Surrey Child Death Review Partnership

2020 - 2025

A five year thematic review of deaths of Children and Young People normally resident in Surrey by suspected suicide 2020- 2025

The prevention of suicide is a local, national and international priority. Suicide in children and young people has a devastating impact on friends, families and the wider community.

"Every child has the right to grow up in loving, nurturing and safe environments, with supportive relationships and access to quality, age-appropriate and rights-based mental health and psychosocial support.

When we ignore children's right to good mental health and wellbeing, we undermine their enjoyment of all other rights. Conditions like anxiety and depression influence a child's ability to learn, develop, form relationships, reach their full potential and contribute to the world.

Historic under-investment in mental health has led to serious gaps in prevention and care for children, adolescents and caregivers with mental health problems." (1)

[1] #OnMyMind: Better mental health for every child | UNICEF

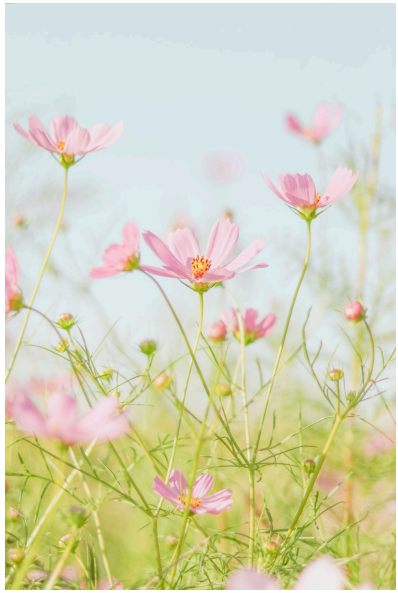
This thematic report contains sensitive content which refers to details on deaths by suspected suicide.

If you are struggling to cope, please call the Samaritans for free on 116 123 (UK and the Republic of Ireland) or contact other sources of support, such as those listed on the Healthy Surrey and Mindworks website. Support is available around the clock, every day of the year, providing a safe place for you, whoever you are and however you are feeling.

For further information visit Children and young people's emotional wellbeing and mental health | Healthy Surrey

INTRODUCTION

The purpose of this report is to influence and inform multi agency planning, the learning should be applied by organisations across Surrey. It should support commissioners and system leaders to develop evidence based commissioning, improve practice and inform learning and strategies.



This five year report follows the publication of two previous reports on deaths of Children and Young People by suspected suicide in Surrey and aims to ensure a focus on the current picture (2)

Child Death Review (CDR) is the process to be followed when responding to, investigating, and reviewing the death of any child under the age of 18, from any cause. It runs from the moment of a child's death to the completion of the review by the Child Death Overview Panel (CDOP). The process is independent of any care given and aims to support families and identify changes and learning that could save lives in the future.

(2) Thematic-Review-of-Adolescent-Suicide-Final.pdf (surreyscp.org.uk))
9-year-Probable-Suicide-Thematic-Review-Surrey-1.pdf

The Family Voice - Tyler Abdul

It's hard to believe I am writing this for the '*Thematic Review on Child Deaths by Suspected Suicide in Surrey*'. How can it be that, despite our ongoing discussions about mental health, sparked by the grief of losing friends and loved ones to suicide, we still find ourselves facing this heartbreaking reality?! These discussions stressed that suicide is a final act with no "undo" button, and that it solves nothing, but instead creates problems. Yet here I am, painfully aware of the deep sorrow that comes from losing a child this way.

Tyler was a wonderful, funny, and intelligent boy. He had a calm demeanour, with the occasional teenage flare. He loved spending time with friends, whether it was swimming in rivers during summer, hanging out at the local sports centre, or sharing a bucket of KFC. He also spent time with them gaming online, and we'd often hear the squeals of excitement from his bedroom when he beat them in a game.

School was a place for friendship and fun, and he was known by most of the staff on site – including those serving in the canteen. While he often found himself in detention for things that were "not that deep", his intelligence made schoolwork easy. The challenge for Ty was the structured classroom setting where he struggled to focus and remain quiet for the duration of lessons.

I reflect on how an earlier ADHD diagnosis might have made a difference. If we had understood his unique learning needs, we could have provided the support he required and perhaps he wouldn't have been labelled as "disruptive" in class. He was a square peg being forced to fit in a round hole and this led to frustration "I'm trying so hard, but nothing I do is good enough."

Creativity flowed through Tyler. He often found his "flow state" while sewing, turning old clothes into unique pieces, even making creations for friends. Music was another passion, and his love of rap allowed for some valuable conversations between the two of us. Ty would often say, "I need my music," and I now wonder what he meant by that.

The Family Voice - Tyler Abdul

We always encouraged him, reminding him that he could pursue anything any career, and that he would be brilliant at whatever he set his mind too (apart from traditional art). He also had the opportunity throughout his life of pursuing sports clubs, and he tried his hand at hockey, judo, football, and basketball – the latter which he enjoyed and stuck to.

Tyler came from a large, loving family. He was well travelled, visiting family in Africa, the USA, and across Europe. He had so much to live for, and I believe his choice to end his life was impulsive, a moment of despair that felt consuming. If he could return, I know he would say, "I'm sorry, Mum." Though the damage is done, I believe he would genuinely mean it.

Whilst writing the family voice, I want to recognise his grandparents, who played a vital role in his early years while I returned to work. His uncles and aunts embraced him as their own, and his cousins, close in age, created countless joyful memories with him. His little sister,

whom he called "feisty," took great care of him, ensuring he had what he needed amidst his often chaotic world. All of these people have been profoundly affected by his loss.

And whilst not strictly family, let's not forget Tyler's friends, who at just 15 or 16 years old are grappling with the sudden loss of their vibrant companion - the life and soul of the party. The one who encouraged them through difficult times, the one who made them feel that they belonged. They had been enjoying life together just the day before their lives changed forever.

If there's one thing I hope that people take away from this, it's that suicide does not discriminate; it affects all races, classes, cultures, and religions, and we, as a community, each have a role in preventing suicide. We can do this by creating spaces where mental health is prioritised, where open conversations are encouraged, and where every child feels seen and heard. Each of us has a part to play in fostering change for a brighter future.

Tyler was a remarkable boy with so much potential and it is devastating that his life has been cut short. It is devastating that any child's life is cut short by something preventable.

Please follow and support the crucial work of The Tyler Abdul Foundation www.tyfo.org.uk.

Charlene Abdul, Ty and My's mum

Key Points

Between 1st April 2020 and 31st March 2025, 254 neonatal and child deaths of Surrey residents were notified to Surrey Child Death Review Partnership. Of these 13 were identified as due to suspected suicide which is 5% of all deaths in under 18s.

In this time period, of the 36 deaths recorded in the 15-17 year age group 33% were from suspected suicide of which 75% were male.

83% of the children and young people in Surrey who died from suspected suicide had identified issues around household functioning, this compares with 69% in England.

The National Child Mortality Database Thematic Report on Suicide in Children and Young People found that 16% of the children who died by suspected suicide had a diagnosed neurodevelopmental condition, this compares to 31% in Surrey. This is higher than found in the general population.

54% were known to CAMHS either at time of death or previously, this compares to 36% in England.

The data showed 62% of the children and young people within the thematic review engaged in risk taking behaviour, that compares with 49% in England and 23% had problems with the law (66% of these were due to cannabis possession), compared with 9% in England. 23% were known to vape or tried vaping, compared to 9% Nationally.

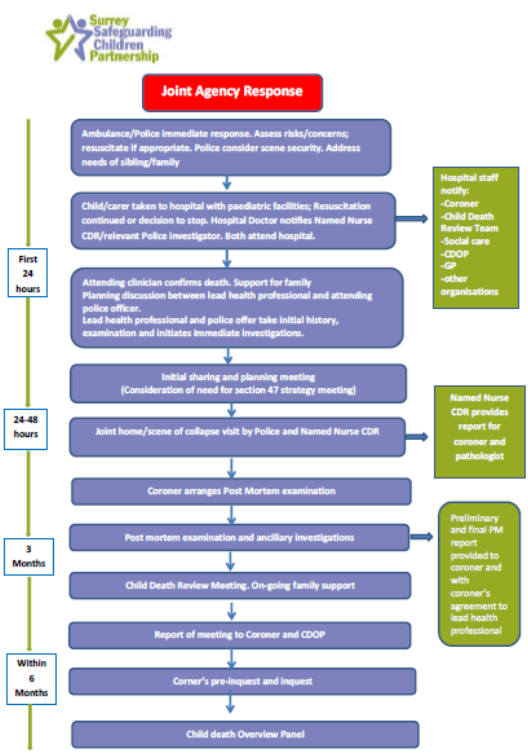
Of the children and young people who died 62% lived in households where parents had separated. 54% had relationship breakdowns with a parent/step parent. 31% had a parent who misused drugs and or alcohol. 15% of parents were known to have a mental health issue and15% of households were known to have domestic abuse.

62% of the children and young people in this suicide thematic review had experienced 3 or more Adverse Childhood Experiences (ACEs).

23% of the children and young people had seen clinicians privately for a mental health or neurodivergent diagnosis.

Child Deaths in Surrey

Between 1st April 2020 and 31st March 2025, 254 neonatal and child deaths of Surrey residents were notified to Surrey Child Death Review Partnership. Of these 13 were identified as due to suspected suicide which is 5% of all deaths in under 18s. Following any suspected suicide of a young person aged under 18 in Surrey the Joint Agency Response is initiated.



The data was analysed as rates to compare with National data and to compare five year data with the most recent annual data.

Published NCMD data shows the rate of suspected suicide in England is 1.8 (95% CI 1.5-2.2) per 100,000 for 2019-2020. Surrey rate is 2.2 (95% CI 0.8 – 4.9) per 100,000, for 2024 - 2025, Because the confidence intervals overlap, there is no statistically significant difference between the rates.

Five year rate for Surrey is 0.98 per 100,000 (95% CI 0.52–1.68). Showing no statistically significant difference to either National or local one year data.

Figure 1: JAR response in Child Death Review in Surrey

“The data for the deaths of children and young people under 18 resident in Surrey from suspected suicide shows that during the period 1st April 2020 – 31st March 2025 there have been 929 years of life lost”

Mental Health and Young Men

Supporting the mental health and wellbeing of young men is an important focus for professionals. Whilst young men may be less likely to access traditional mental health support, they often respond well to strengths-based, practical, and relationship-oriented approaches.

Of the 36 deaths recorded during 2020 - 2025, in the 15-17 year age group 33% were from suspected suicide of which 75% were male.

This data highlights the need to ensure young men are supported with timely, relevant, and accessible mental health resources. It also shows the importance of proactive engagement with challenging stereotypes to help young men navigate life challenges and strengthen their emotional wellbeing.

Positive relationships—with parents, carers, teachers, youth workers and others—can play a protective role in young men's mental health. Encouraging adults in these roles to model open, respectful conversations can help develop a culture of trust and self-reflection.

Young men have a wide range of strengths, interests, and capabilities that can be built upon to support their mental health and emotional wellbeing. By offering respectful, flexible, and strengths-based support, professionals can create environments where young men feel safe to engage, reflect, and thrive. The aim is not only to prevent crisis, but to promote wellbeing, confidence, and connection in everyday life in Surrey. Supporting young men to develop social and emotional intelligence and skills is essential.

Right help at the right time

31% of the young people who died were known to have previously self harmed, had attended emergency departments or been admitted to hospital as a result of a suicide attempt.

54% were known to Mindworks either at the time of their death or previously, this compares to 36% in England.

In Surrey, ensuring that young people receive the right mental health support at the right time is a shared priority across health, education, social care and third sector services. Early prevention, identification, timely intervention, and young person centred approaches are key to helping children and young people build resilience, maintain wellbeing, and access specialist support when needed.

There are guiding principles for effective and appropriate support for accessing help when mental health issues emerge and these include:

- Focusing on prevention.
- Early help, not late intervention: Support should begin when difficulties first emerge, not when problems reach crisis point.
- Strengths-based: Services should focus on what young people do well and involve them in shaping their own care.
- Joined-up working: A whole-system approach—linking schools, families, health services, and the community—is vital.
- Equity and accessibility: Support must be inclusive and reach all young people, including those from minority groups.

Neurodivergent Young People

Neurodivergent young people, including those with a diagnosed neurodevelopmental condition such as autism spectrum disorder (ASD), attention deficit hyperactivity disorder (ADHD) and learning disabilities can experience unique challenges in relation to their mental health and emotional wellbeing. While many thrive with the right support, emerging data highlights a need for greater attention to their mental health needs, particularly in the context of suicide prevention.

The National Child Mortality Database Thematic Report on Suicide in Children and Young People (3) found that 16% of the children who died by suspected suicide had a diagnosed neurodevelopmental condition, this compares to 31% in Surrey. This is higher than found in the general population.

Neurodivergent young people may face a number of overlapping risk factors, including:

- Social isolation or difficulties with peer relationships.
- Sensory processing differences, which can contribute to heightened anxiety or feeling overwhelmed.
- Masking behaviours, which may delay recognition of distress by caregivers or professionals.
- Challenges accessing mainstream services.
- Misunderstanding or minimisation of their needs.

Whilst the numbers themselves are small and not statistically significantly different, this highlights a level of vulnerability among neurodivergent young people in Surrey and underlines the importance of tailored, responsive support. This is because whilst the evidence does not show a causal link between being neurodivergent and suicide, unmet needs, lack of support, and the inclusivity of the environment can contribute to increased distress.

(3) NCMD-Suicide-in-Children-and-Young-People-Report.pdf

Privately funded diagnosis

23% of the children and young people had seen clinicians privately for a mental health or neurodivergent diagnosis.

Families in Surrey may access private clinicians due to waiting lists and eligibility thresholds. Whilst this can offer timely clarity, it also introduces variability and inequalities into the system, since children from lower-income families may remain unsupported whilst other families can bypass NHS waiting times. There are also challenges around the integration of diagnoses into public services, sharing of notes with GPs and the responsibilities of clinicians in shared care agreements(4). In addition to this NICE guidance recommends multi-agency and longitudinal assessments for conditions like ADHD or autism, which may not always occur in private settings (5).

There is information available for parents in Surrey with regard to what they should be looking for when accessing a private clinician. This information can be found on the Mindworks website. Information on private clinicians :: Mindworks Surrey

(4) Parents' Experiences of Accessing Mental Health Services for Their Adolescents With Mental Health Challenges: A Scoping Review - PubMed
(5) Overview | Autism spectrum disorder in under 19s: recognition, referral and diagnosis | Guidance | NICE

Supporting Families

62% of the children and young people in this suicide thematic review had experienced 3 or more Adverse Childhood Experiences.

Of the children and young people who died 62% lived in households where the parents had separated. 54% had relationship breakdowns with a parent/step parent. 31% had a parent who misused drugs and or alcohol. 15% of parents were known to have a mental health issue and 15% of households were known to have domestic abuse. There is a well published evidence base on the cumulative effect of these Adverse Childhood Experiences on negative outcomes for children and young people.

Supporting families with teenagers is a critical intervention point for reducing suicide risk and improving adolescent mental health. Parenting can be challenging and supporting young people can have a negative impact on a parents' mental health as well. Family relationships—including communication patterns, emotional responsiveness, and conflict management—plays a role in young people's psychological wellbeing and resilience. The teenage brain undergoes significant changes during puberty, which can impact decision-making and impulsivity. Supporting parents and carers in understanding these changes and how the late development in teenagers of the front part of the brain, which is responsible for thinking, planning, and controlling impulses, can lead to a tendency to make impulsive decisions, is important.

In Surrey all parents have free access to online parenting courses that include top tips from childcare, education and NHS health experts. Register for free online courses for families - Surrey County Council

Support for others after a disclosure of suicidal ideation

Schools play a vital role in supporting the wellbeing of children and young people. Schools should ensure that young people have clear, supportive, and confidential routes to seek help when they have concerns. This may include access to trusted adults within the school community, such as teachers, pastoral staff, or designated safeguarding leads. In addition, young people should be made aware of other sources of support, including the school nursing service or external organisations such as Childline. Creating a culture of openness and trust helps young people feel safe and empowered to seek help when they need it.

Several of the young people who died had disclosed suicidal ideation to peers or siblings. It is important not be over-responsibilise children of any age. Schools should ensure that all students, staff and parents/carers know, understand and are able to access appropriate and timely advice should they have concerns about their own, or another's' safety or wellbeing. This can be addressed regularly with young people as part of the PSHE Ground Rules/Learning Agreement ensuring clarity of understanding in relation to confidentiality. Additionally, skills, knowledge and understanding, attitudes and values about ways to access appropriate support should form part of the PSHE curriculum.

Schools should have clear safeguarding policies in place. Children and young people should know how they can inform others and schools should help young people to routinely develop social and emotional skills and resilience and through identifying young people with low mood and getting them help early, schools can help prevent escalating suicidal thoughts.

Importance of a strengths based whole school approach

Updates to the DfE Relationships Education, Relationships and Sex Education (PSHE) and Health Education Guidance which is statutory for governing bodies, proprietors, head teachers, principals, senior leadership teams, and teachers, has highlighted the importance of a strengths based, trauma informed, whole school approach.

“Children and young people need knowledge and skills that will enable them to make informed and ethical decisions about their wellbeing, health and relationships. High quality, evidence-based teaching of relationships, sex and health education (PSHE) can help prepare pupils for the opportunities and responsibilities of adult life, and can promote their moral, social, mental and physical development. Effective teaching will support young people to cultivate positive characteristics including resilience, self-worth, self-respect, honesty, integrity, courage, kindness, and trustworthiness. Effective teaching will support prevention of harms by helping young people understand and identify when things are not right.”
(DfE Guidance 15th July 2025) (6)

(6) Relationships Education, Relationships and Sex Education and Health Education guidance

Early Prevention

Early prevention must be evidence based, to reduce the risk of harm and enable the positive impacts of evidence based practice on outcomes for children and young people.

To ensure evidence based universal prevention in Surrey schools, the Surrey Child Death Review Partnership is a partner of the Surrey Healthy Schools whole system approach. This is a commitment to promoting personal, social, health and economic (PSHE) development across the local authority. It champions the links between health, behaviour, inclusion and achievement and centres around the whole system, along with school environments' and all aspects of school life. The approach builds upon strengths to reduce vulnerabilities, applying prevention, intervention and targeted support to reduce inequalities; promoting positive outcomes for children and young people. All Surrey Schools, services and partners are part of a Surrey Healthy Schools whole system approach. (7)

Surrey Healthy Schools

(7) Surrey Healthy Schools | Healthy Surrey

Social Media Use

For 31% of the children and young people in the review there were concerns about their social media use.

A systematised narrative review published in 2020 highlighted four possible risk factors for self-harming behaviours associated with young people's use of social media, these were heavy use, problematic use, experiences of cybervictimisation, and exposure to self-harming content within online spaces. Additionally, the review highlighted two possible protective factors among young people which were social support and social connectedness. (8)

Many of the published studies show an association rather than causation and further investigation is required to understand social media's influence on young people's suicidal risk, particularly regarding protective factors that were evaluated in far fewer articles than risk factors.

The complex interaction between social media use and emotional regulation has also been highlighted in studies, where young people who have difficulties in self-regulating emotions relied on these platforms to cope, with increasing dependence over time. In addition to this the relationship between emotional regulation and suicidal ideation was identified in a systematic review published in 2022 where 70 out of 76 of the included studies reported that people with difficulties in emotion regulation reported higher levels of suicide ideation and more suicide attempts, this was consistent across both adults and young people. (9)

(8) Social Media Use and Deliberate Self-Harm Among Youth: A Systematized Narrative Review - PMC
(9) Relationship Between Emotion Regulation and Suicide Ideation and Attempt in Adults and Adolescents: A Systematic Review - PubMed

Effective Child Death Review

When a child dies, in any circumstances, it is important for parents and families to understand what has happened and whether there are any lessons to be learnt. The NHS in England has standardised child death review procedures underpinned by statutory guidance.

Early support for families is essential to enable them to manage the devastating trauma they will be experiencing. The Child Death Review (CDR) process plays a crucial role in understanding and learning from the death of a child, especially in cases of suspected suicide. When managed sensitively and systematically, it not only helps identify contributory factors but also supports improvements in local services and safeguards other children. In Surrey the role of the designated key worker and the lead health professional are undertaken by the Child Death Review Nurses, this role is vital in ensuring families are supported with care, compassion, and continuity during an exceptionally traumatic time. Having a highly skilled workforce ensures that the voice of the family is central to the process.

”

The compassion and kindness I was shown by our nurse from the very begininng has undoubtedly felt like one of the only reasons at times I had the strength to attempt to navigate my grief alongside the practicalities of every day life and all the obstacles I had to face and still face everyday .

I was in the darkest place when I met my nurse, without her support I wouldn’t be where I am now. This service is the best support offered to anyone who faces dealing with their child’s death.

”

Opportunities not to be missed

Evidence based early interventions, which use a strengths based approach are key to reducing future deaths. The Child Death Review Partnership recommends a focus on:

1. All schools in Surrey implementing a Surrey Healthy Schools Approach, supported by Surrey services and partners.

2. All schools and educational establishments accessing the freely available PSHE training and curriculum resources offered through Surrey Healthy Schools.

3. Professionals across public health, education, mental health, and social care should integrate approaches to strengthening emotional regulation in young people into parenting programmes, family therapy, and wider community interventions.

4. Ensuring that young people receive the right mental health support at the right time through commissioning of services to support the health needs of the population.

5. The higher proportion of suspected suicides among neurodivergent young people in Surrey signals a clear need for enhanced support and system responsiveness. With the right adjustments, early intervention, and a commitment to informed practice, professionals can play a crucial role in improving wellbeing and reducing risk.

6. Schools should have clear safeguarding policies in place and through effective PSHE, the wider curriculum and school culture, schools should assist young people to develop social and emotional skills. By identifying pupils with low mood and getting them help early, schools can help prevent escalating suicidal thoughts.

7. Professionals working with families must be equipped to help and support parents and carers by promoting emotional literacy and emotional regulation.

.

Opportunities not to be missed

8. Strengthening information-sharing processes across Surrey. This includes sharing information about suicide risk with families and carers, in accordance with the DHSC suicide prevention consensus statement, supported by Zero Suicide Alliance's SHARE resource for health and social care staff. Along with strengthening pathways between services and sectors, especially addressing the on-going issues of information sharing between schools and health, whilst upholding a person-centred, joined-up approach to crisis prevention and response.

9. Supporting professionals with the emotional impact on themselves of working with children and young people who are experiencing emotional distress.

10. Supporting parents with the emotional impact on themselves, including proactively signposting to sources of help and support around parenting.

11. Supporting a trauma informed approach across all services in Surrey and provide guidance for children, young people and families to mitigate the impact of any Adverse Childhood Experiences.

12. Signpost parents in Surrey on what they should be looking for if they decide to access a private clinician. Information on private clinicians :: Mindworks Surrey

Methods

This report used data from the CDR data set from 2020 - 2025. The CDRP database includes deaths of Surrey residents (wherever that death may occur). ONS data is used to illustrate long-term trends and comparisons with other countries. There may be a difference between ONS data on child deaths and those reported by the CDRP as deaths of live born babies following termination of pregnancy are excluded in the CDRP database, but included by ONS. ONS data also refers to the year that the death was registered, not when it occurred.

Strengths and Limitations

Strengths

1. The Child Death Review data set is a population–based registry covering all child deaths in Surrey.
2. Multi-source reporting means that there is a rich dataset of good quality information.

Limitations

1. There are a small number of deaths which limits meaningful analysis in those groups.
2. Data on ACEs are likely to be underestimated and better reporting and collection of the data is essential to enable further analysis.

Authors

Anna Miles | Child Death Review Administrator, Surrey Child Death Review Partnership, Surrey Heartlands ICB

Nicola Mundy | Child Wellbeing Professional and Lead for Learning from Child Deaths, Surrey Child Death Review Partnership, Surrey Heartlands ICB

Acknowledgements

Thanks to Louisa Surtees, Public Health Lead, Surrey County Council for support with the document

Version 1: November 2025