Preventing Student Suicide At Universities

Case Report in respect of

our son Naseeb Chuhan (1995-2016)

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Parents of Naseeb Chuhan

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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.**

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[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.

1. Chapter One: Academic and Pastoral Care Concerns at Leeds Beckett University

1.1 Introduction

Our son Naseeb Chuhan was a first-year Human Geography student at Leeds Beckett University (LBU) during the 2015-2016 academic year. He died by suicide at the end of the academic year, 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 chapter of our report documents 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. We then 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.

In 2017 the Institute for Public Policy Research reported that student suicides increased by 79% between 2007 and 2015.[8] This report also identified academic and financial pressures as major factors affecting student mental health and wellbeing. Naseeb's internet searches relating to suicide correspond with him reaching an academic crisis at the end of the academic year compounded further by a 'debt crisis'. 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 up to the end of December 2015, completing all of his work and obtaining some good marks equivalent to A and B. In stark contrast, for five months from January 2016, Naseeb hardly attended university and did not complete any further work. By the end of the academic year he had eight consecutive pieces of work outstanding, including a mandatory assignment as a replacement for an exam which he had missed in January 2016. 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. LBU eventually revealed in October 2019 that attendance monitoring "was not effective and did not provide timely, or accurate, information".[vi]

It is also clear that at a meeting initiated by Naseeb in early May 2016 his Personal Tutor, who was also the Head of Department and Course Leader, 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. The marked deterioration in Naseeb's academic performance and engagement was not recognised with the seriousness it deserved. We cannot think of any paid or voluntary work place where this would have been allowed to happen.

This change reflected Naseeb's vulnerability and should have been evident to any competent university department. Addressing these glaring academic issues earlier could have reminded Naseeb of his commitments and priorities and therefore motivated and directed him back towards his course ambitions and student cohort. If necessary appropriate support could have been put in place to avoid him reaching a crisis level.

[vi] 'Parents' specific points and issues for Dr K' submitted via the Coroner to LBU in October 2017. The answers provided by LBU were only disclosed to us in October 2019 through a separate complaints process, by the BACP.

After the inquest into Naseeb's death we submitted a comprehensive complaint to LBU about our concerns relating to the academic and pastoral care he had received. However LBU refused to investigate our complaint. From 2018 onwards, we spent over a year trying to find an independent complaint route through which we could submit our complaint against LBU. Frustratingly, 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 stating her concerns about the lack of an independent complaint route for families. She later raised this issue in parliament during a House of Commons, Department for Education debate stating "In the case of a student suicide at university, no redress is available to the family if they have concerns about the welfare support that the student received … In particular, when there has tragically been a suicide, how can the family, after the death, continue to have access to redress?" [9]

As part of a complaints process with the British Association for Counselling and Psychotherapy (BACP) 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 in contradiction to LBU's written Attendance Policy, 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 would have presented additional factors for the Coroner to have considered, and we were denied the opportunity to obtain witness evidence from the last member of LBU's academic team to see Naseeb before he died.

This chapter argues for significant issues of accountability and transparency to be addressed in relation to LBU's systemic failure in its duty of care towards our son. In relation to suicide prevention strategies, there are a range of actionable learnings from Naseeb's case which could significantly improve the early identification of and support for students at potential risk of self-harm/suicide.

1.2 Our Complaint Relating to Concerns about Academic and Pastoral Care at Leeds Beckett University (July 2018)

In April 2018, through the LBU Student Advice Service Manager we established that LBU's complaints procedure only allowed for complaints to be made by students on behalf of themselves. The rules stipulated that "Complaints will not be accepted … from parents or other third parties (unless expressly authorized to act on behalf of the complainant)."

The LBU Governance & Legal Services then confirmed "We'd use the principles of the Student Complaints Procedure, but Naseeb's parents can just write in with their complaint and we will, of course, look into it." We then submitted our complaint to LBU as Naseeb's next of kin, given that he was deceased.

Our detailed 12 page complaint included an additional 300 pages of comprehensive supporting evidence. We asked the University to specifically address the following issues:

- **Why our son's attendance, engagement and academic performance was not monitored, recorded and acted on in accordance with LBU's publicly available material in relation to this matter.**
- **Why the University has been unable to supply the precise details of LBU's Attendance Policy in place at the time our son was studying in Leeds.**
- **Our belief that the Head of Department, Course Leader and Personal Tutor, Dr K neglected to provide Naseeb with adequate pastoral care.**

- **Why formal systems for sharing concerns about a student internally were poor or non-existent at the University.**
- **Why the University did not have adequate processes in place to identify students who may be 'at risk' of suicide.**
- **What lessons have been learnt by LBU following the death of our son.**

1.2.1 Monitoring of Attendance, Engagement and Academic Performance

Our complaint sought an explanation for why our son's attendance, engagement and academic performance was not monitored, recorded and acted on in accordance with LBU's publicly available material in relation to this matter.

From January 2016 onwards we know Naseeb's academic attendance was seriously falling as illustrated by subsequent recollections from his course lecturers in a 'Table of academic results and lecturer comments' sent to us in September 2016. For example, Dr M stated: "Unfortunately Naseeb didn't attend any lab sessions and didn't hand in any work for either assignment" and Dr N said: "I don't think he attended much of the module."

Immediately after Naseeb died his Head of Department, Course Leader and Personal Tutor, Dr K told us in a telephone conversation that during his meeting with Naseeb on 5th May 2016 he thought Naseeb had one piece of work outstanding, and one other which he only realised after the meeting had ended, and emailed Naseeb about. When asked about Naseeb's attendance at university he stated that the University did not monitor attendance.

After a series of email communications lasting four months LBU Human Geography Department revealed that at the time of this meeting Naseeb actually had five pieces of work outstanding which had increased to a total of eight by the time he died.

Having obtained a full numbered set of emails from Naseeb's university email account, we are appalled at there being no evidence of a single staff member from LBU initiating any communication with Naseeb about his absence and non-submission of work by letter, email, phone call or text message, over a period of five months.

An email we received from LBU Human Geography Department in Sept 2016 also states that during "field trips...to Newcastle and Manchester...we do not have a record of his or anyone else's attendance" and that "The University does have an attendance policy but it stops short of setting expectations. Lecturers do try and take their own attendance too."

1.2.1.1 Lack of effective systems for monitoring student attendance

Although we have not received any coherent account from LBU of Naseeb's actual course attendance, our research uncovered a lack of effective systems for monitoring attendance:

- **The enrolment email** which Naseeb received in August 2015 states under attendance that "You are expected to attend all timetabled teaching sessions and demonstrate high levels of engagement on your course to fully support your learning and achievement. If you will be absent from University for any reason, please notify your Personal Tutor."
  However the link in the enrolment email to the 'Attendance Policy' only navigates to the 'Student Charter' which does not mention attendance.

- **The University 'General Regulations for academic year 2015/2016'** state that "If you are absent you must notify the University by contacting the relevant Faculty/School office" and "You must provide a medical certificate when you are absent because of illness for more than 7 consecutive days (including weekends)."
- **LBU's 'Course Handbook for BA (hons) Human Geography2015/16 Undergraduate Students'** states that "You must notify your Student Administrator if you are absent for more than one day" and "If you are absent because of illness for more than seven days (including weekends), you must provide us with a Fit Note."
- **LBU Human Geography Department** course administrator explained to us during a telephone call in February 2017 that for the course Naseeb was taking, it has always been the case that "students must attend all lectures and if not able to they must contact their personal tutor to explain why not."
- **LBU's public website** clearly stated that in 2013 the University enhanced and relaunched their Student Engagement Monitoring System (SEMS). This system "collates information about a student's attendance, their engagement with MyBeckett modules, assessment results and contact details in an easy to access, searchable format". A variety of staff "now also have access to this system to enable them to support students more effectively and responsively".[10]
- **LBU's Centre for Learning and Teaching** video for staff training titled 'SEMS' further states "You can look at a student's attendance so if a student is not attending it is a trigger to a Personal Tutor to bring that student in" and that "Low attendance is highlighted in red. This allows the Personal Tutor or Module Tutor to take action to discuss the low levels of attendance with the student and offer support." [11]

At the inquest into Naseeb's death, Dr K stated that SEMS was not in operation in his department when Naseeb died, instead a system of lecturers taking their own paper registers was used. We noted Dr K as saying that SEMS "relies on someone to input that information physically on to the re launched SEMS system and to my mind that didn't quite happen and that is why I asked my staff to take an additional local register ... I don't know if individual module leaders keep that information". He then explained that "my team we didn't use SEMS. It was more reliable for us to use our own local records however temporary those records were."

Without a system for collating this information, it is not possible to monitor attendance in any meaningful way. It is also neglectful to not follow up students when required attendance procedures are not adhered to. There is a dangerous and glaring incongruence here between what LBU's documentation states and the reality in practice. We are deeply saddened and shocked that the University were unable to identify that our son had accumulated a critical level of outstanding work.

1.2.2 Lack of a Coherent Attendance Policy

We have been unable to establish the precise details of LBU's Attendance Policy in place at the time our son was studying in Leeds. We have not received any explanation as to which parts of the LBU 'Attendance Policy' were actually in place when Naseeb was studying at LBU during 2015-2016, despite our requests to clarify this:

- The University full 'Attendance Policy', was received in March 2017 through a Freedom of Information (FOI) request. The accompanying email stated this policy "was approved at the end of

the 2014/15 academic year, however its full implementation is subject to the outcomes of a pilot of a technological attendance monitoring solution which is still to conclude".

- We then asked LBU for a copy of the "preceding Student Attendance Policy which was therefore in full implementation during the academic years 2014-15 and 2015 -16" and to also clarify if any specific parts of the disclosed 'Attendance Policy' were in implementation during these academic years.
- Bizarrely, in May 2017 LBU replied, "We did not have a specific attendance policy prior to 2014/15. Students were bound by the General Regulations and the Student Contract and individual Schools had their own arrangements for attendance monitoring."

As LBU had not clarified the precise details of what actual policy was therefore in place when Naseeb was studying at LBU during 2015-2016, we could only assume that the disclosed 'Attendance Policy' was the relevant policy for this period. In October 2017, prior to the inquest into Naseeb's death, we requested the Coroner's Office forward to LBU a list of questions titled 'Parents' specific points and issues for Dr K':

- With reference to the Attendance Policy and paragraph 5.1. Given the absence of the technical system in 2015/16, how was Naseeb's attendance 'monitored at every timetabled session' and how were 'weekly attendance reports' prepared? Were such reports prepared in Naseeb's case?
  LBU's reply: "attendance monitoring was a paper-based process and... was not effective and did not provide timely, or accurate, information."
- The Attendance Policy for 2015/16 is said to compliment other procedures such as ... 'Student Engagement Monitoring Procedures'. What are these procedures? Can we have copies of the documents detailing these procedures in good time before the inquest?
  LBU's reply: "The Student Engagement Monitoring Procedure [SEMS] was not in place across the University at that time."
- What was the 'weekly absence threshold' as referred to at paragraph 5.1.2 as at 2015/16?
  LBU's reply: The weekly absence "threshold...was not in place in 2015/16. However, in Naseeb's subject area, academic staff took their own records and, if it was felt that a student was not attending, they would be asked to come in to discuss any support they may require with the module leader, course leader or personal tutor".
- Why didn't Naseeb's repeated absences in the second term 'trigger' the academic advisor to contact Naseeb to discuss the reasons for his absence, as required by the Attendance Policy?"
  LBU's reply: "Academic Advisors were not in place at that time."

It is important to note that the above replies were not made available by LBU for the inquest into Naseeb's death. In October 2019 we discovered that LBU had drafted answers to our questions but not disclosed them to the Coroner's Office. The details of this withheld disclosure are explained later in this chapter.

The replies to our questions reveal that in contradiction to LBU's written 'Attendance Policy', the checks and balances required to support students and flag up concern were not in place.

1.2.3 Inadequate Pastoral Care, Support and Record Keeping

We believe the Head of Department, Course Leader and Personal Tutor, Dr K neglected to provide Naseeb with adequate pastoral care. A university document from the LBU Personal Tutor web page emphasises the importance of the personal tutor role. Referring to LBU's own review of research it states that students want "regular, scheduled meetings ... a Personal Tutor who takes an active role throughout their degree"

and “they want to be known, ‘tracked’ and supported throughout”.[12] From all the considerable amount of evidence, we found that the poor quality of pastoral care for Naseeb further compounded the academic crisis he was experiencing.

1.2.3.1 Personal tutorials did not take place

There is no evidence that Naseeb had any personal tutorials with Dr K. After Naseeb died we obtained and thoroughly inspected a full numbered set of emails from his university email account. There is no evidence that the second personal tutor meeting was even initiated by Dr K. At the inquest Dr K also revealed that none of his students attended the second semester personal tutor meeting.

The University’s ‘Guidance for Personal Tutoring’ stipulates there should be at least two meetings held with first-year students, one within four weeks of starting the course and the second meeting early in the second term to “review semester 1 results and all feedback and progress” along with “goal setting and study skills”. The guidance also states that “the Personal Tutor should be proactive in initiating an invitation to the student for meeting appointments throughout the course.” Personal Tutors are directed towards using SEMS to gain “access to student results and information and track activity”.[13]

1.2.3.2 Dr K lacked knowledge of the severity of Naseeb’s academic crisis

Naseeb had missed an exam in January 2016 and then did not complete the resit piece of work set by his module leader, Dr M. At the Board of Examiners meeting in March 2016 it was recorded that Naseeb had missed this exam. Naseeb then also did not take the resit exam scheduled for early April 2016. At the inquest Dr K stated that it is an exception for a student not to attend an exam. He claimed he knew about this missed exam and that there would have been a re-sit procedure. When asked why he did not contact Naseeb about this matter Dr K said “I can’t offer an explanation.”

Naseeb’s internet browsing history shows that on 18th April 2016 he researched “depression help” and on 2nd May 2016 “Is Suicide Honourable?”. Two days later Naseeb visited Dr K and initiated an appointment. The meeting took place the following day on 5th May. Dr K does not appear to have had any knowledge about the severity and seriousness of Naseeb’s academic crisis at this meeting.

A day had lapsed between Naseeb initiating the meeting and it actually taking place. This was ample time for Dr K to check on Naseeb’s academic progress, if there were any actual up to date records. In his notes about that meeting to us Dr K stated “Naseeb rarely made contact with me so I know quite possibly he wanted to discuss something affecting his work.” Despite this, when asked at the inquest whether he had looked up how Naseeb was doing prior to the meeting, Dr K admitted that he had not checked on Naseeb’s progress. He stated “I didn’t have a look at what he was doing.”

Dr K lacked knowledge of the status of Naseeb’s academic performance. During the telephone conversation with us immediately after Naseeb died (as described above in 1.2.1), he told us that Naseeb was worried about his marks being low and when asked about Naseeb’s attendance at university he stated that the University did not monitor attendance. At no point did Dr K indicate Naseeb had been at serious risk of failing his course. He actually reassured us that the University “would not have let him fail”.

After persistent email communication from us, four months later in September 2016 Dr K and Dr L (subsequent Course Leader) revealed that “After speaking with Semester two module leaders it seems Naseeb did not submit any work for semester two”. Therefore when Naseeb met with Dr K on 5th May 2016 he had five pieces of work outstanding including a required exam resit assignment, plus another assignment due in the day after this meeting. A further two assignments were also due in later that month. By 17th May 2016, at the end of the academic year, Naseeb had eight consecutive pieces of work

outstanding which included a mandatory resit assignment for an exam he had missed in January 2016. Naseeb's personal tutor was clearly oblivious of this basic but vital information.

At the inquest, in respect of the meeting on 5th May 2016, Dr K confirmed to the Coroner "I was certainly aware he hadn't attended the exam. I don't think I was aware he hadn't handed in other assignments at that time." Dr K also admitted that with the actual amount of work Naseeb had outstanding he would most likely have failed the year.

After this meeting, instead of supporting Naseeb with the academic crisis he was facing in relation to the volume of work he had outstanding, in a stern tone Dr K focussed purely on a single piece of Naseeb's outstanding work. Later that day, Naseeb received an email from Dr K urging him in capital letters that "IT IS ABSOLUTELY VITAL YOU MAKE CONTACT WITH [Redacted] ASAP TO COMPLETE YOUR OUTSTANDING WORK." This referred to the exam resit work from January 2016 which Dr K "didn't know about" until after his meeting with Naseeb. A week later his university department sent Naseeb an email which assumed he would apply for mitigation and in relation to this piece of work stated "I presume you have completed this assignment as you can't progress with a non-submission for semester 1."

By this date, in fact Naseeb had six pieces of work outstanding and was going to fail his course. He had also revealed that he was struggling to his personal tutor. Within this context, we cannot understand why Naseeb was being required to complete this specific piece of work so that he could progress on the course, unless the University was oblivious to the actual amount of work Naseeb had outstanding.

1.2.3.3 No support or review was put in place for Naseeb

Dr K told us in a telephone conversation soon after Naseeb died that during the May 2016 meeting he had simply directed Naseeb towards the counselling service. Later in August 2016 Dr K's notes about the meeting include advising Naseeb to see "student wellbeing or someone from the student union". No follow up meeting, review of progress or practical support such as a student advisor was put in place.

If Dr K did advise Naseeb to visit the student union, on the evidence available Naseeb was not referred to support services in any informative way. No discussion or explanation about how the student union could possibly be of any help took place.

At this stage we consider Naseeb's profile as being in a high-risk category of suicide. He was a young male student at the end of the academic year, and following a marked change in his academic engagement was facing failing a course he had invested his future in both mentally and financially. Naseeb's insight into his own situation before he died, based upon his answer on the LBU Student Wellbeing registration form, was that he was at risk of failing his course. Dr K's subsequent notes (August 2016) about his meeting with Naseeb in May 2016 state "it was clearly difficult for him to come and see me and admit he was struggling." It is deeply concerning to us that at the inquest Dr K acknowledged it did not even cross his mind that Naseeb may be at risk in any way.

1.2.3.4 No contemporaneous record of the meeting between Dr K and Naseeb

When the meeting took place on 5th May 2016, Dr K did not make any record of its content or duration. It is concerning to us that simple contemporaneous records of such meetings are not kept by personal tutors. It is difficult to believe Dr K's claim that he spent 30-40 minutes with Naseeb. In all his documented accounts of the meeting, which are from memory, there is insufficient substance in what he discussed with Naseeb for the meeting to have lasted this long.

1.2.3.5 Naseeb was spuriously directed to navigate a complex mitigation procedure

We found a copy of the extenuating circumstances and mitigation forms and handbook in Naseeb's belongings after he died. Both the staff and student handbook on this subject stipulate that if an extension of time is requested this can only be applied for "up to your original assessment deadline" and can normally be granted for up to five days (a maximum of 10 days is stated in the Staff Handbook). In the case of a request for mitigation this must be submitted "normally no later than 5 working days from the date of assessment".

The student is expected to obtain and supply documentary evidence to support their application form. On reading this complex code of practice, Naseeb would have realised he had missed the deadline to apply for mitigation for the majority of work he had not submitted. Therefore before he died Naseeb was left to navigate his way through a complex mitigation procedure when his coping resources were overwhelmed. He had told Dr K at the meeting in May 2016 that "things had gotten on top of him".

We were unable to establish from whom within the department Naseeb had obtained the extenuating circumstances and mitigation forms, and what accompanying advice, if any he was given. In October 2017 prior to the inquest into Naseeb's death, we asked LBU through the Coroner's Office to clarify who had sent Naseeb two emails in May 2016 about 'Mitigation', one of which suggested "it is the best solution", and from whom did this person know that Naseeb wanted "to apply for mitigation".

LBU replied that "The emails were sent by a Student Administrator who has now retired from the University. [Dr K] had advised Naseeb to see the Administrator about applying for mitigation or an extension. It is assumed that [Dr K] had notified the Administrator that Naseeb may approach them for advice about the process."

This reply was not made available by LBU for the inquest. In October 2019 we discovered that LBU had drafted answers to a list of questions titled 'Parents' specific points and issues for Dr K' but not disclosed them to the Coroner's Office. The details of this withheld disclosure are explained later in this chapter. As a result we were not able to request further clarification prior to the inquest, regarding the following:

- What information did Dr K notify the Student Administrator of in relation to Naseeb applying for mitigation or an extension?
- To what extent was the Student Administrator, who had been notified by Dr K, aware of how much work Naseeb actually had outstanding?
- What advice did the Student Administrator give Naseeb when he collected the documentation and forms relating to mitigation / extension which we found in his belongings after he died?

Shortly before Naseeb died, he completed a registration form at the LBU Wellbeing Service in which he considered himself at risk of failing his course and was receiving support from "no-one" at present. The following day, on Thursday 26th May 2016, his internet browsing history ended around 9pm. The last website which Naseeb browsed before he died was the University online learning portal for 13 minutes which was briefly followed by interpretations of the lyrics for 'Born to Die' by Lana Del Rey.

1.2.4 Formal Systems for Sharing Concerns about a Student Internally were Poor or Non-existent

In January 2016, we realised Naseeb had missed an exam at the start of the second term. We telephoned the University and conveyed our concerns in the absence of his personal tutor, to one of Naseeb's lecturers, Dr M. In a 'Table of academic results and lecturer comments' (September 2016), she incorrectly

recalls the phone call taking place before Christmas 2015. This phone call actually took place on 26th January 2016 which was after Naseeb had missed Dr M's exam, as verified by our phone records.

At the inquest Dr K could not recall whether the concerns raised were logged within the department or passed on to him. He stated that "it's quite unusual for parents and staff to communicate by telephone and it might be something that [Dr M] treated with the strictest confidence." Effectively our concerns were not shared and Naseeb's subsequent repeated absences did not trigger an academic advisor to contact him.

Prior to the inquest into Naseeb's death we asked LBU through the Coroner's Office, in October 2017, "When Naseeb failed to attend [Dr M's] examination on 11th January 2016 and then failed to hand in any work, what support options were outlined and offered to him, as required by paragraph 5.2.1 of the Attendance Policy?"

LBU replied that Dr M did informally discuss the missed exam with Naseeb but she did not discuss the matter with Dr K as he "was away from the office…[Dr M] did not log this on any system – the team was not using SEMS at that time".

Again, this reply was not made available by LBU for the inquest. In October 2019 we discovered that LBU had drafted answers to a list of questions titled 'Parents' specific points and issues for Dr K' but not disclosed them to the Coroner's Office. The details of this withheld disclosure are explained later in this chapter.

The LBU 'Attendance Policy' states that "Where academic engagement falls below the required levels, tutors will inform the student. In this instance, students will be reminded of their commitments and support options will be outlined and offered if required." [14]

In a 'Table of academic results and lecturer comments' about Naseeb (September 2016), Dr M states "Naseeb sadly didn't attend the examination. He only needed 5% from the exam to pass the module overall...we talked about him only needing to do a minimum to reach the necessary mark to progress." Naseeb did not complete Dr M's exam resit work and missed handing in two further assignments for her in March and April 2016. As recorded in this table, he also did not attend any of Dr M's lab sessions during the second and third term. Dr M therefore witnessed a repeated pattern of non-attendance and non-submissions from Naseeb and yet did not raise concerns.

Throughout the last five months of Naseeb's life when he was hardly attending university and not handing in any work, there appears to have been no communication and sharing of concerns between his lecturers, personal tutor and Head of Course/Department. As going to university is an important and vulnerable time of transition for young people, we believe that working together within academic institutions is critical for safeguarding young people. It is vital to avoid systemic failures in recognising patterns which can result in life-threatening consequences.

1.2.5 Lack of Adequate Processes to Identify Students who may be 'at risk' of Suicide

LBU's staff training document, 'Mental Health Awareness' stated that men are three times more likely than women to take their own lives, "academic problems" can be a risk factor, and key suicide risk warning signs include "Significant changes of behaviour, e.g. becoming withdrawn, when this is not typical of the individual".[15]

After being fully engaged with his course in the first term, Naseeb subsequently missed completing eight pieces of work and there is little evidence that he was in attendance for the last 18 weeks of his course.

Fundamentally it is impossible to assess risk if you are not having any contact with a student or monitoring and recording their progress.

The research 'Trapped in transition: findings from a UK study of student suicide' paints "a picture of students seeking an escape from what was experienced as an increasingly intolerable state of existence where the prospect of failure loomed large. Transitional periods in the academic year are key in providing a context for this state of mind. Three-quarters of the deaths occurred either at the beginning or at the end of the academic year". Detailed accounts show "suicide as a means of avoiding further failure and distress".[16]

As far back as 2002 a management guidance report on reducing the risk of student suicide was produced by Universities UK, of which LBU is a member. It states that in view of increasing student numbers and diminishing resources straining personal tutor systems "it is very important that the widest possible range of staff is made aware of the potential risks for students and that other systems are put in place to ensure that institutional contact is maintained on a regular basis." Furthermore "there is an even greater danger of isolation amongst students living in the private sector." This document states that fundamentally universities have a 'duty of care' to their students, notwithstanding the legal framework they "have a moral duty to pay due attention to any potential risks to their student body and to take steps to minimize those risks when at all possible".[17]

Naseeb was living in the private sector, only required to attend university for two days a week in the second term and entitled to two personal tutorials throughout the academic year, neither of which took place.

1.2.6 What Reviews, Changes and Action did LBU Undertake Following the Death of our Son?

We asked the following questions in respect of Naseeb having died by suicide whilst studying at LBU:

- Had the University conducted any review of service provision at either departmental or university level?
- What changes, if any, had been made with the benefit of hindsight?
- What action had been taken in respect of any staff who did not follow guidelines or procedures?

The question as to whether LBU had "carried out a review of any sort arising out of Mr Chuhan's death?" was asked of the University, prior to the inquest, in enquiries raised by the Coroner in July 2017. The University reply avoided answering this specific question.

In 2018, as part of a complaints process with the British Association for Counselling and Psychotherapy (BACP) in respect of LBU Wellbeing Service (see Chapter 4) we asked the BACP to ascertain whether LBU had learnt any lessons following the death of our son. In October 2019 the BACP disclosed to us a letter from LBU dated August 2019 which stated "Changes have, therefore, been made as part of our ongoing process of review and continual improvement in an attempt to achieve best practice, however these were not made specifically as a result of Naseeb's death."

The changes are consistent with the kinds of approaches needed to address some of the shortcomings we have specifically raised about LBU and it appears to us unlikely that these would be entirely coincidental. They include the following:

- "Introduction of our Student Engagement Monitoring system which tracks academic engagement and attendance allowing course teams to overview a student's progress and therefore prompting a

conversation and follow up where a student's engagement profile indicates non-engagement or poor performance;

- Enhanced staff development for academic and professional services staff regarding mental health and wellbeing;
- Publication of our 'when to refer' guide for staff which covers a range of crises scenarios as well as student life issues that may require specialist professional services interventions;"

1.3 Withheld Disclosure of Information by LBU

On 4th October 2017, over two months prior to the inquest into Naseeb's death, we requested the Coroner's Office forward to LBU a list of questions titled 'Parents' specific points and issues for Dr K'. As we did not receive a response from LBU only our questions could be included in the Final Inquest Bundle of evidence, which we submitted the to the Coroner's Office on 30th November 2017. However we later discovered that LBU had answered our questions but not disclosed them to the Coroner's Office.

In October 2019, as part of a complaints process with the British Association for Counselling and Psychotherapy (BACP) in respect of LBU Wellbeing Service, the BACP released to us 21 documents it had received from LBU. One of these was a version of the document titled 'Parents' specific points and issues for Dr K', which included LBU's replies to the questions listed. We had not previously received a copy of this document and were surprised to see that LBU informed the BACP it had sent this completed version to the Coroner's Office on 28th November 2017.

On receiving the Final Inquest Bundle of evidence, if LBU had submitted the written answers to our questions to the Coroner's Office, it had at least two weeks to flag up that they had not been included. At the inquest into Naseeb's death, LBU's legal team and Dr K (to whom the questions were addressed) avoided answering why these written submitted questions had not been replied to.

In February 2020 we asked the Coroner's Office to check "whether LBU did submit their written answers to our questions to the Coroner's office". The reply we received confirmed that they did "not appear to have received an email from the LBU on 28 November 2017".

The completed version of this document from LBU would have been an important piece of evidence for the inquest. It revealed that in contradiction to LBU's written Attendance Policy, the checks and balances required to support students and flag up concern were not in place and would have presented additional factors for the Coroner to have considered. We were also not aware that the last member of LBU's academic team to see Naseeb was the Student Administrator and therefore could not request the Coroner submit to them our questions which still remain outstanding. The withheld disclosure of this document by LBU also raises important questions and concerns over its conduct in the process leading up to and during the inquest.

1.4 LBU's Refusal to Investigate our Complaint

In August 2018 we received the following reply from the University Secretary which stated that LBU would not be investigating our complaint:

> "… the issues that you have raised were addressed in meetings with you prior to the inquest and during the inquest itself. The inquest was concluded following a thorough examination of the issues, reviewing all of the evidence available and hearing from witnesses. The Coroner issued a Regulation 28 Report for the Prevention of Future Deaths to the Financial Conduct Authority

following the inquest. However, he did not require a further response from the University in relation to any of the points covered during the inquest. If you are unhappy with the findings from the inquest, your legal advisor will be able to advise on any additional courses of action available to you."

In September 2018 we wrote to LBU as the University's refusal to consider our complaint, by suggesting that the inquest thoroughly examined the issues we had raised, was entirely misplaced. We explained the following:

- We have not had a single meeting with anybody from the University since Naseeb died. We visited the University 'Rosebowl' Student Hub once shortly after Naseeb died simply to view the last place where he was seen alive. At this visit we were hosted by the Student Wellbeing Officer and the Director of Student Services; this was not in any sense a formal meeting.
- The scope of the inquest was duly limited as an inquest is not intended to find faults but simply establish facts.[18] Some of the facts supporting our complaint were aired at the inquest, other facts came to light during the inquest. However the inquest did not attempt to deal with any of these as complaints against the University. Hence all the issues raised in our complaint to LBU have never been properly examined and addressed.
- At the inquest, Dr K, Head of Department, Course Leader and Personal Tutor, was the only witness of whom questions relating to academic attendance, engagement, performance and pastoral care could be asked of. His explanations were limited and raised a number of the concerns we have outlined in our complaint. Dr K was also unable to address questions relating to LBU policy and systems including regarding the professional conduct of his own departmental staff.

Most of our questions were not answered by LBU at the inquest and some we were not even allowed to ask. The inquest into Naseeb's death was not an 'Article 2' inquest.[vii] We understand from the organisation INQUEST that often there may be certain aspects of a case, even when issues could be relevant, where a Coroner can decide to limit the detail it is explored in.

Our MP Kate Green also wrote to the Vice Chancellor of LBU, Professor Peter Slee and requested the University to look into the concerns we had raised and provide us with a thorough response. Professor Slee's reply again refused to accept our complaint and invited Kate Green MP to meet with him. Given the University had refused to investigate our complaint and not dealt with it in a thorough, transparent and impartial manner, it became inappropriate for Kate Green MP to meet with the University on our behalf.

1.5 The Absence of an Independent Complaint Route

From 2018 onwards, we spent over a year trying to find an independent complaint route through which we could submit our complaint against LBU. We contacted all the organisations with any responsibility for overseeing universities, namely Universities UK, the Higher Education Funding Council for England, Office of the Independent Adjudicator for Students in Higher Education, and the Office for Students (OfS). They were

[vii] The scope of an inquest is defined by the Coroners and Justice Act 2009 and depends on whether Article 2 of the European Convention on Human Rights is engaged (The Human Rights Act 1998). If Article 2 is engaged, the inquest becomes a wider enquiry of ascertaining 'in what circumstances the deceased came by his or her death'. The inquest into Naseeb's death was not an Article 2 inquest and the 'how' was therefore simply stated as the method by which he took his own life.

all unable to accept our complaint for investigation. A full summary of this process can be found at Appendix A.

Our communication with the OfS spanned six months. Eventually the OFS admitted that they “did not provide fully accurate information” and it was “not able to investigate individual cases”. We have established that there is now an absence of any other appropriate independent complaint routes available to us, as the concerned parents of a young person who died whilst studying at university.

1.5.1. The Department for Education and Parliament

In February 2019 Kate Green MP sent a letter to Chris Skidmore MP, Minister of State for Universities, Science, Research and Innovation, Department for Education. This letter outlined the routes we had explored in relation to our complaints against LBU, stated her concerns about the lack of an independent complaint route for families and asked “where my constituents can now go to seek redress”.

The reply letter from Chris Skidmore MP outlined the remit constraints of some of the organisations we had approached which are listed above. The letter then focussed on what the Government are doing in supporting university mental health initiatives. Ironically, for our situation which relates to a lack of monitoring and recording of student attendance, engagement and academic performance at LBU, the letter ended with the following statement:

> “Universities do take their responsibilities in this area seriously. There is a high awareness of the need to offer support services as part of student services … They adopt local systems to help identify students who may be finding it hard to cope, using information such as course attendance, and referral systems from personal tutors or lecturers.”

Separately, in July 2019 Kate Green MP raised the following issue in parliament during a House of Commons, Department for Education debate:

> “In the case of a student suicide at university, no redress is available to the family if they have concerns about the welfare support that the student received. If a student is dissatisfied, he or she can go to the Office of the Independent Adjudicator, but their family members or parents do not have that access; nor will the Office for Students look at individual cases. May I ask the Minister to use his good offices to talk to colleagues about how we can ensure there is support for family members who have concerns about the care of their children? In particular, when there has tragically been a suicide, how can the family, after the death, continue to have access to redress?”[19]

1.6 The Impact on Naseeb of Poor Academic and Pastoral Care

It is not unusual for students to drift away from academic engagement after the Christmas period. However the glaring deterioration in Naseeb’s academic attendance, performance and engagement was ignored by the University and raises serious concerns. 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. Once a student gets to this point it can be difficult for them to even know where to start. This would have exacerbated Naseeb’s difficulty in being able to tell us or anyone else about his probable academic failure, as he perceived it to be.

Naseeb’s feeling of failure would have been magnified as this was the second time he had not completed his first year at university. He had returned home from the University of West England in April 2014. At the

time we felt he had been too young when he had gone to university at age 18 and Bristol was too far away from Manchester and his large group of close friends.

We believe that this time Naseeb wanted to stay on his university course and pass the first year. This is evidenced by the fact that he initiated a meeting with his personal tutor Dr K on 4th May 2016, which then took place the following day. A few days before he died Naseeb had organised house viewings and secured accommodation for the second year.

Our son also stated in his answers on the LBU Student Wellbeing registration form, the day before we believe he died, that he considered himself at risk of failing his course but was not considering either deferring his course or leaving university. Naseeb would have felt on his own in trying to deal with this and shocked at how he had let himself down in this way. He also stated on this form that he was receiving support from "no-one" at present and confirmed that he was missing lectures and seminars.

Naseeb was bright and Dr K described him as "erudite". However his ability was being let down by his lack of performance and it seems that nobody appeared to notice or bother to say anything to him about that. We cannot think of any paid or voluntary work place where this would have been allowed to happen.

1.7 Recommendations

1.7.1 Accountability

- **There should be a full and independent investigation into our complaint against LBU**.
- **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.**
  If a student has concerns about a university, they can go to the Office of the Independent Adjudicator for a complaint to be independently investigated and where relevant notify the Office for Students. However their next of kin do not have that access.

1.7.2 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.**
  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.[viii]

[viii] 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

- **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.**

1.7.3 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.[ix]**
- **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.**
- **Universities should be required to publish the number of students who have died by suicide whilst registered at their institutions.**

[ix] In October 2019 it was revealed during the complaints process of the British Association for Counselling and Psychotherapy (BACP) that LBU had withheld disclosure of an important document from the inquest into the death of Naseeb. This document would have presented additional factors for the Coroner to have considered and we were also denied the opportunity to obtain witness evidence from the last member of LBU's academic team to see Naseeb.

2. Chapter Two: Payday Loans, Irresponsible Lending and Debt

2.1 Introduction

This chapter of our report lays out inappropriate, unethical and damaging lending practices in relation to our son Naseeb Chuhan who died by suicide whilst he was a first-year student at Leeds Beckett University. We also present clear and actionable steps urgently needed to address these lending practices.

There is widely accepted research that exposes the strong links between mental health and debt,[20] and which led to the Money and Mental Health Policy Institute being established.[21] We are also aware from discussions with student support professionals 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. Financial pressure on students is regularly cited as a key factor[22] and concern about the issue is widespread. Changes in the regulatory framework have been demanded by both debt and mental health charities for a number of years.

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. 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 stated "there is a risk that future deaths will occur unless action is taken." We believe this to have only been the second time that such a report has been issued to the FCA, which represents a significant outcome and indicates a strong verification of our concerns regarding Naseeb's debts by the Coroner.

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. We are disappointed to report that 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, despite the regulations now placing greater emphasis on the importance of such assessments.

Nevertheless, 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."

2.2 Background Narrative

Our son Naseeb was a young student at Leeds Beckett University (LBU). From age 16, he had been used to working, earning money and with our support balancing his income and spending. Naseeb had regularly worked at matches and events for Manchester United FC. Before starting as a student at LBU, he had also spent a year working part time at a local arts centre.

At university Naseeb was on a student finance scheme and had no other source of income. When he died, we discovered that not only did Naseeb have a number of outstanding debts, but also that the last 12 months of his life had been riddled with multiple and repeated loans given to him by various payday loan companies. This led to significant concerns as to whether this lending had breached both the regulatory requirements of lenders and the spirit in which lending ought to be taking place. Our subsequent investigations led to a series of formal complaints, initially to each loan company and then to the Financial Ombudsman Service (FOS).

Naseeb was not able to disclose to either his friends or us, his parents, the full complexity or extent of his debts. In addition to a set of money loans which involved rapidly rising interest and charges, they also included a number of outstanding household bills. This was the biggest debt that he had ever experienced in his life.

Naseeb was borrowing money to pay off his existing debts, had no foreseeable income to do this with, and was unable to meet his essential outgoings. It is the combination of these three circumstances that define Naseeb as having been caught in a debt crisis regardless of the total amount of his debt.

In the last few days of his life Naseeb was transferring pennies between bank accounts to remain within his agreed overdraft limits and avoid paying sizeable bank charges. We believe that the debt crisis he experienced at the end of the academic year overwhelmed Naseeb and was a key factor causing our son's mental distress.

2.3 Summary of Naseeb's Debts, their Impact and Regulatory Issues

The key facts and outcomes from our investigations and complaints are summarised as follows:

- At the time of his death, Naseeb had **ten concurrent debts from seven separate payday loan companies which were still outstanding**. These loans involved **extortionately high repayment levels (above 1,200% APR)**.
- Naseeb also had two additional and sizeable current account overdrafts which brings the total to **12 concurrent loans that were outstanding**.
- At this time, Naseeb had **no way of paying the money back**. He was at the end of his first year at university, not in employment and five weeks earlier had spent all of his final student loan instalment for that academic year on repaying debt and living expenses.
- During the last 12 months of his life, Naseeb had been given 33 payday loans by seven companies. 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**.
- **The FOS 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.

  The other loans that were not identified as 'irresponsible' took place within the same time frame and were often given concurrently to the irresponsible loans. However, due to various

technicalities related to the regulatory framework the FOS were unable to designate those loans as having been irresponsible.

- **We have evidence that the pressure of debt was closely linked to Naseeb's experience of mental distress leading to suicidal thoughts**. The combination of borrowing to pay off debt and being unable to meet all his necessary outgoings placed Naseeb in a 'debt crisis'. His internet searches relating to suicide correspond with Naseeb reaching this debt crisis along with desperate searches for more loans. Naseeb's distress was further compounded by the academic crisis he was also experiencing at the end of the academic year.

  A week before he died, Naseeb attempted to take his own life just after a final application for a payday loan was rejected. He also cited debt as one of the problems he was experiencing to a GP on the day before we believe he died.

- At the inquest into Naseeb's death, the evidence presented exposed how **this pattern of lending had severely damaged Naseeb's mental health and influenced suicidal ideation**. The weight of this evidence led the Coroner at the inquest hearing to then issue a Regulation 28 Report for the 'prevention of future deaths' in April 2018. This was issued to the Financial Conduct Authority who are responsible for regulating financial lending. The report placed the FCA under duty to take action to address the poor conduct and damaging behaviour of payday loan companies.

2.3.1 How the Regulatory Framework allowed these Damaging Lending Practices to take place

After the inquest, from 2018 onwards, we needed to focus our concerns on whether the FCA would in practice deliver the changes needed to have a meaningful impact. Within the FCA's detailed regulations there is a fundamental requirement for any company to assess whether a loan will be affordable for their client before issuing that loan. This requirement was central to the questions asked by the FOS during their investigations, who wanted to know if and how 'affordability' was assessed by a lending company for any given loan.

We therefore researched in some depth the regulations that were in place at that time and correlated them with the issues we had discovered in the behaviour of payday loan companies. Having analysed the entirety of these complex regulations it became clear that there were a number of problems relating to affordability which allowed irresponsible and damaging practice to take place:

- Debts to other companies could be ignored when assessing affordability.
- Small loans did not need to be assessed, so a company could just give these repeatedly.
- Companies could decide themselves how to assess affordability because the FCA had not set any minimum standards for such financial checks.
- Lenders were not required to hold records of their assessments for a minimum length of time, and so could avoid being found to have inadequately assessed affordability.
- Highly implausible figures for income and expenditure could be presented by a client to gain a loan offer. These are accepted by payday loan companies despite their implausibility being easy to identify.
- Credit Reference Agencies were not showing up to date figures for all loans held by a client, so making affordability difficult to assess.

Further problems were identified in addition to those relating to affordability checking:

- The penalties for irresponsible lending were so small as to be simply a 'cost of business'.

- The costs of payday loans were allowed to be extortionate with figures over 1,400% APR being common.
- A loan offer could be gained online in less than half an hour with no minimum time requirement for reflection and review, allowing anxiety and impulse-driven loan applications to be pervasive.

In practice we found the FOS often allowed a benefit of doubt to companies as a result of the above points, in contrast to the FCA's regulatory requirements. In May 2018, we detailed the above regulatory issues in a report submitted to the FCA including a range of measures which could be implemented to address them.

2.3.2 The FCA's Response

The FCA positively accepted the validity of all our concerns. However, they explained that a series of consultations were being completed with many stakeholders towards new policy frameworks and revised regulations. The consultations included a review of how the regulatory system might deal with 'vulnerability risks', and both ourselves and the Coroner were advised that all our concerns would be addressed by the revised regulations. A new set of updated regulations, also known as the 'CONC' (Consumer Credit) rules, were released in July 2018 by the FCA.[23]

We then undertook a detailed evaluation of the new regulations which we submitted to the FCA in September 2018. Unfortunately our research concluded that there would be no effective impact on any of the issues we had raised. However the new rules were not due to take effect until the end of 2018. We were advised by the debt charity Step Change that it would be difficult to assess the effectiveness of a new set of regulations unless a few years had been allowed for them to operate. It would then be possible to evaluate whether and which problems remained.

The approach of the FCA tends towards encouraging voluntary responsibility rather than tightening regulations. While some lending sectors such as building societies may be sympathetic to such voluntary undertakings, the same cannot be said of payday lenders which have a well known record of unethical and destructive lending behaviour.

2.4 Details of the Complaint and Investigation Process

Our complaints and investigations regarding Naseeb's debts took place in two phases which are detailed in this section. The third phase, which followed on from this, required scrutiny of the regulatory framework and is covered under the section below entitled 'Detailed Scrutiny of the FCA Regulations'. To contextualise the entire process the following is a brief summary of all these phases.

1. Initially we submitted separate complaints to each of the seven payday loan companies. These included the history of loans particular to each lender and clearly described Naseeb's financial situation at the time of each of those specific loans. Each company was asked to justify why they gave those loans to Naseeb and to give us evidence of what checks they had undertaken.
2. None of the companies were able to resolve our complaints and so each complaint was directed to the Financial Ombudsman Service (FOS) where seven separate cases were set up. This also required us to investigate what each company could and should have known about Naseeb's financial situation, including an understanding of the data held by Credit Reference Agencies. The FOS identified a number of issues including that 'irresponsible' lending had taken place.

3. Finally we approached the Financial Conduct Authority (FCA) with a request for specific regulatory changes to be implemented, which involved careful scrutiny of the regulations governing payday lending. The inquest into Naseeb's death established that the damaging lending behaviour had contributed to his suicide and that urgent action was needed to revise the regulatory framework. We produced a detailed report of the issues we had identified which was submitted to the FCA. In response to the FCA's reply, we produced a final report which included an analysis of the new Consumer Credit (CONC) regulations that were about to be implemented.

2.4.1 How the Lending took place

'Payday loans' are the commonly used term for High-Cost Short-Term Credit (HCSTC). As the name implies, these are loans given by companies to only be used for a short term period. Payday loans are easy to get and come with very high rates of interest to compensate for the high risk that they may not be repaid. They are intended for unexpected financial costs that would be repaid when the next payday arrives or within a short time frame, for example when a heating breakdown requires urgent repairs to be carried out. Among the various regulations governing payday loans, the FCA stipulates that they are not for long term use, and that companies offering such loans must check they are affordable for their client.

During his life, Naseeb was given loans by a number of payday loan companies, namely Wonga, Quick Quid, Sunny, Peachy, Satsuma, Payday Express and Lending Stream. This began in July and August 2014, when he was given four loans by the payday lender known as Wonga. Naseeb was 19 years old at the time, and as shown by demographic statistics[24] and their advertising, payday lenders often target younger ages. This kind of borrowing was not uncommon for his age group.

The attractiveness of a payday loan with such high interest can be best understood if we examine how the loans are presented, and especially if we consider the position of a young person with little or no credit history.

- While the Annual Percentage Rate (APR) charged on such loans can equate to well over 1,000%, this is never the headline rate given in their publicity. The loans which were given to Naseeb typically gave a figure of 0.8% interest per day (the maximum allowed by the FCA's price cap). If simply multiplied by 365 days this would equal 292% interest per year, a figure which would also be mentioned. However only in subsequent email communications, perhaps only in the final contract agreement, would the real equivalent 'compound' rate be given including all charges involved. In one example from a loan given by Wonga this was 1,477% APR.[x]
- This translates into £6.35 interest for a £50 loan to be repaid after 15 days, plus a one-off charge, which easily seems like a small amount to pay. It can feel worthwhile for a small loan to avoid the dreaded bureaucracy of applying for a better interest rate which a bank might give but which would involve delays and a greater risk of not getting the loan.
- If even on a brief impulse the possibility of acquiring such a loan is sought, a borrower finds they can apply online and then have a confirmed loan within a staggeringly short time period, with all required checks for affordability somehow having happened during this near-instant process. With the applications for such loans made by Naseeb, the time period between application and confirmation was usually about half an hour.

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[x] Three interest rate figures of 0.8% per day, 292% per year, and then also 1,477% APR, were all stated as equivalent rates by Wonga in their loan agreement to Naseeb, dated 21/4/2016; and subsequently 0.8% per day, 292% per year, and 1,672% APR in their final loan agreement to Naseeb, dated 02/05/2016.

- In 2014, Naseeb was one of many thousands of people which the FCA found were given loans they could not afford and which Wonga had given irresponsibly. In October 2014 Wonga were ordered to cancel the debts of 330,000 customers, including Naseeb's.
- However, this experience established payday loans as an easy first option for Naseeb, and payday lenders have frequently been accused of 'grooming' young people. By the end of 2014 Naseeb was working with a regular income and sometimes turned to payday lenders when he needed additional funds. Naseeb was given two loans in December of that year, one by Wonga and another by Quick Quid, both of which he was able to pay back on time.
- Subsequently, from June 2015 Wonga allowed a pattern of back-to-back loans to develop with Naseeb. This was against the rules as such loans are not intended for regular borrowing. As the pattern continued it became, as described by the FOS, "indicative of dependency".
- From late 2015, after Naseeb had started studying at Leeds Beckett University, the number and frequency of loans gradually increased which resulted in the amount of interest also becoming a greater burden. As the total interest began to have an impact on Naseeb's resources to be able to pay such loans, he found himself turning to additional payday lenders. In effect, Naseeb was then given new loans in order to pay off other loans.
- Once a lender came to decide they had already lent him more than they should have, Naseeb then turned to other payday lenders for similarly easy access to a loan. The question then arises as to how another payday lender could be lending to someone who already has more loans than they should, along with a pattern of continuous borrowing? Firstly, there appears to have been little effective tracking of his other debts by the lenders. Secondly, the FOS only measures a lender's responsibility according to their own history of lending.
- Between June 2015 and May 2016 in total Naseeb was given 33 payday loans. The total amount of charges and interest he had repaid during this time period was already in excess of the total amount of payday loans remaining outstanding when Naseeb died. In effect, the final loans which Naseeb was unable to pay when he died would not have been needed if he had never been given payday loans in the first place.

2.4.2 Our Complaints Directly to the Payday Loan Companies

Naseeb was given payday loans in June and July 2015. Fairly soon after that he should not have been given any further loans since the FCA directs that such loans should not be used for longer term or repeated borrowing. However, another 30 loans spread over the next 10 months were given to Naseeb. It was clear to us that this should not have happened.

From the outset our intention with the complaints to individual companies has never been for any financial compensation. Our concern has always been to try and understand how our son was given the number of loans in question and ultimately what can be changed to prevent inappropriate, unethical and damaging lending practices. We believe that such changes could prevent the loss of other lives in the future – a concern that was later shared by the Coroner at the Inquest into Naseeb's death.

In 2017, we therefore began by making complaints to the seven payday loan companies with whom Naseeb had outstanding debts when he passed away.

- A separate complaint had to be made to each company using a range of information and data which we had managed to acquire. Naseeb's email communications with each company told us the

exact time he applied for and was then offered a loan, which gave an indication of the speed and quality of any potential affordability checks that could have been undertaken. Then by logging into Naseeb's payday loan accounts, we gained further data stored in his online profile. This included the amounts that had been declared to be Naseeb's monthly income and expenditure, and his history of acquiring loans from that company.

- Despite some commonalities, the details presented had a variety of differences. Therefore each complaint had to address the specifics of the way each company had lent to Naseeb. This included for each loan given how many loans had previously been given by that company, by other companies, and how many loans he had concurrently at the time that he applied for each specific loan.
- The frequency and number of loans given by each company varied enormously, from a single loan up to well over a dozen. In some cases a company gave multiple back-to-back loans which gave rise to immediate concerns. However, even in the case of a single loan there were questions as to how indebted Naseeb already was to other companies at the time that loan was applied for. In every case he had a significant pattern of recent debts which raised questions that amounted to a complaint. Naseeb was regularly borrowing from a new company to pay off loans from another company, which in itself gave rise to further concerns.
- The companies had a time frame of eight weeks to provide their final response. A number of avoidance tactics were employed by the companies. For example, one company told us that following a death the case and its accounts were closed and could not be re-opened; another that once the amount owed had been written off, the account was blocked; and another that no compensation would be owing to us if we were to pursue a claim, therefore it would be futile for us to proceed with any such claim.
- Final responses were eventually received from only four of the seven payday loan companies – Sunny, QuickQuid, Peachy and Payday Express. No final responses were ever received from Satsuma, Wonga or Lending Stream, in one of these cases there was no reply to our complaint whatsoever. A likely inference here is that by not giving a final response, the company hoped that we might then discontinue our complaints. Such practice also indicates a sense of impunity among the payday loan companies. Many people trying to undertake such complaints would likely be put off by tactics such as these, especially at a time of trauma and grief.

None of the four final responses received contained any agreement with or upholding of our complaints.

2.4.3 Complaints Procedures via the Financial Ombudsman Service

We did not accept the adverse decisions of the four received responses, therefore the set of seven complaints were all passed on to the Financial Ombudsman Service (FOS) in August 2017, to make a judgement on each individual complaint. The following important issues emerged during our dialogues with the FOS in dealing with our complaints.

2.4.3.1 Parallel and multiple lending is not counted.

As stated earlier, within the FCA's detailed regulations there is a fundamental requirement for any company to assess whether a loan will be affordable for their client to take on before issuing that loan. The actual overall affordability of any loan also depends on the total debts a borrower may have with other loan companies.

- We gradually discovered the FOS would accept any company's ignorance of other loans. In effect the FOS only measured a lender's responsibility according to their own history of lending. This meant that after being lent irresponsibly for months by one lender, another lender could begin lending to Naseeb without restriction as long as their own pattern of lending in isolation appeared reasonable. When Naseeb already had a number of debts to other lenders that were still ongoing, those lenders would not have been allowed to give another loan; yet a new lender could do so.
- It fell outside the remit of the FOS to combine all the complaints into one debt profile for the individual. This lack of cross correlation between lenders also made it difficult for the FOS to deal comprehensively with our complaints when attempting to factor in other concurrent lending to Naseeb. The fact that the FOS had to treat our complaint as seven separate complaints is a resulting part of this problem. A wider casualty is a greatly reduced ability for the regulatory system to observe and monitor the overall effects of an integrated set of lending activities.
- Furthermore, the FOS did not feel able to say stronger checks should have taken place in the case of small loans such as £50. This is despite the fact that these may be additional loans given by the same lender or other existing lenders in the same month. Based on the FCA's regulatory principle of proportionality,[xi] the degree to which affordability checks need to be undertaken is in proportion to the size of a specific loan. This means that a single larger loan would require a company to have undertaken greater checks for affordability, but not if it was broken down into a series of smaller loans.

2.4.3.2 Understanding the data held by Credit Reference Agencies.

- In accordance with regulatory principles, the overall affordability of any loan depends on the total debts a borrower may have with other loan companies. With this in mind, we needed to establish what each company would have or could have known about Naseeb's debts to other lenders. It appears that the only way any company can know this information is via the data held by a Credit Reference Agency (CRA), which compiles data given to them by all formal lending operations.
- In the UK there are just three CRAs, namely Experian, Call Credit (now known as TransUnion) and Equifax. We applied by letter along with probate authority to each of the three CRAs for a full statutory credit history report on behalf of Naseeb. By analysing the details and cross-referencing them with Naseeb's actual debt history, we found that:
  Firstly, some companies do not report their lending data to all three agencies, resulting in debts missing from any one of the CRAs sets of data.
  Secondly, payday lending and debt information was often given late to the CRAs and in some instances was entirely missing. A borrower could therefore have recently acquired a number of payday loan debts, and a month later a lender would still not be able to know about them.
- The companies were under no obligation to disclose their methods of operation to us, only the data they held about Naseeb's finances. Therefore we could not know which of the three companies any lender was using for credit checking. However we were able to see those periods where all companies ought to have known about Naseeb's debts when it was consistently recorded by all three CRAs. From this we were able to show the FOS where clear breaches of the regulations may have taken place. It became clear to us that effective operation and use of CRAs would be critical

[xi] The regulatory principle of proportionality is a fundamental principle set by the FCA which is interpreted and applied by the FOS on a case by case basis.

for enabling the avoidance of irresponsible lending, yet in practice the system was both unreliable and inadequate.

2.4.4 Final Assessments by the FOS

- In their final decisions, the FOS confirmed that payday loan companies should not have given Naseeb loans for all bar one month of his first year as a student in Leeds. They stated that a number of the companies did not do adequate checks before lending to him.
- The FOS made particular criticisms of Wonga, the company which gave Naseeb by far the most loans. They stated that from September 2015 onwards Wonga was giving back-to-back loans to Naseeb which were indicative of dependency, that these loans were not affordable, that Naseeb was using them for his day to day living expenses and to pay off previous loans, and that this was *"irresponsible"* lending.
- However, in many specific instances the FOS were unable to assess whether or not companies should or should not have given a loan. The companies were not required to keep the evidence the FOS needed, or were allowed to be selective about the borrower's data that they would disclose. Those companies easily escaped proper scrutiny.
- This also meant that proper tracking of high frequency lending both by the same lender and across multiple lenders could not take place, therefore higher levels of dependency and the risks of developing vulnerabilities were not being adequately assessed.
- Furthermore, our son's actual financial situation was often wrongly assessed at the application stage despite very simple and quick tools being available to show he should not have been given such loans. Naseeb employed the common tactic of presenting himself as having a relatively high income and low expenditure in order to gain a loan. Yet these were usually implausible figures involving unbelievably low expenditure that was a fraction of the Office for National Statistics (ONS) average for a member of the poorest households. This could easily have been picked up and additional checks implemented.
- The penalties given by the FOS to the lending companies for their irresponsible lending to Naseeb amounted to a refund of all interest, fees and charges. However the companies were allowed to offset these against any principal loan amounts that were left unpaid. Only in one case was a company unable to balance this and so were ordered to pay the remaining small amount by way of a penalty, despite the seriousness of the resulting human damage. A significant proportion of Payday Loans routinely become bad debts which is widely known to be part of their business model involving high interest due to this high risk. Such penalties cannot be seen to be much more than a cost of business rather than a deterrent.

A crucially important point in this investigation is that there existed a number of readily available indicators which pointed towards a significant risk that Naseeb would reach a debt crisis. The systems in place failed to be able to pick up and act on these indicators.

2.5 Prevention of Future Deaths Report submitted to the FCA

The inquest into Naseeb's death took place at Wakefield Coroner's Court on 18th and 19th December 2017. The evidence presented at the inquest relating to Naseeb's payday loan debts was compiled from our detailed investigations including the findings from the FOS complaints procedure.

On 9th April 2018 the Coroner Mr Jonathan Leach submitted a Regulation 28 Report for the 'prevention of future deaths' to the FCA regarding the conduct of the payday loan companies in connection with the death of our son.

The inquest established an important link between payday loans and our son's death. In the Regulation 28 Report the Coroner stated "there is a risk that future deaths will occur unless action is taken." The matters of concern were:

> "(1) The conduct of the payday loan companies contributed to his situation in that they were aware that he had become dependent on the loans and that such dependence was encouraged.
>
> (2) Financial checks were inadequate."

2.6 Detailed Scrutiny of the FCA Regulations

Our investigations and the findings from the FOS complaints procedure clearly indicated that existing regulatory mechanisms had been unable to prevent various forms of irresponsible lending. The ability to change these mechanisms, which include the regulations and how they are applied, rests primarily with the regulator which is the FCA. Following on from the Coroner's Regulation 28 Report, we compiled our findings and concerns in the form of an initial report which was submitted to the FCA in May 2018.

The points raised in our submission were generally accepted in principle by the FCA. However, they explained that all the issues in our report would gradually be dealt with during a forthcoming overhaul of the regulations. The FCA made a number of references to a range of reports which they had published over the previous two years. These included Consultation Papers, Feedback Statements, Occasional Papers and most importantly a newly released Policy Statement PS18-19 (July 2018) which included the finalised details of the FCA's forthcoming new regulatory rules and guidance.[25]

2.6.1 Evaluating the FCA's New Regulations

We wanted to know whether the issues we had highlighted would be addressed by specific corresponding changes in the actual new regulations, rather than simply be raised within research and consultation papers. In order to evaluate this we had to undertake an analysis of the new regulations governing HCSTC (payday lending) which were due to be published in the FCA's Consumer Credit (CONC) handbook. We also scrutinised the research that the FCA were carrying out and gradually publishing at that time. These papers covered a number of highly relevant topics in considerable depth such as Predicting and Preventing Financial Distress, Consumer Vulnerability and Duty of Care. The FCA had also conducted a review of the current limit, or 'price cap', on the cost of payday loans.

It was critical for us to understand the background and research that underpinned the FCA's new rules and how they proposed the financial ecosystem would provide solutions to the concerns we had raised. These were clearly shared by the FCA, given the subject matter of their published research.

This detailed work became our final 'evaluative' report, submitted to the FCA in September 2018. There were a number of important and positive regulatory changes which we acknowledged and welcomed.

However, from our analysis the regulations still fell short of being adequately able to prevent the significant pattern of irresponsible lending behaviour which had been recognised by the Financial Ombudsman Service (FOS) in the case of our son Naseeb. While being well intentioned, the new rules would not be robust enough to enable the FOS to apply the regulations in such a way as to adequately address the concerns raised by the Prevention of Future Deaths Report.

2.6.2 Our Findings on Analysing the FCA's Regulations

The concerns raised in our initial report (May 2018), along with the findings from our evaluation of the new regulations (September 2018), are summarised below.

1. **The current system is unable to recognise irresponsible lending as having taken place when it results from the collective impact of multiple lenders.** The regulations and their implementation focus on any one lender's own lending history, largely regardless of a customer's history with other lenders.
   <u>NEW REGULATIONS</u>: *There remains an omission of any strong requirements to accurately quantify a customer's entire set of loans. Therefore the sum totals of all debts will not be assessed when determining whether a loan would be affordable.*
2. **There appears to be no minimum level of checks that is required for a payday loan company to undertake, this is left to the discretion of the payday loan company.** The FOS stated to us that the FCA's CONC sourcebook stipulates "a creditor should take reasonable steps to assess the customer's ability to meet the repayments." However the sourcebook "doesn't set out specific criteria or methods it [the lending company] should use". As we believe our son's case clearly illustrates the implementation of minimum levels and agreed standards of checks are essential.
   <u>NEW REGULATIONS</u>: *There are no requirements for a minimum standard level of checks to be undertaken as part of a company's requirement to measure the affordability of a loan.*
3. **The level of checks is allowed to be proportionate to the amount being borrowed.** This means that for a smaller loan less checks or even no checks are applicable. However if the total loaned by multiple lenders is high, we consider it to be essential that a higher level of checks should be a requirement. In practice our observations show that whilst a loan of £400 from a single lender would require relatively thorough checking, the same loan split across eight lenders would not.
   <u>NEW REGULATIONS</u>: *Affordability assessments will still be undertaken in proportion to the scale of a particular loan application. There is not a requirement for evidence of income or expenditure in respect of small loans which if multiplied or repeated would equate to a large loan. A minimal level of evidence being required as standard could mitigate the many ways in which poor estimates of affordability are arrived at. This is important in a sector where the risk of a borrower being financially vulnerable is high.*
4. **There appear to be no requirements for companies to archive the content of their checks for a specific period of time.** If a company cannot provide the details of the checks they undertook for any borrower, then it becomes impossible to assess whether their checks were adequate or not. It is also impossible to know what that company actually knew at the time of offering a loan.
   <u>NEW REGULATIONS</u>: *The longer term accountability of companies will remain poor as there will still be no requirements to hold detailed data from their affordability checks for a reasonable period of time. It will continue to be difficult to detect irresponsible lending when the results of a company's checks cannot be evaluated.*

5. **The penalties for irresponsible lending are so small, they do not act as a deterrent and are simply seen as a 'cost of business'.** For example, the penalty for Wonga, who were found to have repeatedly breached the regulatory codes at every level, was for them to pay back the charges and interest that Naseeb had paid to them. As Wonga were able to offset this against the principal loan amount which remained outstanding, they were then left with no penalty to pay. In effect this was simply cancelled by Wonga as another bad debt.
NEW REGULATIONS: There is no change to the penalties for irresponsible lending. These continue to be poor and ineffectual deterrents.

6. **Highly implausible amounts of expenditure go unnoticed by payday loan companies. A dependant and desperate borrower soon learns to minimise their declared expenditure in payday loan applications.** Readily available ONS data of average expenditure by the lowest income households could easily provide simple thresholds that can be used to filter out highly implausible figures for income/expenditure. This would automatically gauge whether an application needs additional evidence for employment status and monthly expenditure.
NEW REGULATIONS: There is a continuing absence of requirements to use ONS data to quickly filter out implausible applications. Unbelievably low figures of a customer's monthly expenditure will continue to make unaffordable loans look affordable.

7. **The speedy and instant nature by which a consumer is given a payday loan is concerning. This encourages people to acquire a loan on moments of impulse, when under pressure from a perceived financial demand or difficulty.** A mandatory delay of just four hours before the consumer is committed to the deal has been researched and proposed by the Digital Interfaces and Debt project.[26] Such a delay would allow some time for reflection by the consumer and also reduce the pressure on the lender to complete their checks as fast as possible so as not to lose a customer. Other recommendations include requiring a 'dwell timer',[xii] using multiple choice questions about the loan at the application stage, and that companies should not be allowed to chase customers who decide not to complete an application. Naseeb was regularly sent repeated offers of loans from payday loan companies by both text and email, which continued for many months after he had died despite the companies having been notified.
NEW REGULATIONS: There are still no requirements in relation to the speed at which a payday loan can be acquired.

8. **The interest rates charged by payday loan companies are extremely high, upwards of 1,200% APR and often 1,400% APR or more.** High rates are argued as necessary to account for the costs of operating short term credit. However such extremely high rates, which are 70 times more than a 20% APR credit card, encourage practices that allow damaging bad debts to be seen by companies as simply costs of business.
NEW REGULATIONS: There is no change to the current 'price cap' on the costs of payday loans. The rates of interest and fees are still very high, and the benefits of the last lowering of the price cap were overwhelmingly positive for consumers.[27] Further benefits would be expected from an additional cost reduction.

9. **Naseeb's case is a stark example of high frequency payday loan borrowing over a significant period of time. This itself is a risk indicator for a possible forthcoming debt crisis, and a visible**

[xii] As suggested by the 'Digital Interfaces and Debt' Research project, "A minimum dwell timer on the final application submission page that asks users to reflect on their decision. This will be composed of four timed acknowledgement prompts at fifteen second intervals, all of which must be completed before the application can be submitted."
Dr Ash, J., et al, *Digital Credit, Mobile Devices and Indebtedness* (Newcastle University, 2018)

symptom of dependency linked to financially damaging lending behaviour. Such cases could be pro-actively referred to debt counselling and other supportive programmes as appropriate, before further debts are built up. According to a recent report on consumer debt by the Royal Society for Public Health, "Payday lenders have the most negative impact on mental wellbeing."[28] However, while banks have developed vulnerable customer teams in response to the FCA's own directions a parallel development does not appear to have taken place among payday loan companies.
NEW REGULATIONS: There will continue to not be any tracking of borrowing patterns that are indicative of high vulnerability risks. It remains concerning that high frequency back-to-back loans indicative of dependency and vulnerability will be ignored.

10. **There appear to be no requirements for companies to update Credit Reference Agencies, nor to update these agencies within a specific time frame.** The FOS explained to us "It's up to the lender to decide which credit reference agency they wish to use, and in my experience lenders usually update credit reference agencies on a monthly basis but this may vary from lender to lender." However as described earlier, we were able to ascertain that the timely updating of CRAs by lenders is often not taking place, and lenders may not update all of the agencies.
NEW REGULATIONS: The critical problems of Credit Reference Agencies (CRAs) being unreliable were planned to be addressed by the FCA in the near future. We were therefore unable to comment on these but we did request some essential assurances.

Our evaluative report also advocated for the implementation of special and stricter rules specifically for the HCSTC sector as distinct from other areas of lending, due to its particularly high levels of vulnerability risks.

A potential debt crisis can be avoided if there are strong requirements, adequate methods and minimum standards through which affordability assessments are carried out, and for how customers navigate the process of acquiring a loan. Naseeb's case and the urgency to prevent future deaths underline the need for specific CONC rules to be strengthened in ways that are absent from the FCA's new regulations.

The FCA's subsequent reply in April 2019 was positive yet open ended. They explained they would be continuing to work on the areas pertaining to our concerns for the next two years, after which their intention was to "update our view of the risks posed by firms and how we will supervise them". In addition the FCA wanted to "confirm that the points you raised in your Parents' Evaluative Report and other letters will be considered as part of relevant policy projects".

2.7 Support, Advocacy and Further Research

Step Change and the Money and Mental Health Policy Institute are two charities with an interest in debt and mental health who have shown significant interest in our reports. In response to the FCA's reply to our evaluative report the advice from Step Change was that when regulations are in the process of change, it is not possible to assess their effectiveness with adequate certainty until enough time has passed for real life experiences and evidence to be collated and analysed. With this in mind, we have temporarily suspended our work in this area and hope to review progress in due course.

Our work highlighted the need for understanding various indicators of risk and vulnerability. This is particularly important given that most people who die by suicide have not previously used mental health services[29] and are therefore unlikely to gain support from schemes targeted towards those who use such services. As we have suggested, there is a potential for financial data to be used to provide potentially useful and even life-saving indicators. Our report fed in to work by Money and Mental Health Policy Institute, who have undertaken initial research into this area and have produced a report titled 'DATA

PROTECTING: Using financial data to support customers'[30] to understand the potential for using such financial indicators. The report was able to make a number of worthwhile policy recommendations, despite this being an area needing further work.

Going forwards, the work we have undertaken and the imperative for regulatory change now needs a further research effort to establish the extent to which the problems we have highlighted persist. Based on our investigations and research so far, the concerns we have raised are likely to only be minimally if at all affected by the recent regulatory changes. This is a significant undertaking, and we welcome discussion among interested parties as to how best this can take place and be adequately supported.

2.8 Recommendations

2.8.1 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.

2.8.2 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.**[xiii]
- **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-opened, or that the account was blocked, or no compensation would be owing therefore a complaint would be pointless.

2.8.3 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.

2.8.4 Vulnerability

- **Systems should be developed to track borrowing patterns that are indicative of high vulnerability risks**[xiv]**.**
- **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.

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

3. Chapter Three: GP Care and Systemic Healthcare Issues

3.1 Introduction

At the end of the academic year in late May 2016 our son Naseeb Chuhan, who was a first-year student at Leeds Beckett University (LBU), 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.

This chapter of our report explains 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. A GP Online article published in 2016 states "Every GP should be able to assess the risk of suicide, so it is important to be aware of the warning signs."[31] A recent report about gaps in suicide prevention by Dr Mahajan, states that "the majority of healthcare professionals are not skilled in recognising the warning signs of suicidality and responding to them appropriately." [32]

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, Dr P, did not undertake any form of risk assessment. Naseeb was simply advised to seek counselling from Leeds Beckett University (LBU) Student Wellbeing Service and no referral or follow up appointment was made.

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. Based on this information, prior to the inquest we commissioned an Independent GP Expert Witness Report from Dr Nicholas Kearsley. This report states 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".

The report explains that "It is recognised that patients will usually tell GPs if they have suicidal thoughts and/or intent if such problems are present and they are asked" and "Since he did kill himself a short time afterwards there must be a significant possibility that he would have expressed suicidal thoughts and/or intent." Hence "It was mandatory to ask about suicidal thoughts." At the inquest, this report was not challenged by Dr P who 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 Dr P's conduct. Our concerns were based on her breach of duty of care to Naseeb. At the inquest Dr P explained she had made her judgement for good reason, meaning this breach could be repeated. The GMC decision was to close its provisional enquiry into our complaint as it was "unable to identify any issues that would lead us to launch a full GMC investigation".

The GMC's justification was "GPs don't automatically question every patient on the presence or absence of suicidal thoughts." However this avoided 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 Dr P's

consultation with Naseeb "appears to show an inadequate assessment" and also the GMC's own expert reviews.

In addition 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. Focussed dialogues have therefore taken place with LSMP, Yorkshire Medical Chambers (YMC) from where Dr P was contracted as a locum, the Royal College of General Practitioners (RCGP), and Healthwatch Leeds. These issues included that 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 Dr P in her consultation with Naseeb, but this was not disclosed to the Coroner and YMC by either LSMP or Dr P.

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, Healthwatch Leeds published a report into "people's experiences of mental health crisis in Leeds" which 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." [33]

3.2 Background Narrative

At the end of March 2016, when Naseeb came home for Easter, we had agreed to hire a van with which to bring him home at the end of term in May 2016. Throughout the academic year we saw Naseeb at least once a month but in May we gradually became worried when he stopped responding to our text and phone messages. During the last week of his life we managed to maintain daily contact with Naseeb.

Thursday 19th May 2016

We sent Naseeb more assertive texts to contact us. Naseeb spoke with us on the telephone a number of times that day, sounding subdued and said that he felt low, thought he had been depressed for 4-5 years, was going out less and was not wanting to get out of bed. When asked what the problem was Naseeb said it was nothing in particular, just lots of different things and would talk more when he returned home. Naseeb explained he was going to see the doctor the following day which he had already researched, along with various approaches to treating depression which included counselling.

Naseeb's mother then told Naseeb that she needed to work out how low he was feeling and asked him directly if he had ever tried to take his own life. There was a silence on the phone then Naseeb replied "yes, I tried earlier today." Naseeb said he could not lie to her as the silence would mean she knew already that the answer was yes. He said "I don't want to land this on you" and then told her how he had tried to take his own life. Naseeb's reply was the last thing we had expected him to say. At this point we were in shock and our minds went into a cognitive paralysis.

Naseeb resisted us visiting him in Leeds that evening saying he was recognising his problems and that he wanted to sort them out himself. We obtained assurances from Naseeb that he would see a doctor the following morning and his father arranged to visit Naseeb in Leeds that afternoon with a view to bringing him home. As additional support we also transferred some money directly to Naseeb's account.

After Naseeb died we found out that this attempt to take his own life was just after a final application for a financial loan was rejected. 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.

Friday 20th May 2016

Naseeb registered with Leeds Student Medical Practice (LSMP) in the morning and then met with his father. During their meeting Naseeb said he felt there was nothing in life to look forward to and that he had recently been looking at ideas of death being acceptable, on the internet. Naseeb wanted to stay in Leeds and secure accommodation for the following academic year with his friends. He had organised flat viewings for the next day, so arrangements were made for him to return home the following week and remain in touch with us daily. We encouraged Naseeb to see the doctor during the next few days.

Saturday 21st May 2016

Naseeb's Medical Records were sent by his Manchester GP surgery to NHS England following a request of removal to a new Health Authority.

Wednesday 25th May 2016

Naseeb saw Dr P, a locum GP at LSMP early in the morning. We now know from his internet search history that Naseeb had not slept for at least two nights and had spent some of the night browsing the internet, searching for suicide methods.

From leaving LSMP, Naseeb went directly to LBU Wellbeing Service and registered for counselling by 10.30am.

Thursday 26th May 2016

Naseeb's internet browsing history ends at 21:11pm.

Saturday 28th May 2016

Naseeb was found deceased by his parents.

3.3 Our Concerns about the GP's Consultation with Naseeb

On Wednesday 25th May 2016, the day before we believe he died, Naseeb visited LSMP and was seen by Dr P, a locum GP, who did not risk assess him adequately:

- He presented early in the morning with "low mood" and "thought he may have been depressed for several years". Naseeb described clear symptoms of depression such as "feeling down…poor motivation, tends to isolate himself, rubbish sleeping pattern". The problems he cited included "debt".
- Dr P also did not enquire about how Naseeb's studies were progressing or even if he had enough money to buy food. This is despite the fact that he was a young male first-year student, living in private accommodation and presenting at the end of the academic year, which has been documented is a high-risk time for student suicides.[34]
- No risk assessment was undertaken and no referral was made.
- Naseeb's medical records show he had never needed to see a GP in his entire life, except for once at age 19 with a sprained ankle at a hospital walk in centre.
- Dr P simply suggested that Naseeb could seek counselling from LBU Wellbeing Service and no follow up appointment was made.

3.4 Commissioning a Report from an Independent GP Expert

After Naseeb died we requested documentation relating to his contact with Dr P. On receiving this we became concerned that Naseeb was not risk assessed for harm to self, given that he was presenting with depression and the state he described himself to be in. We then undertook research which identified the need for obtaining a report from an independent GP expert, prior to the inquest into Naseeb's death.

We raised our concerns with the Coroner by letter in April 2017 and at the first Pre-Inquest Review (PIR) hearing in May 2017. At the second PIR hearing (Sept 2017) we requested that the Coroner instruct an independent GP expert to report on the adequacy, relevance and role of the consultation with Dr P on 25th May 2016, in connection with Naseeb's suicide.

3.4.1 Why an Independent GP Expert Report was Needed

Our research uncovered a concerning disparity between Dr P's full record of her consultation with Naseeb and national healthcare guidelines.

3.4.1.1 Concerns arising from the Significant Event Report by Dr P (undated)

It was evident to us that Naseeb had not been risk assessed by Dr P. Instead her record of the consultation focussed on many subjective factors as to how Naseeb presented himself. In the Significant Event Report (SER), Dr P stated after her consultation with Naseeb, that she "did not explore his risk of self-harm because his presentation was of long-standing symptoms with no recent exacerbation". She recalls that Naseeb "seemed relaxed, calm, maintained good eye contact and engaged well in what felt to me like an open conversation. There was no distress and he gave no impression of crisis".

However the fact remained that Naseeb had described clear symptoms of depression, therefore Dr P's report raised a number of concerns.

- Dr P did not get the impression that any of these problems were new or escalating.
  Yet this was the first time Naseeb had ever visited a GP, other than once at a walk-in-centre for a sprained ankle in March 2014. Naseeb was in a frame of mind where he was actively seeking help and when asked directly had already divulged a prior suicide attempt to his mother.
- There is no suggestion in any guidance that suicide risk assessment is only applicable in cases where there is evidence of a recent exacerbation or crisis.
  Naseeb was not assessed at all for any recent exacerbation or crisis. Therefore it was our belief that sensitive questioning could well have identified his suicide risk.
- Dr P reported that the event was discussed at a clinical team meeting of Yorkshire Medical Chambers (YMC), where she was based, on 30th June 2016 with the clinical lead for significant events and several other GP's. During this meeting they "discussed the limitations of structured questionnaires such as the PHQ-9 which prompt us to ask about thoughts of self-harm, but which often are detrimental to rapport and to the flow of a consultation and make a patient feel processed rather than listened to". The subsequent "Practice Reflection" section of the 'Significant Event Report' was left blank.
- The Patient Health Questionnaire-9 (PHQ-9) which Dr P refers to is a short questionnaire that can be used as an objective determinant of risk when a patient first presents with depression symptoms, to screen for the presence, duration and severity of depression. The last item asks how

often the person has, over the past two weeks been bothered by: "Thoughts that you would be better off dead, or of hurting yourself in some way?"

3.4.1.2 National Institute for Health and Care Excellence and Royal College of General Practitioners Guidelines

Through a freedom of information request (FOI) we established that NHS Leeds West Clinical Commissioning Group (CCG) providers, of which LSMP was a member, are expected to "follow best practice according to NICE and Royal College Guidelines". Both these organisations' guidelines 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. There is no mention of suicide risk assessment only being applicable in cases where there is evidence of a recent exacerbation or crisis.

- National Institute for Health and Care Excellence (NICE) Guidelines establish the need for risk assessment and monitoring. Where a patient presents with persistent low mood that has lasted at least two weeks, he/she should be asked about "suicidal thoughts or acts".[35] A person with depression who presents considerable immediate risk to themselves is to be referred urgently to specialist mental health services.[36]
- Royal College of General Practitioners RCGP Guidelines provide that "All patients with depression should be asked about possible thoughts of self-harm or suicide." Furthermore "there is no evidence to suggest that asking someone about their suicidal thoughts will give them 'ideas', or that it will provoke suicidal behaviour." Significantly the guidelines also state that "Some patients will introduce the topic without prompting, while others may be too embarrassed or ashamed to admit they may have been having thoughts of suicide. However the topic is raised, careful and sensitive questioning is essential."[37]

3.4.2 Clinical Negligence Medical Report by Dr Nicholas Kearsley – Independent GP Expert (October 2017).

At the second PIR hearing (Sept 2017) the Coroner directed that "I will not be instructing an Independent GP expert. If Mr Chuhan's parents wish to instruct such an Expert, I will consider the report." We therefore commissioned a GP Expert Witness report from Dr Kearsley which was accepted by the Coroner, pursuant to Rule 23 of the Coroners (Inquests) Rules 2013. This meant the report was not challenged by either Dr P or her legal team at the inquest. Dr P also accepted she should have asked Naseeb about suicidal thoughts.

The GP Expert Witness report from Dr Kearsley concludes that there was "a breach of duty of care". The "GP care fell below an acceptable and reasonable standard" and that "It was mandatory to ask about suicidal thoughts." Thereafter (if Naseeb had said he had suicidal thoughts), "it would have been mandatory to ask about suicidal intent…If he had expressed suicidal thoughts and suicidal intent it would have been mandatory to refer him on an emergency basis to the mental health crisis team whilst arranging adequate supervision in the interim." Dr Kearsley confirms that "Had this happened this may have prevented his death."

The key points in the report are:

- "Any competent GP would have thought that he was presenting with depression. Depression is common in the general population and also relatively common in young people. Being away from home and student life are known to be significant sources of stress for some young people.

It is also recognised that men are at increased risk of suicide compared to women and that they may be reluctant to seek help."

- "It is not adequate GP care to rely on a patient to tell a GP if they have suicidal thoughts and/or intent."
- "It is recognised that patients will usually tell GPs if they have suicidal thoughts and/or intent if such problems are present and they are asked. They do not usually hide this if asked but they will not usually volunteer this information unless they are asked."
- "If he had expressed suicidal thoughts and intent it would have been mandatory to refer him immediately to the mental health crisis team and to ensure that he was adequately supervised prior to being seen. This supervision could be done by family or friends, by keeping him at the medical centre or even by sending him to Accident and Emergency if needed."
- "[Dr P] mentions the limitations of structured questionnaires such as the PHQ-9. Although it was not mandatory to use this or any other structured questionnaire it was mandatory to ask about suicidal thoughts and this is a feature of the PHQ-9 form."

The report also concludes:

> "Since he did kill himself a short time afterwards there must be a significant possibility that he would have expressed suicidal thoughts and/or intent."
>
> "The key issue is that patients should be questioned carefully and sensitively about suicidal thoughts. This is a relatively simple and routine matter for GPs. It is an essential part of the assessment of a patient presenting for the first time with depression like this. He had clear and obvious symptoms of significant depression and to fail to adequately question him was substandard care."

3.5 Our Complaint to the General Medical Council

After the inquest into Naseeb's death, we submitted a complaint to the General Medical Council (GMC) as we had a number of concerns regarding Dr P's conduct, the "breach of duty of care" as stated in the GP Expert Witness report from Dr Kearsley and about wider healthcare issues.

3.5.1 Our Concerns Regarding Dr P's Conduct and Systemic Healthcare Issues (March 2018)

Our complaint outlined the following concerns regarding Dr P's conduct:

- Dr P breached her duty of care to Naseeb by not adequately risk assessing him. She did not adequately question or evaluate his condition and relied solely on Naseeb's subjective presentation rather than referring to an objective, evidence-based assessment approach.
    - In contrast, immediately after he saw Dr P, Naseeb disclosed a very concerning state of wellbeing when answering questions on the LBU Wellbeing Service registration form. He was receiving support form "no-one" at present and within the last two weeks he had been sleeping well "none of the time", had "often" been worrying about things and had "often" felt low in mood. Naseeb had been looking after himself "none of the time" and he had difficulty coping with day to day life "some of the time". On that form Naseeb also

considered himself at risk of failing his course and was willing to accept an appointment on any day at any time.

  - At this point in time Naseeb was at serious risk of failing his first year at university with eight consecutive pieces of work outstanding from January 2016 onwards. He was also facing an escalating debt crisis having accumulated a total of 12 concurrent loans and with no way of paying the money back. Naseeb's internet searches relating to depression and suicide correspond with him reaching a crisis point at the end of the academic year due to the level of outstanding work and the debt crisis he was experiencing.

- We are concerned that from our recollection of the inquest that Dr P went on to explain she had made her judgement for good reason meaning this breach could be repeated.
- Dr P reiterated at the inquest that she saw no value in the use of Form PHQ9, an objective determinant of risk, when a patient first presents with depression symptoms.
- At the inquest Dr P confirmed that it did not cross her mind that Naseeb may be at risk of suicide which brings into question her understanding of red flags relating to student suicide.

We also informed the GMC that Naseeb had actively chosen to visit the GP surgery twice within the last week of his life when he had never seen, or needed to see, a GP before in his entire life, apart from one visit to a hospital walk-in centre with a sprained ankle at age 19. Naseeb candidly completed the registration form at Leeds Student Medical Practice (LSMP) on Friday 20th May 2016, including information about his smoking habit and a detailed section about alcohol consumption. He then returned early on the morning of Wednesday 25th May 2017 to actually see a doctor.

Our concerns relating to systemic healthcare issues were as follows:

- In the 'Significant Event Report' Dr P states she discussed Naseeb's case with colleagues from Leeds Student Medical Practice (LSMP) including practice manager and partner Dr R, on 13th June 2016. At this discussion a possible breach of duty of care was not flagged up.
- Dr P also discussed the case at a clinical team meeting of Yorkshire Medical Chambers (YMC), where she was based, with the clinical lead for significant events Dr Sand several other GP's on 30th June 2016. The issue of whether a risk assessment of suicide was needed in this case was not discussed and again a breach of duty of care was not flagged up.

3.5.2 GMC Assistant Registrar's Decision Reasoning Report (August 2018)

In April 2018 the GMC informed us that they had opened a Provisional Enquiry into the concerns we raised about Dr P. Regarding the systemic healthcare issues we had raised, the GMC stated "we do not believe they raise fitness to practise concerns about a doctor...these failures are related to processes and are therefore systemic in nature." We were advised to raise them locally with the practices or the Care Quality Commission (CQC).

The GMC Assistant Registrar's decision in August 2018 stated that the provisional enquiry is closed as the GMC have been "unable to identify any issues that would lead us to launch a full GMC investigation into [Dr P's] fitness to practise". We were informed that "the concerns raised about [Dr P] do not suggest impaired fitness to practise on her part, as outlined in Section 35(C) 2 of the Medical Act 1983 via misconduct."

3.5.3 Non-Disclosure of Documents by the GMC

We had significant concerns about the GMC 'Assistant Registrar's Decision Reasoning' and requested that they disclose to us the six documents upon which the above decision was based. During September and October 2018 we had a number of communications with the GMC about our request for copies of these documents, listed in Appendix B (i), under the Freedom of Information Act (FOIA), Data Protection Legislation (DPL) and the Medical Act 1983.

We also provided the GMC with our reasons, listed in Appendix B (ii), as to why we were seeking a copy of the full report produced for the GMC by the "independent expert in general practice". In October 2018 we were informed that the GMC Assistant Registrar had decided that the expert report, which took the form of a documented discussion with the expert, should not be disclosed to us as Dr P withheld her consent.

Between October 2018 and June 2019 the GMC explained to us that none of the six documents we had requested could be disclosed to us under either FOIA, DPL or the Medical Act 1983 – see Appendix B (iii).

3.5.4 GMC Assistant Registrar's Decision Reasoning Report - Our Response (February 2019)

In responding to the GMC Decision Reasoning Report we made clear our deep dismay at not having access to any of the documents referred to, upon which this decision had been made. Without proper transparency it is impossible to scrutinise the reasoning behind the GMC's decision. The key points in our response are as follows:

- The GMC Decision Reasoning Report included reference to Dr P's Responsible Officer at NHS England stating "[Dr P] assessed the patient for signs of depression … she made an appropriate assessment." NHS England also provided the GMC with a report which stated "her assessment of the patient's presentation was ample and allowed other clinicians to elicit a picture of the patient's mood and demeanour".

  We do not believe Dr P made an "appropriate assessment" nor that her assessment of our son's "presentation was ample". It is our belief that Dr P relied solely on Naseeb's subjective presentation. This reflects an approach to risk assessment based on non-validated factors which resulted in an inadequate assessment of our son.

- There is a stark contrast between the initial review of our complaint by "a senior medically qualified GMC colleague with experience in psychiatry" and the final outcome. "They commented that, on first review, [Dr P's] consultation record of 25 May 2016 appears to show an inadequate assessment. They explained that young men are a high risk group for suicide…They advised it is not uncommon for patients not to mention suicidal thoughts unless directly asked…they would expect [Dr P] to have asked him directly and specifically about thoughts of self-harm and suicide. They were concerned by the absence of a 'PHQ9' assessment form in the absence of a detailed consultation note."

- This analysis is consistent with what was discussed during a 'Significant Events' meeting at Leeds Student Medical Practice (LSMP) on 3rd June 2016 (a few days after Naseeb was found deceased). A GP "raised concerns regarding the quality of the consultation. No PHQ9, no risk assessment". The outcome of this meeting is noted as "A Partner will discuss the Consultation with Dr S." The record of this 'Significant Events' meeting was only disclosed by LSMP in June 2019 as part of a separate complaints process and we sent this additional information to the GMC in July 2019.

LSMP had also stated to us in October 2018 that "[Dr R] met with [Dr P] on 13th June 2016 … in [Dr P's] professional opinion Naseeb was not in crisis … [Dr R] suggested to [Dr P] to consider documenting a more formal risk assessment in depressed patients in the future as occasionally patients do express suicidal thoughts when asked, even though they did not appear to be severely depressed." The existence of this meeting was not disclosed by Dr P to the Coroner during the inquest into Naseeb's death.

- Dr P would therefore have been aware of the need to formally risk assess a depressed patient by the time Naseeb's case was discussed at Yorkshire Medical Chambers (YMC) Clinical Team Meeting on 30th June 2016. There is no record in the meeting minutes or Dr P's 'Significant Event Report' of any discussion at this meeting about specifically whether a risk assessment of suicide was needed in Naseeb's case.
- The GMC's justification that "GPs don't automatically question every patient on the presence or absence of suicidal thoughts" avoids the central issue which is that a GP should direct such questioning in presentations involving depression, as was clearly the case for Naseeb.
- We believe that the GMC's opinion sets a critical and concerning precedent which is in contradiction with both the NICE and RCGP guidelines available at the time Naseeb saw Dr P. Both guidelines 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.

In August 2019 we were informed by the GMC that there were no grounds to review the closure decision, and "that the information didn't indicate [Dr P] had shown a reckless disregard for her clinical duties".

3.6 Systemic Healthcare Issues

Following advice from the GMC we raised our concerns about systemic healthcare issues directly with Leeds Student Medical Practice (LSMP) where the consultation between Dr P (a locum GP) and Naseeb took place, and Yorkshire Medical Chambers (YMC) from where Dr P was contracted. In both cases we explained that:

> "As Naseeb's parents we wish to prevent similar instances happening again and future deaths. Hence we are looking for a real and positive change in relation to the appraisal of suicide risk and how students are taken care of by Health Centres and GP's. We want the quality and safety of healthcare practice to include a full appreciation of the evidence available around student suicides."

3.6.1 Our Complaint to Leeds Student Medical Practice (August 2018)

Leeds Student Medical Practice (LSMP) is a health centre which specialises in student health and 'Mental Health' is one of its five clinical priorities. Our complaint informed LSMP that in the 'Significant Event Report' by Dr P (undated) it stated she discussed Naseeb's case with colleagues from LSMP including "Practice manager and partner [Dr R]", on 13th June 2016. It concerns us that during this discussion a possible breach of duty of care was not flagged up.

Naseeb had actively chosen to visit the GP surgery twice within the last week of his life. It is our belief that LSMP missed three opportunities to risk assess Naseeb. Firstly, when he registered with the practice on

Friday 20th May 2016, the day after we know Naseeb had already tried to take his own life. He completed the registration form thoroughly, including a detailed alcohol consumption questionnaire. Secondly, whilst he was waiting in reception to see a GP early on the morning of Wednesday 25th May 2016. Thirdly when he actually saw Dr P. We believe that it would be beneficial for students' mental health to be routinely screened on presentation at Health Centres.

3.6.1.1 Outcome of our complaint to LSMP

The following information was acquired during a process which took a year from August 2018 to August 2019 and involved two meetings between ourselves and LSMP along with a number of written communications.

- LSMP was not aware that the inquest into Naseeb's death had taken place or what the outcome was. There were no changes made in response to Naseeb's death until after we raised our concerns with LSMP.
- The Coroners' office was not informed about a 'Significant Events' meeting held at LSMP on 3rd June 2016 (a few days after Naseeb was found deceased). The meeting notes were only disclosed to us by LSMP in June 2019, following our written request. LSMP had provided the Coroner with a 'report' in August 2016. However this was simply a single page letter which listed information from the entry on Naseeb's medical records, as summarised by Dr P following her consultation with Naseeb on 25th May 2016.
- The 'Significant Events' meeting held at LSMP on 3rd June 2016 noted that a GP "raised concerns regarding the quality of the consultation. No PHQ9, no risk assessment". The outcome of this meeting is noted as "A Partner will discuss the Consultation with Dr S." LSMP informed us that the practice does encourage GPs to use form PHQ-9, a simple screening prompt for assessing depression and associated risk.
- LSMP also informed us that "[Dr R] met with Dr P on 13th June 2016 … in [Dr P's] professional opinion Naseeb was not in crisis … [Dr R] suggested to [Dr P] to consider documenting a more formal risk assessment in depressed patients in the future as occasionally patients do express suicidal thoughts when asked, even though they did not appear to be severely depressed."

  Dr P's professional opinion that Naseeb was "not in a crisis" is impossible to substantiate without an adequate risk assessment. It is our view that Dr R did not adequately scrutinise Dr P's professional opinion and simply 'suggested' to Dr P that "a more formal risk assessment in depressed patients in the future" could be 'considered'.
- Through this complaints process, and as part of a separate complaints process with Yorkshire Medical Chambers (YMC), we learnt that LSMP and YMC both devolved proper scrutiny of Dr P's consultation with Naseeb to each other. This resulted in neither organisation adequately analysing or learning from the circumstances of our son's death.
  - There is no documented record of Dr P subsequently discussing with her locum colleagues, at Yorkshire Medical Chambers (YMC), whether a risk assessment of suicide was needed specifically in Naseeb's case.
  - YMC stated in March 2019 that locum GPs are expected to "engage with the significant event process of the practice in which they were working. That is what happened in this case. [Dr P] was already taking part in the significant event process at Leeds Medical Student practice".

- Dr P did not disclose to the Coroner that a 'Significant Events' meeting or her subsequent meeting with Dr R, had taken place at LSMP.
- LSMP did not make any changes or take further action in response to the 'Significant Events' meeting held in June 2016 and Dr R's subsequent meeting with Dr P. LSMP were unable to provide documentation of any other meeting, review or analysis/audit where our son Naseeb's case was discussed.

The central issues for us are to ensure that when a case arises within a medical practice requiring scrutiny of a GP's assessment, proper rigour and emphasis is given towards questioning whether an appropriate and adequate assessment took place. Following on from this appropriate action, learning and changes should be implemented immediately.

3.6.1.2 Changes made by LSMP following our complaint

LSMP informed us that they "see crisis presentation throughout the year". In addition to the end of the first term, beginning of the second term and end of the academic year, "the start of the first term is often anxiety provoking, as is August when students have re-sits and there is uncertainty over their future … it is important to be vigilant year-round."

- LSMP amended their registration form to include contact details for crisis services.
  Our reservations about this kind of intervention are that people in crises are rarely able to digest additional information, especially when on a form which is then handed back to reception.
  We suggested that LSMP insert this information as a loose sheet into the practice registration form so that a patient can keep it.
- LSMP planned to introduce two Patient-Pods placed in the waiting rooms to offer screening to selected patients so that they could complete a PHQ-9 and Generalised Anxiety Disorder (GAD-7) questionnaire in them. The selected patients would be those who self-reported a mental health problem when booking their same day appointment, or if they had been asked to complete screening questions by the GP at a previous appointment.

  This process is dependent on a student knowing they can book a same day appointment and also being prepared to tell the receptionist that they are presenting with a mental health problem. A number of students we have spoken to talk about low self-esteem, embarrassment and shame getting in the way of being able to assert their needs in a public reception space when feeling so vulnerable.

  LSMP was unable to offer screening to all patients when registering with the Practice as they were especially "concerned about the resources we would need to have in place to be able to respond to possible crisis presentations".
- LSMP then informed us that their registration pack now includes information about same day and urgent appointments. All appointments booked through reception are via a yellow slip with space for the patient to write brief details of why an appointment is required.
- Since May 2018 LSMP has an in-house mental health adviser service. If a GP wants to refer a patient to this service, a PHQ-9 questionnaire needs to be completed.
- LSMP will send a letter to the coroner after every inquest to obtain information that can contribute to learning and ensure this is fed back to the clinical staff in a 'significant event review' meeting.

- Mental health training for LSMP clinicians will include the need to recognise contributing factors: academic pressures, financial strain and attendance at university. These will also be highlighted in the locum handbook. We also suggested LSMP could access the Zero Suicide Alliance free training package.

3.6.2 Our Complaint to Yorkshire Medical Chambers (August 2018)

Yorkshire Medical Chambers (YMC) provides locum GPs and is where Dr P was based whilst working as a locum at LSMP. Our complaint related to the Clinical Team Meeting of YMC on 30th June 2016 where Dr P discussed Naseeb's case with, amongst others, Clinical Lead Dr S. It concerned us that the question of whether a risk assessment of suicide was needed in this case was not discussed and a breach of duty of care was not flagged up.

If the question had been asked, considering the other details that were recorded, there would have been a record of this due to the extremely serious nature of the outcome, because Naseeb died. Furthermore, by 30th June 2016, when the Clinical Team Meeting was held at YMC, Dr P would have been aware of the need to formally risk assess a depressed patient. This had been raised with her by Dr R at LSMP during their meeting on 13th June 2016.

3.6.2.1 Outcome of our complaint to YMC

The following information was acquired during a process spanning over six months and involved a number of written communications.

YMC stated there was "no concern regarding a 'breach of duty of care' brought up at this meeting". They could not answer our central question and finally admitted the following:

> "I cannot give you an answer to the question of 'whether a risk assessment of suicide was needed in Naseeb's case' as [Dr S] cannot recall if that was specifically addressed. I cannot therefore confirm that the question of 'whether a risk of assessment of suicide was needed in Naseeb's case' was indeed discussed in that meeting."

3.6.2.2 Changes made by YMC following our complaint

As a result of our complaint YMC began discussing with its groups the following changes:

- More widespread sharing of learning from events across the YMC network. Specifically in relation to this complaint the issue of Risk Assessments in primary care and the role of structured assessment tools to do this.
- Specifically asking the question "was there a breach in duty of care" for all events discussed at YMC.
- As an outcome of our complaint, YMC have now ensured that the contractual requirements for GP members reflect a doctor's duty to raise concerns in accordance with the GMC's Ethical Guidance which states, "all doctors have a duty to raise concerns where they believe that patient safety or care is being compromised by the practice of colleagues or the systems, policies and procedures in the organisation in which they work. Doctors must also encourage and support a culture in which staff can raise concerns openly and safely."

3.7 Policy, Training and Practice

Clinical practice takes place within the context of a wider regulatory and policy framework. We therefore undertook a series of dialogues with relevant organisations concerning the matters arising from our complaints.

3.7.1 Dialogue with the Royal College of General Practitioners (2018)

The Royal College of General Practitioners (RCGP) is the professional membership body for GPs in the UK whose purpose is to encourage and maintain the highest possible standards in general medical practice. In 2018 we informed the RCGP of our concerns in respect of Dr P's consultation with Naseeb and systemic healthcare issues that have been outlined above.

In our dialogue with the Assistant to the Honorary Secretary of Council, Dr Sue Rendel, we wanted to understand how the RCGP ensures that all its members are adequately trained in assessing depression and suicide risk and what specific steps are currently being taken to increase and monitor the effectiveness of how GPs assess suicide risk. The answer to this question remains elusive. We managed to establish that:

- The RCGP sets the curriculum for general practice training and assessment. Assessment of depression and suicidal risk are covered in the module, Care of People with Mental Health Problems. We explained that whilst we understand the assessment of depression and suicide risk is covered in GP training, as GPs have a very important role in suicide prevention, we believe it critical that all GPs are competent in assessing risk. This includes practitioners who have been in practice for a number of years.
- The RCGP informed us that ultimately the GMC and Care Quality Commission (CQC) are the bodies responsible for regulating GPs and general practices. GPs are appraised annually by NHS England to ensure that they are up to date and practising safely and effectively. However "regular training in suicide risk assessment is not mandatory." At present the specific content of each practitioner's appraisal is determined by themselves and related to the GMC's guidance, Good Medical Practice. Hence a GP's ability to risk assess self-harm and suicide may not be included in this appraisal.
- Having "sought advice from colleagues who have knowledge of the direction of travel in appraisal" the RCGP informed us "there are no plans that would alter this in the future".
- In response to the concerns we had raised the RCGP informed us it is "improving and increasing the resources in the Mental Health Toolkit [on the RCGP website], with regard to student health, and developing other resources that can be circulated in different ways to our members to try to achieve a wider coverage".

3.7.2 Dialogue with Healthwatch Leeds (2018 - 2019)

In August 2018 we informed NHS Leeds Clinical Commissioning Group (CCG) via Healthwatch Leeds, and also the Care Quality Commission (CQC), of our concerns in respect of Dr P's consultation with Naseeb and systemic healthcare issues that have been outlined above. The role of Healthwatch Leeds is to gather the views of users of health and social care services in order to identify improvements and influence providers' plans.

Healthwatch Leeds informed us that following on from the concerns we had raised, they are "carrying out a piece of work looking at people's experiences of mental health crisis in Leeds and the support that they

receive". Amongst the findings of their report published in 2019 was "a feeling by some that mental health was not fully understood by GPs, or that they did not consider it to be a priority". A key recommendation from the report was for "All frontline staff in mainstream services to have mental health training e.g. mental health first aid training." [38]

The key points made by the Chief Executive of Leeds CCG, Phil Corrigan when responding to us in February 2019 are as follows:

- LSMP is actively engaged in national forums. Student mental health has been discussed widely in the Student Health Association including at a number of the annual conferences providing opportunities for practitioners to learn and improve services from experiences.
- Following an audit that identified a high volume of students feeling emotionally unwell, LSMP is working with the voluntary sector to identify how best to meet the needs of distressed students presenting to GPs. This has resulted in the practice commissioning Northpoint Wellbeing to deliver two mental health advisors, taking referrals from the GPs in line with agreed criteria.
- Leeds CCG has allocated a Primary Care Liaison Registered Mental Health Nurse to LSMP, for an initial period of three months before a review. The aim of this was to not only support the practice but to help inform the future commissioning of the Primary Care Mental Health Service in relation to the needs of students.

3.7.3 Dialogue with the Department for Health and Social Care (2018)

In August 2018 our MP Kate Green wrote a letter to the Secretary of State for Health and Social Care Matt Hancock MP in which she informed him of our concerns and raised the following questions:

- What training and guidance is available to GPs and staff at health centres when students present with suicidal thoughts?
- What training is available to GPs to help them identify students at risk of suicide- particularly at the end of the academic year when the risk is heightened?
- What training is available to GP practices regarding suicide awareness and how training is maintained as part of continuing professional development?
- What formal peer support processes are in place at Health Centres to discuss and reflect on cases, and what supervisory frameworks are in place?

The reply letter she received from Matt Hancock MP in September 2018 outlined mainly initiatives to support people who have already identified as having mental health concerns and did not specifically answer the questions asked by Kate Green MP.

3.8 Recommendations

3.8.1 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.**

3.8.2 Training

- **Suicide prevention training should be mandatory for GPs within the context of improving mental health literacy[xv].**
  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.

3.8.3 Transparency and Information Sharing

- **Proper transparency is needed from the GMC in respect of all documents supporting their decision reasoning in the case of Dr P's consultation with Naseeb.[xvi]**
- **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 Dr P 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 Dr P'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.[xvii]**

[xv] A recent report about gaps in suicide prevention by Dr Mahajan, states that "the majority of healthcare professionals are not skilled in recognising the warning signs of suicidality and responding to them appropriately". Furthermore that "Standardised and fit-for-purpose suicide prevention training is prominent by its absence in GP training despite strong evidence that it saves lives and saves money." Dr Mahajan, S., *Bridging the Gaps in Suicide Prevention* (Churchill Fellowship, 2022), pages 44 and 49 respectively.

[xvi] The GMC refused to disclose the six documents upon which their decision was based to close the provisional enquiry into the concerns we had raised about Dr P.
The GMC decision reasoning relating to Dr P's assessment of our son is at variance with their own initial review of our complaint by "a senior medically qualified GMC colleague with experience in psychiatry". It is also in stark contrast to the concerns raised in the 'Significant Events' meeting at LSMP in 2016 and the independent GP expert report by Dr Kearsley. The latter was accepted by the Coroner and not challenged by either Dr P or her legal team at the inquest into Naseeb's death.

[xvii] LSMP did not liaise directly with YMC (from where Dr P 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 Dr P, 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 Dr P about this issue.

4. Chapter Four: Issues Relating to Leeds Beckett University Student Wellbeing Service

4.1 Introduction

In late May 2016 at the end of the academic year our son Naseeb Chuhan, who was a first-year student at Leeds Beckett University (LBU), presented at the University's Student Wellbeing Service and requested counselling. It is most likely our son took his own life the following day and a Student Wellbeing Officer is the last known person to have seen Naseeb alive.

This chapter of our report 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".[39]

On examining all the available evidence in relation to when Naseeb requested counselling and how LBU Wellbeing Service responded, we discovered he had presented a series of indicators for elevated mental distress and a potentially high risk of suicide. These were clearly visible from the answers Naseeb gave to the questions on the LBU Wellbeing Service registration form and the manner of his presentation at the service. The contextual related risk factors included that he had arrived in person, at a high risk time of the academic year and immediately on the advice of a GP the same morning.

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. From a complaint process that lasted four years, the unfortunate picture which emerges is 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 assessment in relation to Naseeb's interaction with LBU Wellbeing Service and the BACP's decision reasoning. The Independent Expert's Psychological Report produced by Dr Sam Warner, Chartered and Consultant Clinical Psychologist, found 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.

This report states that the LBU Wellbeing Service registration form clearly indicated "Naseeb was in a heightened/ severe state of mental distress." The form also disclosed that he had no support and was at risk of failing his course. Furthermore the related risk factors associated with Naseeb's presentation would

"raise rather than decrease professional concern about risk" and "invite further assessment and enhanced intervention". The report goes on to say that "the triage system was somewhat ineffective, as all available and relevant information does not seem to have been utilised."

In respect of Naseeb's interaction with LBU Wellbeing Service, there remain significant issues of accountability which need to be addressed, including the BACP's decision making processes and reasoning. We here also argue for 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.

4.2 Summary of Naseeb's Interaction with LBU Student Wellbeing Service

On the morning of Wednesday 25th May 2016, the day before we believe our son died, Naseeb saw a GP who suggested he contact LBU Wellbeing Service. Naseeb had not had any previous contact with mental health support services. Immediately after seeing the GP, Naseeb went straight to the LBU Rose Bowl which is a multipurpose conference venue that also houses Student Support Services, known as the Student Hub.

The reception desk is located in the centre of a spacious ground floor exhibition area which is open plan and surrounded by large glass windows to the exterior. Naseeb asked to see a counsellor at the reception desk and was advised by staff to register for this service on one of the computer terminals dotted around the exhibition space, which he did by 10.34am. The form he was asked to fill in was an online form intended for students to register with the service from any location.

The following is a summary of the contents of this form:

- Naseeb was registering because of mental health concerns. He wanted to discuss mental health/depression and he stated twice on this form that he wanted counselling. He had not had help with this before and was not on any medication.
- A GP had suggested he contact LBU Wellbeing Service and he was willing to accept an appointment on any day at any time.
- In terms of academic performance and engagement, Naseeb stated that he was at risk of failing his course and was missing lectures and seminars. However he did not want to 'defer his course' or 'leave university' which demonstrates Naseeb's wish to continue with his studies.
- In terms of wellbeing criteria, during the last two weeks he had been sleeping well "none of the time". He had "often" been worrying about things and had "often" felt low in mood. He had been looking after himself "none of the time", had difficulty coping with day to day life "some of the time" and was receiving support from "no-one".

The receptionist asked a Student Wellbeing Officer, Ms T to speak with Naseeb while in this space. Naseeb told Ms T that he had seen a GP that morning and been advised to seek counselling. The subsequent interaction which took place between Ms T and Naseeb at this point is still unclear.

We believe Naseeb died soon after his internet browsing history ends around 9pm the following day on Thursday 26th May 2016. That day he was emailed a first counselling appointment scheduled for Friday 27th May 2016, plus two further weekly appointments. He was also sent a link to complete the CORE-10 form which is designed to measure psychological distress and contains a key item on 'risk to self'.[40]

Naseeb did not attend the first counselling appointment on Friday 27th May and was sent an email on Tuesday 31st May cancelling the subsequent appointments. No other communication with Naseeb by LBU Wellbeing Service was attempted. Ms T is the last known person to have seen Naseeb alive.

4.3 Our Complaint to the British Association for Counselling and Psychotherapy Relating to Concerns about LBU Student Wellbeing Service (July 2018)

After the inquest we were compelled to submit our evidence as a complaint to the British Association for Counselling and Psychotherapy (BACP). LBU Wellbeing Service is accredited by the BACP, a professional association for members of the counselling professions in the UK and is required to adhere to the BACP's 'Ethical Framework for the Counselling Professions'. Our key purpose was and continues to be for lessons to be learnt towards better suicide prevention, for which a critical need is now widely recognised.

At the inquest into Naseeb's death most of our questions were not answered by LBU and some we were not even allowed to ask. The purpose of an inquest is to establish facts rather than to find faults[41] and in this case the inquest was not an 'Article 2' inquest.[xviii] LBU refused to investigate a complaint from us and therefore the BACP was the only option available.

Our complaint was submitted as "a 'third party' who can demonstrate sufficient interest, and who has been directly affected by the actions" of LBU Wellbeing Service. The detailed 11 page complaint included an additional 200 pages of comprehensive supporting evidence. We asked the BACP to specifically address the following issues:

- **Why LBU Wellbeing Service has remained unclear about how it is organised, what services it actually provides, the specific roles of staff and how students are adequately risk assessed.**
- **We do not know what our son was offered at LBU Wellbeing Service whilst requesting counselling. The Student Wellbeing Officer's accounts of seeing Naseeb contain contradictions, inconsistencies and omissions.**
- **Why LBU Wellbeing Service failed to pick up red flags, identify risk and assess Naseeb.**
- **Why LBU Wellbeing Service knowingly omits asking students, who are registering for the service, about risk to self. In order to reduce workload, the service irresponsibly relies simply on students self-reporting risk.**
- **Why the CORE-10 simple risk screening form is poorly utilised by the LBU Wellbeing Service.**
- **Why LBU Wellbeing Service did not keep accurate and contemporaneous records of contact with Naseeb and after he died avoided disclosure of documents to us.**
- **Why the University dealt with our visit after Naseeb died insensitively in a public space.**
- **What lessons have been learnt by LBU following the death of our son.**

[xviii] The scope of an inquest is defined by the Coroners and Justice Act 2009 and depends on whether Article 2 of the European Convention on Human Rights is engaged (The Human Rights Act 1998). If Article 2 is engaged, the inquest becomes a wider enquiry of ascertaining 'in what circumstances the deceased came by his or her death'. The inquest into Naseeb's death was not an Article 2 inquest and the 'how' was therefore simply stated as the method by which he took his own life.

4.3.1 Lack of Clarity about Service Organisation, Provision, Staff Roles and Student Risk Assessment

Our complaint explained that we remained unclear about how LBU Wellbeing Service was organised, what services it actually provides, the specific roles of staff and how students were? adequately risk assessed.

The Head of Disability and Wellbeing Services for Students LBU, Ms Jan Daley replied to enquiries raised by the Coroner in July 2017, prior to the inquest into Naseeb's death. In describing the counselling service she did not provide a clear explanation about the specific roles of "counsellors, mental health practitioners". There is no explanation of the role of a Wellbeing Officer, whom Naseeb saw, or the types of appointments the service offers such as "short term counselling (4 sessions), mental health appointment or Wellbeing appointment". Naseeb was sent emails offering him three "Wellbeing Counselling" appointments.

We established at the inquest that Ms T was not a counsellor as the Wellbeing Officer is an administrative role. She stated that in the Student Hub she had talked with Naseeb for no longer than five minutes.

4.3.1.1 How did triage take place?

A 'triage' service, is generally understood to mean ensuring people get the right care and in particular allocating priority according to severity and potential emergency. This is distinct from providing any kind of crisis service.

We have not received any explanation about how LBU Wellbeing Service assesses a student who attends their service for the first time in person. Despite presenting in person at the service on 25th May 2016, Naseeb was still asked to complete an online registration form, in which he had to disclose sensitive information, in a public concourse. Our research and discussions with a number of university counselling services in relation to suicide risk confirm that it is critical for student services to quickly engage and evaluate potential vulnerable students.

During our September 2016 meeting with the Director of Services for Students LBU, Ms W and Ms T we were told the service "operated a triage" system when evaluating priority of appointments provided. However there appear to be no systems in place for appraising students who present in person. Naseeb was effectively triaged in an exposed public place by Ms T who was an administrative worker and not a counsellor. She did not have the training or skills to competently engage or assess him.

There are a number of key contexts surrounding Naseeb's visit which LBU Wellbeing Service would have known:

- Naseeb was seeking counselling at the very end of the academic year, a high risk period especially for male students at a time when many students were returning home. As a first-year male student, the risk of suicide is double that for later years.[42]
- He was arriving in person keen to have counselling in that same week on any day and at any time, rather than making an online enquiry.
- Naseeb was requesting counselling from LBU Wellbeing Service immediately after seeing a GP who had advised him to do so.

No immediate appraisal of the kind of seriousness involved in Naseeb's condition took place and it is of great concern to us that at the inquest Ms T stated at no stage whilst meeting him or looking at his registration form did it cross her mind Naseeb may be at risk of suicide.

4.3.2 The Student Wellbeing Officer's Accounts Contain Contradictions, Inconsistencies and Omissions. What did the Service offer to Naseeb?

We do not know what our son was offered at LBU Wellbeing Service whilst requesting counselling. The Student Wellbeing Officer's accounts of seeing Naseeb contain contradictions, inconsistencies and omissions.

Ms T's 'journal entry' dated 2nd June 2016 states "I was available to see him there and then. Naseeb said he would register instead and asked if he could be seen the same week. Naseeb was then offered an appointment for two days later on the Friday."

This journal entry was made eight days after Ms T's interaction with Naseeb took place and was written the day after we telephoned LBU to inform them of Naseeb's death. The University did not release this document until almost 18 months after Naseeb died, when the Coroner requested a copy of Naseeb's LBU Wellbeing Service registration form.

In her undated police statement, released to the Coroner in September 2016, Ms T simply states that she "offered to speak with him there and then".

Subsequent accounts contain contradictory and inconsistent variations which claim that more was offered than this simple and non-specific availability "to see him there and then". Whilst Ms T's own journal entry and her police statement did not mention a same day appointment, this was introduced in later retrospective statements:

- In the summary of contact with Naseeb sent to us in August 2016, Ms T ambiguously states she "offered Naseeb a same day appointment".
- Later in September 2016, when we met with Ms T, she told us Naseeb had looked "anxious and worried" and that she was "concerned" about him enough to "offer a same day appointment". The 'same day appointment' was with a fully qualified counsellor who "happened to be available" and not with herself. As Naseeb declined a same day appointment Ms T told us she was still "concerned" enough about Naseeb to offer an appointment later that same week for Friday 27th May 2016 which he said he would attend.
- The Head of Disability and Wellbeing Services for Students LBU, Ms Daley's reply to enquiries raised by the Coroner in July 2017 regarding "the nature of the service provided by the Counselling Service" makes no reference to a 'same day appointment' system or how this operated. Ms Daley stated that Ms T "offered to spend some time with him there and then" and that Naseeb would "like an appointment that week if possible".
- At the inquest into Naseeb's death, Ms T suggested she thought Naseeb was aware the 'same day appointment' she offered him would have been with a 'mental health practitioner'. This could have been organised after he had talked with her 'there and then' which he declined to do. Ms T suggested that she wanted to explain the services available to Naseeb and work out what was appropriate for him.
- It also remains unclear as to whether Ms T's offer to "see him there and then" was in a private space. When we met Ms T in September 2016, she stated that all her interaction with Naseeb had happened in the main concourse and that the counsellors are based in private rooms. At the inquest she said she would have offered to talk with Naseeb in a private room, but only after checking if one was available.

Ms T's accounts of offering 'a same day appointment' with a fully qualified counsellor or a mental health practitioner are inconsistent and these are two different types of intervention. As noted above, she told us in September 2016 that the same day appointment was with a *fully qualified counsellor* who "happened to be available" and not with herself. At the inquest Ms T suggested she thought Naseeb was aware the 'same day appointment' she offered him would have been with a *mental health practitioner*.

It is hardly surprising that Naseeb declined talking about his situation in a large open plan public space. Equally, it is highly unlikely that our son would ask to see a counsellor immediately after seeing the GP and then not take up any offer to see a counsellor from that service, in a private space, on the same day.

Naseeb's persistence in seeking support on that day suggests he must have felt a strong and serious compulsion to seek help. Naseeb didn't just give up after seeing the GP, he then walked to the Student Hub, having not slept for at least three consecutive nights and with no money on him and minimal food in his flat. Moreover on the Student Wellbeing Service registration form he indicated that he was willing to accept an appointment on any day at any time.

4.3.3 The Service Failed to pick up Red Flags, Identify Risk and Assess Naseeb

Ms T did not inform any member of staff that she was "concerned" about Naseeb and the fact that he had been advised to seek counselling by a GP that morning did not trigger his LBU Wellbeing Service registration form to be reviewed immediately either. At the inquest into Naseeb's death, Ms T disclosed that when the form was reviewed by a senior practitioner the following morning at 9am, no further action was taken. From the details Naseeb provided on the registration form, it is clear that our son needed an urgent mental health assessment. Instead he was simply sent emails offering a first counselling appointment scheduled for the following day plus two further appointments at weekly intervals.

There was no senior practitioner from the service at the inquest to answer our questions in relation to this. Ms Daley, in a reply to enquiries raised by the Coroner in July 2017, states "If there is anything of particular concern on a registration form, one of the senior practitioners rings the student the same day as the registration form is reviewed to check out what they have written and assess any current risk; they will take further action as necessary."

At the inquest, Ms T recalled "he hadn't really put much information" on the form or elaborated on sections he had ticked. Apparently other students write a lot more information. The service did not take into account the fact that Naseeb had candidly filled in the form in an exposed public space. When assessing risk, the emphasis should be on the content of a form and the context within which it is filled in, rather than the amount a student has written on a form. A summary of the contents of Naseeb's LBU Wellbeing Service registration form can be found at the beginning of this chapter.

According to NHS guidance "People with depression are at particular risk for suicide." [43] We believe the fact that this was the end of the academic year and, from advice given by a GP, Naseeb was then presenting with mental health/depression, receiving support from "no-one", considered himself at risk of failing his course and the condition he described he had been in for the last two weeks on the form should have at least led to a senior practitioner contacting him. Naseeb had filled out his own mobile number on the form and the other number he had given was his parents' home telephone number which also had an answering machine.

In 2022, during the complaint process through the BACP we further analysed Naseeb's answers on the LBU Wellbeing Service registration form. The wellbeing questions on the form mirror the questions on a CORE-10 form[44] which is designed to measure psychological distress, using a numerical scoring system.

On Naseeb's form, of the six wellbeing criteria, three were ticked as being of maximum severity (the lack of support, sleep and looking after yourself items), another two of near maximum severity (worry and feeling low), the final one was of average severity (coping with life). Using the CORE-10 scoring system, Naseeb's answers yield a particularly high-risk severity score of 33 out of a maximum of 40. The guidelines state that any score above 25 is over the severe threshold.[45]

We believe enough information was presented by Naseeb that pointed to a potentially severe risk for which further assessment ought to have taken place quickly.

4.3.4 The Service had removed a question about risk of suicide on their registration form and relied on students self-reporting risk

The LBU Wellbeing Service knowingly omits asking students, who are registering for the service, about risk to self. In order to reduce workload, the service irresponsibly relies simply on students self-reporting risk.

LBU Wellbeing Service's registration form previously had an additional question related to risk of suicide. However, it was revealed at the inquest into Naseeb's death that by the time of Naseeb's visit to the service this question had been removed.

Ms T and Ms W confirmed that the question was removed by staff because they "had so many students ticking it". Worryingly, Ms T elaborated that there were a lot of false alarms and on contacting students the service would be told "I'd had a lot to drink, I don't really feel like that." Due to an 'over reporting' of potential suicide risk the service decided to remove the question.

It seems a ludicrous solution to reduce workload by simply not asking a question about risk to self. As is already the case with a number of university wellbeing service forms we have seen, an ethical and safer approach could be to have refined follow up questions on a form to gauge actual risk to self and further explore students' needs. We are also concerned that students who may feel suicidal when intoxicated are dismissed as 'false alarms'. In response to students feeling suicidal when intoxicated some universities have appointed drug and alcohol workers to confront this worrying situation.

4.3.4.1 The assessment of potential risk to self

Ms W stated at the inquest that it was inappropriate for the service to ask about risk to self on the registration form as this could lead a student to think it was a 'crisis service'. In reality the form is not checked for at least 24-48 hours later and this could lead to a false sense of security on behalf of the student, believing they had told somebody.

The LBU Wellbeing Service webpage and registration form do contain statements about it not being an emergency crisis service. However, we believe these statements act as disclaimers rather than as useful pointers to alternative crisis services. Such statements should not negate the important role of a student wellbeing service to identify potential risk.

The online registration system required a student to read lots of additional information, which most will not, especially someone in the condition Naseeb was in when registering in a public concourse. At the bottom of the registration page a student had to click on text stating "urgent support information" to get to the page which then contains "Urgent Support".

Within the section about 'mental health concerns' on the registration form one of the questions simply asked whether a student has "thought of any solutions to the problems you are experiencing". Naseeb chillingly answered "yes" to this question. At the inquest Ms T explained that as Naseeb had not elaborated

on this answer it was not considered to be significant. We find this concerning and potentially dangerous as research shows that a person who is in the process of deciding to take their own life can exhibit a mood lift on realising they have found a 'solution' to their problems.

LBU Wellbeing Service does not actively and responsibly assess students' risk to self at registration, but rather simply relies on students who are at risk coming forward to report their own condition and its severity. Risk assessment is therefore based on whether a person reveals risk by self-reporting without being prompted, and in Naseeb's case in a public place. Sadly there is ample research that shows self-reporting without being prompted is not a viable approach for adequately assessing suicide risk.

4.3.5 The CORE-10 Simple Risk Screening Form is Poorly Utilised by LBU Wellbeing Service

On Thursday 26th May 2016, the day we believe Naseeb died, he was sent emails for counselling appointments by LBU Wellbeing Service. He was also asked to complete a brief evaluation CORE-10 form.[46] The email stated "This is a simple 10 question measure of how you are feeling before you start counselling."

The Core-10 User Manual states that this form is used by counselling service providers at the first point of contact with a client as it is "an initial quick screening tool" and "can easily be scored by hand ... has been designed to tap into a pan-theoretical 'core' of users' distress, including commonly experienced symptoms of anxiety and depression and associated aspects of life and social functioning. In addition, there is a key item on risk to self". Question number six on this form states "I made plans to end my life" with a number of options a person can tick to indicate frequency.[47]

We are exasperated that Naseeb was not asked to complete this form on presentation to the service in person the previous day, which is what it is designed for. At this point, given that he had candidly completed the GP Practice and LBU Wellbeing Service registration forms, it could well have further flagged up his state of high risk.

Nobody from LBU Wellbeing Service tried to phone Naseeb when he failed to attend his appointment on Friday 27th May. Instead an email was sent letting him know he had missed an appointment and a few days later another email cancelled subsequent appointments. If he hadn't already died he could have been in a state of distress, needing a caring and skilled professional to call him and work out the best way forward.

4.3.6 Inadequate Record Keeping, Information Sharing and Transparency

The Service did not keep accurate and contemporaneous records of contact with Naseeb and after he died avoided disclosure of documents to us.

When we tried to gather information with which to understand Naseeb's interaction with LBU Wellbeing Service, we encountered a lack of transparency and reliability in the information it released. The University did not disclose to us the two most important documents relating to Naseeb's interaction with LBU Wellbeing Service. These are Naseeb's completed LBU Wellbeing Service registration form and Ms T's subsequent journal entry. Both of these documents were only disclosed to us by LBU almost 18 months after Naseeb died, and then only after a request from the Coroner for a copy of Naseeb's LBU Wellbeing Service registration form.

This is despite our request by email on 22nd July 2016 asking "What did he say" at any point of contact with LBU Wellbeing Service. Subsequently, in September 2016 we also visited the LBU Wellbeing Service in

person to view the last place Naseeb had been seen alive and wanting to know what Naseeb had said in his interaction with the service.

The journal entry relating to the interaction between Ms T and Naseeb was completed eight days after he attended the service in person and requested counselling. The date of the journal entry, 2nd June 2016, is the day after we telephoned LBU to inform the Head of Department, Dr K, of Naseeb's death. During this phone call we also asked Dr K to find out if Naseeb had seen a counsellor at the University.

The authenticity of the journal entry contents is questionable as it was written retrospectively in the knowledge that Naseeb had died. The LBU Wellbeing Service registration form was the last piece of writing Naseeb completed before he died. This indicated a severe level of risk and revealed Naseeb's own insight into the state he was in.

4.3.7 The University Dealt with our Visit after Naseeb Died Insensitively in a Public Space

In addition to our central concerns, after Naseeb had died, our visit to the University on 15th September 2016 as grieving parents left us feeling very uncomfortable with the level of care and privacy we received.

Three and a half months after Naseeb had died, we drove to Leeds from Manchester and met with Ms W and Ms T at the reception desk in the LBU Rose Bowl building. This is also where Naseeb had presented to request counselling.

We sat at a table in this public space where they indicated Ms T had also offered to speak to Naseeb. We talked about our deceased son's visit to the service whilst other students were sitting nearby or walking past. We were not offered a drink of water or a cup of tea.

4.3.8 What Reviews, Changes and Action did LBU Undertake Following the Death of our Son?

We asked the following questions in respect of Naseeb having died by suicide whilst studying at LBU:

- Had the University conducted any review of service provision at either departmental, Wellbeing Service or university level?
- What changes, if any, had been made with the benefit of hindsight?
- What action had been taken in respect of any staff who did not follow guidelines or procedures?

The question as to whether LBU had "carried out a review of any sort arising out of Mr Chuhan's death?" was asked of the University, prior to the inquest, in enquiries raised by the Coroner in July 2017. The University reply avoided answering this specific question.

In October 2019 the BACP disclosed to us a letter from LBU dated August 2019 which stated "Changes have, therefore, been made as part of our ongoing process of review and continual improvement in an attempt to achieve best practice, however these were not made specifically as a result of Naseeb's death."

The letter goes on to list the improvements, which include having a duty practitioner in the Student Wellbeing office, Student Hub Team guidance and training, enhanced staff development regarding mental health and wellbeing, and the introduction of initial consultations within the service.[48] In April 2022 the BACP Appeal Decision noted that LBU Wellbeing Service Officers practice has now altered to make "formal record of contacts with students".

These changes are consistent with the kinds of approaches needed to address some of the shortcomings we have specifically raised about LBU Wellbeing Service and it appears to us unlikely that these would be entirely coincidental.

4.4 The BACP Complaint Process 2018-2022

After the submission of our complaint against LBU Wellbeing Service to the BACP in July 2018, there was a delay until January 2019 whilst the BACP suspended our complaint pending the outcome of an investigation by the Office for Students (OFS). We were eventually informed our complaint did not fall within the OfS remit and that OFS staff guidance and wording on its website had been misleading – see Appendix A.

During February and March 2019 we were involved in lengthy discussions with the BACP to decide whether our complaint should be dealt with under the Professional Conduct Procedure (PCP) or Article 12.6.

- Under the Article 12.6 procedure the only sanction available is withdrawal of membership. This procedure is reserved for very serious allegations and requires a higher burden of proof than the PCP. It is also the procedure whereby third-party information can be submitted.
- The PCP route can deal with complaints in different ways ranging from a letter of advice to a formal Professional Conduct Hearing. However its scope would be limited to the concerns we had raised specifically about the service our son received at LBU Wellbeing Service and not the additional concerns we were raising in respect of the service's interactions with ourselves; the circumstances of our meeting with LBU Wellbeing Service in Sept 2016 and the late disclosure of information to us. Only the actual Student Wellbeing Service registration form Naseeb completed would be considered and not the removal of a question about risk of suicide by the service.

Out of the two BACP complaint routes open to us, we chose the PCP route which could deal with complaints in different ways ranging from a letter of advice to a formal Professional Conduct Hearing.

4.4.1 Stages During the Complaint Process:

4.4.1.1 The BACP Investigation and Assessment Committee (IAC) Decision Report (October 2019)

The outcome of the IAC's Decision Report was that the "proceedings test hasn't been met and the complaint should be dismissed". Our response to this report was delayed as it required painful and highly intensive attention and we were then also faced with the Covid-19 pandemic.

4.4.1.2 Our Response (March 2021) to the IAC Decision Report

This response took the form of a 10 page report to the BACP which detailed our concerns following an analysis of the IAC's decision and reasoning. In May 2021 the BACP informed us that they were unable to consider our response to the IAC Decision Report due to our delayed submission. Subsequently in June an email was sent to the BACP from our MP Kate Green requesting that they review this decision.

4.4.1.3 The BACP re-process our complaint (September 2021)

In September 2021 we were informed by the BACP that the IAC Decision Report (Oct 2019) had been processed under a new professional conduct procedure, operational from December 2018. As our original complaint was submitted before this date it should have been assessed under the previous procedure.

Hence the BACP advised they would re-process our complaint under the correct procedure and set a 28-day deadline for us to send a revised version of our 'Response to the IAC's Decision Report (March 2021)'. Our revised version had to remove all references to the IAC decision and could include further written representations in support of our complaint. We submitted nine pages of revised material to the BACP within their deadline.

4.4.1.4 The BACP Pre-Hearing Assessment Panel (PHAP) Decision Report (November 2021)

We were informed that the PHAP had "not accepted" our report and that "there was insufficient evidence to support the complaints made in relation to the actions" of LBU Wellbeing Service. The Panel was "not satisfied" that LBU Wellbeing Service "had failed to assess Naseeb adequately when he made contact with the service".

We were given 28 days from early December to appeal this decision. As the Christmas period is a very sensitive time of year for anyone who has lost a loved one through suicide, we negotiated with the BACP for an extension to this deadline and were informed on Christmas Eve that this had been granted.

4.4.1.5 Our Appeal (February 2022) against the PHAP Decision Report

Our 10 page appeal in response to the PHAP Decision Report (Nov 2021) explained in detail that the Decision Report lacked analytical robustness and contained numerous omissions, unanswered questions and incorrect assumptions. In some cases there was little or no documented evidence to support the decisions reached. One of the key issues we again requested that the BACP address was whether potential risk rather than immediate risk had been presented by Naseeb.

4.4.1.6 The BACP Independent Appeal Assessor's Report (April 2022)

The BACP informed us that our appeal was "unsuccessful" and the decision in the PHAP Report (Nov 2021) was upheld.

4.5 Issues Arising from the BACP's Assessments

The following are summaries of the range of problems we encountered with the way our complaint and the presented evidence was dealt with by the BACP.

4.5.1 Misrepresenting the Evidence

4.5.1.1 The BACP's descriptions depart from the actual evidence

- The IAC Decision Report (Oct 2019) stated "X went to the LBUWS to register for Counselling."
  Our Response (Mar 2021) to the IAC Decision Report explained that all the evidence provided by LBU clearly described Naseeb *asking to see a counsellor at the reception desk*. He was then advised to register on one of the computer terminals by the receptionist, hence Naseeb was not aware that he had to register to see a counsellor when he went to LBU Wellbeing Service.
- The PHAP Decision Report (Nov 2021) noted the GP "had not offered him any immediate treatment or medication".
  Our Appeal (Feb 2022) against the PHAP Decision Report explained this was an assumption for which there is no evidence and creates the impression of presenting a potentially lower level of risk

severity. Naseeb verbally informed LBU Wellbeing Service that he had seen the GP that morning and was advised to seek counselling. He did not elaborate on what, if anything, the GP had offered him.
The BACP Independent Appeal Assessor's Report (Apr 2022) confirmed in relation to this point "I cannot find any conclusive evidence to support the assertion made by the Panel… This is likely to have been an assumption made by the PHAP for which is unsupported by evidence."

- When reviewing Naseeb's answers given on the Wellbeing Service registration form the IAC Decision Report (Oct 2019) did not take into account that Naseeb had considered himself to be at risk of failing his course.

4.5.1.2 The issue of whether Naseeb was offered a 'same day' appointment

The IAC Decision Report (Oct 2019) and the PHAP Decision Report (Nov 2021) accepted without scrutiny, such as cross referencing with the documented material available, written assertions made by LBU to the BACP that the wellbeing officer "offered a same day appointment" to Naseeb which he "declined".

Our Appeal (Feb 2022) against the PHAP Decision Report described all the contradictions, inconsistencies and omissions in relation to this issue that had been explained in detail in our Complaint to the BACP against LBU Wellbeing Service (2018). The Wellbeing Officer Ms T's journal entry did not mention offering 'a same day appointment' with anyone nor did her police statement to DC White. She only mentioned 'a same day appointment' in her summary of contact with Naseeb sent to us later in August 2016. Furthermore, at the inquest the Wellbeing Officer explained that seeing him "there and then" would essentially have entailed explaining what counselling was, and was not a counselling appointment.

The BACP Independent Appeal Assessor's Report (Apr 2022) stated that "Considering the entry on the hub system by [Ms T] and the statement of DS White, no reference is made to a 'same day appointment'. Reference in [Ms T's] records is to 'I was available to see him there and then'."

"The only reasonably reliable evidence is this entry made on the hub shortly after Naseeb's death. There is a lack of clarity as to what was meant by this. There is no clear indication that Naseeb was told he could see a counsellor or a mental health practitioner on the day he attended the student hub."

The report concluded "What Naseeb interpreted [Ms T's] offer to mean, tragically, is pure speculation. There is ambiguity in the evidence about 'there and then' being interpreted to 'same day appointment'."

Despite describing what Ms T actually offered as ambiguous and what Naseeb interpreted was being offered as "pure speculation" the Appeal Assessor still decided "It was a reasonable conclusion for the Panel [PHAP Decision Report Nov 2021] to reach that … Naseeb was offered to speak to someone on the day and that offer was declined." The Independent Appeal Assessor assumes that Naseeb must have been offered something by LBU Wellbeing Service which he then refused, yet there is little and only ambiguous evidence to this effect.

4.5.1.3 The issue of whether Naseeb was offered a 'private room'

The IAC Decision Report (Oct 2019) not only stated that Naseeb was "offered a private room if he wanted to discuss matters" by the Wellbeing Officer but that he was also "offered help completing the LBU Wellbeing Service registration form in a private room". Our Response (Mar 2021) to the IAC Decision Report and our Appeal (Feb 2022) against the PHAP Decision Report explained that there is no mention of a "private room for further discussion" in any document provided by the University including Ms T's June 2016 journal entry or her subsequent witness statement to DC White. As we had stated in our original

Complaint to the BACP against LBU Wellbeing Service (2018), at the inquest Ms T "said she would have offered to talk with Naseeb in a private room, but only after checking if one was available".

The BACP accepted LBU's unsubstantiated assertion regarding this point, which created an impression that more was done than there is any actual documented evidence to support, at face value without scrutiny. The IAC Decision Report's (Oct 2019) assertion that Naseeb was offered a "private room" in which to complete the registration form can only be a fabrication on the part of the BACP as not even LBU have claimed this at any point.

On this matter the BACP Independent Appeal Assessor's Report (Apr 2022) concluded that "There is insufficient evidence to suggest had this conversation been in a private location as opposed to a public area Naseeb would have been more open."

4.5.2 Problems Related to the Assessment of Risk

4.5.2.1 CORE-10 Risk Screening Form

As was detailed in our original Complaint to the BACP against LBU Wellbeing Service (2018) we were concerned that the simple CORE-10 risk screening form was not utilised effectively by LBU Wellbeing Service to assess Naseeb when he presented in person to request counselling at LBU Wellbeing service. This form is specifically designed for use as "an initial quick screening tool" [49] and was instead emailed to Naseeb the day after he presented at the service.

IAC Decision Report (Oct 2019) "considered it would not be appropriate to provide the Core 10 questionnaire upon attendance at the service and indeed it may be potentially unhelpful". The PHAP Decision Report (Nov 2021) stated "the CORE-10 forms" were "not intended to be used as a diagnostic risk assessment tool".

In our Appeal (Feb 2022) against the PHAP Decision Report we explained the Panel had confused the Simple CORE-10 form we had referred to with the entire CORE-10 set of forms.

The BACP Independent Appeal Assessor's Report (Apr 2022) agreed that the PHAP had been mistaken and that our "appeal will be reviewed with reference to the single sided Core 10 form". The Appeal Assessor then made no further reference to the issue we had originally raised about the services utilisation of this form in respect of our son.

4.5.2.2 Identifying the Risk Severity Level

In our Appeal (Feb 2022) against the PHAP Decision Report we explained our analysis of Naseeb's answers on the LBU Wellbeing Service registration form using the CORE-10 quantitative scoring system which yielded a high-risk severity score. With this in mind, we requested the BACP explain what level of risk Naseeb's completed LBU Wellbeing Service registration form represented, what kind of client response on the form would have advised that further assessment should have taken place, and when or how quickly this assessment ought to have taken place.

In reply to these questions, the BACP Independent Appeal Assessor's Report (Apr 2022) stated "It is not within my remit as an independent appeal officer to answer the question above nor is it a question the PHAP could have answered. There is insufficient evidence to reasonably conclude failure to have trained clinician to assess students who present themselves in person to the service and failure to utilise the Core 10 form amounts to unsafe practices." Throughout our original compliant to the BACP (2018) we have

never referred to a “trained clinician to assess students”. The issue we have persistently raised has always been about the need for appropriately qualified staff conducting a robust triage.

4.5.2.3 Immediate Risk and Potential Risk

Our Complaint to the BACP against LBU Wellbeing Service (2018) should have been assessed on the basis of whether in Naseeb’s case enough information was presented that pointed to a potentially severe risk, for which further assessment ought to have taken place quickly. The PHAP Decision Report (Nov 2021) stated “having reviewed the online form completed by Naseeb, the Panel did not consider that it gave any clear indication of an immediate intent to self-harm”. Our complaint was repeatedly assessed for whether or not LBU Wellbeing Service should have identified “that there was an immediate risk.”

In both our Response (Mar 2021) to the IAC Decision Report and our Appeal (Feb 2022) against the PHAP Decision Report we explained that our complaint did not suggest that the identification of ‘immediate risk’ should have been required to advise further assessment. It was our assertion that enough information was presented that pointed to a potentially severe risk for which further assessment ought to have taken place quickly.

The BACP Independent Appeal Assessor’s Report (Apr 2022) finally agreed that “the PHAP have referred to immediate risk and not by reference to the actual complaint that the potential risks were not considered. The complaint is Naseeb was not adequately risk assessed for the potential for self-harm. The Panels assessment will be reviewed in light of this.” However, the Appeal Assessor did not review our complaint in light of potential risks and subsequently referred specifically and only to “immediate risk”.

4.5.2.4 Assessment of potential risk in the absence of a question relating to self-harm/suicide

The BACP also concluded that as LBU Wellbeing Service was not a crisis service it was acceptable for the service to remove a question about risk to self on the registration form. The BACP did not undertake any analysis of whether the information that LBU Wellbeing Service asked for was adequate to be able to make any assessment of risk. In our Appeal (Feb 2022) against the PHAP Decision Report we asked the BACP confirm that without any questions regarding self-harm being raised on the registration form, there ought to be greater alertness to the potential for risk to self and an onus to assess this when related risk factors are present.

The BACP Independent Appeal Assessor’s Report (Apr 2022) again concluded that “They are not and do not advertise themselves as a crisis service.” This avoided our fundamental question which was about assessing potential risk rather than whether or not LBU Wellbeing Service is a crisis service. The assertion that LBU Wellbeing Service is not a crisis service should not be acceptable as a substitute for any lack of adequate triage.

4.5.3 Condoning the Protracted Disclosure of Information

Regarding the issue raised in our Complaint to the BACP against LBU Wellbeing Service (2018) about LBU’s late disclosure to us of two key documents; namely Naseeb’s Student Wellbeing registration form and the Student Wellbeing Officer’s journal entry. We had requested at the second Pre-Inquest Review hearing in September 2017 that the Coroner’s office obtain a copy of Naseeb’s Student Wellbeing registration form as other documentation received from LBU had revealed that this document most likely existed. As was also noted in our complaint to the BACP we had clearly asked for any information relating to Naseeb and his

contact with LBU Wellbeing Service in an email to LBU dated 22nd July 2016, which was soon after he had died.

The entire scenario of us persistently having to prompt information from LBU relating to our son after he died portrays an institution reluctant to cooperate. The IAC Decision Report (Oct 2019) stated that "as we did not specifically ask for the Student Wellbeing Officer's journal entry, LBU only provided it "to the Coroner when it was requested". We were not aware of there being a Student Wellbeing Officer's journal entry, hence this was not specifically requested but simply released by LBU at the same time as the form, which was nearly 18 months after Naseeb died.

The PHAP Decision Report (Nov 2021) stated "this was a complex situation where statutory legal processes and the confidentiality of Naseeb had to be considered … some of the delay in providing information had been due to misunderstandings as to what was required". We explained in our Appeal (Feb 2022) against the PHAP Decision Report that as Naseeb's next of kin we were given prompt access to his medical records after he died. At no point did the University indicate that their delays in disclosing certain pieces of information to us were related to 'confidentiality' or legal processes. Furthermore these 'misunderstandings' have never been specified by LBU and we requested details as to what these were. The BACP Independent Appeal Assessor's Report (Apr 2022) did not address this issue.

4.5.4 Stigmatising Terminology

The IAC Decision Report (Oct 2019) referred to Naseeb having taken his own life as "X committed suicide in May 2016".
In our Response (Mar 2021) to the IAC Decision Report we expressed disbelief that the BACP, a professional association for members of the counselling and psychotherapy professions in the UK, was using stigmatising terminology – "committed suicide" – associated with an outdated prism through which to view suicide. We referred to a range of resources in the public domain which urge people not to use such terminology as the Suicide Act 1961 decriminalised the act of suicide. Mental health and media organisations strictly advise against using this term, instead referring to a person as having taken their own life or that they died by suicide.

4.6 An Independent Expert Psychologist's Assessment of the Evidence

Independent Expert's Psychological Report Concerning Naseeb Chuhan's Interaction with LBU Student Wellbeing Service by Dr Sam Warner – Chartered and Consultant Clinical Psychologist (December 2022).

Based on the available evidence to us, it has always been our carefully considered assertion that LBU Wellbeing Service failed to properly assess Naseeb. After four years of being involved in a harrowing complaints process with the BACP regarding LBU Wellbeing Service, there remain profound disagreements between ourselves and the BACP's three assessments.

Challenging LBU Wellbeing Service and a highly reputable organisation such as the BACP is a daunting task. From all the available evidence, the BACP appears to have lacked rigour and shown partiality towards LBU Wellbeing Service in their decision making. After exhausting the BACP complaints process, by mid 2022 it became important for us to commission an independent expert's assessment in relation to Naseeb's interaction with LBU Wellbeing Service and the BACP's decision reasoning.

In answer to the questions raised by us, Dr Warner undertook a qualitative analysis and developed her independent expert opinion "based on a process of triangulating information from three main sources:

direct knowledge (here in terms of Naseeb's written answers on the registration form) **indirect knowledge** (the written reports and statements of others for example, concerning Naseeb's presentation in-person at the student wellbeing service); and my **specialist knowledge** (based on my knowledge of research and theory, and my clinical experience of self-harm and suicide). This type of approach to analysis and formulation would be used by many practitioners, even if not directly referring to this as triangulation".

From all the available evidence the report makes clear that "Naseeb demonstrated a downturn in his mental health and social wellbeing during the period from December 2015 to his death by suicide at the end of May 2016. Key underlying stressors are likely to include potential trauma associated with the fire in student accommodation and near miss at home [December 2015],[xix] spiralling debt and the prospect of academic failure. Naseeb began to withdraw from his friends and his course, isolation being a key factor in the cause and effect of mental ill-health."

4.6.1 The Level of Risk or State of Wellbeing that was Indicated by Naseeb's Completed Registration Form

The report states that the LBU student wellbeing registration form "functions as a screening tool that aids in the selection of the most appropriate service for a student experiencing some form of mental distress". It then identifies the "Key underlying indicators of Naseeb's mental distress" from his completed LBU student wellbeing registration form as follows:

> "Not sleeping and worrying often are indicators of anxiety. Feeling low in mood is an indicator of depression. This is particularly the case when associated with an inability to look after oneself all of the time and difficulty coping with day to day life some of the time. … These statements are also indicative of heightened self-neglect indicating severe helplessness, and reinforcing Naseeb's need for someone else to help him, as also indicated by his attendance at the GP appointment and the wellbeing centre on the same day."

Dr Warner explains "That Naseeb was able to acknowledge difficulties with his course and attendance (factors sometimes associated with risk of self-harm/suicide for students), when prompted to do so (via questions on the form), may suggest that he would have been able to acknowledge explicitly his feelings of suicidality, if questions on that issue were also included on the form. Albeit brief, Naseeb's answers taken together indicate an elevated state of mental distress at a time when he had no support. It is in this context that Naseeb also stated that he had thought of 'solutions to the problem' … Such solutions did not include deferring his course or leaving the university and as such, consideration of whether this might indicate suicidal intent could be raised particularly as Naseeb had also made reference to an inability to look after himself all of the time and that he had difficulty coping with day to day life some of the time."

Dr Warner makes clear that "Although this interpretation involves 'reading between the lines', this is how mental health and wellbeing assessments often 'work': by putting together different pieces of information to arrive at a hypothesis or formulation of issues and risk. Additionally, professionals who work with students should be aware of the increased risk of suicide at times of transition, which was when Naseeb filled in this form (at the end of the term). And therefore may be expected to be especially alert to anything on forms that might signify hopelessness and suicidal intent."

[xix] In mid December 2015, unknown to us, Naseeb had accidentally set fire to the kitchen in his student flat. The entire kitchen had to be replaced over that Christmas. This would have been a frightening and difficult experience for Naseeb to deal with. During those Christmas holidays he also nearly set fire to the kitchen at home by accident.

The report notes “the ‘acute’ nature of Naseeb’s difficulties was, perhaps, also indicated by his ticking all appointment times and days as being acceptable.”

Dr Warner describes the questions on the registration form as ‘scaling questions’ which “ask for a response to a question as a position on a scale. … Accepting the transferal of data from the student registration form to the CORE-10 form, and the subsequent interpretation of data indicating that Naseeb was at the ‘severe’ level (numerically), tends to support my qualitative analysis that Naseeb’s completed registration form was indicative of heightened mental distress, and thereby suggestive of elevated risk (of self-harm)”.

In addition the report states “the content of Naseeb’s registration form and the time of year at which it was completed would combine to further raise concern about the state of his mental health and his potential risk of self-harm/suicide. In light of there being no direct questions about self-harm/suicide on the registration form, it may be expected that review of the form would lead to an understanding that more information was needed, and this would be needed in a timely manner.”

4.6.2 Should Further Assessment Have Taken Place Quickly?

We asked the question "Was there enough information presented on Naseeb’s completed registration form to indicate a potentially severe risk for which further assessment ought to have taken place quickly?"

The report explains that “when undertaking a risk assessment, if there is a lack of information to enable a confident expert opinion that someone is lower risk, the usual process is to consider that the individual may be potentially ‘high risk’. This understanding remains until sufficient information is provided to revise and/ or cement the opinion. In the meantime, the usual practice is for the individual to be treated as if they were ‘high risk’: this would both trigger the need for further information and an enhanced form of intervention. … The service did operate a type of framework concerning a positive finding of risk, in terms of stating the service would act on ‘anything of particular concern on a registration form’.”

Furthermore, “there was sufficient information on the form to raise concerns about risk, and to trigger the need for further information/ enhanced intervention. However, this is in terms of not knowing enough from the form to denote lower risk, rather than the form providing a clear and positive finding of high risk. Both qualitative and quantitative analysis tended to support a finding that Naseeb was in a heightened/ severe state of mental distress. Severe mental distress is associated with increased risk of self-harm. However, without a direct question about self-harm on the referral form, a positive finding of ‘high risk’ for self-harm could not be made, purely from the answers provided by Naseeb on the form.”

Dr Warner clarifies that “A positive finding of ‘low risk’ needs to be actively made (with evidence, rather than based on the absence of evidence). This does not appear to have happened in this case. … Naseeb’s form indicated he was in heightened/ severe mental distress and this was suggestive of an elevated level of risk of self-harm. It should be noted he was already stating that he was being harmful to himself in terms of self-neglect: he wrote that he had been looking after himself ‘none of the time’ and he was having difficulty coping with day-to-day life ‘some of the time’.”

With reference to the PHAP Decision Report (Nov 2021) which had stated “having reviewed the online form completed by Naseeb, the Panel did not consider that it gave any clear indication of an immediate intent to self-harm”, Dr Warner states “The issue is not only: does the completed form give a clear indication of an immediate (or potential) intent to self-harm, but does the completed form give a clear indication that there is a low risk of an immediate (or potential) intent to self-harm. … Following on from the aforementioned standard approach to assessing risk, the form did not give a clear indication that Naseeb would **not** immediately self-harm. … By contrast there was sufficient information regarding elevated/ severe mental

distress to be alert to the possibility of potential self-harm and the need to gain further information (to evaluate risk), and in the meantime to act as if he was high risk (until assessed otherwise), which Naseeb subsequently proved to be."

The report makes clear that Naseeb's completed registration form contained enough information

> "… to indicate a **potentially** high risk of self-harm, for which further assessment ought to have taken place quickly. … Risk assessments should always present evidence regarding how they adduce low, medium and high risk. This was not the case here. No evidence was presented that demonstrated Naseeb was at a lower level of risk of self-harm or that he did not meet the criteria for high risk of self-harm/suicide. As such, potential high risk could be inferred from his reported mental state and his already self-harming in terms of his self-reported self-neglect, but it would have required further and speedy assessment to confirm this hypothesis. In my opinion, there was sufficient information to warrant asking further questions, in a timely manner".

4.6.3 Removal of the Question about Self-Harm from the Registration Form

Dr Warner states "I am surprised that the Wellbeing Service removed a question about self-harm from the registration form, even in the context of the service not being a crisis intervention service. Understanding risk of self-harm is an important part of all mental health and wellbeing risk assessments: otherwise it is an incomplete risk assessment." Furthermore,

> "… boys and men, in particular, can struggle to express their feelings … More than this when a subject is taboo, people often need explicit permission to speak about it or make reference to it. People who have felt suicidal will often say what a huge relief it is to be asked about suicide and to be able to talk about their feelings. Sadly for Naseeb, neither the GP nor the Wellbeing Service, neither verbally or in writing (as in the registration form) provided explicit permission to make reference to self-harm or suicide. Yet, early detection is a critical prevention strategy. Many people who die by suicide visit a healthcare provider within months before their death … as Naseeb did just prior to his death by suicide. This represents a missed opportunity to ask about self-harm/suicide; to make a more detailed assessment of risk; and perhaps to have directed Naseeb to more appropriate mental health resources."

The report then makes a series of inter-related points:

- "Questions about self-harm, therefore, both act as an indicator of risk and as an indicator of mental health and wellbeing."
- "That questions about self-harm/suicide are important additions to mental wellbeing screening tools is evidenced in the fact that they are included on many existing and widely used mental health and mental wellbeing screening tools, such as the CORE 10. … This can act as a powerful preventative measure, because of the known benefits talking about suicidal feelings and self-harm can bring."
- "Although not a crisis service, a more effective mental health and wellbeing screening tool, would ask about self-harm/suicide, as this question is indicative."
- "Without the range of questions in CORE 10, it is unclear how an assessment is made of when a full CORE 10 assessment becomes necessary."

4.6.4 In the Absence of a Question Regarding Self-harm, was there an Onus to Assess Potential Risk to Self when Related Risk Factors are Present?

We asked the question "Without any questions regarding self-harm being raised on the registration form, should there have been a greater alertness to the potential for risk to self and an onus to assess this when related risk factors are present?"

Dr Warner states that "Undertaking to assess risk level, based on the form used by Naseeb, is a more complex process than assessing a similar form that also asks about self-harm/suicide. This is because potential risk has to be inferred in the former approach. I understand that LBU is concerned about the potential logistical impacts of increased 'false positives'. However, this should be weighed against the devastating impact of the danger of increased 'false negatives', should the question not be asked. If no scaling questions around self-harm/suicide are to be used, I think it is fair to suppose that a greater alertness to the potential for risk to self should be given, particularly when related risk factors are present."

Furthermore,

> "As an example of paying greater attention to other risk factors, there were some immediate additional factors that would have added weight to, rather than decreased, concern about Naseeb. … These three factors: in-person attendance after coming directly, and as instructed, from his GP appointment; at the end of the academic year; and Naseeb's 'anxious and concerned' presentation are factors that are likely to raise rather than decrease professional concern about risk. These additional factors, taken together, would not lead to a relevant professional considering that they provided evidence of decreased risk. Because these additional factors would tend to point to increased risk, using them to assist in the formulation process may have triggered a prompt attempt to engage Naseeb and to find out more information."

4.6.5 Was Naseeb Adequately Triaged?

The report clarifies that 'triage' involves "assessing the severity of mental distress, looking for indicators of risk level, formulating an understanding of the problem and identify the most appropriate form of intervention/ service. This is done on limited information, such as from the referral form, in as timely a manner as is possible. The information that was relevant in triaging Naseeb included: the high level of mental distress self-reported on his registration form; his attendance at the wellbeing centre towards the end of the academic year; coming in-person directly, and as instructed, from his GP appointment; and Naseeb's 'anxious and concerned' presentation. None of these factors point to Naseeb being of low risk of self-harm/suicide. Rather, these factors, particularly taken together, would tend to support professional concern about risk and invite further assessment and enhanced intervention".

In addition, "Naseeb had presented at two places, the GP surgery and the student wellbeing centre, on the same day, explicitly stating he had concerns about depression, and at neither place was he asked about self-harm/suicide. If he was feeling increasingly hopeless at that time, which it be can adduced by his death by suicide a short time after, this may have added to his feelings of hopelessness and helplessness."

Dr Warner explains "The student wellbeing service had a role within the university in understanding self-harm/suicide and in the absence of a direct question on the registration form, the information that was available could have led to further assessment and intervention. I would expect that all wellbeing support staff would have had training to identify key risk factors around self-harm/suicide which, if this was the case, this knowledge could have helped in making an assessment of risk based on what was known about

Naseeb on that day. This includes information from Naseeb's registration form and his presentation, at a time in the academic year of increased risk of suicide." The report goes on to state:

> "As such, and in the absence of clear factors that demonstrated Naseeb was at low risk of self-harm/suicide … this does suggest that the triage system was somewhat ineffective, as all available and relevant information does not seem to have been utilised. This is in regard to identifying 'low risk' indicators, as well as 'high risk' indicators of self-harm/suicide, both of which are relevant in developing a snapshot formulation/ hypothesis."

4.6.6 Was the System Naseeb Experienced Appropriate for Someone Presenting in Person for the First Time as Opposed to Registering Online?

The report points out that "The underlying issue seems to be about whether the service was equipped to deal with a mental health crisis in-person when the person did not disclose suicidal intent, but a risk of potential self-harm/suicide could be inferred, as with Naseeb. Service staff may have assumed that Naseeb knew the services was not a crisis service. However, Naseeb was new to counselling and may have not fully appreciated the distinction until he arrived. This may have been especially the case as he acted on the uninformed advice of his GP (the GP had not asked about self-harm or suicide). As such, this would still suggest that an explicit conversation about self-harm/suicide risk would have been needed to alert him that this was not the right service. Because Naseeb, by default, learnt that neither the GP nor the wellbeing service talked about self-harm/suicide in his moment of crisis, and so he left before a more detailed conversation could have perhaps happened."

Furthermore,

> "It may also be that if Naseeb had not been directed to a computer terminal in an exposed public area, but had been taken to a private room / space to complete a paper form there, there would have been increased opportunity for the professional to stay with him and to read his form before he left the wellbeing service. This would have enabled anything of concern on the form to be picked up immediately with the student. This type of approach would be especially important in the context of there being no direct questions about self-harm/suicide on the form. This is because there were enough issues of concern raised by Naseeb's form to warrant further questions/ intervention, at the time he presented.
>
> As such, it would appear that attention should have been given to the different issues that may be associated with someone who presents in person for the first time as opposed to someone registering on-line. If guidance in respect of this was not available at the time of Naseeb's death by suicide, the system may be understood to have been lacking in this regard."

4.6.7 Points Noted about the BACP Complaints Process

The report identifies a number of issues which "could have aided BACP in enabling their decision-making process". These were that the "BACP needed to be more careful in addressing the specific questions that were raised in the complaint, as mistakes in focus were made"

- "the focus should have been on potential harm rather than immediate harm …
- the shorter Core 10 form rather than the longer CORE 10 forms …

- The use of non-stigmatising language in mental health and wellbeing practice is always important. Unfortunately, BACP was reported to have used stigmatising language in respect of suicide."

4.6.8 The Process of Risk Formulation

In her concluding remarks on "Understanding how to conduct a risk assessment" Dr Warner states:

> "I have also talked about how a process of risk formulation pays attention to both risk and protective factors. I would be interested to know what approach to assessing risk the student wellbeing service utilise, and whether negative factors for risk are understood to be as relevant in assessments as positive factors for risk. This is important because Naseeb's completed registration form did not appear to contain any clear protective factors, but this did not appear to influence the risk assessment at the time."

4.7 The Variance Between the BACP's Three Assessments and the Conclusions Reached by the Independent Expert's Psychological Report

The PHAP Decision Report (Nov 2021) stated the Panel was "not satisfied" that LBU Wellbeing Service "had failed to assess Naseeb adequately when he made contact with the service". This decision was upheld by the BACP Independent Appeal Assessor's Report (Apr 2022). Both of these reports focused on "immediate risk" and failed to review our complaint against LBU Wellbeing Service with reference to assessing the level of potential risk presented by Naseeb.

The Independent Expert's Psychological Report (Dec 2022) makes a number of fundamental points which are at variance with the BACP's assessment outcomes and decision reasoning. These are summarised as follows:

- Interpreting the data on Naseeb's completed registration form numerically indicated that he was at the 'severe' level. A qualitative analysis was also indicative of heightened mental distress and thereby suggestive of elevated risk (of self-harm), also at a time when he had no support. Naseeb was able to acknowledge difficulties with his course and attendance (factors sometimes associated with risk of self-harm/suicide for students), when prompted to do so (via questions on the form). This may suggest that he would have been able to acknowledge explicitly his feelings of suicidality, if questions on that issue were also included on the form.
- If there is a lack of information to enable a confident expert opinion that someone is lower risk, the usual practice is for the individual to be treated as if they were 'high risk': this would both trigger the need for further information and an enhanced form of intervention.
- Due to the removal of a question about self-harm/suicide, based on the form used by Naseeb, assessing risk level is a more complex process as potential risk has to be inferred. There was sufficient information to indicate a potentially high risk of self-harm, inferred from Naseeb's reported mental state and his already self-harming in terms of his self-reported self-neglect, for which further assessment ought to have taken place quickly.
- Understanding risk of self-harm is an important part of all mental health and wellbeing risk assessments: otherwise it is an incomplete risk assessment. Questions about self-harm/suicide also act as a powerful preventative measure due to the known benefits talking about suicidal feelings and self-harm can bring.

- If no scaling questions around self-harm/suicide are used a greater alertness to the potential for risk to self should be given, particularly when related risk factors are present. In Naseeb's case they were: in-person attendance after coming directly, and as instructed, from his GP appointment; at the end of the academic year; and Naseeb's 'anxious and concerned' presentation. These factors are likely to raise rather than decrease professional concern about risk.
- The triage system was somewhat ineffective, as all available and relevant information does not seem to have been utilised. The information that was relevant in triaging Naseeb included the high level of mental distress self-reported on his registration form along with the related risk factors stated in the point above. None of these factors point to Naseeb being of low risk of self-harm/suicide and taken together would tend to support professional concern about risk and invite further assessment and enhanced intervention.
- Attention should have been given to the different issues that may be associated with someone who presents in person for the first time as opposed to someone registering on-line. If guidance in respect of this was not available at the time of Naseeb's death by suicide, the system may be understood to have been lacking in this regard. If Naseeb had not been directed to a computer terminal in an exposed public area, but had been taken to a private room / space to complete a paper form, there would have been increased opportunity for the professional to stay with him and to read his form before he left the wellbeing service. This would have enabled anything of concern on the form to be picked up immediately with the student. This type of approach would be especially important in the context of there being no direct questions about self-harm/suicide on the form. This is because there were enough issues of concern raised by Naseeb's form to warrant further questions/ intervention, at the time he presented.
- A process of risk formulation pays attention to both risk and protective factors. It is important that LBU Wellbeing Service explains what approach they use to assess risk and whether negative factors for risk are understood to be as relevant in assessments as positive factors for risk. This is important because Naseeb's completed registration form did not appear to contain any clear protective factors, but this did not appear to influence the risk assessment at the time.

4.8 Recommendations

4.8.1 Accountability – the University

- **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 including its wellbeing service in cases where a student has died.**
  If a student has concerns about a university, they can go to the Office of the Independent Adjudicator for a complaint to be independently investigated and where relevant notify the Office for Students. However their next of kin do not have that access and submitting a complaint to other organisations such as the BACP is restricted by their remit.

4.8.2 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.

4.8.3 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.**

4.8.4 Training and Guidance

- **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.**[xx]

4.8.5 Assessing Risk

- **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.**

[xx] 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.

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

Appendix A: Our Attempts to Submit our Complaint against LBU through an Independent Complaint Route

The following is a summary of how, from 2018 onwards, we spent over a year trying to find an independent complaint route through which we could submit our complaint against LBU. Each time we contacted an agency we had to repeat the harrowing circumstances of our son's death and our subsequent concerns.

Universities UK (UUK)

We were informed that this is a representative organisation for the UK's universities (of which LBU is a member) and the higher education (HE) sector, which seeks to influence and create policy. As such it could not address our complaint against LBU.

The Higher Education Funding Council for England (HEFCE)

This organisation closed in April 2018 but prior to this explained to us that it had a very limited remit which firstly required the University's internal complaints procedure to be completed.

Office of the Independent Adjudicator for Students in Higher Education (OIA)

We were informed that this organisation is part of the regulatory framework for HE in the UK and is independent of governments and regulators. In cases where a student has complained to their HE provider and the complaint remains unresolved, students can ask the OIA to review their unresolved complaint. However this precludes parents or other representatives of the student from taking a complaint to the OIA. Currently this is the only body able to deal with complaints about HE delivery of academic services, pastoral care and student welfare. In February 2018 the OIA advised the following:

> "As discussed, our Rules provide that we cannot accept a complaint from ''the personal representatives of a student'' unless we received a Complaint Form during the student's lifetime (Rule 3.7). We do not have discretion to waive this requirement. This is because the Rule is a product of Section 12 of the Higher Education Act of 2004 which states that a ''qualifying complaint'' is made by a student or former student. For this reason, our Scheme and our remedies are designed to help resolve individual students' concerns."

Office for Students (OfS)

This organisation was formed in January 2018 (partially merged with HEFCE) and states it is the independent regulator of higher education in England. Our dialogue with them is summarised as follows:

September 2018 – After checking the OfS website and a lengthy discussion with OfS regulation staff, we were advised that our full complaint against LBU did fall within the OfS remit.

October 2018 – We submitted to the OfS two complaints about LBU. Namely our 'Concerns Relating to Academic and Pastoral Care' (see Chapter 1) and in respect of 'LBU Student Wellbeing Service' (see Chapter 4). We waited and finally after being prompted the OfS arranged to review our material and discuss the matter with us.

January 2019 – A telephone meeting took place with three senior staff members of OfS. We were advised that the delay in responding to our submission was because the OfS had received a lot of complaint

submissions since it was set up. The OfS is “not able to investigate individual cases” and the wording on its website had been misleading but had now been updated “to ensure that it accurately describes the OfS’s role”. The OfS staff apologised for this stating it was “unacceptable”.

February 2019 – We received a letter of apology from the OfS Chief Executive, Nicola Dandridge, which admitted that they “did not provide fully accurate information … about how your complaint would be handled and the extent of our powers to intervene in individual cases”.
Our response to this letter stated that there was “now an absence of any other appropriate independent complaint routes available to us” and asked whether they were “able to suggest any way forward for us”.
The reply from the OfS Chief Executive could only explain that, while they were able to identify and investigate specific issues with individual providers as set out in their Regulatory Framework, “those specific issues do not extend to the circumstances that you and your son faced … As you have already accessed the various avenues of investigation, all I can now offer on behalf of OfS are my deepest condolences for your loss”.

Appendix B: Non-Disclosure of Documents by the GMC

(i) During September and October 2018 we had a number of communications with the GMC about our request for copies of the following six documents upon which the 'GMC Assistant Registrar's Decision Reasoning Report' (August 2018) is based. The request was made under the Freedom of Information Act (FOIA), Data Protection Legislation (DPL) and the Medical Act 1983:

- The 'Assistant Registrar's Decision Reasoning stated that "Upon initial review of this complaint, a senior medically qualified GMC colleague with experience in psychiatry was sought for advice. They commented that, on first review, [Dr P's] consultation record of 25 May 2016 appears to show an inadequate assessment."
  Please may we have a copy of the documented record of this advice.
- A copy of the document referred to that details in full "the allegations to be considered by this Provisional Enquiry".
- A copy of the statement referred to made by Dr P's responsible officer at NHS England on 17th May 2018.
- A copy of the referred to NHS England report, provided to the GMC on 2nd July 2018.
- A copy of the referred to full report produced for the GMC by the "independent expert in general practice".
- A full copy of the referred to review of the independent expert's opinion by "a senior medically qualified GMC colleague with experience in general practice".

(ii) We were then asked by the GMC to provide our reasons as to why we were seeking a copy of the full report produced for the GMC by the "independent expert in general practice". We gave our reasons as follows:

- We wish to understand the differences between the expert witness report accepted by the Coroner at the inquest and that commissioned by the GMC. Our son was dearly loved and very precious to us. We wish to know the details of this report to help us understand its findings.
- Our son, Naseeb, did not leave a will. We are his mother and father, next of kin and were duly granted full probate with regards to Naseeb's financial affairs.
- Under the Data Protection Act 1998 / Access to Health Records Act 1990, we were granted Access to Medical Records in respect of Naseeb Chuhan by Primary Care Support England in February 2017.

In October 2018 we were informed that the GMC Assistant Registrar had decided that the expert report, which took the form of a documented discussion with the expert, should not be disclosed to us as Dr P withheld her consent.

(iii) Between October 2018 and June 2019 the GMC explained to us that none of the six documents we had requested could be disclosed to us:

- Data Protection Legislation (DPL) – “only provides a route for living individuals to request their own personal data”.
- Freedom of Information Act (FOIA) – “We are unable to publicly confirm that we hold information about complaints against doctors unless a complaint has reached the stage where information is made publicly available.”
- Medical Act 1983 – “disclosure was opposed and the reasons for closing the complaint had already been provided, the expert discussion document would not assist you further and it would not be in the public interest to disclose.”

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

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[48] The changes made by LBU after Naseeb died, as stated in a letter to BACP dated 30th August 2019, include the following:

- "We now have a duty practitioner in the Student Wellbeing office to handle crisis calls and referrals all day instead of for part of the working day as was the case previously (however, as explained at the inquest we have always had an administrator fielding such calls and same day response capacity for crises)
- Student Hub Team guidance and training on handling enquiries, dealing with students in distress and wellbeing triage conversations
- Enhanced staff development for academic and professional services staff regarding mental health and wellbeing
- Updated information regarding service provision and guidance on mental health and wellbeing issues on our web pages
- Enhanced crisis contact information on our online registration form
- Introduction of initial consultations within the service (including ability to self-book the initial appointment which triggers an automatic email confirmation)
- Reminder SMS (text) for appointments sent automatically on the day of the appointment to the client."

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