7 Minute Briefing: Suicide – Black country CDOP Briefing

1 Background

The sad emergence of a cluster of 5 probable or suspected suicides in the Black Country led to a local preliminary review of cases to identify any emerging modifiable themes or patterns.

2 Response

The Chief Nursing Officer, Black Country and West Birmingham CCG requested a review to be undertaken of the cases with the aim to highlight key safeguarding themes or issues and identify learning and recommendations to support safeguarding practice and help reduce the risk of suicide to children and young people.

The West Midlands Regional CDOP also recognised the increase in probable suicides and coordinated a themed review focusing on deaths by suicide.

This briefing is based on these reports. And factors identified from the five cases.

3 Identified Factors - social

- Reported bullying
- Self-Harm/previous suicide attempts
- Previous bereavement of a close relative/friend
- Isolated – voice not heard: the 'invisible' child
- Separated parents
- Alcohol/substance misuse
- Family financial concerns
- Experience of abuse
- Mental ill health
- Appearing to thrive at school and home but struggling with identity and belonging

4 Recognised impact of COVID

NSPCC (2020) states that many of the risk factors associated with abuse and neglect have been exacerbated by the coronavirus pandemic, while the support services that would traditionally identify and respond to these concerns have been unable to see many of the children and families they work with face-to-face.

It was observed that the number of face-to-face contacts with children from all agencies significantly reduced. Virtual contacts with children and their families largely replaced face-to-face visits. While the use of virtual platforms, a large proportion of children have become invisible, particularly due to the closure of schools.

5 Identified Factors - services

- Contact with Social Care – at any time
- Contact with CAMHS – at any time
- Poor information sharing/information not joined up
- Known to police (young person and/or family)
- Confusing terminology used between agencies
- Perceived non-engagement/hard to reach leading to case closure

6 Considerations and Next Steps

Suicide prevention planning must be joined up and governed.

Organisations should review child self-harm and attempted suicide pathways.

Incorporate ACES into assessments and discharge planning.

Ensure the cumulative harm of ACES is understood by staff.

HEAR THE VOICE OF THE CHILD, ESPECIALLY IN ISOLATION

Review 'was not bought' policies – how do you engage with those considered to be difficult to engage with?

Identify and recognise those 'invisible' children who have found it difficult during COVID.

Support young people to recognise their feelings and seek appropriate support.

7 Further Information

It needs to be recognised that, although unusual to the Black Country, the probable suicide deaths reported are still quite small with unique elements, some of which are unknown, and could remain unknown.

For further information or for the full reports, please contact keren.hodgson@nhs.net Child Death Overview Panel Coordinator, Black Country ICB

Walsall Safeguarding Partnership

Right for Children, Families and Adults