Why does The LEARN Network exist?

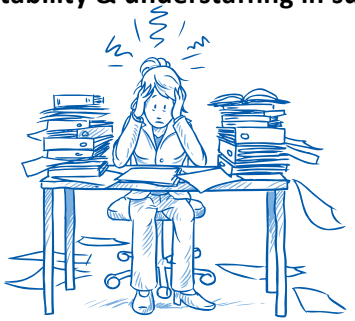
- More young people die by suicide than on the roads
- Bereaved families feel alone, responsible for getting change
- As a community we are not learning from the past.

Our members understand that mistakes are made. We want to make change to prevent future deaths. Our first target is Higher Education…

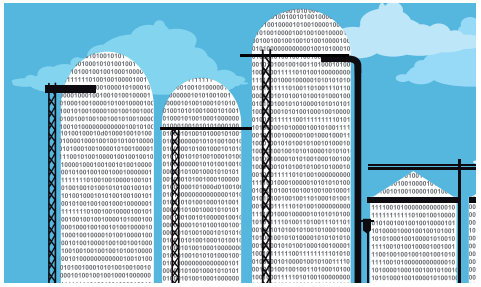
Operational threats to student safety in HE

Critical procedures not understood, not clear, not followed and not safe

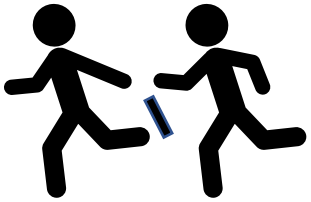
Tutors/academics lack clarity on pastoral accountability & understaffing in support



Poor information sharing within & across departments
Culture of 'academic-only' view of student



No suicide 'postvention' (investigation, contagion, access to means…) risk of repeating same mistakes. Are there patterns?



Incomplete 'hand-offs' and absence of feedback loops 'fire and forget'

Poor understanding of privacy guidelines and culture of fear of doing the wrong thing

Email-driven process: Email overload leads to lost/overlooked information e.g. 'I am anxious'

Reactive culture and lack of 'sense of urgency' that time might be running out

What is LEARN Doing To Improve Safety in HE?

Duty of Care, Human Rights And The Equality Act

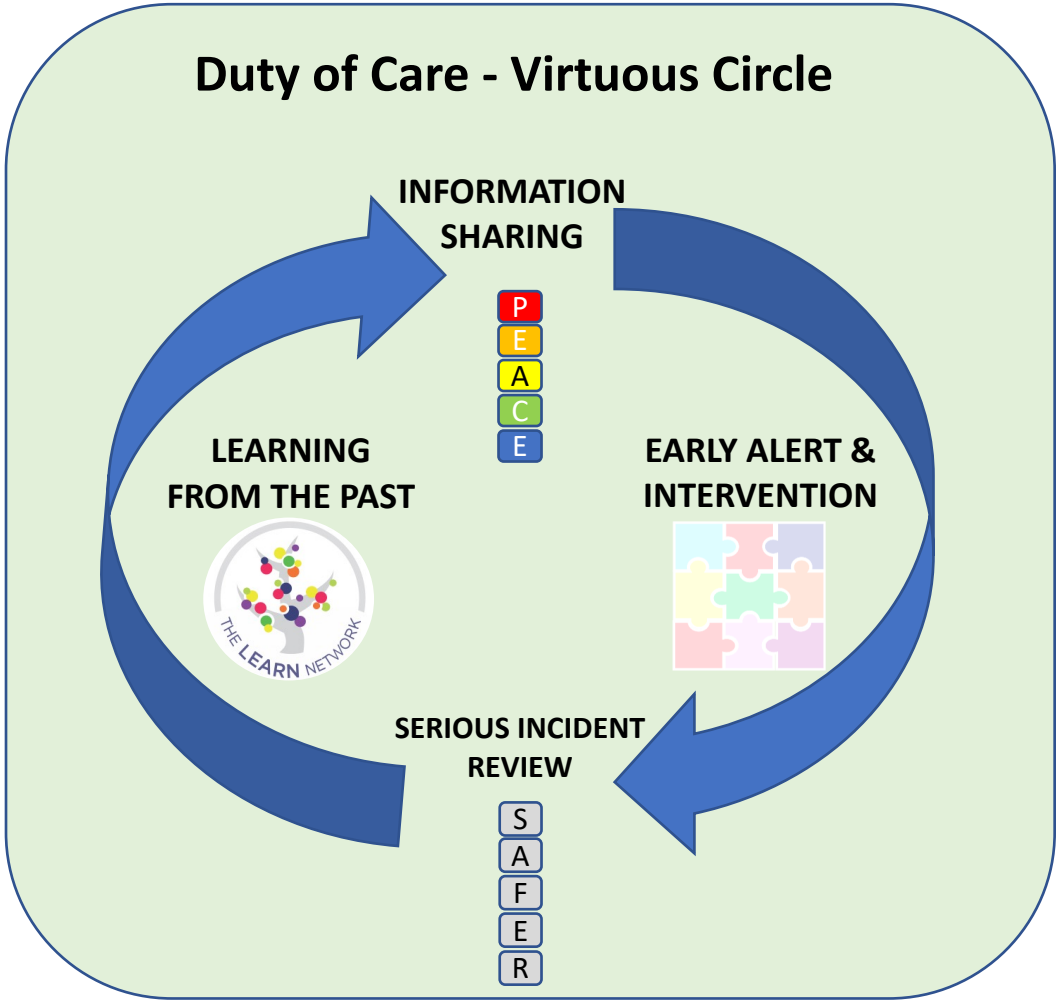
Duty of Care is at the heart of the cultural change that we need to see in the community in order to proactively prevent suicide. Our members are petitioning for clear definition in parliament and are engaged in legal proceedings against an HE sector institution

The LEARN Network

Our group has been created to hear the stories of bereaved families and to connect them with other families who are looking to make change to prevent future deaths. We are all seeking meaning from loss. All of us will be subjected to the Inquest process and our members are involved with INQUEST in improving the process and campaigning to ensure we learn from inquests e.g. Prevention of Future Deaths Reports (see Appendix 3).

Serious Incident Review

We are following-up on a Prevention of Future Deaths notice to implement Serious Incident Reviews in an HE setting. This has the backing of Professor Louis Appleby, is being followed-up by the DHSC and The Chief Coroner in August 2022. Working with HE leaders we are contributing the SAFER framework (see Appendix 1) to a 'Postvention' update to the Suicide Safer Universities Guide. The 1st draft has been produced for dissemination in 2022.



Information Sharing

Encouraging better information sharing regarding concerns about a student, within the institution and with families and friends. We have worked with the ICO to encourage information sharing to save lives. We have campaigned extensively through the press. We are also working with Universities UK on an Information Sharing Consensus Agreement due for release in September 2022. The PEACE approach (see Appendix 1) is part of the UUK work. We are involved in the Zero Suicide Alliance Training Videos.

Early Alert & Intervention

We are involved in the OfS Challenge competition to create step-change in student mental health. We advocate a 'Whole Student' view looking at academic and non-academic factors to identify students at risk. The results of a 3 year project at Northumbria University, examining the potential for technology to identify students in crisis, are due to be disseminated to the HE sector in 2022 (see Appendix 2)

Appendix 1: PEACE and SAFER

INFORMATION SHARING GUIDANCE

P

PROACTIVE:
encourages early intervention – we are trying to prevent getting to the vital interest tests (risk to self/others)

E

EMPOWERING:
empowers students, staff and practitoners to exercise their judgement

A

AGENCY & AUTONOMY:
Student at the centre of decisions. For example always being asked (if possible) for consent to involve others

C

CONTACT:
Clarifies 'emergency' vs 'designated' contacts;. emphasizing safe choices and notifying contacts in advance

E

EASY TO UNDERSTAND:
Gives examples for clarity of how the policy will be used and states exceptional circumstances

SERIOUS INCIDENT REVIEW

S

STUDENT STORY:
The story of events that happened in the students academic and non-academic life. Root causes analysis.

A

ANONYMOUS:
Protects the identity of the people (student, staff, friends & family) involved. A version of the Review to be sharable across the HE sector

F

FAULT-FREE:
No blame or finding fault with people. Aim is to learn and design fault-free/ fault tolerant and safer procedures

E

EFFECTIVE:
Asks: 'Did we execute in accordance with our policies?' and 'how effective are our current procedures?'

R

RECOMMENDATIONS:
What lessons were learnt? How was a life saved? What might be done to prevent future death? The latter should be provided to the Coroner

Appendix 2: Whole Student View

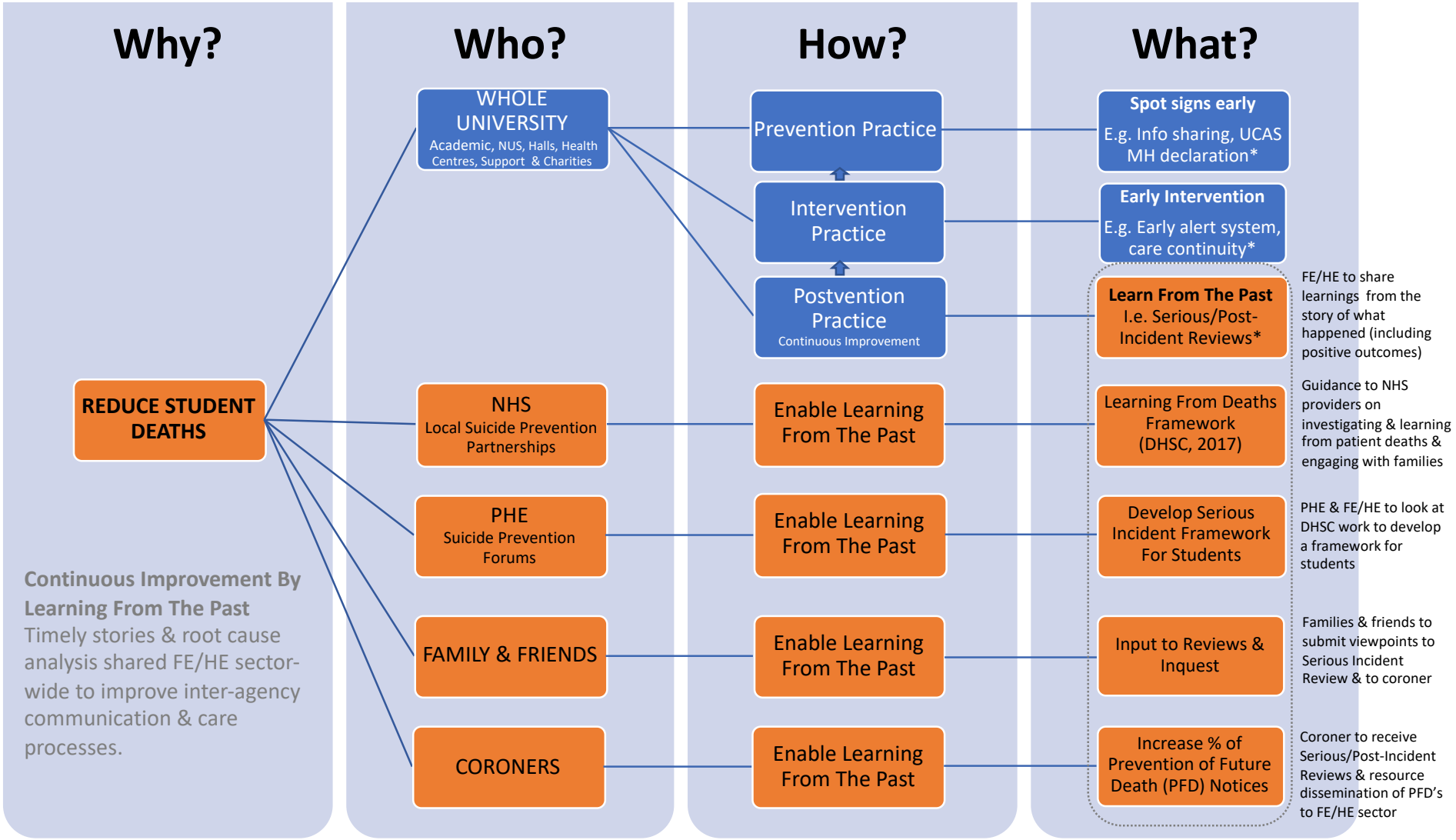
EARLY ALERT & INTERVENTION

Safer Universities have a 'Whole University' approach to mental health (UUK Step Change). They try to understand the 'Student Story' and implement practices to enable them to do 3 things well:

- Spot the signs of poor mental health/wellbeing
- engage in conversation that can promote disclosure
- offer hope for the future and support for student care.

Doing this at scale is challenging which is why an OfS Project* is focused on how technology can create a 'Whole Student View' of academic engagement and wellbeing to support all staff.

Appendix 3: Inquests & Learning From The Past

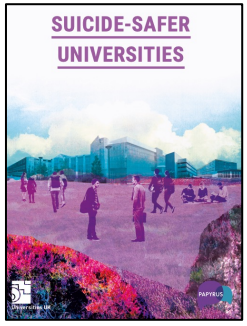


University Guidance outlined by UUK/Papyrus see 'Step Change' and 'Suicide Safer Universities Guide'

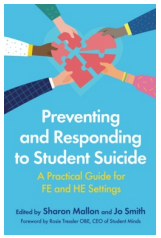
Opportunity for FE/HE, NHS, PHE, Family & Friends & Coroners to enhance learning

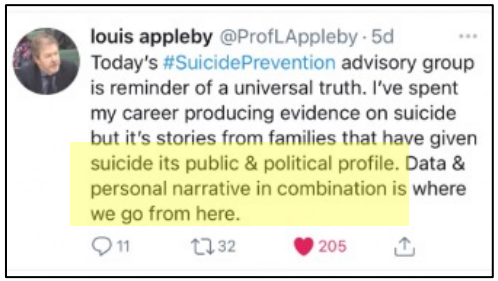
*Examples of actual coroner recommendations from PFD reports

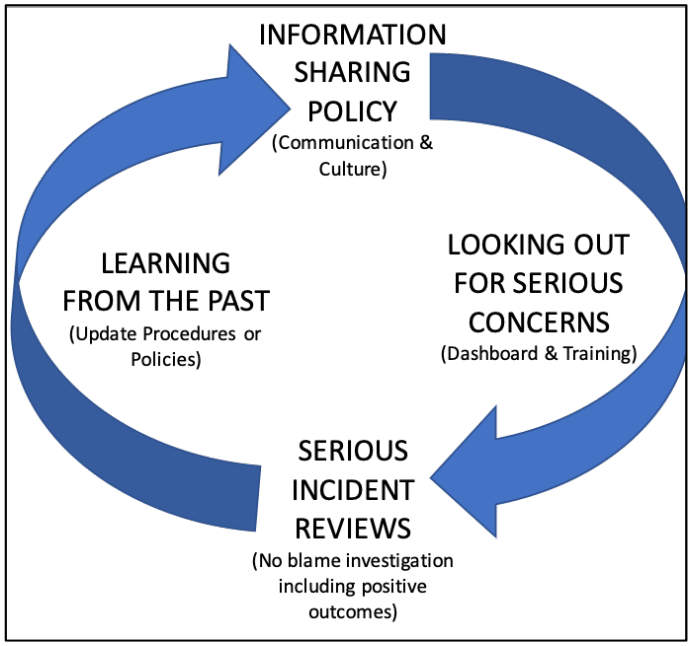
About Us - LEARN'ing From The Past



Universities UK





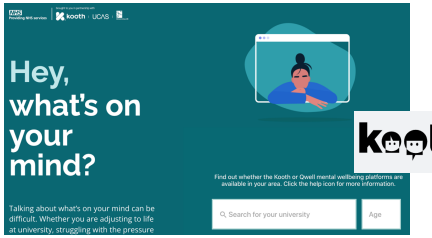


Zero Suicide Alliance — END THE SILENCE END SUICIDE

ico. Information Commissioner's Office

Office for Students — OfS

Public Health England



explore.kooth.com/uni

We are bereaved families, we have extensive lived experience, we are well-connected and highly motivated to help, so use us!!!