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

Foreword

There can be no greater or more enduring loss to a family than that of a child. When the loss is potentially preventable, then the feeling of devastation must be even worse. However we currently find ourselves in a position where suicide is the biggest killer of young people in the UK aged between 16 and 24 years, and in England alone it is estimated that over 180 young people aged 10-19 years took their own lives. This number rises alarmingly to 536 over the age range 10-24 years with far the greater number of deaths being of young males (ONS 2018).

This sharp increase in suicide needs also to be seen alongside an increasing trend in self-harm, a known potential indicator of suicidal thoughts in young people, and when Child and Adolescent Mental Health Services (CAMHS) are under enormous pressure.

As young people develop through adolescence and become more independent, their lives can be filled with many changes. The teenage years, in particular can become a very stressful time. Changes may be physiological, affecting thoughts and feelings. Other strong influences may include, changes within families, such as separation of parents, siblings moving on, within friendships or problems in school including bullying and a pressure to succeed, be it exams or other aspects of their lives
Strong feelings of stress, confusion, fear, and doubt may affect rationale and decision making.

For some young people, normal developmental changes can be very unsettling when combined with other events. Sometimes these problems may seem just too difficult to overcome and for some, suicide may seem like a solution. Imagine the feelings of isolation and despair when young people reach this point.

However, it is also important to recognise the impact upon other people who share part of the lives of young people, troubled in this way. Aside from family members and friends, in many cases there will be countless others, whether staff in schools, other groups and associations where young people may have been active and involved. Others in support networks including voluntary and statutory services –all of whom will question whether or not they had missed signs or signals and opportunities to intervene.

In some situations case review processes may be deployed to help address some of the many questions that may arise following an incident of probable suicide. However in many, perhaps even the majority of cases, these processes are not likely to lead to the developments in practice that may be needed. Evidence clearly suggests that many young people who do take their own lives have lived in relatively stable environments with no suggestion whatever that abuse, or neglect would have been a factor in their lives.

Some of the cases covered by this thematic review are subject to formal serious case or practice learning reviews. In commissioning this report the Surrey Safeguarding Children Partnership (SSCP) has been clear in its desire and determination to set a course to better understand the pressures and influences that lead young people to harbour suicidal thoughts, to create better

awareness of signs and signals and to support parents, families, friends and practitioners including education providers, all of whom are deeply affected by these tragedies.

Specifically the report aims to:

- help develop a greater understanding of (teenage) suicide and the motivations of young people who harbour such thoughts based on local experience aligned to existing national research findings,
- Set out both strategic and especially early learning potential, providing pointers to changes of approach and practice and increased ability to better recognise potentially volatile circumstances
- Build upon learning from the well-established child death partnership
- challenge current capacity and access to support arrangements at a local and national level

This report has been commissioned because the SSCP feel strongly that we need to understand much more than we currently do, in relation to suicide and self-harm in young people. We appreciate that the issues are hugely complex, unpredictable and solutions may be difficult to achieve. However, we are clear that we need to re-double our effort and keep at the forefront of our minds the feelings of absolute desolation on the part of any young person close to suicide, ensuing any young person who expresses thoughts of suicide should not feel isolated or left alone.

Simon Hart

Independent Scrutineer, Surrey safeguarding Children Partnership

1. A Parent's Journey

Whilst this report has understandably sought to protect the identity of those families directly concerned, the Surrey Safeguarding Children Partnership is deeply indebted to Frankie's Mum for offering her very personal perspective on the loss of her daughter.

I believe the aims of the guidance and toolkit are commendable – zero youth suicides in Surrey. I hope that what I have written will be helpful to the professionals aiming to achieve this in their work with families and young people.

My only daughter Frankie was adopted, and I believe that adverse childhood experiences (ACES) which include early trauma and lead to fostering/adoption, were a major factor in Frankie's difficulties. Right up until she died, she longed to know who her natural father was (also unknown to us) and had learned about her difficult birth family history. Early trauma can have lasting psychological effects such as a sense of rejection, which in Frankie's case resulted in a very low self-esteem. Shame played a huge part in her life and an accompanying fear of failure. Also due to her early trauma, Frankie had very real attachment difficulties and it felt impossible for us to form a genuine connection beyond surface level. We would have wanted to really convey that she was totally accepted and acceptable and loved just for who she was and for her to feel genuinely secure in her identity – parenting her therapeutically using empathy so that she felt "heard" when dysregulated, using only natural consequences and never shaming her for her difficult behaviours which were a communication of her stress. I believe that had she been able to receive unconditional love it would have been transformational at her very core and life changing.

Frankie's attachment difficulties were compounded by her high functioning autism. She found "fitting in" socially with her peers a nightmare due to her autistic outlook but as a teenager, was desperate to be "one of the crowd". However, because self-awareness of her emotions seemed impossible for her, she could not put strategies in place to safely handle any mounting stress and the resulting behaviours would only further isolate her socially. This also limited her chances of safe independence which she longed for, like others of her age.

There were activities that helped Frankie. One was physical exercise as she had sensory needs as these would help regulate her (a garden swing, climbing, judo, boxing, surfing) as well as activities that promoted her self-esteem as well as encouraging social interaction. She did well playing bass guitar in a band, achieving her bronze Duke of Edinburgh award, volunteering for both a charity shop and for Disability Challengers. The Labrador we bought when Frankie was seven was also a huge help to Frankie.

Something that also might well have helped Frankie would have been a mentor she could relate to, to take her out and teach her some life skills. This may have helped Frankie gradually learn how to become independent safely.

At times I felt incredibly let down by the lack of support offered to adoptive parents by professionals and the inconsistencies in children and young people's mental health services. We were often floundering and felt on our own and at a loss. From early on, I realised that we needed to keep Frankie safe from hurting herself. We monitored her mobile phone usage and

she was supervised in her use of my password-protected computer at home. We locked our front door so that we could always know she was safe as she had gone missing in the past. Yet when she died suicide was not even on the radar and was a shock I cannot even put into words.

Being given the opportunity to talk about your grief is an important part of getting through a bereavement. The thing that has helped me the most is my faith, which has been the biggest strength by far. I have had to deal with my own honest but endless questioning regarding my parenting, but I am realising that I cannot change the past and nothing brings her back. Therefore, my aim is now to do something seriously worthwhile with the rest of the life I have and to do her proud.

Frankie was genuinely a natural with young children and she showed real kindness. She also had a brilliant (quirky!) sense of humour and had great spirit with a keen sense of justice, standing up for people if she felt they'd been wrongly treated. I truly believe that the world is a poorer place for her loss. What has happened still feels unreal but tragically, permanent. It is unbelievable, a nightmare that will not change. It was a total privilege to have been Frankie's parents and we miss her **every** day. We have had a lot of support from church friends who have been there for us and at our request, they will continue to talk to us about Frankie which means so much – that she has not already become forgotten, a figure from the past.

She was honestly special.

Frankie's Mum

2 Introduction

This report presents 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 aim of this thematic review from 1 April 2014 – 31 March 2020 is 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

'In many cases, suicide is an avoidable death, preventable by identification of risk, public health interventions and high-quality evidence-based care. A robust suicide prevention approach needs to take place at individual and population levels and so needs the input of frontline services, commissioners and policy makers.'[1]

According to the 'International comparisons of health and wellbeing in adolescence and early adulthood.' Research report 2019 by the Nuffield Trust.[2] 'The NHS *Long Term Plan*, which sets out the way care in this country should be delivered given the new NHS financial settlement, is striking for its emphasis on improving the health of children. Health outcomes for young children in the UK are now worse than those in many similar countries. The UK is performing in the middle of the group of similar high-income countries for several indicators, including cancer mortality, suicide death rates and health-related behaviours such as smoking, alcohol consumption and cannabis use.

[1] https://mycouncil.surreycc.gov.uk/documents/s55064/Surrey%20Suicide%20Prevention%20Strategy%202019-2021%20-%20Final.pdf

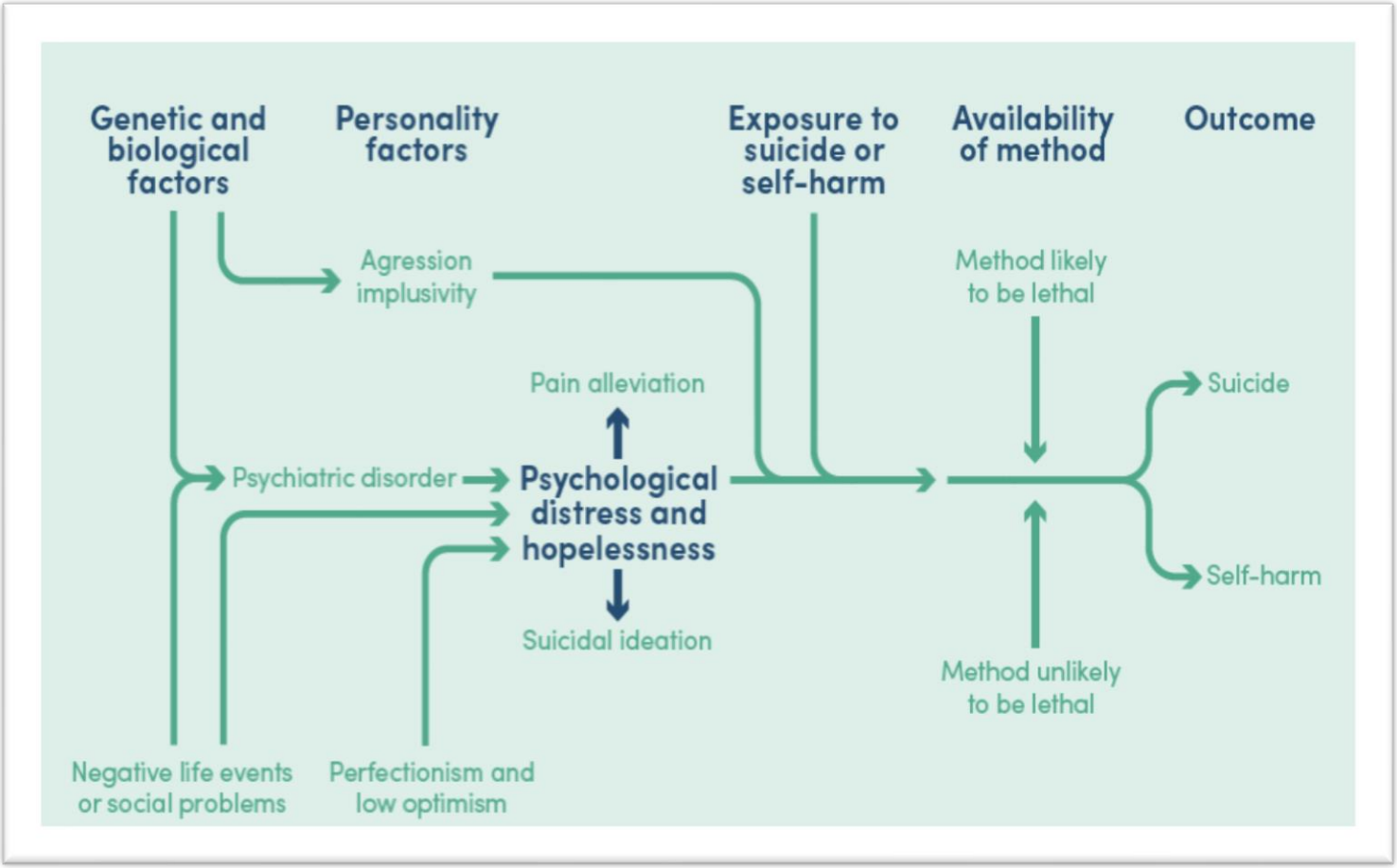
[2] http://www.youngpeopleshealth.org.uk/wp-content/uploads/2019/02/NT-AYPH-adolescent-health-report_WEB-200219.pdf

2 Background

2.1 Risk factors

'Suicide in children and young people is usually the outcome of a complex interaction between biological, genetic, psychiatric, cultural, social and psychological factors.'[3]

Figure1: Key risk factors for adolescent suicide and self-harm.



Source; Hawton, Saunders, O'Connor, 2012

[3] https://phw.nhs.wales/news/averting-tragedy-suicide-prevention-in-welsh-children-and-young-people/thematic-review-of-deaths-of-children-and-young-people-through-probable-suicide-2013-2017-main-report/

2.2 Current epidemiology in Surrey

Chart 1: Percentage of school pupils with social and mental health needs (School age)

School pupils with social, emotional and mental health needs: % of school pupils with social, emotional and mental health needs (School age)

2018 — Proportion - %

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Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	193,657	2.39	2.38	2.40
South East region	–	30,591	2.42	2.40	2.45
Buckinghamshire	–	1,434	1.70	1.61	1.79
West Berkshire	–	438	1.70	1.55	1.87
Slough	–	554	1.83	1.68	1.98
Bracknell Forest	–	340	1.90	1.71	2.11
Wokingham	–	503	1.91	1.75	2.08
Milton Keynes	–	966	2.06	1.94	2.20
Hampshire	–	4,036	2.29	2.22	2.36
Kent	–	5,463	2.36	2.30	2.42
Surrey	–	3,720	2.40	2.33	2.48
West Sussex	–	2,772	2.47	2.38	2.56
East Sussex	–	1,685	2.52	2.40	2.64
Windsor and Maidenhead	–	577	2.67	2.46	2.89
Oxfordshire	–	2,512	2.68	2.58	2.78
Isle of Wight	–	472	2.82	2.58	3.09
Reading	–	659	2.99	2.78	3.23
Brighton and Hove	–	964	3.01	2.83	3.20
Portsmouth	–	788	3.04	2.83	3.25
Medway	–	1,482	3.25	3.09	3.41
Southampton	–	1,226	3.88	3.67	4.10

Source: Department for Education special educational needs statistics https://www.gov.uk/government/statistics/special-educational-needs-in-england-january-2018

In Surrey an estimated 2.4% (n- 3,720) school pupils of school age have social, emotional, mental health needs. This is similar to England (2.39%) and South East (2.42%).

Chart 2: Percentage of school pupils with social and mental health needs (Primary school age)

School pupils with social, emotional and mental health needs: % of school pupils with social, emotional and mental health needs (Primary school age)

2018 — Proportion - %

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Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	103,326	2.19	2.18	2.20
South East region	–	16,094	2.20	2.17	2.24
Bracknell Forest	–	167	1.55	1.33	1.80
Wokingham	–	250	1.63	1.44	1.85
Buckinghamshire	–	751	1.64	1.53	1.76
Slough	–	317	1.77	1.59	1.97
Milton Keynes	–	491	1.79	1.64	1.95
West Berkshire	–	259	1.87	1.66	2.11
Hampshire	–	2,161	2.05	1.96	2.13
Kent	–	2,715	2.14	2.06	2.22
Windsor and Maidenhead	–	234	2.20	1.93	2.49
Surrey	–	2,056	2.22	2.12	2.31
West Sussex	–	1,440	2.22	2.11	2.34
East Sussex	–	932	2.36	2.22	2.52
Reading	–	338	2.37	2.13	2.63
Oxfordshire	–	1,348	2.48	2.35	2.62
Brighton and Hove	–	483	2.50	2.29	2.73
Portsmouth	–	426	2.58	2.35	2.83
Isle of Wight	–	243	2.63	2.32	2.98
Medway	–	757	2.93	2.73	3.14
Southampton	–	726	3.53	3.29	3.79

Source: Department for Education special educational needs statistics https://www.gov.uk/government/statistics/special-educational-needs-in-england-january-2018

in Surrey an estimated 2.22% (n- 2,056) school pupils of primary school age have social, emotional, mental health needs. This is slightly higher than England (2.19%) and similar to the South East (2.20%).I

Chart 3: Percentage of school pupils with social and mental health needs (Secondary school age)

School pupils with social, emotional and mental health needs: % of school pupils with social, emotional and mental health needs (Secondary school age)

2018 — Proportion - %

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Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	75,431	2.31	2.30	2.33
South East region	–	75,431	2.31	2.30	2.33
Buckinghamshire	–	514	1.38	1.26	1.50
Wokingham	–	168	1.57	1.35	1.82
West Berkshire	–	178	1.58	1.36	1.83
Slough	–	215	1.78	1.56	2.03
Milton Keynes	–	346	1.86	1.68	2.07
East Sussex	–	548	2.08	1.91	2.26
Hampshire	–	1,433	2.12	2.02	2.23
Kent	–	2,163	2.15	2.06	2.24
Surrey	–	1,419	2.38	2.26	2.51
West Sussex	–	1,130	2.47	2.33	2.62
Bracknell Forest	–	173	2.49	2.15	2.88
Oxfordshire	–	965	2.52	2.37	2.68
Portsmouth	–	253	2.85	2.52	3.22
Isle of Wight	–	220	3.07	2.70	3.50
Windsor and Maidenhead	–	330	3.12	2.81	3.47
Reading	–	236	3.16	2.78	3.58
Brighton and Hove	–	418	3.42	3.11	3.76
Medway	–	669	3.52	3.27	3.79
Southampton	–	419	4.01	3.65	4.41

Source: Department for Education special educational needs statistics https://www.gov.uk/government/statistics/special-educational-needs-in-england-january-2018

In Surrey an estimated 2.38% (n- 1,419) school pupils of secondary school age have social, emotional, mental health needs. This is slightly higher than England (2.38%) and the South East (2.31%).

Chart 4: Estimated number of children and young with mental disorders- aged 5- 17yrs.

Estimated number of children and young people with mental disorders – aged 5 to 17 New data 2017/18 Count - Count

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Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	-	-	-	-
South East region	–	-	-	-	-
Isle of Wight	–	-	2,285	2,145	2,442
Bracknell Forest	–	-	2,500	2,348	2,673
Reading	–	-	2,989	2,804	3,197
Windsor and Maidenhead	–	-	3,134	2,941	3,351
West Berkshire	–	-	3,272	3,073	3,498
Slough	–	-	3,484	3,268	3,728
Wokingham	–	-	3,487	3,273	3,729
Portsmouth	–	-	3,748	3,518	4,008
Southampton	–	-	4,107	3,854	4,393
Brighton and Hove	–	-	4,496	4,220	4,807
Medway	–	-	5,522	5,183	5,903
Milton Keynes	–	-	5,786	5,428	6,189
East Sussex	–	-	9,635	9,045	10,301
Buckinghamshire	–	-	11,023	10,348	11,786
Oxfordshire	–	-	12,632	11,858	13,506
West Sussex	–	-	15,343	14,403	16,405
Surrey	–	-	23,037	21,625	24,631
Hampshire	–	-	25,320	23,771	27,071
Kent	–	-	29,879	28,050	31,946

Source: NHS Digital

In Surrey it is estimated that 23,037 children and young aged 5- 17yrs have a mental disorder. This data cannot be compared to other areas as it is based on numbers and not % or by a rate per population

Table 1: Hospital admissions for Surrey.

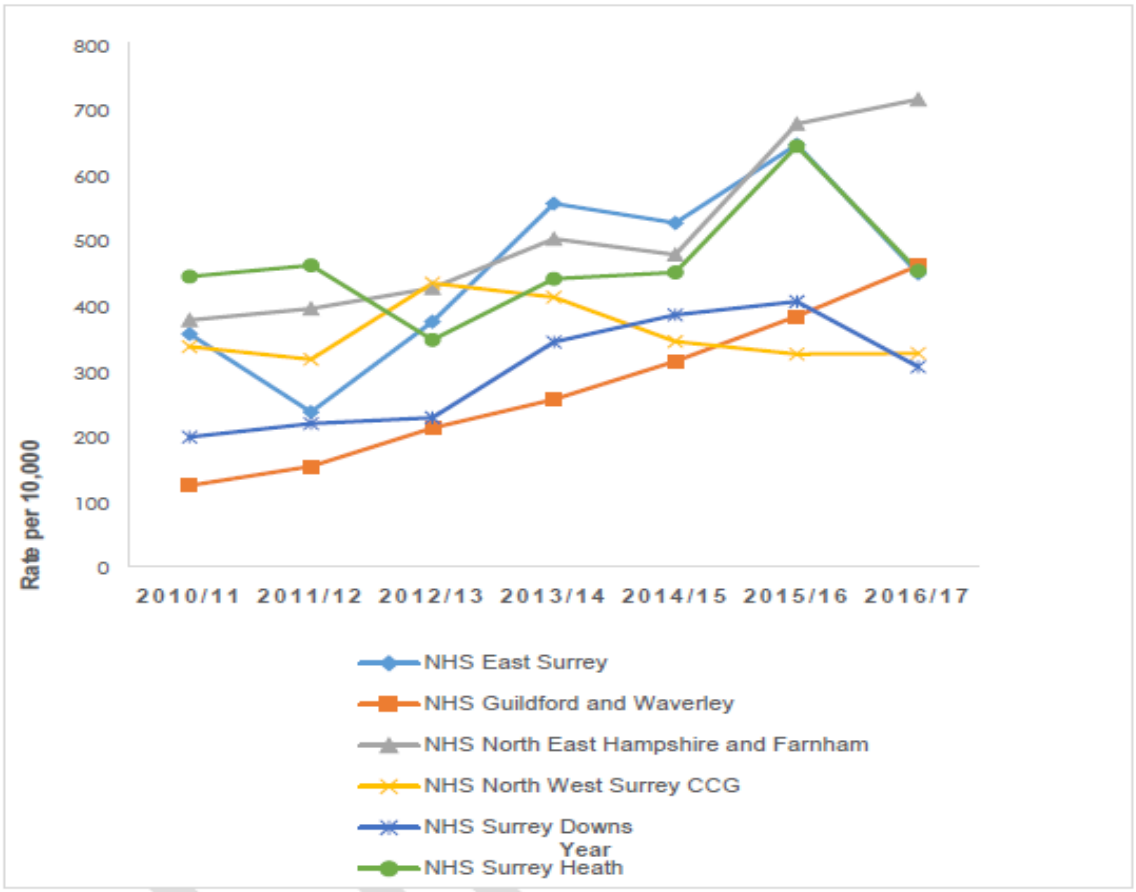
Indicator	Period	Surrey			Region	England	England		
		Recent Trend	Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-14 years)	2018/19	↓	1,760	79.6	87.6*	96.1	184.9		45.1
Hospital admissions caused by unintentional and deliberate injuries in young people (aged 15-24 years)	2018/19	→	1,825	138.3	142.4*	136.9	276.7		56.0
Hospital admissions for asthma (under 19 years) New data	2018/19	→	345	125.1	132.6*	178.4	485.9		50.3
Hospital admissions for mental health conditions New data	2018/19	→	225	85.9	88.9*	88.3	193.9		22.9
Hospital admissions as a result of self-harm (10-24 years) New data	2018/19	–	870	427.0	470.2*	444.0	1,072.7		91.1

1% of suicides in Surrey are among those who are under 25. Suicide in children and young people has a significant emotional and mental impact on other young people, families and the local community.

In Surrey, whilst we have access to data on self-harm resulting in a hospital attendance, not every incident of self-harm will require hospital treatment.

The rates of hospital admissions for self-harm per 10,000 population of 10-24 year olds in Surrey has increased over the last seven years. Data for 2018-19 showed that Surrey had a rate of 427.0 of the directly standardised rate per 100,000; compared to the national rate of 444.0 and the regional rate of 470.2

Figure 2: Hospital admissions as a result of self-harm in 10-24-year-olds 2010 – 2017 by CCG



Source: (PHE Fingertips, 2018)

The increase in rates in those aged 10-17 years may reflect a genuine increase in self-harm rates, increased awareness and help-seeking combined with reduced stigma and/or improved management of self-harm in young people in line with NICE guidance (2004) which advises all children or young people who have self-harmed should normally be admitted overnight to a paediatric ward and assessed fully the following day by the Child and Adolescent Mental Health Team before discharge or further treatment and care is initiated. There is evidence from the Adult Psychiatric Morbidity Survey 2014[4] that rates of self-harm have increased in the community, particularly in 16-24 year old females, with one in nine (11.7%) reporting having ever self-harmed in 2007 and one in five (19.7%) in 2014.

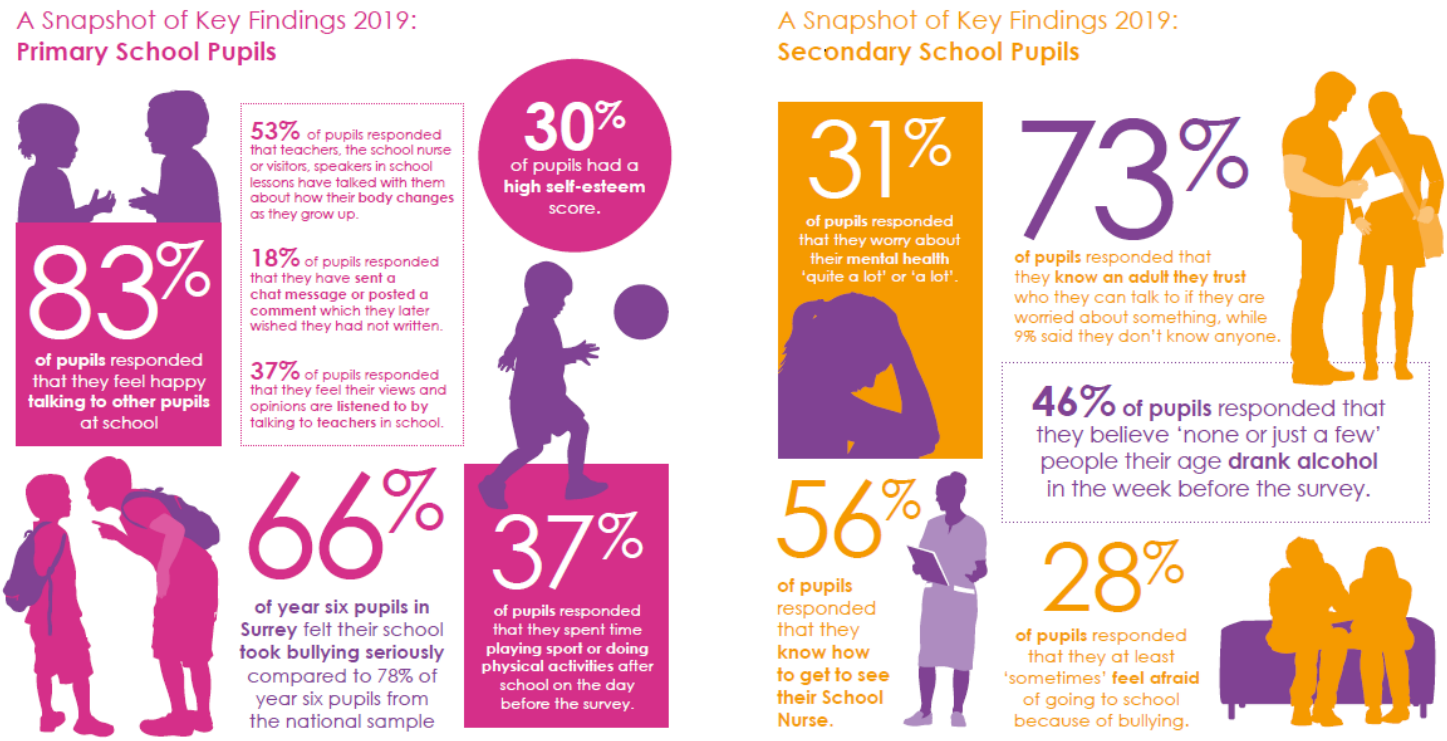
According to ONS data for 2018, despite having a low number of deaths overall, rates of deaths by suicide among the under 25s have generally increased in recent years, particularly 10 to 24-year-old females where the rate has increased significantly since 2012 to its highest level with 3.3 deaths per 100,000 females in 2018.[5]

[4] McManus, S., et al., Mental health and wellbeing in England: Adult Psychiatric Morbidity Survey 2014. 2016, NHS Digital: Leeds

[5] https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/2018registrations

Health Related Behaviour Questionnaire (HRBQ) Data for Surrey. To gain insight into the health of children and young people in Surrey, Schools are able to take part in the Health-Related Behaviour Questionnaire which is carried out by the Schools and Student Health Education Unit (SHEU). This survey produces a detailed and anonymised profile of young people's lives at home, at school, and with their friends. This information is then used by services across the Local Authority to inform health needs assessment and health care planning, and by schools and educational establishments to promote needs-based practice, across the formal and informal curriculum. Below is a snapshot of key findings from the 2019 survey.

Figure 3: Snapshot of findings from Health-Related Behaviour Questionnaire (HRBQ) Data for Surrey.



2.3 Current Policy context and suicide prevention strategy

The Surrey Suicide Prevention Partnership is a multi-agency collaboration between Health, local government, people with lived experience and the voluntary sector. Their published Suicide Prevention Strategy 2019-2021 sets out their approach to reducing suicide in Surrey, based on national and local intelligence/evidence. It also reflects the national suicide prevention strategy ambition and key action areas.

The national suicide prevention strategy for England sets out key areas of evidence-based action for local areas (HM Government, 2012). Through the NHS Five Year Forward View for Mental Health, the Government renewed their commitment to **reducing suicide nationally by 10% by 2020** (NHS England, 2017). In January 2018, the Secretary of State announced a zero-suicide ambition for mental health inpatients.

In January 2019, the first Cross-Government Suicide Prevention Work plan (HM Government, 2019) was published with a focus on social media, self-harm and how technology such as predictive analytics can identify those most at risk.

A reduction in the death rate from suicide is a priority of Surrey's Joint Health and Wellbeing Strategy, signalling the commitment of partners across the NHS and Local Government to work together to save lives lost to suicide, through both whole population and targeted actions. The Surrey Strategy will harness that commitment to achieve the following aim: **To reduce suicide by 10% by 2021 through the coordinated actions of organisations**. This strategy will sit alongside the Emotional Wellbeing Mental Health Strategy for Children and Young People in Surrey 2019-22.

"Our ethos in Surrey is that every single suicide is a tragedy and is one too many. Our ultimate aspiration is, therefore, to eliminate suicide. We recognise the complexity of the factors that lead to someone taking their own life and although we may not be able to prevent every suicide, **we will make zero suicides in Surrey our ambition**. We believe this will facilitate a transformation of attitudes toward suicide locally, making it clear that suicide is not inevitable and that our organisations are jointly committed to the prevention of suicide locally." (Surrey Suicide Prevention Strategy 2019-2021)[6]

2.4 Adverse Childhood Experiences (ACEs)

A report by Young Minds highlights that 1 in 3 adult mental health conditions is related to adverse childhood experiences (Young Minds, 2016). These experiences include neglect, abuse, poverty, parental alcohol or substance misuse, parental poor physical or mental health, and parental suicide. Adverse childhood experiences increase the risk of suicide (Devaney, Northern Ireland).

3. Methods

3.1 Case definition

Children and young people's deaths for this review were defined as probable suicides (intentional self-harm and events of undetermined intent) aged 10 to 17 years normally resident in Surrey, between 1 April 2014 and 31 March 2020.

3.2 Data sources

Information on the children and young people was obtained from the Child Death Overview Panel database.

3.3 Research evidence review

A series of evidence searches were undertaken to review the literature around suicide in children and young people, with reference to issues identified by the Child Death

[6] https://mycouncil.surreycc.gov.uk/documents/s55064/Surrey%20Suicide%20Prevention%20Strategy%202019-2021%20-%20Final.pdf

Review Partnership, who supported the thematic review. In particular, the evidence review sought to identify:

- Evidence of the risk factors for suicide in children and young people.
- Evidence of effective interventions to support the prevention of suicide in children and young people.

Following a series of scoping searches, a thorough review of the evidence was undertaken with a focus on high level evidence sources including NICE Guidelines, the Cochrane Database of Systematic Reviews and point of care tools (BMJ Best Practice, UpToDate and Clinical Key). This was followed by searching original research (primarily PsycINFO via Healthcare Databases Advanced Search, HDAS and the PsycARTICLES database).

Search results from HDAS were filtered based on their title and abstract. Articles that included results of systematic reviews, RCTs and larger studies were given more prominence.

Limits were applied and the search results were limited to studies of children (6-12 years) and adolescents (aged 13-17 years). The results were also limited to include English language articles only and research and reviews from the last 10 years.

Following the filtering process the search results were reviewed, prioritised and collated into themes. In total NICE Guidelines, Systematic reviews and original research articles where collated thematically.

The London, Kent, Surrey and Sussex Regional Searching Guidance (Jan 2020)[7] document informed the search process and approach taken, the search process although very thorough, cannot be described as fully comprehensive due to the limited timescale available.

3.4 Thematic review group

A thematic review group was convened. Members were drawn from academia, safeguarding, public health, child death review team, education and specialist mental health services.

4 Findings

4.1 Children and young people included in this review

Between 1st April 2014 and 31st March 2020, 12 children and young people met the case definition for the thematic review of probable suicide. This represents a 100% increase since the previous 6 year reporting period (1st April 2009 - 31st March 2014). 9 of the children and young people were male (75%) and 3 female (25%). 5 (42%) were aged 10-14 years. The youngest was fourteen years old.

[7] The London, Kent, Surrey and Sussex Regional Searching Guidance (Jan 2020) Regional Searching Protocol Working Group.

Between 1st April 2014 and 31st March 2020, 12 children and young people met the case definition for the thematic review of probable suicide. This represents a 100% increase since the previous 6 year reporting period (1st April 2009 - 31st March 2014). 9 of the children and young people were male (75%) and 3 female (25%). 5 (42%) were aged 10-14 years. The youngest was fourteen years old.

4.2 Summary of children and young people

Figure 4: Percentage analysis of themes of young people in the review

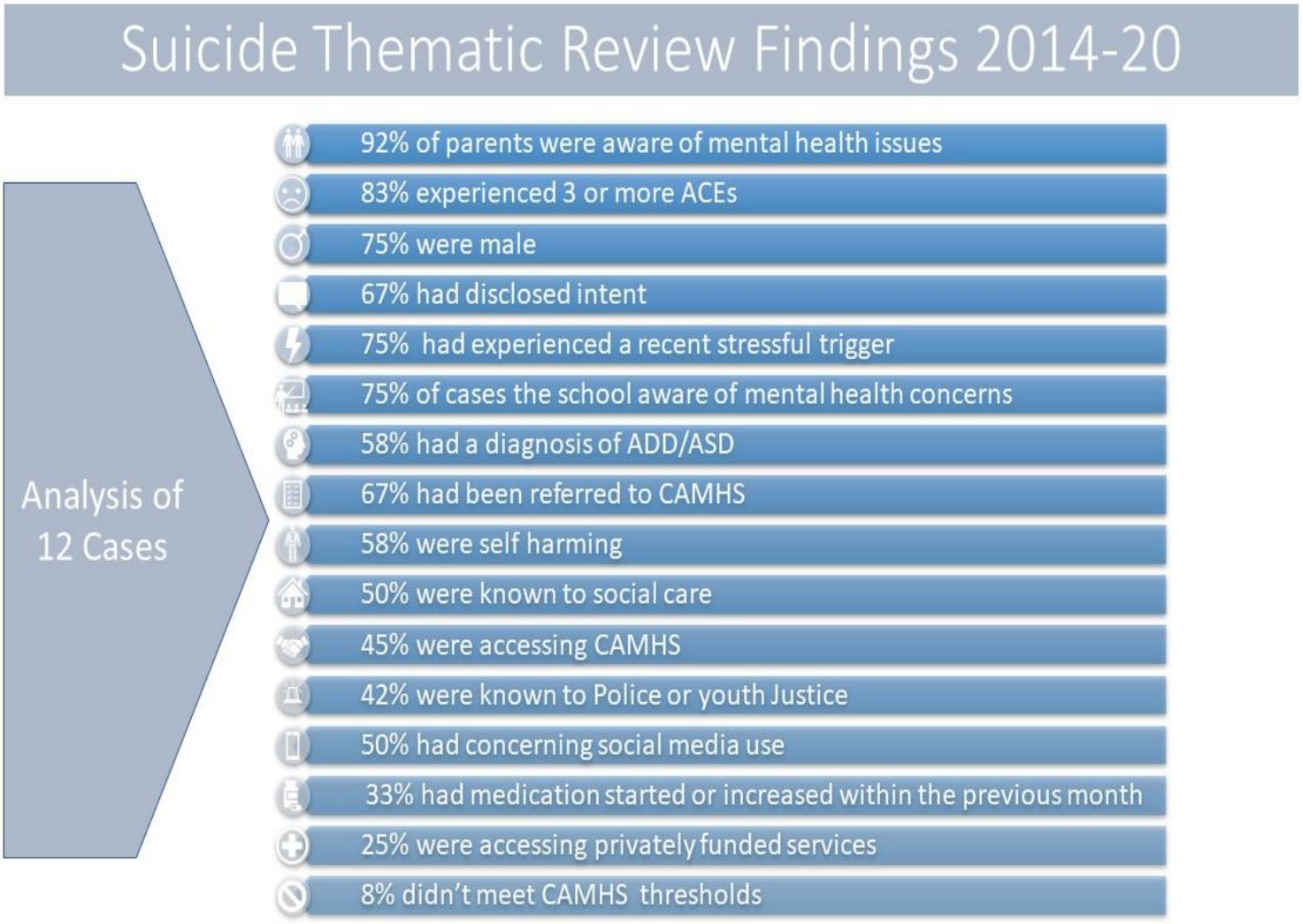


Chart 5: Age and number of children included in the review

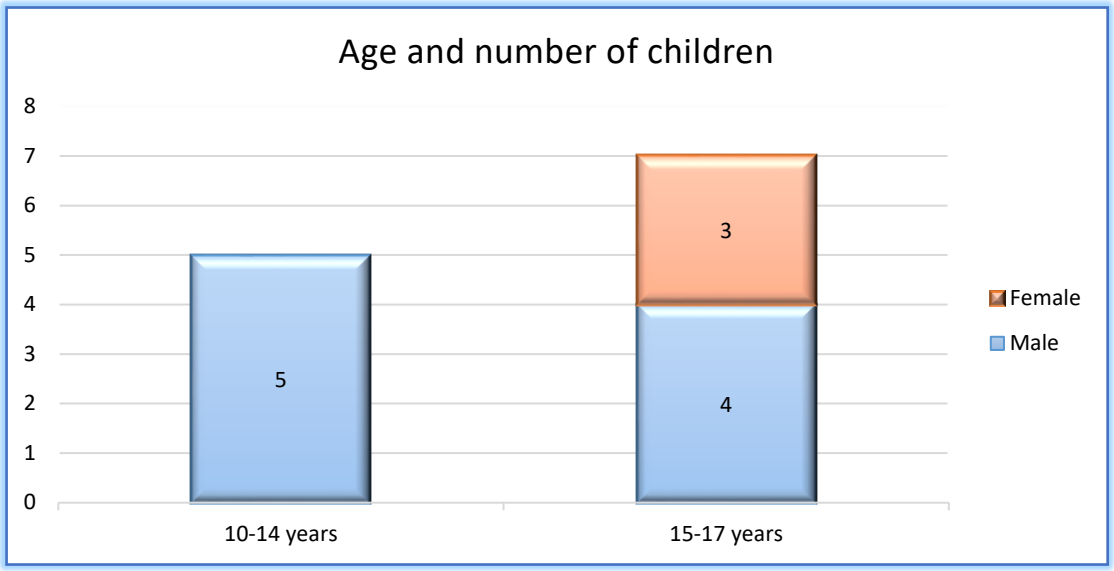
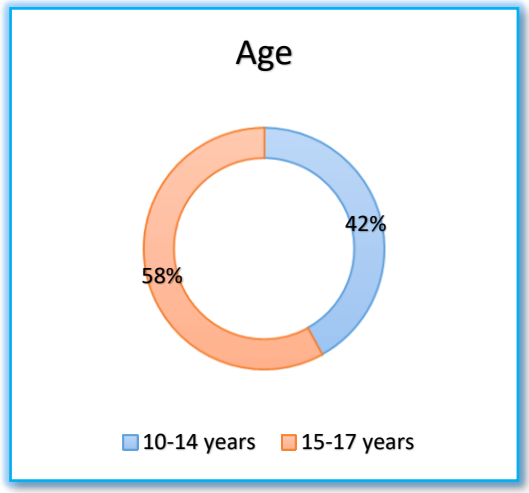


Chart 6 and 7 : Percentage age and gender of children involved in the review



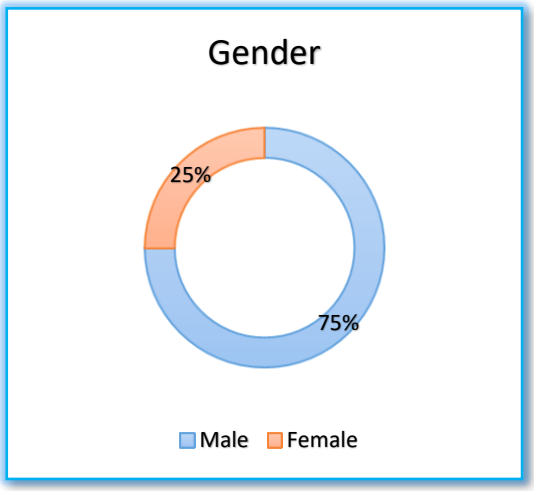


Chart 8: Percentage of children in the review by school year

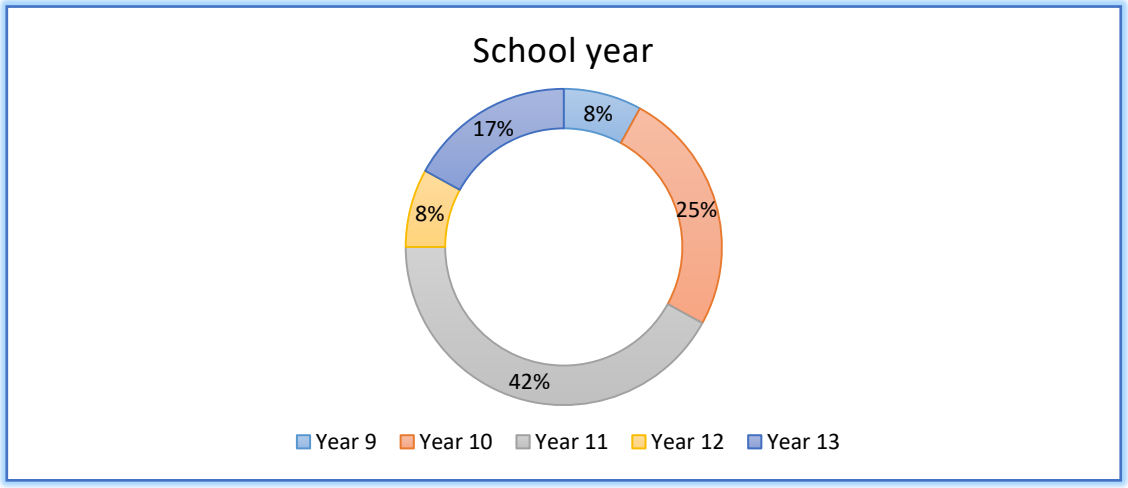


Chart 9: Percentage of children disclosing intent of suicide

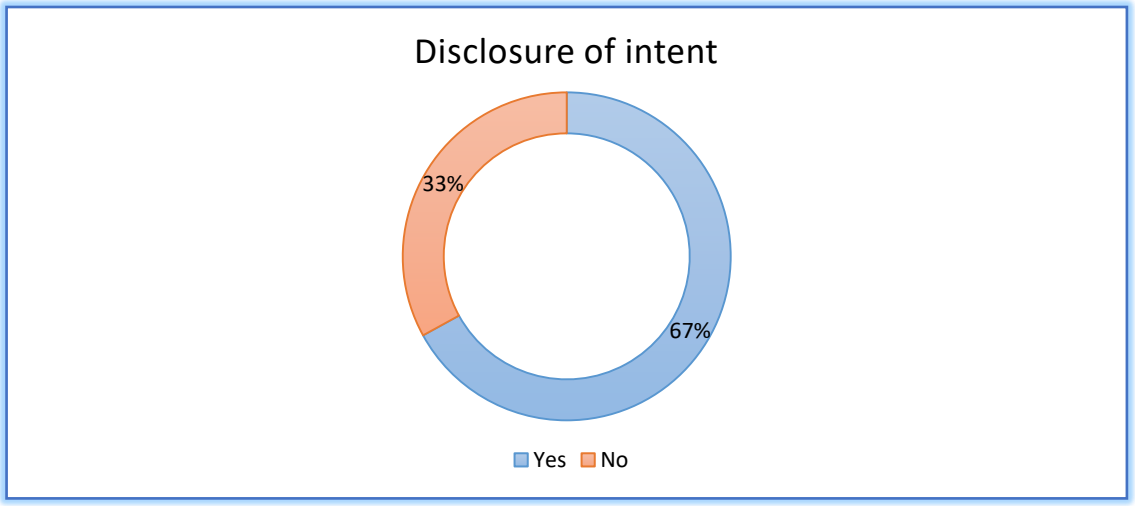


Chart 10: Percentage of previous reports of recorded self-harm incidents

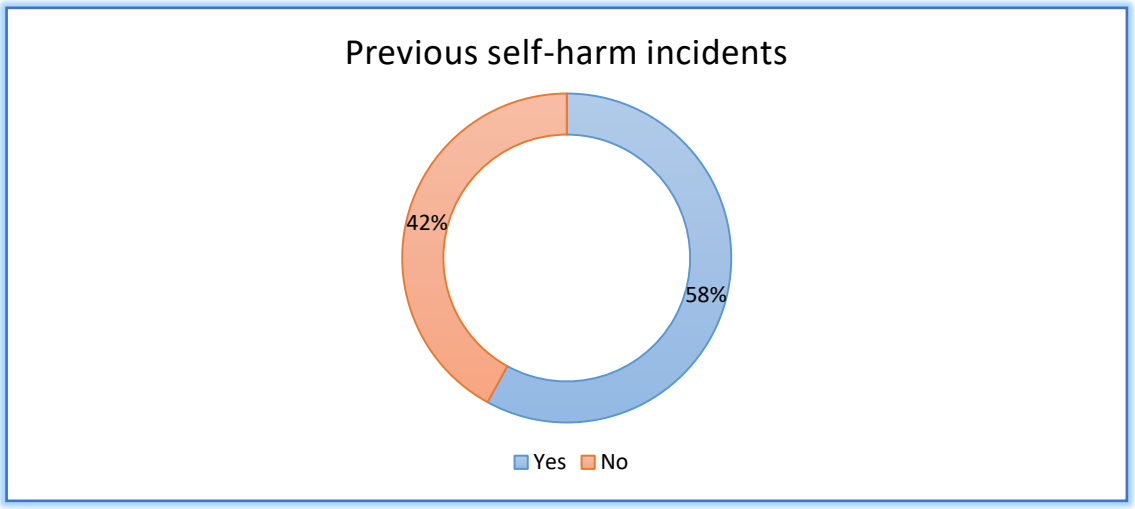


Chart 11: Percentage of children in the review with neuro-development concerns

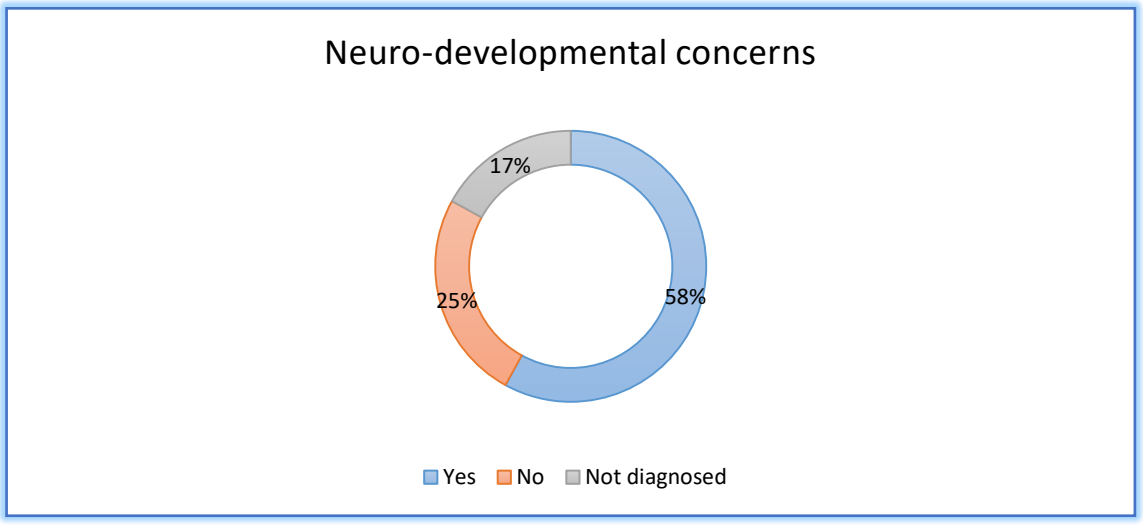
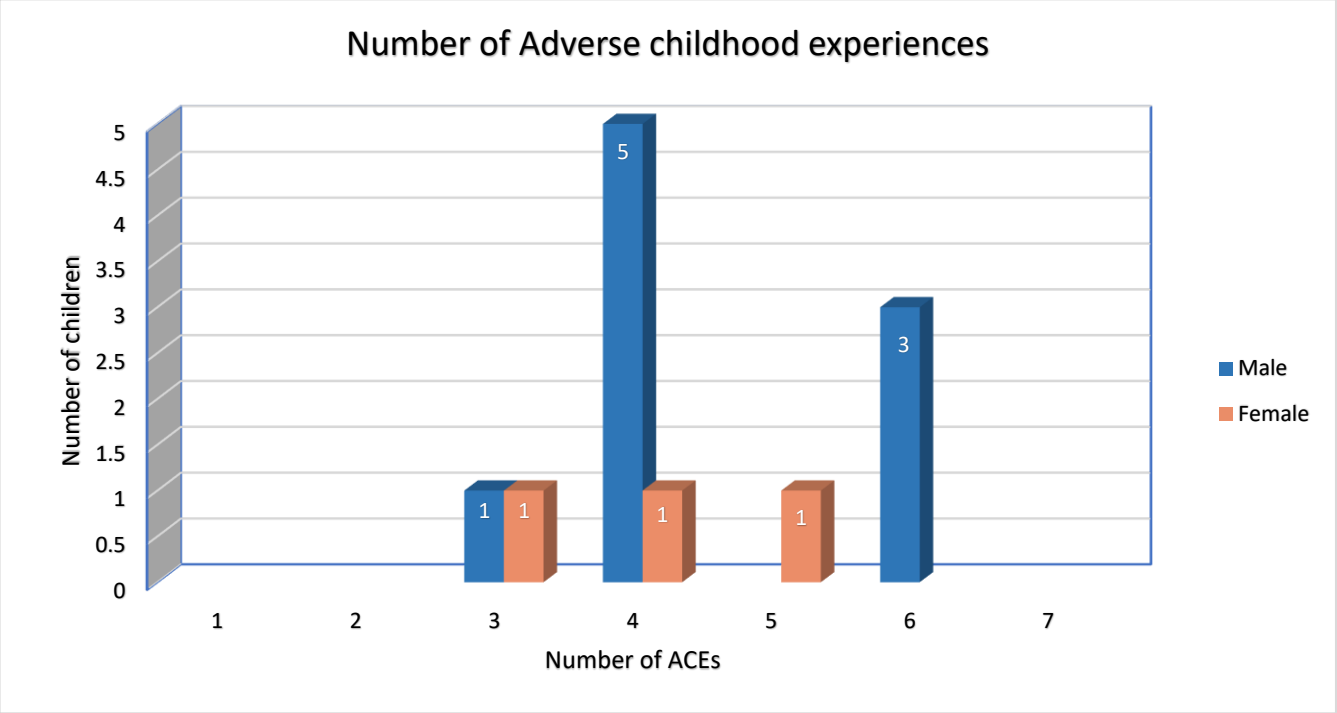


Chart 12: Number of ACEs experienced by children included in the review by gender.



5 Strengths and limitations

A major strength of this report was the multiagency involvement and joint working through the thematic review group. In addition to this, the involvement of the Surrey Child Death Review (CDR) Team and the information held by the Surrey Child Death Overview Panel (CDOP) allowed for an in-depth study of the common themes. In July 2018, a revised version of Working Together to Safeguard Children was published and an additional document for the child death review process entitled "Child Death Review Statutory and Operational Guidance" was published in October 2018. These two statutory documents lay out in detail the processes that must be followed when a child dies. The statutory guidance states that families should be involved in child death review processes and that parents should be assured that any information concerning their child's death which they believe might inform the meeting would be welcome. The high engagement of families in the CDR process in Surrey meant that the review had access to in-depth information including valuable parental input.

Whilst every death from suicide is a tragedy, the small numbers for this review mean that it will not be possible to have statistically robust data on the themes identified. Although we do know that a number of the themes are backed up with supporting published evidence and mirror the national picture.

6. Issues identified in this review

Figure 5: Issues identified in this review:

6.1 Adverse Childhood Experiences (ACEs)

83% of the children in the review had experienced 4 or more ACEs. Dr Vincent Felitti, head of Kaiser Permanente's Department of Preventative Medicine, and Dr Robert Anda, an epidemiologist from the CDC, surveyed over 17,000 patients for their experiences of childhood trauma.[8] Participants were asked about different types of childhood trauma which they referred to as ACEs. Key findings showed that:

- 60% of participants had experienced at least one ACE and 1 in 8 had experienced 4 or more ACEs.
- The higher the ACEs score, the higher the likelihood of developing long-term health problems like heart disease, stroke, cancer and Type 2 diabetes (a dose-dependence relationship).

[8] Felitti, M. D., Anda, R. F., Nordenberg, M. D. et al (1998) 'Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study' *American Journal of Preventative Medicine.* 14.

Figure 6: Breakdown of adverse childhood experiences[9]

Wan et al 2019[10], in their study on associations of adverse childhood experiences (ACEs) and social support with self-injurious behaviour and suicidality in adolescents found that there is little investigation on the interaction effects of ACEs and social support on non-suicidal self-injury (NSSI), suicidal ideation and suicide attempt in community adolescent populations, or gender differences in these effects. A school-based health survey was conducted in three provinces in China between 2013 –2014. A total of 14,820 students aged 10–20 years completed standard questionnaires, to record details of ACEs, social support, NSSI, suicidal ideation and suicide attempt. Wan et al concluded that ACEs and low social support are associated with increased risk of NSSI and suicidality in Chinese adolescents. Strategies to improve social support, particularly among female adolescents with a high number of ACEs, should be an integral component of targeted mental health interventions.

Mind in their report in 2016 '*Beyond Adversity: Addressing the mental health needs of young people who face complexity and adversity in their lives.*'[11] recommended fast-track children for mental health support when they need it, even if they don't meet the usual thresholds for those services, improve training for doctors, teachers, social workers, police officers and charities as well as establishing an expert group to improve understanding of adverse experiences in childhood and provide consistent treatment across the country.

It is important that adverse childhood experiences are not seen in a fatalistic or deterministic way; for example, some children and young people who have had adverse childhood experiences go on to thrive and have positive outcomes despite the trauma and abuse they have experienced. It is essential that practitioners and managers consider childhood adversity and ensure that support and resilience building is part of their work with children and families.

[9] https://www.connectedforlife.co.uk/blog/2017/6/17/the-adverse-childhood-experiences-ace-study

[10] Wan Y, Chen R, Ma S, et al. Associations of adverse childhood experiences and social support with self-injurious behaviour and suicidality in adolescents. *Br J Psychiatry*. 2019;2014(3):146–152. doi:10.1192/bjp.2018.263

[11] https://youngminds.org.uk/media/1241/report_-_beyond_adversity.pdf

6.2 Autistic Spectrum Disorder

58% of the children in the review had a diagnosis of ASD/ ADD. These cases highlighted the importance of understanding the risk of self -harm and suicide in this group of young people. There can be the additional issues of fixation and rigidity of thought processes causing unpredictable and sudden self - harming behaviours.

When carrying out mental health risk assessments in this patient group, the increased vulnerability of this patient group needs to be taken into consideration. Raising awareness that ASD is a known risk factor for suicide would support and assist assessments with the Single Point of Access (SPA).

Mayers et al (2013) explored suicide ideation and attempts in children with Autism.[12] As part of the study, 791 children with autism (1–16 years), 35 non-autistic depressed children, and 186 typical children and risk factors in autism were determined. Percentage of children with autism for whom suicide ideation or attempts was rated as sometimes to very often a problem by mothers (14%) was 28 times greater than that for typical children (0.5%) but less than for depressed children (43%). For children with autism, four demographic variables (age 10 or older, Black or Hispanic, lower SES, and male) were significant risk factors of suicide ideation or attempts. The majority of children (71%) who had all four demographic risk factors had ideation or attempts. Comorbid psychological problems most highly predictive of ideation or attempts were depression, behaviour problems, and being bullied. Almost half of children with these problems had suicide ideation or attempts. Mayers recommended that all children with autism should be screened for suicide ideation or attempts because ideation and attempts in autism are significantly higher than the norm and are present across the spectrum. They stated that this is especially important for children who have the demographic and comorbid risk factors, many of which can be targeted for intervention to reduce and prevent suicide ideation and attempts.

6.3 Medication

33% of the young people had their medication changed or increased in the four weeks prior to their death. All depression medications and specifically selective serotonin reuptake inhibitors (SSRIs) carry a risk of increased suicide in children and young people. The risk is higher during the first month of starting antidepressants and particularly between 1-9 days (Jick et al., 2004). However, research evidence shows that antidepressants are negatively associated with suicide rates. Potential links between antidepressant use and suicide attempt require further investigation to understand the underlying mechanisms of this relationship (Valuck et al., 2012).

Miller et al (2014)[13] looked at antidepressant dose, age, and the risk of deliberate self-harm and concluded that children and young adults initiating therapy with antidepressants at high-therapeutic (rather than modal-therapeutic) doses seem to be at heightened risk of deliberate self-harm. Gibbons at al (2011)[14] examined strategies for quantifying the relationship between

[12] Suicide ideation and attempts in children with Autism. Mayes, Susan Dickerson; Gorman, Angela A.; Hillwig-Garcia, Jolene; Syed, Ehsan Research in Autism Spectrum Disorders; 2013; vol. 7 (no. 1); p. 109-119

[13] Miller M, Swanson SA, Azrael D, Pate V, Stürmer T. Antidepressant dose, age, and the risk of deliberate self-harm. *JAMA Intern Med*. 2014;174(6):899–909. doi:10.1001/jamainternmed.2014.1053

[14] Gibbons RD, Mann JJ. Strategies for quantifying the relationship between medications and suicidal behaviour: what has been learned?. Drug Saf. 2011;34(5):375–395. doi:10.2165/11589350-000000000-00000

medications and suicidal behaviour. They concluded that in children, the results are less clear and further study is required to better delineate which children benefit from treatment and who may be at increased risk as a consequence of treatment.

6.4 Gender

75% of the young people in the review were male. This is in line with the results of the Manchester Suicide in Children and Young People study[15] where they found that the number of male suicides was higher than females, especially in the late teens and early 20s, with a male to female ratio of 2.6:1 in those aged 15-19, and 3.7:1 in those aged 20 and over.

6.5 Substance misuse - drugs and alcohol

25% of the young people in the review had been using drugs or alcohol. According to research, there is a link between risk taking including drug and alcohol use and suicide. Young people using substances such as alcohol and/or drugs are more likely to complete suicide. Studies have shown that personality difficulties are associated with substance misuse (Hawton et al., 1993). Previous research has highlighted that males with substance or alcohol abuse problems are at higher risk for completed suicide (Rowan, 2001). Adolescents with depression or antisocial behaviour and substance abuse are more likely to engage in suicidal behaviour.

The use of substances plays a critical role to suicidal outcomes. Co-existing mental disorders such as depression, ADHD and conduct disorder intensify the relationship between suicide and substance abuse.

6.6 Management of self-harm

58% of the young people were self-harming. Many children and young people who self-harm feel guilty and afraid. There is often a fear of being labelled as attention seeking. The stigma around self-harm stops young people accessing support (Mental Health Foundation, 2012).

6.7 Schools and further education colleges

A number of the young people in the review were finding it hard to access school in a conventional manner.

There was evidence that deaths in school pupils caused considerable distress to the school community and access to bereavement support following a death by probable suicide was important.

6.8 Social care

50% of the young people were known to social care, this is in line with the findings of the Manchester Suicide study where 65% of the young people aged under 20 were known to social care.

[15] http://documents.manchester.ac.uk/display.aspx?DocID=37566

6.9 Multi-disciplinary working within healthcare

A number of the children and young people had sporadic contact across a number of services. This included:

- where the young people attended ED after an episode of self-harm but did not enter any care pathway
- where the young people did not meet the threshold following a CAMHS referral or where the wait time was too long and so they accessed private services
- where the suicide risk of the child or young person was not recognised or documented appropriately by healthcare professionals including CAMHS

As such these opportunities for intervention were missed with little apparent oversight, communication or follow-up of loss of contact.

6.10 Multi-agency partnership working

For a number of children and young people schools sought support from CAMHS on a number of issues and felt that the support offered was not sufficient to support the teaching staff.

6.11 Social media sites and internet use

In 50% of the young people there was a concerning level of social media use identified by parents, along with researching of methods of suicide and self-harm online. In the Manchester study, 26% (74) had used the internet in a way that was related to suicide. 13% (37) searched the internet for information on suicide method and 10 died by a method they were known to have searched on. 4% (11) visited websites that may have encouraged suicide. 10% (29) had communicated suicidal ideas or intent online and 7% (21) had been victims of online bullying—10 in the 3 months prior to death.

Young people below 20 years who died from suicide were more likely to have researched suicide online and to have inappropriate content which may have acted as primer to suicide behaviour. It is suggested that mental health professionals are aware of online behaviours and interactions which play an important role in young people's lives. Online behaviours seem to present with increasing risks that often mental health professionals overlook. 90% of 11 to 16-year olds have a social media account (NSPCC, 2019). Guidelines need to be designed on how key workers should identify these risks and provide support to young people accessing destructive websites and social media platforms online which may exacerbate their current symptoms.

6.12 Media reporting

Some of deaths in these children and young people were widely reported in the media. It is recognised that death by probable suicide in young people is more widely reported than similar deaths in other age groups[16]. Responsible reporting of suicide deaths can minimise any effects on vulnerable individuals and further distress to family and friends[17].

[16] Pirkis, J., et al., Reporting of suicide in the Australian media. Australian and New Zealand Journal of Psychiatry, 2002. 36(2): p. 190-197.

[17] Pirkis, J., et al., Media Guidelines on the Reporting of Suicide. Crisis, 2006. 27(2): p. 82-87.

6.13 Suicide cluster response plans

Published in 2015, the Public Health England document *'Identifying and responding to suicide clusters: A practice resource'*[18] advises that addressing suicide clusters is the responsibility of Multi-agency Suicide Prevention Groups, generally led by local authorities, which should build preparing for clusters into their local suicide
prevention plans. These groups should include relevant organisations that might be affected, including mental health services, schools, colleges and universities**.** This group should work to develop a Suicide Cluster Response Plan. The aim of the plan is to support those affected by suicide and to prevent further suicides. Feedback from organisations facing suicide clusters has shown that a Suicide Cluster Response Plan should be in place before a cluster occurs; lack of such a plan can result in a haphazard response when a cluster is suspected. While use of the term Suicide Cluster Response Plan implies that a cluster has definitely been identified, in reality clusters are more likely to be suspected or there are concerns that one may occur because of the nature or circumstances of a specific suicide or suicides. The plan should be reviewed periodically to ensure it continues to reflect current agencies and partnerships.

Public Health England has a major role in suicide prevention and should usually be informed when local authorities are dealing with a suspected cluster. This should be done via the local Public Health England lead in the first instance. The CDOP should be linked to the Suicide Cluster Response Plan. There should be links between the Multi-agency Suicide Prevention Group and the Surrey Children's Safeguarding Partnership. This review found no evidence of this taking place and no exploration of each death to determine if it was part of a cluster. The response plan is not documented in the Surrey Suicide Prevention Strategy 2019 - 2021.[19] Suicide clusters are of great concern, especially as they predominantly occur in young people and the fact that localities which have had clusters may be at heightened risk of further clusters. In groups particularly vulnerable to imitation (for example those in schools, further education colleges, universities or inpatient psychiatric wards), attention should be paid to possible contagion after even a single suicide. Clusters are not limited to geographical locations and any increase in suicides in young people, based on the PHE document should have triggered a cluster response plan.

6.14 Family engagement

The death of a child, of any age, brings heartbreak and devastation. For any parent to have a child die, whatever the age, whatever the cause is devastating. It seems to break the "normal" rules when a child dies before a parent.

Any bereavement can be immense, but with possible suicide, the grieving process may be more complex, intense and longer, although the actual experiences of grief may be similar to other bereavements.

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[18] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/839621/PHE_Suicide_Cluster_Guide.pdf

[19] https://mycouncil.surreycc.gov.uk/documents/s55064/Surrey%20Suicide%20Prevention%20Strategy%202019-2021%20-%20Final.pdf

After a possible suicide, it can be more difficult or impossible to understand why the child appeared to make that decision. The suddenness and nature of the death can be deeply upsetting or harrowing and hard to make sense of. Also, the sudden nature of the death means there is no opportunity to say goodbye. Some parents/ carers and siblings feel a social taboo in discussing suicide which can make it a difficult topic to talk about openly.

There can be specific challenges for the whole family, and for children and young people when grieving after a possible suicide. Suicide brings particularly strong feelings which are often conflicting, including shock, anger, despair, guilt, shame, blame, relief, betrayal, isolation, confusion, exhaustion and low self-esteem. There may be a desperate 'need to know' in addition to all the other grief responses to sudden death. Thinking can become circular, endlessly trying to find answers to 'why?' and 'what if?' questions, searching to make sense of what has happened in a way that feels bearable. The loss of 'what might have been?' has an even more powerful impact when a death is by possible suicide because of the child's apparent decision to die. The greatest longing can be to go back and put right the terrible wrong of their death, to replay events and have a different ending. Questions can seem unanswerable.

Being given the opportunity to talk about your grief is an important part of getting through a bereavement. Surrey CDR Team proactively contact all families via the named nurse/child death review nurse to offer them bereavement support, the opportunity to contribute to the CDR process and allow their voice and the voice of their child to be heard.

Themes identified from parents and carers during this thematic review included:

Communication between CAMHS and parents of children accessing support

- *When their child was undergoing CBT counselling, parents report they were not told clearly or directly that their child continued to disclose suicidal thoughts during the sessions and as a result they were not aware of the seriousness of the risk for their child or the length of time that the child had been experiencing these thoughts. Words used by CAMHS professional were 'low mood' rather than 'suicide'.*
- *Despite lots of input from CAMHS, parents felt very isolated and alone. Parents report poor communication between CAMHS and themselves.*
- *Parents felt they were kept on the periphery and were not aware of where and what the plan of care/crisis plan for their child was.*
- *Parents were unaware of who was the person in charge/key worker of their child's care. Who had oversight of all the support their child was receiving? What monitoring was going on to assess if child was progressing/deteriorating?*

Wait time to access support from CAHMS

- *Parents felt there are not enough resources in the NHS to cope with mental health problems in adolescents and children. Two families experienced a 6 month waiting list for CAMHS so accessed private support.*
- *Parents felt the time from initial referral to CAMHS to receiving a diagnosis was a prolonged period of time.*

Cancellation of CAMHS appointments

- *When appointments were cancelled due to exams timetable, parents felt that had they been aware and well informed of the risk for their child, they could have and would have actively requested another appointment as soon as possible.*

Multi-agency support

- *Parents felt that all professionals did their bit but would argue this was not done in a co-ordinated way.*
- *One family felt Education were not helpful in supporting their child/family with the behavioural difficulties presenting alongside mental health concerns.*
- *Social care did not offer further support to one family despite the child frequently going missing.*
- *Parents report support from Police was fantastic over the course of their child's mental illness. Police were the only service the parents could guarantee would respond when he called.*

Parental awareness of mental health and when to assess support

- *Parents would like all parents to know that they should not delay in seeking treatment for mental health concerns in their children.*
- *Parents felt that there should have been clearer warnings that suicide risks are increased when people start to improve and respond to treatment.*
- *Parents were not made aware of the increased risk of suicide if a child had ASD.*

Impact on parents/families when supporting a child with suicidal thoughts

- *Parents felt totally exhausted, overwhelmed at times and were desperate for help. Parents report they did not have the skills of a mental health worker and wanted practical help on how to best manage and help their child as they had exhausted all avenues and genuinely did not know what else to do.*
- *Parents felt Social Care were not helpful when they were approached for help during the breakdown in relationship between their child and themselves.*

Some of these issues are similar to those raised by parents nationally. In 2019, Jones et al[20] concluded that the high prevalence of parental unawareness and adolescent denial of suicidal thoughts found in their study suggests that many adolescents at risk for suicide may go undetected. These findings have important clinical implications for paediatric settings, including

[20] Jones JD, Boyd RC, Calkins ME, et al. Parent-Adolescent Agreement About Adolescents' Suicidal Thoughts. *Paediatrics*. 2019;143(2):e20181771. doi:10.1542/peds.2018-1771

the need for a multi-informant approach to suicide screening and a personalized approach to assessment based on empirically derived risk factors for unawareness and denial.

Bereavement, grief and loss can cause many different symptoms and they affect parents/carers and siblings in different ways. Any death may be difficult to understand or make sense of, especially when it is sudden or unexpected. A death by possible suicide is likely to be even more difficult for families to face and to understand. There is no right or wrong way to feel. Bereavement can influence every aspect of well-being, from physical and mental health to feelings of connectedness and the ability to function at work or school. Learning to live with the loss of someone close is one of the most painful experiences we can encounter. Society's response often makes it even harder. All too frequently, people report feeling isolated and being expected to 'get on with it' after a bereavement, even when they had been very close to the person who died or when their death has been unexpected.

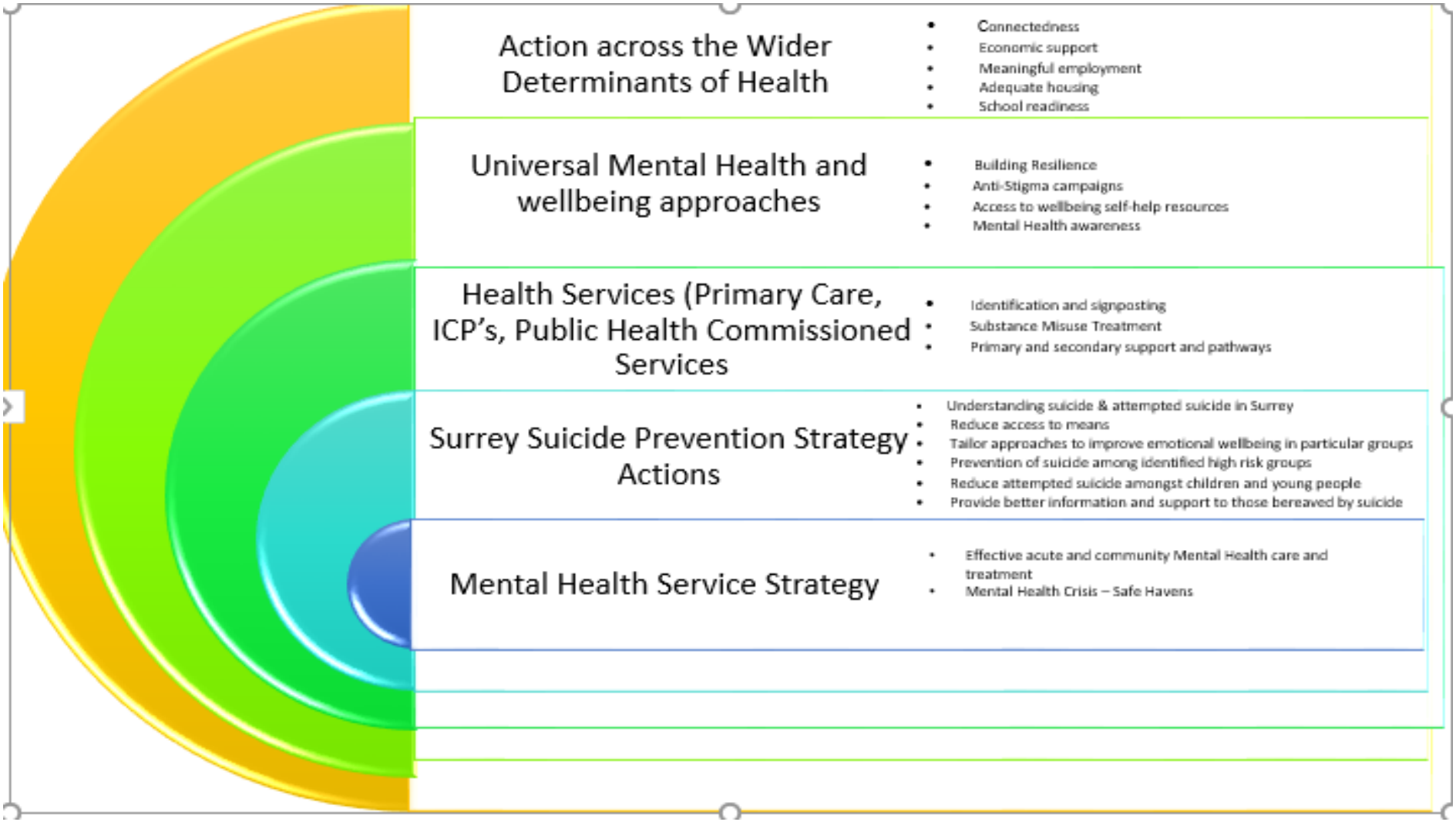
The costs of bereavement are too great to ignore, both for individuals and society. Bereavement increases the risk of mortality and poor health. Providing support to bereaved parents, siblings and families can bring great benefits to individuals and to society as a whole. We also know from evidence that if you have experienced suicide by a close friend or family member that increases your own risk of suicide. Results from Hooven et al (2012) in their study 'Promoting CARE: Including parents in youth suicide prevention' revealed that the youth intervention and combined youth and parent intervention produced significantly greater reductions in suicide risk factors and increases in protective factors than IAU comparison group.[21]

[21] Hooven C, Walsh E, Pike KC, Herting JR. Promoting CARE: including parents in youth suicide prevention. Fam Community Health. 2012;35(3):225–235. doi:10.1097/FCH.0b013e318250bcf9

7 Opportunities for prevention

7.1 Existing activities which contribute to the prevention of suicide

Figure 7: A comprehensive approach to Suicide Prevention in Surrey



Various authors including the World Health Organisation 2018[22] have asserted that suicide is a global public health concern and The Institute for Mental Health indicated that the UK has recently seen a marked increase in rates of suicide and self -harm amongst young people. A recent published Lancet (2018) also asserted that suicide is the second-leading cause of death among young people and rates appear to be increasing.

A systemic review and meta-analysis in EClinical Medicine published in the Lancet (2018)[23] noted that, according to international best practice, most strategies recommend a comprehensive approach to suicide prevention covering universal approaches such as delivering awareness to groups or communities believed to be at higher risk of suicide; delivering to individuals displaying suicide-related behaviours and interventions ranging across settings to include clinical, educational, workplace and community settings and more recently the advocating of interventions to be delivered in digital as well as face to face settings.

Various authors have also asserted that suicides by people aged under 25 highlighted the importance of recognising the pattern of cumulative risk and 'final straw' stresses such as exams that contribute to suicide in children and young people.

British Transport Police were consulted as part of the thematic review and are undertaking ongoing work in reducing access to railways and preventing suicides. British Transport Police are working with Network Rail on a suicide prevention programme.

The suicide prevention programme includes the following initiatives:

- training railway employees to look out for and offer support to people who may be considering taking their own life on the railway – to date, 19,000 railway employees have received training to intervene in suicide attempts (and in 2018/19 rail employees, the Police and public intervened in more than 2,200 suicide attempts on the railway)
- working in partnership with Samaritans and other charities within the wider community to de-stigmatise suicide and promote help-seeking behaviour
- deploying mitigation measures, such as fencing to prevent access to the tracks at high-risk locations
- developing new and innovative ways to meet the suicide challenge on the rail network
- contributing our specialist knowledge of suicide prevention to national strategies and guidance so others can benefit from our experience
- Commissioning bespoke research into rail suicides

[22] WHO 2018 National Suicide Prevention Strategies Progress, examples and indicators

[23] Brodsky B S, Spruch-Feiner A, Stanley B 2018The Zero Suicide Model: Applying Evidence- Based Suicide prevention Practices to Clinical Care.

Our review of current best practices both national and international highlighted the following as key to suicide prevention which could apply to both adults and children.
These are:

1) **Brief Interventions**
   The safety plan intervention (SPI) is seen as a best practice brief intervention that incorporates evidence-based suicide risk reduction strategies such as lethal means reduction, brief problem solving and coping skills, increasing social support and identifying emergency contacts to use during a suicide crisis. It was noted that in conducting SPI, clinicians and patients collaborate to develop a six- step plan for staying safe. These include identifying warning signs, individual coping skills, people and places for distraction, people to contact for help, professionals to contact for help and steps for means safety.

2) **Crisis response planning** which involves individuals use of a small card to write out steps for step for self-identifying personal warning signs, coping strategies, enlisting social support and accessing professional services.

3) **School based awareness programmes** have shown promise in reducing suicidal ideations. These include gatekeeping training for teachers and staff, a youth mental health awareness programme and professional screening of students considered to be at risk. Whole school approaches to promoting emotional health and wellbeing and promoting resilience have been considered as best practice.

4) **Community-based approaches**:
   It was also noted that evidence has demonstrated that deaths by suicide can be reduced through combining a range of integrated interventions that build community resilience and target groups of people at heightened risk of suicide.

5) **Implementing suicide safer places or environments** can also be effective where a range of initiatives enables people to talk about suicide and provide life-saving suicide prevention skills combined with signs or leaflets in appropriate targeted locations or settings and specific support groups or interventions for those at risk.

6) **Reducing access to the means of suicide** remains one of the most evidenced aspects of suicide prevention and this has included physical restrictions as well as improving opportunities for interventions.

7) **Working with local media to prevent suicides**:
   It was asserted that evidence has showed that inappropriate reporting of suicide may lead to imitative behaviour. Best practice has highlighted that local media should adhere to the Samaritan's Guidance on responsible media reporting.

8) **Supporting those bereaved or affected by suicide**:
   It was also acknowledged that those bereaved by suicide are at a high risk of depression, suicide attempt and even suicide. Best practice has highlighted that resources should be

made available to support those bereaved, these could include help at hand cards / booklets via first responders, coroners, local funeral directors, voluntary sector organisations and within the community settings.

9) **Postvention** was also identified as key to suicide prevention:
This is the actions taken by organisations to provide support after someone has died by suicide. Effective support can help people grieve and recover therefore it is a critical element in preventing further suicides.

10) **Education in Primary Care** was also identified as good practice, as studies have shown that Primary care is often the first and last health care contact for people who die by suicide and 50% of GP's surveyed indicated that they have not undertaken any mental health training in the previous 5 years. (Preventing Suicide in Young people 2019)[24]

11) **Suicide is everybody's business:** It has been asserted that a whole system approach is required, with local government, primary care, health and criminal justice services, voluntary organisations and local people affected by suicide having a role to play. It was also noted that suicide prevention can be part of work addressing the wider determinants of health and wellbeing. An example given is the suicide safer communities framework which has been adopted in some areas in England where actions focuses on building communities that are committed to talking opening about suicide, promoting wellness and mental health and supporting those bereaved by suicide.

A report commissioned by HEE and published by the NCCMH[25] noted the Samaritans' slogan that 'suicide is everybody's business and therefore suggested that training programmes should be available and applicable across multiple settings such as within public services, employers and the wider general public. These principles could be applied to the work in preventing death by suicide in children and young people.

8 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

[24] Michail M, Upthegrove R 2019 Preventing Suicide in Young People
Institute for Mental Health, University of Birmingham
[25] NCCMH 2018 Self-harm and Suicide Prevention Competencies Framework; Children and Young People: Health Education England.

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.**[26]

- **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.

- **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.

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

9 Summary

As a partnership **making zero suicides in Surrey is our ambition**. (Surrey Suicide Strategy 2019-2021).

There is no single reason why a child or young person takes their own life. An integrated approach to children's social and emotional wellbeing, using universal and targeted interventions, is recommended by NICE.

This review identified many existing activities that contribute to the prevention of suicide, as well as new opportunities that could inform action. Taking a whole system approach to preventing suicides in Surrey, where we make **'suicide everyone's business'** is essential.

An initial action plan has been developed to take forward the recommendations and is detailed in Appendix 1. The Surrey Safeguarding Children's Partnership (SSCP) will develop a more detailed overarching action plan. This overarching action plan will be monitored through the SSCP Case Review Panel ensuring that a whole system approach is adopted to promote good practice and will support areas that need improvement in order to progress the partnerships ambition.

Appendix 1

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	
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	

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