



Learning from child suicides - implications for suicide prevention work

Dr Bianca Finger-Berry

Critical Incident Lead Officer (Norfolk Children's Services)

bianca.finger-berry@norfolk.gov.uk



Critical Incident Service - Norfolk

Part of the Educational Psychology Service, based in Norfolk Children's Services

Funded by schools funding, subscription model for academies, funded provided centrally for EY settings

- ▶ Support offered following child death, including suicide
- ▶ Support offered following cluster of suicide attempts/self-harm
- ▶ Information session for staff – self-harm and suicide prevention
- ▶ Information session for parents – self-harm and suicide prevention



Background to the review

- ▶ Child death in early 2015 following suicide/self-inflicted harm
- ▶ Concerns raised by schools about children who were attempting suicide
- ▶ Two more pupils died in 2015
- ▶ Discussion at CDOP about suicide/self-harm
- ▶ Public health presentation on hospital admissions due to self-harm

- ▶ Limited national data available at the time of the review, some information available from adult reviews or localised ones



Child Suicides – national picture

Second most common cause of death in the U.K. in the 15-19 year old age group

Deaths from suicide or self-harm (in brackets those classified as apparent suicide)

2010-2011: 70 (62)

2011-2012: 71 (68)

2012-2013: 90 (79)

2013-2014: 80 (65)

2014-2015: 90 (79)

Numbers for younger children (aged 10-14), only coroner suicide verdicts

2011: 9 deaths, plus 7 undetermined intent

2012: 6 deaths, plus 10 undetermined intent



Review


- ▶ Representatives from health, public health, children's services and police
- ▶ Review of 9 children between May 2010 and May 2015 (CDOP: suicide or self-inflicted harm)
- ▶ Links with all age Norfolk Suicide Prevention Strategy

Purpose of the review:

1. Review of deaths of children and young people following suicide or self-inflicted harm
2. Consider conclusions from suicide review
3. Provide information to CDOP, NSCB and Norfolk Suicide Prevention Strategy Group (NSPSG)



Child suicides – Norfolk Overview

- ▶ 9 children under the age of 18 years old, who lived in Norfolk and were classified by CDOP as suicide or self-inflicted harm, May 2010 – 2015
 - ▶ Since then, three more pupils living in Norfolk died from suicide
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Gender and age



- ▶ Three were female and six were male.
- ▶ Four children aged 12-13,
- ▶ Five children aged 15-17






Circumstances of death





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- ▶ **Ethnic background**
 - ▶ **Physical disability and health**
 - ▶ **Socio-economic circumstances**
 - ▶ **In education/employment**
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- ▶ **Children's Services involvement**
 - ▶ **Youth offending**
 - ▶ **CAMHS involvement**
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- ▶ **Poor peer relationships**
 - ▶ **Boyfriend/girlfriend issues prior to death**
 - ▶ **Difficult family relationships**
 - ▶ **Attendance Issues**

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- ▶ **Previous bereavement**
 - ▶ **Family circumstances (previous divorce, living with mother/father/stepparents)**
 - ▶ **Experience of sexual abuse**

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- ▶ **Drug/Alcohol abuse**
 - ▶ **Lesbian/gay/bisexual/transgender/sexuality issues**
 - ▶ **Known bullying issues**
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- **Attendance issues**

- **Academic pressure**





Known issues (mental health, self-harm, suicide ideation, previous suicide attempts)








School (cause of concern, school counselling)






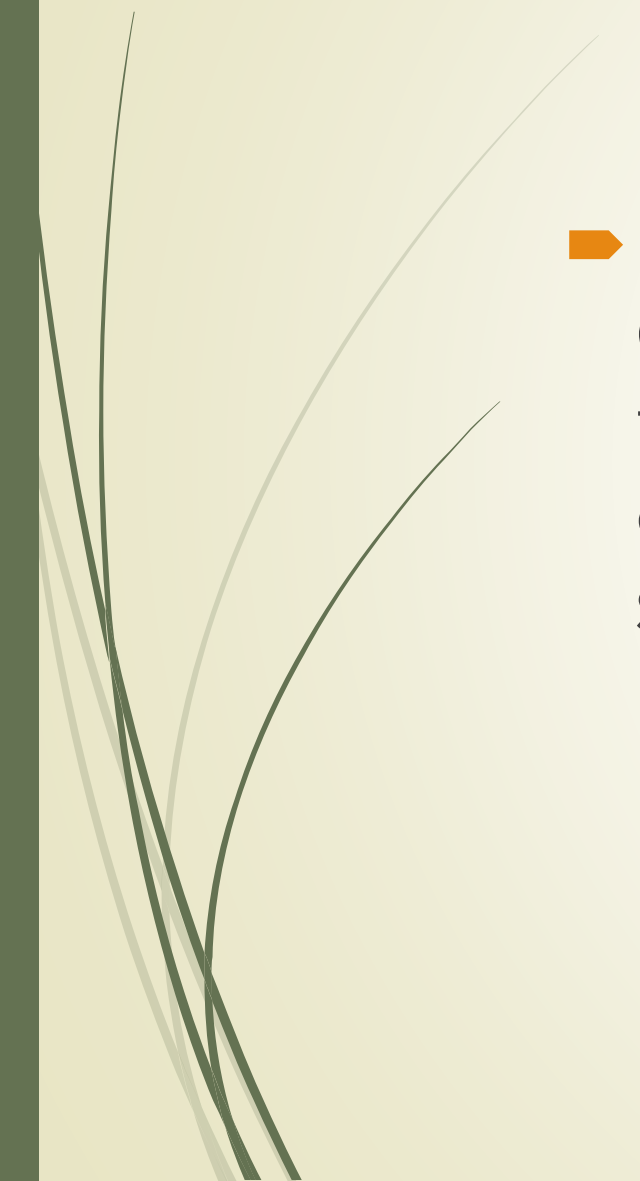
Preventing child suicides

- ▶ Almost all children died through hanging. Reducing access to means would not be possible.
 - ▶ Whilst there was no current CAMHS involvement, most schools were concerned about the young person. In a number of cases schools advised that the young person should see their G.P.
 - ▶ Where children had good peer relationships (apart from one case), friends were concerned and aware of self-harm/suicide ideation.
 - ▶ In two cases children experienced a parental bereavement five years earlier.
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- ▶ Identified stressors may have been boyfriend/girlfriend issues, sexual orientation/sexuality issues, arguments with parents/carers.
 - ▶ Almost half of all children were self-harming. There was no evidence that a risk assessment for suicide had taken place. In some cases concerns rose significantly just before the death.
 - ▶ Children accessed internet sites relating to self-harm and suicide (both with information about how to hurt or kill yourself as well as sites offering help and advice)

National Recommendations

- Agencies that work with young people, especially in health, social care and education, as well as families and young people themselves, can contribute to suicide prevention by recognising the pattern of cumulative risk and 'final straw' stresses that lead to suicide

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- ▶ Improved services for self-harm and access to CAMHS are crucial in addressing suicide risk, but the antecedents identified in the study make clear the vital role of schools, primary care, social services, and youth justice



Initial recommendations

- ▶ **Raising resilience in children and young people**

Most children who experience negative life events do not take their own life and only few will develop mental health problems. Resilient children and young people will be better placed at successfully manage the challenges they face in adolescence and deal with the ups and downs of life.

All agencies should support children's health, including their mental health, and well-being and use effective ways to raise resilience.



- ▶ **Providing for the long-term needs of children and young people who have experienced bereavement**

Children who experienced a bereavement when they were younger will revisit this as they enter their teenage years.

All agencies working with children need to consider the long-term needs of bereaved children and consider re-offering support.

Schools should have a bereavement policy, they need to understand the long-term needs of bereaved children and review them, in particular when they have concerns about children's mental health.



➤ **Guidance for staff**


Clear guidance for staff in relation to self-harm/suicide ideation should be developed. This should include information on how and when to refer, including clear guidance on how to assess for suicide risk so that referrals can be made with all the necessary information. This should include details about consultation services offered by CAMHS.


There are good examples published by some other authorities.

It would be helpful to develop a sample self-harm policy for schools to use if they wish.



Draft policy circulated

- ▶ Introduction
 - ▶ Principles and Values
 - ▶ Definitions
 - ▶ Identifying risk factors
 - ▶ Referral pathway
 - ▶ Important things to remember
 - ▶ Young people who refuse to engage
 - ▶ Engagement with parents and carers
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 - ▶ Appendix 1 Information Gathering Conversation and Flowchart
 - ▶ Appendix 2 The links between self-harm and suicide
 - ▶ Appendix 3 Guidance on sharing information
 - ▶ Appendix 4 Roles and responsibilities
 - ▶ Appendix 5 Useful national organisations/websites
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- ▶ **Training for Tier 1 staff to support children with self-harm/suicide ideation**

With comprehensive guidance, consistent training should be offered to all staff. The training should give staff the confidence to support children with self-harm issues and apply any newly developed guidance.

Suicide prevention should be part of safeguarding training, this applies in particular, but not exclusively to school staff with a direct responsibility for pastoral care and safeguarding.




➤ **Mental health awareness for children and young people**

Friends are often aware of children's self-harm and suicide ideation, some talked to parents or school staff.

We need to raise young people's awareness of mental health issue and give them clear guidance on when and how to access support for themselves or others, especially when they are concerned about suicide ideation.

There is some limited evidence from school based prevention programmes. We recommend to trial a programme, ideally at a school where a high level of self-harm has already been identified. Any pilot programme needs to be effectively evaluated.

A number of schools are running initiatives relating to mental health and it would be useful to collate all information including evaluations and share information about successful projects.

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- **Better information sharing and gathering information about 'near misses'**
 - **Regular reviewing of child deaths – suicide or self-inflicted harm**
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