NCMD
National Child Mortality Database

Knowledge, understanding and learning to improve young lives

# Suicide in Children and Young People

## National Child Mortality Database Programme Thematic Report

**Data from April 2019 to March 2020**

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HQIP

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# Contents

# Foreword

The death of a child by suicide is an unimaginable tragedy. A young life is lost, a family is devastated, the society where it happens is diminished. The risk, it should be stressed, is low but the need to improve prevention could not be higher.

To inform prevention we need evidence. Suicide is complex, rarely caused by one thing, and suicide prevention is also complex. We need to understand who is at risk and when, the stresses and settings, and the response of services. We need to know the numbers – these are not dry data; they tell us the size of the prevention challenge and whether risk is changing.

The National Child Mortality Database is an extraordinary project, providing information on child suicide that few countries are able to collect. It draws on the co-operation of local services across England – being national is crucial to robust findings. It gives us early sight of the full figures, before decisions are made at inquest – many suicides are not officially recorded as such because of ambiguity over what the child intended. Having "real-time" data of this kind became vital during the pandemic.

Suicidal behaviour among children has become a public health priority. Suicide has risen in this age group for at least a decade, in contrast to the more fluctuating pattern in adults. Non-fatal self-harm too has increased and spread to younger adolescents. Young people are becoming more likely to see self-harm as a way of coping with stress. Epidemiological evidence links suicide and self-harm to deprivation. Sociological perspectives point to detachment from the values of wider society.

This new report adds to our understanding by examining the individual tragedies. It shows how varied the circumstances can be. Child suicides can occur in any part of the country, urban or rural, deprived or affluent. The factors that seem to have contributed also vary – from bereavement to bullying and online experience. In over a third, there has never been contact with mental health care.

"Child suicides can occur in any part of the country, urban or rural, deprived or affluent. The factors that seem to have contributed also vary – from bereavement to bullying and online experience."

**Louis Appleby**

What does it mean for prevention? Encourage young people to understand their own emotional health, to ask for help when they need it. Ensure services are skilled and accessible. For all of us, stay vigilant and supportive of family and friends. Most will get through the pressures of adolescence but for some the stresses are serious and the risks are real.

**Louis Appleby**

**Professor of Psychiatry, University of Manchester**

**Chair, National Suicide Prevention Strategy Advisory Group for England**

# 1. Executive Summary

Every child or young person who dies by suicide is a precious individual and their deaths represent a devastating loss for parents, siblings, grandparents, carers, guardians, extended family and friends. Suicide leaves a legacy for families that can have an impact on future generations and the wider community. As with all deaths of children and young people, there is a strong need to understand what happened, and why. We must also ensure that anything that can be learned to prevent future deaths by suicide from happening is identified and acted upon.

This National Child Mortality Database (NCMD) thematic report aims to identify the common characteristics of children and young people who die by suicide, investigate factors associated with these deaths and identify common themes to help inform policymakers, commissioners, those providing services to children and young people and those involved in reviewing deaths of children and young people. It also aims to contribute to the existing evidence base in this area to inform ongoing and future research into the mental health of children and young people. For the purposes of this report, the term "children and young people" refers to those up to the age of 18.

This report looks at deaths that occurred, or were reviewed by a CDOP, between 1 April 2019 and 31 March 2020 and therefore does not cover the period of the COVID-19 pandemic. The NCMD team has continued to monitor suicides of children and young people throughout the pandemic using a real-time surveillance system and has found no consistent evidence that suicide deaths in children and young people increased during the COVID-19 pandemic overall. While there were initial concerns that rates may have increased during the first UK lockdown, this was not statistically significant and baseline numbers remained low. Amongst the likely suicide deaths reported after the first UK lockdown, restriction to education and other activities, disruption to care and support services, tensions at home and isolation appeared to be contributing factors. However, no clear increase in childhood suicides has been identified in these reports, or subsequently. For a detailed analysis, please read the full report entitled Child Suicide Rates during the COVID-19 Pandemic in England and our earlier briefing report entitled Child Suicide Rates during the COVID-19 pandemic: Real-time Surveillance.

## Key findings

### Notification cohort

- There were 108 deaths that were assessed as highly or moderately likely to be due to suicide, where the child or young person died between 1 April 2019 and 31 March 2020, equating to approximately 2 deaths of children and young people, aged 17 years and under, every week in England.
- The overall rate of suicide in England in this period was 1.8 per 100,000 in 9 to 17 year-olds.
- Services should be aware that childhood suicide is not limited to certain groups; rates of suicide were similar across all areas, and regions in England, including urban and rural environments, and across deprived and affluent neighbourhoods.
- Suicides were more common in older groups, with 78% (n=84) of the deaths in those aged between 15 and 17 years and 22% (n=24) in those aged 14 and below.
- Suicides were also more common in boys (2.2 deaths per 100,000 population) than girls (1.5 per 100,000 population).
- Ethnicity was known in 80% (n=86) of deaths. Of these, 79% (n=68) were children or young people described as being from a White ethnic background, and 21% (n=18) were children or young people from a Black, Asian, Mixed or Other ethnic background.
- Where the method of suicide was known (n=106), the most common method of suicide was hanging or strangulation, accounting for 69% (n=73) of deaths. The second most common method was jumping or lying in front of a fast moving object, accounting for 12% (n=13) of deaths.
- Of the 104 deaths where the location of the incident was recorded, 61% (n=63) of the likely suicides occurred within the home, 29% (n=30) occurred in a public place and 12% (n=12) occurred in another location. Of those that occurred in another location, fewer than five children or young people were in a mental health inpatient unit.

**Review Cohort**

These deaths were reviewed during the year 1 April 2019 to 31 March 2020, but the deaths occurred across a number of years. There is partial overlap with the cohort of children and young people in the notification cohort if the death was both notified and reviewed in this reporting period.

Ninety-one deaths were reviewed by a CDOP and assessed as suicide between 1 April 2019 and 31 March 2020. Work was undertaken by NCMD to determine the adverse factors present in the background, social environment and household circumstances of the children and young people who died by suicide. A description of the factors, and the categories they are included within can be found in Appendix A.

While in this report we were able to identify the profile of the children and young people who died by suicide, research is needed to place these factors (e.g., illicit drug use) in context in the wider population, to identify changes in the demographics of childhood suicide (e.g., temporal changes in the age of children and young people). Additionally, the role and mechanisms of a range of risk factors (including neurodevelopmental disorders), and how they may interact and accumulate in these vulnerable children, is also needed.

- Eighty-one (89%) children or young people had more than one factor recorded by CDOPs in their background, social environment and household circumstances, with 51 (56%) children or young people having a factor in 5 or more categories.
- At least 63 (69%) children or young people had factors recorded by CDOPs relating to their household circumstances, including divorce or parental separation, mental or physical health condition in a family member, domestic abuse and living with a family member who was misusing drugs or alcohol.
- At least 45 (49%) children or young people had demonstrated some risk-taking behaviour prior to their death. For example, non-suicidal self-harm was reported in 33 (36%) children or young people and 20 (22%) had previously attempted suicide before they died.
- At least 56 (62%) children or young people had suffered a significant personal loss in their life prior to their death, such as bereavement, loss of friendships and routine due to moving home or school or other close relationship breakdown.
- Eight (9%) children or young people had been bereaved by the suicide of a friend or relative, and a further 9 (10%) children or young people had a friend or relative in their life who had attempted suicide.
- At least 22 (24%) children or young people had a diagnosed mental health condition at the time of their death. Of those 22 children or young people, 11 had more than one diagnosed mental health condition at the time of their death. The most common diagnosis was depression (n=19), followed by anxiety (n=11) illustrating the importance of recognising that children and young people may simultaneously experience a number of different mental health disorders.

- Over one third (n=33, 36%) of the children and young people had never been in contact with mental health services. A third of children and young people (n=30, 33%) were in current contact with mental health services. At least five (5%) children or young people were awaiting assessment by mental health services at the time of their death and five (5%) children or young people were previously known to mental health services but had not been in contact with them during the last twelve months of their life. This suggests that mental health needs or risks were not identified prior to the child or young person's death.
- For thirty-two (35%) children and young people, problems with services were recorded by CDOPs with the most frequently reported issues being poor communication / problems with information sharing between services and quality of service delivery. Poor information sharing between police, schools and health services was specifically highlighted in learning identified by CDOPs.
- Eleven (12%) children or young people were known to have visited suicide related websites or searched for information on methods of suicide.
- At least 29 (32%) children or young people had experienced at least one form of abuse or neglect. The most common forms of abuse or neglect were rape or sexual abuse (n=9) (including sexual assault), emotional abuse (n=9) and physical abuse (n=8).
- At least 15 (16%) children or young people had a confirmed diagnosis of a neurodevelopmental condition at the time of their death. Of these 15, 7 had autism spectrum disorder (ASD) and 6 had attention deficit hyperactivity disorder (ADHD). This appears higher than found in the general population.
- Twenty-seven (30%) children or young people had experienced problems at school including exclusions, regular non-attendance, coursework/exam stresses or concerns about results.
- For 21 (23%) children or young people CDOPs recorded that they had experienced bullying or cyber bullying. The majority of reported bullying occurred in schools.

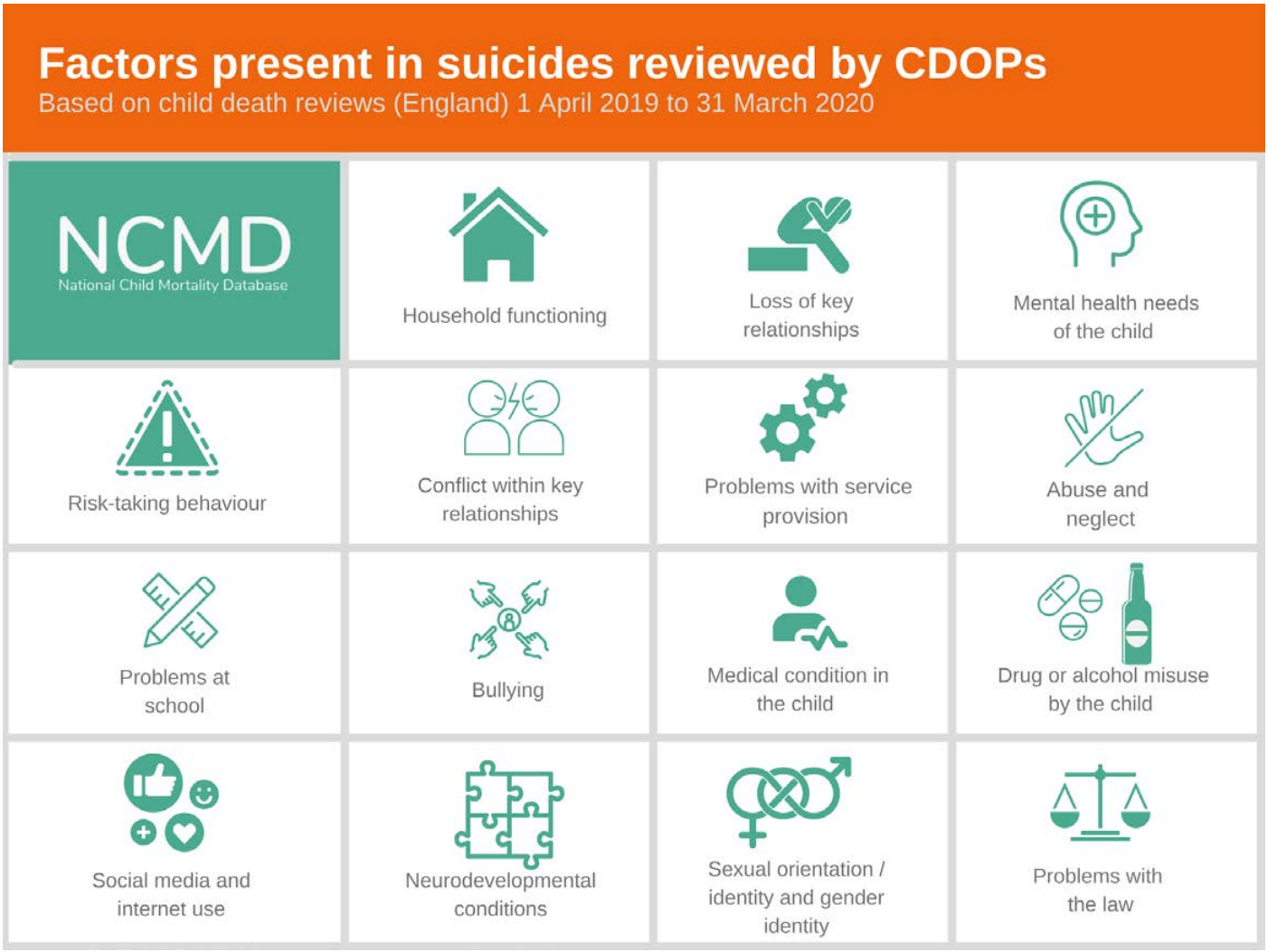
## Recommendations

**How to use these recommendations.**

Everyone who is involved in the provision of services for children and young people should read this report. Individuals should study the recommendations relevant to their sector and areas of practice and take action by utilising quality improvement methodologies in their local area, working collaboratively across agencies, to ensure a systematic approach to improving the safety and effectiveness of their service provision.

The recommendations described below are based on the data contained in the analysis of the notification and review cohorts and the learning points identified by CDOPs.

1. Ensure all frontline staff working with children and young people 10 years of age and over are supported to attend suicide prevention training (also known as "gatekeeper training", a short intervention available online). **Action by: Multi-agency Suicide Prevention Partnerships, Integrated Care System Suicide Prevention Leads, Local Authorities / Association of Directors for Children's Services, Mental Health Providers, Primary Care, Department of Health and Social Care, Department for Education, Independent Schools Inspectorate, Independent Schools Council, Ofsted and the Association of Colleges**
2. Improve awareness of the impact of domestic abuse, parental physical and mental health needs and conflict at home. In addition, agencies should ensure that where a parent or carer is open to adult mental health services, existing processes include systematic risk assessment (including thoughts of suicide) of the needs of the child or young person by all partner agencies to ensure they receive appropriate support. **Action by: Integrated Care System Suicide Prevention Leads, GPs, Adult Mental Health Services, Children and Young People's Mental Health Services, Social care, Alcohol and Drugs Services, Children Services**
3. Review existing national policies and guidance to ensure they emphasise the range of indicators that this report has identified to improve awareness of the possibility of child suicide. **Action by: Department of Health and Social Care, Department for Education, Local Authorities, Independent Schools Council, Independent Schools Inspectorate, Ofsted, Association of Colleges, Criminal Justice System**
4. Ensure all schools and colleges (including independent and faith-based schools) have clear anti-bullying policies that include guidance on how to assess the risk of suicide for children and young people experiencing bullying and when and under what circumstances multi-agency meetings will be called to discuss individual children/young people. The link between bullying and suicide is well established and the guidance published by DfE 'Behaviour and Discipline in Schools' should set out the duties of schools and colleges to respond to bullying and cyber bullying, including referral to other agencies e.g., Police. **Action by: Department of Health and Social Care, Department for Education, Independent Schools Council, Independent Schools Inspectorate, Criminal Justice System**
5. Review local policies on information sharing and escalation to ensure children and young people at risk of suicide can be identified and supported. **Action by: Department of Health and Social Care, Department for Education, Independent Schools Council, Independent Schools Inspectorate, Criminal Justice System**
6. Issue revised guidance to schools on the use of exclusion. Guidance should recognise that when a child or young person is permanently excluded from school or college, any relationships with universal services are at risk of becoming fractured. This should be considered when decisions are being made for a young person's future and should be identified as a potential risk factor for suicide. If a school or college is considering excluding someone there should be multi-agency engagement to discuss other potential solutions. **Action by: Department for Education, School Leadership Teams and Governors, Independent Schools Council, Independent Schools Inspectorate, Ofsted, Association of Colleges**
7. Support the continued roll out of children and young people's mental health services across community settings such as schools, local authorities and criminal justice to improve accessibility (including availability of clear referral criteria, pathways and adult service transition) and capacity of services for children and young people. This should cover the spectrum of prevention, early intervention, and specialist treatment. **Action by: Commissioners and Providers of Mental Health Services, Department of Health and Social Care, Department for Education, NHSE/I, Independent Schools Council, Independent Schools Inspectorate, Ofsted, Association of Colleges, Local authorities, Criminal Justice System**
8. National roll-out of the questions developed in the South-East England Best Practice case study included in this report to ensure appropriate identification and targeting of postvention support (actions taken to support the community after someone dies by suicide). **Action by: National Police Chiefs' Council**
9. Improve information and advice available to parents/carers, primary care and community services about monitoring (signs to be concerned) and support for children and young people, including those who disengage with mental health services. This should include access to local crisis helplines and national resources. **Action by: Mental Health Service Providers commissioned via local authorities and the NHS, Voluntary and Community Sector organisations and independent sector organisations**




# 2. Why was this work undertaken?

"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[1]

In the UK, suicide rates in children and young people are rising and the suicide rate for girls/young women aged under 20 is now the highest since 1981.[2] Internationally, suicide rates in 15 to 24 year-olds have risen in several high-income countries, including Australia, Canada, the UK and the USA, over the last decade.[3]

Those countries experiencing a rise are the most populous, predominantly English-speaking, and with higher levels of income inequality and Gross Domestic Product (GDP).[3] There are many factors which may contribute to the increase in suicide rates including changes in coroner's practice, changing levels of mental health problems in children and young people and use of more lethal methods of suicide.

In July 2018 the standard of proof used by coroners to determine whether an unexpected death was caused by suicide was lowered from the criminal standard of beyond all reasonable doubt to the civil standard of the balance of probabilities. Following this change, there was concern that this may have led to an increase in the number of deaths being registered as suicide, particularly in children and young people. The Office for National Statistics (ONS) examined the impact of the lowered standard of proof on suicide registrations in England and Wales and found no significant change in the reported suicide rate.[4]

1 Myths about suicide, The Samaritans
2 Office for National Statistics, 2020
3 Padmanathan et al, 2020
4 Nasir, Manders, 2020

Young people themselves have reported many factors which they associate with increasing levels of distress, increasing academic pressures, concern about job prospects and financial insecurity.

The National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) has shown that the number of suicides in children and young people increases with age and more boys/young men than girls/young women die by suicide.[5] Young people themselves have reported many factors which they associate with increasing levels of distress including the financial crisis in 2008, increasing academic pressures, concern about job prospects and financial insecurity.[6] In addition, the prevalence of non-suicidal self-harm in England has also increased between 2000 and 2014, particularly among 16 to 24 year-old young women.[7] Rates of self-harm are rising, and at a faster rate for girls/young women than boys/young men.[8] Sexual minority adolescents have higher rates of self-harm and attempted suicide compared with heterosexual adolescents.[9] Mental health disorders are associated with self-harm; 25% of 11 to 16 year-olds with a disorder had self-harmed/attempted suicide in comparison with 3% without.[10] Self-harm is a strong risk factor for subsequent suicide[11] but many young people who self-harm are not known to services.[12]

NCISH have previously identified several themes common to many suicides that could be a target for prevention. These include academic (especially exam) pressure, bullying, bereavement, suicide in friends or family members, physical health conditions, family problems, social isolation or withdrawal, child abuse or neglect, excessive drinking and illicit drug use by the child or young person, suicide related internet use (e.g., searching for details of suicide methods) and mental ill-health, self-harm and suicidal ideas. In addition to improved services for self-harm and mental health, the wide range of preceding factors identified emphasise the role of schools and colleges, primary care, social services and the youth justice system as essential to suicide prevention. In addition, there is evidence that school-based programmes are effective in preventing and reducing traditional bullying, cyber bullying and cyber victimisation.[13]

The publication of the NHS Long Term Plan and the NHS Mental Health Implementation Plan have clearly demonstrated the commitment of Government and the NHS to addressing public concern over the mental health of children and young people. In January 2019, the Government published the first cross-Government suicide prevention plan. The plan has a focus on how social media and the latest technology can identify those at risk of suicide. It also includes greater focus on addressing the increase in suicide and self-harm among young people.[14]

5 University of Manchester, 2017
6 Bould et al, 2019
7 McManus et al, 2019
8 Rodway et al, 2020
9 Patalay, Fitzsimons, 2021
10 NHS Digital, 2018
11 Morgan et al, 2017
12 Ystgaard et al, 2009
13 Bonnell et al, 2018
14 HM Government, 2019

# 3. Methodology

The NCMD Programme was established in 2018 to collate and analyse data on all children and young people in England, who die before their 18th birthday, with statutory death notifications required within 48 hours. The data are collated from the 58 regional Child Death Overview Panels (CDOPs) in England who carry out detailed analysis of the circumstances of death and the modifiable factors relevant to the death as part of the child death review (CDR) process with the aim of identifying common themes to guide learning and inform actions to reduce future child deaths.[15] The CDR process is statutory, with the Children Act 2004 mandating the review and analysis of all child deaths so the circumstances of death that relate to the welfare of children and young people locally and nationally, or to public health and safety, are identified and understood and preventive actions are established. NCMD provides a valuable resource for learning from the deaths of children and young people at a national level. NCMD uses detailed information collected and analysed from the CDR process to inform policies to drive improvements in child health and wellbeing.

Discussions carried out by the NCMD team with key stakeholders in the programme including CDOPs and the NCMD Professional Advisory Group (PAG), identified suicide in children and young people, and the increasing rate of suicide in this group, as a key area of concern and therefore a priority for investigation through a thematic report. This recommendation was formally supported by NHS England. A working group, drawing in expertise in clinical child and adolescent psychiatry, safeguarding, epidemiology, education, quality improvement and behaviour change, and research in suicide prevention, was set up by the NCMD team to explore this topic further. The group also benefitted from the expert input of PAPYRUS-UK, the charity for prevention of young suicide.

The data in this report was submitted to NCMD by CDOPs in England. The data is collected by CDOPs using a set of statutory forms including the child death notification form, reporting form, supplementary reporting form for Suicide or Self-Harm and the analysis form.

This report includes data relating to two separate cohorts of children and young people defined as follows:

| | |
|---|---|
| "Notification Cohort" | Children and young people who died between 1 April 2019 and 31 March 2020 and whose death was coded by the NCMD team as being highly or moderately likely due to suicide. There were 108 children and young people in this cohort. |
| "Review Cohort" | Children and young people whose deaths were reviewed by a CDOP between 1 April 2019 and 31 March 2020 and classified by CDOP as Category 2* on the statutory analysis form, excluding those assessed as substance misuse related deaths. The deaths of these children and young people occurred between 2015/16 and 2019/20. There were 91 children and young people in this cohort. |

* Category 2 relates to deaths due to suicide or deliberate self-inflicted harm. This includes deaths as the result of hanging, shooting, self-poisoning with drugs, death by self-asphyxia, from solvent inhalation, alcohol or drug abuse, or other form of self-harm.

## Limitations

There are several limitations to the analyses included in this report. Deaths by suicide of children and young people are fortunately rare, so the analysis is based on small numbers. In some instances, it is impossible to be sure of the intent of the child or young person and whether they truly intended to take their own life. In addition, the amount of information available varies e.g., extensiveness of toxicology testing, number of witnesses to the event and description of circumstances. Following the publication of new national guidance for CDOPs in October 2018,[15] new data collection forms were introduced and began to be used for deaths occurring after 1 April 2019. This means that for those children and young people included in the review cohort, who died before that date, different data collection forms were used. These changes to the statutory data collection also likely contributed to a low completion rate (49%) of supplementary reporting forms for the review cohort. In addition, variability of practice between CDOPs remains, particularly in what each panel records on the analysis form and whether factors are considered to be modifiable or not.

It is possible that in some instances there was insufficient information submitted to NCMD to determine all the adverse factors present for the deaths within the review cohort. Therefore, the number of individual children and young people with each individual factor present is likely to be the minimum number.

15 Department of Health and Social Care, Department for Education, 2018

# 4. Characteristics of children and young people who die by suicide (Notification Cohort)

The aim of this section of the report is to describe the characteristics of children and young people whose deaths are likely to have been due to suicide. The data presented has been taken from the details provided on the child death notification form which is completed within 48 hours of the death occurring, usually by a Joint Agency Response (JAR) practitioner (paediatrician, nurse or health visitor) or a police officer. The information included in the form is gathered through discussions with the child or young person's family in the 48 hours following the death. It is important to note that some of these deaths may subsequently be re-classified as due to something other than suicide once the full post-mortem, investigation and review process have been completed.

The child death notification form is a national data collection form designed to collect data on all children and young people who die, of any cause, before their 18th birthday. The questions asked on the form must therefore be applicable to deaths of all ages and types. The form collects demographic information on age, sex and ethnic group as well as the suspected cause of death (if known) and a free text narrative account of what was known about the circumstances of death at the time it occurred. It does not collect information on other protected characteristics, although these are collected via the other child death review forms and therefore are included in the analysis of the review cohort.

## How we carried out this work

All children and young people who died between 1 April 2019 and 31 March 2020 and whose deaths were notified to NCMD were reviewed and categorised by four people (three paediatricians and one NCMD Manager with CDOP expertise) to identify probable suicide deaths. Where full agreement could not be reached, the deaths were re-reviewed by each member of the team. Deaths where there was still disagreement were then reviewed by a clinical researcher with expertise in suicide research. In keeping with the approach used in previous research[6], this final review categorised the likelihood that these deaths were by suicide as: high, moderate, low or unclear, based only on the information in the child death notification form. The deaths categorised as being highly or moderately likely to be due to suicide were included in the notification cohort for the analysis.

This section does not include analysis of detailed circumstances or background factors associated with suicide in the children and young people who died due to the limited information required in the child death notification form.

Rates of suicide reported in this section were derived using the ONS estimated population data from 2019 which provide data on the underlying population by sex, age and region of residence for 9 to 17 year-olds (2019 mid-year population estimate (ONS)). They are quoted as per 100,000 children/young people. Where statistical comparisons were performed, we derived a Negative binomial distribution model to calculate the rates of suicide, with and without the variable of interest (e.g., region). P-values for any difference were derived by comparing these two models using the likelihood ratio test.

> Most of the deaths included in this cohort occurred before the implementation of the lockdown measures in response to the COVID-19 pandemic

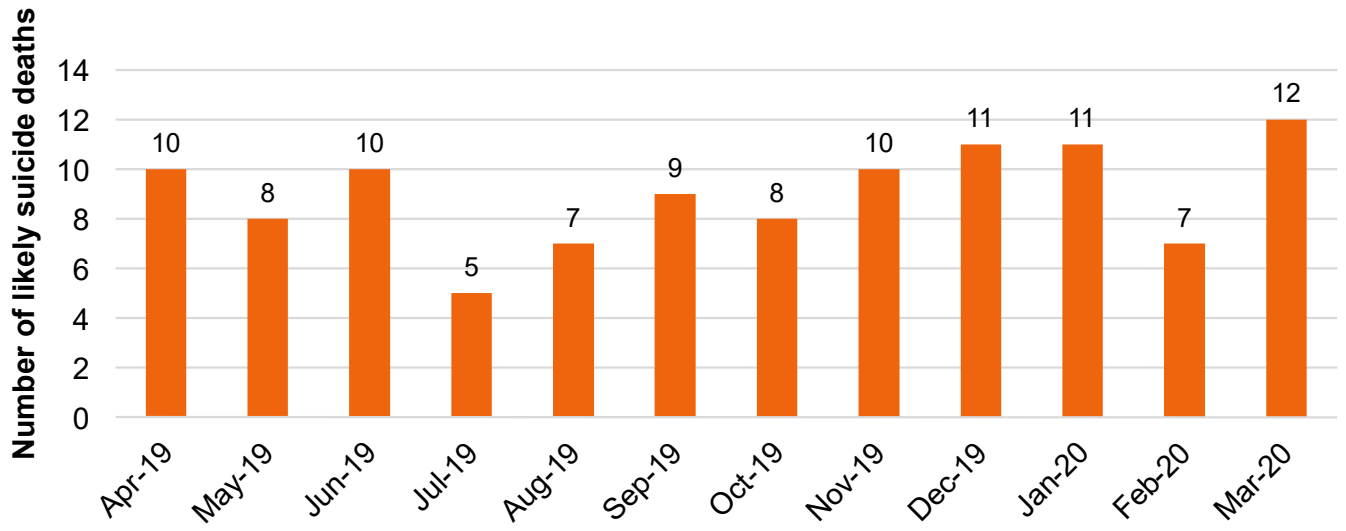
## What we found

NCMD were notified of 108 deaths that were assessed as highly or moderately likely to be due to suicide, where the child or young person died between 1 April 2019 and 31 March 2020. Most of the deaths included in this cohort occurred before the implementation of the lockdown measures in response to the COVID-19 pandemic. The monthly pattern of these deaths is shown in Figure 1, although this should be interpreted with caution due to small numbers and data only being presented for one year.

This compares with lower numbers of suicides per year reported by NCISH for 2014-2016.[7] The NCISH report primarily used coroner's inquest records to obtain data on suicides and the lower numbers reported there suggest that ONS data may under-estimate the number of child suicides in England.

Nationally and regionally, close attention is being paid to the number of suicides via the NCMD real-time surveillance system's trend analysis.

**Figure 1: The number of child/young person death notifications received by CDOPs assessed as highly or moderately likely to be due to suicide by month, year ending 31 March 2020.**



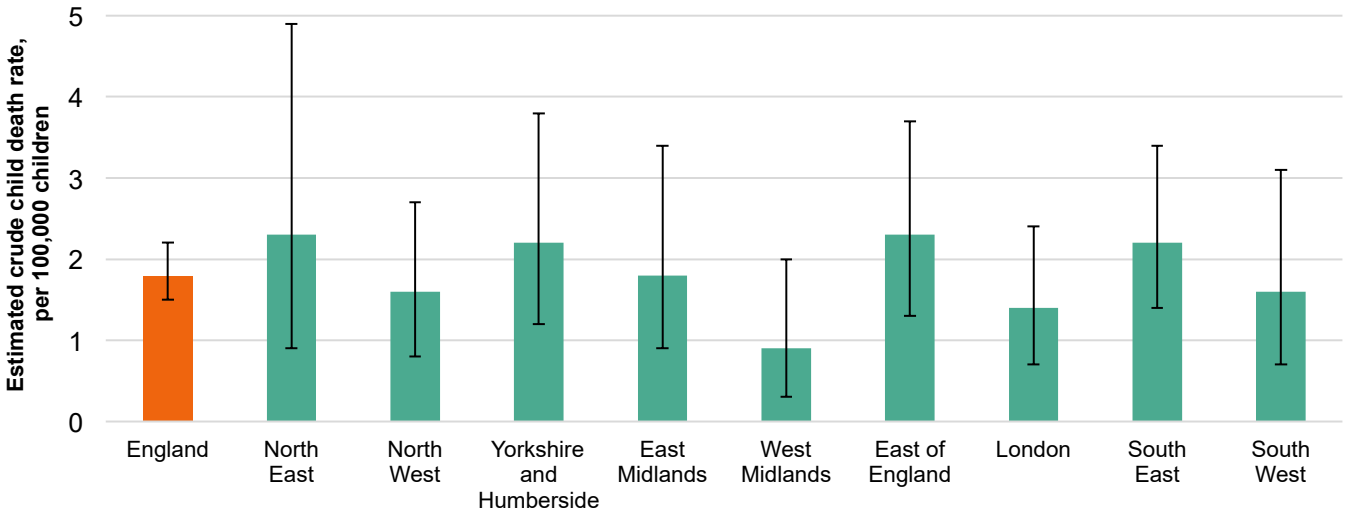

Data source: NCMD

### Region

There were 1.8 child/young person deaths assessed as highly or moderately likely to be due to suicide per 100,000 population in 9 to 17 year-olds. Regional rates across England ranged from 0.9 to 2.3 deaths per 100,000 children/young people (Figure 2 and Table 1). There was no evidence that different regions of England had significantly different death rates (p=0.524).

Each area of residence is classified into either Rural (Rural town and fringe, Rural village) or Urban (Urban city and town, Urban major conurbation) using ONS definitions. There was also no significant difference in suicide rates of children/young people living in urban areas (1.8 deaths per 100,000 population) compared to those living in rural areas (1.7 deaths per 100,000 population) (p=0.920).

**Figure 2: Rate of child/young person deaths assessed as highly or moderately likely to be due to suicide by region, year ending 31 March 2020.**




Data source: NCMD, 2019 mid-year population estimate (ONS)

I represents 95% confidence intervals

In 3 instances postcode was not known or incomplete and data linkage to derive region was not possible

## Age and sex

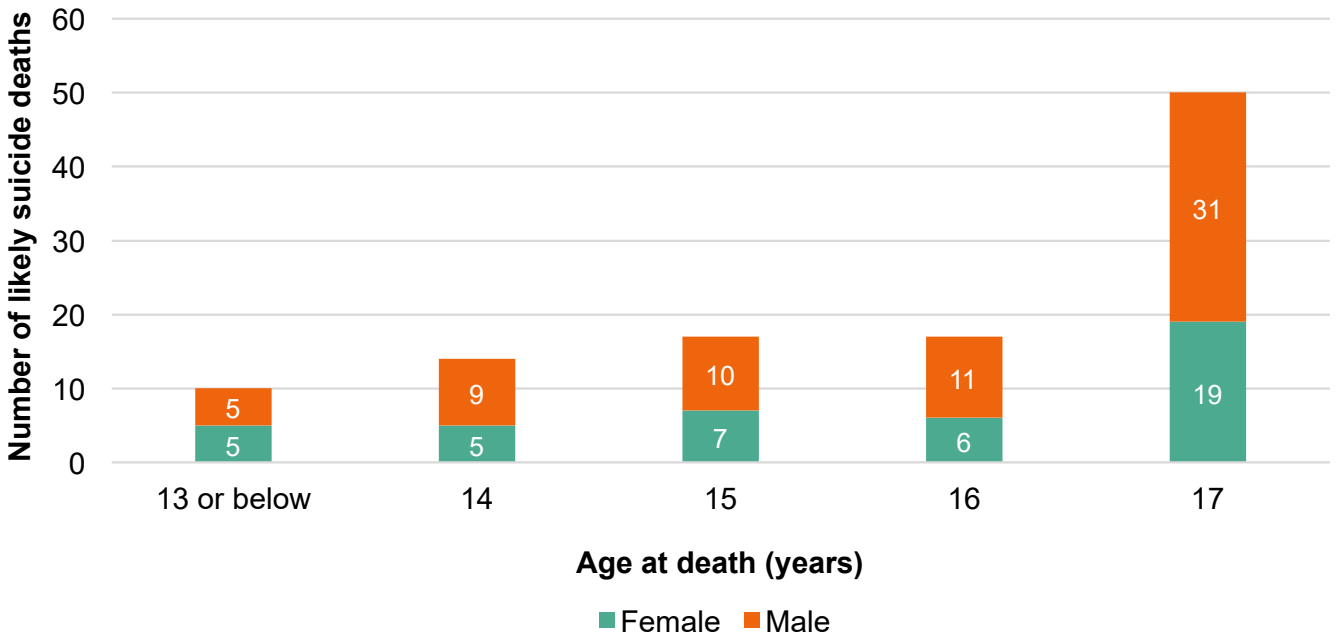
Figure 3 shows the number of likely suicides by age and sex. Most deaths were in children/young people aged 17 years (46%, n=50). There were 84 deaths where the child/young person was aged between 15 and 17 years, representing 78% of all likely suicides. Ten deaths (9%) were in children/young people who were aged 13 or below. This is a higher proportion than that reported in the NCISH (2017) report, where 3% of deaths were of children/young people aged 13 or below. This increase in the proportion of deaths of younger children is a concerning signal, however, the difference may be due to the different methodology used in this report to identify potential suicides at the point of notification. NCISH uses coronial data for analysis, and this report uses data from the child death review process.

The number of likely suicides increased significantly with age where the suicide rate of children/young people aged 17 years (8.3 deaths per 100,000 population) was almost three times higher than that of children/young people aged 16 years (2.8 deaths per 100,000 population) (Table 1).

Sixty-one percent (n=66) of likely suicides were boys/young men (Table 1). Young men aged 17 years accounted for the largest overall proportion of deaths (29%, n=31) (Figure 3). For deaths where the child was 13 or under (n=10), 50% (n=5) were boys and 50% (n=5) were girls.

After adjusting for the gender distribution in population, the death rate of boys/young men (2.2 deaths per 100,000 population) remained higher than that of girls/young women (1.5 per 100,000 population) (Table 1).

**Figure 3: The number of deaths of children/young people assessed as highly or moderately likely to be due to suicide, by sex and age at death, year ending 31 March 2020.**




Data source: NCMD

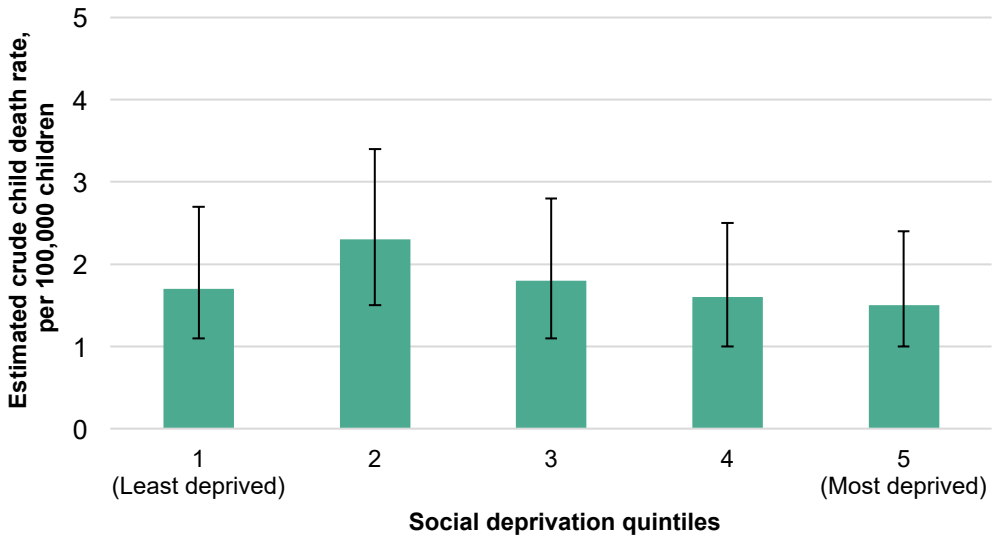
## Social deprivation

In order to explore any possible link between social deprivation and suicide in children and young people, the postcode of each child or young person was linked to its corresponding Index of Multiple Deprivation (IMD 2019) which is an areas base measure of social deprivation calculated to the granularity of around 1,500 people. Each neighbourhood is ranked from most deprived to least deprived, which are then divided into five equal sized groups (quintiles).

Similar suicide rates were associated with children and young people living in the most deprived neighbourhoods of England (n=21, 20%) compared to the least deprived (n=20, 19%) (Table 1). When adjusting for the number of children of the same age estimated to be living within each quintile (Figure 4 and Table 1), there was no significant difference in the suicide rate for those in the least deprived areas compared to the most deprived areas (p=0.390). Thus, there appeared to be no effect of deprivation on the rate of deaths by suicide. This is in contrast to the situation in adults where suicide is strongly socially patterned with higher rates in poorer socioeconomic groups[16]. This finding of no social gradient is different to the pattern seen in most causes of childhood death as described in the NCMD thematic report on Child Mortality and Deprivation.

16 Windsor-Shellard,Gunnell, 2019

**Figure 4: The rate of child/young person deaths assessed as highly or moderately likely to be due to suicide and the estimated crude death rate by deprivation quintiles, year ending 31 March 2020.**




Data source: NCMD, IMD (2019)

I represents 95% confidence intervals

"My son spoke about suicide every day, so it became part of his language and people became immune to it. Knowing what to say was difficult for everyone and not something we discussed."

**Bereaved parent**

**Table 1: The number and estimated rate of child/young person deaths assessed as being highly or moderately likely to be due to suicide by characteristic, year ending 31 March 2020.**

| | Number (%) of deaths | Estimated population (9 – 17 years)* | Estimated crude death rate, per 100,000 children/ young people (95% CI) | p-value |
|---|---|---|---|---|
| **All likely suicide deaths** | **108 (100%)** | **5,886,033** | **1.8 (1.5-2.2)** | |
| Age at death (years) | | | | 0.008 |
| 13 or below | 10 (9%) | 3,420,413 | 0.3 (0.1-0.5) | |
| 14 | 14 (13%) | 634,057 | 2.2 (1.2-3.7) | |
| 15 | 17 (16%) | 624,607 | 2.7 (1.6-4.4) | |
| 16 | 17 (16%) | 607,513 | 2.8 (1.6-4.5) | |
| 17 | 50 (46%) | 599,443 | 8.3 (6.2-11.0) | |
| Sex | | | | 0.042 |
| Female | 42 (39%) | 2,867,247 | 1.5 (1.0-2.0) | |
| Male | 66 (61%) | 3,018,786 | 2.2 (1.7-2.8) | |
| Region^ | | | | 0.524 |
| North East | 6 (6%) | 265,152 | 2.3 (0.9-4.9) | |
| North West | 12 (11%) | 766,943 | 1.6 (0.8-2.7) | |
| Yorkshire and Humberside | 13 (12%) | 578,372 | 2.2 (1.2-3.8) | |
| East Midlands | 9 (9%) | 496,503 | 1.8 (0.9-3.4) | |
| West Midlands | 6 (6%) | 639,818 | 0.9 (0.3-2.0) | |
| East of England | 15 (14%) | 660,032 | 2.3 (1.3-3.7) | |
| London | 13 (12%) | 938,220 | 1.4 (0.7-2.4) | |
| South East | 22 (21%) | 985,645 | 2.2 (1.4-3.4) | |
| South West | 9 (9%) | 555,345 | 1.6 (0.7-3.1) | |
| Area^ | | | | 0.920 |
| Urban | 88 (84%) | 4,911,642 | 1.8 (1.4-2.2) | |
| Rural | 17 (16%) | 974,388 | 1.7 (1.0-2.8) | |
| Social deprivation quintile^ | | | | 0.390 |
| 1 (Least deprived) | 20 (19%) | 1,161,657 | 1.7 (1.1-2.7) | |
| 2 | 25 (24%) | 1,084,237 | 2.3 (1.5-3.4) | |
| 3 | 20 (19%) | 1,101,612 | 1.8 (1.1-2.8) | |
| 4 | 19 (18%) | 1,179,815 | 1.6 (1.0-2.5) | |
| 5 (Most deprived) | 21 (20%) | 1,358,709 | 1.5 (1.0-2.4) | |

*Data source: NCMD, 2019 mid-year population estimate (ONS), IMD (2019)

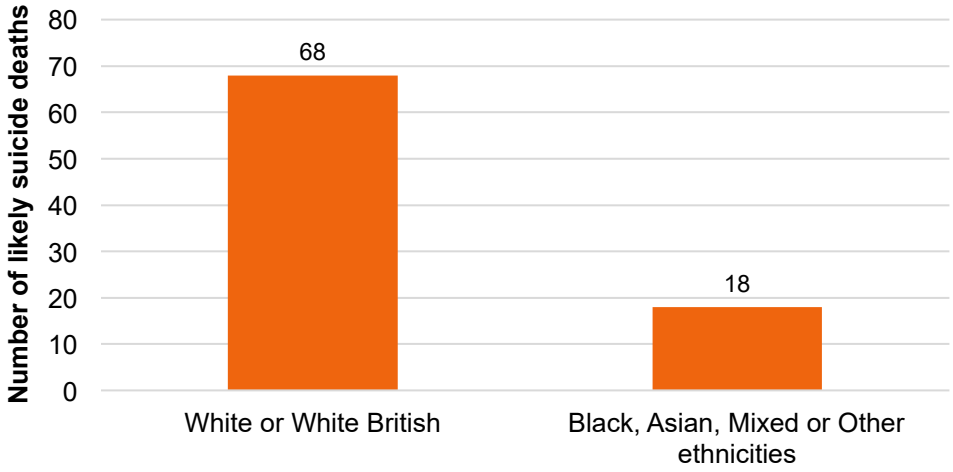
^ In 3 instances postcode was not known or incomplete and data linkage to derive region, area and deprivation was not possible.

## Ethnic group

Of the 86 (80%) deaths where ethnicity was recorded on the notification form, 68 (79%) were of children or young people described as being from a White ethnic background, and 18 (21%) from a Black, Asian, Mixed or Other ethnic background (Figure 5).

This is comparable with general population projections in England for 2020 where 75% of 9 to 17 year-olds are estimated to be from a White ethnic background and 25% from a Black, Asian, Mixed or other ethnic backgrounds[17]. Data published from the latest census in 2021 will allow for a more reliable comparison.

**Figure 5: The number of child/young person deaths assessed as highly or moderately likely to be due to suicide by ethnic group, year ending 31 March 2020.**




Data source: NCMD

In 22 instances, data for the child's ethnic group was not known or incomplete.

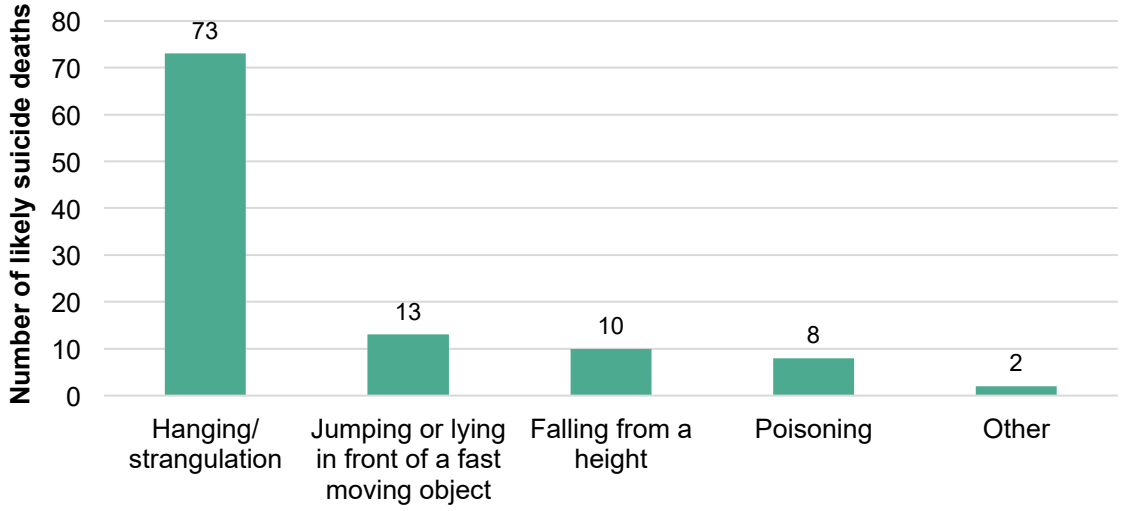
## Method of suicide

The most common method of suicide in children and young people, accounting for 69% (n=73) of all deaths, was hanging or strangulation (Figure 6). This was the most common method for both boys/young men and girls/young women at all ages.

The second most common method was jumping or lying in front of a fast moving object (e.g., a train), accounting for 12% (n=13) of all likely suicides. Both hanging/strangulation and jumping or lying in front of a fast moving object carry a high likelihood of fatality.

17 Wohland et al, 2021

**Figure 6: The number of child/young person deaths assessed as highly or moderately likely to be due to suicide by method, year ending 31 March 2020.**




Data source: NCMD

n=106

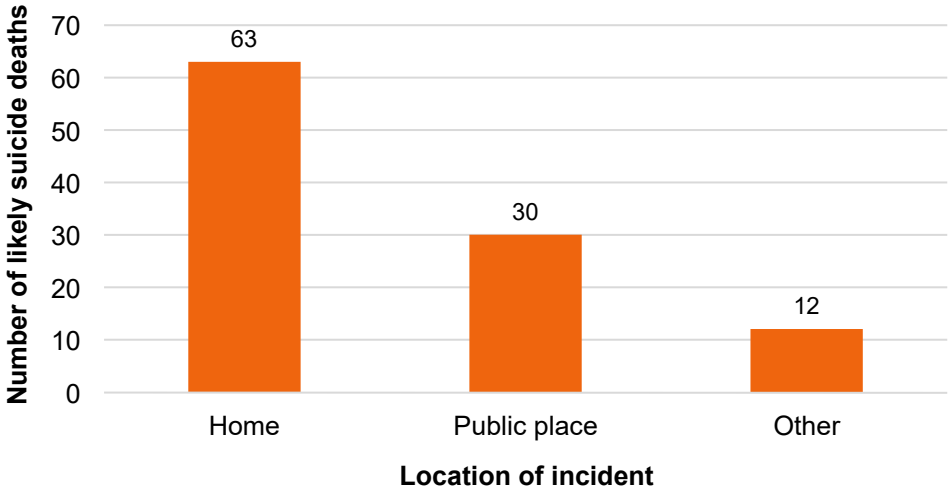
In 2 instances the method was not known, or incomplete.

## Location of incident

Of the 104 deaths where the location of the incident was recorded, 63 (61%) of the likely suicides occurred within the home, 30 (29%) occurred in a public place and 12 (12%) occurred in another location (Figure 7).

Of those that occurred in another location, less than 5 were in a mental health inpatient unit. Out of the 30 deaths that occurred in a public place, the most common areas were railway lines and woodland areas.

**Figure 7: The number of child/young person deaths assessed as being highly or moderately likely to be due to suicide by the location of incident, year ending 31 March 2020.**




Data source: NCMD

In 3 instances the location of the incident was not known or incomplete

Other includes school or college, hospital, other private residences and accommodation.

# 5. Findings from the review of the deaths (Review Cohort)

The aim of this section of the report is to analyse the background factors present in those children and young people who died by suicide. The data presented in this section is from the review cohort and has been taken from the details provided in the finalised child death review provided by the CDOP. This includes information in the child death notification form, reporting form, supplementary reporting form for Suicide or Self-Harm and the analysis form.

The value of analysing data in the Review Cohort is that it identifies features in the background and social context of the child or young person which may have contributed to their suicide risk. The data in this section is submitted following the conclusion of the post-mortem and coronial process and the conclusion of the child death review process.

## How we carried out this work

Deaths that were reviewed by a CDOP between 1 April 2019 and 31 March 2020 (this is different to the date of death, which will have occurred earlier) and were categorised as "Suicide or Deliberate Self-inflicted Harm" (Category 2) were extracted from the NCMD database. This category includes deaths both due to suicide (e.g., those deaths where the CDOP concluded the child or young person had died by suicide) and substance-misuse-related deaths where the intention of suicide remains unclear (i.e. deaths following illicit drug use). These deaths were reviewed by the NCMD team to identify substance-misuse-related deaths where the intention of suicide was unclear. These were deaths where drug, or drug toxicity, was recorded on the Medical Certificate of Cause of Death (MCCD) or the coroner had given a conclusion other than suicide. Where there was doubt, these deaths were reviewed by a researcher with expertise in suicide research to determine whether they were likely to be substance-misuse-related deaths. These substance-misuse-related deaths were then excluded from subsequent analysis.

Using the CDOP classification of death enables identification of any deaths not classified as suicide by the coroner, particularly for those deaths that occurred prior to July 2018 when the standard of proof required for a suicide conclusion at a coronial inquest was higher.

Factors identified by the CDOP were coded by the NCMD team after examining the information documented within the notification, reporting and analysis forms and the supplementary reporting form for Suicide or Self-Harm. Initial coding was undertaken by NCMD staff with many years of experience of sitting on Child Death Overview Panels and involvement in the child death review process. Following the completion of the initial coding, a validation exercise was undertaken with a consultant clinical psychiatrist and a clinical academic with expertise in suicide research who separately reviewed and coded a subset of 10% of the deaths to assess levels of agreement and check for consistency. Disagreements were discussed and case definitions agreed (See Appendix A). All cases were then recoded and the duplicate coding exercise was repeated with a further subset of 10% of deaths. In this second exercise, complete agreement was reached on 89% of codes.

## What we found

In the period 1 April 2019 to 31 March 2020, CDOPs reviewed 105 deaths that they categorised as due to "Suicide or deliberate self-inflicted harm" on the analysis form.

### Substance misuse related deaths

Of the 105 deaths that were categorised as "Suicide or deliberate self-inflicted harm", 14 were substance misuse related deaths.

Most (64%, n=9) were boys/young men and aged 17 (71%, n=10). The most common drug causing death was MDMA (57%, n=8). MDMA is more commonly known as ecstasy or molly, and it is a drug primarily used for recreational purposes. Eight (57%) of the children and young people whose deaths were recorded as substance misuse related were known to have had any previous contact with mental health services. In 79% (n=11) of the reviews into these deaths, the CDOP identified modifiable factors (for example, accessibility of drugs within the home).

For the purposes of this section of the report, the following analysis excludes these 14 substance misuse related deaths and is therefore based on a total of 91 deaths. These deaths were excluded as the suicidal intent of the child or young person was unclear and therefore while self-inflicted could have been due to an accidental overdose.

## Factors present in deaths reviewed by CDOPs

This analysis was conducted by reviewing all of the information submitted by CDOPs for each death in this cohort of 91 children and young people to look for common themes. Due to the small numbers, use of different data collection forms for deaths within this cohort and the variability in review between CDOPs, we have not performed an analysis of modifiable factors for this report.

The NCMD team reviewed the information submitted to NCMD to identify factors recorded for each child/young person that died. The analysis in this section describes the presence of each factor in the deaths in the review cohort but does not include an assessment of the significance of the factor in that specific death. For example, the data shows the number of children or young people that died by suicide where CDOP recorded that their parents were divorced or separated.

It is important to note that the data reported within this section should be interpreted as a minimum number, and that *at least* that number of child death reviews presented information on that factor being present. These factors can often be under-reported and rely on disclosure of this information to the CDOP, the interpretation by the CDOP, and the onward disclosure to NCMD.

A description of the factors included within each category can be found in Appendix A.

Table 2 shows the prevalence of the adverse factors within the review cohort. Out of a total of 91 deaths, 81 (89%) children or young people had an adverse factor in more than one category, with 51 (56%) children or young people identifying an adverse factor in 5 or more categories. The interaction between these factors needs further investigation.

**Table 2: The number of child/young person death reviews with factors present within each category, year ending 31 March 2020.**

| Category | Number (%) of deaths reviewed with at least one factor within the category |
|---|---|
| Household functioning | 63 (69%) |
| Loss of key relationships | 56 (62%) |
| Mental health needs of the child/ young person | 50 (55%) |
| Risk taking behaviours | 45 (49%) |
| Conflict within key relationships | 41 (45%) |
| Problems with service provision | 32 (35%) |
| Abuse and neglect | 29 (32%) |
| Problems at school | 27 (30%) |
| Bullying | 21 (23%) |
| Medical condition in the child/young person | 21 (23%) |
| Drug or alcohol misuse by the child/ young person | 18 (20%) |
| Social media and internet use | 16 (18%) |
| Neurodevelopmental conditions | 15 (16%) |
| Sexual orientation, sexual identity, and gender identity | 8 (9%) |
| Problems with the law | 8 (9%) |

Data source: NCMD

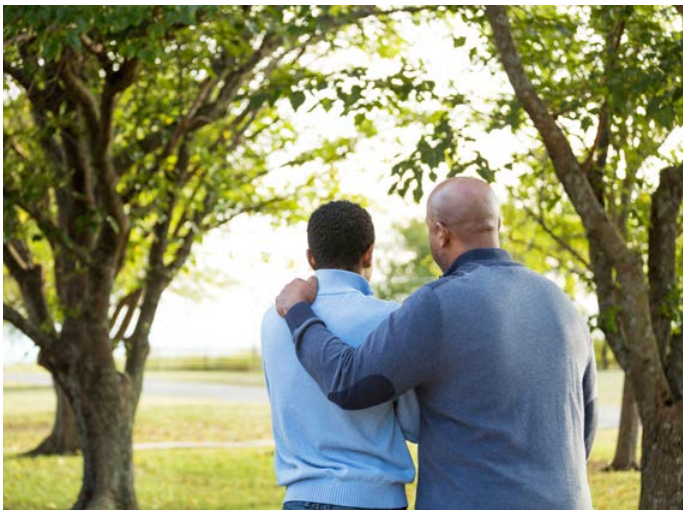
## Household functioning

Children and young people sometimes live in households with complex circumstances and for some this can be challenging. The kind of complex home circumstances that children and young people might live with include living with a parent or carer who misuses drugs or alcohol which may make home life chaotic and unpredictable; exposure to domestic abuse, including hearing it from another room, seeing the consequences of the abuse afterwards and being hurt from being nearby or trying to stop the abuse from occurring; or living with a parent or carer with a mental health problem, which may make it difficult for some parents to cope with family life. Many parents with mental health problems are able to manage their condition and minimise its impact on their children, particularly if they are able to access appropriate support, however they may for example find it difficult to control their emotions and behaviour around their children or recognise and respond to their children's emotional or physical needs.

In addition, some children and young people are carers for family members or friends who are ill or disabled due to a medical condition. This can involve many different activities such as cooking, shopping, helping someone out of bed or looking after younger siblings. The impact of caring for someone can leave young carers feeling stressed or tired and having difficulty juggling school or college and their home life.

Data on divorce or parental separation is also included in this section and CDOPs reported incidents of children and young people struggling to live between two households or experiencing challenges in forming new relationships with a stepfamily. However, it is important to note that the data presented in this section describes deaths where CDOP recorded the presence of that factor in the child or young person's background and data were not routinely collected on whether these factors were significant in the death of the child.

At least 63 (69%) children or young people whose deaths were reviewed in this analysis experienced at least one factor in the household functioning category in their household circumstances. The most common factor was divorce or parental separation (n=37, 41%) followed by a mental health condition in a family member (n=33, 36%). Twenty-eight (31%) children or young people witnessed, but were not directly involved in, domestic abuse within their household. Thirteen (14%) children/young people lived with a family member who was misusing drugs or alcohol. Six (7%) children/young people lived with a family member with a physical health condition including chronic health conditions such as chronic obstructive pulmonary disease (COPD), epilepsy and arthritis leading to mobility problems.



## Loss of key relationships

The loss of any significant relationship for a child or young person can be challenging. Loss can be experienced through the break up of a relationship with a partner, the death of a friend or relative or other bereavement, or "living losses" such as a move of house or school resulting in loss of contact with friends and communities. It is important to note that children and young people have many different types of relationships, which they may grieve the loss of, and this includes more than just their loss of relationships within their immediate family. Information on how many bereaved children and young people had bereavement support is not currently collected in the NCMD database.

At least 56 (62%) children or young people had lost a significant relationship in their life prior to their death. These relationships had been lost for a number of different reasons including bereavement, moving home or school and break up with a boyfriend or girlfriend. Thirty-one (34%) children/young people experienced a move of house or school or had another significant change to their primary environment prior to death, such as moving to England from another country or leaving college. This was the most common way in which the young people in this cohort had experienced the loss of a key relationship. Eight (9%) young people had been bereaved by the suicide of a friend or relative, and a further 9 (10%) young people had a friend or relative in their life who had attempted suicide. Twelve (13%) had experienced the break up of a relationship with their boyfriend or girlfriend in the month prior to their death. Eleven (12%) had experienced a historical loss (i.e., the loss of the relationship occurred more than a year previously) of a friend, relative or other significant person in their life. The majority of the historical losses were due to bereavement (n=6) and lack of contact with a family member (n=5) following a change in family circumstances e.g., parental separation, being taken to live with relatives, entering the care system or separation from a sibling in the care system.

## Mental health needs of the child/young person

In total, it was reported that 50 (55%) children or young people either had a confirmed mental health condition or had experienced previous suicidal or self-harm ideation.

At least 22 (24%) children or young people had a diagnosed mental health condition at the time of their death. Of those 22 children or young people, 11 had more than one mental health condition diagnosed at the time of their death. The most common diagnosis was depression (n=19), followed by anxiety (n=11). It is important to recognise that children and young people may experience a number of different mental health disorders concurrently.

At least 40 (44%) children or young people experienced suicidal or self-harm ideation where they had communicated thoughts around the intention of suicide or self-harm at some time previously.

It was reported that 33 (36%) children and young people had never been known to mental health services during their life (Table 3). This suggests that mental health needs or risks were not identified prior to the child or young person's death.

Thirty (33%) children and young people were known to mental health services at the time of their death with 10 being supported by more than one service. Twenty-four were known to Children & Young People's Mental Health Services (CYPMHS) (sometimes referred to as Child & Adolescent Mental Health Services (CAMHS), 7 were being supported by their GP, 10 were known to other mental health support services including adult mental health services, school counselling services and private counselling services. Fewer than 5 children or young people were an inpatient in a mental health hospital at the time of their death, therefore due to low numbers these deaths are not reported separately.

For at least 5 (5%) children and young people, a referral had been made to mental health services, but they were awaiting assessment at the time of their death. Issues described here relate to delays and long waits for appointments with mental health services.

A further six (7%) children or young people were having difficulty accessing or transitioning between services, suggesting that this period may be a time of particular vulnerability for children and young people. Most children and young people's mental health services provide support up to 18 years of age, however in some parts of the country services are only provided up to 16 years of age. Following this, young people will transition to adult mental health services.

In a small number of instances (fewer than 5) it was reported that the children or young people had disengaged from mental health services for which they were registered at the time of their death. This includes instances where the child or young person was not actively accessing services and instances where the child or young person had been offered support and declined, missed appointments or engaged at crisis point and then disengaged shortly afterwards.

Five (5%) children and young people were previously known to mental health services but had not been in contact with them during the last twelve months of their life, although the reasons for this are not known. This suggests that children and young people who may be vulnerable need ongoing community monitoring and the option to be fast-tracked back to services.

There was insufficient information to assess whether the child or young person was known to mental health services for 9 deaths.

**Table 3: The number of child/young person death reviews by type of contact with mental health services, year ending 31 March 2020.**

| Contact with mental health services | Number (%) of deaths reviewed |
|---|---|
| Known to mental health services at the time of death | 30 (33%) |
| Previously known to mental health services | 5 (5%) |
| Awaiting assessment | 5 (5%) |
| Difficulty accessing or transitioning between services | 6 (7%) |
| Disengaged from mental health services at the time of death | <5 |
| Never in contact with mental health services | 33 (36%) |
| Insufficient information to make a judgement | 9 (10%) |

These findings are consistent with those of NCISH who reported that 40% were not known to services.

The NHS Digital report on Mental Health of Children & Young People in England (2017) shows that 11 to 16 year-olds with a mental disorder were more likely to have self-harmed or attempted suicide at some point (25.5%) than those without a disorder (3.0%). The association with mental disorder was clear in both boys and girls. In 17 to 19 year-olds with a disorder, nearly half (46.8%) had self-harmed or made a suicide attempt.

For recent self-harm or suicide attempts, 11 to 16 year-olds with a disorder were more likely to have self-harmed or attempted suicide in the past four weeks (13.0%) than those without a disorder (0.3%). They were also more likely to have spoken about self-harm or suicide (16.5% compared with 1.4%).

Rates of having ever self-harmed or attempted suicide varied by the type of mental health disorder present and at one in three (34.0%) this was highest in children/young people with an emotional disorder. A quarter of 11 to 16 year-olds with a mental health disorder reported self-harm or suicide attempt and 3.0% of 11 to 16 year-olds without a disorder reported self-harm or suicide attempt.

NICE guidance on self-harm recommends access to psychosocial assessments for children and young people with self-harm or suicidal ideation.

## Risk-taking behaviours

Taking risks is a normal part of growing up and for most children and young people this will be channelled into activities in safe environments. However, for the purposes of this report, risk-taking behaviour refers to the tendency to engage in activities that have the potential to be harmful or dangerous such as attempting suicide or engaging in non-suicidal self-harm, dangerous driving or anti-social behaviour.

At least 45 (49%) children or young people had demonstrated some risk-taking behaviour prior to their death, and 20 (22%) had previously attempted suicide before they died. The most common was non-suicidal self-harm (e.g., cutting) and this was noted in 33 (36%) children and young people. While clearly these behaviours are substantial risk-factors, care givers should note that for the majority of deaths, the suicide was the first known episode of self-harm or risk-taking behaviour.

There was some evidence of illicit drug use in young people who died by suicide. Twelve (13%) young people were known to use illicit drugs with others known for excessive alcohol use.

## Conflict within key relationships

Children and young people can experience conflict within their relationships with family, carers and friends. For the purposes of this section, conflict usually takes the form of arguments. This includes arguments involving the child or young person which can be with household members or with friends/partners. It also includes instances where the child or young person is not involved directly in the arguments but are exposed to this kind of conflict between other household members over a period of time. This section does not include incidents of domestic abuse which is included in the section on problems with household functioning.

At least 41 (45%) children and young people had experienced conflict within their key relationships prior to their death. Thirteen (14%) had argued with their parents/care givers, their partner or another significant person in their life on the day of death. Five (5%) had been involved in an argument within a week of their death and five had been involved in an argument within three months of their death.

In addition, 20 (22%) children and young people experienced other family or household discord due to witnessing arguments within their household, usually between their parents. Examples reported by CDOPs included parents arguing over boundary setting for their children and having different parenting styles. In a small number of deaths (n<5), there was a description of “lots of arguments” in the family home.

## Problems with service provision

CDOPs collect information from all services who had contact with the child or young person during their life or immediately after their death. Therefore, the data presented in this section relates to all services including education, health and social care, law enforcement and any other agency providing services to children/young people. For at least 32 (35%) children or young people a problem with service provision was reported.

The most common issue reported was poor communication or information sharing between professionals. This was reported to be an issue for agencies including GPs, social services, educational institutions, CYPMHS (sometimes referred to as CAMHS), adult mental health services and acute healthcare services. It was noted that communication and information sharing was a particular challenge across service boundaries, for example, local authorities, and when a child or young person moved from one area to another.

The next most common issue was related to gaps in service delivery including lack of, or poor-quality referrals or assessments and lack of awareness by professionals of criteria and pathways for referral. This included referral to gender reassignment services and CYPMHS (sometimes referred to as CAMHS). There were also several instances where there had been a failure to follow an existing guideline or pathway, for example in relation to child sexual exploitation.

## Abuse and neglect

It has been demonstrated that children and young people who have experienced abuse or neglect had higher rates of suicidal behaviours[18]. Children and young people can experience more than one type of abuse, and this can have serious and long-lasting effects on their lives. These include physical, sexual or emotional abuse, neglect (i.e., not meeting the child's basic physical and psychological needs), bullying by an adult in the child's life, sexual exploitation and domestic abuse. The domestic abuse reported in these deaths included episodes of violence between other members of the household (i.e., not including the child or young person who died by suicide) and episodes of violence that directly involved the child or young person.

At least 29 (32%) children and young people in the review cohort had experienced at least one form of abuse or neglect. Of those 29 children and young people, 20 had experienced two or more forms of abuse or neglect. Seven of the 29 children and young people were reported to be known to social care at the time of their death and an additional 11 had had previous input from social care. The most common forms of abuse or neglect that featured in this cohort were rape or sexual abuse (n=9) (including sexual assault), emotional abuse (n=9) and physical abuse (n=8).

The question in the child death review dataset relating to social care changed in April 2019. Therefore, for deaths occurring after that date, more detailed data on how the child or young person was known to social services will be collected.

18 Angelakis et al, 2020

## Problems at school

Twenty-seven (30%) children or young people (21 boys/young men, 6 girls/young women) had experienced problems at school such as worry or concern about coursework or exams, difficulty engaging with schoolwork and non-attendance.

There was CYPMHS (sometimes referred to as CAMHS) or school-based counselling offered to 12 of these children or young people. CDOPs reported some instances where the child or young person did not meet the threshold for counselling from CYPMHS (sometimes referred to as CAMHS).

Eleven (12%) children or young people in this group had been given fixed-term exclusions, had been permanently excluded or had very low attendance. All the exclusions followed a significant decline in behaviour over a short time period. Exclusion from the education system can have an impact on the future focus of children and young people.

Permanent exclusion from school or college is a serious and significant sanction. When a child/young person is permanently excluded from school or college, any relationships with universal services are at risk of becoming fractured. Identifying this as a risk factor for a young person, when a school or college is making a significant decision on that young person's

future is a recommendation from this report. If a school or college is considering excluding someone there should be multi-agency engagement to discuss other potential solutions.

Eight (9%) children or young people were reported to be ambitious, high achieving and successful but a specific adverse event e.g., test failure, argument with a parent, appeared to trigger the crisis prior to their death. The histories of these tragedies indicate that there is a need for school and college mental health provision to be strengthened with better awareness of mental health problems and better integration of CYPMHS (sometimes referred to as CAMHS) within school provision.

A greater awareness and training for the education workforce on the impact of significant life events on children and young people is a further recommendation from this report. There is a need to train the education workforce to identify the risk that a significant life event has on a young person and to have support systems in place.

## Bullying

Bullying includes physical or verbal attacks or threats, social exclusion and sexist, racist or homophobic abuse. For the purposes of this report, it was agreed that this category would be used for peer to peer, or sibling to sibling bullying, while bullying by an adult is classified under abuse and neglect.

At least 21 (23%) children and young people had experienced bullying either face to face (n=18) or cyber bullying (n<5). The majority of reported bullying occurred in school, highlighting the need for clear anti-bullying policies in schools which are effectively implemented. In several instances bullying occurred following a falling out amongst the child or young person's friendship group.

19 Klomek et al, 2009

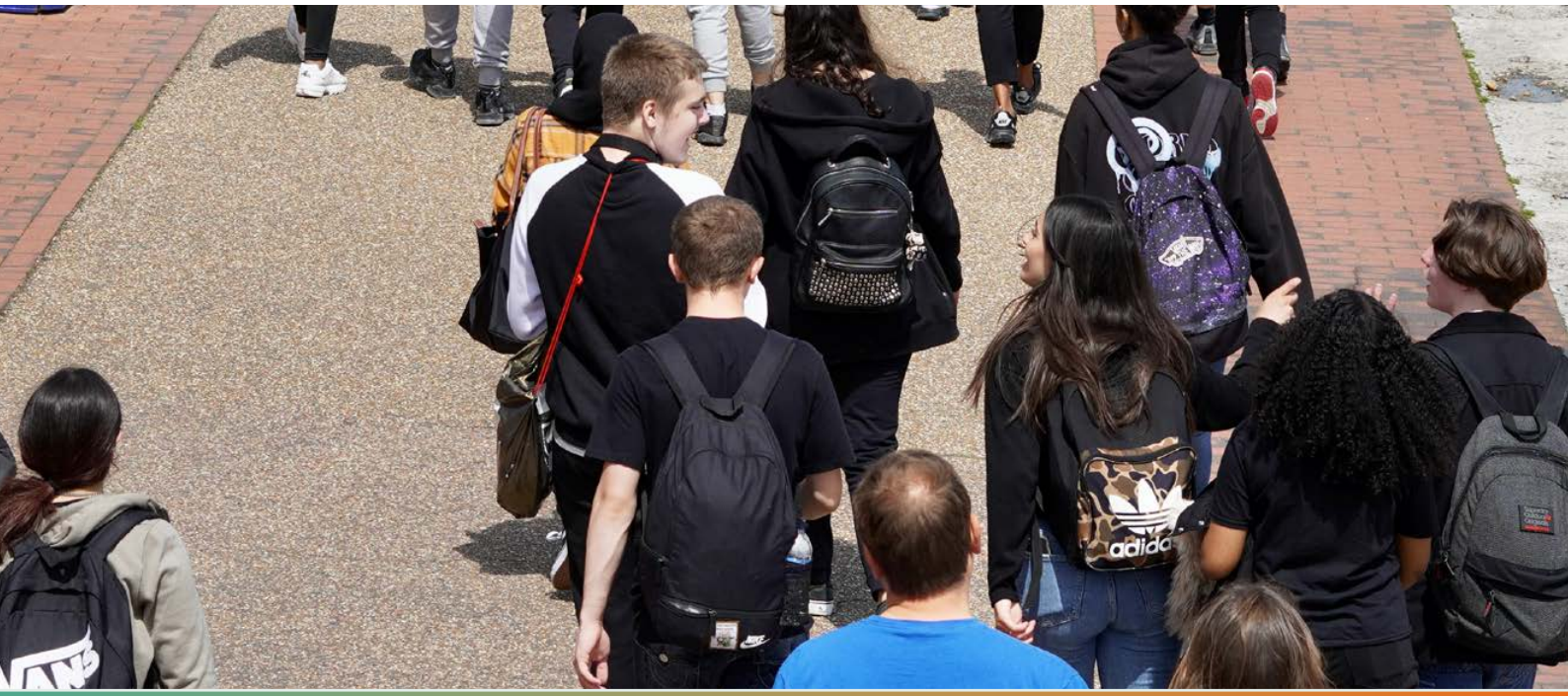
The association of bullying and later suicide attempts is well known and has been convincingly demonstrated.[19] Bullying can impact on the mental health of children and young people in many ways and can sometimes be difficult for adults to notice.

Bullying was also highlighted as a theme in the NCISH report with 19% of children/young people having experienced this. The NCISH report identified that prevalence of bullying was higher in girls and for certain vulnerable groups such as children and young people who identify as LGBTQ+. This suggests that there may be early adverse experiences, but recent stresses or losses may become a precipitating/ contributing factor as this can leave children and young people feeling isolated.

The NHS Digital report on Mental Health of Children & Young People in England (2017) shows that 11 to 19 year-olds with a mental health disorder were nearly twice as likely to have been bullied in the past year compared to those without a disorder (59% vs 33%).

The NSPCC recommends that every organisation that works with children and young people should have an anti-bullying policy statement, which sets out their organisation's commitment to preventing and addressing bullying. Anti-bullying policies and procedures should form part of any wider safeguarding and child protection work. The Anti-Bullying Alliance is a coalition of organisations and individuals that are united against bullying. They provide information and advice on anti-bullying policies on their website.

The National Bullying Helpline is available from 9am to 5pm Monday to Friday on 0300 323 0169 and can provide help for anyone dealing with bullying, experiencing bullying, or trying to prevent bullying whether in school, in the workplace or online.



## Social media and internet use

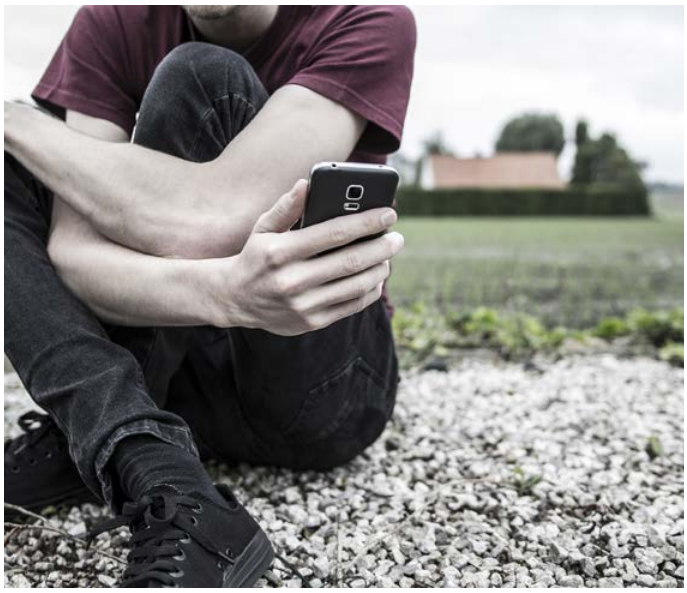
The role of social media and internet use was noted in at least 16 (18%) deaths; for example, suicide related internet use (e.g., searching for information on suicide, communicating suicidal ideas online, visiting "pro-suicide" websites/ chatrooms) and sexting. There were 11 (12%) deaths where the child or young person visited suicide related websites or searched for information on methods of suicide. CDOP records noted examples of message exchanges between the child or young person and their friends or family members during the time leading up to their suicide. It was also noted in two deaths that discussion of suicide was common within the friendship group. There were five deaths (5%) where sexting was noted. There were no deaths where the child or young person was involved in online gambling.

The content children and young people are able to access on the internet relating to self-harm and suicide is of concern, especially for the most vulnerable, such as those with pre-existing mental health problems.[20] The Government draft Online Safety Bill aims to establish a new regulatory framework to tackle online harms. The Online Harms White Paper sets out a range of legislative and non-legislative measures detailing how the Government is planning to tackle online harms, including establishment in law of a new duty of care towards users, which will be overseen by an independent regulator. Companies will be held to account for tackling a comprehensive set of online harms, ranging from illegal activity and content to behaviours which are harmful but not necessarily illegal. The Government has also set an intention to develop a new criminal offence on incitement of self-harm online, subject to ongoing work by the Law Commission, with recommendations expected in 2021.

The Royal College of Psychiatrists Report "Technology Use and the Mental Health of Children and Young People" published in January 2020 concluded that although the internet is most commonly used for constructive reasons, it may also exert a negative influence, normalising self-harm and potentially discouraging disclosure or professional help-seeking. Both cyber bullying and general internet use correlated with increased risk of self-harm, suicidal ideation and depression.

## Neurodevelopmental conditions

Neurodevelopmental conditions are impairments of the growth and development of the brain or central nervous system. Autism spectrum disorder (ASD) and attention deficit hyperactivity disorder (ADHD) are included within this group. At least 15 (16%) children or young people had a confirmed diagnosis of a neurodevelopmental condition at the time of their death. Of these 15, seven had ASD and six had ADHD.



This is more common than that found in the general population.[10] The NHS Digital report Mental health of Children and Young People in England (2017) shows community rates of 1.3% for autism and 1.9% for ADHD. The increased association in children and young people was also seen in the notification data published in the NCMD report Child Suicide in the COVID-19 pandemic in England (2020) and this work adds to existing concerns regarding self-harm and suicide in this group.[21,22,23]

Children and young people with neurodevelopmental conditions are more likely to struggle with emotional dysregulation, more likely to have co-morbid mental health needs and may struggle to communicate their needs to others. They are also more likely to be impulsive.[24] This has implications for practitioners and parents/carers as well as research.

## Sexual orientation and identity

Prior to April 2019, there were no questions in the statutory CDR dataset that asked about the sexual orientation, sexual identity or gender identity of children and young people who died. The children and young people included in this cohort all died before that date and therefore the data described below is based on what was reported by CDOPs in free text fields. At least eight (9%) children or young people had experienced concerns about sexual orientation, sexual or gender identity. The majority of these were concerns about sexual orientation. Concerns about gender identity were reported in fewer than five deaths.

Data suggests that children and young people who identify as lesbian, gay, bisexual, transgender or questioning (LGBTQ) are significantly more likely to have a mental health disorder and history of self-harm and suicide.[9]

20 Dubicka, Theodosiou, 2020
21 Kirby et al, 2019
22 Cassidy et al, 2014
23 Richa et al, 2014
24 Ogundele, 2018

# 6. Real stories from two people who have been affected by a young suicide, and suicidal thoughts and feelings

## Ray's Story

My name is Ray. This is my story.

I was a married father of three; two boys and a girl.

In 1997, my marriage broke down due to my self-destruct button and I moved from the family home to London.

My guilt of leaving my wife and children was taking over my life. I fell into a spiral of depression; I felt I was hurting all those close to me and I wasn't able to focus on my family; my new partner or my job. At work I was making silly mistakes that had big consequences for the company. The depression and dark thoughts got worse, but I managed to keep them hidden from everybody.

The downward spiral continued, and I felt like I'd lost all control, I had this idea that "if I wasn't here, I wouldn't continue to hurt those close to me" and it culminated in me attempting to take my life. It felt so logical at the time, but I didn't understand back then that it couldn't be further from the truth.

Luckily, I was found unconscious and taken to hospital; over time I recovered – my recovery included counselling whilst in an NHS hospital.

I moved from London, back into the family home, and with the support of family and friends I got through it. Fortunately, my children were unaware of what I'd put them, myself and all those close to me through.

However, my marriage broke down again less than a year later and I moved back to London.

I had, over time, built a good relationship with my children; we had regular contact and they came to London to stay with me during school holidays – I also visited them regularly.

Things were going ok, and we'd managed to find a good routine that suited everyone.

On Friday 7th March 2008 at 2:15pm, I received a phone call from my ex-mother-in-law, distraught, telling me my youngest son Ben – aged 14 – had taken his life.

My 17-year-old daughter had come home from school and found him. My world fell apart in an instant. It was never going to be the same.

I dropped everything and without thinking, got in my car and drove to Ben's home, picking my eldest son up from university on the way.

When I arrived, I stayed at the family home, spending a lot of my time in Ben's bedroom. We were numb. We didn't sleep, it was surreal. This happens to others, not us.

I can't explain the atmosphere around the house for the first couple of weeks, except for utter devastation.

It appears that Ben had been run down from too many late nights and had been off school ill in the days leading up to his death. He was also going through a rebellious stage, which as parents of teenagers we can all associate with.

On the day of Ben's death, he was woken up for school but said he still felt ill, and unfortunately, he didn't go to school. He wrote about being picked on in school, about me not living near enough to him, and how he was feeling fed up. He quoted a line from the film *Forrest Gump* and added to it to sum up how low he had become.

"Life is like a box of chocolates, you never know what you are going to get. Me, I just happened to get the wrong life."

None of us could understand that these words came from 'our Ben'.

Our Ben was the life and soul of the party, gave 100% to everything he did.

He was in the county swim squad, had performed in pantomimes, represented his school in the jazz band, choir and rugby team. He played bass guitar and drums, was actively involved with all aspects of the school music department, had lots of friends and enjoyed life to the full.

Unfortunately, he gave no clues to anybody about his inner feelings, or about what was really going on behind the smiles and laughs.

No one saw any signs either; not his mum, myself, his sister or brother, friends or teachers.

Ben's devastating death came around the time of a large number of suicides of young people in the Bridgend area of South Wales. The police investigating Ben's death were looking into any connection with the Bridgend suicides. Although none were found.

I was horrified by the thought of any of Ben's friends being so upset with life, parents or school, that they would see suicide as a way out.

Ben's headmaster and deputy head had visited us on the Sunday after his death to give their condolences and offer help with the funeral and tributes. During their visit I asked if I could address Ben's school year.

I attended the special year assembly on the Monday morning. There were about 200 pupils, as well as councillors from the education authority and representatives from a couple of mental health charities including PAPYRUS Prevention of Young Suicide.

I addressed the children and begged them not to attempt what Ben had done; to not let their friends or family go through the hurt and devastation we went through.

"You can't come back from death. It's final. If you are down or feeling low or suicidal, don't keep it in and to yourself. The feeling will pass. Talk to friends, or family or teachers. You can even get in touch with me for help. Just please don't go through it on your own."

I asked Ben's peers if they could write down their memories of Ben for me as I didn't know what his day-to-day life was like with his friends, as I didn't live with him. The school organised a memorial book for anyone to write in, and passed on three lovely books to the family, of Ben's time at school and adventures with his friends.

Ben was buried a week later on 14 March 2008. The sun was shining just like his smile did.

In the weeks following the funeral I spent a lot of time at Ben's grave at all times of day and night. I also met with some of Ben's friends; a few of us grew closer and formed quite a tight bond, a bond I also formed with a couple of his teachers.

On more than one occasion it was said that being with me was like being with Ben and I felt so proud and honoured that we were so similar.

A couple of months later, I was contacted by one of Ben's friends who was completely down and was having suicidal thoughts. He had a very unsettled home life and had split from his girlfriend. With his agreement, I spoke to the school counsellor, who happened to have been Ben's head of year and form teacher – now a close friend of mine. The school counsellor liaised with his parents, and he got the help he needed.

Every July, the school would hire the local theatre to perform a musical for three nights to the paying public to show off the school's musical, singing, and acting strengths. This particular year the headmaster announced that the musical production would be replaced by a concert in memory of Ben. The content was to be decided between the music department and pupils to honour his memory.

The event was extremely well attended; we laughed, we cried, and we all sang together – putting our hearts and souls into the evening – to make Ben proud.

The concert for Ben raised £4,500, which built a recording studio and music room for the school in honour of Ben.

Over the next couple of years, Ben's friends organised charity band nights in his honour – The Ben Band Nights. They asked me to get involved, which I did with pleasure.

We raised the roof and had great nights and managed to raise a couple of hundred pounds each time. Donating the money between PAPYRUS and the school music department.

Ged Flynn, chief executive of PAPYRUS, attended one of the nights to party with us and gave a talk about the help that PAPYRUS has to offer; he told us about the charity's suicide prevention helpline, HOPELINEUK.

In the years following Ben's death, I have been able to help others that know about my experience – including one of Ben's friends and another young person that had seen me speak at the assembly following Ben's death. They reached out to me and said they couldn't cope with the events happening in their life, so I told them about PAPYRUS and encouraged them to use HOPELINEUK where they got the help they needed and received ongoing support.

I have also happened upon those in need by accident, on my way to work one March I came across a woman in distress and through working on instinct and personal experience, I was able to get her the help she needed. These experiences led me down the path of wanting to help others, but I wanted to be equipped with the tools to do so, so I began volunteering for PAPYRUS.

I'm still in touch with a core group of Ben's friends, who are now in their late twenties; as well as two of Ben's teachers. We all meet up on occasions and I have attended a few of their weddings; I am privileged to be Godfather to one of their children.

We celebrate Ben's life on his anniversary. We meet for a drink and Ben gets a bottle of beer every round! But it also fills me with sadness seeing his friends all grown up, working – some with families of their own – wondering what he would look like, and what he'd be doing. And also, how good it would feel to have my arms wrapped around him again.

It opens up the whole grief and loss feeling, over and over again.

Losing Ben changed and shaped all our lives in so many ways, creating life-lasting friendships. It also made us more aware to look out for the signs of those around us struggling, or in need of help.

When I look at pictures of Ben and his smile it takes me to a quote by the actor Robin Williams…

'All it takes is a beautiful smile to hide an injured soul.
And they will never notice how broken you really are.'

### A Young Person's Personal Story

Before experiencing challenges with my mental health, I loved to dance, filling my time with classes and ballet exams. I have a big and very close-knit family and many of the friends I have now I had when I was 7. I have always been a hardworking and ambitious person. School was important to me, and I always pushed myself to do my best. I remember beginning to struggle with low mood during my GCSE year. Looking back, I was a complete perfectionist, and nothing was ever 'good enough'. I devoted myself to my exams and ended up getting the grades I was hoping for.

However, in the summer between my GCSEs and A-Levels, we received some devastating news. My uncle, who had battled bipolar disorder since his teen years, took his own life. Before this, I don't think suicide had ever entered my world.

With grieving for my uncle and starting my A-Levels at a new college came a shift in my mental health. I began skipping college, spending days in my room and isolating myself from friends and family. I was angry at the world, I was angry at myself for giving up on studying, I was even angry at friends who seemed to have eased through the transition from school to college. I don't remember much from that period of time, but what I do remember is an intense feeling of sadness, loneliness and an inability to see things getting better. I began to take these feelings out on my body and over time, thoughts of suicide crept in.

I luckily had a couple of amazing friends who I could confide in. They helped me reach out to my GP, get support through CAMHS and tell my family what was going on.

Unfortunately, things got worse before they got better. I was incredibly embarrassed with my family knowing I was suicidal and felt deep shame knowing they would feel it was their fault.

There was never a quick fix or turning point, but after staying in hospital after a particularly bad episode, and seeing the worry I caused friends and family, I slowly started to piece my life back together. I accepted support from a crisis intervention team, and over a few months, life began to feel a bit less overwhelming.

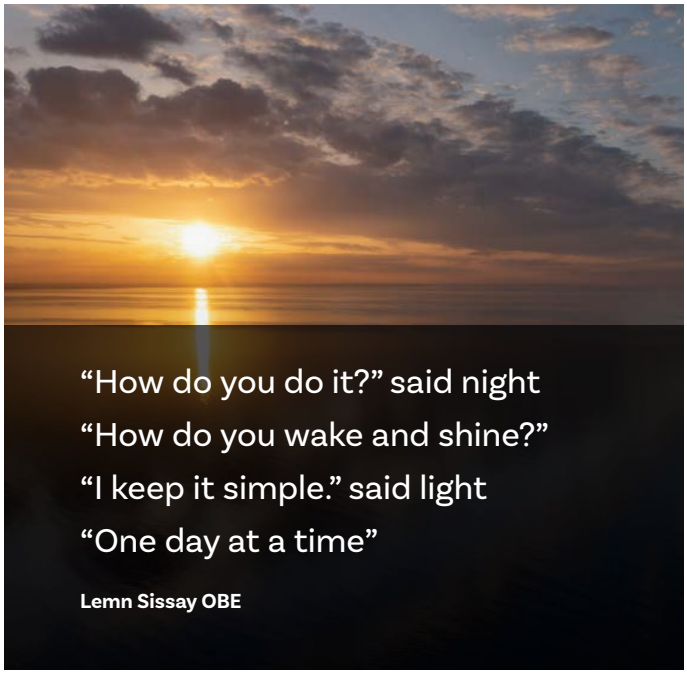
The next few years were difficult, and I continued to struggle with an eating disorder. But I managed to retake college and secure a place at university. I reconnected with friends I had isolated myself from, and 7 years on I have received a first-class honours degree in psychology, undertaken work experience on psychiatric wards, and am 6 months into my dream job. I currently work delivering therapeutic care to children who have suffered neglect, abuse and trauma. I am able to use my experience to empathise with children I work with who are struggling with thoughts of suicide.

Although I have bad days, I know that they end, and good ones follow. If I could give one piece of advice to someone struggling, it would be to reach out. Most people I know have struggled at some point with their mental health and knowing this makes me feel less alone. Use all the help you can, whether that's Hopeline, your GP, friends or family. Know that things will get better.

# 7. Where to get help

Many people, including children and young people experience times of stress or worry during their lives. During the COVID-19 pandemic it has been particularly difficult for some children and young people to cope with the lockdown restrictions and the challenges they bring in terms of isolation from friends, family problems, school closures and changes to their living situation.  While lockdown restrictions have been regularly reviewed, children and young people may also have had to deal with self-isolation because of instances of COVID-19 in their schools or worries about themselves or their family contracting the virus. This is on top of the existing challenges faced by children and young people in their everyday lives. As the lockdown restrictions have eased some children and young people may experience anxiety or distress as expectations and demands have increased.

Feelings like these may ease over time for some children and young people, but there are always steps that can be taken to support children and young people emotionally and help them cope with problems they face.



**Below is a list of places where children, young people and their families can access help:**

### PAPYRUS Prevention of Young Suicide

For confidential suicide prevention advice, contact HOPELINEUK on 0800 068 4141 if you or someone you know is thinking about suicide.

### The Samaritans

Call 116 123 for free. Samaritans work to make sure there's always someone there for anyone who needs someone.

### Shout 85258

Shout 85258 is a free, confidential, 24/7 text messaging support service for anyone who is struggling to cope.

### Childline

Call 0800 1111 for free, confidential support at any time, day or night. Childline is there to help anyone under 19 in the UK with any issue they're going through, big or small.

### Young Minds Parent Helpline

Call 0808 802 5544 for free. If you are concerned about a child or young person's mental health, you can get free, confidential advice via phone, email or webchat from the Young Minds Parent Helpline.

### Every Mind Matters

For help and advice about mental health from the NHS.

### Action for Children

Has lots of tips to help spot signs of mental health issues in children and advice on the action that can be taken to help.

### Barnardos, See, Hear, Respond Hub

A dedicated service to help children, young people and their families or carers with problems caused by the coronavirus outbreak.

### NHS Children and Young People's Mental Health Services

Parents, carers and young people can receive direct support through NHS CYPMHS also known as CYPMHS (sometimes referred to as CAMHS).

### NHS Urgent Mental Health Helplines

NHS urgent mental health helplines are for people of all ages.

You can call for:

- 24 hour advice and support – for you, your child, your parent or someone you care for
- Help to speak to a mental health professional
- An assessment to help decide on the best course of care

### Mind

Provide advice and support to empower anyone experiencing a mental health problem.

### MindEd for Families

A resource for all adults to increase awareness and understanding about the mental health of children, young people and older adults. It includes free e-learning sessions for all those working with CYP (incl. ED sessions).

### Hub of Hope

Mental health support network provided by Chasing the Stigma.

The Hub of Hope is the UK's leading mental health support database. It is provided by national mental health charity, Chasing the Stigma, and brings local, national, peer, community, charity, private and NHS mental health support and services together in one place for the first time.

### Crisis Tools

Unique, co-produced learning guides to increase knowledge and confidence for anyone supporting young people in a mental health crisis.

Crisis Tools is relevant to anyone who may find themselves supporting a young person in crisis including parents, carers and professionals.

### National Bullying Helpline

Available from 9am to 5pm Monday to Friday on 0300 323 0169.

Provides help for anyone dealing with bullying, whether in school, in the workplace or online.

**For those bereaved by suicide, or any other type of death, the following is a list of places where help can be accessed:**

### SOBS (Survivors of Bereavement by Suicide)

Helpline: Call 0300 111 5065 between 9am and 9pm, Monday to Sunday.

Email: email.support@uksobs.org

Exist to meet the needs and overcome the isolation experienced by people over 18 who have been bereaved by suicide.

### Support After Suicide

Finding support isn't always easy. Support after suicide has partnered with AtaLoss.org to help you to find your nearest suicide bereavement support.

The Support After Suicide Partnership is a UK wide network of over 70 members and supporters. The partnership brings together national and local organisations that are involved in delivering suicide bereavement support across the UK and addresses the need for formal, multi-agency, proactive suicide bereavement support.

### Child Bereavement UK

Helpline: Call 0800 02 888 40 between 9am and 5pm, Monday to Friday.

Email: support@childbereavementuk.org

Help children and young people (up to age 25), parents and families, to rebuild their lives when a child grieves or when a child dies. Also provide training to professionals, equipping them to provide the best possible care to bereaved families.

### CRUSE Bereavement Care

Helpline: Call 0808 808 1677 between 9am and 9pm, Monday to Friday.

Email: helpline@cruse.org.uk

Have specialist bereavement experts with experience of all types of loss, can offer support however and whenever the death occurred.

### The Compassionate Friends

Helpline: Call 0345 123 2304

Email: helpline@tcf.org.uk

A charitable organisation of bereaved parents, siblings and grandparents dedicated to the support and care of other similarly bereaved family members who have suffered the death of a child or children of any age and from any cause.

### Childhood Bereavement Network

A hub for those working with bereaved children, young people and their families across the UK.

# 8. Learning from CDOPs


As part of the CDOP review into deaths of children and young people, learning points are identified and taken forward for local action. CDOPs identified learning for many agencies involved in providing services for children and young people including GP services, mental health services, police, schools and colleges and social care. CDOPs are responsible for ensuring these learning points are disseminated locally.

Learning points recorded by CDOPs were extracted and coded by the NCMD team where the following themes were identified:

- **Poor joint working and information sharing.**

  CDOPs highlighted challenges with joint working and information sharing between agencies that have contact with children and young people with mental health issues. They also highlighted incidents of poor information sharing with parents and carers, for example in relation to failure to share information with parents and carers to support them to safeguard their child appropriately. The lack of joined up working and poor information sharing limited meaningful multi-agency dialogue and was particularly an issue where children and young people were engaged with private services e.g., private counselling services. It was often difficult to identify people within private services and therefore to include them in discussions on planning and support for children and young people. In addition, it was recognised that when children and young people present acutely to NHS services, they do not always have access to information held by private services which may help in treating them. The impact of moving schools was also an area of risk for poor information sharing highlighted by CDOPs, with the new school not receiving all the information on the child creating gaps in their history. Poor information sharing between police, schools and health services was also specifically highlighted in learning identified by CDOPs.

- **Lack of confidence amongst professionals to talk about suicide with children and young people.**

  CDOPs recognised a professional practice and development need related to a lack of confidence amongst professionals in talking about suicide with children and young people, including what to do if there is concern that someone might be considering suicide.

- **The importance of safe and accessible spaces for children and young people.**

  Providing safe spaces for children and young people to talk about their mental health and well-being confidentially to ensure their voices are heard was noted by CDOPs to be important. This was particularly the case for boys and young men who are more likely to die by suicide than girls and young women and who are less likely to seek support for their mental health. This reflects the need for accessible spaces and professional support that enables all children and young people to have accessible and non-stigmatising local support. It includes the need to increase awareness for children and young people of how to access support.

- **The importance of recognising the impact of background social factors on the mental health and well-being of children and young people.**

  CDOPs recognised the impact that adults with mental health problems can have on the whole family, as well as the impact of domestic abuse and parental conflict on the relationships of young people, and the impact on children and young people of being carers for other family members. It is important to note that the accumulation of background risk factors can lead to increased vulnerability, and many of the deaths of children and young people reviewed by CDOPs had multiple adverse factors in their backgrounds.

- **The importance of accessibility to mental health services.**

  Referral pathways into mental health services were highlighted by CDOPs as an area for improvement. CDOPs reported that primary care services were often unaware of the referral pathways and what to do if a young person refused a referral to mental health services. Transition between child and adult mental health services was also noted to be an area of challenge and risk to continuity of care.

- **Lack of clear policies on bullying and cyber bullying in schools and colleges.**

  CDOPs recognised that school or college can often be a protective factor for some children and young people, however school or college policies on bullying and cyber bullying were identified as an area for improvement. CDOPs noted examples of policies and guidance which failed to set out clearly the process of raising concerns and under what circumstances safeguarding referrals would be made. The lack of detail in the policies made it difficult for staff to know when and under what circumstances multi-agency meetings should be convened to discuss individual children /young people, and when and how to escalate concerns; all schools are advised to contact their multi-agency safeguarding hub (MASH)/local multi-agency triage for advice on individual children's contexts. This appeared to be a particular challenge for independent schools.

- **The importance of recognition of challenges for children and young people related to their protected characteristics.**

  CDOPs recognised the pressures upon children and young people related to their protected characteristics, including cultural and ethnic diversity, sexuality, gender identity and neurodevelopmental conditions. They highlighted the importance for all agencies to increase their awareness of the challenges and coping mechanisms of children and young people in these communities, particularly at times of additional stress such as school examinations. Learning from the South East England best practice case study suggests children with Education Health & Care Plans (EHCPs) are more visible to school staff than those who may be receiving special educational support.

**Areas of particular good practice**

Through the reviewing process CDOPs have noted examples of good practice in the response of agencies to deaths by suicide, particularly in relation to actions taken immediately following the death of the child or young person. These included:

- Recognition of the impact of suicide on the school and wider community. In particular recognising that when an incident occurs overnight or on a weekend that school staff need to be aware immediately to give them time to put appropriate support measures in place before pupils attend school the following day. Examples were given of school headteachers being contacted out of hours by joint agency response practitioners and police so that the school's critical incident plans could be initiated.
- Timely provision of support by educational psychology and CYPMHS (sometimes referred to as CAMHS) teams to other pupils following the death.
- The Samaritans Media Guidelines for Reporting Suicide are helpful in dealing with media interest in suicides. This guidance gives advice on responsibly and safely covering the topic of suicide in the media.

## Best Practice Case Study: South East Region – Sub-Regional 0-25 Suicide Analysis

### The strategic impetus

'Please can we work together to understand our picture of CYP suicide?' This was the crucial question raised in our Hampshire, Isle of Wight, Portsmouth and Southampton Children's Mental Health Systems leaders meeting in January 2020 as we planned out our shared work for the next two years. All partners agreed and we got underway with planning and undertaking a detailed analysis of 0-18 deaths (suspected deaths by suicide) in the preceding five year period. Little did we know that we were weeks away from Wave 1 COVID-19 lockdown and that very quickly other parts of the South East would be asking exactly the same questions.

We refined a partnership methodology, thanks to proactive support from our Public Health and Police leaders, mental health and safeguarding partners. We extended our analyses to consider all 0-25 confirmed/suspected deaths by suicide in the previous five years in several different sub-regions in the South East and started to build a composite picture together. We asked careful questions about the lives; circumstances; experiences (adversity and trauma); demographics; experience of school, community and home; and the stories of our children and young people. We checked and balanced our findings with partners along the way, often providing richer intelligence or a fuller picture as we went. When the analyses were nearing completion, we sat behind the scenes in the South East NHSE/I CYP Mental Health team and considered the overall picture, specifically where the analyses were similar and where they differed.

**What we learnt**

In summary, we learnt that 70% of our children and young people had experienced trauma and adversity; previous bereavement or self-harm was evident for some children and young people in all of the analyses; in some instances, we had particular questions about postvention support following previous suicide attempts; and there were slight variations in CDOP and JAR approaches in different areas, which helped strengthen our process overall.

The key thing we learnt challenged our Systems Leadership and led to significant change quickly in our region. We were challenged by a previously invisible equality and diversity picture – a picture in which social exclusion, marginalisation and 'othering' was having tangible impact on loss of hope and subsequent loss of life. Social exclusion and marginalisation – the effect of 'othering' – meant that our children and young people in the following communities were evident in all our sub-regional suicide prevention analyses:

- Neuro-diversity
- Our community of colour (BAME)
- Our rainbow community (LGBTQ+)
- The interface with faith and belief (loss of belonging, hidden networks or both support and exclusion)

In the analyses we'd asked different questions to the routine questions our frontline police, health and social care staff initially ask to understand the impact/effect of the loss of life to suicide; our staff told us in those early conversations, that these were often hard questions to ask of significant others, they weren't always sure what to say or how to say it.

> "They [services] felt awkward and didn't know what to say. Saying nothing made me feel rubbish and like my son wasn't important."
>
> **Bereaved parent**

**What changed**

- We co-designed questions to help understand the effect of a suspected death by suicide to target postvention support (to those 40% more likely to develop suicidal ideation having been bereaved by suicide). This support was adapted to include our community of colour (BAME), rainbow community (LGBTQ+) and neuro-diverse community, much as we would routinely provide postvention support to a school or family network. In some areas the leadership commitment was so significant that these changes were implemented within seven working days of Board agreement. These changes started to be adopted all-age not just for CYP.
- The National College of Policing and Public Health England leadership teams shared these questions far and wide nationally to help us disseminate the learning; and NHSE/I and the NHS Confederation arranged briefings regionally and nationally to help develop partnership understanding.
- We asked the South East multi-agency children's workforce to undertake the Zero Suicide Alliance (ZSA) training, to build confidence and emotional literacy to spot potential suicidal ideation and respond/refer. ZSA are currently considering how the learning from the South East might further inform their training materials.
- CYP Suicide prevention strategies started to emerge in our Sustainability and Transformation Partnerships (STPs)/ Integrated Care Systems (ICSs) in a landscape where the previous preventative focus had tended to be adult-centric. In some of these areas community investment in voluntary clinical forces (VCF) (third sector) partners with the trust and confidence of our marginalised/excluded communities emerged, as innovative community transformation.
- Our CDOP, Safeguarding and Mental Health dialogue changed – the potential to breakdown invisible divides between safeguarding and mental health commissioning emerged, enabling an iterative strategic service design and commissioning dialogue.

**Andrea King (Assistant Director of Programmes, CYP, Mental Health Clinical Delivery Team, South East Region) & Linda Hill (Suicide Prevention Transformation Programme Manager, NHSE/I South East Region)**

# 9. Sharing learning

It is important to share learning as widely as possible to reduce the number of children and young people who die by suicide. Links should be established between CDOPs and multi-agency suicide prevention partnerships to achieve this. Regular review of deaths locally and near misses (serious incidents) generates learning and helps to identify any local factors.

In addition, development of a national community of practice to share learning and examples of good practice across CDOPs, via the NCMD website should also be considered.

It is important to share learning as widely as possible to reduce the number of children and young people who die by suicide.

# 10. Next steps to improve data collection

Work by NCMD is ongoing to continuously improve the data completeness and quality by further developing the statutory data collection forms. This aims to better support and guide the CDR process and provide more granular and comprehensive data to support deeper understanding of deaths by suicide. Consequently, we recommend:

1. Introduce sub-categories to the "Suicide or deliberate self-inflicted harm" category of death within the child death analysis form. This will enable CDOPs to determine between deaths due to intentional suicide and substance misuse related deaths where the intent of the child or young person was unclear. This will facilitate more timely and detailed national analysis.
2. Ensure the adverse factors highlighted in this report are recognised, recorded and graded appropriately in the statutory analysis form by CDOPs.
3. Improve the completion rate of the supplementary reporting form on Suicide (currently 49%) to ensure the best possible data collection on protected characteristics and background factors.
4. Develop a Joint Agency Response (JAR) pro-forma specifically for suicide to support JAR professionals to ask the right questions in the first 24-48 hours, when responding to the death by suicide of a child or young person.

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# 12. Appendices

## Appendix A: Definition of factors

| Factor | Definition |
|---|---|
| Mental health needs of the child | Children and young people with a confirmed diagnosis of one or more mental health conditions at the time of their death. Examples include: depression, anxiety, eating disorders, post-traumatic stress disorder, suicidal ideation. |
| Risk-taking behaviours | Children and young people who have previously attempted suicide or have engaged in non-suicidal self-harm. Those who have shown non-compliance with treatment or medication and other risk-taking behaviours such as driving while under the influence of alcohol. |
| Household functioning | Factors within household circumstances that may contribute to the child's vulnerability or mental ill health. Examples include family members with a medical or mental health problem. Alcohol or substance misuse by a family member, domestic abuse and divorce or parental separation. |
| Loss of key relationships | The loss of any significant relationship for a child or young person. Examples include break-up of a relationship with a partner, the death of a friend or relative or other bereavement, or a move of house or school resulting in loss of contact with friends and communities. |
| Conflict within key relationships | An argument or any other conflict between the child or young person and any significant person in their life. |
| Bullying | Children or young people who have been the victim of bullying either online or face to face. Examples include physical or verbal attacks or threats, social exclusion and sexist or racist or homophobic abuse. |
| Social media and internet use | The presence of negative social media or internet use in the child's life. Examples include suicide related internet use (e.g., searching for information on suicide, communicating suicidal ideas online, visiting "pro-suicide" websites/ chatrooms) and sexting. |
| Problems with service provision | Any problem related to the provision of any service to children and young people. Examples include poor information sharing and communication between professionals, gaps in service provision (e.g., poor quality or absent referrals). |
| Abuse and neglect | Children or young people who have been subject to any form or abuse or neglect. |
| Problems at school | Any problem at school including fixed term or permanent exclusions, regular non-attendance, coursework or exam stresses or concerns about results. |
| Medical condition in the child | Children and young people with a confirmed diagnosis of one or more medical conditions at the time of their death. This includes chronic health conditions, chromosomal, genetic or congenital anomaly, malignancy, or any other medical condition. |

| Factor | Definition |
|---|---|
| Drug or alcohol misuse by the child | Children and young people who have previously used drugs or alcohol or have used drugs or alcohol excessively. |
| Problems with the law | Children and young people who were the known perpetrators of a crime, known to the criminal justice system or youth offending service. |
| Sexual orientation, sexual identity and gender identity | Children and young people who had worries or concerns around sexual identity, sexual orientation, or gender identity. |
| Neurodevelopmental conditions | Children and young people with a confirmed diagnosis of one or more neurodevelopmental condition at the time of their death. This includes autism spectrum disorder (ASD), attention deficit hyperactivity disorder (ADHD), and any other neurodevelopmental conditions. |

## Appendix B: Glossary of terms

| | |
|---|---|
| Gross Domestic Product (GDP) | A measure of the size and health of a country's economy over a period of time. |
| Likelihood ratio test | The likelihood ratio test is a statistical test of the goodness-of-fit between two models. |
| Negative binomial distribution model | A distribution of data or events (like the 'normal' distribution) which is useful for investigating rare events. |
| p-value | The probability that the differences seen may be due to chance. |
| Postvention | Postvention refers to the actions taken to support the community after someone dies by suicide. |
| Self-harm | For the purposes of this report, we have used the NICE definitions of suicide and self-harm: An act of self-poisoning or self-injury, irrespective of motivation. |
| Suicide | For the purposes of this report, we have used the NICE definitions of suicide and self-harm: An act of self-harm that results in death. |

## Appendix C: Examples of Suicide Prevention Training

- Health Education England self-harm and suicide prevention competency frameworks
- Zero Suicide Alliance Gateway Training
- MindEd suicide and self-harm prevention

NCMD
National Child Mortality Database

Knowledge, understanding and learning to improve young lives


## National Child Mortality Database (NCMD)

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