Pan-Dorset Safeguarding Children Partnership

Post Suicide Intervention Protocol following an unexpected death by suspected suicide of a child or young person

Context

The death of a child or young person by suicide is a rare event but it can have a widespread impact on other young people and adults who may have been very close to the young person, may have prior experience of suicide or may have their own mental health difficulties. In very rare cases a situation of "suicide contagion" may arise. Risk factors for suicide contagion are recognised and there is evidence that early intervention directed at vulnerable individuals may reduce the risk.

The local guidance was developed to build on existing processes following the death of a young person . We have a well- established process of joint agency investigation of unexpected child deaths that considers the cause of death, safeguarding concerns in relation to the wider family, bereavement care needs of the immediate family and peers and seeks to learn any possible lessons that might inform changes to practice. In addition, the educational psychology service has a crisis response model for supporting schools and colleges in the aftermath of a young person's death. These two processes have been drawn together to ensure effective information sharing, identification of vulnerable peers and consideration of what support should be offered. The roles of the 2 processes are delineated, timescales laid out and all relevant information is subsequently drawn together at the child death review meeting for reporting to the Child Death Overview Panel (CDOP).

This document should be read in conjunction with 'Identifying and responding to suicide clusters: A practice resource, Public Health England 2019'.

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/839621/PHE_Suicide_Cluster_Guide.pdf

The death of a child or young person by suicide is a rare event. Over the last five years across the whole of Dorset 12 young people have sadly died in circumstances that have led to initial consideration of suicide as the cause although it should be noted that this has not always been confirmed at inquest. The criteria for concluding death has been by suicide are stringent and, in some cases, where the young person's intent was unclear the coroner may give a different verdict at inquest (in approximately one third - half of cases).

Although death by suicide is a rare event it can have a widespread impact on other young people and adults who may have been very close to the young person, may have prior experience of suicide or may have their own mental health difficulties. In very rare cases a situation of "suicide contagion" may arise.

"Suicide contagion refers to the process whereby one suicide or suicidal act within a school, community or geographic area increases the likelihood that others will attempt or die by

suicide" (headspace school support fact sheet). This is a very rare event but there are factors that are known to increase the risk of contagion including:

- Age – young people may be more susceptible to this phenomenon.
- Inadvertently creating the impression that suicide was a positive outcome for the young person.
- Over-simplification of communication about why the young person has died (can lead to over identification by other young people).

Individual risk factors include:

- Pre-existing mental health difficulties +/- drug and alcohol problems.
- Previous suicide attempt by the individual.
- Family difficulties / violence / history of suicide.
- Other bereavements.
- Social and / or geographical isolation.
- Males are statistically more at risk than females.

Following the suicide of a young person, the National Suicide Prevention Strategy highlights that effective post-suicide interventions at a community level can help to prevent "copycat suicides" and suicide clusters. The Samaritans similarly highlight the importance of post suicide intervention protocols in their step by step guide. https://www.samaritans.org/how-we-can-help/schools/step-step/

While to date we have not seen a problem with suicide contagion in Dorset we have seen how the unexpected death of a young person can impact on their peer group and, we did sadly see the death of a young person by suicide following an unexpected traumatic bereavement. Our experience following that death and other subsequent deaths has been that rapidly assessing the risk to the peer group and implementing support may be of value in reducing the risk of subsequent deaths. While this has been managed informally so far, largely led by the police, it was felt that a more formal multi-agency arrangement should be developed to ensure a robust process is in place that builds on existing support structures. The widespread use of social media amongst young people means they have very fast access to information which may be distressing and / or misleading. It is therefore important that while a professional response will not be able to match the social media in terms of speed it should be prioritised by agencies and should be initiated as quickly as possible.

Existing processes:

In considering how to respond to a suspected death by suicide it is important to be aware that there are existing processes that operate in relation to all child deaths with variations in the details depending on the circumstances of the death. The aim of local services is to ensure a robust mechanism for reducing the risk of subsequent suicides but without duplicating processes. The following sections summarize existing processes.

1. The rapid response process to an unexpected child death:

Child Death Review: Statutory and Operational Guidance 2018 outlines the processes to be followed following the death of any child or young person under the age of 18 years.

In the case of an unexpected death there is a 'rapid response' involving police and health with input from children's social care. The purpose of the rapid response is to investigate how the young person died, consider if there are any safeguarding concerns that need to be considered for other children within the family or home, provide initial bereavement support to the family and to identify any immediate actions that may be needed to reduce the risk of subsequent deaths. Vulnerable individuals are identified and, action is taken to

ensure that they are aware of how to access support. In the case of young people this would generally involve contacting their parents +/- GP and consider if any other support is indicated depending on their particular circumstances.

2. The Child Death Phase 1 information sharing meeting:

This meeting is convened within one working day of the child's death and is chaired by the designated doctor for child deaths (or their representative). The people invited include police, social care, health visitor or school nurse, school representative and other professionals involved with the child, for example a CAMHS worker. The purpose of the meeting is to clarify what is known so far and to build up a picture of the child and family by sharing information between agencies, to consider bereavement support needs primarily of the family but also of others identified at this stage as vulnerable, consider potential media interest and how this should be addressed, the next steps in the investigation and any outstanding actions.

3. Educational Psychology Support:

The Educational Psychology Service works closely with schools in both local authority areas, dealing with a wide range of issues both for individual children and young people and whole school matters. Their work is generally outcome driven with a focus on solutions. Work relating to individual children and young people needs consent from the families.

Educational Psychology Services (EPS) have an established pathway for supporting schools when a school is affected by a bereavement. They generally work by helping the setting's senior leadership team to assess the significance and impact of the event and to draw up a plan to help the school staff to support the school community. They recognise that deaths may occur in widely differing circumstances and that the response needs to be tailored to the situation and the context of the school. They provide support to the staff working directly with children and young people and can advise on communication with children, young people and families. They may, as part of the plan, provide some direct work to the school community. They have a range of resources including:

- advice about support for those young people at high risk of suicide,
- advice about support for parents of young people at high risk of suicide,
- advice for supporting siblings of young people who have attempted or died from suicide,
- templates for information that may need to be shared with families.

They can also advise on other sources of support if needed.

Key issues to consider in any response to a suicide or possible cluster:

1. **Local surveillance - within a community and within organisations, for example, schools.** Any significant increase in self injurious behaviour should also be noted and there may need to be information sharing between acute hospital trust emergency departments and other agencies.

2. **Information sharing** - within organisations and between agencies. Confidentiality is important and the family of the deceased young person should be involved in planning what information should be shared. Organisations should consult with their information governance leads and / or Caldicott Guardian. Consent from young people identified as vulnerable and in need of support should be sought from them and their family prior to sharing detailed information about them with other agencies.

3. **Media issues** -mainstream and social. Any information released to the media should be agreed in advance with the family of the deceased young person. A lead communications team should be identified and all requests for comment should be directed to that lead. Support in working with the media is available at www.samaritans.org/media-centre/media-guidelines-reporting-suicide. It is important to minimise the details provided about the mode of death and focus on providing positive information about sources of support for those that may be vulnerable. Young people access much information via social media, but comments posted may be negative as well as positive. Organisations such as schools may consider setting up a memorial page that can be moderated and taken down after an agreed period of time. They should also ensure that people know how to raise concerns about any negative posts.

4. **Bereavement support.** Family should be given support including:

   - A copy of 'Help is at Hand'.
   - Details of 'Survivors of Bereavement' by Suicide (SoBS).
   - Identification of immediate additional psychological support needs.
   - Advice to see their GP (or mental health worker if they have one) regarding their health and well-being.
   - Agreeing how they will be communicated with (some families will choose a representative from the wider family or a close friend to receive phone calls, texts or emails on their behalf).

   Other key individuals should be considered for example, fellow service users within a mental health unit / staff / carers, in schools, staff can be severely impacted and need HR/ Occupational Health support. It is important to provide clear concise information about common grief reactions and support this with written information.

5. **Prevention.** Identify vulnerable individuals for example, using a 'circles of vulnerability' model. **See Page 6**.

   The aim is to achieve a generalised risk reduction for the wider peer group by providing information about the normal responses to grief, supporting positive health and wellbeing messages and signposting to sources of support both on-line and face to face. **See Appendix No 3.** for support groups.

   For those identified as vulnerable, a lead professional should be identified to speak directly to them, to assess their level of risk and provide support and signposting. Supportive conversations allow a non-judgemental exploration of thoughts and feelings for example, 'Kitchen Table' conversations. **See Appendix No 2**.

   If a young person seems to be developing a mental illness a conversation should take place with the CAMHS service and a referral could be considered.

6. **Monitoring and Review.** The group responding to the suicide will need to decide at the outset the criteria for stepping down the formal response. This may be when all young people identified as vulnerable have been confirmed to have support in place or they and their family / carers know how to access it if needed. As the incidence of suicide is very low in adolescents it is difficult to determine a time scale based on the number of deaths.

   Key dates for example, funeral / inquest / anniversary of death should be considered as times of potentially increased risk.

Sudden unexpected death of a child or young person where suicide is known or suspected

The following process should be followed:

1. The 'rapid response' to an unexpected death will be initiated through the normal Child Death process.

2. The designated doctor will inform MASH health representatives so that they can gather information about who is working with the family. They can coordinate CAMHS, AMHT or Child in Care team for the Phase 1 meeting.

3. The designated doctor for child deaths will ensure that the CAMHS Service Manager or Named Doctor for Safeguarding in Dorset HealthCare are informed of the death. Note: not all young people who commit suicide are known to the local CAMHS team, but it is helpful if they are aware of the death in terms of supporting other vulnerable young people that may be affected by the death and are currently open to CAMHS.

4. The Phase 1 information sharing meeting will include the Headteacher, Principal or Senior Educational Psychologist (EP) for the area, CAMHS representative (if open to CAMHS), community mental health team if involved with the family, Child in Care Team if appropriate, GP, MASH health representative as well as police and social care practitioners.

5. The child death team will focus on:

- the investigation of the death
- consideration of any safeguarding issues in relation to other children in the family or home
- the support needs of the family
- media considerations (Police COMMS team generally lead)
- immediate learning / actions arising
- support needs of any individuals identified as being vulnerable who would not be able to access support through the school / college of the young person who has died.

6. An urgent 'Critical Incident Meeting' should be convened and should include the Headteacher, EP, mental health service representatives (CAMHS and / or in-house service), Early Help representative/early help service and/or social worker. The Youth Offending Team should be invited as they may know some of the peer group. It may be appropriate for a police officer to be invited. This should be discussed with the investigating officer. Specific consideration should be given to include a faith or community leader. Ideally a list of vulnerable peers should be drawn up before the meeting. Their families should be contacted to inform them of the death and consent should be sought for discussing them at the meeting to consider how support can be offered. If that is not possible, a first meeting could consider issues relating to the whole school and a second meeting could be convened 24 - 48 hours later to consider specific young people after consent has been obtained.

The purposes of the Critical Incident Meeting are to:

- Consider how the school community will be informed of the death in terms of timing, group size, language to be used. It should include general advice about the normal range of reactions in terms of thoughts and feelings and general sources of information about how to cope with such sad news. Detailed information about the mode of death should not be provided and there must be prior agreement with the deceased child's family as to what information may be shared.

- Decide, with consent of the deceased child's family, what information should be shared with families. (Template letters are available through the EP service).

- Consider how to respond to media interest (the local authority communications team may be able to offer advice.) It is important that any statement to the media should be agreed beforehand with the child's family. Communications teams can seek guidance if needs be from the Samaritans best practice media guidelines at www.samaritans.org/media-centre/media-guidelines-reporting-suicide .

- The use of social media needs to be considered. It may be helpful for the school / college to set up a memorial page which they can then moderate and close after an agreed interval. Young people will need to be advised who to speak to if they have concerns about any posts made.

- To attempt to identify peers / staff who are at increased risk to themselves or others as a consequence of the event, and who may need additional support, there is a three-stage process:

  - To identify those who have a proximity to the event using the '**Circles of Vulnerability Model':**
    - Geographical proximity – for example, those closely involved at the time of the death, witness to the death or in contact with the deceased person just before the incident.
    - Psychological proximity – those who may identify with the deceased for example, same treatment group, same class, same clubs, same challenges.
    - Social proximity – family, friends, romantic partner or ex, key staff.

    or Any perceived culpability / responsibility by individual or group

  - To identify those who are at higher risk of distress due to pre-event experiences or predisposition. These factors could include:
    - Previous bereavement / trauma/ loss (note a significant loss to a child may not have been recognized as significant by the adults around them)
    - Pre-existing Social Emotional Mental Health issues
    - Alcohol and Substance misuse
    - Pre-existing home instability / stress factors
    - Neurodevelopmental difficulties
    - Learning difficulties
    - Cultural differences and / or language needs

  - To look for protective factors in those individuals highlighted in the two stages above. These could include:
    - A strong positive family relationship
    - Good prosocial support
    - Ongoing therapeutic support

- Engagement with a prosocial activity such as a sport group
- Constancy in ‘normal’ routines
- Evidence of the ability to problem solve situations and reflect on differing actions and outcomes

The meeting will then weigh up relative risks and protective factors to attempt to highlight those individuals who present a significantly increased risk of harm to themselves or others as a result of the death. A designated member of the critical meeting will look to highlight the meeting’s concerns with the child’s family/ young person/ staff member and advise about relevant agencies that can offer help including advice about referrals if needs be.

Consider key dates when risk may be increased and what steps could be taken to support people around those times for example, around the time of the funeral, the inquest, the deceased person’s birthday and the anniversary of their death.

The local authority should inform youth workers in the community, as they will be engaging more informally with young people who may be affected and are well placed to provide support and flag any concerns.

7. A review meeting(s) should be convened to monitor progress and decide when the process can be stepped down. Approximately 6 weeks after the response has ended a multi-agency debrief meeting should be convened. This should seek to evaluate the impact of the response and identify any learning for dissemination through a multiagency quality assurance process.

8. The educational psychologist involved in the critical incident response will be invited to attend the child death review meeting to share any learning identified. The child death review report will be shared with the Child Death Overview Panel for strategic oversight.

References:

1. **Identifying and responding to suicide clusters. A practice resource. September 2019**
   https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/839621/PHE_Suicide_Cluster_Guide.pdf

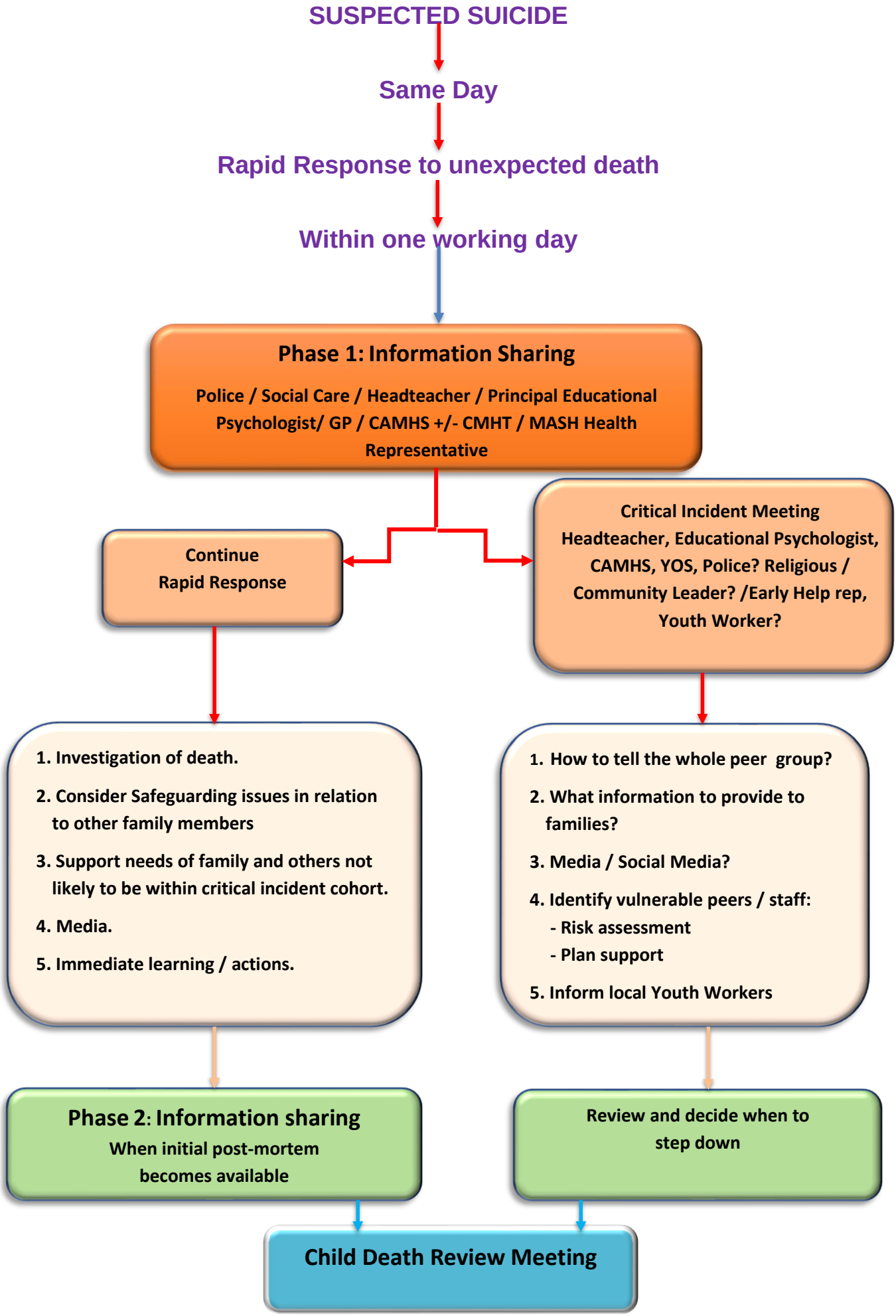
2. **HM Government.** ***Preventing suicide in England: A cross government strategy to save lives.*** **London: Department of Health; 2012.** Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/430720/Preventing-Suicide-.pdf

3. **Local Suicide Prevention Planning: A practice resource, October 2016** available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/562280/PHE_local_suicide_prevention_planning_a_practice_resource.pdf

4. **Suicide and self-harm in Britain: researching risk and resilience,**
   McManus S, Lubian K, Bennett C, Turley C, Porter L, Gill V, with Gunnell D, Weich S. (2019) Suicide and self-harm in Britain: researching risk and resilience using UK surveys. NatCen: London.

5. **Improving young people's health and wellbeing: A framework for public health**
   Produced by Public Health England and the Association for Young People's Health

APPENDIX 1


SUSPECTED SUICIDE
Same Day
Rapid Response to unexpected death
Within one working day
Phase 1: Information Sharing
Police / Social Care / Headteacher / Principal Educational Psychologist/ GP / CAMHS +/- CMHT / MASH Health Representative
Continue Rapid Response
Critical Incident Meeting
Headteacher, Educational Psychologist, CAMHS, YOS, Police? Religious / Community Leader? /Early Help rep, Youth Worker?
1. Investigation of death.
2. Consider Safeguarding issues in relation to other family members
3. Support needs of family and others not likely to be within critical incident cohort.
4. Media.
5. Immediate learning / actions.
1. How to tell the whole peer group?
2. What information to provide to families?
3. Media / Social Media?
4. Identify vulnerable peers / staff:
- Risk assessment
- Plan support
5. Inform local Youth Workers
Phase 2: Information sharing
When initial post-mortem becomes available
Review and decide when to step down
Child Death Review Meeting

APPENDIX 2

Kitchen Table Talks – an approach to reaching and supporting peers after a young person's suicide.

Identifying and responding to suicide clusters: A practice resource. September 2019.

"A project in Westfriesland, an area in the North West Netherlands offered "kitchen table talks" with young people after they had experienced the suicide of a friend. The aim of these talks was to validate distress, strengthen solidarity, empathy and empowerment within the friendship group. The sessions were facilitated by mental health nurses, but were not therapy, and they were held at a location the friends chose for themselves.

The kitchen table talks helped the young people share their experiences. Three key questions facilitated this:

- How did you hear about it? What did you do when you heard that your friend had died?
- How are you getting on now? (Can you sleep, eat, go to school?)
- What are your future plans?

Young people reported that after the talks they felt a sense of relief that they had been able to talk and not feel judged. The friends said they felt closer to each other and more confident that they were all there for each other."

Support Groups:

CHILD BEREAVEMENT UK: helps children, parents and families to rebuild their lives when a child grieves or dies. They support children and young people up to the age of 25 who are facing bereavement, and anyone affected by the death of a child of any age.
Call: 0800 02 88840
Website: https://www.childbereavementuk.org/pages/category/elephants-tea-party

CHILDLINE: Childline is a counselling service for children and young people up to their 19th birthday in the United Kingdom provided by the NSPCC
Call: 0800 1111
Website: https://www.childline.org.uk/

CRUSE BEREAVEMENT CARE / HOPEAGAIN: is a national charity offering support to children and adults following bereavement. There is a separate website for young people which is overseen by professionals.
Call: 0844 477 9400 (Cruse) 0808 808 1677 (Hopeagain)
Email: helpline@cruse.org.uk
Website: www.cruse.org.uk
Website specifically for young people: https://www.hopeagain.org.uk/

DORSET EDUCATIONAL PSYCHOLOGY SERVICE (EPS): is a professional psychological support service for children and young people, families, schools, communities and other settings.
Call: The senior educational psychologist in your locality area:
East Dorset Alison Pinks, 01202 868224, Purbeck Anna Ridley, 01929 557000, North Dorset Deborah Gill, 01258474036, Dorchester, Alison Pinks, Weymouth and Portland, Pamala Melville, 01305 762400, West, Petrina Tipping, 01308 425241
Website: https://www.dorsetcouncil.gov.uk/children-families/sen-and-disability-local-offer/education-and-learning/services-to-help-support-your-child/educational-psychologists.aspx
http://www.dorsetnexus.org.uk/Services/823

BCP EDUCATIONAL PSYCHOLOGY SERVICE (EPS): is a professional psychological support service for children and young people, families, schools, communities and other settings.
Call: The Principal Educational Psychologist or the Senior Educational Psychologist in your locality area:
Principal EP Vanessa Grizzle 01202 262009, East BCP (Bournemouth and Christchurch) Ulla Cheshire Tel: 01202 456388, West BCP (Poole) Jo Bispham Tel: 01202 262009
Website: https://www.fid.bcpcouncil.gov.uk/kb5/poole/fis/advice.page?id=rmdKg_9NBFk

GRIEF ENCOUNTER: support for bereaved children and their families to help alleviate the pain caused by the death of someone close.
Call: 0808 802 0111 / Main Office 0208 3718 455
Email: contact@griefencounter.org.uk
Website: https://www.griefencounter.org.uk/

MOSAIC: is a Dorset-wide charity offering a pathway of support to bereaved children, young people and their families.
Call: 01258 837071
Email: info@mosaicfamilysupport.org
Website: https://mosaicfamilysupport.org/

APPENDIX 3

PAPYRUS: is a national charity specialising in suicide prevention and support centering around three key principles: Support, Equip and Influence.
Call: 0800 068 4141
Email: admin@papyrus-uk.org
Website: https://papyrus-uk.org/

SAMARITANS: 24-hour confidential listening and support for anyone who needs it.
Call: **116 123**
Email: **jo@samaritans.org**
Website: https://www.samaritans.org/

SIMON SAYS: is a local Hampshire based charity providing support to children and young people who have been bereaved.
Call: 023 8064 7550
Website: https://www.simonsays.org.uk

SURVIVORS OF BEREAVEMENT BY SUICIDE: is a self-help and support group for those bereaved through suicide.
Call: 0300 111 5065
Email: sobs.admin@care4free.net
Website: https://uksobs.org/

THE COMPASSIONATE FRIENDS: support for bereaved parents who have lost a child of any age and from any circumstances.
Call: 0845 123 2304 / **0345 120 3785**
Email: info@tcf.org.uk
Website: https://www.tcf.org.uk/

THINKUKNOW: is the education programme from NCA-CEOP, a UK organisation which protects children both online and offline.
Call: 0800 1111 (Childline number)
Website: https://www.thinkuknow.co.uk/

WINSTON'S WISH: is a national charity aimed at supporting bereaved young people and their families. The site has lots of information for schools and other professionals.
Call: 08452 030405 / 08088 020 021
Email: ask@winstonswish.org.uk
Website: https://www.winstonswish.org/

YOUNG MINDS: is an independent charity that promotes good mental health and to meet the needs of vulnerable and excluded children and young people.
Call: 0808 802 5544
Website: https://youngminds.org.uk/

BEREAVEMENT AND SUPPORT FOR FAMILIES AND EDUCATIONAL SETTINGS
https://www.fid.bcpcouncil.gov.uk/kb5/poole/fis/site.page?id=E-GOWcpQTdA
FIND – Family information Directory.