Practitioner Briefing: Multi-agency Learning Review Theme Suicide and Self Harm (April 2018)

The outcome of the review concluded that the death of the young person could not have been foreseen or prevented by anyone. Agency responses to the young person and the family were thought to be timely and appropriate.

On a population basis the circumstances surrounding the death were not unique to them alone; research tells us that young people suicide is an area of concern that continues to grow.

Improved services for self-harm and access to child and adolescent mental health services (CAMHS) are crucial to addressing suicide risk. However, the vital role of schools, primary care, social services, and youth justice services cannot be underestimated and considered as part of a prevention plan. Agencies that work with young people and families, can contribute to suicide prevention by recognising the patterns of cumulative risks.

Many young people experience similar issues in adolescence, but do not take their own lives, which makes it difficult to conclude or establish cause and effect. However, the antecedents identified in both a study by Manchester University and an audit by the North of Tyne Child Death Overview Panel clearly indicate an important role for all local services.

The use of chronologies by agencies is thought to be a valuable tool for capturing significant life events and in highlighting patterns in behaviour and risk. Use within the school setting was thought to be particularly relevant.

The review also highlighted a number of issues relating to information sharing: firstly, the importance of effective information sharing between professionals for ensuring a timely response to young people who self-harm; the importance of multi-agency decision making and outcomes being shared routinely with GPs; and the potential value of multi-agency discharge meetings by CAMHS (Children and Young People Services for Northumberland Tyne & Wear), for those young people who have seriously self-harmed or attempted suicide, so that all key professionals, particularly schools, are informed about outcomes and any ongoing risks in order to offer ongoing support post intervention.

Statutory guidance tells us that fears about information sharing must not be allowed to stand in the way of the need to promote the welfare and protect the safety of children. Information can be shared without consent if a practitioner judges that there is good reason to do so, and that sharing of information will enhance safeguarding in a timely and effective way. Guidance indicates that multi and inter-agency work starts as soon as there are concerns about a child's welfare, not just when there are questions about possible harm. Effective safeguarding systems are those where all professionals share appropriate information in a timely way and can discuss any concerns about an individual child with colleagues and local authority children's social care.

The review questioned why in serious incidents of self-harm information is not automatically shared given the level of risk from such incidents and the likelihood of it happening again. This issue requires further debate in work going forward.

The full report has not been published for reasons of confidentiality. For more information contact Sue Kirkley, NSCB Co-ordinator susan.kirkley@newcastle.gov.uk 0191 2777426

HM Government (2015), Information Sharing: Advice for Practitioners Providing Safeguarding Services to Children, Young People, Parents and Carers.

HM Government (2015), *Working Together to Safeguard Children: A Guide to Inter-agency Working to Safeguard and Promote the Welfare of Children.*

Manchester (2016), *Suicide by children and young people in England. National Confidential Inquiry into Suicide and Homicide by People with Mental Illness* (NCISH). University of Manchester.