occurred within university-managed accommodation.

Recommendation

5. The **safety of university-managed accommodation** should be reviewed, including physical safety, high-risk locations, the criteria for welfare checks, and signposting for support, particularly out-of-hours.

- Institutional settings such as universities present a particular risk of suicide clusters. Six reports indicated potential suicide clusters due to proximity in time, place, or both, though no direct connection was identified between the students.

Recommendation

6. **Suicide prevention activities** should be **enhanced** after a single death on the grounds that any suicide has the potential to lead to a **cluster**. Policies to respond to the aftermath of a suicide death should be reviewed to ensure they are in line with Public Health England guidance.

- How a university responds to a death (postvention) is a vital part of prevention. Those at particular risk might include those who knew the person who died or were facing similar stresses.

Recommendations

7. When a suicide takes place on or near the campus, universities should **review the safety of the location**, e.g., accessibility, and consider discouraging the placing of tributes to avoid drawing attention to the site as a suicide location.
8. Anyone affected by a student's death by suicide should be **offered or signposted to appropriate support**.

Suicide prevention within university systems: National learning from serious incident reports

Most of the reports we reviewed identified points of learning, to improve internal processes. These are set out in detail in the section "Learning identified within serious incident reports" (pages 26-29). However, many of these lessons are likely to be relevant nationally.

- Many of the reports noted that access to mental health and other support could be improved in terms of awareness, signposting, and reviewing the needs of specific groups, e.g., international students, students with disability or neurodiversity, students in their first year of study, students who have experienced violence or other adverse life events, and students known to be experiencing problems with finance or accommodation. While some reports identified a need for support services to ensure active follow-up following contact, many placed the responsibility on the student to seek further help.

Recommendation

9. **Access to mental health and other support** should be reviewed, particularly for those at additional risk or likely to experience problems of access (see groups listed in the text above).

- The reports identified problems with information sharing, communications and a lack of collaborative working internally between academic and pastoral supports, with the student, the student's family, and with other agencies such as the NHS. There were problems of confidentiality, with reports citing a lack of understanding of what data could be accessed and shared within or between organisations involved in the student's support.

Recommendations

10. **Information sharing** internally and externally, including best practice in the use of IT systems, should be reviewed with a view to **encouraging** routine information sharing, e.g., between academic and non-academic staff.

11. Universities should **review** how well **confidentiality arrangements** are working under recent UUK/PAPYRUS guidance on information sharing and guidance on sharing information with accommodation providers.

Universities UK/PAPYRUS/Samaritans guidance

We found most serious incident reports were broadly in line with the underlying principles of the UUK/PAPYRUS/Samaritans postvention guidance and template and most identified learning to reduce the risk of recurrence or of a similar incident. Here we suggest some amendments to the guidance based on our learning from serious incident reports.

- The most important change is to include families at an early point in the serious incident investigation process, giving them a chance to contribute to the questions that will be asked.
- The focus on institutional actions rather than individual circumstances may have led to the latter being missed, with opportunities for prevention unexplored, and giving the impression of a defensive, inward-looking process. Serious incident investigations must be conducted with an understanding of suicide risks specific to young people, and the guidance should reflect this (see section on the guidance below).
- Further guidance is also needed on expanding investigations to include the most serious incidents of non-fatal self-harm.

Recommendations

12. **Input from bereaved families** should be a key part of the serious incident investigation process, and their questions should be answered as far as possible. This would allow HE providers to look for learning beyond the institutional response, including at the events and stressors students face.
13. A decision about the appropriate level of **independence** should be part of the initial setting up of an investigation, with consideration given to the perceptions of a bereaved family or the wider public, while serious incident reports should routinely record the degree of independence of the reviewer(s), recognising that this may vary according to circumstances of the death and practical considerations.
14. The serious incident review process should be granted sufficient status within an HE provider, ensuring it is conducted by people with the right skills and level of independence, who have the relevant training, experience and knowledge, as well as an **understanding of suicide risks** specific to young people.
15. There should be an addition to the UUK/PAPYRUS/Samaritans guidance that all reports be **signed-off** by a member of the senior leadership team/senior executive board to demonstrate institutional acceptance of the recommendations, and a **commitment to implementation**. Identified actions should be reviewed biannually/annually to ensure they have been embedded and concerns have been addressed and if not, what further action is required.
16. A **supplement to the guidance** in relation to investigating the most serious incidents of **self-harm** should include (a) eligibility for investigation, and (b) involvement of the student who self-harmed, including an offer of support.

Safety messages for the wider system

Our national review has identified additional measures that reflect the wider context in which suicide prevention takes place – including policies, standards, and relevant data.

- One of the main messages from the families we spoke to reported was of feeling excluded from and not listened to in the process of finding out what happened to their loved one. Some had a perception that universities can be evasive and reluctant to answer important and painful questions. Some gave accounts of distressing experiences at inquest in finding themselves in opposition to a powerful organisation. For these families the grief of losing a child is compounded by a lack of transparency. We suggest a version of the duty of candour be introduced to the HE sector. This would have an aim of ensuring openness and transparency with families after a suspected suicide, with similarities to the model in the NHS, but tailored to and developed by the HE sector. The timing fits with the proposed Hillsborough Law with its intention to reduce the culture of defensiveness in the public sector.

Recommendation

17. A **duty of candour** should be introduced to the HE sector, setting out and organisational responsibilities to be **open and transparent with families** after a suspected suicide. It would include a duty to provide information on what happened, at the earliest point. It should be developed and shaped by the sector itself to ensure it is appropriate to the HE setting.

- Data relevant to student suicide is improving, with different data collection systems, such as ONS, offering their own perspective on prevention. There would be benefit in bringing these sources together as a more comprehensive national picture.

Recommendation

18. A **collaborative forum** should be established for **sharing of statistical data** relevant to the prevention of student suicide nationally.

- Having established this review of serious incident investigations, with a high level of participation by universities, we need to ensure that opportunities for national learning continue.

Recommendation

19. This **national review** of higher education student suicide deaths should be established as a **long-term initiative**, across the UK. It should explore the inclusion of other providers (i.e., Further Education colleges) and include more precise guidance on the inclusion of incidents of non-fatal self-harm. Such an initiate would also allow for the monitoring of progress within the HE sector against the recommendations in this report, to ensure learning is occurring.

Appendices

Appendix 1: Definitions

Throughout this document, the following expressions have the meaning set opposite:

2023 to 2024 academic year:	1 August 2023 to 31 July 2024.
Incident of non-fatal self-harm:	A serious incident that could have led to a fatality, either due to the potentially dangerous nature of the method used or an interruption that specifically prevented suicide. HE providers determined whether an investigation was appropriate in relation to incidents of non-fatal self-harm.
Mature student:	Undergraduate students who are over 21 years of age, or postgraduate students who are over 25 years of age, when they begin their studies.
Prevention of Future Deaths:	Coroners in England and Wales have a duty to issue a Prevention of Future Deaths (PFD) report to any individual or organisation where they believe actions could be taken to prevent future deaths. In a PFD report the coroner identifies areas of concern and the recipient(s) have 56 days to respond, outlining their proposed or taken actions.
Report:	The serious incident report prepared by a HE provider following a suspected suicide death or an incident of non-fatal self-harm by a higher education student.
Review:	Our independent, national evaluation of the serious incident reports submitted to us.
Suspected suicide:	A suicide death unconfirmed by coroner inquest or investigation.

Appendix 2: Abbreviations

AOC	Association of Colleges
AY	Academic year
HE	Higher Education
HESA	Higher Education Statistics Agency
IHE	Independent HE
NCISH	National Confidential Inquiry into Suicide and Safety in Mental Health
ONS	Office for National Statistics
PFD	Prevention of Future Deaths
UCAS	Universities and Colleges Admission Service
UMHAN	University Mental Health Advisors Network
UUK	Universities UK

Appendix 3: NCISH 10 standards for investigating serious incidents

The NCISH has developed an abbreviated set of 10 standards of good practice for investigations conducted by NHS and independent sector mental health provider organisations following serious incidents (Table 5). These standards are based on our recommendations from previous reviews of serious incidents in the NHS, where we have assessed the quality of serious incident reports and developed safety recommendations for the prevention of future deaths. They also aided the development of the Royal College of Psychiatrists Principles for full investigation of serious incidents.

We have adapted these standards for use in the HE sector and have aligned them with the main principles for conducting a serious incident review as outlined in the UUK/PAPYRUS/Samaritans postvention guidance and template. Seven of the 10 NCISH standards are consistent with the main principles of the UUK/PAPYRUS/Samaritans guidance (marked by *).

Table 5: NCISH standards for investigating serious incidents

	NCISH standard
1.	Are there **clear terms of reference** (ToR), specific to the individual/incident, which set out the scope of the investigation and the timescale for conducting the review?*
2.	Was the investigation conducted by a senior member of staff, who was clearly **independent** of any prior involvement with the student?*
3.	Were **family members** given the opportunity to contribute to the investigation?*
4.	Is it clear from the serious incident report whether the investigation acquired access to **full case records** detailing the student's time at the university? If there are records' missing is this clearly stated and are caveats made on the reliability of the findings and appropriateness of the recommendations?*
5.	Are the **contributory factors** leading to the incident presented?
6.	Is there sufficient information to enable a **thorough understanding** of the circumstances of the death/incident, as well as the activity of the services involved?*
7.	Is the serious incident report **coherent**? Is there a clear and logical pathway from the ToR to the contributory factors to the recommendations; and is it clear how the recommendations could be used in prevention?
8.	Is the serious incident report **accessible** to a lay reader? Is the report not too lengthy and written in plain English with all specialist vocabulary explained?
9.	Does the serious incident report have an associated **action plan** with a timescale for review?*
10.	Does the serious incident report provide details of what needs to change and is there evidence of how **learning** will occur internally?*

* Indicates consistency with the UUK/PAPYRUS/Samaritans guidance.

Appendix 4: Expert advisory group

Samantha Buss, Student Minds Advisory Committee

Rowan Fisher, Universities UK

Ged Flynn, PAPYRUS Prevention of Young Suicide

Lee Fryatt, The LEARN Network

Jane Harris, University of Oxford

Debbie Laycock, Samaritans

Dr Simon Merrywest, The University of Manchester

James Murray, The LEARN Network

Professor Sandeep Ranote, NHS GM Integrated Care

Phil Scarffe, University of Birmingham, representing UMHAN

Dr Mark Shanahan, University of Surrey, representing The LEARN Network

Professor Jo Smith OBE, University of Worcester

Dominic Smithies, Student Minds

Dr Dominique Thompson, Buzz Consulting

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