Cumbria Suicide Cluster Prevention Protocol: Implementation Following a Suspected Child Suicide.

Contents

Introduction.

Any death from suicide is a tragedy that has a devastating effect on family, friends and the wider community. The impact following the suspected suicide in a child is a devastating loss that affects all those involved. A suspected suicide in a child needs a specific response to ensure that the risk of a cluster is minimised through a system wide preventative approach, and individual level support for affected young people.

Suicide clusters refer to an unusually high number of suicides or attempted suicides that occur closely in time and/or location, typically among individuals who share some form of connection, whether it be geographical, social, or situational. These clusters can arise due to suicide contagion, where the knowledge of one suicide influences others, particularly within vulnerable populations. In areas like Cumbria, the effects of these clusters can be devastating, both for families and the wider community.

Suicide contagion is the phenomenon where exposure to suicide, whether through direct relationships, media coverage, or community awareness, increases the likelihood of others engaging in suicidal behaviour. This can occur when vulnerable individuals identify with or are emotionally affected by the deceased, potentially viewing suicide as a coping mechanism or solution to their own struggles. Suicide contagion is more likely in close-knit communities or among specific social groups, and managing its risk is crucial in preventing suicide clusters.

This protocol is intended for local authorities, ICB, mental health services, children and young people's services, educational institutions, community leaders, police, and health professionals in Cumbria. It has been developed to support professionals and the direct responses following a suspected suicide in a child.

The over-arching purpose of this protocol and multi-agency response is to minimise the risk of a cluster of suicides and ensure that the best support is in place for the community and individuals, drawing on public health guidance outlined in "Suicide prevention: identifying and responding to suicide clusters"[1]. This process must be utilised in conjunction with the statutory child death review processes following the death by suicide of a child aged under 18, as outlined in "Working Together to Safeguard Children 2023"[2].

Key objectives of this protocol

- Early Identification of Suicide Clusters
- Prevention of Contagion (spread of suicidal behaviour)
- Immediate Response to Emerging Clusters
- Long-Term Support and Resilience Building
- Community Engagement and Awareness
- Data Monitoring and Evaluation

[1] Suicide prevention: identifying and responding to suicide clusters - GOV.UK (www.gov.uk)
[2] Working together to safeguard children 2023: statutory guidance (publishing.service.gov.uk)

1. Overview of Current Statutory Child Death Review Process.

The death of a child is a devastating loss that profoundly affects all those involved. Since April 2008 all deaths of children up to the age of 18 years, excluding still births and planned terminations, should be reviewed by a Child Death Overview Panel (CDOP) to accommodate the national guidance and statutory requirements. From 1st April 2019 notifications of still births and planned terminations where a clinician is not present have been notified and reviewed by the CDOP.

The publication of the Child Death Review Statutory and Operational Guidance in 2018[3] builds on the requirements set out in Chapter 5 of Working Together to Safeguard Children 2018, now updated in Chapter 6 of Working Together to Safeguard Children 2023. This document details how individual professionals and organisations should contribute to guided standardised practice nationally for Child Death Reviews and enable thematic learning to prevent future child deaths.

Child Death Review partners, the Local Authorities and Integrated Care Boards for Cumbria now hold responsibility for the delivery of the Child Death Review Process as set out in the Children Act 2004, as amended by the Children and Social Work Act 2017. This process is undertaken locally for all children who are normally resident in Cumbria.

The purpose of the Child Death Review Process is to try to ascertain why children die and put in place interventions to protect other children and prevent future deaths wherever possible. The process intends to:

- Document, analyse and review information in relation to each child that dies in order to confirm the cause of death, determine any contributing factors and to identify learning arising from the process that may prevent future child deaths
- To make recommendations to all relevant organisations where actions have been identified which may prevent future deaths or promote the health, safety and wellbeing of children
- To produce an annual report on local patterns and trends in child death, any lessons learnt, and actions taken, and the effectiveness of the wider Child Death Review Process
- To contribute to local, regional and national initiatives to improve learning from Child Death Reviews.

The local notification process of a suspected suicide in a child.

Local Authority Public Health teams must be notified of a death in a child due to suspected suicide. There are two routes for this notification:

- Through the Real Time Alert surveillance through which Public Health nominated suicide prevention leads and other partners are notified of all local suspected suicides.
- Through the Public Health Enquiries mailbox in each Local Authority. Please include 'Child Death' in the subject header.
    - Cumberland Council: Public.HealthEnquiries@cumberland.gov.uk
    - Westmorland and Furness Council: Public.HealthEnquiries.WAF@estmorlandandfurness.gov.uk

[3] Child Death Review Statutory and Operational Guidance (England) (publishing.service.gov.uk)

This dual process will ensure that the notification is received in a timely manner. This notification is done in addition to the Child Death Review Process and the responsibility for this notification lies with all organisations aware of the child death due to suspected suicide. This notification process will enable Public Health leadership and system co-ordination should a response be required to reduce the risk of a subsequent cluster of suicides.

1.1 The Joint Agency Response Meeting.

The first stage of the statutory Child Death Review process is a Joint Agency Response Meeting (JARM). A JARM will be triggered in full for all child deaths that are sudden or unexpected.

An unexpected death is a term used at presentation for the death of an infant or child whose death was not anticipated as a significant possibility 24 hours before the death, or where there was a similarly unexpected collapse leading to or precipitating the events which led to the death. Within this process the lead agency will be either the Police or the Consultant Paediatrician involved in the care of the child, who will inform the Child Death Review Officer, who then ensures a meeting takes place within 72 hours of the child's death. The aim of the JARM is to enable the sharing of information, multi-agency discussions and planning to safeguard other individuals if identified. In the tragic event of a suspected suicide, the JARM will consider whether any other young people may be vulnerable to self-harm/suicide and ensure that the most appropriate support is in place for them. It is essential that all required professionals and key professionals attend this meeting and any subsequent meetings. The possibility of a potential suicide cluster involving young people must always be assessed and reviewed. This process will be supported by the Public Health nominated Suicide Prevention lead or representative.

The JARM must take a decision regarding the risk of a suicide cluster and this decision will initiate the implementation of this protocol. If no risk of cluster is identified, then this decision and rationale should be recorded in the JARM minutes and no further action in relation to this protocol is required. The statutory Child Death Review Process will continue.

Should the JARM decide that there is a risk of a cluster, the implementation of this protocol will be initiated, which should also be recorded in the minutes. The nominated Public Health suicide prevention lead or a representative will be responsible for organising a Cluster Prevention Strategic Group meeting and a subsequent Cluster Prevention Delivery and Risk Management Group.

1.2 Education Settings.

1.2.1 Notifications

Children Services in Cumberland and Westmorland and Furness Councils will be notified through the statutory Child Death Review process that there has been a death in a young person. If the death happens outside of school time, the school will be contacted through the relevant emergency contact. The school will attend the JARM and will be aware that the child death is a suspected suicide.

On initiation of this protocol, the education settings will be contacted by the Assistant Director of Education or a nominated person. The initial conversation with the education setting should include an offer of bereavement support and any other support that the setting may need. This and subsequent discussions with the setting should include information about the risk of contagion and suicide clusters in young people. This will culminate with a request that the setting undertakes a risk

assessment based on the Circles of Vulnerability (Appendix 1). Public Health leads can support these conversations.

Early notification is crucial in ensuring the school receives accurate information from a reliable source and can plan how they will support other pupils and staff. The school will play an important role in mitigating the risk of a suicide cluster, and aiding recovery, but only if they are able to respond to the situation appropriately. By making immediate contact with the school, we can ensure that they are best equipped to deal with the devastating aftermath of a suspected suicide and that other vulnerable children are identified and safeguarded.

1.2.2 Risk analysis

Certain factors increase the likelihood of suicide clusters, including:

- **Geographical proximity** (small rural communities)
- **Age groups** (youth and young adults, especially vulnerable after the loss of peers)
- **Shared environments** (schools, workplaces, social circles)
- **Social media impact** (copycat behaviour encouraged by widespread media reporting or social media discussions)

The evidence regarding the Circles of Vulnerability should be discussed with the setting, preferably the Head Teacher or Safeguarding Lead. The setting should be advised to complete the data gathering tool (Appendix 2) in advance of the partnership response. The setting will be advised to complete this based on an increase in risk to a child due to the suspected suicide, to ensure that adequate support can be put in place. The education setting will also be sent a template letter for parents (Appendix 3).

Public Health and Education will undertake this conversation with other settings or youth groups if a high level of risk is identified.

This completed data gathering tool should be sent securely to the nominated Chair of the Cluster Prevention Response and Risk Management Partnership, via Public Health if required.

2. The Cluster Prevention multi-agency response.

The cluster prevention multi-agency response meetings will be organised following the decision at the JARM and will take place within two working days of the JARM, where possible.

2.1 Confidentiality and Information Governance

It is required that all agencies abide by their existing information governance policies and procedures. Whilst it is important that multiple agencies work together and share essential information, it is also crucial that confidentiality and data protection are considered. This should be discussed with the family by their key worker and consent obtained where possible.

The implementation of a Strategic Group, and a Response and Risk Management partnership allows for a system wide response to the contagion risk, but also ensures that individual risk assessments are completed by the most appropriate partnership.

The cluster prevention multi-agency response can be delivered by a single group, or by two groups as outlined below. This decision rests with the Public Health Suicide Prevention Lead and is dependant on local circumstances. The two-meeting approach is recommended when there a wide-ranging

community response involving partners that do not need to be involved in the risk assessment of young people. This two-meeting approach therefore ensures data protection and privacy during the risk assessment discussions. A single meeting approach can be implemented when the Chair is satisfied that all members have a role in assessing and reducing risk of harm in young people.

2.2 The Cluster Prevention Multi-Agency Strategic Partnership

The Cluster Prevention Multi-Agency Strategic Partnership will provide leadership and oversight of the system wide response, identifying necessary actions and clearly recording the responsibility for their implantation, either by represented partners or the Cluster Prevention Response and Risk Management Partnership. This strategic partnership will form the first response meeting and will take an initial strategic view of the actions required to reduce the risk of a cluster.

This group will be chaired by the relevant Public Health suicide prevention lead or representative. This is a strategic group with a broad range of membership responsible for providing leadership and oversight for the system-wide response.

The key areas for discussion include:

- Information sharing
- Surveillance
- Communications
- Bereavement support
- Lessons learnt
- Policy and protocol development

The notes and action log for this meeting will be taken in real time to inform the subsequent Cluster Prevention Response and Risk Management Partnership. All participants will receive the minutes and action log the day following the meeting.

On completion of the Cluster Prevention Multi-Agency Strategic Partnership, partners are given time for a break and then the Cluster Prevention Response and Risk Management Partnership will meet.

2.3 The Cluster Prevention Response and Risk Management Partnership

The partnership will be responsible for reviewing all the information captured by the education setting, identifying young people at increased risk of harm associated with the suspected suicide, and developing care plans with the providers. These care plans and associated action will be recorded at the meeting and sent securely to the members by the day following the meeting.

The partnership will also be responsible for implementing any actions delegated to them by the Strategic Partnership.

This partnership is chaired by a Safeguarding representative from the Strategic Partnership. The membership of the partnership will be limited to service delivery partners and may vary dependant on the nature of the response. This smaller group of relevant service providers are responsible for

the risk assessment and management of people potentially affected by the suspected suicide. This partnership is also responsible for implementing actions as allocated by the strategic group.

Invitations to the response partnerships.

The nominated Public Health suicide prevention lead or a representative will be responsible for co-ordination of the cluster prevention response. The membership for these groups can be found in the draft Terms of Reference in Appendix 4 and 5. Public Health will have an established distribution list for the local response, which is updated annually as part of the protocol review process. This initial invite for both Partnerships will include an anonymised summary of the situation, draft ToR and an agenda (a template can be found in Appendix 6).

2.4 Subsequent meetings

Subsequent meetings will continue based on need but will always take place sequentially. This response needs to be timely, so subsequent meetings will be arranged in a timescale that allows actions to be implemented but also enables timely escalation if required.

2.5 Duration of the response

The cluster prevention response is time-limited, and partnerships should only meet for as long as it is necessary. There is currently no national guidance on how long this response should last. The length of the response will depend upon the level of risk to individuals and within the community. Partnership members should remain vigilant and use the partnership contacts as a platform to raise any concerns.

2.6 The stepping down process

The cluster prevention response should only be stepped down when it is agreed that all individuals who were identified as being at risk have been appropriately safeguarded. This will be a recommendation from the Chair of the Response and Risk Management Partnership. The decision to step down should ultimately be made by Chair of the Strategic Partnership in conjunction with its members. The Strategic Partnership must ensure that there is sufficient recovery support in place for education settings, including support to develop policies and training for staff to ensure the setting is well equipped to continue support pupils and staff.

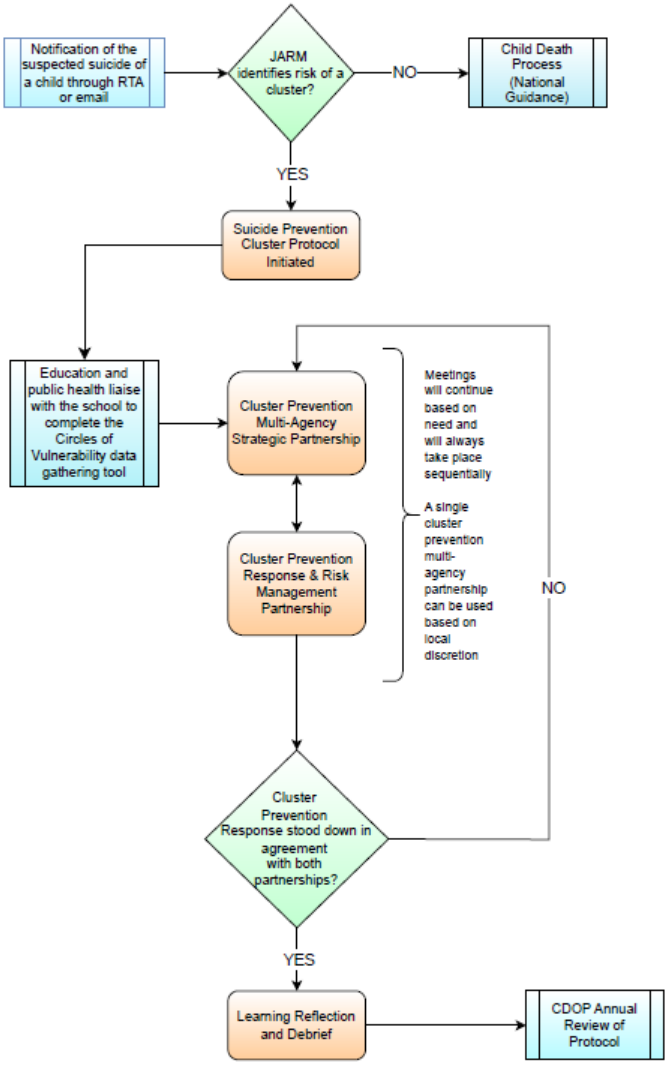
The stepping down process should ensure that the following are in place:

- Ensuring that where necessary, agencies continue to work together to support those affected;
- Planning support for significant dates and anniversaries.
- Ensuring community agencies (i.e. police, schools, healthcare teams etc.) are aware of how to communicate future concern;
- Providing the group with an opportunity for reflection and documenting that learning;
- Ongoing surveillance of suicide and self-harm in the area, especially as geographical areas that experience a suicide cluster may be at risk of further (‘echo‘) clusters in

the future. It might also be advisable for the group to ensure vigilance around anniversaries of suicide clusters.

Normal Safeguarding procedures remain in place once the response is stepped down.

<u>The diagram below provides a summary of the process to implement this protocol.</u>



3. Learning and Reflection Debrief.

All expected and unexpected child deaths are required to have a Child Death Review (CDR) meeting as part of the statutory response. This is a multi-agency meeting where all matters relating to an individual child are discussed by professionals directly involved in the care of that child during their life. This meeting is held prior to the Inquest.

The purpose of the CDR Meeting is to discuss and review the background history, treatment and outcomes of investigations to determine, as far as possible:

- the likely cause of death;
- to ascertain contributory and modifiable factors across domains specific to the child, the social and physical environment and service delivery;
- to describe any learning arising from the death and, where appropriate, to identify actions that should be taken by an organisation involved to improve the safety or welfare of children or the child death review process and to review the support provided to the family and to ensure that the family are provided with the outcomes of any investigation into their child's death.

All professionals involved with the JARM and cluster prevention response meetings will be invited. Learning from the case will be identified and actions and recommendations made. Information discussed at this meeting will be shared with the coroner in preparation for the Inquest and will be shared with CDOP in the form of a Draft Child Death Review Analysis Form.

Public Health leads will work with Education colleagues and the setting to write a summary report for the Suicide Prevention Leadership Group, the relevant Director of Public Health and the relevant ICB suicide prevention leads.

4. Monitoring and Evaluation

Regular monitoring and evaluation will ensure the effectiveness of the Suicide Cluster Prevention protocol

- This protocol will be reviewed after every implementation to capture lessons learnt.
- It will be reviewed on an annual basis by CDOP sub-group. The CDOP and the Suicide Prevention Leadership Group will be informed of the reviews and any amendments communicated to partners.

Version Control.

Name	Position	Amendment	Reason	Page	Section	Date and initials
Vicky Snape	Registrar	Refresh of protocol to clarify process	Review against PHE and Lancashire documents	All	All	
Vicky H-Putt	Consultant	Review of amendments to reflect experience and reflections	Review of amendments and feasibility	All	All	VHP, 25.07.2024
Lindsey Ormesher	Children and Families PH Lead	Review of document	Review of content	All	All	LO 21.08.24
Carol Stewart	Consultant	Comment on amendments	Comment on amendments	All	All	CLS 02/09/24
Carol Stewart	Consultant	Suggested amendment s		All	All	CLS 06/09/24
Vicky H-Putt	Consultant in Public Health	Update based on partner feedback	Review of amendments from partners	All	All	VHP 17/09/24
Louise Elsworth-Barnes	Suicide Prevention Lead	Review	Minor questions for clarification	Pg 4 & 7		LEB 18/09/24
Vicky H-Putt	Consultant in Public Health	Review and inclusion of appendices	Updating content of appendices.	App. 1-6	Appendices	VHP 20/09/24
Vicky H-Putt	Consultant in Public Health	Amendment of education notification process	Process has been updated county-wide	Pg 5-6	Education settings	VHP 09.01.2025
Vicky H-Putt	Consultant in Public Health	Amendment of education notification process, meeting structure and flow chart	Feedback from Education and from Public Health Cumberland	All	Education Settings and Cluster Prevention Multi-agency response	VHP 29.04.2025
Vicky H-Putt	Consultant in Public Health	Inclusion of email addresses	Ensure notification process	5	Overview	VHP 09.06.2025
Vicky H-Putt	Consultant in Public Health	Agreed as final	Review by CDOP, CSPLG, Children's Services complete	All	All	VHP 09.06.2025