East Sussex Safeguarding Children Partnership

Learning Briefing
Child Suicide

Introduction:

Every child or young person who dies by suicide is a precious individual and their deaths represent a devastating loss for family and friends. Suicide also leaves a legacy for families that can have an impact on future generations and the wider community, including the school community. As with all deaths of children and young people, there is a strong need to understand what happened, and why, to ensure that any learning is identified and acted upon.

Over the past two years (up to June 2024), the East Sussex multi-agency response group, which is convened when a child has died of suspected suicide, has been sadly used eight times.

East Sussex Safeguarding Children Partnership (ESSCP) has also undertaken two rapid reviews following the suspected suicide of a child, where abuse or neglect is known or suspected. In one of the cases, Lead Safeguarding Partners agreed to commission a full Local Child Safeguarding Practice Review (LCSPR), to explore further learning, which will be published later in 2024. In the other case, Lead Safeguarding Partners felt that the rapid review had sufficiently identified learning and an action plan was produced. This was monitored by the ESSCP Case Review Group.

What is a Rapid Review?

A serious child safeguarding incident (SCSI) is where a child has died or been seriously harmed, and abuse or neglect is known or suspected.

Following notification of a SCSI to the National Child Safeguarding Panel, there is a requirement for the safeguarding children partnership to undertake a **'Rapid Review'** within 15 working days.

The Rapid Review is a multi-agency process which considers the circumstances of the SCSI. The purpose is to identify and act upon immediate learning, and consider if there is additional learning which could be identified through a local Child Safeguarding Practice Review.

This learning briefing highlights key learning from local and national safeguarding cases which have featured suicide. It also includes learning arising from the review of child suicides by the Sussex Child Death Overview Panel.

National learning:

Understanding the characteristics of the children impacted by mental health conditions is important for multi-agency partners, to ensure the appropriate service provision to support those children. In their 2022/23 annual report, the National Child

Safeguarding Panel highlight that of all rapid reviews relating to fatal incidents, were abuse and/or neglect was known or suspected, 12% were due to suicide. However, the data shows this increased to nearly a fifth (20%) for female children compared with just 6% of male children.

Of the 134 rapid reviews involving teenagers, just over half were recorded to have one or more mental health conditions (nearly two thirds were female, and one third male; ten children were recorded as having a gender identity different to the sex registered at birth or being non-binary).

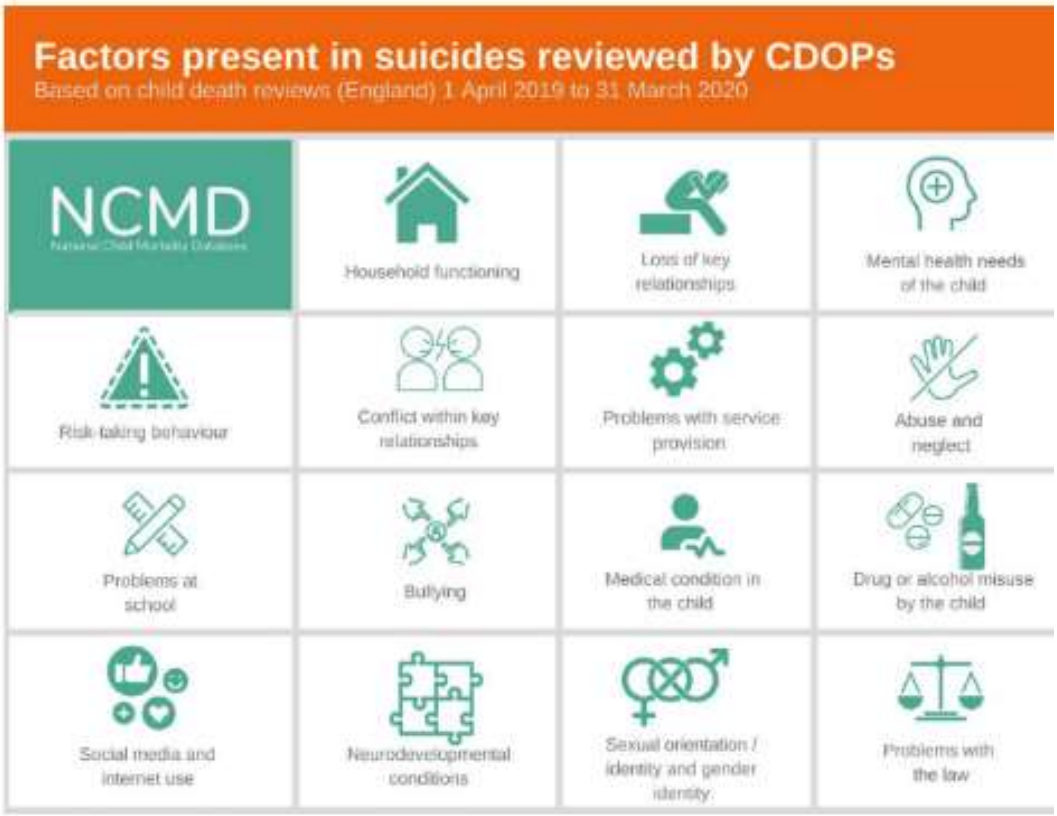
In addition, 40% of teenagers with reported mental health conditions were also recorded as experiencing alcohol and/or substance misuse. These figures suggest that safeguarding practitioners need to be aware of the impact of other risk factors and/or key characteristics which may affect a child's mental health and risk of harm.

Although these suicides have been subject to a rapid review due to the link with abuse and/or neglect, the Panel encourages agencies involved in safeguarding to have an awareness of the variety of factors that may add to risk as well as those 'final straw' stresses that may lead to suicide.

The **National Child Mortality Database** reviewed all child deaths, by suicide, between April 2019 and March 2020. Of the 91 child deaths by suicide, they found 15 common background features. Nearly 90% of children had more than one factor recorded, with more than half (56%) having a five or more factors present. The largest present factor was personal loss; 62% of children had suffered a significant personal loss in their life prior to their death, such as bereavement, loss of friendship and routine – due to moving home or school) – or other close relationship breakdown.

"The majority of people who feel suicidal do not actually want to die - they do not want to live the life they have."

The Samaritans - Myths about suicide



Local learning:

The Sussex Child Death Overview Panel (CDOP) continues to review deaths of children who have tragically died by means of self-harm and suicide. CDOP members continue to work alongside public health colleagues to inform suicide prevention workstreams across Sussex. The collective understanding of suicide and associated safeguarding risks within our communities have continued to be a theme within our reviews.

Key local learning that has been identified includes:

- The importance of ensuring a child or young person's voice is captured and considered. This applies to professionals working in settings such as primary healthcare (GPs) and all educational environments (including home schooling).
- Clearer messaging in schools and colleges is needed to inform and support young people in recognising signs that friends or peers may be experiencing issues. They also need to be made aware of who they can share their concerns with, and to trust that they will be acted upon.
- Parents need help to know how to discuss self-harm and suicide with their children and have access to support when needed.

In 2022 the ESSCP conducted a rapid review following the suspected suicide of a young person. There had been previous children's services involvement and history of self-harm. The child was also awaiting an appointment with the Gender Identify Clinic following a referral from their GP in 2020. A multi-agency response group meeting was held to respond to the incident and identify other children who may require professional support.

Lead Safeguarding Partners agreed that a LCSPR should not be undertaken as neither abuse or neglect was known or suspected. However, the case did raise a number of learning points and actions to take forward. These included:

1. **Access by children aged 14-16 who are being "electively home educated" to education at institutions whose primary purpose is post 16 education and training, and the co-ordination of welfare support provided to them.** The Partnership felt that the case exposed the inherent vulnerability of Electively Home Educated (EHE) children accessing provision from a large institution whose focus is on older students, without oversight from a pastoral team familiar with the safeguarding needs of this age group or reintegration support from the Children's Services Authority. The Partnership proposes that the pathways to college based 14-16 provision, and the support arrangements for vulnerable children accessing those pathways, should both be reviewed with colleges, secondary schools and East Sussex County Council Children's Services.

2. **The support offered by services to children and families where a child or young person have survived a suicide attempt.** The Partnership proposes to explore further with Sussex Partnership Foundation Trust (SPFT) what mental health support families should expect following a suicide attempt by a child (in this case resulting in hospitalisation) and whether any changes to the pathways or the offer need to be considered.

3. The need for agencies to make **timely referrals for substance misuse support for young people**. The Partnership will remind education providers in particular of the services and support available.

4. The need for local agencies to provide meaningful **mental and emotional support to children and young people with gender dysphoria issues** while they wait for specialist support. Ensure referring agencies are aware of guidance/local options for support, including that for parents/carers.

Action taken since the rapid review:

The ESSCP Case Review Group has monitored the action plan that was developed following the rapid review. The below is a summary of actions that have been taken since the rapid review:

- ✓ All post 16 colleges participated in a safeguarding review of college provision for students aged 14-16. (these students are made up of two groups – EHE students, and students accessing the college as Alternative Provision, organised by schools). Strengths and areas for development were identified and shared with relevant colleges, and all secondary Heads. Individual Colleges have reported that significant improvements have been made since– for example in considering the separation of under-16 and over-18 year old students, and the creation of pastoral hubs for this group of students.
- ✓ Children/young people who are admitted to hospital following suicide attempt will be assessed by Mental Health Liaison in a rapid and timely manner. This work with young people will include their families and create a care plan to identify and engage with community provision and ensure they are followed up appropriately. This follow up includes for those not known to CAMHS a 7/7 follow up call from paediatric liaison.
- ✓ SPFT have also recruited to a (interim) CAMHS Suicide prevention lead who is working across Sussex.
- ✓ Professional development sessions in schools were undertaken in January and July 2023 to promote the timely identification of substance misuse needs and making appropriate referrals.
- ✓ The independent Cass Review made recommendations on the services provided to children and young people who are exploring their gender identity or experiencing gender incongruence. We know many families, children and young people in Sussex are looking for emotional wellbeing and mental health care to support them. NHS Sussex has shared a list of services and support that professionals can signpost children and their families to: **Support for children and young people exploring their gender identity**

Learning for practice:

The ESSCP offers training courses on suicide and self-harm. This includes two virtual introductory awareness courses on suicide (working with families with children up to 16 and over 16). The courses help equip professionals working with families to pick up on vulnerabilities, identify who might be at risk and start an open conversation about suicide, as this is one of the best ways we know to prevent suicide.
The next introductory course is on 18 September 2024. More details about this course and others can be found at the: **East Sussex Learning Portal**.

The ESSCP invite you to discuss the issues raised in this briefing in your team meetings or during group supervision. We encourage your responses to be included in your team minutes and forwarded to the safeguarding lead within your organisation.

Points for discussion:

- What learning did you expect, or what surprised you about learning from this review?
- How confident are you in understanding self-harm? Do you know where to access additional information and/or training if necessary?
- What are the challenges associated with talking about self-harm and suicidal feelings with children? How confident do you feel asking children about their emotions?
- When was the last time you used the Pan Sussex Child Protection and Procedures Manual?