Surrey All Age Suspected Suicide Themes and Learning

Speakers:

Nicola Mundy, Child Wellbeing Professional and Lead for Learning from Child Deaths, Surrey Heartlands ICB, Jolene Llewellyn, SAR Coordinator, Surrey Safeguarding Adults Board, Georgia Tame, Domestic Abuse Related Death Review Co-ordinator, Safer Communities, Surrey County Council, Karan Sandhu, Engagement Activity, Partnership Officer, Surrey County Council

September 2024

Why the data is important

"The death of a child by suicide is an unimaginable tragedy. A young life is lost, a family is devastated, the society where it happens is diminished. The risk, it should be stressed, is low but the need to improve prevention could not be higher. To inform prevention we need evidence. Suicide is complex, rarely caused by one thing, and suicide prevention is also complex. We need to understand who is at risk and when, the stresses and settings, and the response of services. We need to know the numbers – these are not dry data; they tell us the size of the prevention challenge and whether risk is changing."

Louis Appleby Professor of Psychiatry, University of Manchester Chair, National Suicide Prevention Strategy Advisory Group for England (1)

- Between 1st April 2014 and 31st March 2023, 488 neonatal and child deaths of Surrey residents were notified to Surrey Child Death Review Partnership, Of these 18 were identified as due to probable suicide.

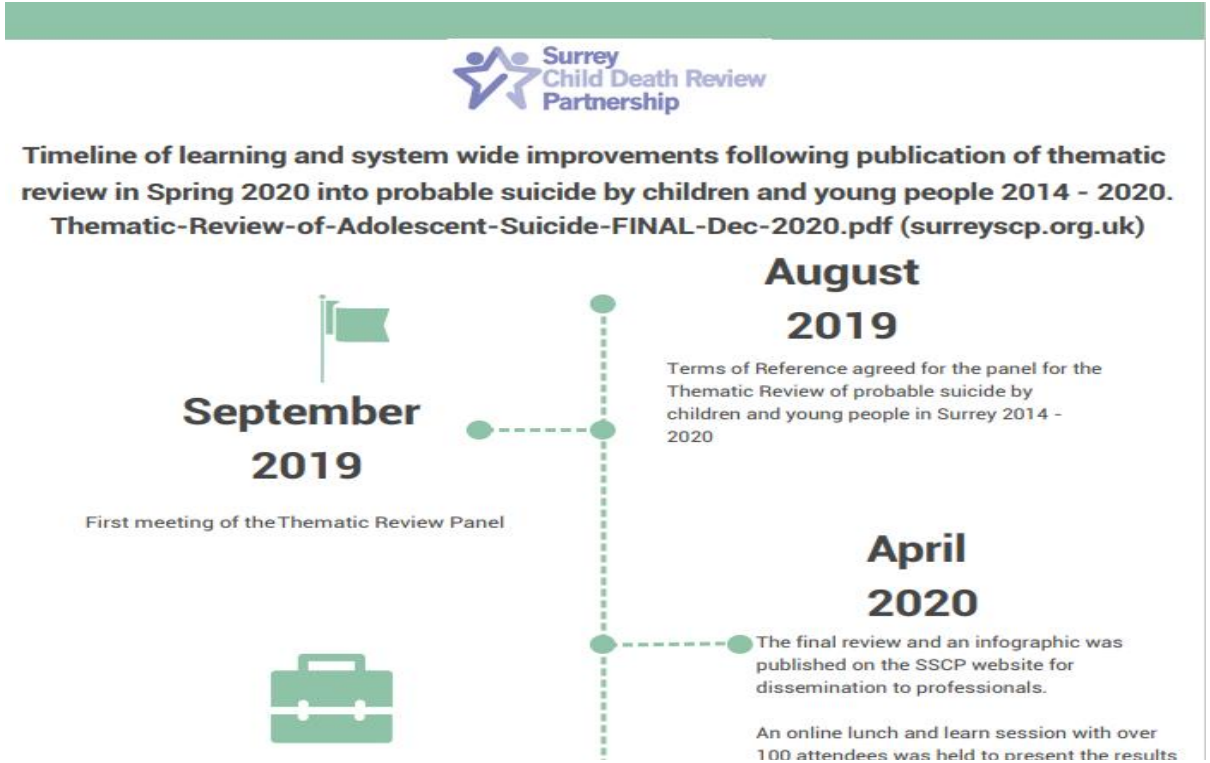
- In their report 'Suicide in Children and Young People National Child Mortality Database Programme Thematic Report Data from April 2019 to March 2020' The National Child Mortality Database identified a number of key issues for the children and young people. Those whose died in Surrey due to probable suicide have been mapped against these issues and those areas where the percentages are higher than England will be analysed in more detail.

- It should be noted that due to low numbers there is no statistically significant difference between the Surrey figures and England, but they do highlight a trend.

Table to show key issues identified in Surrey compared to published data from National Child Mortality Database

	NCMD 2020	Surrey 2015-CDOP year 2022-23 so far (18	% where not
household functioning	69	83	6
loss of key relationships	62	44	6
mental health needs of child	55	83	0
risk taking behaviour	49	89	6
conflict with key relationships	45	67	6
problems with service provision	35	44	24
abuse and neglect	32	39	0
problems at school	30	72	0
bullying	23	22	0
medical condition in the child	23	39	0
drug or alcohol misuse by the child	20	33	0
social media and internet use	18	28	0
neurodevelopmental condition	16	39	0
sexual orientation/identity and gender identity	9	11	0
problems with the law	9	28	0

Actions to date



Timeline-of-learning-from-adolscence-probable-suicide-in-Surrey.pdf (surreyscp.org.uk)

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Safeguarding Adults Review (SAR)

Jolene Llewellyn – SSAB SAR Coordinator

surreysafeguarding.adultsboard@surreycc.gov.uk

Safeguarding Adults Review (SAR)

This is a multi-agency review process which seeks to determine what relevant agencies and individuals involved could have done differently that could have prevented harm or a death from taking place. The purpose of a SAR is not to apportion blame. It is to promote effective learning and improvement to prevent future deaths or serious harm occurring again.

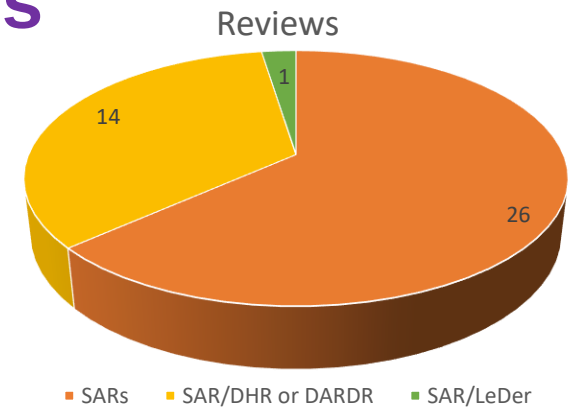
Under the Care Act 2014, the Safeguarding Adult Board must commission a SAR for an adult with care and support needs if there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and condition 1 or 2 is met:

- Condition 1: the adult has died, and the SAB reason to believe that the death resulted from abuse or neglect
- Condition 2: the adult is still alive, and the SAB has reason to believe that the adult has experienced serious abuse or neglect.

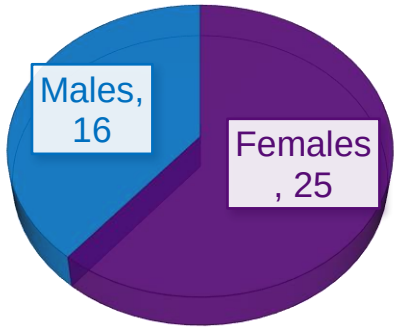
Statutory guidance for Adults is outlined within The Care Act 2014: Safeguarding Adults

SARs & Joint Reviews

24/09/2024	
Number of Reviews	41
SARs	26
SAR/DHR or DARDR	14
SAR/LeDer	1



GENDER



24/09/2024	
Females	25
Males	16

Themes

Of the 41 cases,

- 31 had evidence of Mental health issues
- 20 died by suicide or suspected suicide
- 13 experienced Domestic abuse
- 6 Neglect
- 5 Featured substance misuse
- 3 cuckooing
- 2 died by Murder

Recommendations from reviews

- SSAB to receive assurance from partner agencies that their suicide risk and prevention strategies include a commitment to develop suicide risk and safety plans with adults and their families (where appropriate), (in line with NICE guidelines on self-harm 2022) by a lead professional, following a serious incident of self-harm or a suspected suicide attempt.
- Surrey Police has recommended that ‘flags’ or ‘alerts’ are created on the Niche recording system as per policy, following incidents involving suicidal behaviour.
- Explore options for developing a more flexible and person-centred approach to service delivery within community mental health and substance misuse services, with less reliance on office-based appointments
- Opportunity to escalate to the National Panel for wider consideration

Learning points

Inadequate Suicide Risk Assessment and Management: The risk of suicide was not appropriately assessed or managed, with critical elements like comprehensive safety plans missing.

Impact of Adverse Childhood Experiences: severely impacted their mental health and transition to adulthood. Adult mental health services had limited understanding of their trauma.

Fragmented Information Gathering and Sharing: There was a failure to collect and share comprehensive historical mental health information among the involved agencies.

Family Involvement in Care Decisions: Louise's family was not sufficiently involved in the assessment and care planning processes, limiting the support they could provide.

Good practice

Despite the challenges, the reviews also give opportunity to identified examples of good practice, such as

- persistent efforts by some professionals to engage and support the individuals, even if they have disengaged
- flexible approaches to care.
- significant efforts by voluntary sector accommodation providers to prevent homelessness.

surreysab.org.uk/safeguarding-adults-reviews/

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Leave this site

Bereavement

The death of a loved one can be devastating. Bereavement is a common experience after losing someone close to you and can affect people in different ways.
For more information on bereavement please visit the Healthy Surrey website.

Published Safeguarding Adult Reviews

Rose (April 2024) – In relation to an unexpected death

Publication Statement from the SSAB Chair
Summary Report
Statement from Rose's mother

Ella (March 2024) – In relation to an unexpected death

Publication Statement from the SSAB Chair
Executive Summary

Louise (February 2024) – In relation to an unexpected death

Publication Statement from the SSAB Chair
Executive Summary

Zahra (February 2024) – In relation to an unexpected death

Publication Statement from the SSAB Chair
Executive Summary

How to use legal powers to safeguard highly vulnerable dependent drinkers | Alcohol Change UK

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Karan Sandhu
Engagement Activity Partnership Officer

About my role

- Supporting key Board priorities
- Building and sustaining relationships with partners
- Developing the communication Strategy
- Supporting the work of sub-groups and forums

Surrey Coalition - Disability Empowerment Network Sessions

- Delivery of key SSAB updates at the DENs meetings
- Linking in with key agencies to understand how to share key information
- Meeting with residents and individuals who have experienced the 'safeguarding process'

Other Key Activities

- Links with the Surrey Minority Ethnic Forum (SMEF)
- Surrey Community Action
- Safeguarding Partner's breakfast (Diocese of Guildford)
- Changing Future's and Surrey Adult Matters

SSAB Resources

- Sign up to our newsletter by emailing us at surreysafeguarding.adultsboard@surreycc.gov.uk
- Head over to twitter and follow us at @SurreySAB
- YouTube - https://www.youtube.com/@surreysab
- Don’t forget to visit our website for more news and resources https://www.surreysab.org.uk/

- Webinars and learning events - https://www.surreysab.org.uk/training/learning-webinars/

Domestic Abuse Related Death Reviews

Georgia Tame – DARDR Coordinator, Surrey County Council

Fran Richiusa – DARDR Coordinator (maternity cover - starting from 24th October 2024)

Home Office consultations…

Last year the Government launched a Domestic Homicide Review legislation consultation on reviews conducted after fatal domestic abuse cases. In February 2024, they announced that the name of these reviews will be changed from 'Domestic Homicide Review' to '**Domestic Abuse Related Death Review**', to better reflect all deaths which fall within their scope.

Following this, in May 2024, the Home Office launched a new consultation seeking views on an updated version of the statutory guidance. This consultation ended on 1st July 2024.

Fatal domestic abuse reviews renamed to better recognise suicide cases - GOV.UK (www.gov.uk)

Updating the domestic homicide review statutory guidance - GOV.UK (www.gov.uk)

What is a Domestic Abuse Related Death Review (DARDR)?

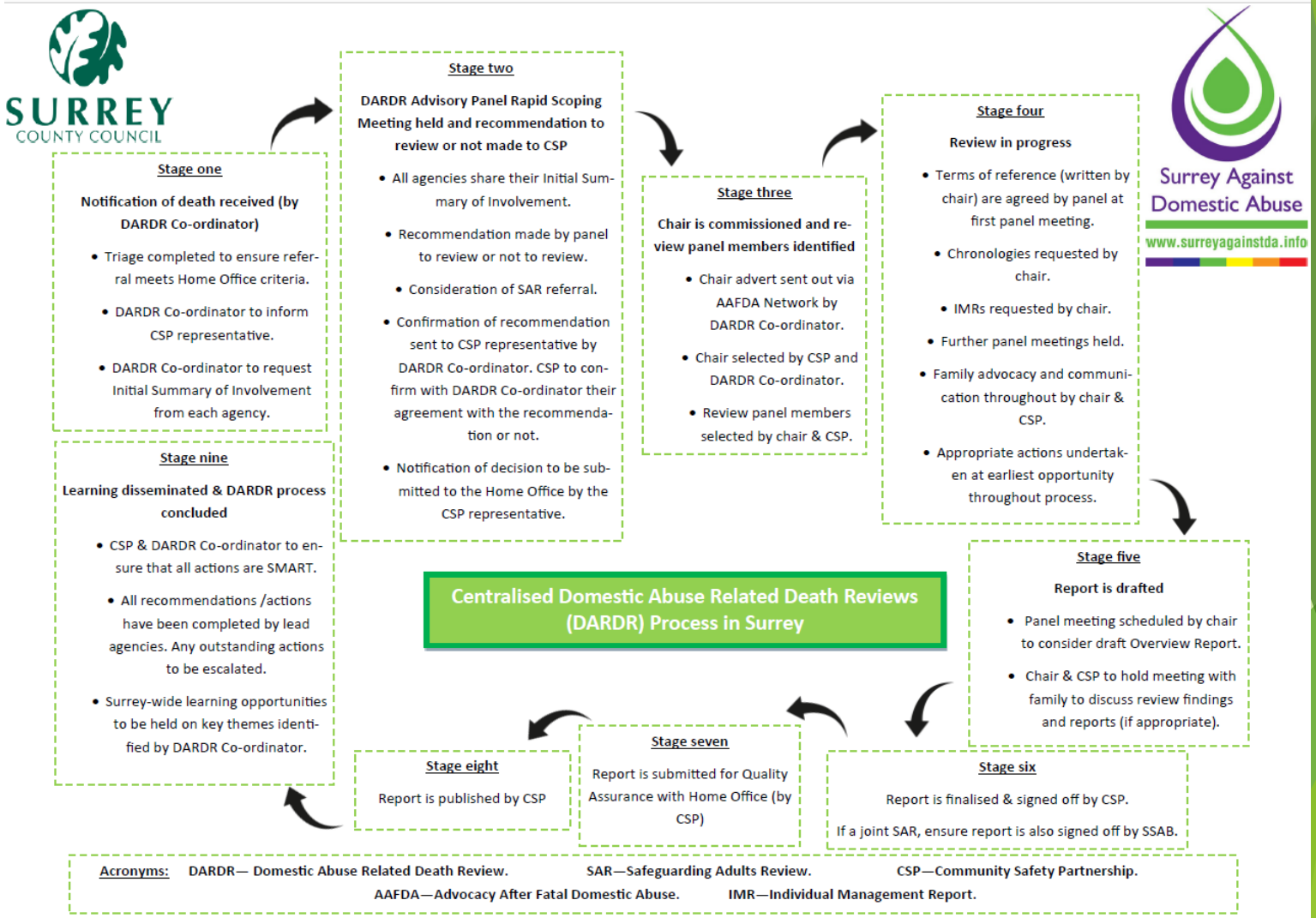
A “Domestic Abuse Related Death Review” means a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by:

- (a) a person to whom she/he was related or with whom she/he was or had been in an intimate personal relationship, or
- (b) a member of the same household as herself/himself, held with a view to identifying the lessons to be learnt from the death.

Where a victim took their own life (suicide) and the circumstances give rise to concern, for example it emerges that there was coercive controlling behaviour in the relationship, a review should be undertaken, even if a suspect is not charged with an offence or they are tried and acquitted. Reviews are not about who is culpable.

The purpose of a DARDR is to:

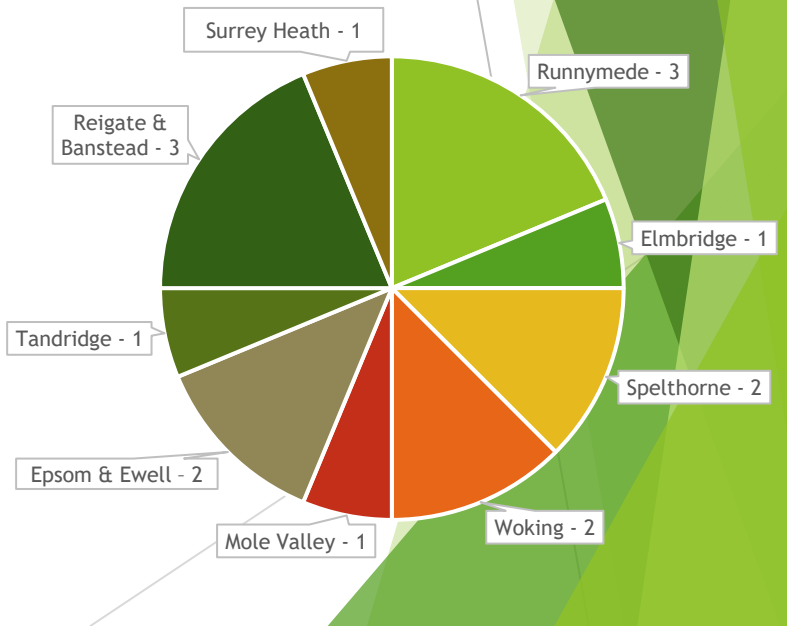
- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;
- Apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;
- Prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;
- Contribute to a better understanding of the nature of domestic violence and abuse; and
- Highlight good practice.


SURREY
COUNTY COUNCIL
Surrey Against Domestic Abuse
www.surreyagainstda.info
Centralised Domestic Abuse Related Death Reviews (DARDR) Process in Surrey
Stage one
Notification of death received (by DARDR Co-ordinator)
• Triage completed to ensure referral meets Home Office criteria.
• DARDR Co-ordinator to inform CSP representative.
• DARDR Co-ordinator to request Initial Summary of Involvement from each agency.
Stage two
DARDR Advisory Panel Rapid Scoping Meeting held and recommendation to review or not made to CSP
• All agencies share their Initial Summary of Involvement.
• Recommendation made by panel to review or not to review.
• Consideration of SAR referral.
• Confirmation of recommendation sent to CSP representative by DARDR Co-ordinator. CSP to confirm with DARDR Co-ordinator their agreement with the recommendation or not.
• Notification of decision to be submitted to the Home Office by the CSP representative.
Stage three
Chair is commissioned and review panel members identified
• Chair advert sent out via AAFDA Network by DARDR Co-ordinator.
• Chair selected by CSP and DARDR Co-ordinator.
• Review panel members selected by chair & CSP.
Stage four
Review in progress
• Terms of reference (written by chair) are agreed by panel at first panel meeting.
• Chronologies requested by chair.
• IMRs requested by chair.
• Further panel meetings held.
• Family advocacy and communication throughout by chair & CSP.
• Appropriate actions undertaken at earliest opportunity throughout process.
Stage five
Report is drafted
• Panel meeting scheduled by chair to consider draft Overview Report.
• Chair & CSP to hold meeting with family to discuss review findings and reports (if appropriate).
Stage six
Report is finalised & signed off by CSP.
If a joint SAR, ensure report is also signed off by SSAB.
Stage seven
Report is submitted for Quality Assurance with Home Office (by CSP)
Stage eight
Report is published by CSP
Stage nine
Learning disseminated & DARDR process concluded
• CSP & DARDR Co-ordinator to ensure that all actions are SMART.
• All recommendations /actions have been completed by lead agencies. Any outstanding actions to be escalated.
• Surrey-wide learning opportunities to be held on key themes identified by DARDR Co-ordinator.
Acronyms: DARDR— Domestic Abuse Related Death Review. SAR—Safeguarding Adults Review. CSP—Community Safety Partnership.
AAFDA—Advocacy After Fatal Domestic Abuse. IMR—Individual Management Report.

DARDR Stats / Themes

(August 2024)

- 16 ongoing reviews – 8 standalone DARDRs and 8 joint DARDR/SARs.
- 15 female victims and 1 male victim.
- 12 of the victims died by suicide.
- Evidence of mental health issues in ALL cases.
- Substance misuse featured in 11 out of 16 reviews.
- Children (0-18) involved in 10 out of 16 reviews.



Training opportunities

- Due to the significant increase in DARDRs involving suicide in Surrey, SCC commissioned AAFDA (Advocacy After Fatal Domestic Abuse) to deliver Suicide After Domestic Abuse: Research, Risks and Reviews Training – CPD Accredited.
- Learning objectives:
  - Appreciate prevalence of suicide after domestic abuse.
  - Recognise the links between domestic abuse and suicide.
  - Value the experience of a family member bereaved by suicide after domestic abuse.
  - Recognise the challenges faced for families, advocates, Community Safety Partnerships and DHR Chairs when reviewing suicide or unexplained death following domestic abuse.
  - Recognise the role of the Inquest and Coroner in DA related suspected suicides.
- We have recently booked AAFDA to deliver the 'Self Care in DHRs' training to regular panel members involved in Surrey DARDRs. This training will be taking place in November 2024.
- Learning objectives:
  - Describe the impact of vicarious trauma
  - Recognise importance of Self Care
  - Identify sources of support during and after the DARDR process
- We are also currently looking into more learning and training opportunities in the future (e.g. Giving Children a Voice in DHRs).

georgia.tame@surreycc.gov.uk

fran.richiusa@surreycc.gov.uk

DHR@surreycc.gov.uk

Georgia Tame – DARDR Coordinator, Surrey County Council

Fran Richiusa – DARDR Coordinator (maternity cover - starting from 24th October 2024)

Any questions?

Contacts:

Nicola.mundy2@nhs.net