

1

Background

Over the past decade, the national suicide rate among young people has steadily increased. This trend was also observed locally therefore, in 2023 the Pan-Lancashire Child Death Overview Panel (CDOP), in collaboration with Public Health, commissioned a thematic review of suicide in children and young people. From this review, key themes were identified, and system wide recommendations were made. In 2021 the National Child Mortality Database (NCMD) published a thematic review on [Suicide in Children and Young People](#) incorporating data from CDOP's across England. In 2024 the NSPCC published [Suicide: learning from case reviews](#). These reviews saw system wide learning and recommendation outputs.

2

Why is it important?

Suicide is everyone's business. The tragic loss of a child due to suicide has far-reaching consequences for family, friends, their peers and the rest of society. Suicide is complex and can be impacted by a range of psychological, social, economic and cultural risk factors.

We need to understand who is at risk, the lived experiences of children and young people, and the response of services when raising awareness, address the stigma and prevent. Reviews undertaken identified vulnerabilities commonly seen in cases of child suicides, including complex home circumstances, bullying, loss of key relationships, existing mental health needs, bereavement and risk-taking behaviours.

3

Local learning

Learning from local reviews is reflective of the findings identified in national reviews.

Complex home circumstances, the presence of traumatic events, the [voice of the child](#), their lived experience as a whole and the effect of trauma should be at the centre of suicide prevention and risk management. When risk is identified, a multi-agency approach was identified to be more effective, as well as ensuring timely information sharing and escalation when appropriate to manage risk.

4

National learning

The need to recognise risk factors and take in to account the lived experiences of children and young people was recognised within national reviews undertaken. To effectively work to prevent suicide, agencies and professionals should work to understand the connectivity of risk factors and ensure that there is effective multi-agency working and information sharing. The voice of the child should be at the core of work to prevent suicide.

5

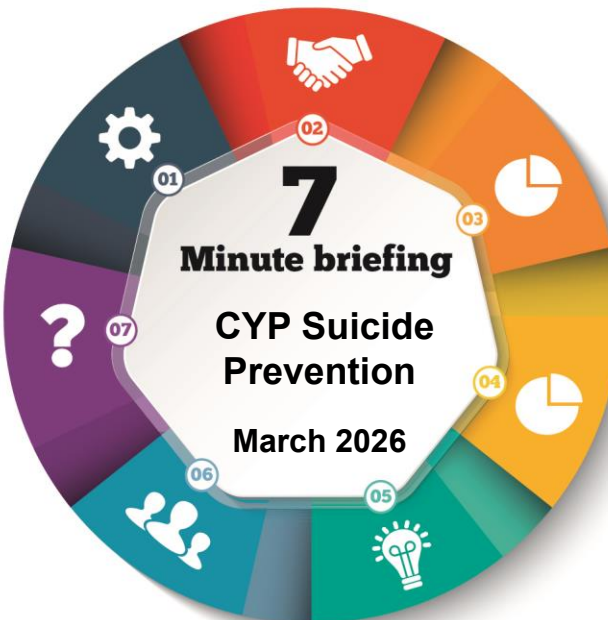
What has been done?

Local authorities, in collaboration with multi-agency partners, have developed suicide prevention strategies and action plans.

Each local authority has their own suicide prevention strategy:

- [Lancashire](#)
- [Blackburn with Darwen](#)
- [Blackpool](#)

Suicide prevention is delivered on both a local and a Lancashire and South Cumbria (LSC) footprint in line with LSC workstreams.



7

Resources

Public Health commissioned training for staff:

- [Blackburn with Darwen](#)
- [Lancashire](#)
- [Blackpool](#)

Helplines, text lines & Hubs

- [Shout](#)
- [Papyrus & HopelineUK](#)
- [MIND & Young Minds](#)
- [Samaritans](#)
- [Initial Response Service](#)
- [Hub of Hope](#)
- [Blackpool Light Lounge](#)
- [Elliot's Place](#)

Other

- [Kooth](#)
- [Amparo](#)
- [Togetherall](#)
- [Think Family](#)(Lancashire)
- [Think Family](#) (Blackpool)
- [Solace](#) (Blackpool)
- [NHS Suicide Prevention Toolkit](#)
- [NCISH Annual Report](#)

6

What can I do?

You can increase your knowledge of suicide awareness by completing suicide awareness training - [LSC Integrated Care Board :Lancashire and South Cumbria Suicide Prevention Training Consortium](#).

You can familiarise yourself with key organisations such as the Hub of Hope and MIND and support key health promotion days such as [World Suicide Prevention Day](#). The voice of the child is key, ensure that you understand their lived experiences whilst supporting children and young people. Remember to 'think family' whilst working to provide support.