Wakefield Safeguarding Children Partnership

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Review of a cluster of four apparent suicides of children

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1.1 Between May 2017 and February 2018 four local children apparently took their own lives by hanging. The circumstances of each case were reported to the then Wakefield and District Safeguarding Children Board (replaced by the Wakefield Safeguarding Children Partnership in September 2019) which decided that the criteria for conducting a Serious Case Review (SCR) had been met in respect of one of the children (Child 1) and the SCR report has been published at www.wakefieldscp.org.uk/about-us/serious-case-reviews/ (Serious Case Review Laurie).

1.2 The Board decided that the criteria for conducting SCR's had not been met in the other three cases (Child 2, 3 and 4). However, as several agencies had been involved in providing support to Child 2, 3 and 4, it was decided to conduct a further review to identify both the single and multi-agency learning arising from this 'cluster' of four apparent suicides, in order to improve practice and learn more about how to prevent children taking their own lives. (The term 'suicide cluster' describes a situation in which more suicides than expected occur in terms of time, place, or both and usually includes three or more deaths (1)). This cluster review also encompassed the learning from the SCR in respect of Child 1. This report is a summary of the key learning derived from the cluster review.

1.3 Wakefield Safeguarding Children Partnership wishes to express sincere condolences to the families and friends of the four children who died.

The Children:

1.4 All four children were either 17 or approaching their 17th birthday at the time of their deaths. Child 1 was a child in care at the time of his death, having been removed, along with his siblings, from the care of his mother and stepfather at the age of ten. After almost five years in a successful foster placement, Child 1 returned to the care of his mother and stepfather. His return to his birth family was approved and monitored in accordance with statutory guidance.

1.5 Child 2 lived with her mother and younger sibling. Her maternal grandparents also appeared to be an important influence and Child 2 was staying with them at the time of her death. Child 3 lived with her mother and stepfather. She had only elder siblings who were no longer living in the family home at the time of her death.
Child 4 lived with his mother, stepfather and an adult step-sibling.

Antecedents of suicide:

1.6 Many of the known antecedents of suicide in children and young people were present in the lives of these four children. Each child had at least one parent with a

history of mental health problems which can be a key factor in the development of mental health problems in their children (2).

1.7 Child 2, 3 and 4 had made previous suicide attempts. Suicidal ideation was also apparent in the cases of Child 1, 2 and 4 although the difficulties in engaging with Child 3 towards the end of her life restricted opportunities to enquire about suicidal intent. Child 1, 2 and 3 self-harmed. All four children had a history of low mood and depression. Child 4 was affected by bereavement and bereavement by suicide was present in the lives of Child 1, 2 and 3. Social isolation was an issue for each of the children, although it took different forms.

1.8 Child 1 and 2 experienced emotional abuse as a result of witnessing domestic abuse. Child 2 may have experienced emotional turmoil when she disclosed she was gay to family and friends. Child 3 experienced sexual abuse in that she disclosed a rape to her boyfriend in the summer before she took her own life.

1.9 CAMHS and other agencies experienced difficulties in engaging with Child 1, 2 and 3. The role of parents in engagement difficulties was apparent but went largely unaddressed by agencies.

1.10 This review also highlights suicide antecedents which have received less attention in the research literature particularly the potential impact of being a young carer, the impact of transfer to post 16 college education and transition to adulthood generally.

1.11 It is acknowledged that antecedents of suicide are common for children generally and there is no suggestion that the presence of several suicide antecedents in a child's life is a predicter of risk or a risk multiplier. Additionally, concern has also been expressed that an over focus on suicide antecedents could skew professional attention towards the risk of suicide when this may not be the key concern. However, practitioner awareness of the antecedents of suicide, including the antecedents highlighted in the lives of these four children, including those which are less prominent in research, will help inform the assessment and management of risk in the future.

Primary Care (GP Practices):

1.12 Child 1's GP practice had insufficient information to contribute as effectively as possible to his healthcare as a child in care. The GP practice was unaware of the statutory arrangements for monitoring his return to live with his birth parents and was also unaware of Child 1's lack of engagement with the CiC nurse (he declined annual CiC health assessments for three consecutive years).

1.13 GP practices missed opportunities to follow up upon the emotional health and wellbeing of both Child 2 and 3. For example Child 2's GP could have attempted to

contact her or her family after she was discharged from CAMHS after being on a waiting list for ten months and Child 3's GP could have followed up on a notification that she had attended Hospital Emergency Department (ED) following an overdose whilst on a CAMHS waiting list. GP practices also sometimes overlooked opportunities to check on the wellbeing of the children when they saw them for non-mental health related appointments.

1.14 At Child 3's request, the GP practice removed her mother's telephone contact details from her records when she was 15 years old. The removal of her mother's telephone number later prevented the GP from telephoning the mother when CAMHS discharged Child 3 shortly before she took her own life. The relevant clinical commissioning group has advised the review that the GP decision to accede to Child 3's request to remove her mother's phone number from her records has been carefully reviewed and that the prevailing view was that acceding to her request was an appropriate decision. Had her request not been acceded to, the CCG felt that there was a risk that Child 3 may have disengaged from the care offered by her GP practice. However, it is not known whether the reasons for Child 3's request were explored with her.

1.15 Child 3's GP practice is a 'young person friendly' practice with a regular 'teenage clinic'. It may be of value for other GP practices to consider taking steps to become young person friendly as ten minute GP appointments may be insufficient to explore the issues presented by troubled adolescents.

Hospital Emergency Departments:

1.16 Both Child 2 and 3 attended a Hospital ED after taking overdoses of medication. The relevant Hospital Trust did not have a risk assessment tool, developed specifically for use with children or young people attending hospital following a self-harm incident. The only tool available to the front line professionals at that time was an adult focussed risk assessment tool.
The Trust lacked a local evidence-based guideline or care pathway to direct staff in the provision of effective care and management when children and young people are admitted following self-harm. The national guidance underpinning practice at that time was a 2014 publication from the Royal College of Psychiatrists.

Child and Adolescent Mental Health Services (CAMHS):

1.17 All of the children who took their own lives had been in contact with Child and Adolescent Mental Health Services (CAMHS) in the period prior to their deaths. The review highlighted the following areas of learning for CAMHS:

- <u>Waiting times:</u> Child 2 was on a CAMHS waiting list for eight months and subsequently ten months. Child 3 was on a CAMHS waiting list for eleven

months. The (draft) CAMHS Operational Policy was found to be in need of review as it provided limited opportunities for the service to take a strategic approach to demand and capacity modelling and it was unclear how the capacity to manage planned and unplanned activity had been formulated.

- Support provided to children and their families whilst on a waiting list*:* Whilst on a CAMHS waiting list, Child 3 attended hospital after taking an overdose and her mother later contacted CAMHS to express concern about her ongoing low mood and self-harming behaviours. Whilst CAMHS provided support and advice on both occasions, there is no indication that any action to expedite Child 3's case was considered. It was recommended that CAMHS should undertake an audit to review the children and young people on their waiting list to ensure appropriate support, advice and action is considered.

- Re-referrals of children within a short period following discharge treated as a new referral*:* Child 2 was re-referred to CAMHS after her previous period of therapy had ended nine weeks earlier. Despite this, Child 2 was treated as a new referral and spent a further ten months on a waiting list. The appropriateness of treating this re-referral as a new referral is questioned.

- The comprehensiveness of risk assessments: Risk factors disclosed by Child 4 were noted but not fully explored resulting in insufficient understanding of what was underpinning his low mood and suicidal ideation. The Sainsbury's risk assessment tool used by CAMHS did not screen for problems at school or college. Given that these are one of the highest risk factors for depression in young people (3), these appear to be significant omissions. A further omission was that fact that Child 4's anxiety was not assessed or diagnosed in the context of his depression. Anxiety with depression is a higher risk indicator for suicide.

- Safe discharge from CAMHS: The risk assessment to inform the discharge of Child 3 from the service fell below expected practice and she was given insufficient time to respond prior to the discharge taking effect.

- Communication and Effectiveness of Safety Plans: Safety plans were not always communicated to parents or communicated with sufficient clarity. A safety plan was discussed with Child 3, then aged fifteen years and four months but not with her mother. Whilst the safety plan for Child 4 was verbally communicated to his mother, she was not given information which was specific enough to keep him safe and it was not until she later discovered the medical care plan addressed to their GP and copied to Child 4, that the family became aware that Child 4 had previously placed a ligature around his neck. It appeared to be standard practice for 16 and 17 year olds seen by CAMHS to briefly involve the parent/carer in the face to face assessments following which the

majority of the time would be spent with the child alone. This may have been a key factor in unsatisfactory communication of safety plans to parents/carers. Additionally, fuller exploration of family composition may have helped CAMHS to have involved other family members in safety plans.

- Assessment, and provision of, any support required by parents/carers of children in contact with CAMHS: Parents are generally expected to play a key role in information sharing, safety planning and support for their child. In many cases they are capable of doing this without additional support. However, research has shown that CAMHS practitioners sometimes over-estimate the abilities of parents or carers to help keep their children safe and protect them from the risk of suicide (4). There was no consideration of the impact of Child 2's mother's chronic ill health on any safety plan drawn up. It is not known if CAMHS were aware of the mental health issues affecting Child 2's maternal grandmother at the time the safety plan was agreed with her prior to the child's discharge from hospital shortly before her death. Additionally, Child 4's mother may have benefitted from support when she temporarily gave up work to care for Child 4 during the period before he took his own life.

- Offering support to parents/carers of children and young people who are at risk of serious self-harm is a key issue. Whilst there are currently pockets of support for parents/carers of children with specific needs, the review was advised that the CAMHS provider was currently examining the facilitation and start-up of a parents support group and crisis helpline. Funding through new models of care was being explored. This is a service which could have made a difference in the cases of Child 2 and 3.

- Communication between CAMHS and other agencies, particularly schools and colleges: CAMHS appeared to operate separately from partner agencies outside the health economy. The lack of communication with schools and colleges appeared to be driven in part by reluctance of the children for information to be shared with their school or college. However, CAMHS practitioners did not consider breaching a child's lack of consent to share information.

- The extent to which the views of the child are sought: There was a period during which Child 2's mother was declining CAMHS appointments on her daughter's behalf which led to the child's discharge from the service but CAMHS did not confirm that the declined appointments accorded with Child 2's wishes despite the fact that she was sixteen years and nine months old at the time. Additionally, there was no indication that Child 3 was spoken to by the CAMHS practitioner after attending hospital following an overdose.

Secondary Education

1.18 The children attended local schools for their secondary education with the exception of Child 1 who attended school in an adjacent local authority area in which his long term foster care placement was located. After leaving his foster care placement in Year 10, he was initially supported to remain in the out of area school, but after experiencing difficulties which put him at risk of permanent exclusion, he transferred to local alternative educational provision where he was able to settle and complete Year 11. Moving schools/education provision in Year 11 can be very disruptive and transferring to post 16 college early was an option which could have been considered for Child 1.

1.19 Both Child 2 and 3 attended the same school. The former received support in respect of emotional struggles although the school missed an opportunity to refer her to a youth group for LGBTQ+ young people aged 13-19 when she disclosed she was gay. Although Child 2 had support within school, contact with external providers may have been useful especially during the school holidays to ensure continuity of support. Additionally, a referral to the LGBTQ+ would have connected her to a network from which she may have derived additional support. As stated elsewhere in this report, her school did not appear to pick up Child 2's young carer responsibilities.

1.20 Child 3 presented with symptoms of anxiety, including panic attacks linked to her academic studies. The school ensured she accessed the services of an Educational Psychologist and was also supported by a learning mentor. The school experienced difficulties in successfully engaging with Child 3's parents and could have adopted a more persistent approach including home visits.

1.21 Child 4's school was unaware of any indications of concern. It appears that Child 4 did not disclose his anxieties in respect of bereavement and examination pressures. Whilst Child 4's year 11 attendance was very good, the number of occasions when he was late for school increased from 1 in year 10 to 17 in year 11 which could have been explored further.

School Nurse Service:

1.22 The school nursing service played a valuable role in supporting schools and colleges following the deaths of the young people. However, there is a need to clarify the role they could usefully play in suicide prevention in children and young people. The service had limited involvement with Child 1 and no contact with Child 2, 3 or 4. The school nurse service was generally uninformed about their GP attendances, CAMHS referrals etc. An exception was the notification the service received after Child 3 attended Hospital following an overdose, which appeared to present an opportunity for the school nurse to contact her school. However, this review has been advised that, for information sharing purposes, the school nurse service regard schools as

‘external agencies’ and they can generally only share information with schools if the child or their parent consents.

1.23 The review has also been advised that the school nurse service lacks the capacity to engage in preventative work. The review therefore recommended that the school nurse service should be reviewed to clarify how best to utilise this valuable service, with a specific focus on what the service could contribute to suicide prevention in children and young people.

1.24 The school nurse service has no presence within local post 16 colleges, although referrals are accepted.

Transition to Post 16 College Education

1.25 All four children left their schools at the end of year 11 and moved to post 16 colleges, although Child 2 studied two of her three A level courses on her previous school site. Child 1 died during the third term of his first year of post 16 college education. Child 2 died during her first term. Child 3 died a fortnight after leaving college during her first term. Child 4 died early in his second term of post 16 education.

1.26 Transition from school to post 16 college can be a very challenging time ‘when trouble with the step-up in demand is experienced at the same time as social, intellectual and emotional challenges’ (5) alongside ‘the need to re-construct peer groups, to become more autonomous learners, to adjust to the increased workload and to develop identity-in-practice i.e. moving from the person I was, to the person I have become’ (6). For children who were already vulnerable, as Child 1, 2 and 3 were known to be, transition may have been even more challenging.

1.27 The focus on becoming more autonomous learners is understandable accompanied by increasing college expectations in respect of maturity and personal responsibility by students. This may have contributed to less rigorous monitoring of absence as was the case in respect of Child 4. Attendance is a leading indicator of concerns about pupils and should always be monitored closely. Colleges need to bring themselves up to the standard of absence of monitoring achieved by schools.

1.28 Post 16 colleges need to be proactive in seeking out safeguarding information about students who may be enrolling with them and schools need to be responsive in promptly providing relevant information. In Child 3’s case, her school did not provide her college with the safeguarding information they possessed.

1.29 Although many students withdraw from college during the first term, Child 3 could have been offered more support when she decided to withdraw. Her college had become aware of her vulnerability and had been providing both academic and pastoral support. Contact with her parents could also have been considered.

1.30 When Child 4 became mentally unwell and was absent from college, meetings at college were offered to Child 4 and his mother but were cancelled as Child 4 was not well enough to attend. It would have been beneficial to have considered a home visit. Child 4's apparent suicide may have been triggered by his imminent return to college. With the benefit of hindsight, it is questioned whether it was entirely appropriate for the college to send Child 4 all the work he had missed before there were clear signs that the treatment he was receiving from CAMHS was having a positive effect.

Transition to Adulthood

1.31 Becoming an adult is not something which happens on a set date but is a process affected by factors such as maturity, an individual's human capital (including educational attainment) and social capital (including interpersonal relationships). Additionally, young people face entering an economy which, since the financial shocks of 2007/8, has led to lower paid and less secure employment for many. Furthermore, the ways in which young people consume entertainment and interact on social media has exposed them to increasingly intrusive advertising depicting a lifestyle which is often at odds with day to day reality.

1.32 It is unclear to what extent the changes in their lives which accompanied looming adulthood affected the children subject of this review. In Child 1's case he was contemplating moving to independent or semi-independent living but was said to have been anxious about discussing this with his parents who had made such a major emotional investment in his return to their care less than two years earlier. He was on a college course preparing him for a career in hairdressing but this had not been going well in the months prior to his death.

1.33 In Child 2's case she had been coping with some emotional turbulence after sharing her sexual orientation with her family and peers. Additionally, it is possible that she may have perceived her role as a carer for her mother as a complicating factor as she became an adult, perhaps wondering who would care for her mother if she left home for education or employment.

1.34 In Child 3's case her educational aspirations had suffered a setback as her emotional struggles had impacted on her ability to study for her A levels and she had left college during her first term and planned to start work in a hairdressing salon. It seems possible that she may have felt that she was not meeting her own expectations and those of others.

1.35 Child 4 was seen as a high achiever and so the interruption to his A level studies arising from the mental health issues, which suddenly made it impossible for him to attend college or even get out of bed, may have come as a very unwelcome

interruption in his envisaged path to academic achievement and well remunerated employment.

Young Carer responsibilities

1.36 Child 2 was a young carer for her mother and her younger sibling. A young carer is someone under eighteen who helps look after someone in their family, or a friend, who is ill, disabled or misuses drugs or alcohol (7). Being a young carer can have a significant impact upon the child's health, social life and self-confidence and generate stress through the need to juggle their education and caring. On a positive note, children can learn many useful skills by being a young carer.

1.37 CAMHS referred Child 2 to the Youth Work team's Young Carer programme but after attending an initial meeting, she disengaged. At that first session she completed a self-assessment of how caring affected her. Whilst some of her responses indicated that she viewed her caring responsibilities in a positive light, she also wrote that she sometimes found them stressful and felt she couldn't cope.

1.38 It is not known whether Child 2's young carer responsibilities were a factor in her suicide. Research indicates that young carers experience more adverse mental health issues than the general population of children and young people and that female young carers are at greater risk of self-harm or suicide than male young carers (8).

Early Help

1.39 The local Early Help strategy identifies the potential need for Early Help for young carers and their family. The provision of Early Help services should form part of a continuum of help and support to respond to the different levels of need of individual children, young people and families. Arguably the needs of Child 2 and 3 and their families could have merited the offer of Early Help.

1.40 It should be noted that Early Help is not a discrete service but a process in which one agency takes the lead in bringing together all relevant agencies. It is also a voluntary process which requires consent. However, consideration of the need for Early Help could have allowed practitioners to adopt a more holistic approach to meeting needs and assisting in sharing information. However, the agencies involved with Child 2 and 3 when Early Help could have been considered were their school, GP practices, Hospital Emergency Department (ED), school nursing service and CAMHS. Feedback from practitioner learning events which informed this review indicated that awareness of the Early Help strategy was variable amongst key partners and there was a lack of clarity about how levels of need were defined and the process to be followed in some agencies.

Think Family

1.41 Think Family**,** an agenda which recognises and promotes the importance of a whole-family approach, does not appear to have been a prominent feature of agency involvement with these children and their families. For example, Child 2's mother was in contact with a range of services to address her physical and mental health needs. However, there is no indication that any of these services considered the impact of her needs on her children and in particular, whether Child 2 might be fulfilling a young carer role.

Communication and information Sharing:

1.42 This review has highlighted a number of communication and information sharing issues which need to be addressed in order to enhance the capability of agencies to work together in an informed manner to prevent suicide and serious self-harm by children.

1.43 A key area which needs to be addressed is information sharing between health services and schools and colleges. The schools and colleges attended by the children were largely unaware of Hospital ED attendances, GP referrals to CAMHS, the child's interaction with CAMHS, including whether or not they were on a waiting list, whether or not they were engaging with CAMHS or the detail of any safety plans put in place. One might have assumed that the school nursing service was a vital conduit for information sharing between health services and schools but this was not the case.

1.44 Other key areas of information sharing are information sharing with the parents/ carers of children at risk of harm, information sharing within the health economy (fully utilising the opportunities of health agencies having adopted the 'SystmOne' electronic patient record), information sharing within the education sector (safeguarding information sharing deficits between school and post-16 colleges) and feedback to referrers.

1.45 Clearly issues of consent need to be fully respected but agencies which contributed to the review identified a number of improvements they could make to information sharing policy and practice such as considering when overriding an absence of consent may be justified.

1.46 The review recommended a two stage approach to addressing the issue of communication and information sharing. The first stage would be to obtain assurance that agencies have addressed any deficits in information sharing disclosed by this review. These include Caldicott Guardians within NHS providers and commissioners reviewing the data sharing models between the providers using 'SystmOne' and issuing guidance in relation to implementing the sharing of patient information without consent and providing greater clarity for GP practices in deciding when it is appropriate

to seek the consent of children and young people to share information from their medical records via 'SystmOne'; the need for a system to inform CAMHS of when Educational Psychology are involved with any pupil referred to CAMHS; greater clarity over the circumstances when, and the process by which, the lack of consent to information sharing by a child can be over-ridden; and ensuring referrers receive feedback when appropriate such as Youth Work informing CAMHS when Child 2 quickly disengaged from young carer support.

1.47 The second stage is to develop an information sharing protocol for suicide prevention as recommended by Public Health England (9). The agreement would outline the need for each involved organisation to co-operate and provide the legal basis, as well as operational guidelines, for how information will be shared. A key aim of the protocol would be to ensure that all parties have confidence in what and how data is being used, as well as ensuring data protection measures are in place.

Impact of the child suicide on the family

1.48 Some of the families of the children who died contributed to this review. One child's mother was preoccupied with being blamed for her son's death. One child's girlfriend disclosed very hurtful social media messages which wrongfully implicated her in his death. One child's maternal grandmother disclosed the devastating impact of adolescent suicide on the family. Parental and grand parental guilt appears to be a major issue for those providing bereavement support to address.

Multi-agency response to Suicides of Children and Young People:

1.49 One apparent consequence of the changes to the educational landscape over recent years is that school engagement with the local authority's Educational Psychology service is variable. An issue on which assurance needs to be sought is the extent to which all schools have robust and rehearsed plans for responding to crises such as pupil suicides. Educational Psychology provide valuable crisis management support as a free service but only to those academies which invite them in.

1.50 Educational Psychology has little or no engagement with post 16 colleges and so similar assurance will need to be sought in respect of college crisis plans.

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