# A Retrospective Review of Risk Factors for Suicide in Looked After and Accommodated Children in Glasgow

## Case File Analysis

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The views expressed in this report are those of the authors and do not necessarily reflect those of Glasgow Child Protection Committee and partner agencies

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## Summary

The present report was requested by the Glasgow Child Protection Committee (CPC) to complement the Significant Case Review (SCR) process in the city. The focus on young people who had taken their own lives was considered following concerns that the SCR process for individual cases is not sufficiently focussed on understanding risk factors, but instead concentrates on procedural aspects of each case as a means of future prevention and risk reduction. The five cases selected for inclusion in this report were those identified by the SCR sub-group as those young people who had committed suicide between 2006 – 2012 and were, or had been looked after and accommodated. Methodology involved a comprehensive analysis of social work case files and health files where available, and analysis of relevant documents including any SCR reports. In effect the work was a case study approach to the investigation due to the small number of cases included.

Despite limitations in the research process, which include the small number of cases and the availability of information, the work has identified a number of risk factors that were common to all the young people. These include being bullied; accommodation issues; being victims of abuse and exploitation; displaying antisocial / aggressive behaviours; absconding; mental health concerns (not necessarily diagnosis) and alcohol misuse. There were also a number of parental factors that were common to all the young people including separation, relationship problems, aggression and mental health. While it is not possible to point to any risk factors or circumstances that could have prevented or predicted the deaths of the young people it is hoped that this work will provide an indicative baseline for continued monitoring of the looked after and accommodated population and aid professional recognition and management of possible risk factors. While it is difficult to make general recommendations from such a small number of cases, looking at the above factors in combination may be a starting point for future developments to support workers in assessment and risk management.

The work has provided further evidence of the adversities and abuse that children and young people in the looked after and accommodated system have endured and which contribute to their vulnerability and risk in many areas of their life course development, in addition to the risk of suicide.

# 1. Introduction

## 1.1 Background to the Research

Self harm and suicide are important public health issues in adolescents, with suicide being the second most common cause of death in young people worldwide (Patton et al 2009). Children and young people in care are a particularly vulnerable group whose circumstances and histories may be consistent with a higher risk for self-harm and suicide.

In Glasgow, Social Work Services manage a database of children and young people who die and are known to social work at the time of their death. The circumstances of their deaths are recorded and annual reports detail child and young person deaths. While the majority of children die from natural causes often related to complex health problems or disability, there have been a small group of young people, over the age of 12, who over the last five years have taken their own lives.

Following the death of a looked after and accommodated young person in October 2011 an internal review of the case was undertaken which raised the wider issue of adolescent suicides. While the number of such deaths is relatively small, it was considered that a broader piece of work would look at a number of cases and any learning from such cases would be disseminated across all partner agencies to inform future practice.

The Child Protection Committee Significant Case Review Sub-Group gave consideration to undertaking a formal review of those young people who were or had been looked after and accommodated, where suicide was given as the cause of death between 2006 and mid-2012. This work follows on from previous research completed by Glasgow Looked After and Accommodated Children Joint Planning Group (Cowan 2006). This report reviewed all deaths of young people with experience of care who had died in Glasgow, and in which suicidal behaviour was implied or clearly present. It aimed to identify common risk factors which retrospectively suggested the young people were at an increased risk of suicidal behaviour and points to where interventions could be applied in future cases. It involved a thorough case file analysis of 12 young people. The current 2006 – mid-2012 research builds on the 2006 report but has some significant differences with a more specific remit to look at

deaths only attributed to probable suicide and also involves a dual agency case file analysis of health and social work files.

### 1.2 The Scottish Perspective

Data spanning up until 2010 shows that Scotland has the highest overall mortality rates from all causes in younger working adults aged 15-44 years, since 2002 in women and 2004 in men, when compared with other Western European countries (Whyte and Ajetunmobi 2012). The main cause of death varies with age and gender. Suicide is the leading cause of deaths in Scotland in males aged 15 – 34 and the second most common cause of death in females in this age range (General Register Office 2010). Suicide rates in Scotland are now significantly higher than in England and Wales, though are comparable with Northern Ireland. This is a change that has occurred over recent decades. In 2010 the suicide rate among working age Scottish men was 73% higher than in England and Wales compared with 1968 when the rate in Scotland was just 6% higher than England and Wales (Whyte and Ajetunmobi 2012). Scottish suicide rates for women in 2010 were almost double that of England Wales. It is not just a discrepancy within the UK. Scotland's suicide rate has been above the Western European mean since 1993 for both sexes. Data from the period of 2001 to 2005 shows Scotland to have the third highest suicide rate for men and the fourth highest suicide rate for women out of 16 Western European countries (Whyte and Ajetunmobi 2012).

Within Scotland mortality from suicide in men climbed dramatically from the mid-1970s to peak in 1993 (Information Services Division Scotland, 2012). There has been a slight decline from 2003 onwards. Despite this the incidence of male suicide in 2010 was 50% higher than in 1968. In contrast the suicide rate in working age women peaked in 1978 and then reduced and has remained stable since the early 1980s (Whyte and Ajetunmobi 2012). In 2010 the female suicide rate was 26% lower than in 1968, though remains still above the Western European average (Whyte and Ajetunmobi 2012). Platt et al (2007) identified that male suicide rates were approximately three times higher than females, and that male suicide rates decline with age.

The National Records for Scotland (2012) define probable suicides as deaths resulting from intentional self harm (codes X60–X84, Y87.0 of the International Classification of Diseases,

Tenth Revision (ICD10)); and events of undetermined intent (ICD10 codes Y10-Y34, Y87.2). In 2011 there were 889 deaths in Scotland attributed to intentional self harm or "event of undetermined intent". However there was a change of coding of deaths implemented by the National Records of Scotland in 2011 following the World Health Organisation update to the International Statistical Classification of Diseases and Related Health Problems, which now classifies drug abuse deaths from acute intoxication as poisoning, resulting in some of these being classified as suicides. Prior to 2011 these deaths would have been classified under mental and behavioural disorders. For comparison with previous years, under the old coding system 772 deaths in Scotland in 2011 would have been attributed to self harm or "event of undetermined intent". Under the old coding system the rate of suicide in Scotland between 2007 and 2011 was 15.3 deaths per 100,000 population. In 2006 to 2011 there were 223 deaths of young people aged between 10 and 19 in Scotland from intentional self harm or "event of undetermined intent". 154 of those were classified as intentional self harm (General Register Office for Scotland, 2013).

### 1.3 FAI Erskine Bridge

As part of the literature review for this report the authors were requested to reference, and indicate any learning, from the recently published Fatal Accident Inquiry into the suicide of two young women at the Erskine Bridge (Anderson 2012). While it is difficult to incorporate case specific recommendations into an aggregated research study it is worth noting a number of points that were made in the FAI.

Evidence from an expert witness indicted that children in care are at increased risk of suicide, from the fact that they are in care, and that risk increases where there are additional factors. The additional risk factors, distilled from the available evidence, are highlighted later in the report and these should contribute to an individualised risk assessment, and raise concerns amongst professionals. The self-harming behaviour and threats of suicide were two factors that repeatedly re-occurred throughout the document as particular risk concerns in the two young women. Perhaps most importantly, and despite a number of concerns around practice and management issues, the expert witness indicated that the suicides probably could not have been predicted.

### 1.4 The Glasgow perspective

Almost half of Glasgow's residents, 283,000 people live in the 20% of most deprived areas in Scotland and the city as a whole has one of the poorest health profiles of any Scottish or UK city. Glasgow City had has the highest rate of suicide in relation to neighbouring local authorities and the major urban centres in Scotland. Suicide rates for Glasgow, along with Dundee, are higher than the national average (www.understandingglasgow.com).

### 1.5 Looked After Children

As of 31st July 2012 there were 3740 children in Glasgow looked after by the local authority (Scottish Government, 2013). This equates to 3.8% of Glasgow's population of children (National Records for Scotland, 2012) compared to total Scottish figures for looked after children being 1.47% of the population (Care Inspectorate, 2013). In Glasgow 977 of looked after children were living at home with parents and 1277 were living with friends or relatives. 1203 were in foster care, 18 in "other community placement" and the remaining 265 were in residential accommodation.

Looked after children are a vulnerable group, particularly those in the care system who are known to have a higher rate of psychiatric disorders (McCann et al., 1996, Dimegen et al., 1999). A surveillance study comparing looked after children with controls found the risk of psychiatric disorder to be increased by more than four fold in the looked after group (Ford et al., 2007). A national study of young people in Scotland looked after by local authorities found that 45% of looked after children have a psychiatric disorder (Meltzer et al, 2004). There was no significant difference in prevalence rates with placement type i.e. with parents, foster care or residential care. In this study 22% of looked after children and young people had tried to harm, hurt or kill themselves. The rate of self-harm in Scotland was more prevalent among older children, aged 11–17 (28%) than younger children (6%) and among those in residential care (39%) compared with children placed with their birth parents (18%) or in foster care (14%).

Looked after children also have a slightly higher mortality rate from all causes than the general population of children (Care Inspectorate Report, 2013). Between 2009 and 2011 30

looked after children in Scotland died. Five of these deaths were attributed to suicide (16%). A similar audit undertaken in 2002 found that 11 out of 50 deaths of looked after children between 1997 and 2001 were suicides (22%) (Scottish Executive 2002), suggesting a higher rate of suicide in looked after children than in the general population.

There has been a large body of research regarding risk factors for suicide in adults. In recent years there has been work undertaken to identify predisposing and precipitating factors for suicide in children and adolescents. Relatively recently attention has turned to the mental health and emotional needs of looked after children. However the focus to date has been on identifying the needs of this group in order to determine the need for targeted interventions. Further work is required to be undertaken identifying the specific risk factors for suicide in this vulnerable group of children and young people. This paper aims to address this deficit in looked after and accommodated children (LAAC) in Glasgow; who may be considered a particular group at risk as living away from parents has been identified as being associated with suicide risk (Evans 2004).

## 2. Aims

The primary aim of this paper is to identify themes and risk factors in cases of suicide between 2006 and mid-2012 in children and adolescents in Glasgow who were or had been looked after and accommodated and were known to social work at the time of their death. The aim is to identify potential indicators of suicide risk that workers across health and social work agencies should be aware of to try to reduce future suicides in this vulnerable group by means of an appropriate and timely intervention. The authors will identify themes and issues that impact on practice to inform the dissemination of specific learning points across agencies.

The report will provide an overview of the current research regarding risk factors for suicide. This is to inform the review and support the development of a case file data collection tool rather than to provide a comprehensive systematic review of the literature which is outwith the scope of this paper.

The specific personal circumstances of each case will be reviewed in an anonymised fashion, along with procedural aspects of the cases to identify areas of learning in the procedural approach to such cases which are transferable to future practice. The paper does not aim to critique management of cases or to identify mistakes or missed opportunities but rather to provide a knowledge base for identifying children and young people at risk of suicide. Another secondary aim is to identify areas for further research in this high risk group.

The overall objective of the report is to add to the current knowledge of professionals across health and social work agencies in Glasgow, regarding the early identification of risk of suicide to facilitate timely interventions in looked after and accommodated children and young people. The work does not, and cannot, replace other methods of case review, as it does not focus on individual cases, but is an anonymised overview of the selected cases.

## 3. Methods

The cases identified for inclusion in the study were preselected by the Child Protection Committee sub group as those young people whose death was recorded as suicide, or it was considered to be suicide, and they were looked after and accommodated at the time, or shortly before the time of death. All had some continuing contact with social work at the time of death.

The primary method of data collection was via social work and health case file analysis – both electronic and paper. Where available, Significant Case Review and other reports were also consulted. A decision was taken not to interview professionals involved in the cases; some of the deaths were a number of years old, and the analysis was not designed as a formal practice review of the cases. Additionally, many of the workers had been previously interviewed as part of formal review processes.

Drawing on previous work undertaken in Glasgow (Cowan 2006), and including the latest research findings on suicide and young people, a data capture form was designed containing identified risk factors (see appendix 1). For each case two members of the research team worked together on reviewing electronic and paper case files – social work records, followed by health.

Information was recorded in relation to three time frames where applicable – lifetime, last 12 months and last month before death. The data was collated on an Excel spreadsheet and analysed in terms of descriptive statistics. The limited number of cases available, and limited data, precluded any more sophisticated statistical analysis. The included cases have been anonymised as Case 1, Case 2 etc.

| Case | Social Work Notes | GP Notes | CAMHS notes | LAAC Health Notes | Child Health Notes | Child Protection Unit files |
|---|---|---|---|---|---|---|
| **1** | Y | N | Y | Y | N | Y |
| **2** | Y | Y | Y | Y | N | Y |
| **3** | Y | N | Partial | Y | N | Y |
| **4** | Y | Y | N | Y | N | Y |
| **5** | Y | Y | Y | Y | Y | Y |

**Table 1:** Access to case notes for each young person

- Case 1: GP notes destroyed as policy is to destroy GP notes three years after death. Child health notes destroyed as policy is to destroy child health notes three years after death.

- Case 2: Child health notes destroyed as per Case 1.

- Case 3: GP notes destroyed as per Case 1. Glasgow CAMHS notes reviewed but care was transferred to a CAMHS team in a different health board. This team was contacted, but unable to locate notes (either destroyed, or misplaced when service relocated). Child health notes destroyed as per Case 1.

- Case 4: CAMHS notes not located. Child health notes not located.

**3.1 Ethics and confidentiality**

As an audit of specific cases to inform child protection / safeguarding policy and practice in health and social work, full ethical research approval was not required under the guidelines for each agency. Health and social work senior managers, via their own individual processes, and under the auspices of the Child Protection Committee, provided full approval for the audit and methodology. The work was overseen by a steering group comprising of senior managers and clinicians from both agencies, who also facilitated full access to case records.

Individual names, or clearly identifying factors, were not recorded on the data capture forms and all reference to individuals, or specific areas of the city, were anonymised. The report was approved by relevant managers and the Child Protection Committee prior to publication.

# 4. Risk Factors: The Evidence Base

In order to facilitate comparison, with the author's permission, the risk indicators utilised in the 2006 report have been used in this review (Cowan, 2006). However following a review of the literature some additional risk factors have been added to compile a comprehensive data collection tool. It must be noted that although there is extensive literature on suicide and self harm in general, there is a lack of evidence with regards to risk factors for suicide in young people who have or were at the time of death looked after and accommodated. Therefore the evidence base from young people and adults must be drawn on to facilitate work to identify risk factors specific to young people with an experience of being looked after and accommodated. The relevant literature has been reviewed but as previously stated this paper does not aim to provide a comprehensive review of this area. However it is hoped that the following will provide the literary context for the risk indicators that were included in the data collection risk indicator tool used in this paper.

## 4.1 Social Factors

Several social and demographic factors have been identified as risk factors for suicide. It is known that completed suicide is more common in males than females (Platt et al 2007). Research in Scotland, comparing rural versus urban areas, found there to be higher rates of suicide in remote rural areas (Levin and Leyland, 2005). When adjusted for age and deprivation the risk in men of suicide was significantly higher in remote rural areas compared to urban areas, whereas the risk of suicide was lower for women in accessible rural areas.

Unemployment has been a well researched risk factor for suicide (Neelemann, 2001). Poverty and deprivation have also been linked to suicide (Neelemann, 2001; Rehkopf and Buka, 2006). Neelemann (2001) reviewed results from three cohorts finding that the unemployed and those with lower socio-economic status are 2.2 times more likely to die by suicide than those employed or from higher socio-economic groups.

Marriage can be a protective factor against suicide (McLean et al., 2008) and high levels of social support from friends, school and family are thought to also reduce the risk of suicide. Therefore evidence was sought of romantic relationships as well as evidence of networks of

friends. An abusive relationship was hypothesised as potentially diminishing the protective element of having social supports and has been found in adults to increase the risk of suicide attempts and mental health problems (Campbell, 2002). Both victims and perpetrators of bullying in adolescents have been associated with an increased risk of suicide attempts (Klomek et al, 2007).

The literature is unclear as to whether exposure to a friend who has attempted or committed suicide has any association with attempted or completed suicide (Bridge et al., 2006). Therefore it was felt that this would be a useful area to review in these cases.

**4.2 Social Work History**

Information was sought to identify any common factors within social work histories that might be indicators of risk of suicide. Information regarding processes that were thought to possibly be protective for suicide, by means of identifying and addressing areas of risk, were sought such as if the young person had a key worker identified in the files and a documented care plan review within the last six months prior to death. Of interest was the age and reason the young people first became Looked After and Accommodated; child protection and vulnerable young person procedures; how long they were looked after; age on leaving care; number of care placements and the predominated care placement. Multiple placement moves has been linked to a poorer outcome in terms of unemployment and social exclusion in adulthood (Dixon and Stein, 2006), both which are risk factors themselves for suicide. Significant accommodation issues such as homelessness, use of refuges, multiple house moves and issues in the community related to housing were identified as life stressors and as a proxy for socioeconomic disadvantage. Interventions used to address areas of concern were collected to compare across the group.

**4.3 Familial Factors**

Parental mental illness is known to be a risk factor for suicide in adolescents (Brent et al., 1993, Qin et al., 2002). A family history of completed suicide has also been well documented as significantly increasing the risk of suicide (Qin et al., 2002). Bridge et al. (2006) reviews the literature on loss of a parent through bereavement, divorce or separation.

Several studies show that loss of a parent increases the risk of suicide. Family discord is also a risk factor for suicide (Bridge et al., 2006). Childhood sexual and physical abuse has been found to be positively correlated with self harm, suicidal ideation and completed suicide in adults (Santa Mina and Gallop, 1998).

Positive parental relationships have been found to be a protective factor for suicide and also can be a mitigating factor of risk of suicide for other risk factors such as childhood sexual abuse, where the parent is not the perpetrator (McLean et al., 2008). As social connectedness has been found to be a protective factor for suicide, it was speculated that an ongoing relationship with biological siblings may also be protective and thus was included as an indicator to gather information from case files.

**4.4 Personality/Behaviour Factors**

A review of the literature commissioned by the Scottish Government in 2008 found that robust research regarding personality factors as risk factors for suicide is lacking due to heterogeneity between reviews and studies within individual reviews (McLean et al., 2008). There are a wide range of personality and behavioural factors which have been linked with an increased risk of suicide such as hopelessness, extroversion, impulsivity, anger, aggression, irritability and anxiety. Due to the lack of definitive evidence in this area it was decided to collect data on the factors that were thought to most likely be documented in case files. Indicators such as hopelessness, low self-esteem and introversion were gathered from records of direct reports from the young people themselves or from subjective reports from professionals. The subjective nature of this was felt to be an unavoidable necessity in order to gather information on these areas and hopefully add to the evidence base. It was decided that some of the personality/behavioural indicators used in the 2006 paper (Cowan, 2006) i.e. recklessness, impulsivity and risk taking behaviour, were highly subjective as these would rarely be reported directly by young people and that proxy information could be gathered through a variety of indicators such as absconding, risky sexual behaviours, substance use, criminal convictions etc. It was hoped that this would provide a more objective account indicative of such personality and behavioural factors.

Research undertaken in Glasgow found gay, lesbian and bisexual young people to have higher rates of suicidal ideation, self harm and attempted suicide compared with population data (Coia et al., 2002). This corroborates with other research that this group of young people are at particularly risk of suicide (D'Augelli, 2002). Therefore issues regarding sexuality were an important indicator to consider.

### 4.5 Mental Health

It has been established that a number of psychiatric disorders carry an increased risk of suicide including affective disorders, psychotic disorders, personality disorders, and childhood disorders encompassing disorders such as conduct disorder and ADHD (McLean et al., 2008). Therefore it was important to gather information both about formally diagnosed psychiatric disorders and evidence suggestive of symptoms of mental disorders as it is known that this group of young people often do not have their mental health needs recognised. It was also of interest to gather data on referral to and input from child and adolescent mental health services. It is known that almost a quarter of patients who commit suicide had been in contact with mental health services in the previous year and a quarter of those have been discharged from a psychiatric inpatient unit within three months before their death (Appleby et al., 1999).

### 4.6 Health

There is evidence to suggest that increased frequency of presentation to a GP may be indicative of increased risk of attempting suicide. In a small case series attendances for mental health concerns, abdominal pains and headaches were found to be increased in adolescents who go on to attempt suicide compared with those who don't (McNeill et al, 2002). Therefore it is important to capture this data. Looked After and Accommodated Child Health (LAAC Health) reviews were thought to be important to assess in this study as they are potential opportunities to identify risk factors for suicide and to intervene. It was decided to review whether there had been a LAAC Health review in the last twelve months prior to death, which is the minimum recommended frequency for such reviews in Glasgow.

Chronic illness is a known risk factor for suicide (Bridge et al., 2006). Functional impairment due to illness is an identified risk factor. There are a number of studies which suggest an increase in suicide in people with epilepsy and diabetes mellitus in particular (Greydanus et al., 2010).

Misuse of alcohol and acute alcohol use are known to greatly increase the risk of both completed suicide and self harm (Cherpitel, Borges and Wilcox, 2004; Neeleman, 2001). Neeleman (2001) found that the standardised mortality ratios for death by suicide in those misusing alcohol was 8.5 times higher than those of controls and that suicide was 10.1 times higher in those using illicit drugs than controls. Use of alcohol starting before the age of 13 has been found to be associated with suicidal ideation and attempted suicide (Swahn and Bossarte, 2007). Previous literature confirms the association between illicit drug use and suicide (McLean et al., 2008). Use of tobacco as well as illicit drugs has been found to be a risk factor in adolescents for suicide attempts after controlling for co-morbid psychiatric disorders (Miller et al., 2011). It was decided to review age of initiation of tobacco use to determine if early use may have a similar association with suicide as early alcohol use.

Risk taking sexual behaviour was an important indicator to review, not only as a proxy for impulsivity, but also as potential mediator for mental health problems. Young people having unprotected sex put themselves at risk of sexually transmitted infections and pregnancy which may have a detrimental effect on their mental health. However it is also increasingly recognised that this vulnerable group of young people are at risk of sexual exploitation resulting in potential mental health sequelae.

**4.7 Acute Life Crises**

The acute life crises indicator was placed to capture unique information about each case that may not be recorded under the other risk indicators but was thought by the reviewers to be an event that may significantly predispose to and precipitate mental health problems. Bereavement of a close friend or relative was thought to be an important potential risk factor. It is hypothesised that such events could add to other risk factors in the causality of the ensuing suicide.

## 4.8 Self Harm

Previous suicide and self harm attempts are known to be the biggest indicator for predicting future suicide. A systematic review by Owens et al (2002) estimated that up 2% of patients who attend hospital following self harm will commit suicide within the subsequent year and that this will rise to above 9% within the following 9 years. Neeleman's 2001 meta-analysis found that people who self harmed were 24.7 times more likely to commit suicide compared to those who do not. Voicing suicidal ideation or thoughts of self harm is an important indicator of suicidal intent and has also been found to be a risk factor for completed suicide (Brent et al., 1993).

# 5. Findings

As previously indicated, limitations in respect of the small number of cases the researchers were asked to look at has precluded any significant statistical analysis of the data. The findings are therefore generally presented as descriptive data to provide a sense of the circumstances of the young people.

## 5.1 Demographics and Social Background

Five cases were identified and included in the study; three females and two males. The average age at death was 16 years old; the youngest was 13 and the eldest was 19. When first known to social work all the young people lived in urban areas. At the time of death three lived in private accommodation (two by themselves, one with their partner) and two lived in residential units. The legal status of the cases at time of death is outlined in *table 2*.

| Legal Status | Number of Cases |
|---|---|
| S66 | 1 |
| Probation | 1 |
| Voluntary | 2 |
| S70 (3) | 1 |

**Table 2:** Legal status at time of death

Attempts were made to ascertain the highest level of education achievement of the cases. For two of the young people, this information was not available. One young person was still at school, and another one was in training. One of the young people was noted as having achieved higher qualifications.

## 5.2 Social Work Input

*Table 3* provides details of keyworkers at time of death. Attempts were made to ascertain the quality of relationship between each young person and their keyworker, but this information was only available for one case.

| Key worker ID | Number of Cases |
|---|---|
| Youth justice | 2 |
| Social worker | 1 |
| Leaving care | 2 |

**Table 3:** Keyworker ID

All five young people were known to social work for considerable periods of time; the average age of first contact with social work was 4.4 years, with a range of before birth to13 years of age. Reasons for first contact with social work are outlined in *table 4*. Three of the young people had been on the child protection register, with an average age of child protection referral of three years old. The two young people who had never been referred for child protection concerns entered the protection process via Vulnerable Young Persons (VYP) procedures. All five young people had attended children's hearings and all had been placed on supervision orders at various times. The average age of being placed on a supervision order was six years of age.

| Reason first SW | Number of YP |
|---|---|
| Outwith parental control | 2 |
| Parental drug use | 2 |
| Sexual health concerns and absconding | 1 |

**Table 4:** Reason for first contact with social work

All five young people had been LAAC; the age of first LAAC ranged from six months to fourteen years, with an average age of eleven years. The average number of placements was 6.4, with a range of one to twelve placements.

- Case 1 had only one placement in a residential home
- Case 2 had a total of ten placements, their major placement being a kinship placement with their grandparents on a home supervision order
- Case 3 had a total of two placements, both in residential homes
- Case 4 had a total of seven placements, their major placement being a residential home

- Case 5 had a total of twelve placements, their major placement being a residential home

*Table 5* details the age at time of death of each case, and the age at which they left care.
Three of the cases had documented evidence of a care plan review in the six months preceding death.

- Of the two cases known who were still LAAC at the time of death, one had a care plan review within six months prior to death and the other had a care plan review dating slightly more than six months prior to death.
- Of the remaining three cases, two had a care plan review within six months prior to death.

| Case | Age When Left Care | Age at Death |
|---|---|---|
| 1 | N/A | 13 |
| 2 | 16 | 17 |
| 3 | 17 | 18 |
| 4 | N/A | 16 |
| 5 | 17 | 19 |

**Table 5:** Age when left care and age at time of death

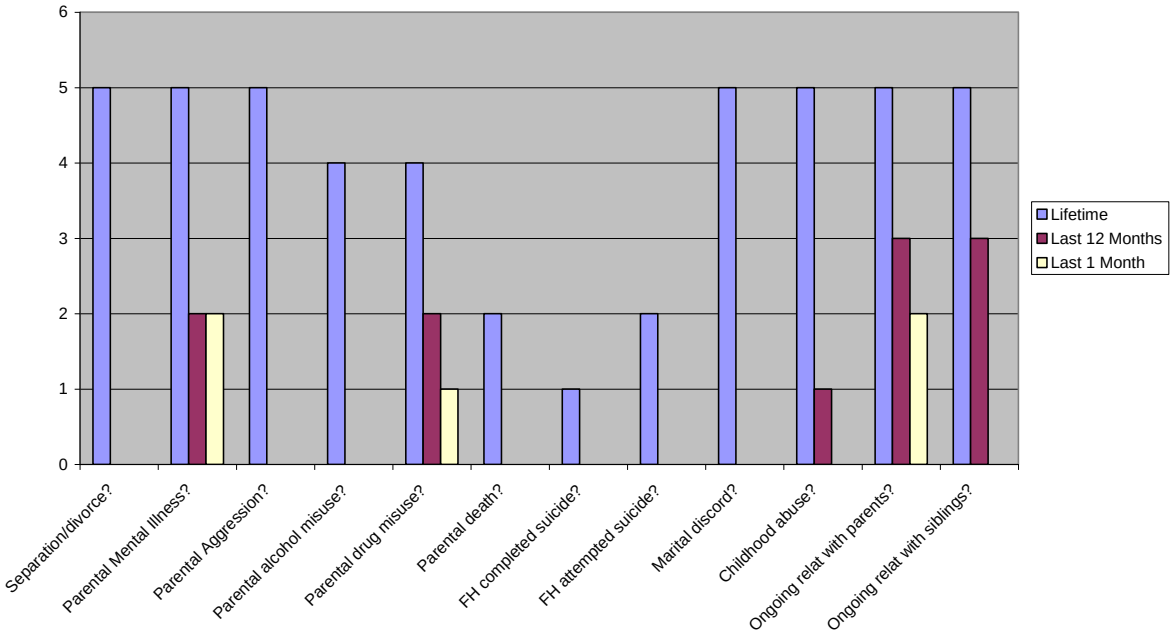
### 5.3 Familial history

*Chart 1* provides a visual summary of familial problems over time. All five young people had a history of parental separation/divorce, and all five had a history of parental mental illness and parental aggression. One young person had a history of their parent having being sexually abused in the past.

All five were also recorded as having had issues with housing over the years, and three young people had (in the past) become homeless with their families. One young person was housed by Women's Aid after fleeing domestic violence with their mother.

Four young people had a history of parental drug use and parental alcohol abuse. Only two young people are recorded as having had parental contact in the month preceding death.

**Chart 1: Familial Factors**



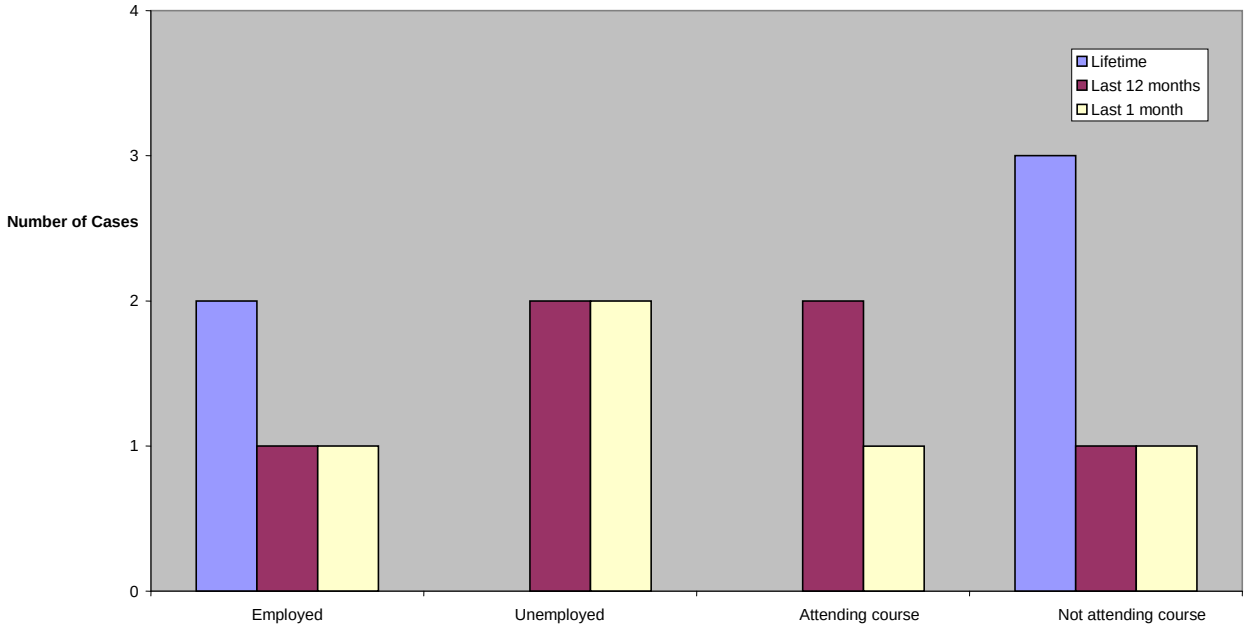

## 5.4 Relationships

All five young people had cultivated social relationships over their lifetimes, although data indicates that three had become more isolated in the month prior to death. Of note, all five had been victims of bullying at some point in their lives, although none reported bullying in the month prior to death. Four were also recorded as having been perpetrators of bullying at some point. There were no instances of friends of the deceased attempting to commit, or completing suicide, in any of the cases. One young person was reported as being in a physically abusive relationship during their lifetime and in the last twelve months of their life but not in the last month.

## 5.5 Employment

*Chart 2* summarises the employment/educational situation of the young people at time of death. One young person was employed and one was attending training. The remaining three were either unemployed or not attending a training course they had enrolled for.

**Chart 2: Employment/Education**




## 5.6 Abuse and exploitation

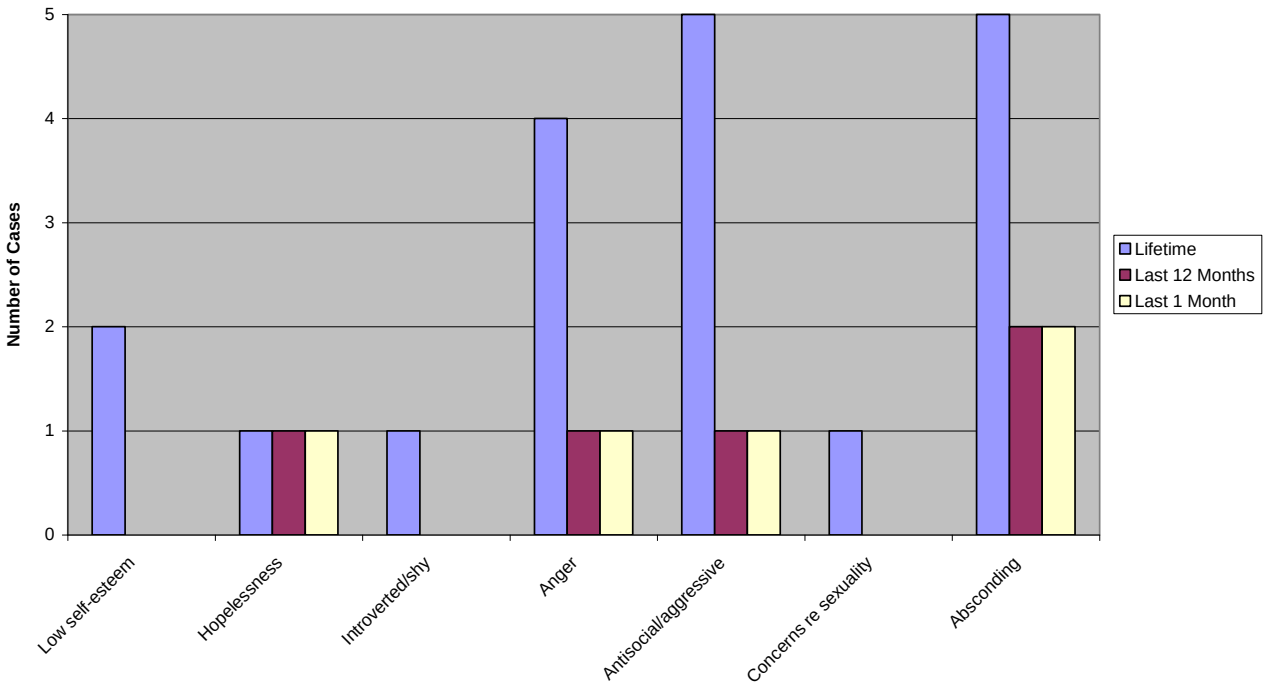
All the young people had been victims of childhood abuse in their lifetimes.

- 1: Sexual and physical abuse
- 2: Neglect and physical abuse
- 3: Emotional, sexual and physical abuse
- 4: Emotional and physical abuse
- 5: Emotional, physical and (possible) sexual abuse.

Additionally four of the case files contained indicators of sexual exploitation and abuse into their teens. This included substantial sexual activity in early adolescence and incidents of rape; but also noted were older partners, or older 'friends' which in the context of a recent Glasgow social work report (Rigby and Murie, 2013) is considered a strong indicator of sexual exploitation in the looked after and accommodated population.

## 5.7 Personality/Behaviour

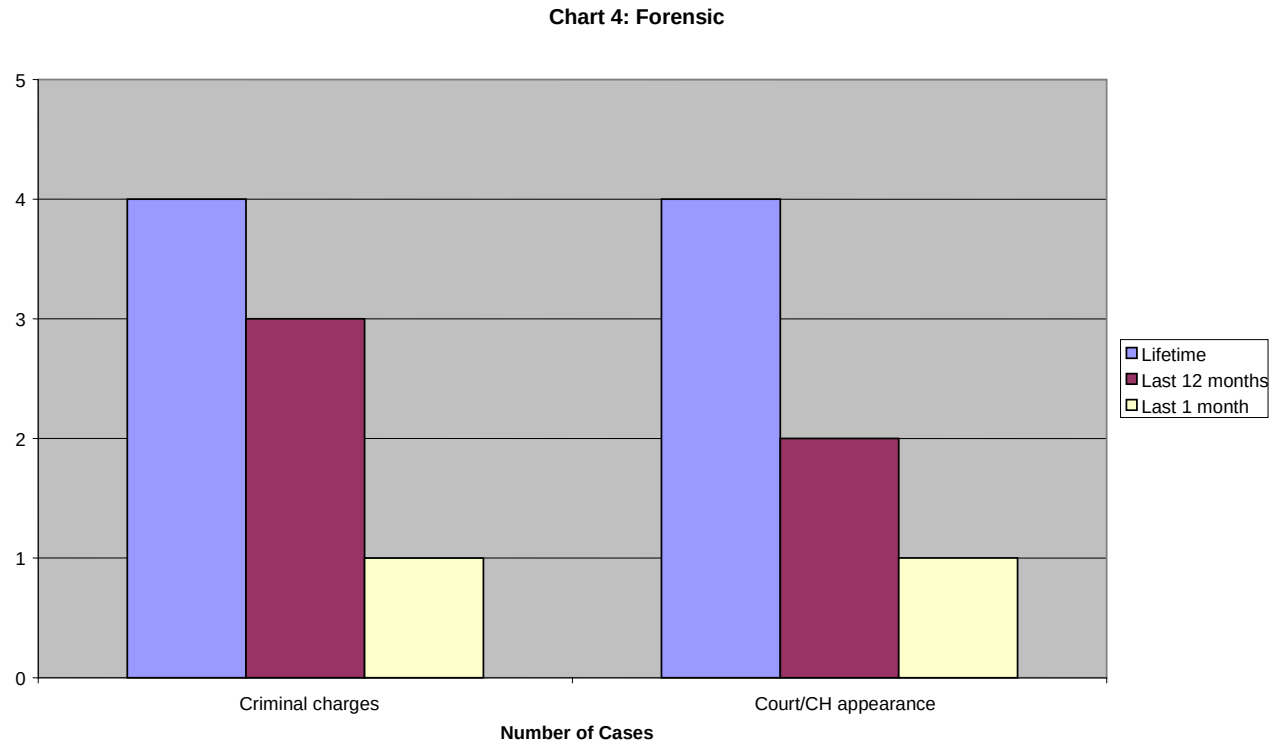
**Chart 3: Personality/Behaviour**




Of note is that all five young people had at some point been involved in antisocial/aggressive behaviour, and all five had a lifetime history of absconding from their place of residence. However, there was no clear picture of escalating behavioural problems in the month preceding death. One young person had expressed concerns regarding their sexuality.

## 5.8 Forensic history

Four of the young people had a history of offending behaviour, and three had received criminal charges in the year preceding death. One had appeared in court in the month preceding death. None of the young people had received a custodial sentence. Please see *Chart 4* for summary.




## 5.9 Mental Health

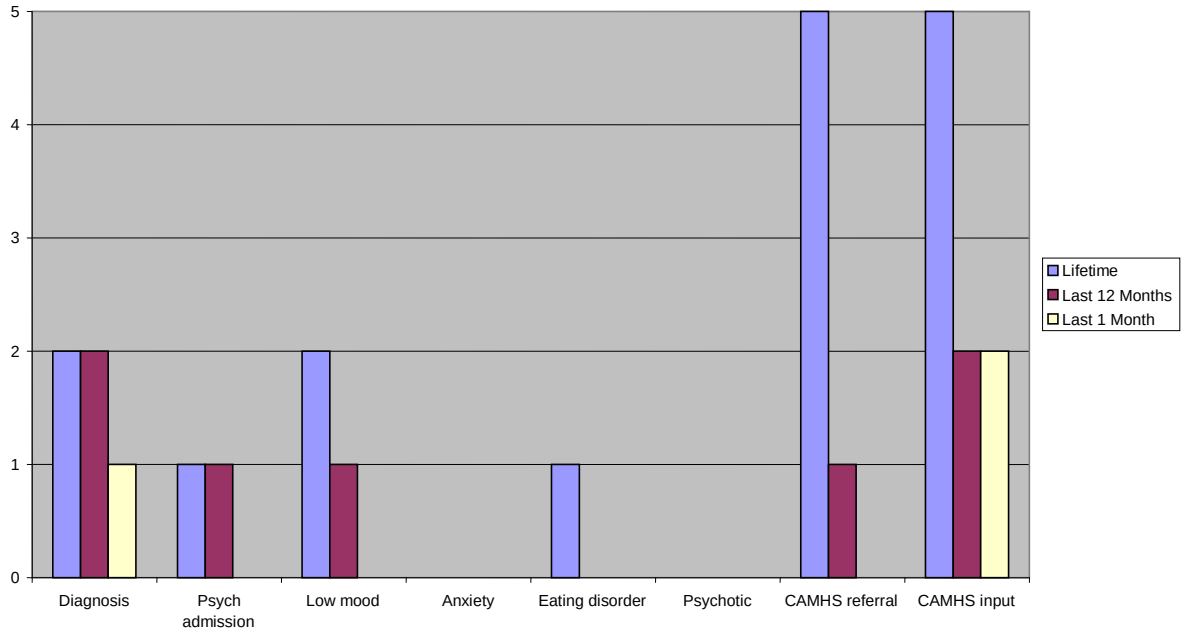
Please see *Chart 5* for a summary of mental health factors and note that this documents symptoms (eg low mood, anxiety, eating disorder) as opposed to a formal diagnosis of psychiatric disorder.

Records obtained showed that all five young people had been referred to CAMHS over the course of their lives, and two remained in contact with CAMHS at the time of death. The other three young people had failed to engage with CAMHS during their lifetime. One young person had been a psychiatric in-patient in the year prior to death. Two young people had received a psychiatric diagnosis and one had been described as having traits suggestive of autistic spectrum disorder.

- Case 1: Referred to both local CAMHS and Forensic CAMHS. Neither service felt the young person was suffering from psychiatric problems, and there were difficulties with engagement of the young person with services. A review of the health case file after death highlighted cannabis misuse and possible conduct disorder.

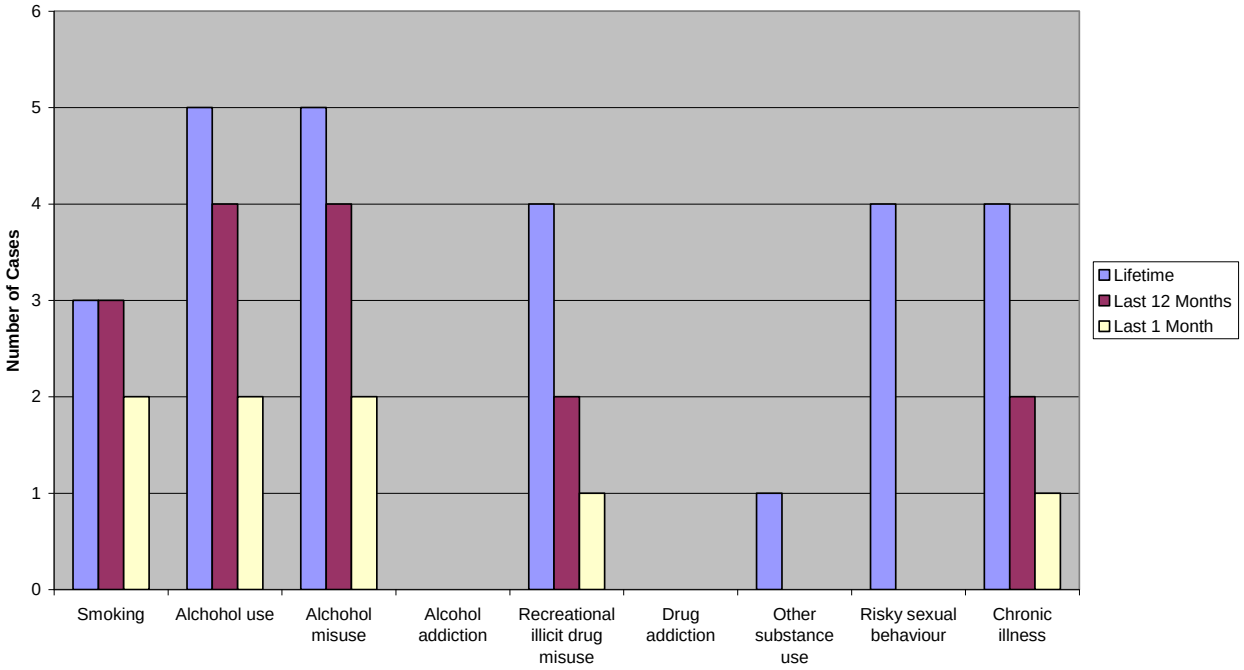
- Case 2: The young person was referred to CAMHS in 1995 and 1996 but did not attend. The young person attended a single appointment in 2000 but did not engage following this. In the last twelve months of their life the potential of referral to CAMHS was suggested by the criminal justice social worker , due to concerns about deliberate self harm, but the young person refused to attend.
- Case 3: Spent a single night in a psychiatric hospital in 2004 due to suicidal thoughts. Was again a psychiatric in-patient in 2007 and subsequently under the care of CAMHS. Diagnosed with depression and emerging personality disorder, and commenced on the antidepressant fluoxetine. Remained under the care of CAMHS, and on fluoxetine, at the time of death.
- Case 4: Seen at Yorkhill Hospital Department of Child and Family Psychiatry at the age of three for possible ADHD. Later seen by LAAC mental health nurse who did not feel he had ADHD but was "emotionally traumatised", and did not engage with follow up.
- Case 5: Initially referred to CAMHS in 1995 (age 3 ½). Discharged as no ongoing concerns. Referred to CAMHS in 1998 and 2008 but did not attend. Referred to Forensic CAMHS in 2008 due to possible PTSD, but did not receive a diagnosis. Diagnosed with post-natal depression by GP during the last twelve months of her life and commenced on an antidepressant (initially fluoxetine; changed to citalopram). Remained on citalopram at the time of her death.

**Chart 5: Mental Health**




## 5.10 Physical Health

**Chart 6: Physical Health**




Four young people had consulted their GP in the year prior to their death and one had done so fourteen times with abdominal pain, back pain and postnatal depression. One young person

had seen their GP in the month prior to their death with a lower respiratory tract infection. Three young people had a LAAC health review in the 12 months prior to their death. Of the two that had not, one had left care and the other had been referred to the LAAC nurse in the month prior to their death.

Four of the young people had a lifetime history of chronic illness: asthma in three cases, and musculoskeletal pain in the other. One young person had pancreatitis and required a cholecystectomy, surgical removal of the gallbladder, for chronic abdominal pain in the year prior to their death.

### 5.11 Substance use

All five had issues with alcohol misuse at some point in their lives, and in two cases there were recorded concerns of alcohol misuse in the month prior to death. Four of the young people had a lifetime history of recreational drug misuse, and two were recorded as using drugs in the year leading up to suicide. There were no recorded concerns regarding either alcohol or drug addiction.

Three of the young people had a history of smoking, and two of them continued to smoke in the month prior to death. One of the young people started smoking at the age of four, and another at the age of six. *Table 6* outlines the age at which the young people began drinking alcohol and taking illicit drugs.

| Case | Age First Drank Alcohol | Age First Took Drugs |
|---|---|---|
| 1 | 12 | 9 |
| 2 | 15 | 11 |
| 3 | 16 | N/A |
| 4 | 6 | 11 |
| 5 | 13 | 13 |

Table 6: Alcohol and drug use

### 5.12 Acute Life Crisis

Two of the young people had experienced a close bereavement at some point in their lives, although not in the year preceding death. Other significant life crises are recorded in *table 7*.

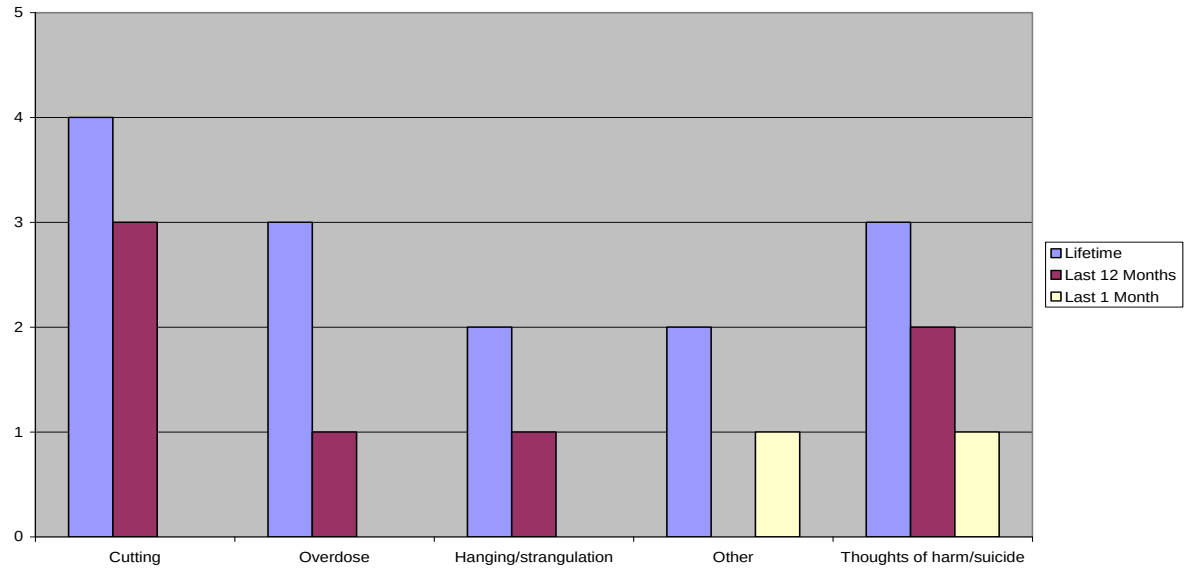
| Case | Details of Crises |
|---|---|
| Case 1 | Three days before death, brother (viewed him as father figure) received custodial sentence for murder. |
| Case 2 | Father sent to prison when young person was nine. |
| Case 3 | Sexually assaulted on multiple occasions. |
| Case 4 | Three months before death, mum given six months prison sentence for supplying drugs (released one month before death). Mum also victim of attempted murder. |
| Case 5 | Became a mother one year before suicide |

**Table 7:** Acute Life Crises

### 5.13 Self Harm

Four of the young people had a history of cutting, and three had a history of overdose. One of the young people had an incident of self harm (dragged a brick across their arm) in the month before death. One young person had reported thoughts of wanting to harm themselves in the weeks leading up to death. There was one young person with no specific evidence of self harm as indicated from the factors considered here. Whether alcohol use can be considered intentional self harm (Care Inspectorate 2013) for this young person is a debateable concept.

**Chart 7: Self Harm**




## 5.14 Multi-agency input and processes

In 2000 the Glasgow Child Protection Committee established multi-agency procedures for young people who are considered to be vulnerable. The purpose of these procedures were to provide multi-agency guidance for professional staff working with children and young people who are considered to be at significant risk, either through their own actions or at the hands of others. Young people with concerns around self harm and suicide are one of the target groups; the procedures were first established following the death of a young woman who had been LAAC.

Underpinned by GIRFEC, Getting it Right for Every Child, the procedures detail how agencies should work together to protect children from harm and they sit alongside single and multi-agency child protection procedures. The procedures are intended to give guidance in the assessment, decision making and co-ordination of a multi-agency response to the complex needs of this group of children/young people; providing some contextual information regarding risk factors and detailing minimum requirements of a multi-agency forum to protect and support young people.

There is ample evidence in the case files of substantial multi-agency involvement over the years and contact with different agencies at different times, and often all at the same time. All

five cases had been known to multiple services, with as many as seven services involved at the time of death in one case.

Over the period of contact for each young person, at various times there were issues identified of limited information sharing, both between agencies and within agencies. All but one of the young people had been subject to VYP processes at some point of professional contact; however the use of VYP was erratic and there was no evidence of consistency between the cases. The one case where no evidence of VYP was found did not differ substantially from the other cases.

**Decision making with multi-agency collaboration**

In a retrospective case file analysis, where the outcome is already known, it is too easy to suggest that wrong decisions were taken at certain points in the process and contact with young people. In the cases looked at for this study there were examples of decision making and assessment, which in hindsight could be viewed differently eg a children's hearing terminating a supervision order four months before the death of a young person as the panel members considered the young person would receive enough support from a criminal justice worker as a care leaver; an assessment of no risk of suicide months before death; statements in care plans that risk had reduced and the young person was more stable when a thorough reading of contemporaneous case notes indicates otherwise. Without focussing on specific examples, in each case inconsistent decision making and questionable assessments of risk and need, not supported by the evidence, indicates this is an area that requires further investigation across all agencies.

**Multi-agency contact**

Despite the amount of single and multi-agency contact over the years there was evidence in the case files of variable engagement and contact with agencies, most notably concerns about young people's failure to engage with CAMHS and attend appointments. For those young people subject to VYP processes there was some inconsistency in contact, with one young person not being seen by their social worker in the three months preceding their death.

# 6. Conclusions

The work has identified a number of risk factors present for the young people, all of which are signposted in the literature. Before discussing these in greater detail it is worth reflecting on some of the limitations of this case file analysis in terms of generalisability of the findings, and highlighting that the conclusions can only be seen as indicative.

## 6.1 Limitations

The work has focused on a particularly disadvantaged group of young people, whose risk factors and life experiences place them in the highly vulnerable category. However, the sample size is too small to draw any definite conclusions and there has been no control group with which to make any definitive comparisons. Primarily this piece of work has further reiterated the risk factors present for this vulnerable group and highlighted the difficulties of attempting to identify those most likely to take their own lives. It should be viewed as baseline research, from which further work can be undertaken in a systematic and longitudinal framework.

There were difficulties in getting access to health files. This was largely due to files being destroyed. The minimum retention period for NHS health records in Scotland, including mental health files, is three years after death (Scottish Government, 2008). GP electronic records currently have to be kept indefinitely but GP practices switched to this electronic system at varying times. Three of the five young people had died more than three years before the completion of this review. The Scottish Government require that each organisation produce its own retention schedule providing it is not shorter than the minimum retention periods specified by the Government. However retention periods can be longer if the organisation can justify this particularly in terms of the Data Protection Act. For the purposes of future research in this area it may be useful for the health board to consider applying longer retention periods for medical records of young people who commit suicide, particularly where there have been identified child protection concerns.

Social work files were readily available but difficult to read as information was often not filed chronologically. As a result the authors were not certain that the records were complete.

It is notable that social work files did not hold detailed information about educational attainment for all cases, considering the benefits that education can provide young people in terms of a predictable structure and routine, sense of achievement and emotional support. Intellectual or creative ability can be a protective factor for mental health and ongoing educational or vocational activities require to be promoted particularly for this vulnerable group.

Some information was difficult to obtain from the notes, for example regarding the quality of the relationship between the young person and their keyworker, symptoms of mental health problems, personality factors and the intent behind self-injurious behaviours. This type of information may not be recorded frequently because it is subjective and difficult to evidence, or it may not have been considered. However it would be important for professionals working with young people to reflect on these areas as they should inform future care plans as well as developing therapeutic working relationships.

With any retrospective case file review, there is always the possibility that data was not recorded rather than being absent. Without speaking to the professionals involved it is impossible to be certain of the completeness of the data that was recorded. It should also be noted that on review of the data in one case there was uncertainty as to whether the cause of death was suicide or death by misadventure. However the cases had been preselected as being identified as suicides and it was outwith the remit of this paper to confirm the cause of death.

### 6.2 Indicative risk factors

All five young people had the following risk factors present over their lifetime, however, there is not sufficient evidence to indicate these can be seen as primary individual, or even collective, risk factors.

- Bullied
- Housing / homelessness issues
- Abuse and exploitation
- Antisocial / aggressive behaviours
- Absconding

- Mental health concerns (not necessarily diagnosis)
- Alcohol misuse
- Parental separation / divorce / relationship problems
- Parental mental illness
- Parental aggression / domestic violence

How these indicators combine with other risk factors, chronic or acute, remains unknown and requires further investigation with a larger population and within a longitudinal methodological framework. It is also worth reiterating that as the young people were at some time looked after and accommodated away from home, living away from parents is another risk factor common to all (Evans 2004), although not all were away from home at the time of their deaths.

All of the young people had been recorded as having issues with housing and / or homelessness over their lifetimes. The average number of care placements was six, reflecting the instability of their lives. Of note all of the young people had experienced significant lifetime events which were classed as "acute life crises" including bereavement, sexual assault, close relatives being imprisoned and childbirth. All children had been the victims of childhood abuse and four presented with indicators of continuing sexual abuse and exploitation into their teens.

Lifetime parental mental illness and parental relationship discord and aggression were ubiquitous in this group. There were also high rates of parental substance misuse. This highlights the need for early identification and intervention in families and relationships, as a possible means of promoting protective factors for child development.

All the young people had been able to form social relationships during their lifetime, but they had all also been victims of bullying at some point as well as the majority also being perpetrators of bullying. This suggests ongoing difficulties in peer relationships in this group. Three of the young people were noted to be becoming more isolated in the month before their death and rates of contact with parents and siblings in the month before death were low, suggesting a lack of supportive familial relationships.

The majority of the group were unemployed or not attending an educational placement again highlighting the lack of protective factors in this group.

All the young people had a lifetime history of anti-social/aggressive behaviour and absconding, but it is interesting that there was no clear pattern of escalating behavioural problems in the month before death. The majority of the group also had a history of criminal charges with one having a court appearance in the month before death. All of the young people had a lifetime history of alcohol misuse with most having a lifetime history of recreational drug misuse. Substance misuse tended to commence at a young age, and smoking in a couple of cases at a very young age. There were significant concerns with regards to the mental health of this group of young people over their lifetime, with all having been referred to CAMHS. However, it was also recorded that there were significant problems with engagement with CAMHS in this group. Two young people were being treated for a mental disorder at the time of their death, one under the care of their GP and the other was attending CAMHS.

There were also high rates of physical health complaints with most of the group having consulted their GP in the year before death and in one case there had been fourteen consultations during this period. Four young people had a lifetime history of chronic illness, mainly asthma. Annual LAAC Health reviews did appear to be occurring in a timely manner.

Lifetime rates of deliberate self harm were high within the group. In the month before death one young person had self harmed and one young person had reported thoughts of wanting to harm themselves. It is interesting that one young person had never self harmed, attempted suicide or voiced suicidal ideation before committing suicide – and concerning that the absence of self harm, suicide attempts or suicidal ideation does not exclude the risk of completed suicide. A limitation, as in any case file review, is the difficulty in differentiating thoughts and acts of self harm from suicidal intent.

Multiple service involvement was common to all cases throughout the lifetime and in the months preceding death. Unfortunately, either whilst in the care of the local authority or within two years of leaving care these young people committed suicide. Several years of

involvement, and for some a lifetime input, from numerous services does not seem to have addressed many of the underlying issues for this group of young people.

Despite the apparent lifetime adversity for these young people, their chronic or acute circumstances do not appear to be fundamentally different to many other looked after and accommodated young people. The results highlight substantial adversity, exposure to traumatic life events, risk factors for suicide and a lack of protective factors in this group. However, any professional working with young people involved with social work services will recognise these themes in this group of young people, the majority of whom do not go on to commit suicide. The fact that most young people who self harm do not commit suicide presents extreme complexities in the decision making process, and attempting to assess who may be at 'higher' risk, requires further investigation to support professionals in undertaking risk assessments and developing management plans. All the factors present for these young people may be a starting point, but they cannot be seen as the key risk indicators for a wider population.

From background circumstances and life events it is difficult to see how the suicides could have been predicted from the applicable risk factors in individual cases. Some of the young people had been seen by professionals in the weeks prior to their death and there were no concerns identified with regards to immediate risk of suicide. Similarly, any missed appointments or meetings cannot be linked directly to the deaths. Interestingly, a recent Care Inspectorate (2013) report intimates that when young people had died as a result of self harm, conclusions by local authorities that the deaths could have not been foreseen may not be supported by the evidence. The report cited evidence that most of the children had made threats of self-harm or had previously harmed themselves and that professionals did not always recognise risk factors. However unfortunately self harm and threats of self harm are not sensitive or specific predictors for future suicide and therefore can only alert professionals to the need for closer assessment to identify appropriate interventions as the majority of young people who self harm do not go on to commit suicide.

Overall, there are few definitive conclusions that can be drawn from this present work, beyond messages of continued vigilance and awareness of suicide risk amongst young people in the care system. Similarly, while there were some problems with access to services,

engagement and regularity of contact at various stages, it is not possible to identify any one factor, or a number of factors, that could have prevented, or predicted, the final outcome. The indicative findings suggest that further work is required to build on this baseline evidence to support professionals in decision making, risk assessment and management. This work needs to link into the wider discourse around suicide prevention and reduction programmes; although the difficulties of intervening effectively to prevent suicide are substantial (Platt 2011).

### 6.3 Future Work

From this work it is evident that further research with a larger sample size and a comparison group of similar young people who have not committed suicide is indicated to provide further in depth understanding of the issues in Glasgow. The authors would have wished to have undertaken analysis of a comparison group but due to constraints of time and resources only the original remit could be completed. It would also be valuable to follow up prospectively a group of young people who become looked after and accommodated. A carefully designed study could address the difficulties in interpretation from case file reviews particularly with regards to subjective items and the risk of lack of recording of relevant data. To facilitate future research the issue of retention of health records after death requires to be addressed.

The matter of obtaining and recording information with regards to educational attainment would be useful to explore as this may be an indicator for risk of suicide and is an area where an appropriate intervention may be able to reduce overall risk. Future work may wish to gain appropriate agreement to access educational records. Consideration with regards to the documentation of the nature of relationships between the young person and the keyworker and the young person's personality factors may aid reflection of these areas by professionals and the young person, which may then inform care planning. This may also assist professionals in the development of therapeutic relationships with the young person. It was outwith the remit of this paper to consider the types of interventions offered and their outcomes, although evidence from previous work in Glasgow indicates problems in identifying the type and nature of work undertaken (Cowan 2006). Clear understanding of work undertaken would be invaluable to identify targeted interventions in this vulnerable group.

It would be appropriate to consider dissemination of the findings of this paper to social workers, health clinicians and other relevant professionals. While this paper aims to aid understanding of the risk factors in a group of young people who committed suicide to inform future practice developments, it should also aid professionals in identifying risk and appropriate and timely interventions in similar vulnerable young people.

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# Appendix 1 - Suicide Review Audit Tool

## Static Risk Factors

| Key Indicator | Individual Risk Factors | Outcome | Comments |
|---|---|---|---|
| **A. Background** | Gender | | |
| | Age at death | | |
| | Cause of death | | |
| | Accommodation at death (with family/foster family/children's unit/secure unit/other) | | |
| | Legal status at death (voluntary/supervision order/under MHA/other) | | |
| **B. Social** | Social disadvantage: DEPCAT/SIMD score for first known address – record postcode | | |
| | Urban/rural – whether from urban/rural area U/R | | |
| | Highest level of educational attainment (standard grade/higher/other) | | |
| **C. Social Work History** | Key worker at time of death identified Y/N and description of nature of relationship with keyworker – engaged, positive, difficult to engage etc | | |
| | Age first known to SW | | |
| | Reason first known to SW | | |
| | Child protection investigation lifetime Y/N | | |
| | Age first placed on child protection register | | |
| | VYP age first | | |
| | Age first at children's hearing | | |



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|---|---|---|---|
| | Age first placed on supervision order | | |
| **Key Indicator** | **Individual Risk Factors** | **Outcome** | **Comments** |
| | Age first LAC | | |
| | Reason for LAC | | |
| | Legislation for LAAC | | |
| | Age first LAAC | | |
| | Number of placements | | |
| | Major placement type – most common placement type e.g. foster family/children's unit/secure unit/other | | |
| | Length of time LAAC | | |
| | Age left care | | |
| | Evidence of recent care plan (within 6 mths prior to death) Y/N | | |
| **D. Familial** | History of parents being sexually abused Y/N state nature | | |
| **E. Substance use** | Age when started drinking alcohol | | |
| | Age when started taking drugs | | |
| **F. Mental Health** | Autistic Spectrum Disorder traits Y/N | | |



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## Risk Factors – to record over time periods

| Key Indicator | Individual Risk Factors | Lifetime | Last 12 months before death | Last 1 month before death | Comments |
|---|---|---|---|---|---|
| **1-Social** | Employment status<br>E= employed, U= unemployed<br>A= attending educational placement<br>N= not regularly attending provided educational placement | | | | |
| | Bullying victim (state if physical or verbal) Y/N | | | | |
| | Bullying perpetrator (state if physical or verbal) Y/N | | | | |
| | Social Relationships (evidence of friends/romantic relationships) Y/N | | | | |
| | Physically abusive Relationship (evidence of being in such an abusive relationship) Y/N | | | | |
| | History of friend completing suicide Y/N | | | | |
| | History of friend attempting suicide Y/N | | | | |
| **2-Social Work History** | Interventions – other services involved e.g. befriender/drug and alcohol services/other | | | | |
| | Accommodation issues – e.g. homeless/other | | | | |
| **3-Familial** | Parental separation or divorce<br>Y/N | | | | |
| | Parental mental illness Y/N, state nature | | | | |


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|---|---|---|---|---|---|
| | Parental aggression Y/N | | | | |
| **Key Indicator** | **Individual Risk Factors** | **Lifetime** | **Last 12 months before death** | **Last 1 month before death** | **Comments** |
| | Parental alcohol misuse Y/N | | | | |
| | Parental substance misuse Y/N | | | | |
| | Parental death Y/N | | | | |
| | Family history of completed suicide Y/N | | | | |
| | Family history of attempted suicide Y/N | | | | |
| | Marital discord – do parents have an acrimonious relationship Y/N | | | | |
| | History of childhood abuse – Y/N, state if physical, sexual, emotional or neglect | | | | |
| | Evidence of ongoing relationship with parents - contact with parents Y/N and comment on nature of contact e.g. written, visits, overnight visit, supervised/unsupervised | | | | |
| | Evidence of ongoing relationship with siblings contact with siblings Y/N and comment on nature of contact e.g. written, visits, overnight visits | | | | 48 |
| **4-Personality /Behavioural** | Low self-esteem/social inadequacy Y/N | | | | |
| | Hopelessness Y/N | | | | |
| | Introversion –or described as shy Y/N | | | | |

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|---|---|---|---|---|---|
| | Anger – Y/N | | | | |
| | Anti-social behaviours – aggressive or violent Y/N and comment on nature e.g. verbal/physical | | | | |
| **Key Indicator** | **Individual Risk Factors** | **Lifetime** | **Last 12 months before death** | **Last 1 month before death** | **Comments** |
| | Sexuality – concerns from young person re sexuality Y/N<br>State sexuality if known | | | | |
| | Absconding – Y/N, state where absconds to e.g. to a specific place or opportunistic | | | | |
| **5-Forensic** | Criminal charges Y/N | | | | |
| | Court / CH appearances regarding criminal charges Y/N | | | | |
| | Custodial sentence Y/N | | | | |
| **6-Mental Health** | Mental illness diagnosis Y/N | | | | |
| | Psychiatric admission Y/N | | | | |
| | Low mood symptoms Y/N | | | | |
| | Anxiety symptoms Y/N | | | | |
| | Eating disorder symptoms Y/N | | | | |
| | Psychotic symptoms e.g. hallucinations/delusions Y/N | | | | |
| | Referral to CAMHS | | | | |
| | Input from CAMHS | | | | |
| **7-Health** | GP consultations – number in last 12 months only and | | | | |

| | | | | | |
|---|---|---|---|---|---|
| | reason for attendance | | | | |
| | LAAC Nurse Consultations in last 12 months only Y/N | | | | |
| | Smoker Y/N | | | | |
| | Alcohol use Y/N | | | | |
| | Alcohol misuse Y/N | | | | |
| | Alcohol addiction Y/N | | | | |
| **Key Indicator** | **Individual Risk Factors** | **Lifetime** | **Last 12 months before death** | **Last 1 month before death** | **Comments** |
| | Recreational Illicit drug use Y/N | | | | |
| | Drug addiction Y/N | | | | |
| | Other substance use Y/N State if aerosol/legal high etc | | | | |
| | Risky sexual health behaviour Y/N and state nature e.g. unprotected sex, older partners, soliciting | | | | |
| | Chronic illness – e.g. chronic pain or debilitation Y/N and state nature | | | | |
| **8-Acute Life Crises** | Bereavement of close relative or friend Y/N | | | | |
| | Other – any other significant issues, state nature | | | | |
| **9-History of self harm** | History of cutting Y/N | | | | 50 |
| | History of overdose Y/N | | | | |
| | History of attempted hanging/self strangulationY/N | | | | |
| | Other attempts at self harm Y/N | | | | |

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|---|---|---|---|---|---|
| | Voiced suicidal ideation/self harm thoughts Y/N | | | | |

COMMENTS FROM SCR / CASE REVIEWS ETC

| JOINT | SOCIAL WORK | HEALTH |
|---|---|---|
| | | |

OTHER COMMENTS