Preventing Student Suicide At Universities

Case Report in respect of

our son Naseeb Chuhan (1995-2016)

EXECUTIVE SUMMARY

with Preface and Recommendations

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Parents of Naseeb Chuhan

22nd April 2023

To receive a copy of the full report, please visit www.naseebchuhan.com/case-report

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Preface

In May 2016 our beloved son Naseeb Chuhan sadly took his own life. He was 21 years old and a first-year student at Leeds Beckett University (LBU) studying Human Geography during the 2015-2016 academic year.

Naseeb was sharing a flat in Leeds with a fellow student who was a long-standing friend and had planned with his parents and flatmate to return home to Manchester for the summer on Monday 30th May 2016. According to his friends Naseeb had specifically started to withdraw from social life in May 2016 whereas prior to this he had always been the first to organise meeting up with friends. On Saturday 28th May 2016, Naseeb was found deceased by his parents.

Naseeb was an intelligent, thoughtful and inquisitive young man. He had a creative imagination, a strong sense of social justice, and cared deeply about this world. Our beautiful son had a rich interest in history, politics, the arts and he loved reading, listening to music, playing squash and cycling. Naseeb was very sociable, he had a sharp sense of humour and enjoyed the company of a wide range of friends. All who knew and loved Naseeb have been shocked and deeply saddened by his death. As his parents we are left devastated, ghosts of our former selves.

After Naseeb died, we gathered a range of information as a part of our investigation into the circumstances surrounding his suicide. We found that Naseeb was facing an escalating debt crisis having accumulated a total of 12 concurrent loans and with no way of paying the money back. He was about to fail his first year at university with eight consecutive pieces of work outstanding from January 2016 onwards.

By reviewing Naseeb's internet browsing history, we established that he did not sleep at all for close to half of the 78 nights before he died. As the intensity of academic and debt stresses increased, Naseeb's sleep pattern deteriorated and there are blocks of consecutive days and weeks where he did not sleep. The day before we believe Naseeb died, he tried to obtain support from a GP and the University Student Wellbeing Service. Despite him presenting with clear indicators of potential suicide risk, Naseeb was not risk assessed adequately.

Naseeb did not appear to have any useful guidance for his academic struggles from his university or any proactive referrals to debt counselling for his debts. From our knowledge of Naseeb's internet searches it seems the false 'solutions' he found from the internet became the only solutions. Upon looking at Naseeb's web browsing, we have been horrified by the kind of material available across the internet which continues to concern us.

With guidance from our barrister, we liaised with the Coroner directly and undertook the challenging role of being our own solicitor. Following two Pre-Inquest Review (PIR) hearings the inquest into Naseeb's death took place at Wakefield Coroners Court on 18th and 19th December 2017.

This report is based on all the relevant evidence obtained and research undertaken leading up to the inquest into Naseeb's death, what happened at the inquest and the subsequent complaints and advocacy processes we have since been involved in. This work has identified major problems with key organisations in terms of basic levels of care and accountability for their students, clients and patients and makes clear recommendations for their rectification.

There is a growing body of evidence-based research that suicide is preventable. A central part of our work has been to hold these organisations to account for their actions and the issues we have exposed represent significant failings, without which we believe our son would still be alive. The aim of our work has been to encourage learning, generate positive change from what happened and to prevent such suicides.

Over the last seven years, bearing witness to, documenting and analysing what our son went through has been a harrowing experience. This has compounded our trauma and allowed us little space to properly grieve.

Along this journey we have greatly valued the support received from Julie-Anne Luck LLB, Patrick Cassidy LLB, Kate Green MP, David and Suzanne McAllister, Aidan Jolly and the charities Papyrus, INQUEST, Step Change, Money and Mental Health Policy Institute.

Naseeb's memorial website can be found at www.naseebchuhan.com

Balwant Kaur and Kuljit Chuhan
Naseeb's parents

Executive Summary

Our beloved son Naseeb Chuhan, was 21 years old, and in his first year of studying Human Geography at Leeds Beckett University (LBU). In late May 2016, at the end of the academic year, he sadly took his own life.

After Naseeb died, we gathered a range of information as a part of our investigation into the circumstances surrounding his suicide. This revealed that Naseeb was facing an escalating debt crisis having accumulated a total of 12 concurrent loans and with no way of paying the money back. He was also about to fail his first year at university with eight consecutive pieces of work outstanding from January 2016 onwards. We found that Naseeb had not received any useful guidance for his academic struggles from LBU or any proactive referrals to debt counselling for his debts.

The day before we believe Naseeb died, he tried to obtain support from a GP and then LBU Student Wellbeing Service. Despite him presenting with clear indicators of potential suicide risk, Naseeb was not risk assessed adequately.

In 2017 the Institute for Public Policy Research reported that student suicides increased by 79% between 2007 and 2015.[1] This report also identified academic and financial pressures as major factors affecting student mental health and wellbeing.

Our work highlights major problems with key organisations in terms of basic levels of care and accountability for their students, clients and patients and makes clear recommendations for their rectification. This is based on all the relevant evidence obtained and research undertaken leading up to the inquest into Naseeb's death, what happened at the inquest and the subsequent complaints and advocacy processes we have since been involved in.

There is a growing body of evidence-based research that suicide is preventable. A central part of our work has been to hold these organisations to account for their actions and the issues we have exposed represent significant failings, without which we believe our son would still be alive. The aim of our work has been to encourage learning, generate positive change from what happened and to prevent such suicides.

Academic and Pastoral Care Concerns at Leeds Beckett University

There are critical concerns about the monitoring and recording of student attendance, engagement and academic performance at LBU, along with the level of pastoral care that Naseeb received. The end of the academic year has been well documented as a high-risk time for student suicides. We believe Naseeb was allowed to reach an academic crisis that significantly contributed to his mental distress and coping resources being overwhelmed. This was compounded by a debt crisis.

As Naseeb was allowed to lose track of his course commitments for such a long time, eventually he was behind on an overwhelming amount of work. Naseeb was left trapped as a student with feelings of low self-esteem believing he would fail the course which was important to him and that he had invested his future in. The day before we believe Naseeb died, he stated on the LBU Wellbeing Service registration form that he considered himself at risk of failing his course, was missing lectures and seminars and receiving support from "no-one".

- Naseeb performed well in the first term and completed all of his work. In stark contrast, for five months from January 2016, he hardly attended university and did not complete any further work. Despite this there is no evidence of a single staff member from LBU initiating any communication

with our son about his absence and non-submission of work by letter, email, phone call or text message, over this period.

- The Personal Tutor (who was also the Head of Department and Course Leader) with whom Naseeb initiated a meeting in early May 2016, lacked knowledge of the severity of Naseeb's academic crisis and the many assignments he actually had outstanding. No follow up meeting, review of progress or support was put in place to avoid Naseeb reaching a crisis level. The marked deterioration in his academic performance and engagement was not recognised with the seriousness it deserved.
- As part of a separate complaints process in respect of LBU Wellbeing Service, in October 2019 it emerged that LBU had withheld disclosure of an important document from the inquest into the death of Naseeb. This document revealed that the tracking of student attendance, engagement and academic performance along with systems required to flag up concern and provide support were not in place. This evidence would have presented additional factors for the Coroner to have considered.
- After the inquest (December 2017) into Naseeb's death, LBU refused to investigate a comprehensive complaint we submitted about our concerns relating to academic and pastoral care. We then found that all the organisations with any responsibility for overseeing universities were unable to accept our complaint for investigation. In 2019 our MP Kate Green wrote to the Minister of State for Universities and raised her concerns in parliament about the lack of an independent complaint route and access to redress for families of a student who has died by suicide whilst at university.

There are significant issues of accountability and transparency to be addressed in relation to LBU's systemic failure in its duty of care towards our son. From our research we also propose a series of systemic changes towards better suicide prevention for university students, and to ensure that concerns raised by parents are dealt with in cases where their child has died whilst at university.

Payday Loans, Irresponsible Lending and Debt

There is widely accepted research which exposes the strong links between mental health and debt,[2] and we are also aware that students are significantly targeted by payday loan companies. Steadily increasing suicide rates among students in the UK have gained public attention including in the national media with financial pressure on students regularly cited as a key factor.[3] Changes in the regulatory framework have been demanded by both debt and mental health charities for a number of years.

During the last 12 months of his life, Naseeb had been given 33 payday loans by seven companies and by the time he died had 12 concurrent loans outstanding. The amount of charges and interest that Naseeb had paid over this period was greater than his total outstanding loans from payday loan companies. Therefore, he would still have had money remaining in his bank accounts if he had never borrowed in the first place.

All of the payday loan companies rejected our complaints to them, and we then referred each of them to be investigated by the Financial Ombudsman Service (FOS) which ruled that over half of the loans were given irresponsibly. The loans were:

- Unaffordable for Naseeb. Adequate affordability checks were not undertaken and his ability to repay was never verified by any lender.
- Given to Naseeb back-to-back, after repaying one loan he was given another.
- Used to pay off previous loans and encouraged dependency on further loans.

All of these factors breach the regulations for such lending.

In December 2017, during the inquest into Naseeb's death we raised serious concerns regarding the debts he had accumulated, which were severely amplified by irresponsible lending and significantly impacted on Naseeb's wellbeing and potential for self-harm. Based on the evidence presented the Coroner issued a *Regulation 28 Report* for the purpose of preventing future deaths to the Financial Conduct Authority (FCA), which is the regulator for such lending. This report clearly stated "there is a risk that future deaths will occur unless action is taken."

- Many of the loans given to Naseeb should not have taken place, and the fact they had meant the regulations and how they are enforced needed to be reviewed and changed. After the inquest, as Naseeb's parents we undertook a detailed analysis of the new Consumer Credit regulations which govern such lending, published by the FCA in 2018. Our analysis aimed to assess whether the new regulations would include changes that could address the specific concerns we had raised in any meaningful way.
- Disappointingly, the changes we had hoped for were either omitted or would be ineffectual to achieve the outcomes that could make a difference. Our 10-point list of issues which the FCA has not addressed includes, for example, there being no change to the tokenistic penalties for irresponsible lending; no change to the extortionate interest rates such companies are allowed to charge; and there are still no minimum requirements specified for assessing whether a loan would be affordable or not. We also highlighted a number of loopholes that payday loan companies used to give unaffordable loans repeatedly and avoid properly assessing affordability.

The FCA recognised that our work to date has contributed towards the changes that are needed. In writing to us regarding their ongoing work to assess compliance with their regulations and to drive improvements among high-cost lenders, the FCA stated, "We will take your concerns into account during this work and will examine whether there is systemic evidence of high-cost lenders not paying due regard to our affordability requirements ... and will consider what further regulatory action is appropriate."

GP Care and Systemic Healthcare Issues

In late May 2016 Naseeb visited Leeds Student Medical Practice (LSMP) and was seen by a GP. It is most likely our son took his own life the following day and it later transpired the GP had not risk assessed him adequately.

Our work shows there were failures in duty of care and assessment of potential suicide risk along with systemic healthcare failings in information sharing, evaluation and learning. During our attempts to have these concerns properly investigated we have encountered contradictory findings along with a lack of transparency. We also document what has changed as a result of our complaints and propose recommendations for further changes.

GPs have a vital role in identifying potential suicide risk. [4] On analysing the evidence in preparation for the inquest into Naseeb's death even though Naseeb stated clear symptoms of depression it became evident to us that the GP did not undertake any form of risk assessment. Naseeb was simply advised to seek counselling from LBU Student Wellbeing Service and no referral or follow up appointment was made. According to a recent report about gaps in suicide prevention by Dr Mahajan, "the majority of healthcare professionals are not skilled in recognising the warning signs of suicidality and responding to them appropriately." [5]

- We established that the guidelines LSMP are expected to follow state that a patient who presents with persistent low mood which has lasted at least two weeks should be asked about suicidal thoughts or acts.
- Prior to the inquest we commissioned an Independent GP Expert Witness Report which concluded that there was “a breach of duty of care”. The “GP care fell below an acceptable and reasonable standard” as Naseeb had presented with “clear and obvious symptoms of significant depression and to fail to adequately question him was substandard care”. At the inquest the GP accepted she should have asked Naseeb about suicidal thoughts.
- After the inquest, in 2018 we submitted a complaint to the General Medical Council (GMC) regarding our concerns about the GP's breach of duty of care to Naseeb. We were also concerned that this breach could be repeated as at the inquest the GP explained she had made her judgement for good reason.
- The GMC closed its provisional enquiry into our complaint with the justification that “GPs don’t automatically question every patient on the presence or absence of suicidal thoughts.” Thereby avoiding addressing the central issue that a GP should direct such questioning in presentations involving depression, as was clearly the case for Naseeb.
- The GMC also refused to disclose the six documents upon which their decision was based. These included advice from “a senior medically qualified GMC colleague with experience in psychiatry” who commented that the GP's consultation with Naseeb “appears to show an inadequate assessment” and also the GMC’s own expert reviews.

There are a number of systemic healthcare issues arising out of Naseeb’s experience, concerning the role of GPs and health centres in the prevention of student suicide. We undertook a series of dialogues with LSMP, Yorkshire Medical Chambers (YMC) from where the GP was contracted as a locum, the Royal College of General Practitioners (RCGP), and Healthwatch Leeds.

- LSMP was not even aware the inquest had taken place and there were no changes made in response to Naseeb’s death. LSMP had documented their concern about the absence of a risk assessment by the GP in her consultation with Naseeb, but this was not disclosed to the Coroner and YMC by either LSMP or the GP.
- Our discussions included mental wellbeing screening, objective evidence-based risk assessment, addressing a breach of duty of care, transparent information sharing after a suicide has taken place, and GP suicide prevention training which is currently not mandatory.

In 2019, following on from the concerns we raised about Naseeb’s case, a report by Healthwatch Leeds found that “mental health was not fully understood by GPs” and made a key recommendation for “All frontline staff in mainstream services to have mental health training e.g. mental health first aid training.” [6]

Issues Relating to Leeds Beckett University Student Wellbeing Service

Immediately after his consultation with the GP, Naseeb presented at the University’s Student Wellbeing Service and requested counselling. Naseeb most likely took his own life the following day and a Student Wellbeing Officer is the last known person to have seen our son alive.

Our work documents LBU Wellbeing Service’s lack of robust and effective procedures for identifying, assessing and responding to student risk of self-harm/suicide. We also present a series of urgently needed

improvements to the standards by which such services operate and how concerns raised by parents are dealt with in cases where their child has died whilst at university.

An in-depth guide for students' unions states that the most common mental health problem reported by students was "mental distress (92%)". The key triggers for this were "course deadlines (65%), exams (54%) and financial difficulties (47%)". Significantly, "three quarters of the deaths studied in a University setting had occurred either towards the end or at the start of the academic year".[7]

- On examining the available evidence, we discovered Naseeb had presented a series of indicators for elevated mental distress and a potentially high risk of suicide. These were clearly visible from the answers he gave to the questions on the LBU Wellbeing Service registration form and the manner of his presentation at the service.
- Our son was not adequately risk assessed either during his visit to the service or afterwards when his presentation and the registration form should have been examined. Instead he encountered a questionable process of 'triage' in an exposed public place by an administrative worker who did not have the training or skills to competently engage or assess him.
- After the inquest into Naseeb's death, in the absence of a complaint route via LBU, we made a formal complaint to the British Association for Counselling and Psychotherapy (BACP) in respect of LBU Wellbeing Service which is accredited by the BACP. This complaint process lasted four years and what emerged was a catalogue of sustained misrepresentations by the BACP who rejected our complaint. Their decision reasonings show a lack of focus, rigour and were not supported by the available documented evidence.
- In late 2022 we commissioned an Independent Expert's Psychological Report, from a Chartered and Consultant Clinical Psychologist, in relation to both Naseeb's interaction with LBU Wellbeing Service and the BACP's decision reasoning. The report states there was sufficient information "to indicate a potentially high risk of self-harm, for which further assessment ought to have taken place quickly" as inferred from Naseeb's "reported mental state and his already self-harming in terms of his self-reported self-neglect". This was despite a question about self-harm/suicide having previously been removed from the standard form used for students to complete. The report goes on to say that "the triage system was somewhat ineffective".

In respect of Naseeb's interaction with LBU Wellbeing Service, there are significant issues of accountability which need to be addressed, including the BACP's decision making processes and reasoning. From our research we also propose improvements related to training and guidance, assessing risk and issues of transparency. The implications for lessons to be learnt and services improved towards better suicide prevention are profound.

Executive Summary – Recommendations

The University and its Student Wellbeing Service

Accountability

- **There should be a full and independent investigation into our complaint against LBU including its wellbeing service.**
- **There should be a statutory requirement for universities to have a duty of care to their students.**
- **University internal complaints procedures should allow for complaints to be pursued by the next of kin in cases where a student has died.**
- **An independent route should be available for the next of kin to take a complaint against a university in cases where a student has died.**
  While a student who has concerns about a university can have their complaint independently investigated by the Office of the Independent Adjudicator, their next of kin do not have that access.

Indicators for Prevention and Support

- **Universities should be required to routinely monitor attendance, academic engagement and performance.**
- **Policies must be in place to follow up non-engagement or poor performance and be robustly adhered to by all staff.**
- **All universities should have processes in place to identify students who may be 'at risk' of suicide.**[i] In respect of university students, mental health training for all staff should include the need to recognise potential stress factors such as academic pressures and financial strain.
- **Universities should have formal systems in place for the sharing of concerns internally about a student that can identify patterns which could result in life-threatening consequences.**
  Teaching staff, administrative and support services must work together in safeguarding young people.
- **Personal tutors should be required to have consistent and regular contact with their students and simple contemporaneous records kept of the content and duration of such meetings.**
- **Within the context of improving mental health literacy, suicide prevention training ought to be mandatory for pastoral and academic tutors.**
- **Students who are experiencing an academic crisis should have immediate and appropriate support put in place with regular follow ups of progress.**

[i] Identifying risk of suicide is important as research shows roughly 70% of people who take their own lives have not identified or registered as having mental health difficulties. As a result, strategies which primarily focus on people with a previous history of mental health difficulties will be severely limited in identifying and supporting people who are at risk of suicide. Only "28% of general population suicides were in people who had been in contact with mental health services in the previous 12 months". Appleby L., Kapur N., Shaw J., Hunt IM., Ibrahim S., Gianatsi M., et al., *National Confidential Inquiry into Suicide and Homicide by People with Mental Illness: Annual report 2017* (University of Manchester, 2017), p4 and p108. Available from https://documents.manchester.ac.uk/display.aspx?DocID=37560

Transparency

- **A university should be required to disclose all relevant documents and information to the Coroner and also the next of kin with full transparency and timeliness, when a student dies whilst studying at the institution.**
- **After a student has died, the university should disclose to the next of kin the details of any review of, and changes to, service provision which may have come about from the learning as a result of that death.**
- **Student Wellbeing staff should be required to keep contemporaneous records of interaction with students.**
- **Universities should be required to publish the number of students who have died by suicide whilst registered at their institutions.**

Accountability – the BACP

- **An independent review of the BACP's decision making processes and reasoning needs to take place in light of the Independent Expert's Psychological Report (Dec 2022).**
  This report profoundly differs with and challenges the BACP's assessment outcomes and decision reasoning.
- **The BACP should review and improve the accuracy and rigour in how it analyses complaints, in view of a series of critical points raised by this report.**
  The BACP misrepresented the focus of our complaint and the evidence. It accepted without questioning an ineffective triage system and a failure by the service to identify and act on *potential* risk of self-harm/suicide.

Training and Guidance – Student Wellbeing Service

- **All Student Wellbeing staff must receive guidance and training on suicide prevention, handling enquiries, identifying and dealing with students in distress and wellbeing triage conversations.**[ii]

Assessing Risk – Student Wellbeing Service

- **Questions about self-harm/suicide should be an essential part of mental health and wellbeing risk assessments.**
- **Risk formulation should be based on the presence or absence of both risk and protective factors.**
  Naseeb's completed registration form did not contain any clear protective factors, but this did not appear to influence the risk assessment.
- **Student Wellbeing Services should be clear about the methodology they utilise for assessing risk and evaluating severity.**

[ii] This must include how to identify key risk factors around self-harm and suicide, and the different issues associated with a student who presents in person for the first time to a service rather than registering on-line. In such circumstances a student could complete a paper form in a private room, where a professional can review and explore anything of concern on the form immediately with the student.

Debt

Loan Companies – Affordability

- **Loan companies must be required to include loans to other lenders when assessing whether a proposed loan would be affordable.**
  This would prevent them being able to lend to someone who was already over-indebted to other lenders.
- **Loan companies should conduct affordability assessments for all loans, however small.**
  Companies would then not be able to loan larger amounts through a series of small loans and so avoid having to assess whether they were affordable.
- **A basic minimum level of affordability checking should be specified rather than be left to the discretion of the lender.**
  There is currently no minimum level of information that should be assessed for evaluating the affordability of a loan.
- **The data held by Credit Reference Agencies (CRAs) must be updated promptly by loan companies, who should also be required to update all CRAs.**
  Assessing the affordability of a loan is hampered when this updating can be delayed by a few months and companies may not be updating all CRAs.
- **The FOS should be able to combine complaints against multiple lenders into one debt profile.**
  This would enable a full understanding of the affordability of a customer's entire set of loans. The FOS had to treat our complaint as seven separate complaints which made it difficult to correlate them and understand their combined impact.

Deterrence and Accountability

- **The penalties for irresponsible lending by payday loan companies must be adequate enough to provide a real deterrent.**
  Currently they are so small that simply by cancelling the initial loan as they have to with many of their bad debts, the companies can offset any penalty they may have had to pay.
- **Lenders ought to be required to hold detailed data from their affordability checks for an adequate period of time so that they can be accountable.**
  While financial records have to be kept for a number of years there is no similar requirement for records of affordability checks. In Naseeb's case, some lenders escaped scrutiny by simply being unable to provide details of their affordability checks.
- **The price cap on the costs of payday loans should be lowered further.**
  Even though the interest and fees payable on loans was capped in 2015, it is still too high with figures over 1,400% APR.
- **Lending companies should not be allowed to chase customers who decide not to complete an application.**[iii]
- **Companies should be accountable for giving false information in response to complaints for the purpose of rejecting that complaint or to avoid having to deal with it.**
  We encountered examples of lending companies claiming that Naseeb's accounts could not be re-

[iii] Naseeb repeatedly received automated emails and texts encouraging him to complete a loan application.

opened, or that the account was blocked, or no compensation would be owing therefore a complaint would be pointless.

Loan Application Procedures

- **There should be a mandatory delay after a payday loan application is made to reduce impulsive and anxiety-driven borrowing decisions**.
  It usually took Naseeb just half an hour between making an online application and receiving a payday loan – including all the required checks.
- **Quick comparisons with data from the Office for National Statistics (ONS) such as average spending by the poorest households should be used to highlight potentially implausible applications**.
  It is common for people to overstate their income and reduce their expenditure to get a payday loan, such as using a figure for monthly spending that is ten times lower than the income. Such unlikely ratios could also be easily detected.

Financial Vulnerability

- **Systems should be developed to track borrowing patterns that are indicative of high vulnerability risks.**[iv]
- **Tougher rules specifically for the payday loan sector are needed due to its distinctively high levels of financial vulnerability.**
  Currently they are no different than for any other lending including by banks and building societies whose loans are far less risky.

Healthcare

Risk Assessment

- **All GPs should risk assess a patient who presents with depression for the first time in accordance with guidance from NICE and RCGP. This would play a crucial role in suicide prevention.**
  A standardised baseline for risk assessment which is objective, evidence-based and does not rely on a patient's subjective presentation should be followed.
- **All GPs should record lack of risk as good practice when seeing a patient with low mood as it prompts the GP to make the direct risk assessment in the first place.**
- **Health centres should screen the mental wellbeing and risk to self of patients at the earliest possible opportunity.**

Training

- **Suicide prevention training should be mandatory for GPs within the context of improving mental health literacy.**
  In respect of university students, mental health training for practitioners should include the need to recognise potential stress factors such as academic pressures and financial strain.

[iv] Naseeb's debt history developed a worrying pattern which could have been picked up. Such risk indicators are particularly important to recognise given that research shows most people who are suicidal have not identified or registered as having mental health difficulties.

Transparency and Information Sharing

- **Proper transparency is needed from the GMC in respect of all documents supporting their decision reasoning in the case of the GP's consultation with Naseeb.**
- **When a coroner is involved in a patient's death, in addition to health centres sending a 'report' which lists information from the entries on a patient's medical records, the documentation sent should also include minutes of all meetings held where the case was discussed such as Significant Event meetings and staff appraisals.**
  LSMP's Significant Event meeting record and a record of the subsequent meeting between LSMP and the GP were not disclosed. If they had been available when preparing for the inquest into Naseeb's death, this could have raised sufficient concern for the Coroner to instruct an independent GP expert to report on the GP's consultation with Naseeb in May 2016.
- **When a coroner is involved in a patient's death, a GP should also be required to disclose the content of all meetings held where the case was discussed.**
- **When a coroner is involved in a patient's death, a health centre should remain in contact with the coroner's office to obtain information from the inquest findings to ensure the relevant learning takes place. GP practices should liaise directly with the organisation that a locum GP is contracted from, when a concern about the quality of a locum GP's assessment has been raised.**[v]

[v] LSMP did not liaise directly with YMC (from where the GP was contracted) regarding concerns raised about the quality of her consultation with Naseeb. Later in June 2016, at the clinical team meeting of YMC attended by the GP, whilst it is evident that some discussion of Naseeb's case took place this did not include the key issue of whether a risk assessment of suicide was needed. Despite LSMP already having raised concerns with the GP about this issue.

Glossary

BACP	British Association for Counselling and Psychotherapy
CCG	Clinical Commissioning Group
CONC	Consumer Credit Rules
CQC	Care Quality Commission
CRAs	Credit Reference Agencies
DPL	Data Protection Legislation
FCA	Financial Conduct Authority
FOI	Freedom of information request
FOIA	Freedom of Information Act
FOS	Financial Ombudsman Service
GMC	General Medical Council
HCSTC	High-Cost Short-Term Credit
IAC	BACP Investigation and Assessment Committee
LBU	Leeds Beckett University
LSMP	Leeds Student Medical Practice
NICE	National Institute for Health and Care Excellence
OfS	Office for Students
ONS	Office for National Statistics
PHAP	BACP Pre-Hearing Assessment Panel
PCP	Professional Conduct Procedure
PIR	Pre-Inquest Review
RCGP	Royal College of General Practitioners
SEMS	Student Engagement Monitoring System
YMC	Yorkshire Medical Chambers

References:

Within this document, the majority of research referred to was published and available before Naseeb died.

Executive Summary

[1] Institute for Public Policy Research, *Not by Degrees: Improving Student Mental Health in the UK's Universities* (Institute for Public Policy Research, 2017).

[2] MIND, *In The Red: Debt and Mental Health* (MIND, 2008). Report available from https://www.bl.uk/collection-items/in-the-red-debt-and-mental-health (accessed 25/04/23).

[3] Thorley, C., *Not By Degrees,* (IPPR, 2017), pages 34-35; available from https://www.ippr.org/files/2017-09/1504645674_not-by-degrees-170905.pdf (accessed 25/04/23).

[4] Russ, S., et al, *Suicide risk assessment and management* (www.gponline.com 18/05/2016).

[5] Dr Mahajan, S., *Bridging the Gaps in Suicide Prevention* (Churchill Fellowship, 2022), page 44.

[6] Healthwatch Leeds, *Mental Health Crisis in Leeds* (Healthwatch Leeds, 2019).

[7] National Union of Students, *Mental Health and Suicide Prevention* (National Union of Students, 2016), p30.