city & hackney safeguarding children board

Multi-Agency Case Review

'X'

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This multi-agency review seeks to learn from the tragic death of X who took his life in October 2016. He had just had his sixteenth birthday and was in Year 11 at school, preparing for GCSEs. X lived with his mother and father. His older sister had just moved away from home to university, outside London. With other local multi-agency reviews into recent suicides by young people in Hackney it will inform local awareness, practice and strategic responses with a view to improve work to prevent self-harm and suicides.

The City and Hackney Safeguarding Children Board thanks X's family and the practitioners who worked with X for their involvement and contribution to the review.

1. Background Summary

1.1. X had experienced (social) anxiety for some time and had received intermittent psychological support for this from age 8 years. From January to May 2009 he was seen at First Steps, a local NHS psychological service for children and young people. Between January and May 2009, he was seen by a psychologist for adapted Cognitive Behavioural Therapy (CBT) to help him manage the triggers of anxiety and to help him cope. After seven sessions X and his mother reported improvement and it was agreed that the sessions would cease but that if concerns re-emerged they could self-refer to the service or ask their GP to re-refer them.

1.2. In December 2009, aged nine, X was re-referred to First Steps by his GP as he had a persistent cough which was thought to be anxiety related. The First Steps re-assessment noted that X had problems with managing his anger.

1.3. In July 2012, aged 11, X's GP re-referred him to First Steps as he was anxious about his SATs exams and about some street dance performances which he was taking part in. His anxiety had prevented him from completing his SATs exams at the end of Year 6. This was followed up in the new term when X had started at secondary school. Advice was given by telephone in October. X's parents were seen by the service at the beginning of December 2012 and two weeks later X, aged 12, was seen by a psychologist for an assessment; and some adapted CBT approaches were suggested for him.

1.4. Further sessions were offered for January 2013 but X and the family declined these as there had been an improvement. It was agreed with X's father that the service would be held open for X and the family to see how X managed upcoming exams and then the family and First Steps could review if there was a need for a service.

1.5. X was seen by the First Steps service twice in September 2013 (approaching 13 years) for adapted CBT to assist him with managing his anxiety; he was also offered mindfulness techniques to assist him. It was agreed to cease sessions as X and his father reported improvements. They were advised about self-referral or re-referral via the GP if X needed further assistance. There was no further contact with the First Steps service after this. The service noted that the parents were very supportive of X and his therapy.

1.6. In early April 2016 X, aged 15 and six months, was seen by his GP. He was worried about excessive blushing; said to be something he had experienced "all his life". X found it uncomfortable and embarrassing and was acutely distressed about it. He could not identify a specific trigger to the blushing. X had undertaken internet research on the issue and did not want medication but wished to be referred for endoscopic thoracic sympathectomy (ETS) surgery[1]. The GP agreed to look further into possible treatment options. A few days later, after seeking additional clinical advice, the GP spoke again with X. A conservative approach was recommended with the possibility of a referral to the dermatology service. X was keen to be referred to dermatology. He was advised that he would probably grow out of the problem, but it was agreed that a referral to the dermatology service would be made. The GP also invited X to speak with him further if he wished. The referral to Dermatology was made two days later.

1.7. In June 2016 X was seen in the Dermatology Department of the local hospital. It was noted that the flushing was triggered by emotion and exercise. X reported that it was having an impact on his confidence as he approached his GCSEs. X was keen to have surgery for this. The consultant discussed the complications of surgery. X's mother has told this review that X was unhappy with the dermatologist's reluctance to refer him for surgery. A gel was prescribed and X and his parents were advised to discuss the possible treatments with the GP. It was also suggested that CBT may be useful. He was not seen again in the Dermatology Department.

1.8. X saw the GP again in mid-July. He said that the gel had not worked. X was still keen for surgery. The GP discussed the risks of this, about which X and his father were already aware. Alternative approaches of CBT or beta blockers were suggested, and it was agreed that X would trial increasing doses of beta blockers first as he was reluctant to take up CBT. CBT or a re-referral for surgery would be considered if this did not work.

1.9. X (15 years and 11 months) was seen again by the GP in early September. The excessive

[1] https://www.nhs.uk/conditions/blushing/treatment/

blushing was continuing and X also now complained of excessive sweating. The beta blockers were reported to have had no effect. X only wanted surgery; he was clear that he did not want to be referred for CBT or to have longer acting beta blockers. The GP agreed to refer him. The GP discussed the matter with colleagues before referring X to be considered for thoracic surgery, at a different hospital, in mid-September. The GP re-referred X to a third hospital to be considered for surgery a few days before X died. (This review has been advised that the second hospital – to which X was referred in September – would not have considered X for surgery for this matter until he was 18).

1.10. At secondary school (Sept 2012 to October 2016) there were no concerns about X. He was excluded for a few days in Year 9 (November 2014) for possession of a small amount of cannabis; it was thought that he was holding this for another student, rather than for his own use. It was noted that in December 2014 X had had some authorised absences to attend his GP – but the school did not know what these attendances were for. (This review has noted that there is no record that X attended his GP in 2014.) His school record was normal apart from a period of poor attendance in Year 10. At the end of Year 10 X was assessed to be a little behind in some subjects, but this was not seen by staff as a problem.

1.11. X's attendance at school in the Autumn term 2016 was 100%. X was seen as an able student, predicted to get A and A* grades across the board. He was well liked by staff and was popular with his large group of peers (boys and girls). Both his parents were appropriately involved with the school and seen as supportive of X.

1.12. X was never seen, by the school, as vulnerable or in need of additional support. The school was unaware of his history of social anxiety or worries about blushing. The school had not noted any physical aspects of X's blushing.

1.13. *After his death the school learned that X had been involved in what peers alleged as 'recreational drug use'. This had not been known at the time as an issue for X, but the school had been raising the general issue of drug use with parents more widely.*

2. X's death and the immediate antecedents

2.1 On the last Friday of October 2016, shortly after his 16th birthday X attended a party with some of his friends. *They later reported that X had seemed to be 'very down'.* In the early hours of the Saturday morning X texted his mother to ask for a lift home. His mother was away from home that weekend and replied reminding him of that and advising him to get a

cab. An hour later he sent her a further text apologising for troubling her and saying he loved her.

2.2 In the middle of the Saturday X texted his father (and mother, who was still away) to tell them that he had taken an overdose. X's father called an ambulance saying that X had told him that he had taken an overdose of paracetamol, Xanax[2] and whisky. The ambulance took X and his father to the local Emergency Department. He was triaged by a paediatric nurse. It was assessed that there was no need to admit him to a children's ward for assessment or treatment at that point; he was taken to the Adult Emergency Department for assessment.

2.3 X disclosed that he had taken 13 paracetamol (6.5 mg) and 25 Xanax (50 mg); he said that he had also drunk whisky the previous evening. On arrival X was alert and cohesive. His blood levels for paracetamol showed that he was below levels for medical treatment. He was not tested for Xanax levels as he showed no symptoms and a urine test would not have shown levels of Xanax in his body. He was referred to Psychological Medicine for assessment for self-harm, as per the agreed guidelines.

2.4 X's mother returned to London and was present with X, at hospital later that day.

2.5 X was assessed, initially alone, by the hospital on-call Senior House Officer (SHO) for Psychological Medicine. X stated that after returning home in the early hours he had continued drinking whisky alone and then decided to take an overdose. He had woken after midday and no longer wanted to end his life and so texted his father (and mother[3]). X said that the primary cause for his action was anxiety. He said that he had been experiencing anxiety for about a year (from Year 10) and more recently had had some suicidal thoughts, although he had not acted on them or planned to act on them. The overdose was described by him, as an impulsive act, it was not pre-planned. He had been 'self-medicating' from February 2016, initially with Diazepam[4] and later with Xanax. X changed to Xanax as he was worried about becoming addicted to Diazepam. X denied using the drug daily, saying that he took it only occasionally. He had sourced the drugs illegally, through a local dealer. X was also very troubled about excessive facial flushing and wished to have surgery, then 'everything would be perfect'. The SHO also spoke with X's mother.

[2] **Xanax** - A benzodiazepine used to treat anxiety, not recommended for under 18s and not available in UK, except by Private Prescription. It is addictive. See appendix.
[3] X's mother has told this review that X had vomited at home before texting his father and her. It is not clear if the hospital were aware that X had vomited or when he vomited. This may have had implications for the amount of drugs in his body.
[4] **Diazepam** - A benzodiazepine used for the treatment of anxiety, muscle spasms and convulsions (fits). It is addictive.

2.6 The assessing SHO and on-call (off-site) Child and Adolescent Mental Health (CAMHS) Psychiatric Registrar discussed the assessment on two occasions. It was agreed that X was no longer suicidal or at risk of self-harm and did not meet criteria for admission. X wished to return home and his mother was happy for him to be discharged.

2.7 It was agreed that X could be discharged home with a Safety Plan. X was to take a few days off school, his mother would take a few days off work to be with him, his mother was to remove all remaining pills (although X said that there were none left), the SHO was to refer X to CAMHS for an urgent appointment, X was to tell his parents if he was feeling 'down' or suicidal and his mother was to check in with him regularly, X could come back to the Emergency Department alone or with his parents and they were given the Mental Health Crisis Line and CAMHS telephone numbers. X and his mother went home at 8.30 pm.

2.8 The assessing SHO sent the referral to CAMHS the same evening. An Emergency Department nurse sent a referral to Children's Social Care (X and his family were not known to CSC.)

2.9 Through the night X's parents checked on X regularly. His mother was disturbed about 6.30 am by X who had been looking for a bag. When she asked about it, he said that he may go to football in the morning, the bag was for his kit, and she said that they could talk about it when he gets up. His father checked on him about 9:00 am and he appeared to be sleeping.

2.10 At 11:00 am X's mother went to wake him and found him to be lifeless. He had pulled his hoodie up over his head, his face to the wall, hiding that he had suffocated himself. (X sometimes slept in his hoodie with the hood up.) X's mother rang for an ambulance and started CPR. The ambulance crew examined X and noted that he was pulseless, his heart had stopped, and rigor mortis was evident. His death was verified.

2.11 A multi-disciplinary Rapid Response Meeting[5] was convened in the first week of November to review the circumstances of X's unexpected death and plan what actions should be taken. It was noted that X had written a suicide note relating to his overdose on the Friday night/Saturday morning which he had not shared with his parents until his return from the Emergency Department on Saturday evening. *(The assessing SHO was not aware that X*

[5] A Rapid Response Meeting or process is part of the **Working Together to Safeguard Children, 2015, Chapter 5** and **London Child Protection Procedures** relating to Unexpected Child Deaths. The purpose of the meeting is to bring key professionals together as quickly as possible to consider the unexpected death and plan bereavement support, any safeguarding that is required, information gathering to inquire into the death and to plan to learn lessons as part of the child death overview process. http://www.londoncp.co.uk/chapters/unexpected_death.html

had written a suicide note). In that note X had stated that he felt that he was suffering from addiction to Xanax, which he thought was causing depression, anxiety, and paranoia. The Police took X's phone and Xbox for forensic examination. It was confirmed that arrangements were in place for bereavement support for X's family, close friends, and for students and staff at X's school. It was noted that the CAMHS had noted a new trend of young people using Xanax in conjunction with alcohol to achieve a "buzz" or to use benzodiazepines to self-medicate anxiety. The CHSCB chair was also to be consulted about commissioning a review to learn from X's death.

2.12 A further Rapid Response Meeting was held two weeks later. It was noted that in the Emergency Department assessment after the overdose X did not display the typical symptoms that would be expected from the reported levels of overdose of paracetamol, Xanax and whisky. Possible reasons for this are that he may have built up a tolerance to Xanax, given his previous use; X may have over-estimated the number of tablets taken; or the Xanax may not have been pure Xanax. It was also confirmed that a urine test for Xanax cannot show the levels in the body. There was no information available to this meeting about whether there was relevant information on X's phone or Xbox.

2.13 At the inquest the Police gave evidence that they had examined X's phone, reviewing emails and texts for a month prior to his death. There were no emails or texts about suicide or X's intention to harm himself, prior to the texts that X had sent his parents on the day after his overdose. The search history of the web browser showed that during the early hours after X had returned home from hospital after the overdose, he had made numerous searches about suicide and one site in particular had shown methods.

2.14 The Coroner noted that there had been no prior known history of self-harm or suicidal thinking but that X had a history of anxiety related to the extreme facial blushing. The GP had sought to help X find a solution to the facial blushing. His family was supportive and loving and he had positive elements in his life with friends and lots of activities. The risk assessment in the Emergency Department showed no physical risk to X from the overdose and the psychological assessment showed a lower short-term risk of suicidal thinking or action but that in the longer-term X needed support with his anxiety. He was discharged with an appropriate Safety Plan. The evidence from X's phone, about the web searches he had made of suicide websites, showed that X had intended to take his life. As a result, the Coroner decided that X's death was as a result of suicide.

3. Family views about services received, what may have helped X, lessons learned and possible actions

3.1 X's family were advised of the review and invited to contribute. X's mother met with the Independent Reviewer to represent the family.

3.2 X's mother had reflected a lot on what had happened and had thought a great deal about adolescent suicide since X's death. She and the mother of another young person from X's school who took her life a few months after X have done a lot of work with the school in thinking about how to support young people under stress.

3.3 X's mother described X as 'full of life', at times fidgety; 'he lived life at 100 mph'. He was adventurous, funny and quirky. He could be determined about what he wanted and could not wait until he was old enough to do what he wanted. X was very bright. He was also very popular. He could be imaginative. He was sporty, enjoying football and street dance, when younger. He partied hard in his GCSE year and gave up football on Sundays as it was hard to get up. He was altruistic and worried about issues of inequality, such as Black Lives Matter.

3.4 However, X was also anxious. He had tics when he was younger and developed a persistent cough, both as a result of anxiety. He had CBT for that. He had social anxiety and developed problems with blushing. He had researched blushing on the internet and wanted surgery to deal with it. He challenged the consultant who said that surgery was not available on the NHS showing him that it was. The family thought that the GP had 'lost' the follow up referral for surgery (*this review had confirmed that this was not the case*). X's appointment for the thoracic surgeons arrived after X died. It has been noted as part of this review that X would not have been considered for surgery (endoscopic thoracic sympathectomy ETS)[6] until he was 18; and only after considering the possible psychiatric impact.

3.5 X's parents had not known, until his overdose, that X had been self-medicating with Xanax. X's mother has learned that Xanax can cause suicidal ideation. X said he felt depressed at

[6] NHS: Treatment - Blushing https://www.nhs.uk/conditions/blushing/treatment/

his addiction to Xanax which he had got 'through the internet' and he thought he was a 'victim' to it. (*X told the psychiatrist that the drugs were sourced from a dealer.*) "Like all parents", X's parents had wondered about X possibly using drugs (particularly cannabis/skunk) and alcohol but in their view, these had not been a problem for X.

3.6 On the way home after the overdose X's mother wondered if the drugs were still influencing or clouding X's thinking. He spoke passionately about Black Lives Matter, but this seemed to be out of context, given what had just happened. They talked about the risks of him self-medicating and he agreed that he would no longer do it.

3.7 When they got home, X showed his mother and father the suicide note he had written, which they had not seen before he went to hospital.

3.8 X's parents watched X at times through the night, as mother was advised to do by the hospital.

3.9 X's mothers' reflections after X's death included not being surprised that this happened at the end of the half-term break as she thought X was anxious about going back to school. He had been going in to school during the holiday as he was trying to catch up with the course work for his GCSEs, although, at the Parents' Evening prior to his death the staff had been very positive about X and his progress. She also wondered whether X was missing his older sister. They were very close, and she had just gone off to university.

3.10 She had come to wonder, in hindsight, if X had been determined to take his life. X's friends said that he had been 'really down' on the Friday night. He had changed the screen-saver on his phone to read 'I love you all', surrounded by angels and emojis with a message to say that his girlfriend would know the access code number to his phone. It was discovered from his phone that X had accessed a specialised suicide website, which discussed possible methods.

3.11 In terms of lessons that could be learned from X's death X's mother felt that the agencies who responded to X's overdose and then suicide were thorough. She had understood that if he had been under 16 he would have been kept in hospital. *(This was not the case. If he had required treatment for the overdose, such as a drip, consideration would have been given to whether he should be admitted to a children's ward, given his age. As the psychological assessment showed that X had mental capacity and was no longer suicidal and did not require observation or treatment he was discharged; this would have been the case if he was under 16.)*

3.12 For X's mother the key issues were the need for preventative approaches to support young people who are anxious and help and prevent them acting on suicidal thoughts. Since X's death there have been talks about drugs at school. The school, with a charity set up by X's mother and another mother have asked young people about their worries. One of the students' worries was knife crime and where young people can go for safety if they are feeling under threat.

3.13 Another key issue is 'Who do young people talk to if they are feeling anxious or depressed'? Young people will not necessarily go to a counsellor. X's mother wondered whether there could be staff mentors – perhaps younger teachers or the sports teachers, who are more approachable? How can young people be helped or encouraged to talk to each other? One of X's friends regretted that although they were good friends they had not talked to each other about their worries. X's mother wondered whether there is a role for peer mentors perhaps from the 6th Form or Year 11 who are looked up to; but she also wondered if that would be effective – would students speak to those peers? Could issues about stress or anxiety be raised in tutor groups? Is there a need for separate boys' and girls' groups?

3.14 She thought that Helplines can be useful but can also be slow to answer - would young people wait? Also, it is important that Helpline numbers are kept up to date. Some of the information about helplines on noticeboards at school was not accurate.

4. Practitioners' Views

4.1 As part of the systemic approach to this review practitioners who were directly involved with X and his family were asked to meet with the Independent Reviewer and some Review Panel Members to share their thoughts about their contact with and provision of services to X. Such an approach also allows this group of frontline practitioners and their managers to think beyond the individual child and family being considered to the wider systemic context of cohorts of children or need locally and to think about patterns of response. The group was also asked to consider the analysis and emerging themes identified by the Review Panel. The group met jointly, except for the Headteacher, who was unable to attend and was seen alone. The Deputy Headteacher was present in the group discussion.

4.2 The school had been unaware of X's history of social anxiety going back to primary school days or that he had been supported from time to time by First Steps, the psychological service. It was questioned whether there should have been a formal note of this from his primary school on transfer to secondary school. The group thought that this raised questions about proportionality and the 'need to know', and of how parents may have concerns about schools making prior judgements about students at admission. It was also suggested that the transfer of information from primary schools generally was not always of good quality. It was suggested that parents generally (not X's parents specifically) are reluctant to share information about a student's mental health for fear of how a school (not specifically X's school) may respond to this. Experience from mental health practitioners suggested that parents may hold views about how a school will respond, including whether attendance at health or counselling therapy appointments are deemed to be authorised or unauthorised absences. There may be a need for myth-busting information and education from schools to dispel such beliefs.

4.3 No service, or practitioner, was aware that X had experienced suicidal thoughts before the overdose or that he was 'self-medicating' to help him manage this.

4.4 For the GP service the priority was to support X with his facial flushing, which was causing him a great deal of anxiety. At the time X was clear that the flushing was the only problem that he had; and he was adamant that surgery, rather than the less interventional approaches offered, was what he wanted. The GP service has considered, after X's death, whether it would have been possible to explore further whether X was experiencing wider anxiety and whether a more assertive approach to recommending CBT should have been tried. These are hindsight thoughts but raise an important point; namely that when a young person is very troubled by one issue it will be important to consider whether this is a symptom

of a wider issue rather than the cause.

4.5 In relation to the mental health assessment after X's overdose, the SHO has noted that at that time, in late 2016, less was known about Xanax and its use or effects, including from withdrawal, if addicted. X had said that he had not been taking Xanax every day. If such an assessment were being undertaken now more consideration should be given to the risk of withdrawal and its possible impact on emotions and thinking.

4.6 Reflection on X's death had raised the question for medical practitioners about whether there is sufficient education about drug misuse for doctors in training; and how this can be kept up-to-date. There may be a need to review the CAMHS Crisis Pathway in relation to drug use as a factor in mental health assessments in young people. Related to this was the issue that drug or alcohol use may increase impulsive behaviour and irrational thinking. *(The post mortem showed that there was still a significant amount of Xanax in his blood which could have influenced his thinking.)*

4.7 There is a question about whether an adult focussed mental health service in the Emergency Department, out of hours, when CAMHS practitioners are unavailable on-site, meets the specific needs of young people. There is no doubt that the assessment of X was thorough (see section 5) and it was supported and overseen, at a distance, by the CAMHS Registrar; who would have come in to the hospital to see X, if necessary. CAMHS has increased its direct service to the Emergency Department into the evenings, Monday to Friday, since the suicides of X, and another child. The practitioners' and managers' group noted that there were still times at night and at weekends when CAMHS was not available, however. At those times, an older young person would be seen by an adult specialist, unless it was identified that a child and adolescent specialist should be called in.

4.8 An additional consideration raised by the practitioners in relation to mental health assessments, particularly in relation to risk of self-harm or suicide, is how to consider a young person's use of the internet or social media as influencers (positive or negative) on risk-taking behaviour; and to know or advise young people about which are useful and neutral sites to visit for support and advice or how to be aware of issues to consider in case a website is advocating risky behaviour.

4.9 More widely, X's death had raised for practitioners the challenges of working with young people in the field of drug and alcohol awareness and prevention. The school had developed sessions for students and information for parents before X's death and has further refined them since. For this group of practitioners, there were questions and soft

intelligence about possible 'pockets' or areas of drug use by young people in some parts of the borough with patterns of behaviour and a culture of how young people access drugs through dealers, through the web or support each other to access drugs, without parents' knowledge, by use of bank cards. Peer pressure and increasing independence away from adult supervision for older young people and gatherings of young people where alcohol and drugs may be available may lead young people into risk taking behaviour which they are ill-equipped to manage. Soft intelligence suggest that drugs are sometimes available at young people's parties. Some young people spoke about this after X's death. In X's school there is a system for young people to anonymously share their worries about the welfare of a peer (this system is wider than drug use).

4.10 The practitioners thought that it should be noted that cannabis is probably stronger and more damaging than many parents realise and that young people, who can be impulsive and risk-taking may be experimenting with a range of other substances. Local information suggests that young people experiment with cocktails of mixed drugs and alcohol; which may have given names; but as the cocktails change so do the names. It is hard for practitioners who are not drugs specialists (and for parents) to know about or keep up with this more hidden world of young people. There are also questions about the authenticity or contamination of drugs available through dealers or the web.

4.11 It was thought that young people (and parents) need accurate information about drugs, including the short and longer-term possible side-effects. Young Hackney[7] works in this field and can support young people and practitioners with this. The practitioner group thought that it would be useful to have a local multi-agency strategic approach led by the Safety Partnership and Health and Wellbeing Board to lead this issue; including how to raise drug and alcohol awareness in schools through PSHE (personal, social, health and economic education).

4.12 A related question was how services respond to awareness that a young person is in possession of or may be using drugs. The practitioners thought that there is a need to consider a more public health / safeguarding approach to drug use rather than an investigative / criminal approach. It is also important to destigmatise ways for young people to ask for help (drugs or mental health issues).

4.13 Is enough known about risk and anxiety in the wider community and among young people following a young person taking their life? Shortly after X's death there were questions about

[7] Young Hackney is a Council service which provides a range of resources for children and young people; including activities, advice and community involvement. This includes advice about drugs and alcohol. https://www.hackney.gov.uk/young-hackney

whether his death would encourage other young people to harm themselves. There was no evidence of such 'contagion' locally. At the time, First Steps reviewed the vulnerability and service to a number of identified young people in its service who it was thought may be disturbed by X's death. It was noted that generally there may have been an increase in reports of self-harm; but it is not possible to say that this came about because of X's death.

4.14 The practice group noted that the internet and specifically social media in a variety of forms are now central to young people's lives and are very important influences in their behaviour and decision-making. It was suggested that the CHSCB should review its guidance on **Online Safety**[8] to ensure that it covers advice and safeguarding in relation to internet and social media use when young people may be looking for advice about drugs, self-harming behaviour and suicide.

4.15 In addition to these considerations the practitioners responded to and were in agreement with the emerging lessons suggested by the Review Panel, drawn from the analysis of the agency reports to this review. These are discussed further in the next section.

5. Findings

5.1 Prior to X's overdose and subsequent suicide no practitioners, from any service, who met or worked with him, in the preceding twelve months, were aware of his chronic anxiety. The school staff, who knew X well, were unaware and had had no concerns about him with regard to anxiety or flushing, or any worries about his emotional health based on his behaviour. The possibility of drug use (cannabis) and alcohol use was considered by the school, but not thought to be a serious risk. His worry about flushing (and excessive sweating) was known to the GP and local Hospital Dermatology Department, but it was not seen as being of such a level to require referral to CAMHS or that X was at risk of self-harm because of it. The GP had recommended CBT as an approach to the flushing but X had been clear that he did not want this. X had not shared with any practitioner or his family that he had had suicidal thoughts until the assessment after his overdose. It was not known until then, by anyone, including family, that he had been 'self-medicating' with illicit drugs for approximately nine months (by X's own report).

5.2 It can be concluded from this that there were no missed opportunities by any professional staff to recognise that X was a risk to himself prior to the critical weekend at the end of

[8] http://www.chscb.org.uk/wp-content/uploads/2017/09/CHSCB-Safeguarding-in-the-Context-of-Access-to-Technology-and-Use-of-Social-Media-Handbook-digital-version.pdf

October 2016.

5.3 X's parents were supportive and involved appropriately with the school and the GP in relation to X. They were both seen at hospital and appropriately concerned in relation to the overdose. No agency had any concerns about X at home.

Response to X's overdose

5.4 The key work with X about possible risk is the crisis assessment in hospital, after the overdose. The confidential Health Trusts' Serious Untoward Incident Inquiry (SUI) undertaken jointly between the Mental Health Trust and Hospital Trust after X's death concluded that the assessment and discharge plan were appropriate; there was a low level of risk, X was remorseful, expressed no further suicidal intent (at that time) and was looking to the future. Plans were in place to supervise X over the next few days and for timely follow up support. The SUI's view is that X's suicide could not have been predicted.

5.5 This review has raised one area of practice which may have required greater exploration, however, namely X's use of illicit medication and access to it and whether he was addicted. At the time the possible impacts of physical or psychological withdrawal from Xanax generally, or from an overdose of 25 Xanax (as stated by X) do not appear to have been explored fully. Risks of withdrawal may include "effects such as headaches, muscle pain, extreme anxiety, tension, restlessness, confusion, mood changes, difficulty sleeping and irritability". *(See the Appendix to this review for more information about Xanax.)*

5.6 It is recognised, in hindsight, that X's state of mind may have deteriorated overnight – *including possible access to and influence by a suicide website, which was not known at the time of the Health Trusts' SUI.* X's family have queried, however, whether X may have been determined – which raises a question about whether X may have concealed his state of mind during the mental health assessment. At the time of the assessment he may also still have been under the influence of the drugs in his system – however, it is clear that he gave the staff the impression that he was rational, open and honest and understood what was happening.

5.7 Regarding multi-agency co-operation and information sharing in relation to the overdose, it is evident that there was good co-operation and consultation between the hospital SHO and the CAMHS Registrar during the assessment while X was an in-patient and appropriate follow up with immediate referrals to CAMHS and to Children's Social Care. The Ambulance Service also made a timely referral to CSC, with X's father's consent. The work in this short

period followed protocols and agency guidelines; although it has been noted, in addition, that it would have been appropriate to consider that X should also have been referred to substance misuse services. A practice question is whether this is best done in a crisis assessment or in the follow up after the event with a fuller assessment, such as would have been done by CAMHS.

5.8 No systemic or organisational issues were identified that impacted on the work done or decisions made. A question has been raised about the hospital policy for children over 16 being assessed and treated in an adult focussed Emergency Department. This review has been advised that this is not hard and fast. The Trust's SUI review did not see this as a negative factor. X was seen initially by a paediatric nurse. He did not need to be admitted to a ward. If he had shown signs of sedation or had been unconscious, he would have been admitted. Following X's death, the Hospital Trust has agreed that vulnerable 16 and 17-year olds who are seen in the Emergency Department with significant safeguarding or self-harm concerns can be given the choice to be admitted to a paediatric ward, if deemed suitable by the senior paediatric team, and that admission is required for treatment or observation.

More generally – support to X prior to the overdose

5.9 One systemic issue which may have influenced X's mental state given his high anxiety over flushing was what the family thought might have been a delay in re-referral to the Thoracic Team for assessment for ETS surgery and X not knowing that this had happened. The GP did refer X again in the September, as agreed. However, the September referral to the first hospital was not accepted and a second referral was then made. X and his parents did not appear to know about this. This review has also been told that he would not have been considered for such surgery until he was 18 years old and that a psychological assessment in relation to the impact of such surgery would have been required.

5.10 The School has raised the question of whether they should have been informed about X's prior history of anxiety and occasional treatment by First Steps. This would have enabled them to keep a watchful eye on him or to have a greater understanding if he showed any anxious behaviour – which he did not. They have also raised a wider systemic question about the quality of information about students which transfers from primary to secondary schools – it is sometimes insufficient. That wider question is not the remit of this review. The Hackney Learning Trust, with Headteachers, may wish to explore that separately, if it is a common theme in secondary schools locally. The view formed here is that this is a proportionate issue and that there needs to be a judgement about what information is shared

between services. There is also the issue of consent. For a Year 7 student on transfer that is likely to be parental consent but for older children the young person may need to be consulted. The practitioners' discussion suggested that there is soft information in the wider system that parents are reluctant to share information about children's mental health with schools for fear that schools may make (unfair) judgements which may impact on decisions about admission or about student's behaviour.

5.11 In relation to X's use of drugs the school has said that, in hindsight, it has learned that it should have explored more fully the possibility of X's own drug use when he was found with cannabis in school, rather than accepting that it belonged to someone else. He was suspended for a few days. This does raise the methodology of dealing with such issues and whether a safeguarding / preventive and exploratory approach is used or whether a firmer authoritative approach is used. A question is that while the law must be followed, and schools must be able to ensure order; young people may not open up about drug use if they see it as a 'punishable' issue.

5.12 This review has found that practitioners who met with X and his family were open and sensitive to his needs. He was able to express himself well and it is clear that practitioners heard and noted his thoughts and wishes. In the critical assessments after the overdose X's experiences and problems were ascertained and considered appropriately based on his own account and some corroboration from parents. It is possible to question, in hindsight, whether he concealed some information – but he appeared open. The work done by all agencies met X's ethnic and cultural needs, as white British.

Information which has come to light after X's death from which we can learn about local systems and responses and learning following an unexpected child death

5.13 We must be careful not to make judgements about the professional practice at the time based on hindsight, however there may be important lessons to be learned for the way in which services are designed and offered for young people like X and their families.

5.14 Local services responded appropriately to X's unexpected death using the agreed processes set out in **Working Together to Safeguard Children 2015** (now 2018)[9], the London Child Protection Procedures and local processes. Two Rapid Response Meetings[10] were convened; the first, to set in place support arrangements for family, peers and

[9] **Working Together 2018** https://www.gov.uk/government/publications/working-together-to-safeguard-children--2
[10] London Child Protection Procedures Section 9.5 Rapid response service for unexpected child deaths http://www.londoncp.co.uk/chapters/unexpected_death.html#twelve_five

professionals and to agree what investigation and wider learning would be required. The second was a follow up to that.

5.15 It was noted in the first meeting that the police had taken X's phone and Xbox for examination. However, there was no formal feedback through the local multi-agency child death review processes about what examination was done on them and what, if anything of significance, was found to understanding the antecedents to X's suicide. The police did not attend the second Rapid Response meeting and no information was given to the Child Death Overview Panel when seeking to learn public health lessons from X's death about what was found, or whether there was any other information which may have been of value for safeguarding other identifiable young people. The police advised the Inquest that they had searched X's phone and discovered information about searches of suicide websites in the hours just before X's death. As noted in a parallel Learning Review (Child Y), when a child takes their life there may be a need to review their digital footprint **immediately** to identify if any other young people may need to be safeguarded because of associated behaviour or 'contagion'. Also, from a Child Death Review, public health and learning perspective, valuable wider lessons may be learned from understanding if a person who takes their life has accessed specific websites or social media, which may have influenced them. The CHSCB or Child Death Review Partners may wish to explore this issue further.

5.16 Another lesson from the Rapid Response process was that it was not routine practice to test for the presence of benzodiazepines (Xanax) following an overdose. It was not done for X as he was not displaying any negative symptoms and he had admitted to taking Xanax, which a test may have confirmed, but the test would have had limited value and would not have assisted with treatment as it cannot show the levels of benzodiazepines in the body, only that they are present.

5.17 Appropriate arrangements were put in place to provide support for the family, peers and the school. The school was supported by education psychologists in the immediate period after X's death. A lesson that has been learned from this is that the Hackney schools' critical incident plan did not specifically cover organisation responses to suicide. The Hackney Learning Trust may wish to review this. Such a response should consider risks of 'contagion' and increases in self-harm by other young people; although there is no clear evidence that this was the case following X's death.

5.18 It is noted that First Steps, the local child and adolescent psychological service, reviewed their current patient caseload to risk assess any impact of learning of X's death on young people known to the service, with a plan to increase vigilance and support where

necessary. This was good practice.

Initiatives to support young people's mental health in schools

5.19 Following X's death and the later death of another child in the school, Child Y, the school with the local CAMHS and a charity set up in memory of both young people has introduced a range of initiatives to improve understanding about risks of drug-taking and to improve the opportunity to talk about stress and mental health. It is important that these lessons and approaches are shared across Hackney schools in a preventive way.

5.20 This review has been advised that the local CAMHS is progressing the Wellbeing and Mental Health in Schools initiative (WAHMS). This provides sessions from a CAMHS clinician in participating schools to develop closer links between the school and CAMHS, with training, consultation, support, signposting and liaison. The aim is to build capacity in the participating schools and to assist in increasing understanding of students' mental health needs, assisting referrals to CAMHS of identified students and developing strategies for the school to help students in the school setting. These activities are part of each school's Wellbeing Action Plan. This is an early intervention service to support students who may have a mental health need. There is also a Crisis Workstream which has identified additional resources for staffing by CAMHS, such as availability into evenings and at weekends, including at local hospitals. It is hoped that the crisis service will provide a more suitable service for young people who may otherwise go to Emergency Departments. There will also be additional sessions by CAMHS within Emergency Departments. It is understood that Hackney CCG and Council were unsuccessful in their bid to be a 'trailblazer authority' in response to Government initiatives to roll out the plans for improving the mental health of young people in schools with closer liaison, initiatives and resources between CAMHS and schools[11].

Drug use and alcohol use amongst young people

5.21 After X's death intelligence came forward confidentially from bereaved peers who had been shocked by the tragedy. They spoke of patterns of drug taking and access to drugs by young people. It is clear that this is hidden from parents and teachers, for understandable reasons. From this softer information, which is hard to evidence, and from information from **Young Hackney** for this review it would appear that there are sub-cultures of drug taking

[11] **Government Response to the Consultation on Transforming Children and Young People's Mental Health Provision: a Green Paper and Next Steps;** Dept for Health and Social Care and Dept for Education; July 2018 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/728892/government-response-to-consultation-on-transforming-children-and-young-peoples-mental-health.pdf

amongst young people in the borough which will require a public health approach alongside a policing approach.

5.22 Young Hackney provides a Substance Misuse Service, commissioned by Hackney Public Health, which aims to prevent and or delay first drug use, or provide harm reduction information where required. This includes one to one support for young people, with two main functions: **One-to-one Treatment** (for those who present with experimental, recreational and functional use); and **Prevention** in the form of raising understanding and awareness around drug and alcohol use / misuse and reducing harm (with young people, professionals and parents). In relation to prevention activities before X's death, schools were offered drop-in sessions for young people. X's school had used this service. It is understood that X attended one of those sessions with a friend.

5.23 Since X's death the service has provided sessions in X's school within the PSHE curriculum and confidential drop-in sessions for students. It has also assisted the school in reviewing its Drugs Policy. The Service also supported a workshop for parents at X's school covering YouTube music culture and the misuse of prescription drugs, such as Xanax.

5.24 With regard to a wider understanding of drug use by young people in the borough the Young Hackney Substance Misuse Service has provided this review with data showing an increase in known use of Xanax from a very low number in 2016/17 with a small but significant increase in 2017/18, including use by children aged 14 and 15. In 2016, Xanax was on the periphery of presentations to the service; in 2017 presentations increased to show an emerging (all be it a small) trend. Information provided by partner agencies to the Substance Misuse Service shows few services were seeing many presentations of Xanax misuse use within their respective services; but there is evidence that it has been a factor in a small number of recent cases.

5.25 The Service has used Facebook & Twitter to promote messages to young people and regularly raises issues about risk of Xanax use in drug and alcohol awareness classes (reaching 680 students in the academic year 2017/18).

5.26 As well as its own services the Young Hackney Service also promotes **Talk to Frank**[12] a website which provides good information and advice about drug use.

5.27 Young Hackney, the Hackney Learning Trust and the CHSCB may wish to seek a formal report on the take up of drug awareness services in all schools in the Borough and promote

[12] https://www.talktofrank.com/

the lessons that have arisen from the responses in X's school.

5.28 Information from the practitioners who attended the Focus Group for this review suggests that practitioners are not confident in terms of up-to-date knowledge of jargon and use of drugs by young people or of how to discuss drug use with young people. This is a wider systems issue relating to staff awareness, competence and confidence.

Learning from the wider context of research and data about adolescent self-harm and suicide

5.29 A review into one young person's death can give a picture of how local services may be operating and whether any improvements may be required. Lessons from X's death will be considered locally alongside the reviews into the deaths of two other young people. However, the CHSCB and its partners must also seek to learn from the wider picture and research into adolescent self-harm and suicide to consider prevention and treatment options in the commissioning and provision of local services; as well as ensuring up-to-date knowledge and skills for practitioners at the front line. Appendix 3 of this report summarises some key research and data on **Suicide by Children and Young People** published in July 2017[13] and the **NCISH Annual Report for 2018[14]** which provides additional data.

5.30 The 2017 report sets out a number of key factors which can influence suicide in young people, alone or in combination. The report refers to ten common themes previously found in a previous study of suicide by children and young people up to 20 years of age. These are family factors, e.g. mental illness; abuse and neglect; bereavement and previous experience of suicide; bullying; suicide-related internet use; academic pressures especially related to exams; social isolation or withdrawal; physical health conditions that may have a social impact; alcohol and illicit drugs and mental ill health; self-harm and suicidal ideas. Of the suicides studied 51% of the young people were in education (school or college) and of those 43% were experiencing academic pressures (32% exam pressures). Another important factor in suicide was prior self-harm, 52% had a history of self-harm; cutting or overdose were the most common. 58% had previously expressed suicidal thoughts or hopelessness. 7% had had an episode of self-harm in the week prior to the suicide. 41% had a diagnosis of a mental disorder – most commonly an affective disorder such as bipolar or depression. 16% of the young people were receiving anti-depressants. The presence of one of these factors is not an indication that a young person will take their life but that they

[13] **Suicide by children and young people.** National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH) Manchester: University of Manchester 2017 *See section 9 of this report.*
[14] **The National Confidential Inquiry into Suicide and Safety in Mental Health.** Annual Report. October 2018 University of Manchester *See section 9 of this learning review for a summary of key issues.*

may be in need of support and intervention. It will be seen that X does not meet all of these antecedents – although he had been experiencing anxiety and suicidal ideation but had not shared it with family or professionals, except anxiety, in relation to his distress at flushing and sweating. The national data serves to signpost indicators for risk assessment, treatment and commissioning options which should be considered in service planning and delivery.

5.31 The research notes that **illicit drug use** and **no prior contact with services** with regard to self-harm or suicidal thinking were common in young males (but also seen in young females to a lesser degree). This is the case with X.

5.32 It is not clear that X was experiencing acute academic pressures, one of the stressors/antecedents highlighted by the study. The school had no concerns and were not aware that he was worried about his studies; he was predicted to do well. His mother wondered whether the timing of his overdose and suicide may have been influenced by worries about his school work.

5.33 Another dynamic mentioned in the research as an antecedent **is suicide related internet use**. X's mother has told this review that X accessed a suicide website; police reported on this to the Inquest. This was in the early hours after he had returned from hospital after the overdose. It appears to have been in crisis and as noted above, there are questions about X's state of mind and emotional state at this time and whether his judgement might have been impaired from the drugs he had taken or whether he was affected by withdrawal symptoms or an increase in anxiety. It is understood from the police evidence to the Inquest that the forensic review of X's phone searches, for the month prior to his death, did not show that he had been using the web to seek information about suicide (or other self-harm or mental health websites) in that period, before the fatal night. He told hospital staff that he had had suicidal thoughts for some months and it is known that he researched his physical ailment (flushing) to inform himself about causes and options.

Use of the internet and social media in self-harm and suicide

5.34 Understanding this issue is important in a wider context than X to increase practitioners' understanding of the importance of internet use in self-harm and suicide to see if there are opportunities to help young people make informed judgements about what they access and prevent a young person acting on what they have read or understood from the web. Recent media interest in this issue about a young person being influenced by self-harm images on Instagram[15] is relevant here. It raises questions about how schools

[15] https://www.theguardian.com/technology/2019/feb/04/instagram-to-launch-sensitivity-screens-after-molly-russell-death

and other services advise young people on safe internet use and risk, particularly in relation to self-harm, suicidal ideation and other mental health issues, such as eating disorders, where 'advice' provided by a website may not be neutral.

5.35 The Practitioners' Group noted the importance of social media and digital media to young people and that their use cannot be ignored. They are an important influence in young people's lives and a source of information (fake or real) on which young people base decisions. Young people increasingly have a relationship with and relationships through digital media.

5.36 Research published by Bristol University in May 2018[16] on using the internet for suicide-related purposes notes the following findings. *"… This study explored the suicide-related online behaviour of two contrasting samples of distressed users, focusing on their purpose, methods and the main content viewed. In-depth interviews were conducted in the UK between 2014–2016 with i) young people in the community; and ii) self-harm patients presenting to hospital emergency departments. Data were analysed using methods of constant comparison. Suicide-related internet use varied according to the severity of suicidal feelings. In the young people sample, where severity was lower, use was characterised by disorganised browsing without clear purpose. A range of content was 'stumbled upon' including information about suicide methods. They also pursued opportunities to interact with others and explore online help. Self-harm patients were a higher severity group with a history of suicidal behaviour. Their use was purposeful and strategic, focused around 'researching' suicide methods to maximise effectiveness. They made specific choices about content viewed; many consulting factual content in preference to user generated accounts, while help content and communication was avoided. Findings indicate further action is necessary to improve online safety. Also, novel online help approaches are needed to engage individuals experiencing suicidal crisis. Awareness of the nature of suicide-related internet use and how this may reflect the status of an individual's suicidal thinking could be beneficial to clinicians to promote safety and indicate risk.*"

5.37 The NSPCC Report: **On the edge; ChildLine spotlight: suicide[17]** provides useful information about what young people say to and seek from ChildLine when thinking about suicide or self-harm. Chapter 2 covers: **The role of the internet**. It notes that young

[16] **Using the internet for suicide-related purposes: Contrasting findings from young people in the community and self-harm patients admitted to hospital**; Biddle et al, University of Bristol, 24 May 2018 https://research-information.bristol.ac.uk/en/publications/using-the-internet-for-suiciderelated-purposes(e2b9be6a-89b7-4a12-ad8d-226fa4426048).html

[17] **On the edge; ChildLine spotlight: suicide;** NSPCC, 2014; https://library.nspcc.org.uk/HeritageScripts/Hapi.dll/search2?CookieCheck=43416.5807625926&searchTerm0=C5246

people seeking advice about suicide prefer to do so over the internet rather than by phone and often use other websites and/or join in suicide and self-harm discussion fora and chat-rooms. The young people feel that they can make relationships with other young people experiencing similar problems to them; and so do not feel so alone. Some had used other websites to research painless methods or where to buy products, if considering overdosing. Some reported being triggered by harmful content that they had seen online 'normalising' suicidal behaviour. Some gave examples of seeking support through social media but experiencing bullying and hate messages which actively encouraged them to self-harm or kill themselves. The report advocates the need for social media sites to have a duty of care to young people to protect young people from harmful content. The report makes a number of recommendations about actions to support young people. These include actions to promote peer to peer support, advice for parents and carers, advice for professionals, and recommendations for government and service providers.

5.38 X's mother told this review of the site that X had accessed just before his death. It is a well-constructed and attractive site; created by a person who has considered suicide in their own right. It has a warning that it is only for those over 18, but that is easily dismissed. While encouraging hope and advising that users seek help it also has a drop-down list of methods and analyses research into their efficacy and techniques. A troubled person can easily skip the help section and click straight on to detailed instructions on how to take your life effectively. The site has links to other sites. Another site that this author trialled did have a pop-up chat window asking if I 'needed help'. I declined the chat not wanting to explore what kind of help – dissuasive or persuasive - that might be. Both sites looked as professional as other sites that we use all the time for information.

5.39 A key public health question is to consider how do we help young people distinguish between different types of site offering advice and support in the fields of self-harm and suicide? The SCR 'Child J', Lambeth SCB, 2016 raised this issue with regard to sites aimed at eating disorders – so-called 'Pro-Anna' sites aimed at advocating anorexia. How do we help troubled young people understand that such sites may not be neutral? How can we increase knowledge about the use of these sites?

5.40 There is also a role to understand more fully the young person's digital footprint after death (or serious self-harm) – not only to protect identifiable others in social groups, who may also be at risk, but to increase understanding of how troubled young people use such sites in order to provide public health and educative responses.

5.41 A final question is: how well informed are frontline practitioners about such sites, to enable

them to provide guidance to troubled young people or to consider asking questions about access to such sites in assessments (this was raised in the practitioners' group)?

5.42 Local suicide and self-harm prevention strategies should consider the importance of the internet and social media as a dynamic or influencer in young people's behaviours and from this what public health approaches can be devised to mitigate their more negative aspects.

Supporting Peers' Awareness and Peers as Supporters

5.43 X's mother has thought about what may have helped X. She wondered if he would have spoken more easily with peers about his anxieties. She thought that he and boys like him (more-so than girls) would not easily go to staff or counsellors. She raised a question about peer mentors or advisors as a possibility. It is clear, in hindsight, that X's peers had noted some issues about his behaviour but this was not shared until after his death; and there was no information that they had thought him to be self-harming or suicidal. One friend does seem to have taken him to a drop-in session on drug use.

5.44 The NSPCC/ChildLine report: **On the edge, 2014** notes the importance of peers (and family members). ChildLine had seen a year on year increase in the number of young people seeking advice about a friend or family member where they had concerns about suicide. Being worried about a peer can be a burden in several ways – anxiety, constant focus on the friend, not feeling equipped to help, feeling that if they sought help it might lead to suicidal acts, and other impacts. If that vulnerable friend is then successful in suicide (or serious self-harm) it can leave the peer feeling guilt that they have not been able to prevent it.

5.45 The NSPCC/ ChildLine report has a section on **Encouraging peer to peer support**. This includes increasing understanding of mental health, helping young people understand how they can support their peers, teaching active listening skills and where the peer supporter can get help. This does not necessarily mean establishing organised peer support or mentoring schemes but supporting young people who are already trying to help their friends; behaviour which is going on all the time informally.

5.46 The Anna Freud Centre is trialling approaches to organised peer support schemes in schools and community organisations[18], on behalf of the Government, to promote young

[18] **Peer Support for Children and Young People's Mental Health and Emotional Wellbeing Programme** https://www.annafreud.org/what-we-do/schools-in-mind/our-work-with-schools/peer-support-for-CYP-s-MH-programme/

people's mental health and emotional wellbeing. The approach is to be evaluated through independent research. It may be premature, therefore, to seek to introduce formalised peer support schemes or mentoring, except through these trials, until more is tested about the methods, outcomes and pro and contra-indications. This is something that could be considered and planned for, however.

5.47 Informing and advising cohorts of young people through general mental health awareness and wellbeing programmes in schools is an approach that can raise awareness and help students in looking out for and supporting their friends; or in a worst-case scenario knowing when to report worrying behaviour, even anonymously. Schools or other services will then need a safe process for following up such reports.

Boys / young men, anxiety and seeking or providing help

5.48 X's mother raised a question about how young men can be encouraged to seek help. X had had brief episodes of therapeutic help when he was younger and they were reported to have been successful. He declined referral for CBT in relation to his chronic and excessive blushing. Was the reluctance to talk about his worries and suicidal thoughts with his mother and father or friends a gender issue, an adolescence issue or an anxiety issue? Possibly all. In the work that X's mother has done in the school she has seen it as a gender issue and suggested that boys may find it easier to talk in boys' groups rather than mixed groups. She also thought that going to a counsellor was seen as something that boys are reluctant to do.

5.49 The NCISH 2017 report on **Suicide by Children and Young People** noted gender in-balances. Fewer males under 20 had been known to local authority services or CAMHS prior to suicide.

5.50 This may be a public health education issue. It is hoped that the initiatives to increase understanding about and responses to mental health and wellbeing in schools will help address such a gender-cultural issue, if it exists. It may be useful to offer gender specific tutor groups or support groups and ensure that there is access to male tutors or counsellors as well as to undertake work on feelings and well-being for young men.

6. Recommendations

A number of the recommendations made in the parallel review for Child Y are relevant to this review of X and are included here from 6.6. New recommendations arising from this review are 6.1 to 6.5 and part of 6.6.

6.1 The Hackney Public Health Service, with local Police and Young Hackney should review the need for and availability of local public health programmes, including awareness raising for young people, parents and professional staff about the acquisition, use of and impact of illegal drug use by young people. (See paragraphs 5.21 – 5.28)

6.2 Local primary, acute and mental health services should review guidance and training for practitioners (including adult focussed practitioners) who undertake mental health assessments of young people to equip assessors to consider the role of drug and alcohol use in mental health, self-harm and suicidal thinking. This should include how to access information about the risks of withdrawal on cognitive and affective ability and impulsivity in risk assessments. (See paragraphs 5.21 – 5.28)

6.3 The Hackney Learning Trust should review with schools how information about a child's vulnerability, including issues of emotional or mental health can be passed on to the new school when a child transfers, to ensure that the new school is able to support the child. This should include reassurance to parents that such information will be without prejudice. The Learning Trust should consider providing a specimen draft Mental Health Policy for use within schools which will include an explanation to parents on terminology in mental health and the school's approach to young people taking time out from lessons to attend mental health services. Such a draft Mental Health Policy should seek to learn from the national trail blazers, trialling the approaches from the Green Paper on Children's Mental Health in Schools. (See paragraph 5.10 and paragraphs 5.19 – 5.20 and the DfE announcement on the work of the trailblazers[19])

6.4 The City and Hackney Safeguarding Children Board should review its Internet Safety Policy and guidance to local agencies to ensure that they cover risk from social media sites which purport to give advice about mental health, drug use, eating disorders, self-harm and suicide and how parents and professionals can be assisted to help young people recognise such risks. The policy should also consider the issue of culture and 'contagion' among young people sharing information which may be harmful to them. (See paragraphs 5.35 – 5.41)

[19] https://www.gov.uk/government/news/one-of-the-largest-mental-health-trials-launches-in-schools

6.5 The Hackney Clinical Commissioning Group should review the provision of Child and Adolescent Mental Health specialists in Emergency Departments of local acute hospitals to ensure that there is sufficient cover at night and at weekends. This should include an audit of the numbers of young people requiring a mental health assessment and the percentage of those seen by an adult focussed practitioner.

6.6 The Health and Wellbeing Board should expedite the completion and publication of a Local Strategy for Prevention of Suicide by Young People and consider whether this should be a Strategy to prevent self-harm and suicide by young people. The Board should set a timescale for completion and set out how the strategy will be implemented, monitored and reviewed; what key indicators should be collected regularly about young people's mental health, self-harm, attempted suicide and suicide; and what the local resources are. A Head Teacher representative should be co-opted to the Steering Group. (Child Y Recommendation)

That strategy should include local approaches and actions on how to support children and young people in assessing the content of websites which purport to give advice about mental health, self-harm or suicidal thinking. (See paragraphs 5.34 – 5.42) (See also 6.4 above)

6.7 The Clinical Commissioning Group, Local Authority (including the Director of Public Health and Director of Education) and the East London Foundation Trust Child and Adolescent Mental Health Service with local Head Teachers and Chairs of Governing Bodies (or their equivalents) should build on the positive links between schools and CAMHS started in the WAHMS project. A strategy and action plan should be devised to set out steps for this and be presented to the CHSCB and the Health and Wellbeing Board. (Child Y Recommendation)

6.8 The CHSCB should consider convening a conference for Head Teachers and Chairs of Governors (and their equivalents) or working with their local representative bodies to promote the lessons from this review and the parallel reviews of young people's deaths by suicide. The purpose of such a conference / liaison would be to raise awareness and learning between schools about children's mental health and risk. This should include the national picture with regard to increasing understanding about children's mental health in schools and the local lessons from this and other reviews; including study and exam stress, bullying, impact of social media and peer pressure. Such an event would build strong links to the WAHMS project. It could promote a review of whole school mental health approaches or policies, including a specimen approach. It could also provide guidance and develop mentors on Immediate School Recovery and Support Programmes in relation to child

deaths, by suicide. The CHSCB should consider inviting the charity created by X's mother and the mother of Y, another young person to assist with such a conference or wider liaison in order to promote the lessons from one school more widely. (See the revised guidance Mental health and behaviour in schools, November 2018 published by the Department for Education[20].) (Child Y Recommendation)

6.9 The CHSCB should seek reassurance from partners that there is in place, a robust and coordinated response to suicide by a young person, in the context of identifying and mitigating the impact on other children and young people. This is likely to be as part of the revised Rapid Review process following a critical incident, as set out in Working Together to Safeguard Children 2018, chapter 4. This should include if and how a young person's digital footprint will be assessed to see if there are indications that others may be at risk of harm. (Child Y Recommendation)

6.10 The CHSCB should ask the Director of Education to review the generic guidance to schools on responding to critical incidents and its accessibility to ensure that it covers child deaths and support to peers and schools, including where a student takes their life. (Child Y Recommendation)

6.11 The CHSCB or successor Child Death Review Partners[21] (when they come into place) with the Child Death Overview Panel should consult with the Metropolitan Police and the Local Coroner about the investigation of child deaths by suicide in relation to access to electronic equipment used by the young person which may give a greater understanding of influences on the young person and their state of mind, over time. This will enable the Child Death Review Process to build up a clearer public health picture of the possible use of specialist websites, online advice services, social media and other important influencers on young people's decision-making and impulsivity. (Child Y recommendation)

6.12 The CHSCB should provide an anonymised summary report of the key lessons from this review for frontline practitioners and first line managers across the multi-agency network. The CHSCB should also consider providing bespoke briefings and materials for key designated and named leads in local services to enable them to cascade the lessons from this report and the parallel reports to frontline practitioners.

[20] https://www.gov.uk/government/publications/mental-health-and-behaviour-in-schools--2
[21] **Working Together to Safeguard Children 2018**; Chapter 4: **Improving child protection and safeguarding practice;** & Chapter 5: **Child death reviews**

7. Appendix 1

The City & Hackney Safeguarding Children Board response to X's death

7.1 Following notification of X's death, Rapid Response meetings were convened in line with the City and Hackney Safeguarding Children Board's process for managing unexpected child deaths[22].

7.2 The Independent Chair of the CHSCB decided not to initiate a SCR. The National Panel of Independent Experts[23] concurred with his view that the case did not meet the criteria as defined in 5(2)(a) and (b)(i) and (b)(ii) of the Local Safeguarding Children Board Regulations 2006. There was no evidence noted that abuse or neglect were either known or suspected factors in X's death.

7.3 The Independent Chair agreed that a multi-agency case review should be undertaken to analyse what happened, why, and to identify any practice improvements that should be made by organisations to safeguard and promote the welfare of children and young people.

7.4 The multi-agency review was to be line with the principles for learning and improvement set out within Working Together 2015 *(4:11)* and conducted in a way which:

- recognises the complex circumstances in which professionals work together to safeguard children;
- seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;
- seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight;
- is transparent about the way data is collected and analysed;
- and makes use of relevant research and case evidence to inform the findings.

7.5 **Agencies were asked to comment specifically on:**

a) Were practitioners aware of and sensitive to X's needs? Was risk identified and was planning effective to ensure X's needs were met appropriately?

[22] The Child Death Overview Panel
[23] The Serious Case Review Panel

b) *When, and in what way, were X's experiences ascertained and taken into account when making decisions about the provision of services? Was this information recorded?*

c) *When, and in what way, were the parent's experiences ascertained and taken account of when making decisions about the provision of services? Was this information recorded?*

d) *What were the key relevant points/opportunities for assessment and decision making in relation to X and his family? Did assessments and decisions appear to have been reached in a timely, informed and professional way? Did the agency liaise/engage appropriately with other agencies?*

e) *Did actions accord with assessments and decisions made? Were appropriate services offered/provided, or relevant enquiries made, in the light of assessments and was the family signposted to appropriate support?*

f) *Were there any issues, in communication, information sharing or service delivery, between those with responsibilities for work during normal office hours and others providing out of hours services?*

g) *Was practice sensitive to the racial, cultural, linguistic and religious identity and any issues of disability of X and family, and were they explored and recorded?*

h) *Were senior managers or other organisations and professionals involved at points in the case where they should have been?*

i) *Was the work in this case consistent with each organisation's and the LSCB's policy and procedures for safeguarding and promoting the welfare of children, and with wider professional standards?*

j) *Were there organisational difficulties being experienced within or between agencies? Were these due to a lack of capacity in one or more organisations? Was there an adequate number of staff in post? Did any resourcing issues such as vacant posts or staff on sick leave have an impact on the case?*

k) *Was there sufficient management accountability for decision making?*

Appendix 2

Xanax

https://www.medicines.org.uk/emc/files/pil.1657.pdf

Extracts from the Medicines leaflet supplied with Xanax:

What Xanax is and what it is used for?

Xanax is a tranquilliser containing the active ingredient alprazolam. Alprazolam belongs to one of a group of medicines called benzodiazepines. Benzodiazepines affect chemical activity in the brain to promote sleep and to reduce anxiety and worry.

Xanax tablets are only used to treat severe anxiety and severe anxiety associated with depression. Xanax is not recommended for the treatment of depression.

Xanax tablets should only be used for short-term treatment of anxiety. The overall duration of treatment should not be more than 12 weeks including a period where the dose is gradually reduced (this is called dose 'tapering').

Children and adolescents Do not give this medicine to children and adolescents below the age of 18 years because safety and efficacy have not been established.

Xanax with food, drink and alcohol It is important not to drink any alcohol while you are taking Xanax, as alcohol increases the effects of the medicine.

If you stop taking Xanax Always see your doctor before you stop taking Xanax tablets as the dose needs to be reduced gradually. If you stop taking the tablets or reduce the dose suddenly you can get 'rebound' effects which might cause you to become temporarily more anxious or restless or to have difficulty sleeping. These symptoms will go away as your body re-adjusts. If you are worried, your doctor can tell you more about this.

Dependence and withdrawal symptoms It is possible to become dependent on medicines like Xanax while you are taking them which increases the likelihood of getting withdrawal symptoms when you stop treatment.

Withdrawal symptoms are more common if you: - stop treatment suddenly - have been taking high doses - have been taking this medicine for long time - have a history of alcohol or drug abuse.

This can cause effects such as headaches, muscle pain, extreme anxiety, tension, restlessness, confusion, mood changes, difficulty sleeping and irritability.

In severe cases of withdrawal you can also get the following symptoms: nausea (feeling sick), vomiting, sweating, stomach cramps, muscle cramps, a feeling of unreality or detachment, being unusually sensitive to sound, light or physical contact, numbness and tingling of the feet and hands, hallucinations (seeing or hearing things which are not there while you are awake), tremor or epileptic fits.

Other side effects that may occur are: Very common: may affect more than 1 in 10 people - Depression - Sleepiness and drowsiness - Jerky, uncoordinated movements - Inability to remember bits of information - Slurred speech - Dizziness, light-headedness - Headaches - Constipation - Dry mouth - Tiredness - Irritability

Common: may affect up to 1 in 10 people - Loss of appetite - Confusion and disorientation - Increased sex drive (men and women) and erectile dysfunction - Nervousness or feeling anxious or agitated - Insomnia (inability to sleep or disturbed sleep) - Problems with balance, and unsteadiness (similar to feeling drunk) especially during the day - Loss of alertness or concentration - Inability to stay awake, feeling sluggish - Shakiness or trembling - Double or blurred vision - Feeling sick - Skin reactions - Change in your weight

Uncommon: may affect up to 1 in 100 people - Feeling elated or over-excited, which causes unusual behaviour - Hallucination (seeing or hearing things that do not exist) - Feeling agitated or angry - Incontinence - Cramping pain in the lower back and thighs, which may indicate menstrual disorder - Muscle spasms or weakness

Concern about young people using Xanax as a recreational drug

In the last two years there has been an increase in concern about young people using Xanax as a recreational drug and sourcing it through the ‘dark web’ or dealers, with increasing risk to themselves of harm or death – see for example:

http://www.bbc.co.uk/newsbeat/article/39870899/what-you-need-to-know-about-xanax
https://www.theguardian.com/society/2018/feb/05/xanax-misuse-uk-dark-web-sales-health

8. Appendix 3

Relevant findings from research into suicide by children and young people

8.1 Understanding that there may be other young people like X gives impetus to learning and improvement, to seek to develop local preventive responses and public health approaches when there may be earlier signs in a young person's life. There are two relevant research studies led by The National Confidential Inquiry into Suicide and Homicide by People with a Mental Illness. The first is a review of suicide by young people under 25. The second is the Annual Report 2018, covering a wider field and age range but with additional relevant findings to this review. Not all the antecedents and themes identified in the cohort studied were applicable to Y, but some similarities can be seen. The full analysis from the research is too detailed to be included here but should be examined when considering local suicide prevention strategies for young people.

8.2 Findings from Research Report: **Suicide by Children and Young People;** The National Confidential Inquiry into Suicide and Homicide by People with a Mental Illness: July 2017[24]. The research report gives a view of suicide by children and young people under 25 in England and Wales in 2014 and 2015.

8.3 The Key Messages from the 2017 Research are:

- Suicide in children and young people is rarely caused by one thing; it usually follows a combination of previous vulnerability and recent events.
- The stresses that we *(the research)* have identified in young people before suicide are common in young people; most come through them without harm.
- Important themes for suicide prevention are support for or management of family factors (e.g. mental illness, physical illness, or substance misuse), childhood abuse, bullying, physical health, social isolation, mental ill-health, and alcohol or drug use.
- Specific actions are needed on groups *(we have)* highlighted: (1) support for young people who are bereaved, especially by suicide (2) greater priority for mental health in colleges and universities (3) housing and mental health for looked after children (4) mental health support for LGBT young people.

[24] **Suicide by children and young people.** National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH). Manchester: University of Manchester, 2017.
https://www.hqip.org.uk/wp-content/uploads/2018/02/8iQSvI.pdf

- Further efforts are needed to remove information on suicide methods from the internet; and to encourage online safety; especially for under 20s.
- Suicide prevention in children and young people is a role shared front-line agencies; they need to improve access, collaboration and risk management skills. A later, more flexible transition to adult services would be more consistent with our findings of antecedents across the age range.
- Services which respond to self-harm are key to suicide prevention in children and young people and should work with services for alcohol and drug misuse, factors that are linked to subsequent suicide.

8.4 Common themes identified in the research were:

- Family factors (such as mental illness)
- Abuse and neglect
- Bereavement and experience of suicide (by others)
- Bullying
- Suicide-related internet use
- Academic pressures, especially related to exams
- Social isolation or withdrawal
- Physical health conditions that may have social impact
- Alcohol and illicit drugs
- Mental ill health, self-harm and suicidal ideas

8.5 The research sought to identify common antecedents for the young people in the cohort who were aged below 20, by gender.

The common antecedents were:

- Previous contact with social care/local authority services (at any time)
- A history of self-harm
- Contact with CAMHS (at any time)
- Self-harm by cutting
- Psychiatric diagnosis
- (Being or having been) a looked after child
- Bereaved
- Experienced abuse

- Bullied
- Self-harm by self-poisoning
- Contact with youth justice/police (at any time)
- Excessive alcohol use

All of these antecedents were found to have been more prevalent for females – but were also present for males.

- Illicit drug use
- No prior contact with services

These two antecedents were more prevalent in males under 20 – but were also present for females.

8.6 What the research findings say about prevention:

"The circumstances that lead to suicide in young people often appear to follow a pattern of cumulative risk, with traumatic experiences in early life, a build-up of adversity and high-risk behaviours in adolescence and early adulthood, and a 'final straw' event."

The significant event may not seem severe to others and thus risk may be hard to recognise by family or professionals unless the history of past and present problems is also taken into account.

8.7 A model for prevention is suggested for use at different ages and stages (see Figure 12 in the study for more detail of the model). The possible interventions include:

- supporting vulnerable young children and their families
- promoting mental health in schools to address bullying and online safety
- services for self-harm and alcohol and drug misuse in young people
- healthy workplace and campus initiatives, and
- crisis services.

8.8 Other dynamics to be noted in considering support and preventive services for particularly vulnerable young people are:

- Bereavement services, especially when young people have been impacted by suicide

of another person

- Internet safety (particularly for under 20s) in relation to websites which give information about suicide methods
- Greater staff awareness in front line services of suicide awareness and better multi-agency co-operation
- Self-harm should be seen as a crucial indicator of risk suicide and should be taken seriously – even if it appears minor. This may be the most important area for local development with regard to suicide prevention for young people; including psycho-social assessment, prompt access to psychological therapies and services for co-occurring problems such as alcohol or drug misuse.

Additional Findings from the NCISH Annual Report October 2018[25]

8.9 For children and young people **under 20** who took their lives:

- 41% had been in contact with services (mainly CAMHS – 34%) in the previous three months.
- Mental illness was reported in 40%. The most common primary diagnoses were affective disorders, especially depression.
- Academic pressures overall were noted in 63%; with exam pressures being 27%.
- Previous self-harm was found in 49% and suicidal ideas (at any time) was 59%.

8.10 In 29% of all cases (any age) there had been a **recent history of self-harm** in the preceding three months. For under 25s this was 39%, with a higher proportion for females (51%). Patients with a history of self-harm more often had a diagnosis of personality disorder compared to other patients.

8.11 For patients who died as a result of suicide who had a **recent history of self-harm** (within three months) immediate risk of suicide at the professional last contact was judged to be low or not present in 76% (all ages) – lower than the risk for patients with no recent history of self-harm. Risk was also assessed as lower in this group when seen a week prior to death; or in the longer-term risk assessments. *Author note: The research does not seek to explain this lower scoring in risk assessments for those with a recent history of self-harm. It would appear to be a dynamic to be considered in depth when undertaking such risk assessments where self-harm has been present.*

[25] **National Confidential Inquiry into Suicide and Safety in Mental Health, Annual Report: England, Northern Ireland, Scotland, Wales.** October 2018. University of Manchester https://www.hqip.org.uk/resource/national-confidential-inquiry-into-suicide-and-safety-annual-report-2018/#.W8CTcvZFyUk

8.12 **What could have reduced the risk** (all ages)**?** Clinicians views were: Closer supervision, closer contact with the patient's family, improved compliance with treatment, a decrease in caseloads and access to psychological treatment. *(See paragraph 170 of the report.)*

9. Appendix 4

Reading

National Confidential Inquiry into Suicide and Safety in Mental Health, Annual Report: England, Northern Ireland, Scotland, Wales. October 2018. University of Manchester
https://www.hqip.org.uk/resource/national-confidential-inquiry-into-suicide-and-safety-annual-report-2018/#.W8CTcvZFyUk

Suicide by children and young people. National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH). Manchester: University of Manchester, 2017. https://www.hqip.org.uk/wp-content/uploads/2018/02/8iQSvI.pdf

Transforming children and young people's mental health provision, December 2017 A Green Paper
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/664855/Transforming_children_and_young_people_s_mental_health_provision.pdf

Government Response to the Consultation on Transforming Children and Young People's Mental Health Provision: A Green Paper and Next Steps, July 2018
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/728892/government-response-to-consultation-on-transforming-children-and-young-peoples-mental-health.pdf

Mental health and wellbeing provision in schools; Review of published policies and information Research report; October 2018 Rebecca Brown; Department for Education
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/747709/Mental_health_and_wellbeing_provision_in_schools.pdf

Young Minds Report on: A&E Attendance by young people with psychiatric conditions almost doubled in five years – new figures October 2018
https://youngminds.org.uk/about-us/media-centre/press-releases/ae-attendances-by-young-people-with-psychiatric-conditions-almost-doubled-in-five-years-new-figures/

Mental health and behaviour in schools – revised guidance November 2018, Department for Education
https://www.gov.uk/government/publications/mental-health-and-behaviour-in-schools--2

10. Useful Organisations / Resources

Talk to Frank https://www.talktofrank.com/ Provides good information and advice

Young Hackney Substance Misuse, Advice and Referral Line 0208 356 7377 available 9am to 9pm Monday to Friday

Kooth from XenZone, is an online counselling and emotional well-being platform for children and young people, accessible through mobile, tablet and desktop and free at the point of use. https://www.kooth.com/

ChildLine https://www.childline.org.uk/

Papyrus https://papyrus-uk.org/ Charity/campaigning organisation to promote awareness and research to prevent suicide by young people

Papyrus-Hopeline UK https://papyrus-uk.org/hopelineuk/ Helpline and website for young people – and others who are worried about them

Samaritans https://www.samaritans.org/

Young Minds https://youngminds.org.uk/resources/