18 month update report on the

Thematic Review

Deaths of Children and Young People through probable suicide 2014- 2020

"The death of a child is the most difficult thing any family can go through. 'Child death review' is a term used to describe the formal processes that happen after a child dies. There are some elements that take place for every child death, and some that may not be needed depending on the circumstances. By law all child deaths should be reviewed to try to prevent future deaths where possible."

'When a child dies.' NHSE (2018).

Contents

1 Introduction

This 18 month update report presents an update on work undertaken to date in response to the findings of a thematic review commissioned by Surrey Safeguarding Children Partnership in response to a number of suspected suicides by children and young people during the period 2014-2020. The report also provides an update on deaths that have occurred in the period between the 2014-2020 report and up to 19th October 2021.

The aim of the published thematic review from 1 April 2014 – 31 March 2020 was to identify patterns and themes in deaths by probable suicide amongst under 18s in Surrey and to look at how we can work more effectively together to prevent further deaths. Every child's death is a tragedy and we need to work in partnership to look at the evidence surrounding each of these deaths and work together to implement system wide improvements based on best practice to prevent future child deaths.

The work was supported by the detailed information held by the Surrey Child Death Overview Panel (CDOP); a multi-agency panel with responsibility for comprehensively reviewing all child deaths in Surrey, in order to better understand how and why children die, identify modifiable factors and learning that could prevent a similar death in the future. Whilst each child death is reviewed individually by the panel, this thematic review provides the opportunity to look across all the deaths by probable suicide over a six-year period

2 Background

In 2019 following a number of suicides amongst children and young people in Surrey a thematic review was initiated, and it completed at the end of March 2020.

The review highlighted a number of 'opportunities not to be missed', **these included the importance of reducing and protecting children and young people from the impact of ACEs.** Since the publication of the thematic report Unicef have published

their report 'On My Mind'[1] on promoting, protecting and caring for children's mental health. This report provides more evidence on the impact of ACEs on children's brain development. 'Mental health is tied to critical moments of brain development, which can be affected by factors such as toxic stress triggered by adverse childhood experiences (ACEs), such as physical and emotional abuse, chronic neglect and violence. Research has shown that exposure to at least four ACEs is strongly associated with sexual risk taking, mental health conditions and alcohol abuse; it is even more strongly associated with problematic drug use and interpersonal and self-directed violence.' **If Surrey is to work to reduce suicides, then universal early years support and interventions on reducing ACEs should be 'front and centre' of any work across the system.**

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2.1 Updates on the local picture since the initial review.

Following the review there have been five further suicides in Surrey in under 18s up to 19th October 2021 and the rates of hospital admissions for self-harm per 10,000 population of 10-24 year olds in Surrey have increased over the last 18 months. Data for 2019-20 showed that Surrey had a rate of 453.6 of the directly standardised rate per 100,000; compared to the national rate of 439.2 and the regional rate of 508.9.

Hospital admissions for mental health conditions in 2019 -20 for under 18s are worse in Surrey than the national average at 110.0 per 100,000 compared to 89.5 for England and 93.4 for the region.

A 13.5% cut in 0-19 service provision 2015 - 2020 through a reduction in the community contract identified a number of risks through the Equality Impact Assessment for children and their families/ carers and universal provision, including that 'it is likely that reduction in service will also impact on families as a whole because the 0-19 services take into account the health and wellbeing needs of the family unit as part of their early help and safeguarding remit.'[2] The Unicef report on 'My mind the state of the world's children 2021. Promoting, protecting and caring for children's mental health' says 'Parenting is foundational to children's mental health. However, for many caregivers, fulfilling this critical role requires support'. The cuts to services will impact on this support provision. This issue of cuts to universal support to parents was also highlighted in another equality impact assessment into the impact of the changes to Children's Centres in Surrey and the reduction in the universal provision identified, 'Children and families considered to have less/ lower level needs will have fewer opportunities to access provision as the delivery of universal services is significantly reduced, or in some locations moved to being signposted elsewhere.'Annex-1a-Childrens-Centre-Equality-Impact-Assessment-2019-FINAL.pdf (surreycc.gov.uk)

[1] SOWC-2021-full-report-English.pdf (unicef.org)

[2] SURREY COUNTY COUNCIL (surreycc.gov.uk).

The National Child Mortality Database Programme Thematic Review of Suicide in Children and Young People April 2019 – March 2020 has since been published.[3] These figures will include children and young people from Surrey. They identified several factors present nationally and these have been mapped against the 17 suicides since April 2014. **The figures are too small for statistically significant differences in data, but they do highlight areas of concern and potentially modifiable factors locally.** (These figures below may be subject to change as more information becomes available).

	NCMD 2020-21%	Surrey 2015- CDOP year 2021-22 so far (17 cases)%	% where not known (open to child death review case)
household functioning	69	82	6
loss of key relationships	62	41	6
mental health needs of child	55	88	0
risk taking behaviour	49	88	6
conflict with key relationships	45	71	6
problems with service provision	35	47	24
abuse and neglect	32	35	0
problems at school	30	71	0
bullying	23	24	0
medical condition in the child	23	41	0
drug or alcohol misuse by the child	20	29	0
social media and internet use	18	24	0
neurodevelopmental condition	16	41*	0
sexual orientation/identity and gender identity	9	12	0
problems with the law	9	24	0

[3] NCMD-Suicide-in-Children-and-Young-People-Report.pdf

Neurodevelopmental condition * A further 24% (5) of cases had traits of neurodevelopmental condition but were undiagnosed. Of these 5 cases 80% were seen by CAMHS.

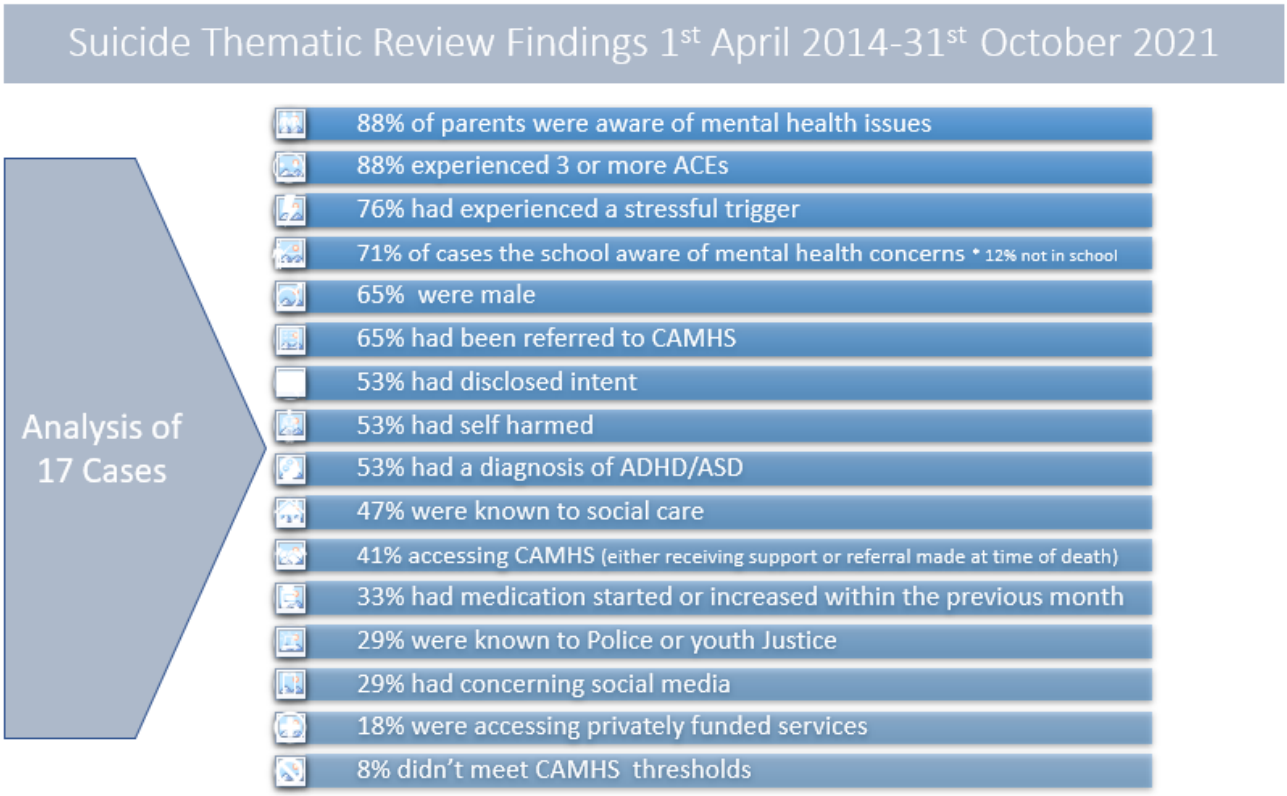
3 Overall Findings updated and including those in the initial thematic review

3.1 Children and young people included in the updated thematic review

Between 1st April 2014 and 31st October 2021, 17 children and young people met the case definition for the thematic review of probable suicide.

3.2 Summary of children and young people in the updated thematic review

Figure 1: Percentage analysis of themes of young people in the updated review



Whilst the numbers are too small to make statistically significant comparisons with the previous 6-year report, we have seen an increase in the children and young people included in the review who have:

- Experienced three or more ACEs.
- Had a diagnosis of ADD/ ASD.

4. Initial recommendations and action plan

Recommendations and opportunities not to be missed are summarised below. These were selected as there is a real chance that development of these opportunities could inform action to prevent deaths of children and young people through suicide.

- **Management of self-harm:** Full implementation of NICE guidance for the management of self-harm relating to children and young people.

- **Prevention of alcohol and substance misuse:** Ongoing action to restrict access of children and young people to alcohol, and full implementation of NICE guidance to prevent substance misuse, since alcohol and substance misuse pose a particular risk to children at risk of suicide.

- **Work across the County to mitigate ACEs:** Optimising provision and access and ensuring continued engagement with interventions for children who have experienced ACEs such as sexual abuse, sexual assault or domestic violence; and engagement with SSCP Partnership to raise awareness of the importance of protecting children from the effects of domestic violence and sexual abuse to prevent suicide and self-harm.

- **Timely support for children and young people in crisis, with support for completing effective referrals to be offered**: by CAMHS and support for other professionals and organisations working with those children and young people. Where suicide risk of the child or young person is recognised, risk assessments are updated in a timely manner by healthcare professionals including CAMHS.

- **Professionals must be clear that young people's need to be safeguarded overrides their right to confidentiality.**[4]

- **Implementing a Surrey Healthy Schools Approach:** All Surrey schools are engaging and taking a Surrey Healthy Schools approach, which includes the delivery of known evidence based programmes and supports access to specialist mental health advice and pathways for sign-posting. The Surrey Healthy Schools Self-Evaluation Tool will signpost schools to appropriate support and guidance and will assist them in developing appropriate actions to aid physical and mental health and wellbeing.

- **All Surrey schools are engaging and accessing the Targeted Approaches to Mental Health in Schools**; initially undertaking the Emotional Wellbeing and Mental Health Training before accessing additional training, including training to support schools with their understanding of self-harm, in order to ensure that more targeted training is embedded in a whole school approach to prevention.

[4] https://learning.nspcc.org.uk/media/1541/gillick-competency-factsheet.pdf

- **Better knowledge and awareness for parents:** Exploration of evidence-based ways of increasing knowledge and awareness of self-harm and other risk factors for suicide; safety planning; help seeking, accessing services and tackling stigma along with tailored support so they can support their children.

- **Suicide cluster response plan:** The Surrey Suicide Prevention Partnership should ensure they have built in preparing for clusters into their local suicide prevention plans and this should be linked into the Surrey CDOP processes.

5 Summary Update:

A number of actions have been completed since the publication of the initial thematic review:

- An infographic of the thematic review has been published on the SSCP website for dissemination for professionals.
- A lunch and learn session was held on the results of the thematic review as part of the CDR partnership learning programme. (see Appendix 1 for evaluation)
- The CDR team facilitated four virtual webinars in October 2020 to support the dissemination of lessons identified in the thematic review.
- The launch of *the SSCP Suicide Prevention toolbox* coincided with the webinars, this toolbox contains multiagency resources to help prevent suicide and support Parents/Carers, Children/Young people and Practitioners dealing with a crisis situation.
- Feedback received in March 2021 from the Section 11 self-assessment audit reported that: *"the CCG section 11 submission was excellent and has shown the Partnership that you are not only meeting the requirements of the S11 standards but in many areas you have also provided us with examples of excellent practice"*.
- The scrutiny panel were particularly interested in examples of good practice; one example highlighted was "*the range of evidence provided to demonstrate that your organisation actively promotes multi-agency work to improve outcomes and keep children safe, e.g. the thematic case reviews and the thematic review of adolescent suicides".*
- Positive feedback on the thematic reviews was also highlighted in the *Peer Review Report of Surrey Safeguarding Children Partnership* completed by Our Safeguarding Children Partnership for Cornwall and the Isles of Scilly in December/January 2021:*"The quality of both of these reports was high, with clear analysis and identification of areas of learning…….. This was an effective route to collate the learning from a number of cases and share that learning across the partnership".*
- Increased multi-agency, co-ordinated response to a suspected suicide in Surrey with initiation of Information Sharing and Planning Meeting as part of formalised plan of action, including for those who are near death or anticipated to die whilst in Intensive Care
- Support and care for parents and earlier contact with CDR Nurse.
- A multi-agency task and finish group was initiated to develop an action plan based on the opportunities not to be missed identified in the thematic review.
- A Children and Young People's sub-group of the Surrey Suicide Prevention Strategy has been formed to take forward the monitoring of the action plan developed by the Task and Finish Group.

Gaps still to be addressed:

- Work is underway to develop an 'Admission Avoidance' protocol that will support the police to make decisions about the application of S136.
- Next steps for 'SSCP Self-Harm Protocol: Practitioner Guide' to be agreed.
- Seeking assurance / evidence from substance misuse services commissioned by Public Health of:
  a) Practitioners access to suicide prevention training and resources
  b) evidence that intervention is reducing and preventing substance misuse for young people
- Effective referrals from and liaison with schools by acute health services following attempted suicides. Outstanding action is to clarify the process with safeguarding and education for safety plans to be forwarded from the hospital to schools – with consent from the CYP
- Seek assurance / evidence that CSPA are responsive and making good decisions where children are presenting with suicidal ideation and self-harm
- Review effectiveness: gaps/barriers across the whole system and propose improvements to partnership working with children and young people at risk of suicide and self-harm.
- NHS Trusts to audit current practice against the NICE guidelines on self-harm and ensure adherence specifically:
  - Ensuring that people who present to Emergency Departments following self-harm receive a psychosocial assessment and appropriate care.
  - Raise awareness among staff of the complex issues contributing to self-harm
- Practitioner Guidance about Consent to be developed
- Key school and education setting staff have undertaken additional training to support their setting's understanding of self-harm.
  - Training for schools and education settings
  - Agenda at DSL meeting & Education safeguarding forums
- Wider dissemination to parents of portion of suicide prevention toolkit for parents
  - Evaluate the best host site (sites) to make this accessible to parents.
  - Link to the toolkit on SSCP
- Explore potential commissioning gap in services which meet parent's needs while children are supported or seeking support for suicide and self-harm
- Provide a cluster response in place for children and young people who attend schools or education establishments in Surrey but who live out of area. Currently the Surrey Child Death Review Partnership, do not offer a rapid review response for these children and the responsibility for organising this sits with Public Health and the Surrey Suicide Strategy Group as outlined in the PHE document, identifying and responding to Suicide Clusters. 'Each local authority area should have an established Multi-agency Suicide Prevention Group, led by the public health suicide prevention lead. Public Health England has issued guidance on developing local suicide prevention plans and setting up local multi-agency groups to deliver on these plans. Multi-agency Suicide Prevention Groups are responsible for developing local suicide prevention action plans. These should include a plan for responding to possible suicide clusters.[5]

[5] Identifying and responding to suicide clusters (publishing.service.gov.uk)

- There is currently a need for a response to identify children who attempt suicide and to ensure that effective support is in place for them and any others in their immediate ‘circle’ of friends and family.

Appendix 1:

Suicide Thematic Review Workshops evaluation

Over two days in October over 200 participants attended one of four online sessions on 'Probable Suicide by Children and Young People in Surrey Thematic Review Learning Event' which were accredited for CPD by the Faculty of Public Health.

The Learning outcomes from the day were:

Aim: For Surrey Safeguarding Children's Partnership to support the dissemination of lessons identified in the thematic review through a learning event.

Participants would have an updated knowledge of:

- The learning and themes identified in the thematic review
- How a Surrey Healthy Schools approach supports schools in assisting children and young people to develop skills that build emotional resilience
- The experience of a local school in responding to a probable suicide by a pupil
- The role of CAMHS in supporting staff working with children at risk of suicide
- What actions organisations across Surrey will be taking to support children and young people at risk of suicide

Evaluation of event:
Key Figures: Probable Suicide by Children and Young People in Surrey Thematic Review Learning Event.

Learning Gain: **1.11** (scale is 1-5 so 1.11 is ok as many will start off at 3 and can only go up to 5)
(pre: 2.44 post: 3.55)

Global Learning Gain: **1.00**
(pre: 3.10 post: 4.10)

Completion Rates

Evaluation	Total Completed	This Event	Global
Pre-Booking	218	108.5%	93.3%
Post Event	70	34.8%	40.3%

Comments from participants following the event included:

Question - What impact do you think the learning from this course will have on your work with children and families. Please give at least two examples.

"I feel I have a better understanding of signs to look for and that it doesn't always need to be the stereotypical people.
I am more aware of the different support networks available to children and families."

"I am now aware of the suicide prevention toolkit which I will actively promote to services as well as within my organisation
I will also challenge schools to ensure they know who their mental health key person is and ensure they go to them for help and advice."

"How to complete a CAMHS referral and the suicide tool box resources on your website"

Other comments:

"The course was very interesting with lots of useful information that I will be sharing with my colleagues."

"Good content, varied speakers and participants."

"The meeting rooms probably could have been afforded more time for professionals to feed back in."

"Better understanding of risk factors for suicide in young people."

"To be honest I did feel a little out of my depth with this course in the beginning. However the facilitators were great and I have learnt and have a clearer understanding. I will be feeding back my team at the next meeting and I will be testing them with your quiz, many thanks"

"Extremely well organised, really interesting and informative (to a non-clinician), mixed use of media - presentations from different sectors, video, case studies, inter-active, so always engaging, helpful to understand roles of different agencies and support tools available, better appreciation of clinical services."

Future work from workshops identified under opportunities not to be missed.

1. Better knowledge and awareness for parents:

- Importance of clear communication and ongoing communication regarding risk and how to support child.
- Are there parent support groups in Surrey?-chat mentioned teens talking parent group I think.
- School nursing (possibly other appropriate services) supporting schools to deliver health and wellbeing sessions/information for parents. How to look after their own wellbeing and how to support their child. Could be face to face where appropriate, or recorded.
- Information sessions for parents re social media and technology.. some schools already do this themselves – (their used to be some national funding…) look to CEOP etc for materials (Jane Dufton may have more information re this element).
- Link to **'Professionals must be clear'** ensure there is common understanding of terminology… eg 'low mood' what does this actually mean? Being a little down… or at serious harm??
- Ensure professionals and parents have a shared understanding – don't use abbreviations and acronyms.
- All agency professionals to assist schools to ensure that they are working with their school nurse, their Specialist for Inclusive Practice and their Primary Mental Health Worker.
- More focus upon identifying appropriate parent interventions.. earlier – holistic.. especially where they or their child is receiving therapy.
- Help to ensure parents are more informed about when their child is at risk.. and the level of risk.

2. Management of self-harm:

- Importance of professionals being clear in their communication with parents and ensuring they understand risks for their child. How can we skill parents up?
- Discharge planning meetings from hospital – How can we work better as multi-professionals in best interest of the child? – often discord between professions in Acute setting (Children's general ward not best place for child), Parents asking for respite care/foster care (Social care feels this is not in best interest of child), parents stating they can't cope/keep child safe and only 2 respite beds in extended hope for whole of the county.
- Support schools with the management of self-harm – in particular where there are clusters/groups of pupils doing it 'together'. This is very difficult to deal with.
- Are people consistently using safety plans? Does a safety plan mean the same thing across all agencies and schools? Is there consistency about terminology? How they are developed? Their purpose?
- Support schools with the management of self-harm – in particular where there are clusters/groups of pupils doing it 'together'. This is very difficult to deal with.
- Are people consistently using safety plans? Does a safety plan mean the same thing across all agencies and schools? Is there consistency about terminology? How they are developed? Their purpose?

3. Prevention of alcohol and substance misuse:

- One participant asked what we were not doing in Surrey that is detailed in the NICE guidance and add that in.
- Detox bed provision in Surrey? Is there enough resource?
- Effective PSHE support for schools. (Funding for Specialist Teachers for Inclusive Practice?)
- Ensure schools are supported by effective PSHE training… which is credible and 'best practice' supported by the PSHE Lead for Surrey CC.
- Ensuring discussions are managed in a 'safe' way.
- Ensure that any work in schools, or to support schools is in line with the Surrey CC Drug Education Guidance.
- Ensure that any input takes a normative approach – highlights actuality… not perception. Takes an empowering/skills and asset based approach – not a deficit model.
- Information for parents re drug and alcohol issues – could be linked to above sessions re health and wellbeing. Also linked to basic understanding of brain development. Catch 22 do work on this.
- Focus upon the development of cultural and social capital.. activities for all pupils to build self-esteem and confidence.
- Ensure schools have a comprehensive PSHE curriculum in place (See support in Surrey Healthy Schools).
- PSHE Association have produced lesson plans to assist schools.
- For families there is sometimes an unhelpful loop – that if a parent/carer will not access alcohol services – they are unable to access mental health services…Issues can then spiral downhill as people are not getting the assistance they require.

4. Work across the County to mitigate ACEs:

- Importance of universal and early help provision. Are Staffing levels and resources sufficient across organisations – under resourced and under staffed
- More effective whole system working – more joined up working. Good communication with other partners. Health workers using team around the family.
- Ensure that prevention work – whether universal or more specialist – focuses upon protective factors and positive activities and experiences. Deficit models of health and counterproductive

5. Timely support for children and young people in crisis, with support for completing effective referrals to be offered:

- Timely support is everyone's business allowing children to talk and be open. Recognition that not all children need referring to CAMHS but better utilisation of advice early from CAHMS to support practitioners.
- Professionals being able to talk openly about suicide.
- Recognising increased risk with ASD
- Excitement about toolbox and ability to print off resources

- Knowing what services are out there to signpost children and families to. Pleased that this is captured in toolbox
- Healthy schools approach not well known to other professionals. Sounds excellent as an approach and should be adopted by all schools.
- Ensure schools, whether independent or not are given information from health services/hospitals etc. Health services and hospitals to be clear around the notion of consent, esp where families do not want school to know.
- Sometimes schools are left to provide support over and above their role… especially when a child is suffering and they are going through the referral process…. Schools do not necessarily have the right skills to be able to support pupils with severe needs – schools need more assistance. (Note from SL: what is the role of the PMHW here? Is it that there isn't sufficient support or is it that a school is not utilising support from their PMHW? Or is it capacity?)

6. Professionals must be clear that young people's need to be safeguarded overrides their right to confidentiality.

- Recognising safeguarding risk and need to build relationships across professionals to support child and family.
- Lead professional and how to manage conflict that can emerge between agencies.
- How/where to access appropriate resources such as the toolkit and crisis management.
- Around confidentiality – safeguarding trumps confidentiality. Ground rules in school – usually in PSHE stresses the importance of understanding confidentiality and lessons should address supporting friends… sometimes this means sharing information with a 'trusted' adult.
- Ensuring that ALL young people have a trusted adult.
- Ensure words are used – not acronyms. –
- Ensure schools know which services they can access and what the services do. Services should have clear info on their websites for schools to access. Wider Surrey services should be aware so they can signpost.
- Graduated response must be given high profile so protocols are understood and followed.

7. Implementing a Surrey Healthy Schools Approach:

- Healthy schools approach not well known to other professionals. Sounds excellent as an approach and feel should be adopted by all schools
- Ensuring that services are also supporting this approach – that they know which themes and standards they can support schools with – and recognising that there is lots of signposted support included in the Self-Evaluation Tool.
- Ensure that Surrey Healthy Schools is seen as the builder of universal prevention and effective practice for all schools and services.

8. All Surrey schools are engaging and accessing the Targeted Approaches to Mental Health in Schools;

- All services should ask if the school is engaging in TAMHS.. they should ask a school if they know who their school nurse is, their PMHW and their Specialist Teacher for Inclusive Practice and whether they are engaging in Surrey Healthy Schools.
- Ensuring that Targeted Approaches to mental Health in schools is kept as high profile – built into the graduated response. The role of PMHWs, STIPs and Eps are clear – and that the training and support that can be delivered/accessed is clear.
- Ensure that the Everybody's business training is prioritised, especially for agencies, services and school Mental Health Leaders.

9. Suicide cluster response plan:

- Cluster response is important and understanding how to support kids and why others may attempt suicide and others not.
- Ensure that all (schools and services) have a planned protocol in place which considers the ripple effect of suspected suicide… giving consideration to how many families within a number of schools one death can impact upon.
- Ensure that schools are communicated with – ensure that schools do not find out of suspected suicide or 'near misses' via social media or pupils. (Speak to Julia Jethwa – Reigate Secondary School re a process they have developed).
- Also discuss with Jane Dufton – she has been developing an identification tool to support schools.
- Also Eikon have written a policy (internal policy) to support them to cope with the wide ranging ripple effect of a suspected suicide.

Appendix 2

Thematic Review of Adolescent Suicide in Surrey Action Plan

What do we want to achieve	What will we do?	How will we know this is working? (How much? How well? What difference has this made?)	Governance oversight	Lead	Target date	Progress Blue/Green/ Amber/Red
SSCP to drive forward a whole system approach to promote and support effective local approaches to suicide reduction and to promote awareness of available support for young people, their friends families, carers and professionals.	SSCP to develop an overarching action plan to promote good practice and support areas that need improvement, this will include: • Development of a toolkit to be used by children, young people, parents, carers, professionals that provides support in signposting to appropriate resources • SSCP to work alongside Commissioners to ensure services reflect need	Effectiveness of actions will be monitored through the SSCP Case Reviews Panel Evaluation of the effectiveness of the toolkit and its use will be assessed through feedback from children, young people, parents, carers, professionals Evidence through service delivery and improvements in service waiting times	SSCP	SSCP Case Review Panel	October 2020	MASTER PLAN SSCP Action Plan thematic
SSCP to share the learning and recommendations from the Thematic Review of Deaths of Children and Young People through probable suicide across all partner agencies	SSCP to provide briefings across Surrey on identified learning and recommendations from the Thematic Review of Deaths of Children and Young People through probable suicide	Evidence of briefings undertaken Recorded attendance at briefings Participant evaluation of briefings	SSCP	Surrey Children's Services Academy SSCP learning into Practice group	October 2020	
SSCP to be assured that all partner agencies (including, Children's Services, Health, Education, Police, Youth Services, Boroughs and Districts, Voluntary Sector and Faith Sector) take action in response to the recommendations highlighted in the Thematic Review of deaths of children and young people through probable suicide	SSCP to request all partner agencies to develop and submit relevant action plans in response to the recommendations highlighted in the Thematic Review of Deaths of Children and Young People through probable suicide SSCP will review submitted action plans to ensure actions identified are specific, measurable, achievable, relevant and timely.	SSCP will seek assurance by regularly reviewing evidence from all partner agencies that actions identified in individual action plans have been undertaken and learning has been embedded.	SSCP	SSCP Sub-groups	October 2020	