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INDEPENDENT PUBLIC MENTAL HEALTH CONSULTANCY

Tony Ryan Associates
Supporting service and organisational development

An Independent Review of Actions Taken Following a Group of Suicide Events in Rotherham

Dr Elaine Church MBChB MPH FFPH
Dr Tony Ryan RMN BSc(Hons) PhD

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FINAL

Executive Summary

Since 5th November 2011, there have been four deaths by suicide of young males in Rotherham aged between 15 and 19 years of age and two identified severe self-harm incidents (including an 11 year old attempted suicide in March 2014). Two of those who died by suicide and one of the severe self-harm incidents, were students attending the same school (School A) in Rotherham. There has also been a 20 year old who died by suicide and who was an ex-pupil of school A.

Based on the national suicide rates in 2011 within the 15 to 19 years age group, Rotherham would be expected to have one young person (aged 15 to 19) die by suicide every two years - (this also applies when considering the national average suicide rate in 15 to 19 year olds between 2001 and 2011). Within three calendar years in Rotherham (January 2011 to December 2013 there have been four suicides in people aged 15 to 19 years (compared to an expected rate of 1.5 in 3 years based on national rates).

A multi-agency response was established promptly to investigate the suicides within School A and assess whether they were related and what action needed to be taken to prevent further suicides.

Early in the process the Director of Public Health sought advice from Public Health England (PHE) regarding concern that Rotherham may be dealing with a suicide cluster – advice from PHE was to refer to it as "an investigation and prevention response related to suicides".

Providing assistance following a young person's suicide requires a sensitive and well-planned approach. Responding to the occurrence of multiple young people suicides provides an even greater challenge. Rotherham was faced with an unusual and complex set of circumstances which emerged over time following the recognition of a death occurring of a pupil at the same school as the initial death by suicide and a further severe self-harm incident..

This was a complex situation within a national policy and guidance vacuum. Whilst also needing to address these events practically, there was also a need to learn quickly how to deal with such a series of incidents. Whilst in retrospect it can be seen that there are issues that could have been addressed more effectively, Rotherham have been keen to learn from their response hence undertaking an independent review of lessons learnt.

It needs to be acknowledged that Rotherham was learning and gaining knowledge on suicide postvention throughout the response and which developed and became more sophisticated over the time period the incidents were managed.

The delivery of crisis response services in the aftermath of a young person's suicide is referred to as "*suicide postvention*".

Effective postvention is itself a primary form of prevention as well as support.

Successful suicide postvention is dependent on a timely efficient and targeted response.

The intention of this independent review is to describe and share learning from this co-ordinated, system-wide community response. This report includes a series of recommendations based on the lessons learnt and shared following a series of interviews with members of the three groups established under complex safeguarding procedures, examination of the minutes of the various groups established and emails / correspondence.

Rotherham has a history of good partnership working and although it is clear the agencies involved worked well together (the majority of those interviewed reported this), events happened in such a way as to somewhat mitigate against the timeliness of the overall postvention response.

To reiterate, it should be acknowledged that what has happened in Rotherham was a very unusual set of circumstances, very few people would have had similar experiences to draw upon for direction and that it was an extremely stressful process for all participants. Nevertheless, interviewees spoke positively about the desire of group members to work together and deliver a multi-agency solution to address the issues they faced.

Key findings

1. Identification of connection between the suicides and young people at risk

1.1. The discovery of a potential link between two suicides at a school via the CDOP led to a sequence of events, which was unusual and complex. Rotherham agencies had to deal with this situation within a national policy and guidance vacuum.

1.2. There were 15 months between the first and second suicides and the episode of near miss self-harm associated with School A occurred a further three months after the second suicide. The establishment of the first CDOP meeting in March 2013 identified a possible issue at the school with regards to the two suicides being potentially linked.

1.3. The lack of a clear national framework for action at the outset added to the difficulty in securing a clear early plan of action. However, the introduction of the multi-agency response under the RLSCB complex safeguarding procedures and the use of the Melbourne Guidelines (May 2013) to develop the Rotherham LSCB multi-agency guidance (June 2013), was helpful in providing a useful framework for action and a more organised approach to the meetings.

1.4. The initial police investigation into a possible link between suicides also added a further layer of complexity and delay to the multiagency response due to the need for police to be able to carry out forensic examination and interviews at the outset. Amongst the large amount of information gathered there was no evidence to substantiate criminal activity in the events under review.

1.5. There were issues with regards to confidentiality in light of the extremely sensitive nature of information pertaining to some specific individuals. Several people reported feeling uncomfortable about some of the discussions relating to some young people. This was not helped by the perception there appeared to be considerable uncertainty in the preliminary meetings, until facts had been more clearly established.

1.6. A cohort of young people were identified as high risk and their support needs assessed including:

- Work carried out to date including needs assessment and service provision
- Risk assessment of named individuals
- Identification of lead practitioners
- Engagement with parents

All the families of the young people involved were working with Social Workers, CAMHS professionals and the police. Although some families were more engaged than others, no families refused help, support or input.

1.7. Those interviewed felt that individual young people and families who needed support were identified and that a lot of effort went into this process, particularly by duty teams. The response by CAMHS and children's social workers was considered to be excellent. The response by police was also rated highly.

1.8. Support was provided by two named police officers in Rotherham, although these were not trained Family Liaison Officers (FLOs). This support was very much welcomed by one of the bereaved families. Indeed there was overwhelmingly positive feedback with regards to the police role and interventions within the response.

1.9. The balance between a vulnerable case / individual safeguarding approach and a broader public health population at risk based approach was challenging at times for many stakeholders.

1.10. It was felt that agencies needed to be quicker in responding e.g. in providing contact details, etc to ensure no delays in the implementation of the community response plan.

2. Identification of wider communities at risk

2.1. Four levels of "target risk groups" were identified and agreed, however, some people interviewed felt that there were different levels of understanding with regards to the four levels of risk. The identification of at risk individuals appeared to be predominantly focussed on the high risk individuals within School A and was not expanded to include broader vulnerable groups.
Overall there was insufficient identification of wider communities at risk and although "mapping" was mentioned in various strategic meetings, this was not produced.

2.2. There appeared to be insufficient contextual data / intelligence provided to the various groups on the epidemiology of suicides and deliberate self-harm in Rotherham. Although some routinely available local data was provided on young people suicides and CAMHS

activity with regards to DSH by individual schools, there were caveats with regards to data quality. This could be improved by the development of a real time surveillance system.

2.3. There is a lack of clarity as to what plans were put in place to ensure that support is offered to all bereaved families prior to the anniversary and the Inquest dates as per the current multi-agency guidance. A bereavement support pathway is currently being developed.

2.4. During the same time period that the response was underway, there were two further suicides in school aged children in Rotherham (17 year old male August and 16 year old male December 2013). While these did not appear to be linked to the first two suicides under investigation, the relevant part of the Community Response Plan (although in draft) was not initiated fully. Support was offered to the two schools affected via Educational Psychology and was offered to the families of the young people. Given the scale of the response in School A and the number of young person suicides, from a geographical point of view these two suicides should have been included within the cohort of young people suicides in Rotherham requiring an equivalent level of response.

2.5. There was little engagement with the wider community, other schools (particularly those where other suicides occurred) and voluntary sector organisations, youth clubs, sports clubs, faith groups and other relevant groups / organisations). The strategic group was uncertain as to whether additional publicity would have made the situation worse, the guidance recommended wider awareness raising. The lack of voluntary sector agencies included in the groups was mentioned by several interviewees (e.g. Samaritans). The latter having developed guidance for a media reporting approach (Step-by-Step) to postvention in schools and *Help is at Hand* (a resource for the bereaved).

3. The immediate response to parents, young people and the community

3.1. There was a perception of a lack of knowledge and expertise, early in the process, with regards to young people suicides. People felt they were working in unknown territory. Attempts were made to secure outside expertise early, however it was apparent that even national agencies e.g. PHE and NHS England lacked the policy guidance and expertise in this relatively new area in UK.

3.2. Some parents requested clear information to be made available for young people about where to go for help. Parents will know when there has been a suicide and require information to help them help their children and to provide reassurance that services are available to provide support when needed. Some parents felt the school should have targeted information to parents.

3.3.At a meeting held between three affected / bereaved parents on 1st July 2013 and the leads of the multi-agency response, the parents raised some useful issues which were incorporated into the action plan. It was reported that parents commented that "*they are grieving too*". Counselling was available via GPs but there did not appear to be sufficient access. Parents felt it would be useful to have a single point of contact to explain what support is available.

3.4. Parents felt that police should have interviewed all witnesses and people at the scene and that the investigation should have commenced much earlier. They also felt there should have

been follow up police interviews and that the same police officer should undertake those interviews.

3.5. School A offered information, guidance and support to the specific year groups who knew the deceased student and their known friendship groups, including the siblings' friendship group. A decision was taken not to involve younger year groups who would not have known the student who had died in this school of over 2,000 students.

3.6. There was no evidence of any formal communications **to all parents and students** within the school and outside of the school community with regards to the suicides e.g. local sports and youth associations, church and other groups where pupils may congregate outside of school. Other schools in the vicinity were not made aware of events. A general letter was sent to all parents in Rotherham just before school exams (June 2013) to signpost students to local support services should they feel stressed or worried.

3.7. Police examined access to suicide sites visited, contacts and messages sent. However, they did not have the ability/resources to investigate social media.

3.8. There did not appear to have been an issue with the establishment of memorial sites, etc; a memorial was set up on Facebook.

3.9. Overall, the provision of appropriate and timely information was insufficient including information about suicide risk, how to talk about suicide and about available services. The lack of information provided directly on suicide and self-harm at the time, was contrary to current community postvention guidance including the current RLSCB multi-agency guidance (June 2013) as is the lack of engagement with the local media. The lack of national and local guidance at the outset contributed to the lack of awareness raising.

4. Establishing support to the index school

4.1. Early in the response, there was a significant problem in communication between the Director of Public Health (DPH), Director of Children Safeguarding and Families (DCSF) and the Head Teacher (HT) at School A for various reasons, which culminated in significant difficulties in effectively initiating and implementing an effective multi-agency postvention response.

4.2. Although the Head Teacher of School A, in conjunction with the LA Director of Children Safeguarding and Families and the Director of Learning, agreed to carry out the necessary postvention work in the school and with partner agencies through the appointment of an Assistant Head, there was a difference of opinion between the School and the rest of the Strategic Group about the initial response and later how important parts of the community plan should be implemented. Achieving agreement appeared to have been very difficult.

Academies and schools under the provisions contained within sections 157 and 175 (respectively) of the Education Act 2002; and statutory guidance "Working Together 2013" have a legal "*duty to cooperate*" in safeguarding and wellbeing of pupils.

4.3. Whilst every effort was made to ensure joined up working and thinking in the initial stages, it was extremely difficult to have confidence that school A was effectively working

alongside the multi-agency group as the school did not recognise, at the time, that there was significantly heightened anxieties outside the school about what was happening at the school (including a police investigation). It is acknowledged that once the Assistant Head was appointed, the school was felt to be more involved. The newly recruited Assistant Head, Pastoral lead and the remainder of the school staff worked extremely hard within the structures and processes of the multi-agency response as far as possible, which enabled implementation of parts of the community response.

4.4. However, it was also reported during interviews by some individuals that they felt that they were held somewhat responsible for what had happened at the school and it was difficult to get their points of view across in the strategic meetings. This is in contrast to the perception of others interviewed, who felt that the approach to the school was more positive and supportive. It was suggested that a single point of liaison for the school would have helped and that coproduction of a Community Response Plan moving forwards would be helpful in moving towards this.

4.5. In effect, the issues relating to the problematic communications with the school has meant that the postvention response has not been as effectively delivered in School A in Rotherham as it could have been given the scale and joined up positive approach of all the agencies.

5. The Development of the Community Plan

5.1. As previously stated, the lack of a clear national framework for action at the outset added to the difficulty in securing a clear early plan of action. At the start of the process, there was ambiguity about the role of the initial multi-agency meetings established by the DPH and where it fitted within the current structures and processes established at Rotherham Borough Council. However, the introduction of the Melbourne Guidelines (May 2013) and the subsequent development of the Rotherham LSCB multi-agency guidance (June 2013) was helpful in providing a useful framework for action and a more organised approach to the meetings. This formalised arrangement within adapted guidance "*Rotherham multi-agency guidance for preventing and responding to behaviours which may indicate potential suicide or self-harm clusters*" (June 2013). This Community Response Plan is included under RLSCB and this should ensure that there is a clear strategic response, which all agencies are signed up to, established early on in future i.e. as early post-incident as possible. The Strategic Group was established on 2nd May 2013 and it was agreed on the 5th September to meet bimonthly until the lessons learnt report was completed. The work of the Operational Group and JIT was completed in July 2013.

5.2. There was a perception of a lack of knowledge and expertise, early in the process, with regards to young people suicides. People felt they were working in unknown territory. Attempts were made to secure outside expertise early, however, it was apparent that even national agencies e.g. PHE and NHS England lacked the guidance and expertise in this relatively new area. This was further compounded by the apparent link between two of the suicides and a severe self-harm incident, which led to an initial police investigation to assess whether a criminal act had taken place. As the Police had to carry out an investigation to see whether a criminal act had taken place, this resulted in other work being delayed or the course of work being changed until the police had completed the work required.

5.3. The Community Plan developed in Rotherham (based extensively on Melbourne guidelines), lists the key steps through preparedness, intervention, and follow up stages, however the plan remains very general and not specific to Rotherham. The plan will need further adaptation for local use following this review. (Rotherham Multi-agency Guidance for Preventing and Responding to Behaviours which may Indicate Potential Suicide or Self-Harm Clusters, June 2013).

5.4. Although there was a lack of information provided directly on suicide and self-harm, which is contrary to the current RLSCB multi-agency guidance (June 2013), the subsequent guidance developed recommends proactive working with media to help to ensure sensitive media reporting that encourages help seeking and does not increase the risk of further suicidal acts.

5.5. With regards to the established meetings, generally it was felt that there were too many meetings and too many attendees at many of these (i.e. several people attending from one agency / professional group). It was also felt the meetings were too long and there was extensive overlap of discussion.

5.6. It was perceived that agencies needed to be quicker in responding in the initial stages e.g. providing contact details and identifying senior leads.

5.7. As stated within the community plan, coroners and coroners' officers can offer immediate support. There was little evidence that this happened in Rotherham; one of the bereaved families felt there was a lack of support from the local Coroner. Concerns were also raised with regards to the Inquest process and different standards that appear to exist within different coroner areas.

5.8. An action plan was developed to ensure actions were implemented and monitored via the Strategic Group (see appendix 4), the last update to the action plan was November 2013. It was not clear at that point who had overall responsibility for ensuring the plan was implemented, who and what agency was responsible for delivery of which actions by when, the action plan is now being monitored by the Rotherham Suicide Prevention Group.

5.9. There remains a lack of clarity on the lead organisation and lead responsible for implementing the community plan moving forwards. This is particularly important for future postvention in specific schools and the ongoing surveillance / longer-term follow up actions. Although recorded in the minutes of the strategic group on 19th December that "*the aftermath of the work of the strategic group now belongs with the Suicide and Self-harm Prevention Group*" –if the Suicide Prevention Group is where the accountability now lies, the relationship between the suicide prevention group and the Rotherham Local Safeguarding Children's Board (and RLSAB) with regards to a future suicide and the threshold for initiating the community response remains unclear. Furthermore, the governance structures around the Suicide Prevention Group and the lines of accountability are not clear either. This is vital for the Group to be able to deliver in the future and needs to be clarified and clearly documented to ensure the postvention process continues. Step 7 of the current community plan "*Link to Longer Term Suicide Prevention Work*" seeks to ensure the link between the crisis response and a longer-term programme of suicide risk reduction and community recovery.

5.10. Under the new national safeguarding arrangements (post April 2013), neither Public Health or PHE are statutory partners of LCSB. Guidance states that PHE will work with "local arrangements for safeguarding, liaison with NHS Commissioning Board to access local expertise and advice". Directors of Public Health are expected to play a full part in their authorities to meet the needs of vulnerable children for example by linking effectively with their local Safeguarding Children's Board. Further clarity is required nationally and within Rotherham, about the relationship between Public Health, the Health and Wellbeing Board (HWBB) and the local Safeguarding Boards particularly with regards to further implementation of the postvention follow up response.

The emotional health and wellbeing of young people is not one of the current priority areas for Rotherham HWBB.

5.11. There was substantial agreement that the multi-agency working was effective and that people and agencies worked well together to try to deal with the issues. It should also be acknowledged that this was a very unusual set of circumstances, very few people would have had similar experiences to draw upon for direction and that it was an extremely stressful process for all participants. Nevertheless, interviewees spoke positively about the desire of group members to work together and deliver a multi-agency solution to address the issues they faced.

5.12. Multi-agency working was very good across all organisations apart from engagement with the HT of School A. Although this possibly could have been avoided, there are lessons to be learnt about engagement between schools, health, social care and police in a genuine partnership.

5.13. The need for a Serious Case Review (SCR) was considered and it was agreed that this sequence of events did not meet the criteria for a formal SCR.

5.14. In the future it may be useful to have a section on suicide / self-harm postvention responses incorporated into the Educational Psychology Directorate's Incident Response in Schools Plan. This could form part of the schools' commissioning of LA Educational Psychology services on an annual basis. In future (post-suicide cluster), this would enable a simplified approach, which could be led by schools with support from Educational Psychology and other health and social care colleagues as appropriate along with public health. Should it be suspected that a suicide cluster is occurring or there is a high profile local suicide, then the full multi-agency Community Response Plan should be initiated. Both plans would need to be consistent with each other.

5.15. In reality the current response should continue whilst the risk remains high i.e. for at least a period of two years (according to Samaritans guidance).

5.16. It is also essential the impact of cumulative traumatic events is considered as part of any community response. For example, pupils may have links to a pupil who died by cancer and a pupil who died by suicide.

Recommendations

We have made seven specific recommendations here and go on below to describe some of the actions that would be necessary to implement these recommendations. There are also two areas for further consideration that are raised at the end of our recommendations that should also be considered.

1 Local stakeholders, led by an agreed lead agency, should agree procedures for the ongoing development of the Community Response Plan and the associated Action Plan (with clear timescales and identified leads) ensuring the Action Plan remains an ongoing and up to date plan.

2 The Rotherham School Incident Plan should be updated alongside the community response plan to include available support services for suicide / attempted suicide within Rotherham.

3 The current Rotherham Suicide Prevention Strategy Action Plan should be updated and thereafter re-updated annually and include the use of suicide audit to inform its redrafting.

4 The Rotherham Health and Wellbeing Board should develop a Public Health Mental Health and Wellbeing Strategy within which the emotional needs of young people are clearly addressed and are prioritised at Cabinet level in the council.

5 A clear communications strategy should be developed between Rotherham MBC and its strategic partners. This should proactively promote suicide prevention approaches.

6 The Rotherham Police and Coroner's Office should consider some of their specific roles and responses to deaths by suicide in light of this report.

7 Primary care and mental health service commissioners should review their relevant commissioning strategies in light of this report.

There are also two additional issues for consideration by the CEO of Rotherham Borough Council and the Director of Public Health respectively:

1. Consider recommending that CEO of Rotherham Borough Council writes to Minister of Education and the Minister of Health regarding the issue of School A failing to engage in the multi-agency response as an issue of national policy. This has implications for others school academies that do not engage in incidents that require a coordinated strategic response.

2. The Director of Public Health should consider sharing learning with a wider audience, including Public Health England and NHS England and other Local Authorities.