Pan-Lancashire

Suicide Thematic Review*

March 2013

This review was completed by Pan-Lancashire Suicide Thematic Task and Finish Group on behalf of the Pan-Lancashire Child Death Overview Panel.

Representation:

Agencies represented during this review:

Pan-Lancashire Child Death Overview Panel

SUDC Service

Lancashire Children's Social Care

East Lancashire NHS

NHS Lancashire (Safeguarding)

Blackpool NHS

Lancashire Constabulary

East Lancashire Child and Adolescent Mental Health Service (CAMHS)

Lancashire Education (Schools)

CYP Integrated Health Service

Inclusion and Disability Service

Central Lancashire Public Mental Health

Blackburn with Darwen Public Health

* This is an anonymised report to maintain confidentiality; requests for the full report should be made in writing to the Pan-Lancashire Child Death Overview Panel for consideration using the following email address: lscb@cyp.lancscc.gov.uk

Introduction

Suicide is the intentional and deliberate act of taking one's own life; it is a multi-faceted phenomenon involving the interaction between biological, psychological, sociological, environmental and cultural factors. One of the most significant risk factors in youth suicides is the exposure to and experience of adversity in childhood (Deacon et al, 2012).

Research suggests that certain situations put children and young people at more risk of suicide, including suffering loss or bereavement, relationship issues, experiencing bullying and/or racism, living in isolated areas and living in unhappy circumstances (NSPCC, 2008).

Papyrus (2012) report that suicide is a leading killer of young people in the UK; furthermore, there are hundreds of children and young people who attempt suicide who never hit the headlines. Suicidal thinking is very common and impulsivity in young people can shift thinking into behaviour with little warning; this can make it difficult for coroners to determine intent which may partly explain some of the local and national inconsistencies in inquest verdicts.

When considering children and young people it can be increasingly difficult to establish intent especially when taking into account impulsivity, accidents and self harm e.g. children and young people who deliberately self-harm may kill themselves by accident.

Furthermore, the National Institute for health and Clinical Excellence (NICE) define self harm as self poisoning or self injury irrespective of the apparent purpose of the act including poisoning, asphyxiation, cutting, burning and other self inflicted injuries. Deacon et al (2011) report self harm and suicide are often considered to be separate issues, as self harm is deemed to be the intent to live and a coping mechanism for individuals suffering emotional distress. Most cases of self harm do not result in suicide; however, self harm is known to be a risk factor in suicidal behaviour.

Within Lancashire there has been increasing multi-agency concern that there may be a 'spike' in the number of children and young people taking their own lives and further investigation was required to identify if there was evidence to support this. A number of professionals were tasked with completing this piece of work and therefore, the pan-Lancashire Child Death Overview Panel (CDOP) decided to coordinate this by setting up a specific suicide thematic task and finish group.

This report will consider the pan-Lancashire deaths where the child has died as a consequence of their own actions and aims to inform the CDOP and the pan-Lancashire (Blackburn with Darwen, Blackpool and Lancashire) Local Safeguarding Children Boards (LSCBs) of any themes/ trends, gaps in service provision and identify recommendations.

Method

The Lead Nurse for Sudden & Unexpected Death in Childhood (SUDC) and CDOP Coordinator identified the relevant deaths from April 2008 – July 2012. For the death to be included in the data there was a requirement for the child or young person to be a resident of Blackpool, Blackburn with Darwen or Lancashire in accordance with local authority boundaries. If the child or young person was a Child Looked After (CLA) residing out of the placing authority boundary, the child was still deemed to be a resident of the placing authority.

The data was presented to the first multi agency suicide thematic task and finish group which met in September 2012. The following agencies were represented: Children's Social Care (CSC), East Lancashire NHS, NHS Lancashire (Safeguarding), SUDC Service, Blackpool NHS, Lancashire Constabulary, East Lancashire Child and Adolescent Mental Health Service (CAMHS), Education (schools), CYP Integrated Health Service, Inclusion and Disability Service, Central Lancashire Public Mental Health.

A small review group of professionals were identified to complete an in depth review of the 10 most recent deaths as these would have the most information available and would be most relevant to present time. The agencies represented on this group were CSC, Education (schools), Inclusion and Disability Service, Health and CAMHS. Unfortunately Public Mental Health was not able to be represented at the review group; however, guidance was sought from the Public Mental Health representative on how best to complete this review. The professionals brought their notes to the meeting and a number of factors were considered when reviewing each case (In depth review grid available in appendix 1); emotional stressors identified were devised from the groups own professional judgement and not any other definition; additionally the Group identified and noted gaps in service provision and emerging themes.

Results

Child deaths as a result of their own actions (2008 – 2012)

The data provided in this section of the report relates to all 21 children and young people that died as a consequence of their own actions, from April 2008 through to July 2012. From the data in figure 1 it can be seen that there is no apparent spike in the number of self-inflicted deaths.

Figure 2 shows there are more males (16) than females (5); 15 of the deaths were of young people in the category 15 – 18 years (this category refers to young people aged up to the day before their 18th birthday), 6 were of children aged 14 years old and under.

There are no deaths of this cause recorded for Blackburn with Darwen or Blackpool; of the 21 deaths, 11 resided in Central Lancashire, 5 were deemed to be residents of East Lancashire and 5 were North Lancashire residents (figure 1 and 4). However, from figure 3 it can be seen that self harm rates in Blackpool and Blackburn with Darwen are very high, with Lancashire's rates also much higher than the national

average. The comparison between figure 3 and table 1 highlights the increasing prevalence of self harm in the 3 Local Authority areas.

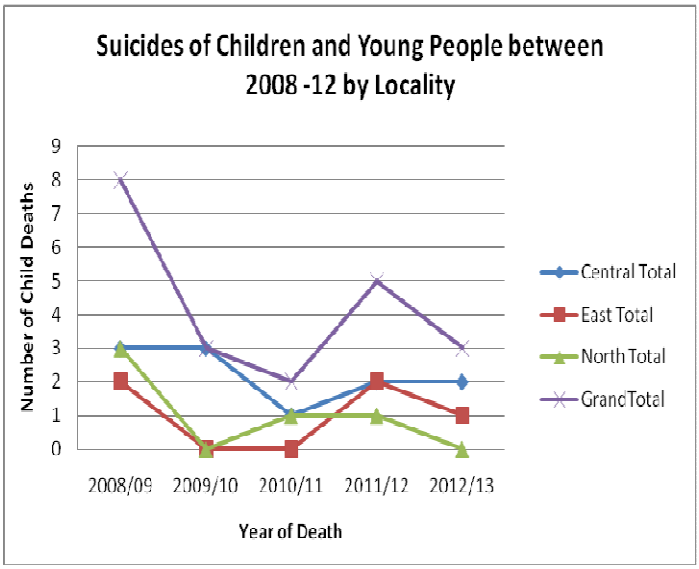


Figure1; number of suicides from 2008-2012 by locality.

Figure 2 has been removed to maintain confidentiality

Figure 2; child suicides from 2008 – July 2012 by gender and age group.

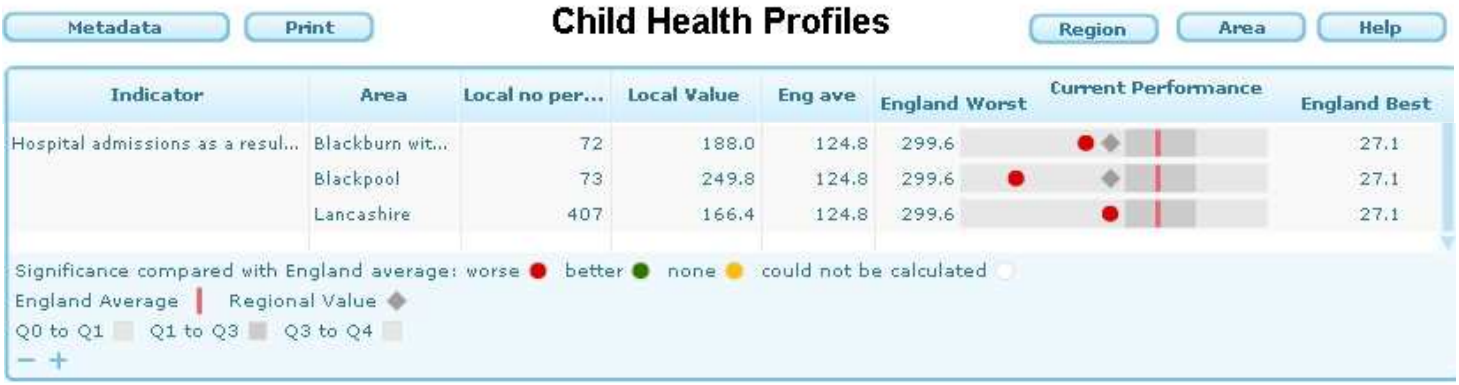
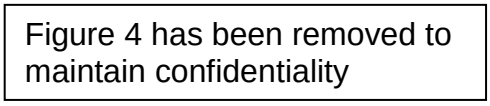


Figure 3; ChiMat Data Hospital Admissions for Self Harm (0 – 18 years) per 100,000 population (2010 -11)

Local Authority	Rate
Blackburn with Darwen	178.0
Blackpool	203.8
Lancashire	163.9

Table 1; Rate of emergency hospital admissions for self harm (0-18 years) per 100,000 population (2007/08 – 2009/10) (Deacon et al, 2011)



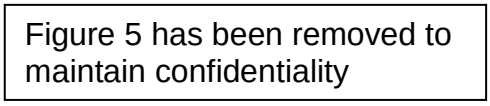


Figure 4; mode of suicide by gender and locality

Figure 5; mode of suicide by coronial verdict

It can be seen from figures 4 and 5 that hanging is the most common mode for young people to take their own lives; the inquisition verdicts for children who have died as a result of their own actions are different as seen in figure 5.

In Depth Review Results

The results reported in this section relate to the 10 deaths used in the in depth review only; these cases range from October 2010 – July 2012 (the raw data is provided in appendix 2).

Of the 10 deaths, 5 were children and young people from Central Lancashire, 5 were residents of East and North Lancashire. 7 young people were aged 15 years to the day before the 18th birthday.

The common themes identified from the in-depth review were:

- Males (8 out of the 10)
- Hanging as a method of death in 8 of the cases
- 7 of the children and young people were part of a reconstituted family
- 6 of the children and young people were known to different services (which included CSC)
- 6 children and young people were from ethnic minority backgrounds
- 5 of the children and young people lived within a dysfunctional family life (this included the following factors this list is not exhaustive – sofa surfing, drugs, alcohol); additionally, it is interesting to note all 5 of these children and young people were a part of a reconstituted family

The review group used a framework based on the national strategy ‘Preventing Suicide in England’ (Sept, 2012) to collate the findings under the six key ‘Areas for Action’.

1. Key high-risk groups

- 8 were young males
- All the children and young people had identifiable emotional stressors (e.g. exam stress, transitional issues, argument with boyfriend/ girlfriend/ parent or carer etc)
- 5 children and young people and/or parent/carer were known to Mental Health Services
- Fewer than 5 children and young people were known to self-harm
- Fewer than 5 children and young people had Special Educational Need
- Fewer than 5 were known to the Youth Offending Team (YOT) and Lancashire Constabulary

2. Mental health in specific groups

- Fewer than 5 children and young people were Looked After (CLA, previously or current)
- Fewer than 5 children and young people were known to have suffered some form of abuse
- Fewer than 5 children and young people were known to misuse drugs and/or alcohol
- 6 children and young people were of an ethnic minority or mixed race background
- 8 were males

3. Reduce access to the means of suicide

- 8 children and young people had died as a result of hanging

4. Information and support available to those bereaved or affected by suicide

- As part of the rapid response to some of children and young people's deaths, there was an ‘actual’ initial multi agency meeting rather than a virtual meeting
- 10 received a SUDC coordinated rapid response and were provided with a copy of the CDOP guide for parents and carers (FSID, 2010). A number of families were provided with a copy of “Help is at hand: a resource for people bereaved by suicide and other sudden, traumatic death” (DH, 2010). The SUDC Service also provided support resources from Winston's Wish, a national charitable organisation that supports families and siblings who have been bereaved

5. Media approach when reporting on suicide and suicidal behaviour

- Information from this section has been removed to maintain confidentiality

6. Support research, data collection and monitoring

- Self-harm is increasing on a pan-Lancashire basis and it is reported there is no consistent way of recording the incidence of self-harm across agencies
- Rates of self harm are higher in females (Lancashire JSNA)
- Self harm rates are higher in young Asian women (NICE)

- Inquisition verdicts vary for children who die as a consequence of their own actions

Discussion

Following the initial analysis of all data available to the group, there is no apparent spike in the number of children dying as a consequence of their own actions.

This review has highlighted that different inquisition verdicts are concluded, with none of the 10 deaths reviewed in depth having an actual verdict of 'suicide'; this is an issue that has been identified amongst professionals nationally. Most inquisitions conclude an open or a narrative verdict which has an impact on local and national statistics (BMJ, 2011).

The warning signs of suicide are difficult to detect; Papyrus (2001) conducted a survey of parents whose children had taken their own lives and found that much of what parents now thought might have been indicative of suicidal intention remained difficult to distinguish from ordinary teenage behaviour. As explained in the introduction for a coroner to record a verdict of suicide evidence must indicate suicidal intent beyond reasonable doubt (Linsley et al, 2001). Gunnell et al (2011) further explains some coroners conclude an open or accidental verdict in the belief this avoids adding to the family's distress. Therefore, the difficulty experienced by coroners to determine intent and conclude consistent inquest verdicts was acknowledged.

It is widely known that young and middle aged men are at greater risk of suicide and that the most common method of suicide amongst men and women is ‘hanging and strangulation’. The findings in this report reflect these facts (Preventing Suicide in England, 2012). Additionally, half of the males were known to the Youth Offending Team (YOT), this raises the suggestion of risk taking behaviours in adolescents being a risk factor to a young person dying as a result of their own actions.

The raw data (appendix 2) highlights the difficulties professionals face in identifying children and young people that are vulnerable to suicide. In the circumstances reviewed all of the children and young people were deemed to have some degree of emotional vulnerability, with only 5 out of the 10 children and young people receiving some form of support from the mental health services (none of the children and young people were diagnosed with a mental health condition). Therefore, it is recognised within this report that children and young people with a mental health diagnosis are not necessarily pre-disposed to suicide. There is no consistent Lancashire wide approach to supporting children and young people who are emotionally distressed rather than having a mental health issue.

This review highlighted half or more of the children and young people reviewed had at least one of the following factors: were of an ethnic minority, lived within a reconstituted family, family life was dysfunctional or they were known to services. Consequently, this raises the question of how are we supporting children who are in emotionally difficult situations? Are we aware of services available to address emotional health needs? Do professionals who work with children and young people have the required skills to support them in a culturally sympathetic way?

Sixty percent of the children were from ethnic minority backgrounds. Seven of the young people had left school and were above the age of 16 years old, some were in or waiting to start college education and some were not in further education. This could suggest that this transition time might be particularly difficult for children and young people, or that attendance at school is a protective factor which disappears once they leave school. It can be quite an adjustment going from schools to a larger further education establishment.

Furthermore, access to universal health services for young people post statutory education is sporadic across Lancashire. College health nurses are accessible for some young people, but not all college/sixth form establishments have this provision. Those who do not continue on to further education do not have direct access to such health care provision. It has been recognised through this review that the transition from school life onwards may be a particularly vulnerable time for children and young people (as discussed above) and is a risk factor in relation to the cases we have reviewed. It has also been highlighted that universal '0-19' teams in reality do not deliver a service to young people beyond school age in all parts of Lancashire. As many adult services do not work with those under the age of 18, there is an obvious gap in services for the 16 – 18 years age group.

Devaney et al (2012) reported that children and young people have less resilience when exposed to chronic risks such as continuing family conflict, long term poverty and multiple changes of home and school. They explain resilience develops through gradual exposure to difficulties at a manageable level of intensity, and at a point in the lifecycle where protective factors can operate. This requires the support of others typically family and peers. This supports the findings from this report which has identified similar risk factors. The present report has also identified the majority of cases reviewed were from chaotic or reconstituted families, which may have affected their ability to develop resilience.

There is no evidence that specific cognitive styles and behaviours lead people to suicide; however, there are indications that suicide is associated with a constriction in cognitive style (Sheehy et al, 2002). Although, impaired problem-solving is a well-established suicide risk factor and those at high risk tend to endure impairments in their social and interpersonal problem-solving abilities. This is often most noticeable in difficulties experienced when conceptualising, identifying and formulating appropriate solutions to familiar social problems.

For some children and young people there may be no apparent reason for having suicidal thoughts, and the circumstances leading up to a suicide attempt are different for everybody. Suicidal thoughts often coincide with times of 'change', and turning those thoughts into actions may sometimes be done on impulse such as after an event that seems like 'the last straw'; however, others can be following plans that have been made for some time (Papyrus, 2008).

The in-depth review highlighted the importance of professionals to have the appropriate skills to enable them to engage with children and young people effectively. This is in line with Devaney et al (2012) who identified that professionals need to have a skill set to engage with young people who do not necessarily want to engage.

Furthermore, Deacon et al (2011) report self harm is a known risk factor for suicidal behaviour; the authors acknowledge suicide and self harm are often considered separate issues, with self harm identified as a coping mechanism for emotional distress. The NSPCC (2009) suggest suicide and self harm are part of the same continuum, with both being a response to emotional distress. NICE (2002, NSPCC (2009)) report half of all people who commit suicide will have self harmed at some point in the past. Fox and Hawton (2004, NSPCC (2009)) estimate for every child that commits suicide, there are between 40 and 100 that have self harmed; this supports the view that not all self harm leads to suicide.

Madge et al (2008) found that 17.8% of young people (15 and 16 years old) had self harmed in their lifetime. Similarly, this review found 20 percent of children and young people had documented evidence of previous self harm. However, this does need to be treated with caution as Deacon et al (2011) report self harm is often a hidden and secretive behaviour which children and young people are reluctant to admit and talk about. This supports the need for staff to have appropriate skills for engaging with children and young people as explained by Devaney et al (2012).

The results from this review are quite high when comparing the findings from the Mental Health Foundations national inquiry, which reported between 1 in 12 and 1 in 15 children and young people (aged 11-25) self harm. However, when considering the NICE findings it may have been anticipated the results from this review would have been higher.

All the cases reviewed received a Rapid Response as part of the SUDC Protocol, and as part of that response an initial discussion must take place to share information and plan what should happen next between the lead agencies (Working Together to Safeguard Children, 2010). Within Lancashire this initial meeting is usually a ‘virtual’ discussion which is in line with the statutory guidance and the pan Lancashire SUDC protocol; however, in some of the children and young people's deaths reviewed an ‘actual’ meeting took place and they were found to be invaluable to the professionals involved. They have resulted in more clear co-ordination of all agencies involved, their roles and moreover, the family and school community was better supported; even so, meetings are not consistently held and there has been variation in the lead agency that organises the meeting.

The completion of this review identified the lack of specialist bereavement care for families (including siblings); although all families will have received some generic support this is inconsistent across the county. As part of the rapid response leaflets and written guides for coping with bereavement are provided; however, there is not always a service to direct parents/ carers to. It is also known that a young person who has died as a result of their own actions can be distressing for the friends and the school community. The Critical Incident Support Team (CIST) is a group of specialist educational psychologists that are trained to support schools and young people through these difficult periods; however, this is not a statutory service and academy schools are particularly vulnerable should such an incident affect their school.

Some of the reporting of these children's deaths has had massive implications not only for individual families but also communities including schools. Reporting through the press has had a negative impact on individuals and has also resulted in safeguarding concerns for the child’s peers. The media has an obligation to report

responsibly adhering to the Editors Code of Practice (2009) which states that excessively detailed reporting of suicide methods should be avoided. However, this does not take into consideration the wider issues, impact and consequences for families of exposing their personal information to the general public. It is unknown if the LSCBs have assurances from local media for responsible reporting.

The Royal College of Psychiatrists is leading a campaign to reduce the stigma attached to mental illness. Tadros et al (2001) reported that stigmatisation of suicide has very deep roots in our collective thinking and judgement amongst the public and professionals alike. Suicide deaths quite quickly become public knowledge and it is generally best to be open and honest from the start when talking to others about the child's death.

The prevention of suicide in children and young people clearly needs multiple strategies and a multi-agency approach to care.

Identified Issues arising from the review

- Following the initial analysis of all data available to the group, there is no apparent spike in the number of children dying as a consequence of their own actions

- The majority of the deaths (16 of 21) were in males with 15 in the 15-18yr age range. Of the ten cases reviewed in more detail, 6 were from ethnic minority backgrounds and 7 belonged to reconstituted families

- This review has highlighted that there is a variation in inquisition verdicts, with none of the 10 deaths reviewed in depth having an actual verdict of 'suicide'; this is an issue that has been identified amongst professionals nationally. Most inquisitions conclude an open or a narrative verdict which has an impact on local and national statistics (BMJ, 2011)

- Children and young people with a mental health diagnosis are not necessarily pre-disposed to suicide and there was a stronger link with emotional distress. However, there is no consistent Lancashire wide approach to supporting children and young people who are emotionally distressed rather than having a mental health issue

- To help children in emotionally difficult situations to improve their resilience, more information is needed on the support available and how to access it

- There is inconsistent access to universal health services for young people post statutory education across Lancashire. In some parts of Lancashire the'0-19' teams do not deliver a service to young people beyond school age and, as many adult services do not work with those under the age of 18, there is an obvious gap in services for the 16 – 18 years age group

- The in-depth review highlighted the importance of all professionals having the appropriate skills to enable them to engage effectively with children and young people

- There is a lack of specialist, post-suicide, bereavement care for families (including siblings) across Lancashire

Recommendations to LSCBs **(based on findings and discussions held during the Task & Finish group)**

Developing a consistent Lancashire wide approach to supporting and increasing the resilience of children and young people who are emotionally distressed but do not have a mental health diagnosis:

- Review the provision of support for children and young people who demonstrate their emotional distress by self-harming

- Include specific work with BME communities to increase the understanding of need in this area

- Review the availability of self-management and problem-solving training for children and young people with a view to increasing their resilience to crises that occur in their lives

- Ensure that projects working with troubled families focus on emotional resilience as a high priority

In some parts of Lancashire the'0-19' teams do not deliver a service to young people beyond school age and, as many adult services do not work with those under the age of 18, there is an obvious gap in services for the 16 – 18 years age group:

- Ensure equitable access to both universal and specialist services for all 16 – 18 year olds, in particular those not accessing further education, as they are often the most vulnerable and most in need of services

All professionals should have the appropriate skills to enable them to engage effectively with children and young people:

- The Boards should consider completing a review of training to develop professionals' skills when dealing with a young person who presents with emotional issues and they have concerns for e.g. STORM training and Youth Mental Health First Aid training which both aim to develop the confidence and skills of staff

There is a lack of specialist, post-suicide, bereavement care for families (including siblings) across Lancashire

- Following its recent review of bereavement services, CDOP should contact all current providers to encourage the provision of more specialist post suicide support

Appendix 1 – In depth Review Grid

Appendix 1 has been removed to maintain confidentiality

Appendix 2 – Raw Data

Appendix 2 has been removed to maintain confidentiality

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