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EXAMPLES OF RESPONDING TO CRITICAL INCIDENTS

an outline of a Psychologist's responses to traumatic incidents in schools

Calderdale Educational Psychology Service

INTRODUCTION

I have included a number of real-life critical incidents which span a period of over 20 years in order to illustrate the issues which can emerge from such work.

I have been personally involved in supporting and advising schools, centres and staff during this period.

The cases have been presented in a way which illustrated that each one is a unique event and will have its own particular slant or emphasis.

My general advice is that a calm objective supportive role will always be appreciated by those individuals tasked with managing the situation (as they will also be personally caught up in the emotions, confusions and tensions of the setting).

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Principal Educational Psychologist Calderdale 2004-
Principal Educational Psychologist Salford 1984-2002
Critical Incident Consultant Cheshire (subsequently Cheshire East & Cheshire West) 2008-
Developed Psychological Debriefing Model (for adults or children) 2000-
Trained Critical Incident teams across the UK 2004-
Trained Emergency Response Teams West Midlands
Member of West Yorkshire Emergency Planning Group

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DEFINITION

A "critical incident" is described as any significant and severe event which seriously traumatises a group of pupils, staff or whole school.

A child death clearly does this, but this may also include a bomb, serious fire or school bus accident (not always involving death).

- An incident resulting in post traumatic stress?
    - A person who experienced, witnessed, or was confronted with an unusually traumatic event/events which has both of these elements:-
        - The event involved actual or threatened death or serious injury or a threat to the physical integrity of self or others
        - The person's response involved intense fear, helplessness or horror (in children this may be expressed instead by disorganised or agitated behaviour)

- A working definition (e.g. Cheshire CIT handbook)
    - Handling crises is a normal part of school life. Some incidents, however are of a more critical and overwhelming character in which staff, pupils and parents may experience acute, even prolonged, distress.
    - Cheshire schools have for instance faced:-
        - The murder of a pupil by a stranger
        - The murder of a pupil by a parent
        - Fatal road traffic accidents
        - Serious injuries on school trips
        - Student suicides
        - The consequences of terrorist incidents
        - Major arson attacks
        - Meningitis deaths

GENERAL ISSUES

In this time I have developed a particular knowledge and experience in supporting schools responses to critical incidents (i.e. sudden child/staff deaths or major accidents). The following general issues have emerged and are applicable to most incidents .More specific features are outlined in the cases given below and are related to particular circumstances of the each of the incidents.

Complexity

Schools are rather complex organisations and represent a wide community. When there is a child death it will impinge upon the family, immediate peer group, but also teachers (past and present), other families, non teaching staff (particularly secretaries who field the telephone calls), managers of the school, religious groups, and members of the local community.

The "state of emotional health" of the institution and its leadership is a very important factor (e.g. whether there has been a recent critical inspection, a change of leadership, adverse publicity and a history if their critical incidents etc).

There is a need for external advisors to obtain an overview of the community, its history and relevant factors as soon as possible.

See Appendix 1

Nature of the incident

Clearly the level of trauma, the risk to others, clarity of the reason for the incident etc will affect the level of reaction on the part of the children. However there are some relatively minor accidents, which might be exaggerated by the response of the emergency services, which will induce a higher level of trauma in the children (e.g. the special school mini-bus incident – Case 15).
Advisors need to cultivate a calm, reassuring and knowledgeable behaviour in themselves.
Realise that it is easier to heighten the tension and concern by our behaviour.
There is a need to model and encourage calm planned response in management team.

Helplessness

In most cases schools faced with a critical incident, feel helpless and look to "experts" to sort the problem out for them. The spotlight falls upon the leadership team (or more usually the Headteacher) to guide, lead, deals with parents, press, and investigators and are given advice from all and sundry, which is often contradictory. Local Education Authorities have been very helpful as guides and suppliers of experts, but this role is becoming increasingly more difficult as LEAs staffing has been reduced and they are required to be business partners with school and to lose the traditional pastoral role they had.
There is a clear role of consultant to guide and support schools through the incident, to empower and support the leadership and ensure that the needs of the whole community are being met.

Demand for counselling

There is a culture which expects that children will automatically need counselling as a result of such as trauma. This is increased by an attitude in the press and by the feelings of helplessness outlined above. Many children under normal circumstances are attention-seeking and this typical behaviour may be exaggerated during critical incidents. It is important that staff do not overreact to such behaviour and imply that it is a serious problem.
There is a need to emphasise that the sometimes extreme responses are a normal reaction to trauma and that counselling individuals at this stage may in fact pathologise their problems.
The need for and effectiveness of natural support groups, family, school, friends during this time cannot be overemphasised.

Need to reassure parents

Schools feel a constant need to reassure parents, and teachers have a tradition in giving logical explanations to questions. When there is no clear explanation as to the reason for the trauma (particularly in the early stage of for example a case where a child hangs itself) schools will sometimes give out the theory or assumed explanation to parents which is then later shown to be fallacious thus undermining the credibility of the school.
Heads should be advised only to give factual information, other colleagues directed not to speculate and the Head to become the only conduit of all factual information as it emerges.

Role of the Media

The media is hungry for exciting stories and always wants more facts than are available. i.e. they want the details of the incident, the reactions of staff and pupils and the reason for the incident today (in order to fit today's TV bulletin or tomorrow's paper) and are unwilling to wait for a "considered" response. The level of press interest is dictated by whether or not it's a "quiet news day" or the "secondary news value" e.g. bullying, crime related, poor teacher supervision etc.
LEAs have press officers who should be briefed but sometimes the head and press officer need to be supported and guided in their management of information.

Levels of support at an incident

Not all institutions want or need the same level of support (although there is some evidence to show that some leaders, who may have had problems before the incident, would have benefited from a more extensive support at the time, had they been able to ask for it).

a) Telephone support - This is the level that many colleagues request and/or need and there is enormous value in having an independent and emotionally removed specialist to talk the issues through with.

b) Physical presence - Many individuals welcome the physical presence of the consultant in order to talk through the whole process. A model of "sitting with auntie" is usually adopted and many Heads really welcome this personal approach. In some cases it may be possible to stand by as the Head meets parents, staff, children or press, but maintain the "supporting the supporters role".

c) Guidance/debriefing role - Meeting with staff (particularly class teachers of "proximity group"), parents, other school supporters (EWO, EPs).

d) **Direct work** - with groups of children e.g. psychological debriefing.

e) **Individual case work -** with children with specific problems (very exceptional as it still remains important to work with pastoral staff within school or parents).

f) Concept of Light Touch i.e. It is important to be involved at the least intensive level but always maintain the model of facilitating the natural support systems available in the school community.
Over a number of years I have become convinced that by using a solution-focussed approach the light-touch intervention has proved the most effective e.g.

- it is a social-interaction model not a medical model of support
- it reflects the needs of children and their supporters (not our "need to be needed")
- it will allow those very needy individuals, who need intensive work, to emerge naturally
- it is manageable within our scarce resources

See Appendices ii

MODEL OF SUPPORT (see Appendix 2)

There are 3 levels of support which can be applied to school systems.

i) GROUP RESPONSES
a) Training - awareness raising, developing policies for critical incidents.
(*Increasingly needed as there is an increase in litigation by parents against schools who manage incidents badly, leaving too many casualties)*
b) Activating - facilitating the leaders, supporting the supporters to guide, inform and help children and their parents. Empowering staff to cope.
(*Most important form of support/consultation service)*
c) Peer support - using psychological debriefing to mobilize group support systems in staff and children.
(Specialized service which can be provided)

ii) INDIVIDUAL RESPONSES
a) Support for the supporters - providing guidance and counselling for individual staff/parents who are supporting the children.
(Most common and effective system of consultation where it is part of the group support)
b) Dealing with casualties - Providing direct or consultative support for individuals who may suffer post-traumatic stress reaction to the incident.
(*Many such individuals may have entered the crisis carrying an excess of emotional baggage, personal issues, or relationship difficulties from unrelated long-term existing issues)*

iii) PREVENTION OF COMPASSION FATIGUE

"Compassion fatigue" is typically described as being emotionally (and physically) work-out from carrying long-term responsibility for other people's problems and personal demands.

a) Prevention - good work-load management and supervision of staff.
b) Treatment - Counselling and job transfers.

EXAMPLES OF PARTICULAR CASES

Case 1: Adventure Holiday Death

An 11 year old girl from a Catholic school was killed on an adventure holiday. She was accompanied by 6 peers who tried to save her life.

Actions

- Advise Head to manage process and deal with staff and children when they returned from holiday.
- Provide psychological debriefing for staff.
- Provide psychological debriefing sessions for proximity peer group.

Issues

- Catholic priest no religious conflict with process (work carried out in his house).
- Centre lied to police (about the way they had dealt with the incident) and children shared concerns and these communicated to parents by children.
- Mismanagement by centre (later found guilty as it took 3 hours to rescue her in a Land Rover but RAF helicopter could have done it in 20 minutes).
- Need to set up support group before imminent move to high school.
- Individual child who was excluded from process by her parent 2 years later needed counselling.

Case 2: Death from Meningitis

An 11 year old boy who died suddenly from meningitis at an inner city school. Taken home ill on Thursday, admitted to hospital on Friday, died Friday evening.

Actions

- Advise Head to manage process. This was belated as she had 2 TV camera crews in school on Monday morning, much to the staff's displeasure.
- Debrief staff.
- Liaise with health authority.
- Work with families.
- Psychological Debriefing with class-mates.

Issues

- Main problem was the secondary issue of meningitis.
  i.e. - lack of clarity from Health Authority to staff (called them back to repeat).
  - fear in the community "dirty school" keeping children home.
  - fear from children about "black death"
  - fear of staff for their own children (in shower with scrubbing brush).
- Responses from press about frequency of meningitis nationally
- Cultural difficulty that inner-city children have in expressing emotions (did respond to modelling by EPs).
- Effective use of child planned assembly in the round.

Case 3: Road traffic death inner-city school

An 11 year old boy returning to school at lunch time was killed after being struck by several cars whilst he was crossing a road

Actions

- Advise Head to manage the process.
- De-brief staff to manage community reaction.
- Psychological debriefing for peer group.

Issues

- Dept Head (who had just obtained a headship of another school) was very embarrassed about not being able to take part in staff debriefing (it took approx 1 hour for her to say that it related to her loss of grandchild from "cot-death", therefore getting individual debriefing!).
- Severity of children's reactions (i.e. vivid imagery) related to exaggerated press reporting of ".....child being tossed like a ping-pong ball between cars before being smashed into bloody pulp....."

Case 4: Father suicide of nursery-aged child

A nursery aged child became very disturbed following the suicide of her father. Was re-referred later following the inquest hearing.

Actions

- Advise Head and nursery staff on management.
- Advise mother following second referral.

Issues

- Initial reactions more related to the adult reactions to the death, their being upset and the child reacting to this.
- Problem was later complicated by mother initially telling child that her father had "been taken ill and had died in hospital". The inquest, which was reported in the press, revealed that he had been found hanging from the stairs by his wife. The child naturally could now no longer believe anything her mother said! Moral is to be truthful within the known facts and at the child's level of understanding

Case 5: Teacher death on outward bound week with children

A popular, young, male teacher (26 years old) died in his bed on the last day of a week with his class at an LEA centre in North Wales. Some children were taken ill, as he was during the week and the doctor was called. He was an asthmatic and this was initially thought to be the cause, but he was later shown to have had an unusual virus which attacked his heart, which had a congenital defect.

Actions

- Advise the head on management of the process and also provide substantial personal support as she is a single woman living on her own.
- Debriefing the staff (particularly the school's secretary and class teacher who was with him just after he died) and the governing body
- Psychological debriefing of peer group

Issues

- Staff concern about the effects on children about being near death and their problems about managing the process whilst getting the children back safely to their parents.
- Main issue was the misinformation about asthma as the cause of death (i.e. it had been stated conclusively in the local paper) N.B. some 30% or more children have asthma and this emerged as a significant issue during the children's debriefing.

Case 6: Deaths of 5 young men following car chase of their stolen car

5 young men of 16 who had recently left two inner city high schools were killed when their car ran into a tree. It was at a time when there was a national debate about the value of police chases, and the local community blamed the police for the deaths. The funeral had all the ceremony of a mafia funeral.

One child not associated with the incident rather ill-advisedly suggested that "they only had themselves to blame and that the police were only doing their job". His family car was attacked on arrival to school, and he was systematically bullied.

Actions

- Advising the Head on managing the process.
- Debriefing a group of pupils.
- Counselling child who was victimised, advising a change of school.

Issues

- Finding that over 30 young people(including many in school) had been in the car, from the time it was stolen at 2.30pm and when the accident occurred at 9.30pm.
- Strong community belief that police were at fault which made it very difficult for school staff to take a strong "anti joy-riding position". This also effected any factual phase of debriefing.

Case 7 Suicide of ultra-Orthodox Jewish student

A young man attending an Ultra Orthodox Jewish college died after falling from the 17th floor of a high rise block of flats. He had been sent to the college from Canada and the flats were occupied only by the non-Jewish population.

Actions

- Advise and counsel the rabbis who managed the school.

Issues

- Cultural and religious problems with suicide as a cause of death (actually it was later discovered that he had made other attempts on his life, and his parents had chosen not to tell the college officials before his death) Issues relating to the long distance from his parents.
- Concerns about what the wider community might think and interfere with the college managers.

Case 8 Death of disabled child attending mainstream school

A 7 year old wheelchair-bound disabled child had been with the same class since the nursery and died due to a complication during a routine operation.

Actions

- Advise the Head on managing the process.
- Debrief the staff, particularly the class teacher.
- Psychological debriefing of the class.

Issues

- Adaptation of debriefing for younger children.
- Children concerned that all disabled children might die suddenly (death unrelated to child's condition). School is resourced for physically disabled children.
- Child's disability took up lots of space and required additional equipment, therefore the "space" left by his death was greater than average. Class had learned to behave differently so as to include him, now were no longer required to do this.

Case 8: Death by hanging of secondary pupil

A 12 year old mixed-race boy who came home went up to his bedroom and was discovered 30 minutes later, hanging off door by his younger brother.

Actions

- Advising Headteachers of secondary and primary schools on management of the process.
- Debriefing staff in conjunction with community policeman.
- Psychological debriefing of brother's peer group in primary school.

Issues

- Concerns that bullying (racism) might be an underlying issue (did not appear to be the case).
- Lack of clarity whether it was suicide or extreme attention-seeking.
- Sensitivity of circumstances of younger brother's finding the body children when asked in the group if they could ask questions. Very impressive how sensitive they were, how helpful the process was to the boy.

Case 9: Death by hanging of 9 year old girl

Following an argument with her mother, a problematic young girl, went upstairs and was found some 45 minutes later having hung herself on bedroom door. Head told children in assembly, reasonable announcement on radio until child's uncle contacted TV station and suggested that child was being bullied. School then put under siege by national press and TV. Mother persuaded to come forward and deny stories.

Actions

- Advising Headteacher on process.
- Debrief staff and support school secretary on management of information.
- School visit to observe assembly and debrief changed to an all-day presence as the siege on the school began at 11am.
- Accompany Head when he was interviewed by local newspaper reporter.
- Psychological debriefing of peer group(coincidence that this was the same class who had been debriefed 2 years before when disabled child died - see Case 8 above).
- Advise and counsel mother.

Issues

- Particular problems of dysfunctional family (uncle's need to be "famous for 15 minutes").
- Major community reaction incensed at uncle's behaviour.
- Staff feeling under siege from inaccurate national press reporting e.g. ".....children collapsed with grief as Head told them in assembly.....child desperate because of a campaign of bullying....school refused to take bullying seriously.....etc".
- Mother upset at photograph of her daughter given by uncle (school were asked for a photo but I suggested that mother should have the opportunity of choosing her own) Later local paper printed large example of mother's choice of photo.
- Reality that it was the school clerk who was the first point of contact for parents, press and advisors and needed to be properly briefed and debriefed at the end of each day.

Case 10: Secondary pupil killed in banger racing accident

Four teenagers were injured (one died) when the old car they were driving overturned on waste ground. There were a large number of children involved in this unsupervised activity in vehicles sold for a few pounds to anyone.

Actions

- Advise Head on the management of the process.

Issues

- What is level of "acceptable risk" for young people?
- Feelings of responsibility of driver at the time.
- Large number of pupils involved in this activity.
- Concern about funeral which might become circus e.g. discussed with family that school not closed but that cortege driven past school so that pupils could show respect at nominated time.

Case 11: Child witnesses of murder on street

Two 11 year olds were walking along a street in the early evening and were suddenly startled as an assailant leapt out of bushes and stabbed a neighbour several times, violently in the chest and neck. The witnesses and victim's screams attracted others and the victim's death throes were witnessed by over 20 children. The death was drug related and the children's parents refused to allow them to give evidence to the police.

Actions

- Advise Head on management of process.
- Debrief of staff, particularly with reference to their legal position (having consulted LEA legal department).
- Arrange for individual children to receive counselling.

Issues

- "Conspiracy of silence" putting particular stress on the witnesses and their families.
- Teachers being told facts by children and sworn to secrecy, conflict between duty as citizen to police takes precedence over their duty of care and confidentiality to children.
- CPS guidelines on possibility of counselling potential child witnesses (can discuss reactions, not events).

Case 12: Death of secondary aged disabled pupil in a special school

A 14 year disabled girl, collapsed with a fit and had a heart attack before she was picked up by the ambulance.

Actions

- Advise head on the management of the process.
- Debrief the staff.

Issues

- Although child death is more frequent in the primary disabled population (see Case 14 below), it is rarer at secondary level, and is particularly unusual actually in school. (Staff have been able to avoid the issue directly in past experiences).
- Concern about levels of supervision and appropriate emergency actions having been taken.
- Parents levels of understanding particularly helpful to staff.

Case 13: Primary special school with approx 2 child deaths to manage per year

The Head and staff of a primary special school with an increasingly disabled and fragile population were concerned with their ability to manage the deaths of 2 children per year on average over the last 3 years.

Actions

- Meeting with Senior Management Team.
- Whole staff training day.
- Development of Management policy for child deaths.

Issues

- Focus had been on Head personally dealing with every bereavement but in future to be shared between all the management team.
- Wider issue of staff grieving for "less disabled" population that used to attend the school.
- Morbid preoccupation with room filling up with retained of equipment belonging to dead children.
- Discussion with Health Authority, challenging policy of Special Care Baby Unit that most extreme cases were no longer being kept alive whatever the level of disability.

Case 14: Special school bus accident

A special school bus was hit by a van, as a result of the van driver having a heart attack at the wheel. When information was passed to the local hospital it was dealt with as a major alert although none of the children were injured physically.

Actions

- Advise Head on management of process.
- Psychological debrief of children.
- Advise parents on children's reactions.

Issues

- Difficulties of debriefing a number of children who are unable to speak because of their disability.
- Accompanied by LEA official who had wanted to interview individual children, in order to check that school bus driver had behaved appropriately.
- Emergency responses actually more traumatic to children than the accident itself.
- Parents needing reassurance that sleep disturbances were temporary and to be expected.

Case 15: A nursery who had one of their pupils killed by a mother's partner

A children's centre initially asked for help because their secretary had committed suicide. In the initial visit it emerged that staff were also being called as witnesses on the murder case about one of their pupils who had been killed 6 months before.

Actions

- Advise Centre Management team.
- De-brief whole staff.
- Provide information support for staff witnesses.
- Liaise with police-liaison team.
- Liaise with care services managers.

Issues

- Failure/anger about secretary's suicide.
- Feelings/reactions about 2 deaths intermingled.
- Issues about child safety and future actions.
- All staff had feelings of anger/concern about the murderer before the death, but these did not translate into actions.
- Difficulties in relating to the child's mother.

Case 16: Secondary pupil who stabbed and killed a friend

A Year 11 pupil, excluded from another school in Year 10, befriended by a very popular student. Group were in the victim's house, all became drunk, arguments and one boy stabbed another with a kitchen knife.

Actions

- De-brief Head teacher and service staff.
- Consultation with school counsellor.

Issues

- Very strong reactions against "comer-in" who did the stabbing.
- Initial lack of information about the circumstances.
- Long gap between death and the legal outcome.
- Pupil's needed to be supported through exam process (Year's 10 and 11).
- School in "special measures" – OFSTED inspection problems.

Case 17: London bombing – school party in close proximity

A secondary school youth group who were staying in Russell Square, close to one of the bombs, were severely restricted by the security "blanket" and not in communication with home for a significant period of time.

Actions

- Support and advice to Youth Service managers who were dealing with the issue in Calderdale.
- Advice and guidance to parents who assembled.
- Offer of support to students if needed.

Issues

- Biggest problem was parents not knowing what had happened and whether pupils were safe.
- Emphasis of "being available" to well-organised management team.
- Need for on-site staff to brief students about not worrying parents on their mobile phones.

Appendix 1

FACTORS WHICH AFFECT THE WAY IN WHICH ANY CENTRE COPES WITH ANY CRITICAL INCIDENT

INTENSITY OF TRAUMA

	MILD				SEVERE
• Fatality or injury	1	2	3	4	5
• Adult or child	1	2	3	4	5
• Particular circumstances	1	2	3	4	5
• Numbers involved	1	2	3	4	5
• Size of proximity group	1	2	3	4	5
• Location in/outside	1	2	3	4	5
• Risk to others	1	2	3	4	5
• Clarity of information	1	2	3	4	5

LEADERSHIP	Developmental				Paralysed
	1	2	3	4	5
MANAGEMENT TEAM	Involved				Marginalised
	1	2	3	4	5
RESILIENCE OF CENTRE	High				Low
	1	2	3	4	5
PUBLICITY	Informative			Challenging	
	1	2	3	4	5

Appendix 2

SUPPORT FOR INSTITUTIONAL TRAUMA

Unsuccessful Model of Intervention

Individual Treatment	**Possible Interventions**	**Outcomes**
Individual Staff	Personal counselling Professional support	Pathologise symptoms Become "victims" Feel themselves a "failure"
Individual children	Individual treatment Provide confidentiality	Increase dependency "Individualise" the problems Increase "contagion" effect
Individual Parents	Provide support Listen and empathise	Validate criticisms of decision Separate from others
Group/Centre Effects		**LOSS OF COLLECTIVE FEELING** **INCREASE IN REFERRALS** **DISEMPOWERMENT** **MORE CASUALTIES FOR SERVICES TO TREAT**

Successful Intervention Model

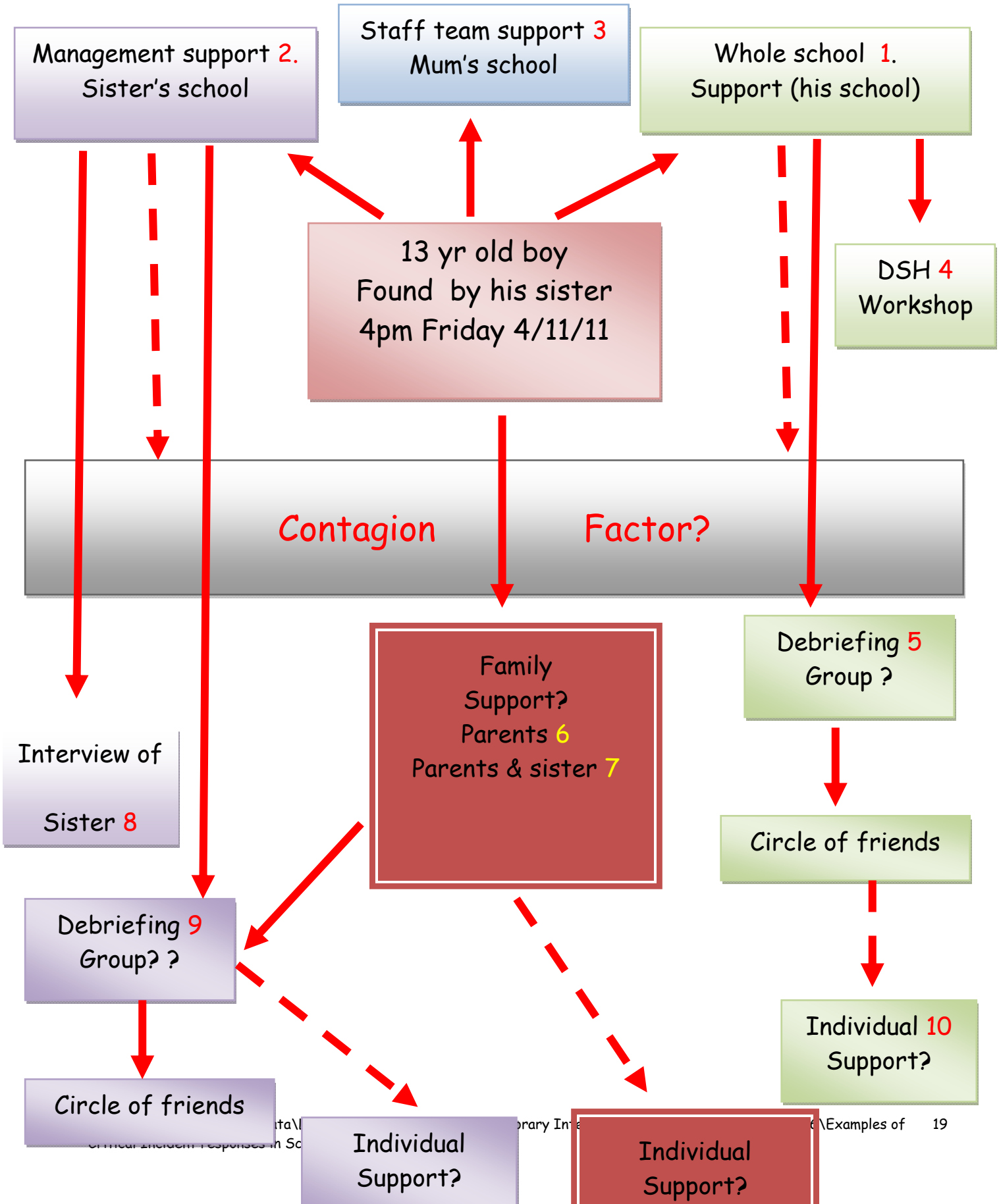
Group Support Model	**Possible Interventions**	**Outcomes**
Staff	Awareness Raising of change process Prepare and support for leadership Develop Coping strategies They support children through change	Accept the difficulties faced Acknowledge their feelings Empower them as leaders They work collectively
Parents	Awareness raising Share coping strategies for change Indicate that treatment is available	Acknowledge and support Support the child in the family General advice not "hands-on"
Children	Supported by parents and staff Peer-support by debriefing	Collective "problem" (not pathology) Increased empathy and care
Casualties will emerge (staff, parents, children)	Only after the above strategy	Individual treatment available **MAINTAIN GROUP TO THE LAST** **LIMIT THE INDIVIDUAL DAMAGE** **DOES NOT PATHOLOGISE INDIVS** **REDUCES CASUALTIES**

Appendix 3

USING A LIGHT TOUCH APPROACH WITH A CRITICAL INCIDENT

- Death of Year 11 pupil at home because of stabbing by her sister after a fight
- PEP involved by Senior Officer already in school
- PEP joined Senior Officer and Head at school
    - taking appropriate materials
- Psychological De-brief for Headteacher
    - emphasis of teaching phase
    - reinforcement of actions taken
    - suggestion of other actions
- Accompanied Headteacher in telling staff (responding to questions)
- Accompanied Headteacher in telling Year groups of pupils (being there)
- Going around school talking/listening to staff as pupils allowed to grieve Collectively
- Talking informally to groups of pupils
- Leaving school – later calling Headteacher to discuss progress

MANAGEMENT OF ACCIDENTAL DEATH



November 2011-February 2012 +++

Incident

13 year old boy found by his 14 year old sister hanging in his bed room. She called the ambulance and was being talked through resuscitation by paramedics when mother arrived home from school. He was taken to hospital and declared DOA.
He attended a selective grammar school, was in the top stream, a highly talented musician and played representational football and cricket.

Actions by EPS

1. **Contacted Friday pm for advice by School A**
   PEP contacted at home Friday pm for advice by DHT from school
   Spoke to him Saturday and Sunday re. telling pupils, managing social networking, press release, letter to parents, informal support to pupils
   Main issue was to emphasise "Accidental Death" not "Suicide"
   PEP in school Monday am, pupils allowed to support each other in dining hall, advice to staff

2. **Contacted school B to advise on reintegration of sister**
   She wanted to attend mock exam
   Support & advice as above re other pupils

3. **Contacted by School C for advice & guidance**
   Mother was a teacher in a small local primary school
   Whole staff in shock and feeling guilty about keeping her late on that particular night.
   Complicated by the school administrator having lost her 23 year old son, killed by a hit-and-run driver previous August
   PEP & EP ran a debriefing session for all the staff

4. **Whole-staff workshop on deliberate self-harm School A**
   Coincidentally school had planned a workshop on their staff development day but CAMHS had let them down
   EPS filled in as we felt that it enabled staff to discuss critical incident and look at the wider context of pupil emotional-well being

Concerns about Contagion

These have been discussed with the pastoral care staff in both schools as evidence from other cases indicated that there was a danger of "copy-cat" behaviour from other pupils, particularly where the deceased child was a popular & successful pupil (as opposed to a "lone-outsider")
There is also a concern where social networking sites romanticise and create an iconic, overemotional reaction. Both schools have reacted strongly to stop speculative social networking communication and encourage open supportive comments on their schools websites.
As well as staff supervision and conversations with pupils, debriefing sessions should be offered to the proximal groups (i.e. those closest to the boy)

5. Debriefing Workshop Boys friends School A

PEP & EP ran psychological debriefing session for 11 fellow pupils (4 girls, 7 boys)
They represented school friends, music group friends, ex girl friend, sporting friends.
Very articulate and supportive of each other
The 2 hour session enabled the group to share facts, thoughts, feelings and plans and we will follow up in January
The EPs did not feel that there were any identifiable concerns about contagion

6. Contact from family to work with parents

PEP had a 3 hour session in the family home with the parents
Main concern was the fact that they were not able to talk to their daughter about her experience (she had given her evidence to the police and did not want to upset her parents by talking about it)

7. Work with parents and daughter

PEP had a further 3 hour session with all 3
Main outcome was the shared story of his death and how they might support each other as a family
Often in these situations the children become "proxy parents" on a temporary basis and look after the adults

8. Interview of sister

PEP met with sister to agree agenda for group work with her friends
To reassure her that she would be supported
To identify any particular problems /issues she might have

9. Debriefing workshop daughters friends School B

PEP & EP ran a psychological debriefing session for sister and close group of 6 girlfriends at her school.
No concerns about contagion and group very positive about supporting their

friend.

10. **Individual work**

Former "girl friend"	Family Issues
School friend (girl)	Family Issues
Sister overcontrolled/ parenting role?	

11. **Presentation to Coroner** **(**Family request)

Residuals

Circle of friends (i.e. a mutually self-supporting group with a shared story about the deceased boy/family, who would look after each other and communicate openly)
Circle of friends School A
Circle of friends School B
Supportive return to work context for mother
Possibility identifying individuals who might need specific individual/group support. These may emerge and be identified by pastoral staff in school. EPS to be consulted and decide whether they or more intensive support is required
Advice/involvement with any of the parties as needed
Evidence to the Inquest?