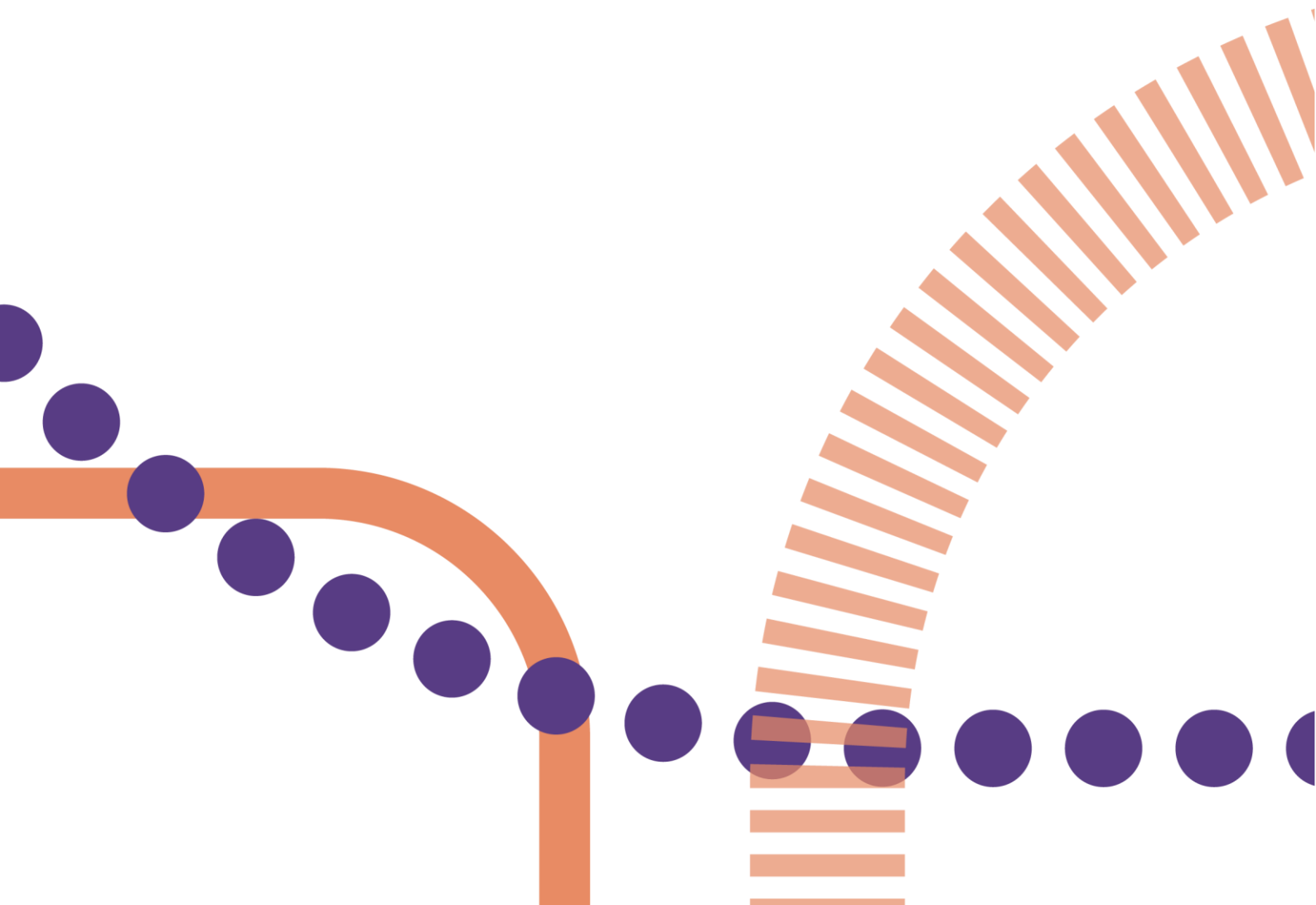
THE CHILD **SAFEGUARDING**
PRACTICE REVIEW PANEL

Adolescent suicide

The child behind the story: understanding cumulative harm through lived experience

July 2026



Introduction

Adolescence, defined by the World Health Organization as the developmental stage between the ages of 10 and 19, is widely recognised as a key transitional period. Although overall mortality during this stage is low, suicide is one of the leading causes of death among children in England and therefore accounts for a disproportionate number of deaths within this age group.

The Child Safeguarding Practice Review Panel's Annual Report 2024–25 highlights that suicide has been the second most common cause of death in serious child safeguarding incidents reviewed by the Panel in recent years, most often involving older adolescents. These serious incidents involve circumstances where children have died or been seriously harmed and abuse or neglect is known or suspected, and they sit within the broader national context of suicide in children and young people.

This briefing draws on learning from serious child safeguarding incidents relating to adolescents who died by suicide and abuse or neglect is known or suspected and includes a small number of incidents where children suffered serious harm through self-harm or actions intended to end their life.

National evidence shows that adolescent suicide is rarely the result of a single factor, but reflects interacting and often cumulative influences, including mental health, adversity, relationships, and wider social factors. Suicide should therefore be understood within the context of children's lived experiences, rather than as an isolated incident. Self-harm can feature in the lead-up to suicide, but should not be assumed to be a precursor to it, and should be understood as part of a wider picture of escalating vulnerability. This briefing aims to support practitioners and leaders to reflect on how suicide risk can develop over time.

Who is this document for?

This briefing is for practitioners and leaders across safeguarding services, including professionals in health, education, children's social care, police, youth justice, and the voluntary and community sector.

It is particularly relevant for those working with children and young people whose experiences include multiple or overlapping forms of harm or adversity over time, and who may be known to more than one service, and where concerns about suicide may emerge.

How to use this resource

This briefing is a learning and reflection resource, drawing on a defined set of serious child safeguarding incidents. It is intended to support professional curiosity and discussion about how suicide risk may develop and escalate over time, particularly where children and young people have experienced multiple and overlapping forms of harm or adversity. It is not intended to provide a comprehensive overview of adolescent suicide and should be used alongside local and national guidance.

Practitioners and leaders are encouraged to use this resource in supervision, team discussions, learning events, or multi-agency forums to reflect on practice and explore how cumulative harm can be better understood from the child's perspective.

Why is it important for children and young people?

Taking a holistic view of children's experiences and considering how cumulative harm may relate to suicide risk is essential for understanding how existing vulnerability can be compounded and intensified.

This perspective helps practitioners to recognise how distress or feelings of overwhelm may build and contribute to thoughts of suicide. Focusing only on the point of crisis can miss how risk has developed across different aspects of a child's life.

A cumulative and child-centred approach supports earlier recognition of vulnerability and a more informed understanding of children's experiences, rather than viewing incidents as isolated.

What is the evidence base?

National data highlights the scale of suicide among children and young people in England. The latest Office for National Statistics data shows that 204 suicides were registered among young people aged 15 to 19 years in England in 2024, alongside 18 among children aged 10 to 14. This is an increase from 168 deaths by suicide among 15 to 19-year-olds in 2022.

The Child Safeguarding Practice Review Panel (the Panel) sees only subset of these deaths because it reviews serious incidents where abuse or neglect is known or suspected to be a factor. Between 1 April 2024 and 31 March 2025, the Panel was notified of 20 children who had died by suicide. Suicide has consistently been the second most common likely cause of death over the last three reporting years, with 64 suicides accounting for 14% of the 454 deaths reported to the Panel during this period (see our most recent Annual Report).

Evidence shows that some children and young people are more at risk than others. The Office for National Statistics undertook a large longitudinal study following children and young people in England between 2011 and 2022. Higher risk was identified among boys and young people with Special Educational Needs, as well as broader differences in risk linked to family circumstances, living arrangements, and wider social and economic context. Variation in suicide is also seen between ethnic groups, reflecting complex social and contextual influence, rather than a single explanatory factor.

Research consistently shows that suicide is associated with multiple, interacting factors rather than a single event. Evidence from the National Child Mortality Database (2021), NSPCC case reviews (2024), and the Royal College of Paediatrics and Child Health (2020) highlights a combination of adversities, including personal loss, bullying, neurodevelopmental needs, abuse or neglect, family conflict, and social isolation, which can interact and build over time. Research also identifies increased vulnerability among some groups, including young people who identify as LGBTQ+, often linked to experiences such as discrimination and social isolation. Across research, many children were in contact with multiple services prior to their death. Although signs of risk were often

present, these were not always fully recognised or responded to as risk escalated. Further information and links to the research referenced in this section are provided below.

Key facts and figures

The figures below draw on a sample of rapid reviews relating to serious incidents between 1 July and 31 December 2025, including 20 deaths by suicide and 2 incidents of serious harm following self-harm. The Panel examined this recent sample to provide an up-to-date picture of the children involved and to compare findings with the 3-year trends described above.

While the sample is relatively small, the findings are broadly consistent with those longer-term trends and provide a useful snapshot of the most recent incidents seen by the Panel.

Age

- 55% of children were aged 16–17
- 45% of children were aged 11–15

Ethnicity

- 59% of children were from White backgrounds
- 14% from Mixed or Multiple ethnic backgrounds
- 14% from Asian or Asian British backgrounds
- 9% from Black or Black British backgrounds
- 5% from Other ethnic backgrounds

Gender, identity, and sexual orientation

- 55% of children were girls and 45% were boys.

- Information on sexual orientation and gender identity was not recorded in most of the reviews in the sample (20 children). One child was identified as LGBTQ+. There is a learning point here for everyone conducting safeguarding reviews about the importance of including as much information as possible about all aspects of the child's identity if we are to learn as much as possible from these tragic incidents.

Mental health and support

- 91% of children had a recorded mental health need (diagnosed or undiagnosed), most commonly low mood, anxiety, self-harm, and suicidal thoughts. These often co-existed with other difficulties, including trauma and emotional dysregulation.

- Needs were not always clearly identified or consistently recorded, including whether conditions were formally diagnosed.

- Around half of children were receiving support at the time of the incident:

    - 41% were open to CAMHS
    - 23% had previously been known or referred to CAMHS

Disability and additional needs

- Additional needs were commonly identified and often overlapped with mental health needs.
- 36% of children had a recorded disability. A further 18% had a suspected disability. Needs included a mix of mental, physical, and learning or developmental difficulties.
- 41% were described as neurodivergent, although the specific nature of these needs was not always recorded (for example, autism or attention deficit hyperactivity disorder).
- Speech and language needs were identified in a small number of cases, although recording was inconsistent.

Prior harm and service involvement

- Most children were already known to services, indicating that suicide often occurred in the context of existing concerns.
- 90% were known to children's social care, either at the time of the incident or previously. At the time of the incident, 27% were on a Child in Need plan, 14% on a Child Protection Plan, and 19% were in care.
- Children had experienced a range of harms prior to death or serious harm, including:
    - neglect (55%)
    - physical abuse (55%)
    - domestic abuse (45%)
    - emotional abuse (36%)
    - sexual abuse or exploitation (32%)
    - bullying (18%)

Around three quarters (73%) experienced more than one form of harm, indicating the multiple and overlapping forms of harm and adversity experienced by so many of the children described in these serious incidents.

Common issues

Learning from the reviews identified several recurring themes. These themes rarely occurred in isolation and often interacted over time, shaping children's experiences and increasing vulnerability.

Harm and adversity were often experienced together

Children frequently experienced more than one form of harm, including abuse, neglect, and bullying, alongside mental health or additional needs.

Escalating risk over time

Suicide was frequently preceded by earlier concerns, including self-harm, overdose, or suicidal thoughts, with many children already known to services.

Ongoing and repeated service involvement

Many children were known to multiple services over time, reflecting recurring or sustained needs; however, the Panel can see from the reviews that this did not consistently translate into relational practice, shared understanding, or coordinated risk assessment.

Coordination across services

Involvement from multiple agencies did not always result in a shared understanding of risk or coordinated response.

Mental health needs and ongoing distress

Many children experienced complex and overlapping emotional and mental health needs alongside other adversities. As these became more familiar over time, they were not always responded to with sufficient urgency or depth.

Ethnicity and identity

A substantial proportion (42%) of children in the rapid review sample were from Black, Asian, Mixed or Multiple, and Other ethnic backgrounds (compared to the child population of England). While patterns of need and service involvement were broadly similar, children's experiences are best understood within the context of intersecting factors, including identity, culture, and wider circumstances.

Neurodiversity, disability, and additional needs

A notable proportion of children had identified or emerging additional needs, forming part of a wider picture of their experiences.

Understanding needs and experiences

Key aspects of children's needs and identity were not always brought together, limiting understanding of risk. Limited time and changes in professionals reduced continuity of relationships, making it harder to build trust and reducing opportunities for professional curiosity to explore less visible aspects of their lives.

Experiences of education reflected additional need

While most children in the rapid review sample were in education, some experienced absence, exclusion, or were not in education, employment or training. A proportion were also receiving SEND support or undergoing assessment for an education, health and care plan (EHCP), indicating additional needs alongside other difficulties.

Care experience and living arrangements

Some children were living in care or institutional settings, including residential care or hospital, often following significant adversity. Entering care was not always recognised as a potential source of trauma, and support arrangements could carry assumptions that risk had reduced. Children's ongoing vulnerability was not always understood in the context of their prior experiences, and corporate parenting responsibilities were not consistently reflected in how risk was identified and managed.

Hallmarks of good practice

The reviews also identified features of practice that helped professionals better understand children's experiences, recognise escalating vulnerability, and respond to risk.

- Seeing children’s experiences as part of a cumulative picture of harm, distress, and need over time, taking account of repeated experiences and ongoing service involvement rather than responding to incidents such as self-harm or suicidal thoughts in isolation.
- Maintaining a holistic understanding of the child’s lived experience, including harm, poor mental health, family relationships, education, and care experience.
- Avoiding premature withdrawal of services where concerns remain, maintaining professional curiosity, and bringing together information across services to develop a shared understanding of risk over time.
- Sharing information effectively across services to support coordinated responses and avoid fragmented understanding.
- Ensuring safety planning is developed collaboratively, shared appropriately with relevant professionals and family members, and reviewed as risk changes over time.
- Recognising that distress may be expressed in different ways, particularly where there is trauma, neurodiversity, or disability.
- Maintaining consistent relationships and support to enable children’s experiences and changing needs to be understood over time, supported by conditions that enable relational practice, including appropriate caseloads and resources aligned.
- Recognising that children receiving support, including those who are looked after, may remain vulnerable and can continue to experience harm and distress. This includes questioning assumptions about reduced risk, maintaining professional curiosity, and understanding children within the context of their lived experiences. Corporate parenting responsibilities should be reflected in responses to ongoing vulnerability.

Reflective questions and discussion points

These reflective questions and discussion points can be used by multi-agency practitioners and leaders in team meetings or supervisions to help you explore the issues raised in this briefing paper.

For practitioners

1. How do you build an understanding of this child's lived experience over time, including previous service involvement, and consider what presentations such as self-harm or suicidal behaviours may indicate about wider distress and risk?

2. How do you recognise that distress may be expressed differently, including for children with neurodiversity, disability, or additional needs?

3. Are you able to recognise escalating vulnerability? What helps you to do that?

4. What assumptions related to race, ethnicity, identity, or care experience might influence how you understand or respond to this child and their situation? How well do you understand all aspects of the child's race, ethnicity, identity or care experience – where might there be gaps in your knowledge or understanding?

5. How do you ensure that the child's voice and lived experience are understood and not lost within assessments, processes, or service thresholds?

6. When a child is receiving support, including being looked after, how do you remain alert to ongoing vulnerability, rather than assuming risk has reduced?

For leaders

1. How might supervision, including reflective or clinical supervision where appropriate, support practitioners to think critically, reflect, and explore uncertainty, rather than focusing only on case management? What models or approaches support this?

2. How do you ensure practitioners can access and use historical information, alongside current concerns, to develop a shared understanding of children's lived experiences across services?

3. What enables or limits continuity in professional relationships, and how do workforce pressures and caseloads affect practitioners' ability to understand and respond to children's needs?

4. How do you create a culture that supports professional curiosity, respectful challenge, and recognition of different presentations of distress, including for children with neurodiversity, disability, and those from different racial and ethnic backgrounds?

Case study 1

This Local Child Safeguarding Practice Review (LCSPR) shows how harm across different areas of a child's life can build over time, increasing vulnerability to suicide, particularly where information is not brought together across services. Read the full LCSPR available on the Kent Safeguarding Children Multi-Agency Partnership website.

Molly was a 14-year-old girl of White British heritage who died in 2024 after taking her own life. She was registered as a young carer from the age of 9, supporting her

mother, who had significant mental and physical health needs. Although her older sister was considered their mother's primary carer, Molly had regular caring responsibilities, which likely increased during periods of time when her older sister was not staying at home.

Molly's parents separated when she was 6 and her contact with her father decreased over time. Services did not routinely involve or share information with him, and some understood from Molly's mother that he did not have parental responsibility, which was not the case. Her father raised concerns to services about Molly's wellbeing and reported being concerned about what he saw her posting on social media in the period before her death.

Molly's school recorded persistent low attendance and raised concerns about unmet basic needs. A possible autism assessment was discussed but not progressed. Although Molly reported anxiety about school, she also received support there and valued her close friendships. School supported Molly to complete a referral to an emotional wellbeing service, where her self-harm and suicidal thoughts were discussed. The devised safety plan was not shared with those who needed to know and decisions about educating at home were also not properly communicated.

Following a decision for Molly to be electively home educated, uncertainty about what she should be doing regarding schoolwork caused additional pressure in the home. Molly also lost access to school-based support and had reduced contact with her close supportive group of friends.

Key information about Molly's circumstances was not consistently brought together across services, and in the period prior to her death where there was less professional oversight as a result of elective home education. Molly's deteriorating mental health including self-harm, suicidal thoughts, disordered eating, and an overdose, was not fully understood or responded to.

Learning points:

- Recognising cumulative harm, where caring responsibilities, unmet needs, family circumstances, and disrupted education combine to increase risk.
- Identifying and responding to emerging needs, including potential neurodiversity, particularly where these may underpin school non-attendance and emotional distress.
- Recognising self-harm and suicidal thoughts as indicators of escalating risk, requiring a coordinated multi-agency response.
- Ensuring effective communication between adult and children's services, particularly where parental health needs may impact a child's daily life.
- Bringing together information from different services, including school concerns, disclosures, and family context, to develop a shared understanding of risk.
- Where concerns exist, a clearly identified professional is needed to maintain an understanding of a child's wellbeing and risk, particularly when withdrawal from school reduces contact, visibility and access to support.

- Ensuring the decision to withdraw a child from school involves all those with parental responsibility and is clearly understood, including the implications for support, monitoring, and access to services.

Case study 2

This Local Child Safeguarding Practice Review (LCSPR) demonstrates how multiple and interconnected vulnerabilities can develop and escalate over time, increasing suicide risk, particularly during periods of transition and instability. Read the LCSPR executive summary available on the Southwark Safeguarding Partnership website.

H was a 16-year-old young person of White and Turkish Cypriot heritage who experienced significant adversity from an early age. Her parents separated when she was 10, and her mother's mental health deteriorated, leading to instability at home

At 12, H shared that she identified as a girl and subsequently experienced bullying, social exclusion, and discrimination at school. This period also marked notable behavioural changes, which led to her moving between family members due to concerns about her behaviour and the family's ability to manage her needs.

By 13, H had tried to die by suicide and continued to experience low mood and suicidal thoughts. Services were involved with H and her family for several years, responding to concerns including parental mental health, low school attendance, and emerging mental health difficulties. H received support from CAMHS and was referred to gender identity services; however, contact with services was not consistent over time.

At 15, risks escalated significantly, including missing episodes, exploitation, and substance use. At 16, she entered care when her family felt unable to keep her safe. While in care, her vulnerability increased further, with frequent missing episodes, multiple placements, and ongoing exploitation, including involvement with an adult male.

In the period before her death, H was living in semi-independent accommodation but often stayed away. She remained in contact with the individual exploiting her, who assaulted her on the day of her death.

Learning points:

- Developing a holistic understanding of how mental health, identity, exploitation, family adversity, care experience, and education interact over time.
- Recognising the impact of transitions, particularly entry into care, as a potential source of trauma requiring coordinated support.
- Identifying and responding to emerging and unmet needs, including how these affect relationships, education, and wellbeing.
- Recognising the impact of bullying, discrimination, and disrupted education on isolation and vulnerability.

- Maintaining professional curiosity, particularly where concerns persist, including recognising indicators of exploitation and challenges in sustaining engagement.
- Strengthening multi-agency coordination and communication, particularly during transitions, and ensuring children's needs, including gender identity, are recognised and supported, including while awaiting specialist services.

Further resources

Find more information on the Panel's online learning hub: https://childsafeguarding.independent-panel.uk/hub-topic/adolescent-suicide where you can access other resources on this topic.

Suicides in England and Wales - Office for National Statistics

National Child Mortality Database (2021) – Suicide in children and young people

Office for National Statistics (2025) – Risk factors for suicide in children and young people in England (2011–2022)

NSPCC – Suicide: learning from case reviews (2024)

Royal College of Paediatrics and Child Health (2020) – State of Child Health: Suicide

Stonewall (2017) – School Report: The experiences of LGBT pupils in Britain's schools

The Trevor Project (2024) - United Kingdom Survey on the Mental Health of LGBTQ+ Young People

NICE – Self-harm: assessment, management and preventing recurrence (NG225)

NHS England – Staying safe from suicide: best practice guidance

NHS England / MindEd – Self-harm and suicide prevention learning and resources

Office for Health Improvement and Disparities – Suicide prevention guidance and resources

National Confidential Inquiry into Suicide, Homicide and Safety in Mental Health (NCISH): Implementing a personalised approach to risk