National review of higher education student suicide deaths

(academic year 2023 to 2024)

What did we do?

We **reviewed serious incident reports** into suspected suicide deaths or incidents of self-harm from all higher education providers in England to:

- collate their **key findings**
- assess their **quality** against existing UUK guidance
- identify **good practice** and **areas for improvement**

What we found

A commitment to prevention from universities

169 Incidents reported

104 (62%) Reports submitted for review

70% Students known to university support services

23% Incidents in university-managed housing

Mental ill-health & academic problems

Most reports broadly in line with the UUK guidance

Action plans consistently developed

But families often not involved in the review process

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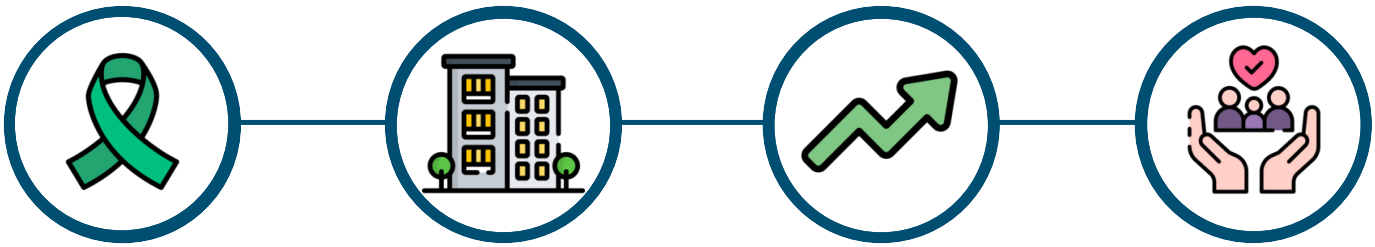
Our recommendations

Safety concerns



Mental health awareness & suicide prevention training

Review safety of university-managed housing

Enhance suicide prevention activities after a single death

Postvention support

Suicide prevention within university systems

Access to support for those at additional risk (e.g., neurodiversity)

System-wide information sharing and best practice in IT systems

Review confidentiality arrangements

The UUK/PAPYRUS/Samaritans guidance

Involve families

Appropriate level of independence of reviewers

Senior leadership sign-off

Wider safety

A **duty of candour** should be introduced to the HE sector

A collaborative forum for the **sharing of statistical data** should be established

A **national review** of higher education student suicide deaths should be established as a **long-term initiative**