Browne Jacobson

Advocacy in Action: Inquests, suicide and self-harm

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Pupil A was, seemingly, an ordinary and content 16-year-old pupil. He had underperformed in his GCSEs but had ultimately obtained the grades he needed to study his chosen A-Levels and was making active plans to study at university. The Designated Safeguarding Lead at his school had become aware that Pupil A had experienced low mood in previous years and had self-harmed in the past. The DSL consulted with safeguarding colleagues at the school and was regularly engaging with Pupil A to monitor his well-being. Pupil A was in receipt of medication to manage severe and longstanding headache symptoms but his presentation at school did not give rise to any particular concern for his welfare. Sadly, and unbeknownst to Pupil A's family, healthcare providers or school, he was struggling to manage his situation and ended his own life with an intentional overdose of his prescribed medication one night in his bedroom.

Suicides amongst young people are, sadly, on the rise, with possible causes including increased incidence of family bereavement, bullying associated with sexuality and gender identity, and an emerging trend for suicide-related internet use. Despite the best efforts of educational settings, it must also be recognised that the series of COVID-19 related lockdowns throughout 2020 may have had a detrimental impact on the mental health and home lives of many vulnerable pupils and may also have reduced schools' ability to identify and act on safeguarding concerns.

In the case of Pupil A, Browne Jacobson Barristers represented the school in preparation for and at the inquest. The school was granted Properly Interested Person status and was asked to provide witness evidence very late on in proceedings. The school had not been invited to the Pre-Inquest Review Hearings and at the point we were instructed had little information about the scope and purpose of the inquest. The school was keen to assist the Coroner's inquest process but was, understandably, anxious to understand what the issues and risks might be.

Once instructed, our Senior Associate Barrister, Ian Perkins, was able to engage with the Coroner's Office to quickly obtain all of the procedural history and relevant evidence. We identified a number of key areas which were likely to be explored at the inquest, including the school's level of knowledge as to Pupil A's prior self-harm, whether the school was or should have been aware that Pupil A had suicidal thoughts, whether its monitoring had been sufficient and whether it had erred in not sharing the limited information it had with others. In addition, we identified some other areas such as bullying, exam performance and absence which, whilst not central to the inquest, might be used to generate criticism if not properly considered. We met with the school and its witnesses, who had never previously attended an inquest, to ensure that they knew what to expect and that their evidence would address the relevant issues.

At the inquest itself all of the issues identified were indeed raised, but our preparations ensured that the school was able to demonstrate that there had been no failings or missed opportunities on its part in Pupil A's case. However, when the actions of Pupil A's community GPs and treating consultants came under scrutiny from the Coroner, there was an attempt to suggest that Pupil A had expressed school-related anxiety to them which might have explained his poor mental health. Having a barrister at the hearing meant the school was well

placed to question the medical professionals and able to demonstrate to the Coroner that this evidence was not in fact consistent with Pupil A's medical notes and that had Pupil A expressed such concerns this would likely have been recorded.

By attending the inquest for the school, we were able to ensure that other Interested Parties were not able to unfairly aim criticism at the school to deflect from their own potential failings. Crucially, we were also able to ensure that issues which are common to many pupils, such as poor exam performance, occasional absenteeism and low-level disagreements with fellow pupils, were not unfairly construed as major concerns.

This case demonstrates the importance of legal representation in the lead up to and at inquests relating to pupil deaths but also highlighted a number of key lessons that, had Pupil A's school been less diligent, may have resulted in adverse findings against it. These included the need for:

- clear policies for pupil welfare, setting out the thresholds for safeguarding interventions
- safeguarding staff to be adequately trained and to take key decisions collaboratively with colleagues
- decision making to be clearly justified, rigorously scrutinised and recorded
- welfare monitoring to be accurately recorded and accessible to key staff
- information sharing around pupil welfare concerns to be supported by policies and based on clear and recorded evidence

The sad case of Pupil A also shone a light on the need for all practitioners to remember that mental health and welfare concerns are not always obvious and that young people who may be struggling can also be adept at hiding that fact from those around them. Schools may therefore need to question their existing thresholds for taking action and sharing information for potentially vulnerable pupils.

Browne Jacobson Barristers regularly appear at inquests, Disability Discrimination Act claims, EHC Appeal hearings and Independent Review Panel hearings for exclusions for both schools and local authorities. Our team of barristers also provide specialist advice and advocacy services to the Department for Education and Further Education settings and specialise in disciplinary proceedings. You can instruct one of our barristers either through Browne Jacobson's Education Team or by contacting our Lead Clerk, Claire Smith, at Barristers@brownejacobson.com or on 0330 045 2323.

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