Welcome to

surrey safeguarding ADULTS BOARD

Suicide Prevention Awareness - Learning from Safeguarding Adult Review (SARs) /Domestic Abuse Related Death Reviews (DARDRs)

CHANGE THE NARRATIVE

Introduction to joint working

Domestic Abuse Related Death, Safeguarding Adult Review and suicide prevention

International Association for Suicide Prevention

Content

1	**Wellbeing and Support**
2	Surrey Surveillance data
3	Suspected suicide response and learning work
4	Statutory reviews
5	Strategic plans
6	Further training

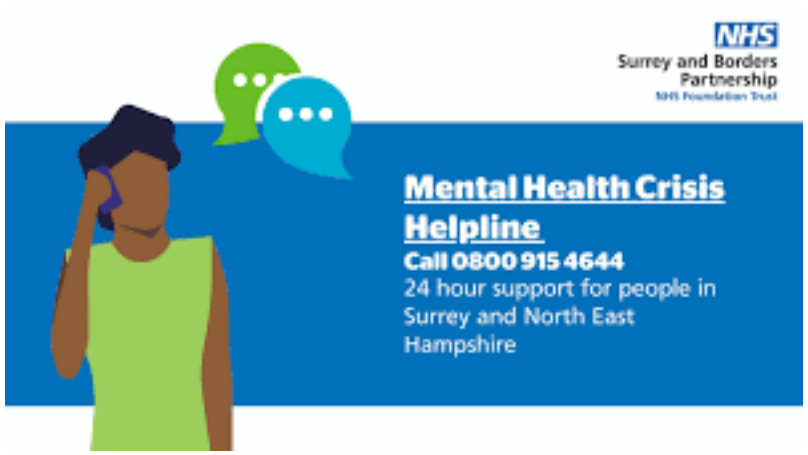
Wellbeing

In this session you will not be asked to share your own personal experiences

- Please do not share any names of people
- Please do not share any media stories
- Please do not share anything about methods or locations

If today is not the right day to attend the session and you feel its too much, you will not be judged for leaving. We will contact everyone after with support details.

Mental Health Crisis Support- Adults



Dealing with an adult mental health crisis - www.healthysurrey.org.uk/mental-wellbeing/crisis

Mental Health Crisis Support- Children and Young People

CYP HAVEN

Based in four different locations around Surrey; Redhill, Shepperton, Ash and Epsom.

Open: 6 days a week, Monday to Friday on our phone line between 3.30pm and 7.30pm and Sunday 1-4pm on 01483 519436.

The CYP Haven is a safe space where you can talk about your concerns, worries, and mental health in a confidential and friendly, supportive environment. The friendly staff will be able to give you advice and support on a wide range of issues. Whatever is bothering you, come and have a chat

Surrey Support After Suicide Service

07483301214 surreysupportaftersuicide@rethink.org

Monday - Friday : 9am - 8pm

Surrey Suicide Bereavement Service

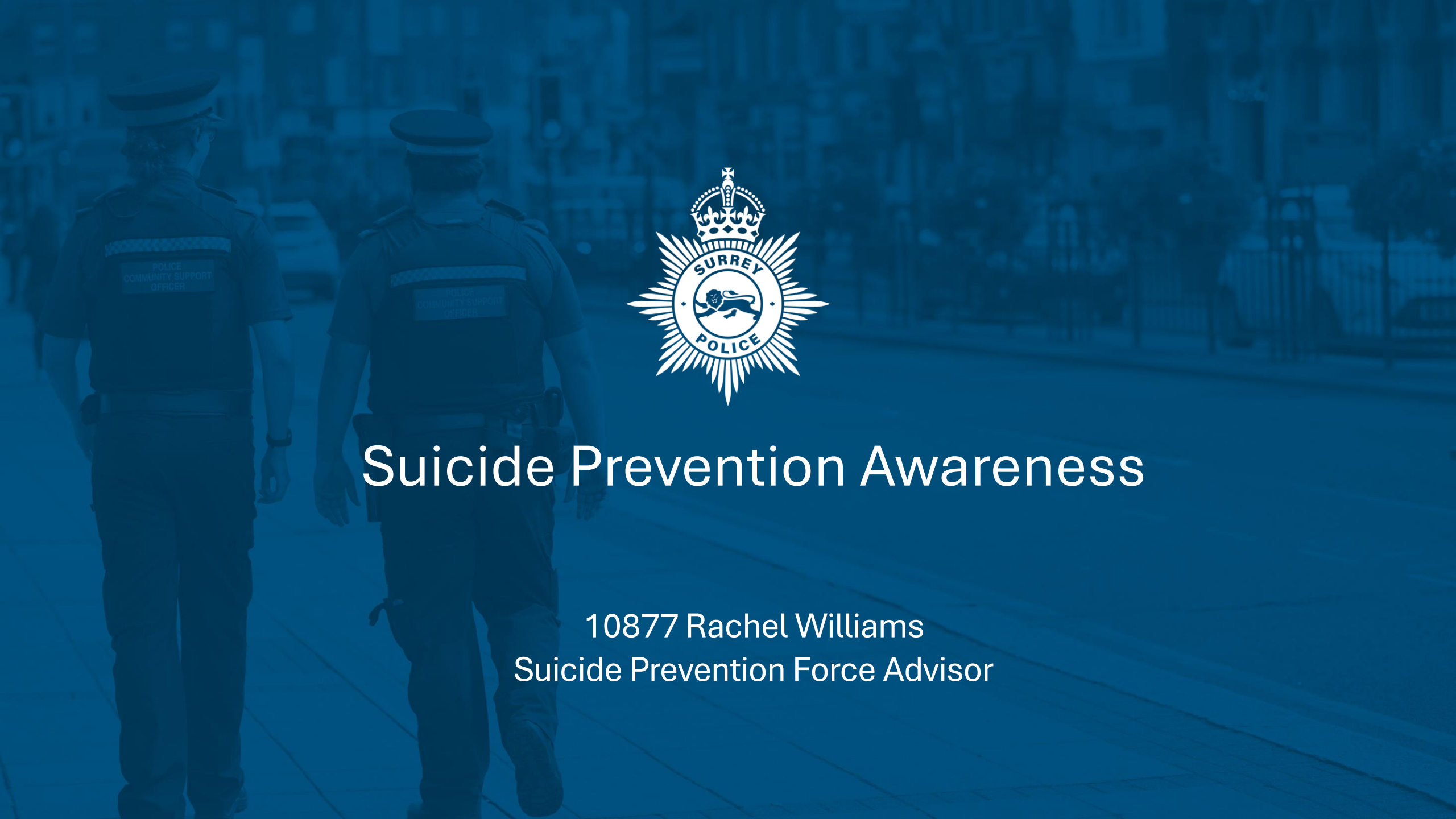
01737 886551 info@ssbs.org.uk

Monday - Friday : 9am - 5pm

Language

Source: Language-guide-for-talking-about-suicide.pdf (shiningalightonsuicide.org.uk)

Don't say	What to say	Why
Committed suicide	• Died by suicide • Death by suicide • Suspected suicide	Using the word 'commit' implies suicide is a sin or crime, it has not been a crime in England since 1961. Using the word Commit reinforces the stigma that suicide is a selfish act and personal choice. Using neutral phrasing like 'died by suicide' helps remove shame or blame.
Failed suicide	• Attempted suicide • Suicide attempt	Saying 'failed' or 'unsuccessful' is inappropriate because it implies that the opposite would be a positive outcome.
Successful suicide	• Died by suicide • Death by suicide • Suspected suicide	Saying 'successful' or 'completed' is inappropriate because it frames a very tragic outcome as an achievement or something positive
Cry for help	• Emotional distress • Need help and support	Suicide attempts must be taken seriously. Describing an attempt as a 'cry for help' dismisses the intense emotional distress that someone may be experiencing.



Suicide Prevention Awareness

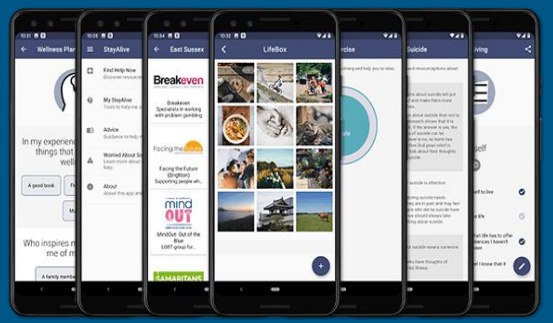
10877 Rachel Williams
Suicide Prevention Force Advisor

Wellbeing Support

Suicide is a tragic and distressing subject matter. It is likely to directly or indirectly touch many of us in our lives and have profound and long-lasting effect. This presentation talks about suicide and risk factors associated with it.

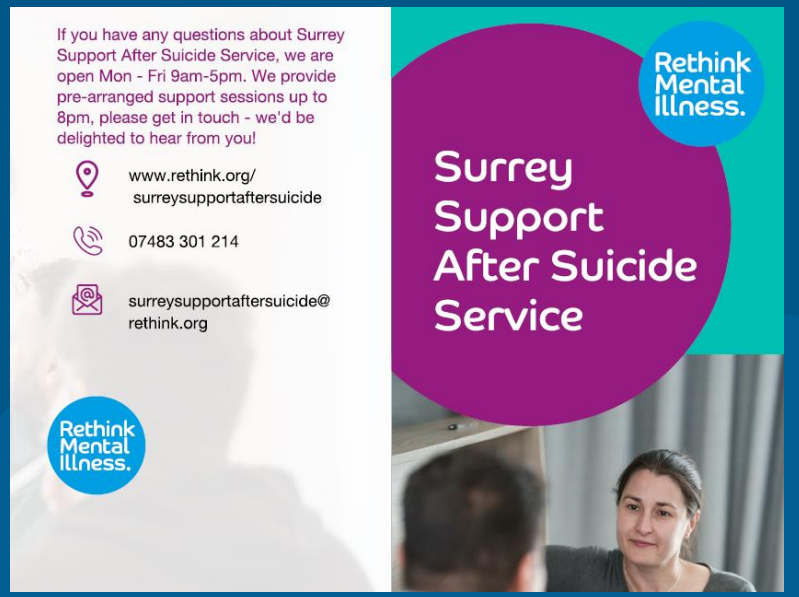
Please ensure that you protect your own safety, health and emotional wellbeing first and step away from this presentation if needed.

StayAlive



SAMARITANS

Small Talk Saves Lives



Background

- Historically, suicide data provided by Office of National Statistics (ONS) post Coroner inquest – up to 2-3 years after death in some cases.
- It is the Coroner at inquest, who deems the death a suicide and prior to that, it is referred to as a suspected suicide.
- In July 2020, the Suicide Prevention Advisor role was recruited, within Surrey Police, and developed the Real Time Surveillance (RTS) system recording suspected suicides which occur within Surrey.
- Police officers attend all incidents of sudden or unexpected deaths outside of hospital settings and identify suspected suicides and send notification to the Force Advisor.
- Force Advisor applies a three-stage process to consider whether the death is a suspected suicide and should be added to the RTS

Three stage process to identify suspected suicides

Stage One

Does this death meet the Oxford English Dictionary definition of suicide?

Stage Two

Does the death meet The Office of National Statistics (ONS) definition of suicide?

Stage Three

Does the death meet the Ovenstone Criteria (Ovenstone, 1973)?

Ovenstone Criteria

Each of the following, on its own, can be treated as sufficient evidence of Suspected Suicide (unless, of course, positive evidence that the fatality was accidental exists):-

Direct Evidence
- Suicide note
- Clear statement of suicidal intent to an informant
- Behaviour demonstrates suicidal intent

Indirect Evidence
- Previous suicide attempts
- Prolonged depression
- Instability, i.e. marked emotional reaction to recent stress or evidence failure to cope (e.g. breakdown)

The following are conditions which, by themselves, should not be used to indicate Suicide or Suspected Suicide:
- alcoholic or drug addiction
- mental illness (unless suicidal related)
- incurable disease
- Under the influence of alcohol/drugs at time of event (may make it more or less likely to be Suspected Suicide)
- Age of child (do not assume that the younger the child, the less likely to be suspected suicide)
- Location (e.g. if no other reason to be there i.e. not an official or unofficial crossing point)
- ‘Trespasser’ status

RTS Database

- The RTS Database records:-
  - Demographics

Name | Gender | Age at attempt | Address | Home Borough | Employment Status

  - Details of event, such as date, method and location

Date of Death | Method | Location | Location Borough | Note of Intent found?

➢Risk Factors (not a complete list)

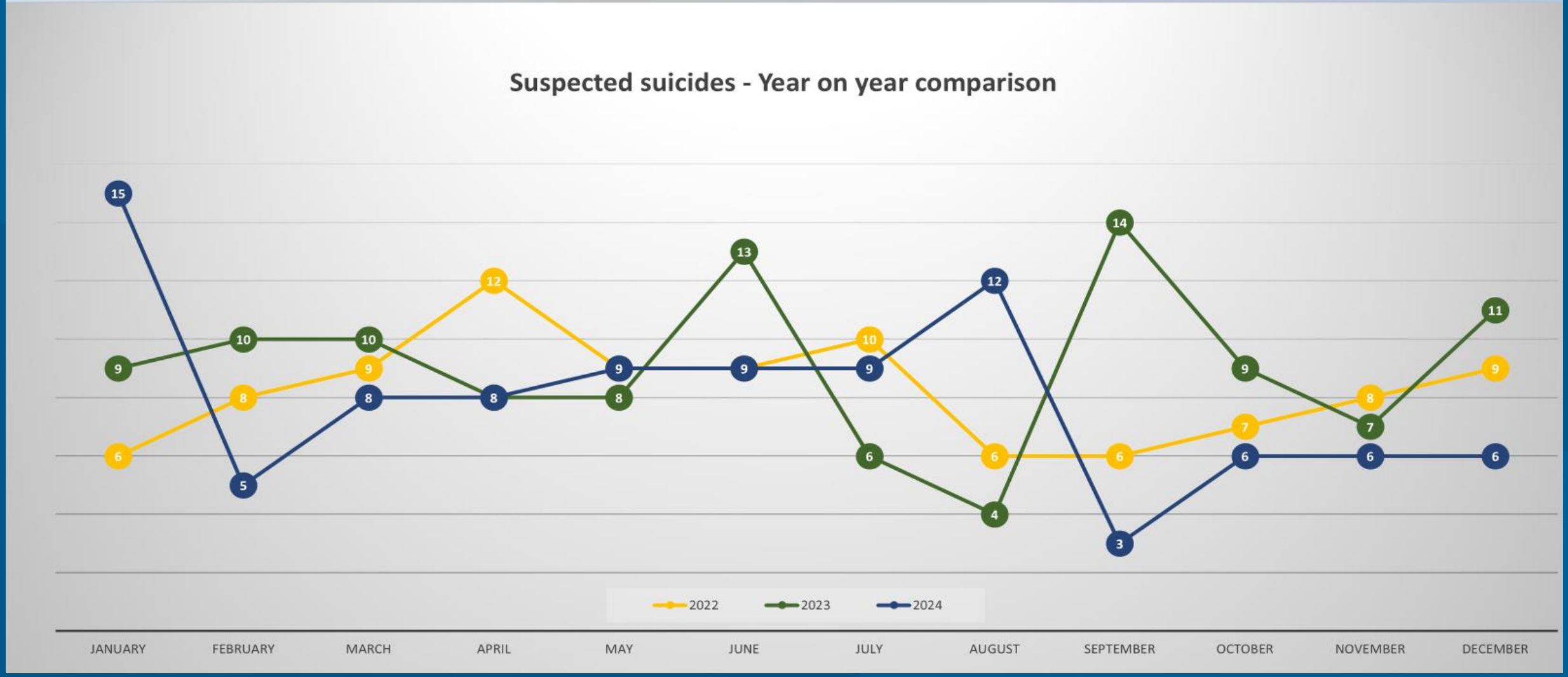
How the RTS is used

- Data collated on the RTS is analysed to identify trends, clusters, high risk locations and individuals
- Data is shared with Public Health Surrey through QES system to identify targeted suicide prevention work and learning.
- Nationally, all forces record suspected suicides which are submitted to the National Police Chiefs Council (NPCC) who hold a National RTS.
- Where high risk locations, individuals, clusters or contagion are identified, multi-agency fast-time response meetings are held to minimise the identified risks
- From location details, mapping of high risk locations can be completed to inform prevention work
- Annual Reports created

Extract from RTS Annual Report 2024

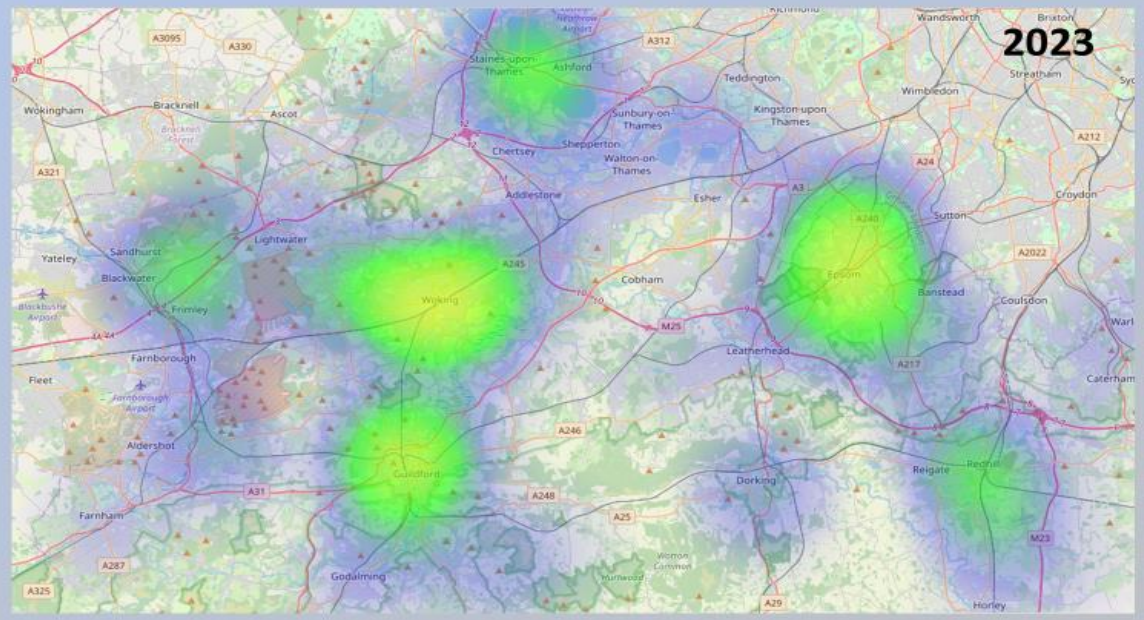
Suspected suicides – year comparisons

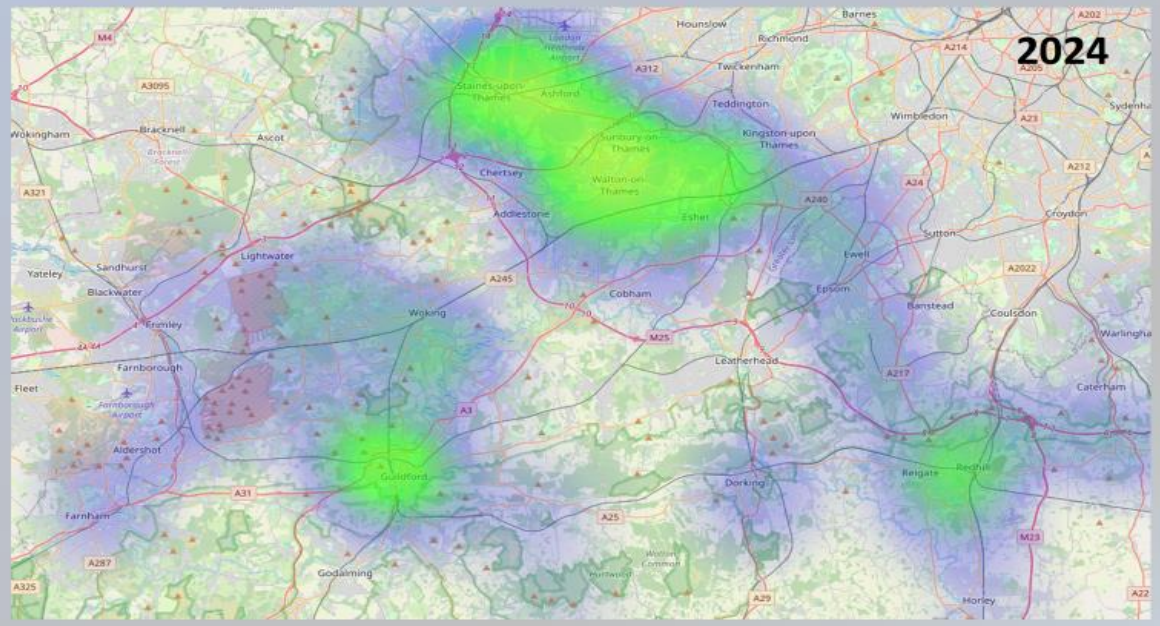
Between 1st January 2024 to 31st December 2024 ninety six (96) suspected suicides were recorded on the RTS. This is compared to one hundred and nine (109) recorded in 2023 and ninety nine (99) in 2022.



Extract from RTS Annual Report 2024

Heatmap of Suspected Suicides 2023 vs 2024





The heatmaps above relate to suspected suicides in 2023 and 2024 and show the concentration of deaths in the county across all ages.

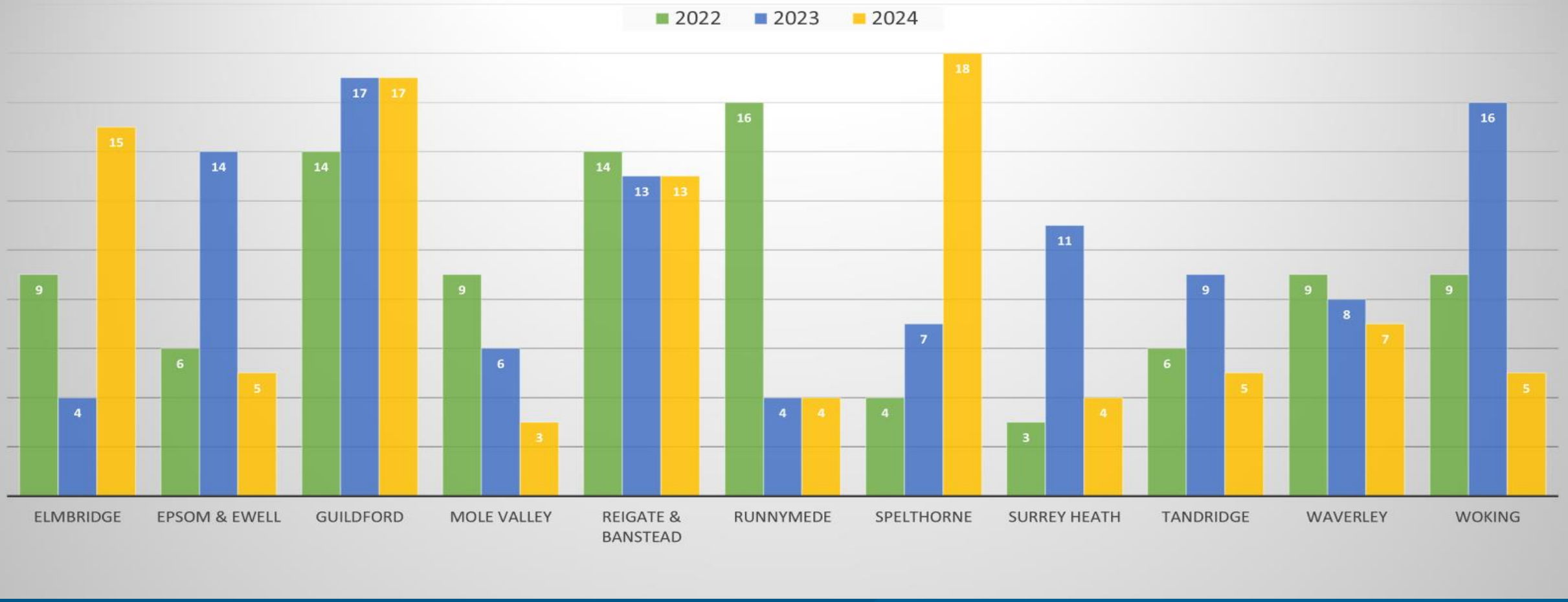
In 2023 higher concentrations were located in the Woking, Epsom & Ewell and Guildford areas. The 2024 data shows that the highest concentration of deaths was located in the boroughs of Spelthorne and Elmbridge.

Further details are provided within this report.

Extract from RTS Annual Report 2024

3 Year Comparisons for Boroughs

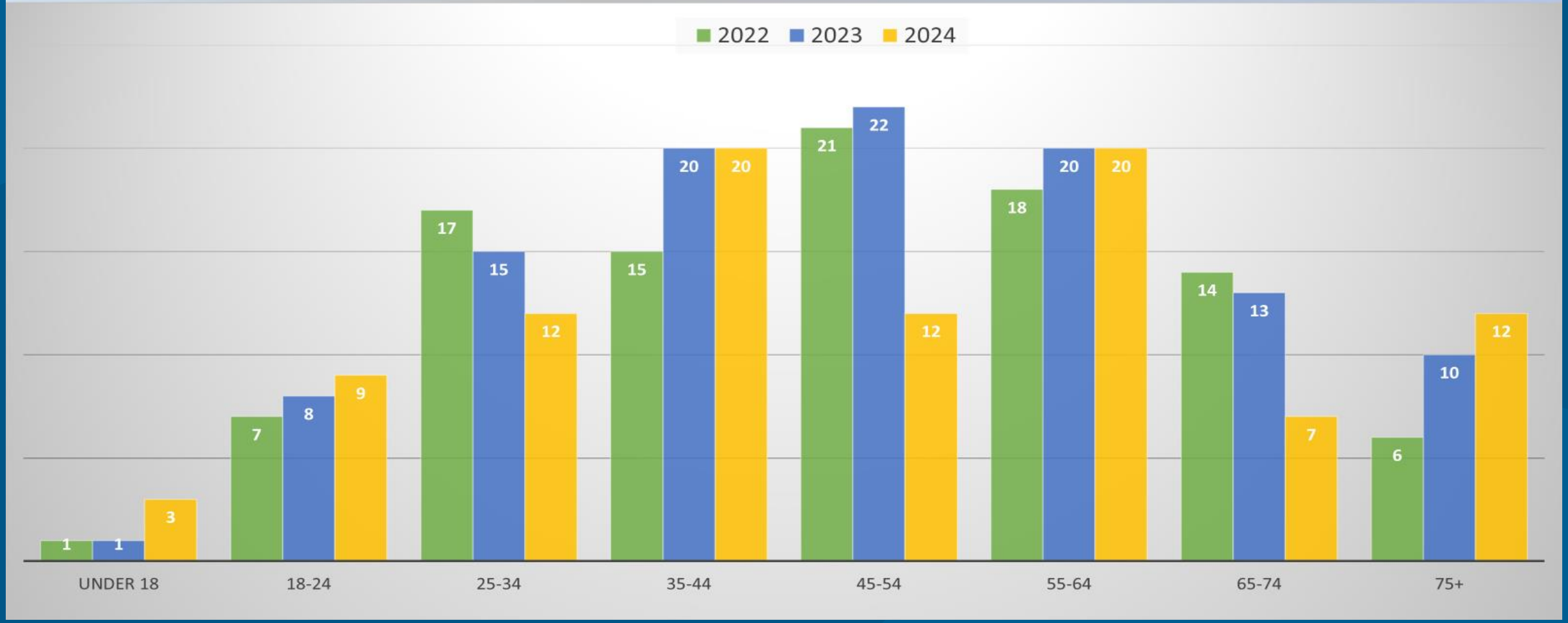
Guildford Borough's numbers are consistently high and are above the national rate per 100,000 population. Epsom and Ewell have seen a substantial decrease in numbers between 2023 and 2024 and are below the national rate per 100,00 population, although their numbers spiked in 2023 compared to 2022. Waverley and Mole Valley are showing a year on year reduction over the last three years.



Extract from RTS Annual Report 2024

3 Year Comparisons for Age range

There has been a steady increase, year on year within the 18-24 and 75+ age ranges. The Children and Young People age range (up to 25 years old) in particular is showing an increase in suspected suicide. There are dedicated multi-agency partnerships that consider suspected and attempted suicides in this age range. These services monitor suicide incidents and complete targeted prevention work when appropriate.

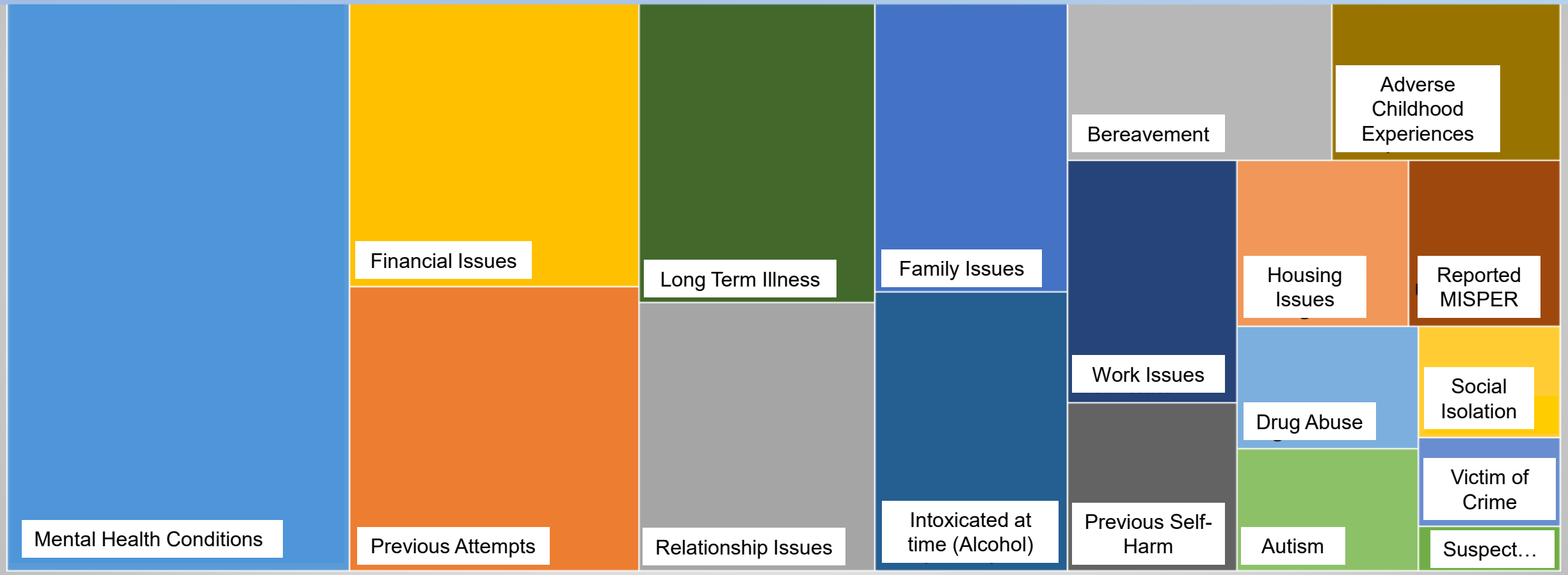


Extract from RTS Annual Report 2024

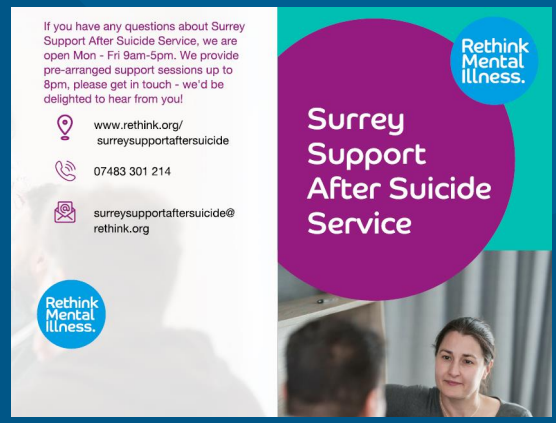
Risk Factors /Characteristics of Suicide

Information provided regarding potential risk factors/characteristics is subjective. It has been gathered early and it has not been confirmed or corroborated. None of the factors should be seen as a simple reason or interpreted as part of a direct link to the suicide.

The chart displays the 18 highest recorded risk factors/characteristics.



Referral to Suicide Bereavement Support



- Research shows that those bereaved/affected by suicide are more likely themselves to die or attempt to die by suicide and it is recognised that best practise is to provide those bereaved/affected by the death with help and support at the earliest opportunity.

- Surrey Support after Suicide, provided by Rethink provide help and support to those affected by suicide, including witnesses, first responders, neighbours, colleagues and care professionals. –

- Automatic referral by Force Advisor for those who may be directly affected, as identified through data collated for the RTS.

Safeguarding Referrals

- Safeguarding referrals are made by the police when an individual is identified as having Care and Support needs **and** is experiencing, or is at risk of, abuse or neglect.

- In cases of untimely or sudden death, a safeguarding referral is required where the death results in care or support needs arising for another person, such as the death of an adult who cares for another adult or child/ren. Or if the deceased is currently known to Social Services.

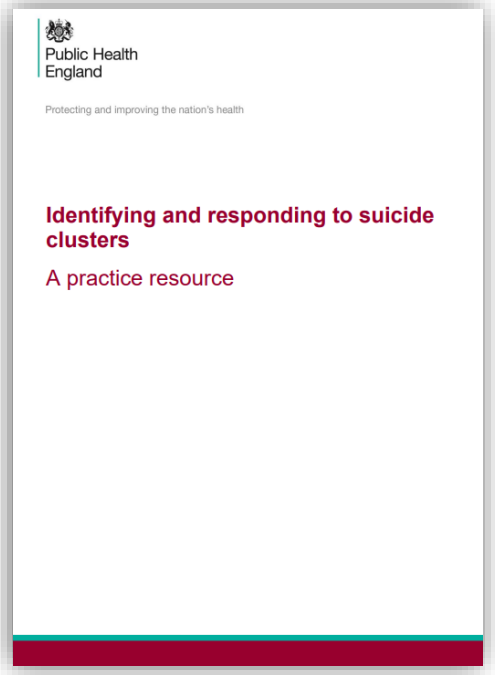
Item 2: Suspected Suicide Response and Learning Work

Presenter: Nanu Chumber-Stanley

Public Health Programme Lead, Suicide Prevention
Surrey County Council Public Health Team

Key Documents

- Surrey Suicide Prevention Strategy 2025 to 2030
- Identifying and responding to suicide clusters A practice resource
- Suicide prevention strategy for England: 2023 to 2028 - GOV.UK
- www.healthysurrey.org.uk/mental-wellbeing/professionals/suicide-prevention-strategy



Surrey suicide prevention strategy 2025- 2030

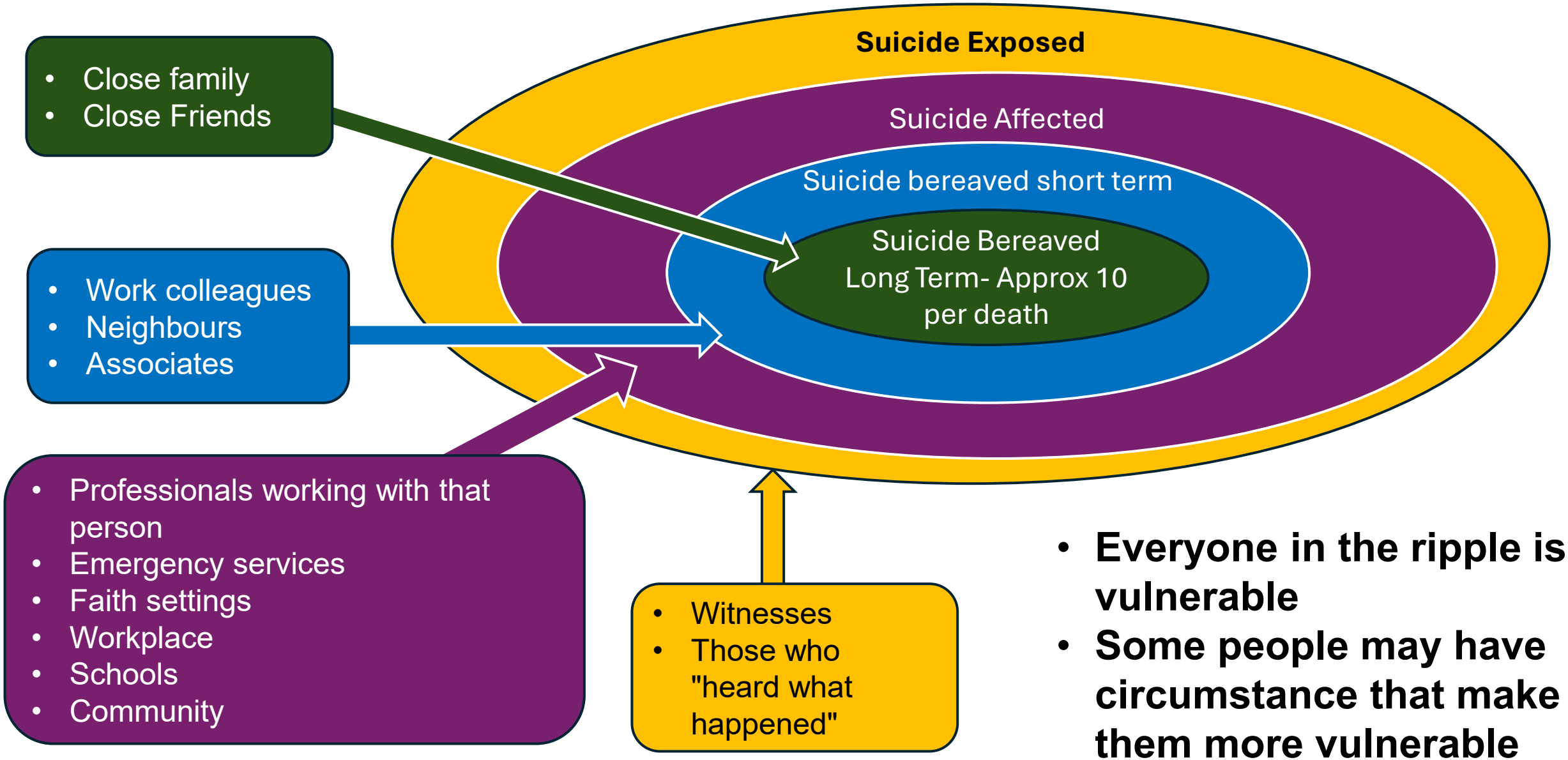
This strategy sets out our approach to reducing suicide in Surrey. This has been informed by:

- Feedback from people with lived experience
- Local intelligence
- Local learning
- National and intelligence/ evidence
- National suicide prevention recommendations.

Surrey has identified five action areas that cover the eight priorities in the national strategy.

We invite organisations in Surrey to complete the **strategy action form** to share the work you are doing.

Response work: Suicide Social Contagion- Ripple effect of suicide

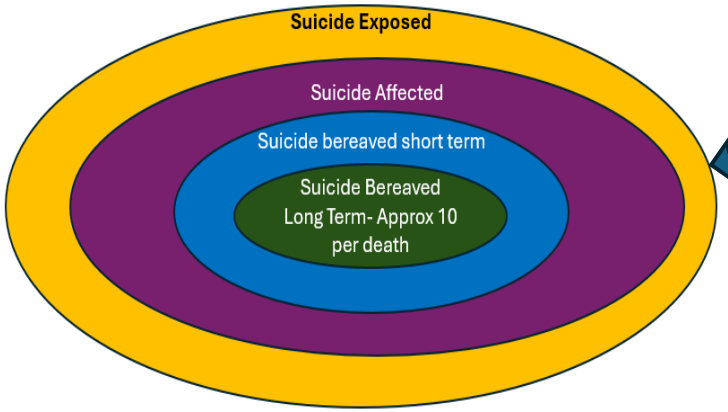


- **Everyone in the ripple is vulnerable**
- **Some people may have circumstance that make them more vulnerable**

Real-time Surveillance

RTS Notification comes in from Surrey Police

Suicide Prevention Team Review- staff rota



Short term response: immediate response

Guidance

1. PHE Cluster guidance
2. PHE guidance
3. Locally developed guidance

Medium/ Long term response

1. Review social contagion risks
2. Partnership meetings
3. Set up projects
4. Deliver training
5. Comms

Safeguarding duty

Concerns speak to Head of Safeguarding

Embed learning into prevention plans

Example- Working Process Example with Adult Social care

Part A: Surveillance

Real time surveillance suspected suicide

1. Public Health to check the case against LAS
2. If known and not recorded as deceased inform MASH Team
3. If person is a carer- Police will put in a SIGNS form (known as SCARF) where appropriate.

Line Manager/ Team manager: If person was in regular contact with social care- offer of bereavement support to staff working with that person

Attempted suicide surveillance

1. Surrey Police will put SIGNS form in for the person
2. Public Health will not get any details on case

PH notification form: CYP example
Form for reporting concerns around self-harm/suicide risks and group behaviour in children and young people (<25) - Surrey County Council

Part B: Cases and response

Intelligence from partners: BTP, Car parks, other community

Step 1: Public Health will request that the person is referred to MASH (PH will not get any details on the case)

Step 2: In cases where the person is a frequent attendance and PH informed of the person. PH will check LAS.

- If known inform MASH contact
- If not known seek assurance that Police SIGNs form submitted
- If previously referred in didn't meet criteria- ask area to refer to MASH

ASC Case management: person presenting repeatedly with suicidal ideations. PH can offer guidance on:

- Social contagion mapping
- Social contagion risk
- High risk locations
- Novel methods
- Staff training
- Training workforce commissioned contractors- eg care agencies.
- Workforce health: commissioned contractors- eg care agencies offer workforce health programme

Part C: Learning

RTS learning
Share partners

- Key themes
- Demographics

Suicide Audit

- Key themes
- Known to ASC
- Known to MH
- Opportunities
- Learning

Learning: meetings

- Regular update safeguarding
- Regular share with local area leads
- Share learning with Surrey Heartlands and Frimley Leads

Joint working with safeguarding

Suspected Suicide and Attempted Suicide Surveillance

- Review RTS data
- Ask questions
- Professional curiosity
- Open and transparent discussion safeguarding lead/Police
- Keep Public Health focus
- Share concerns
- Hand over

Learning to prevention

- Take recommendations that are appropriate to Public Health
- Hand over actions to right agency to carry out
- Embed action plans
- Actions review

Projects/ services/ service improvements development

Suicide Audit

Statutory Reviews

- Provide suicide prevention support
- Recommend right agency
- Keep Public Health focus
- Review reports
- Provide recommendations against local strategy/national strategy

Concerns shared from surveillance have instigated reviews

Statutory Reviews

Domestic Abuse Related Death Reviews (DARDRs)

A "Domestic Abuse Related Death Review" means a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by:

(a) a person to whom she/he was related or with whom she/he was or had been in an intimate personal relationship; or

(b) a member of the same household as herself/himself, held with a view to identifying the lessons to be learnt from the death.

Where a victim took their own life (suicide) and the circumstances give rise to concern, for example it emerges that there was coercive controlling behaviour in the relationship, a review should be undertaken, even if a suspect is not charged with an offence or they are tried and acquitted. Reviews are not about who is culpable.

Safeguarding Adults Reviews (SARs) Care Act 2014 (s44)

A SAR is a review of a case involving an adult with care and support needs (whether or not the local authority has been meeting any of those needs), where:

(a) the adult died or was seriously injured; and the SAB knows or suspects that the death resulted from abuse or neglect; and

(b) there is reasonable cause for concern about how services worked together to safeguard the adult

AND – (c) a SAR can be initiated for any other case involving an adult in its area with care and support needs.

Themes from SARs & DARDRs

TRAUMA

Needs

- **Domestic Abuse**
- Homelessness and Housing
- Removal of children
- Mental health difficulties
- Physical health difficulties
- Substance misuse

Service Issues

- Need for knowledgeable & caring service response
- Multiagency communication & Information sharing

Outcome

- Suicidal ideation/ Suicide

The Surrey SAB and Domestic Abuse Strategies

Surrey Safeguarding Adults Board (SSAB) 3-Year Strategy

Adults who are not able to meet their own needs, and/or are subject to abuse and/or neglect, typically experience chronic traumatic stress

In addition to Action Plans for each SAR; the SSAB has identified priority themes:

- self-care difficulties
- domestic abuse
- suicide prevention

Fits with the Partnership's priorities:

- prevention
- better understanding of trauma
- better person-centred care
- promotion of a Think Family approach
- improved multi-agency working

Surrey Public Health Domestic Abuse Strategy

The Council has identified priority themes:

- person-centred & collaborate support
- survivors & children together
- healthy relationship awareness & education
- a whole-system response: partnership development, culture change & a consistent approach
- prevention & accountability (perpetrators)

These themes are informed by the learning from the DARDRs

Surrey Against Domestic Abuse

- Domestic Abuse Related Death Reviews | Healthy Surrey
- DHR-Statutory-Guidance-161206.pdf
- DA Strategy_Final_2024-25.pdf

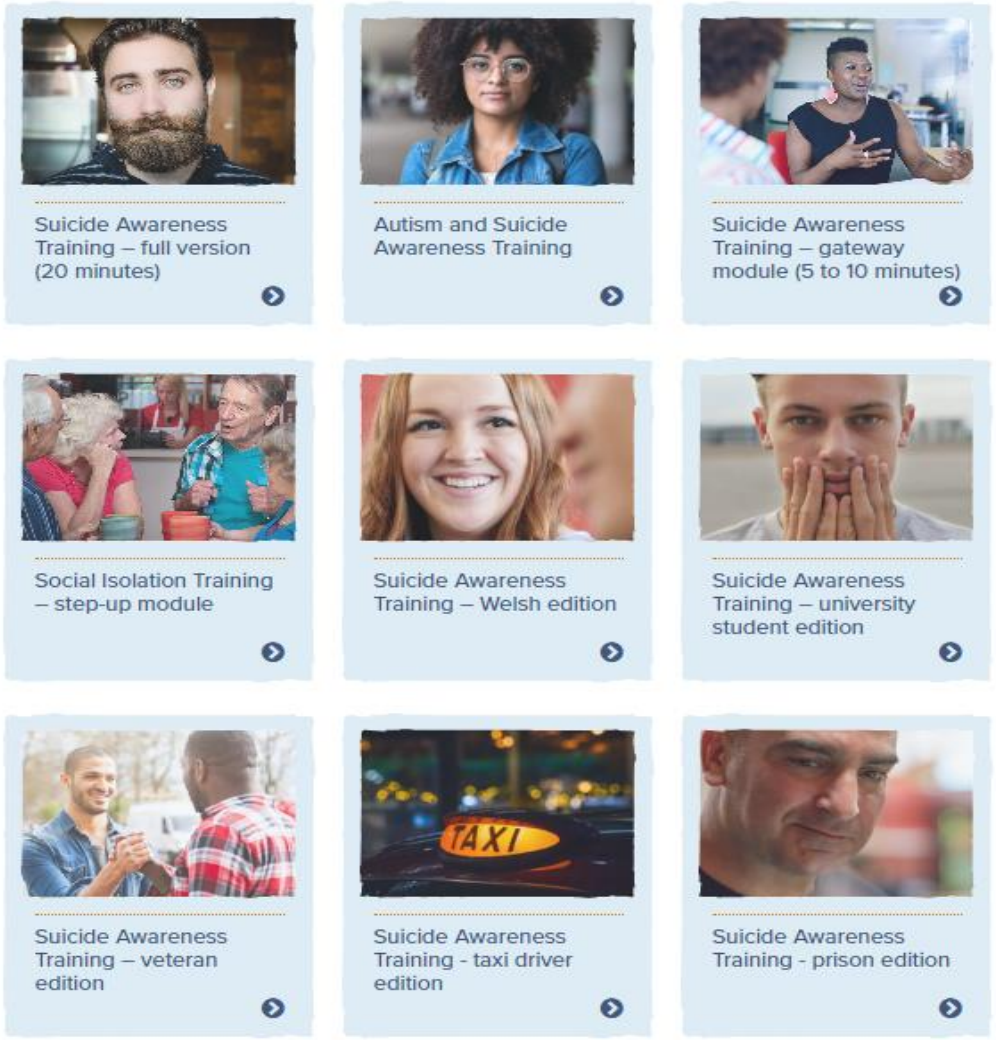
- Homepage - Surrey Safeguarding Adults Board
- Safeguarding Adult Reviews (SARs) - Surrey Safeguarding Adults Board
- Strategic Plan - Surrey Safeguarding Adults Board

3rd Friday of every month – SAR/DARDR drop in sessions

Please email - DHR@surreycc.gov.uk or surreysafeguarding.adultsboard@surreycc.gov.uk

Suicide Prevention Is Everyone's Business

Free online training available to anyone.



Zero Suicide Alliance

Because ONE life lost is ONE too many

Open up. Save a life. Take the training.

[Free online training from Zero Suicide Alliance]

Other Training

safeTALK	SFA Suicide First Aid	ASIST LivingWorks
suicide alertness for everyone	Understanding Suicide Intervention	Applied Suicide Intervention Skills Training
• 3.5 hrs • **Suicide Alert- Identify, keep person safe until help arrives**. • Face to face • Delivered as part of response work in Surrey	• 1 day • Online and face to face • Offered by Public Health • Limited courses	• 2 days • Face to face • Suicide Intervention • Not commissioned by Public Health.
Publichealthtraining@surreycc.gov.uk	Publichealthtraining@surreycc.gov.uk	Publichealthtraining@surreycc.gov.uk

Suicide and Safeguarding- next learning events

Date	Theme
TBC	• Housing & accommodation • Parental alienation • Removal of children
TBC	The life course approach of abuse: • Child abuse • DA as an adult • Suicide risk
TBC	Workforce health: • High-risk occupation groups • Workforce support • Coroners inquest

Once these sessions have been released, for more information or to book your place please visit the Surrey Safeguarding Adults Board Webinar page.

www.surreysab.org.uk/training/learning-webinars/