Written evidence submitted by the National Police Chief’s Council (NPCC) Suicide Prevention and Response Portfolio lead, Chief Constable Paul Crowther on behalf of all Police Forces.

1.1 Background
1.2 Chief Officers support the NPCC by taking responsibility for crime and policing issues from a national operational perspective.

1.3 The portfolio on Suicide Prevention and Response works closely with the Mental Health portfolio, and currently has a work plan covering four main themes: -

- Working with Public Health England, other police forces and partner organisations to test the collection of real time data in relation to suspected suicides
- Working with a range of stakeholders and advisors to produce a Strategic Statement of Purpose and contribute to the production of Approved Professional Practice (APP)\(^1\) in relation to Suicide Prevention and Response by the College of Policing
- Looking at multi-agency referral arrangements for those vulnerable to suicide, in the context of current safeguarding work and the new Care Act of 2014.
- Looking at new intervention techniques, including social media

1.4 The first thing to say is that many of the issues that impact on Suicide Prevention from a policing perspective are inextricably linked with mental health services and their capability and capacity.

1.5 The recent Home Affairs Select Committee on Mental Health and Policing explored these issues, and reported in February 2015; however, some issues have been amplified in this submission due to their relevance to the subject.

2. Executive Summary
2.1. At risk Groups include Men; People in contact with the Criminal Justice System (particulary those involved in Child Sexual Exploitation and Indecent Images of Children); people suffering from Acute Stress, Anxiety, Depression and Personality disorders and those bereaved by suicide.

2.2. There are differing calculations used to determine the financial cost of suicide, but a conservative estimate puts it at £8.87 billion per year across the UK. The social and human costs are substantial and much more difficult to quantify.

2.3. The police and other public bodies have legal duties and responsibilities to prevent suicide, however there is a lack of a joined up multi agency approach and little clarity as to which agency has the lead role at any given point. Multi Agency Risk Management Arrangements should be introduced to address this.

2.4. The Care Act 2014 in England does not explicitly include suicide risk and it’s application and process in relation to suicidal adults needs clarification.

2.5. The impact of suicidal incidents places a significant demand on the police service and use of the power of detention unders S136 of the Mental Health Act 1983 has been rising.

2.6. The College of Policing has produced Approved Professional Practice on Suicide prevention and Response for police officers and staff to help them better understand the phenomenon of suicide and respond to it effectively.

2.7. Police should be involved in the formulation and discharge of local suicide prevention plans.

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\(^1\) This product has been subject to public consultation which closed on the 17\(^{th}\) August 2016
2.8. There is a need for effective joined up bereaved support across partner agencies, including the Police, Coroner, Local Authority, Public Health and 3rd sector.

2.9. Local partners should work together to design out suicide opportunities in buildings and infrastructure.

2.10. There is a significant need for better data sharing between public authorities regarding people at risk.

2.11. Only the police seem to be subject of independent review following a death or serious injury after police/health intervention.

2.12. The lack of capacity within health to deal effectively with Crisis Care, in turn can defeat police actions to save life or reduce risk.

2.13. The provision and placement of Health Based Places of Safety (HBPoS) does not seem to be based on demand modeling causing significant delay for the patient and the police.

2.14. There is a significant tension that exists between the power of detention under S136 and the grounds for detention in hospital under the Mental Health Act. The Safeguarding legislation and capability does not seem to be integrated in a way that properly protects the vulnerable.

2.15. There are concerns with the operation and objectives of some Street Triage schemes which may be more concerned with limiting demand on stretched health resources than protecting the vulnerable.

2.16. There is a need for much better provision in Primary Care to deal with Acute Stress, Anxiety, Depression and Personality disorders to provide upstream prevention.

2.17. There should be a provision for third party referrals to mental health services for assessment as part of upstream prevention.

2.18. There should be more vigorous enforcement of the media guidelines produced by Samaritans and the reporting of Coroners Inquest details should also comply with the guidelines.

2.19. There is a need for real time data capture in relation to suspected suicides and attempts.

3. Terms of Reference
In relation to the published Committee terms of reference, commentary is provided in respect of each item below:

3.1. The factors influencing the increase in suicide rates, with a focus on particularly at-risk groups
3.1.1. There has been reporting by the National Suicide Prevention Strategy Advisory Group\(^2\) that links the down turn in the UK economy and the worldwide economic crash, to adverse impacts on the mental health of the population and the rise in suicide rates since 2008. This reporting also comments on the impact of unemployment on suicide rates but highlights the complexity of these issues as the economy has improved and employment rates have risen in recent years.

3.1.2. There are also reports regarding the impact of social media on suicidal behaviours especially amongst young people\(^3\).

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\(^2\) Preventing suicide in England: Two years on – February 2015

3.1.3. When we consider at-risk groups (apart from particular occupational vulnerabilities), the following would appear to be significant from a policing perspective:

3.1.4. Men
Suicide is the biggest single killer of all men in the UK and they are three times more likely to take their own lives than women. Police are collaborating with national charities such as CALM (Campaign Against Living Miserably) and Samaritans to try and raise awareness of male vulnerability and well-being. This initiative has recently been supported by HRH the Duke of Cambridge through the Coal Face Coalition.

3.1.5. People in contact with the criminal justice system
In particular those arrested for Child Sexual Exploitation (CSE) and Indecent Images of Children (IIOC) offences.

3.1.6. Operation NOTARISE was a 2014 joint national child safeguarding investigation coordinated by the National Crime Agency (NCA) with all UK forces participating. 24 apparent suicides were recorded during the operation. Consequently bespoke guidance was produced by a working group of law enforcement, academia and health professionals. The bespoke guidance advocated the use of Liaison & Diversion services that currently operate in approximately 53% of police custody suites across the country which will hopefully rise to approximately 80% by 2017/18 to assist officers in their risk management of people arrested and/or charged with offences relating to online Child Sexual Exploitation.

3.1.7. The NPCC Online CSE Pursue Board chaired by Chief Constable Simon Bailey recently reviewed the complex issue of suicides involving IIOC offenders and in consultation with the NPCC lead for Suicide Prevention and Response, a decision was reached to re-establish the aforementioned sub-working group and task its members with refreshing the original operation Notarise guidance and make it available to all Law Enforcement agencies. A longer-term objective of conducting wider research and consulting with appropriate international agencies is also underway with the College of Policing. The interim guidance has been produced and will be linked to the Suicide Prevention and Response APP.

3.1.8. People suffering from Acute Stress, Anxiety, Depression and Personality disorders
There is significant research that links stress, anxiety, depression and personality disorders to heightened risk of suicide. Many of the people police intervene with during suicidal behaviour fall within this group. What makes them particularly at risk is that the primary treatment mechanism is inadequate.

3.1.9. Serious shortfalls in mental health service provision and the significant negative consequences this can create for individuals, families and the nation as a whole are well documented and there have been a number of recent initiatives at Governmental and Organisational levels to address the issues. These have included the drive for Parity of Esteem between physical and mental health services and the Mental Health Crisis Care Concordats published in England and Wales.

3.1.10 The report from the independent Mental Health Taskforce published in February 2016 makes some powerful statements as to the current state of our mental health services in England and the challenges they face:

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4 https://www.thecalmzone.net/2016/05/the-calm-before-the-storm
5 ONS Statistical bulletin: Suicides in the United Kingdom: 2014 registrations
6 https://www.thecalmzone.net/2016/05/the-calm-before-the-storm
7 Suicide by people in a community justice pathway: population-based nested case–control study
Carlene King, Jane Senior, Roger T. Webb, Tim Millar, Mary Piper, Alison Pearsall, Naomi Humber, Louis Appleby and Jenny Shaw
8 Suicide Prevention Risk Management - Perpetrators of Child Sexual Exploitation and Indecent Images of Children
10 The Five Year Forward View for Mental Health - A report from the independent Mental Health Taskforce to the NHS in England - February 2016
“Mental health services have been underfunded for decades, and too many people have received no help at all, leading to hundreds of thousands of lives put on hold or ruined, and thousands of tragic and unnecessary deaths.”

“More than a quarter (28 per cent) of suicides were amongst people who had been in contact with mental health services within 12 months before their death, amounting to almost 14,000 people in the ten years from 2003-2013.”

3.1.11 These are just two of the many findings of the report, which also makes a number of recommendations for wholesale improvements that will require substantial investment in mental health services over the coming years.

3.1.12 People Bereaved by Suicide
Friends and relatives of people who die by suicide have a 1 in 10 risk of making a suicide attempt after their loss11. There are examples of good practice where local authorities and 3rd sector organisations have collaborated to provide proactive support to bereaved people. This needs to be a national standard and is subject to further comment at P().

3.2. The social and economic costs of suicide and attempted suicide
Attempts to quantify the economic and social cost of suicide have been undertaken in both national and international research, and the following are some of the estimates:-

• Scotland: £1,290,000 per case in 200412
• England: £1,450,000 per case in 200913

3.2.1. If we look at the UK suicide figure for 201414 of 6122 and use the financial multiplier for England of £1.45 million (as it is the most recent study) it gives us a figure of £8.87 billion. This is substantially more than twice the annual budget of the Metropolitan Police (£3.26 b in 2013/14) and 7.62% of the NHS England annual budget (£116.4 b in 2015/16).

3.2.2. Dealing with the full range of suicidal behaviour and crisis related incidents places a significant demand on police resources.

3.2.3. Any reduction to the huge costs of suicide, can only be beneficial, both in cutting down the personal cost to individuals and their families and friends, but also in relieving the financial cost and burden on services to the public - those organisations delivering front line services directly affected by the issue, such as health, social care, the police and rail transport operators.

3.3. The measures necessary to tackle increasing suicide rates, and the barriers to doing so—in particular the Committee will consider the role of:
Local authorities and partner organisations, including police, transport police, the rail industry, fire services, schools, youth services, and drug and alcohol services

3.3.1 The Police Role and Multi Agency Arrangements
The police have various legal obligations to support those in mental health crisis and to prevent suicide:

11 PHE (supported by NSPA) “A practice resource Local suicide postvention planning” unpublished resource (to be published in September 2016)
14 In 2014 there were 6122 suicide deaths of people aged 10 and over in the UK. (Office for National Statistics: Suicides in the United Kingdom, 2014 R
• The primary objective of an efficient police force is the protection of life and property (defined by the first Commissioners of Police for London in 1829).
• The duty to protect life, reinforced by Article 2 of the European Convention of Human Rights (the right to life), and how this extends to people at risk of suicide (Keenan v United Kingdom 2001).
• The duty of care that might exceptionally arise when the police assume responsibility towards a particular member of the public (Hills v Chief Constable of West Yorkshire [1989]).
• When considering the requirement to keep and analyse data for the prevention of suicide, the Management of Police Information (MOPI) codes of practice stipulates that police data will be recorded, stored and used to support public protection.

3.3.2 Just as the police have their responsibilities, so do other public bodies including health, social care and local authorities.

3.3.3 Statutory Safeguarding requirements are in place across the UK underpinned by both adult and child safeguarding legislation, which place duties and responsibilities on public authorities to cooperate and protect vulnerable people.

3.3.4. Failure to comply with these duties and responsibilities can lead to a range of sanctions at both individual and organisational level. It can also lead to other consequences such as the loss of public confidence or the issue of a Regulation 28 notice by a Coroner

3.3.5. What there doesn't seem to be is a statutory or nationally agreed multi agency arrangement or model to ensure all of these public bodies operate in a joined up way and are clear on where their duties and responsibilities begin and end in terms of suicide prevention.

3.3.6. It might be expected that upstream prevention would be the responsibility of health, public health and education; and that police, ambulance and emergency health staff will have responsibility during a suicide crisis. But who takes the lead for on-going management of people post intervention and mental health assessment? Should this be the Local Authority in their safeguarding role? And who has access to the best information regarding risk?

3.3.7 The reality is that responsibilities and tasks are currently spread across a range of agencies and the situation would be greatly improved by the creation of Multi Agency Risk Management Arrangements for suicidal people, as we have in place for dealing with other risks such as MAPPA\textsuperscript{15} for dangerous offenders, MASH\textsuperscript{16} for children at risk and MARAC\textsuperscript{17} for domestic violence.

3.3.8. Safeguarding
When we look at the safeguarding legislation in place to protect vulnerable adults there are some key differences within the UK.

3.3.9. In essence the Adult at Risk definition (which focuses on abuse and neglect) in the Care Act 2014, which has recently been introduced in England does not explicitly include adults at risk of suicide, albeit in subsequent guidance the term ‘neglect’ has been held to extend to self-neglect. For those in the ‘At Risk’ category there is a duty on the Local Authority to investigate and take steps to prevent.

3.3.10. By contrast the equivalent legislation in Scotland does include self-harm explicitly in it’s at risk definition, and so you move immediately to a duty to investigate and a duty of cooperation amongst relevant agencies.

\textsuperscript{15} Multi Agency Public protection Arrangements
\textsuperscript{16} Multi Agency Safeguarding Hub
\textsuperscript{17} Multi Agency Risk Assessment Conference
3.3.11. It has been our experience in England that there is a degree of confusion and a lack of consistency amongst local safeguarding teams and adult social services as to whether suicidal people should be referred via the Care Act, and in any case it does not seem to provide a very dynamic mechanism for support.

3.3.12. **Demand on Police Resources**
Estimates as to how much time police spend dealing with mental health incidents has previously been put at least 20%\(^\text{18}\) however when it comes to the demand caused by suicidal activity the picture is not so clear.

3.3.13. We do know that the number of S136 detentions in England has been increasing and now stands at some 23,602 for 2014/15\(^\text{19}\). This represents an increase of 14.1% on the previous year\(^\text{20}\). Many of these will be a response to a threat or attempt at suicide.

3.3.14. When you compare these numbers to the criminal justice demand facing the police service for the same period\(^\text{21}\), its significance in relation to threat risk and harm becomes obvious.

- 534 homicide offences
- 29,265 rape offences
- 4,862 firearms offences
- 709 offences against children aged between 10 and 15.

3.3.15. The British Transport Police (BTP) maintain significant records of the volume of suicidal incidents on their jurisdiction, which will be covered in their own written submission, however it is worth noting that it outstrips much of their volume crime demand and as an operational priority comes second only to Counter Terrorism on their National Strategic Threat Assessment under the National Intelligence Model (NIM).

3.3.16. What we do know from other forces is that the levels of demand that impact on certain specialist services such as police hostage negotiators are substantial.

3.3.17. Police Negotiators are selected and trained at a regional level and undergo pass or fail training courses. All of the scenarios used in the current regional training programme involve some element of suicidal activity. This is a reflection of the huge percentage workload they face in relation to suicide which ranges generally from 60% to 86% from those forces responding to our data request.

3.3.18. We also know that police control room staff often have to field calls in relation to people in crisis and threatening suicide. South Wales Police, as one example have implemented a comprehensive training programme for their control room staff in order to equip them to deal with this issue.

3.3.19. In order to better equip police officers to deal with this particular risk laden area of demand, we have produced a Strategic Statement of Purpose, outlining the police role in relation to suicide and have collaborated with the College of Policing to produce APP which will be the prime delivery mechanism for the key elements of the statement of purpose.

3.3.20. A video based product to assist in suicide intervention, produced by Network Rail, BTP and the Samaritans, called the ‘Learning Tool’ is also available to all forces via the College of Policing’s primary E-Learning platform NCALT (National Centre for Applied Learning Technologies).

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\(^{19}\) http://www.npcc.police.uk/documents/edhr/2015/Section%20136%20MHA%20201415%20Data.pdf
\(^{20}\) http://digital.nhs.uk/searchcatalogue/?productid=19118&q=s136&sort=Relevance&size=10&page=1#top
\(^{21}\) ONS Statistical bulletin: Crime in England and Wales: Year ending March 2015 - CSEW
3.4. Local Suicide Prevention Plans
We have already mentioned the report from the Mental Health Task Force - The Five Year Forward View for Mental Health - and it includes specific recommendations for improved service responses to mental health crisis and suicide; with the need for multi agency suicide prevention plans to be in place at a local level by 2017, 24/7 crisis response services in all areas and the achievement of a new 10% reduction target for suicides by 2020/21.

3.4.1. The NHS and Department for Health have accepted the recommendations, and we feel it important that police are involved in the formulation and discharge of these plans through multi agency arrangements.

3.4.2. We also believe these plans should include the need for effective joined up bereaved support across partner agencies such as the police, HM Coroner, Local authority, Public Heath and the third sector. There are examples of best practice where such arrangements are in place and work effectively such as the partnership in Durham involving the charity “If U Care Share Foundation.”

3.4.3. These plans should also include the identification of suicide hotspots and specific buildings or infrastructure such as bridges that attract suicidal behaviour. There is guidance from Public Health England (PHE) on dealing with both suicide clusters and hotspots\(^\text{22}\). The aim should be to try and design out suicidal opportunity and restrict access to means of suicide and understand local drivers for suicide contagion. There is significant research that shows restricting access to the planned means of suicide to be an effective technique with little displacement to other locations or means of suicide\(^\text{23}\). The Police can play a part in identifying these locations, making recommendations and providing community support and reassurance in respect of contagion.

3.5. Data Sharing
A fundamental requirement to enable multi agency working is the need for better data sharing between public authorities regarding individuals at risk of suicide. Despite the exemptions in the data Protection Act that allow for data sharing to preserve life or in the best interests of the data subject, there are different approaches to data sharing across the different public agencies.

3.5.1. The Police rely on The Management of Police Information statutory codes of practice (MOPI), whilst health rely more on seeking consent from the patient and the role of their ‘Caldicott Guardians’\(^\text{24}\), in ensuring compliance with the Mental Health Act Codes of Practice and patient confidentiality. This often creates a number of operational tensions that can prevent dynamic information sharing about risk. This issue has been subject of previous recommendation to the Home Affairs Select Committee on mental health and policing.

3.6. Accountability
There appears to be an inconsistency in the level of oversight and accountability when someone dies after contact with police as opposed to a death after contact with health.

3.6.1. We can supply many case studies which involve people who have been subject to life saving interventions by the police, who have then been handed over to health for assessment, who have subsequently been released and gone onto to kill themselves.

3.6.2. In these circumstances the police actions are subject to review by the Independent Police Complaints Commission (IPCC) as a death after police contact which will look primarily at whether any criminal or conduct issues need to considered, whilst the health actions are subject to an internal Serious Case Review, which seems to focus on lessons to be learned rather than accountability.

\(^{22}\) PHE - Identifying and responding to suicide clusters and contagion - A practice resource September 2015, PHE - Preventing suicides in public places - A practice resource November 2015

\(^{23}\) http://www.ncbi.nlm.nih.gov/pubmed/15949453

\(^{24}\) A Caldicott Guardian is a senior person responsible for protecting the confidentiality of patient and service-user information and enabling appropriate information-sharing. Each NHS organisation is required to have a Caldicott Guardian; this was mandated for the NHS by Health Service Circular: HSC 1999/012.
3.6.3. We believe that an independent enquiry touching on all relevant services is required to ensure that accountability and opportunities to enhance partnership working in the public interest are properly explored. The Coroner in England and Wales will review issues within the scope of the Inquest, but this is largely limited to establishing the identification of the deceased and the cause of death. The Coroner can issue a regulation 28 notice to those organisations which he or she feels need to make improvements to prevent future deaths, however the sanction effect of these notices is limited as they are not enforceable.

3.7. Mental health services and other parts of secondary care, including A&E and psychiatric liaison services

3.7.1. We are extremely concerned that the lack of capacity within health to deal effectively with Crisis Care, can in turn defeat police actions to save life and reduce risk.

3.7.2. One of the main ways in which police will engage in suicide prevention is by responding to or intervening with people in crisis, particularly those threatening or attempting suicide.

3.7.3. When we look at what powers and legislation exists to support suicide prevention from a crisis management perspective, the current landscape appears to us to be fractured and unsupportive.

3.7.4. It is also worth noting that of the four national suicide prevention strategies in place in the UK\(^\text{25}\) all but the English strategy have explicit objectives regarding crisis care and support.

3.7.5. When the police encounter someone who is suicidal (and may in fact be attempting suicide) in a place to which the public has access, it is usually to the power under S136 of the Mental Health Act 1983 that they turn. This preserved power of arrest should be used where the officer suspects the subject is suffering from a mental disorder, and is in need of immediate care or control and there is a risk that if not made subject to that care or control they will go on to harm themselves or another.

3.7.6. As already referenced the number of people detained under the Act has risen significantly in recent years and it is well documented in various reports that mental health services have struggled to cope with the demand\(^\text{26}\).

3.7.7. There is also regular commentary regarding the number of S136 detentions that are not converted into a S2 or S3 detention in hospital. The MHMDS\(^\text{27}\) data shows that only some 20% of detainees under S136 nationally are further detained in hospital following assessment, and it is believed that a similar number will be subject to voluntary admissions. Recent research by Sussex University suggests that some 50% of S136 detainees are released with no follow up plan\(^\text{28}\). In some quarters these figures are used to suggest that police are using S136 inappropriately.

3.7.8. The police however, make a judgement to detain someone to prevent loss of life and manage risk. If someone is attempting to take their own life, then albeit this can sometimes be a rational decision, in most cases it is a response to some sort of life crisis, that leads to depression, acute stress or anxiety disorders. Mental ill health and personality disorders are

\(^{26}\) The Five Year Forward View for Mental Health - A report from the independent Mental Health Taskforce to the NHS in England - February 2016, “A safer Place to be” – the Care Quality Commission 2014
\(^{27}\) Mental Health Minimum Data Set
also significant contributors to suicidal behaviour\textsuperscript{29}. These are all Mental Health disorders as defined by the Mental Health Act 1983 as amended and the associated Codes of practice. We must also remember that the police officer making the judgement is not a clinician and will use an experiential and common sense approach.

3.7.9. The fact is that many people subject to S136 detention, following assessment, are subject to voluntary admission to hospital or referral to home crisis teams, and so the level of formal detentions in hospital should not be considered as the key indicator of whether police are using the power appropriately.

3.7.10. The purpose of the power however is to facilitate a Mental Health Assessment rather than deal specifically with the risk issues. The mental health assessment as described by the codes of practice appears to constitute a number of hurdles, which have to be overcome before formal detention can be achieved.

3.7.11. First of all, there has to be evidence of a mental disorder, which requires inpatient treatment and that treatment must be available. It is our experience that although most suicidal people are suffering a mental health condition as described above (acute stress, anxiety, depression or personality disorder), because the national policy is for these conditions to be treated in primary care, it is only those with serious and enduring mental health issues that pass this initial test for inpatient treatment.

3.7.12. If we get past this stage, then the assessment will look at risk and consider whether the person represents a risk of serious harm to themselves or another. And if we get over that hurdle there is a final reminder that the least restrictive means must be sought.

3.7.13. It would appear then that S136 is actually being used by the police to manage risk and prevent harm, but is a key mechanism in bringing people in crisis into contact with medical services. It would be better if there were better arrangements in primary care and 3rd party referral systems to provide this link instead of waiting until crisis point has been reached.

3.7.14. The current management of Health Based Places of Safety (HBPoS) would also seem to be particularly adhoc in many areas of the country, and not necessarily built against a robust analysis of demand. For example in London there are 25 HBPoS managed across 10 mental health trusts, yet the reality is that Police in London often encounter substantial delays and difficulties in placing detained subjects at a London HBPoS within a reasonable timeframe. The actual number of S136 detentions in London is only some 13 per day. Surely if the HBPoS were brigaded amongst the 10 trusts and situated strategically in accordance with a needs based analysis, then the management of 13 cases a day in London would be achievable to a very high standard and probably at much less cost. It is fair to say that the Health in Justice Commissioners and their partners in London are currently carrying out such a needs assessment.

3.7.15. Due to the current problems with accessing HBPoS the Metropolitan Police have issued the following instructions to their officers.

\textsuperscript{29}http://www.nimh.nih.gov/health/topics/borderline-personality-disorder/index.shtml
3.7.16. As many of the people encountered in a suicidal state also have other needs or issues such as drug and or alcohol dependencies, financial or relationship difficulties, the concept of pegging all further help on a formal diagnosis of a serious and enduring mental health condition, would seem to be a very narrow approach. Would it not be more appropr
appropriate for people in crisis to be subject of a dynamic multi agency assessment which looks across a much broader spectrum of vulnerability in order to help the individual recover from their crisis?

3.7.17. It is therefore vitally important that there are sufficient health and social care services working with partners such as the police, to provide a real focus on upstream prevention, as well as effective dynamic multi agency response arrangements to deal with crisis situations when they do occur.

3.8. S136 and Street Triage schemes
3.8.1. We support the need for much better multi agency arrangements especially between health and police. This would include joint training and a joined up response to crisis incidents.

3.8.2. In recent years we have seen the introduction of ‘Street Triage’ schemes across the country, utilising various operating models. Many of these schemes have objectives or performance targets linked to a reduction in S136 detentions, but often without any associated increase in upstream prevention to reduce the number of people getting into crisis in the first place.

3.8.3. Any reduction in inappropriate detentions is welcomed, but if the use of the power is both lawful and necessary to protect the subject or the wider public then it should be used. Failure by the police to use an available power to protect the public may well attract adverse outcomes, criticism and even legal proceedings, especially in circumstances where the decision is affected by local schemes, objectives or procedures which have more to do with limiting demand on over stretched health services than protecting the public.

3.8.4. We can produce examples of where people have gone on to take their own lives following a Street Triage intervention that did not lead to a S136 detention and mental health assessment where perhaps it should have done.
3.8.5. Baroness HALE (deputy President of the Supreme Court) in her textbook on mental health law (5th edition, 2010) argues that S136 is under-used, not over-used.

3.8.6. The pressure, whether implied or explicit, to reduce the use of the power and allow triage the space to operate, has on some occasions led to officers detaining people in fact without detaining them in law (BBC3 Film “Don’t section me!”), to generate space for the nursing encounter to occur.

3.8.7. In some circumstances this is creating unlawful detentions, and then Street Triage nurses are in effect, unlawfully releasing people from what, in reality, is a detention under S136. We know this is creating conditions in which sub-optimal clinical assessments are occurring by sole nurses rather than more thorough assessments by an Approved Mental Health professional (AMHP) and a doctor approved under S12 of the MHA 1983.

3.8.8. That said, there are also many positive outcomes from Street Triage Schemes, not least the joint working between police and health and the shared understanding of each other’s operational context, but they should be operated within clear parameters and within the law.

3.8.9. Another area that contributes to failures and difficulties in managing the risk of suicide is the difficulty in securing urgent admissions to hospital under the Mental Health Act.

3.8.10. Based on research it is clear that Clinical Commissioning Groups in England and Local Health Boards in Wales often do not comply with S140 Mental Health Act, which provides a legal duty to specify hospitals that can receive patients urgently. Those who do comply, seem to fail to commission those hospitals in any kind of different way so as to allow patients in police custody who need admission, to access them in a timely way.

As such, where suspects arrested for offences are detained in police custody pending an application being made for admission, there are very real difficulties for custody sergeants who are regularly faced with taking the decision about whether to unlawfully detain someone to keep them safe; or whether to release someone who has been flagged as either suicidal or posing a risk to others. We estimate this happens about 10 times a day, over 3,500 times a year.30

3.9. Primary care services
There is a huge need for much better provision in Primary care for Acute Stress, Anxiety, Depression and Personality disorders to provide upstream prevention as per P3.1.8.

3.10. Referrals from non-statutory services - local support groups, faith groups, carers, friends and family.
There should be a capability for this to happen as part of upstream prevention as previously stated. This in turn should prevent people getting into crisis and reduce the need for police intervention.

3.11. Media reporting of suicide, the effectiveness of guidelines for the reporting of suicide, and the role of social media and suicidal content online
Samaritans have produced media guidelines31 which concentrate on not reporting the method of suicide or the particular history of the individual. These guidelines are based on research and are widely respected by the suicide prevention community, however they often get overlooked, especially in local media, and it is felt that a much harder line should be taken in relation to compliance with the official guidelines.

30 Based on Freedom of Information data requests and data sampling from a number of UK forces.
Reporting of Coroners’ findings is often very graphic and again we have concerns that this may contribute to contagion. Some analysis within BTP found a potential link to suicides at a hotspot location following media reporting of Coroner’s findings.

3.12. The value of data collection for suicide prevention, and the action necessary to improve the collection of data on suicide.

There is a particular management saying – ‘if you can’t measure it you can’t manage it.’ In every aspect of police work we record relevant data and then analyse it to identify vulnerability that needs a particular focus of resources or support.

3.12.1. In relation to suicide the official data provided by the Office for National Statistics is derived from the outcome of Coroner’s inquests, which will often be completed many months after the fatal event occurred. This does not provide for the sort of dynamic analysis that the police would apply to any other issue.

3.12.2. Some forces such as the BTP and the Police Service of Northern Ireland employ a process, which involves making an initial judgement in advance of the Coroner’s Inquest. In the case of BTP they use the Ovenstone Criteria32 to try and understand suicidal intent. They will look at all apparent suicides in the previous 24 hours, and having applied the criteria make a judgement as to whether suicide is likely. This judgement is used for analytical and deployment purposes and is not communicated to families or released in the public domain.

3.12.3. Without this daily overview of where potential suicides are occurring, forces such as BTP would not have the required picture of vulnerable locations, communities and people on which to target their activity.

3.12.4. Public Health England has worked with the NPCC lead to test these concepts in a wider context with pilot sites in Leicestershire, South Yorkshire and Durham. The findings from these pilots were mixed and PHE is still reviewing the potential for a wider real time recording process.

3.12.5. The final comment to make is on the legal burden of proof in the Coroner’s Court in England and Wales, before a suicide finding can be returned. Although suicide hasn't been deemed a crime in the UK since 1961, the criminal standard of proof remains. This means that the Coroner has to be sure beyond a reasonable doubt that the case was a suicide, rather than using the civil burden of proof (on the balance of possibilities) that is available for all other findings other than unlawful killing.

3.12.6. This higher standard of proof we believe has contributed to the introduction of narrative findings, where it is more difficult for the ONS and academic researchers to establish the true extent of suicide

4. Recommendations

1. We need a more integrated legislative and procedural framework to create an effective multi agency capability in relation to suicide prevention. This would involve a revamp of S136, clarification of the Care Act 2014 in England and Adult and Child Safeguarding. Also the establishment of Multi Agency Risk Management Arrangements for suicidal people, and a positive duty in relation to data exchange.

2. There should be clarity of role for all public services in relation to suicide prevention, so that expertise can be targeted in the correct way, and effective training applied. This should also include a review of accountability mechanisms.

32 http://bjp.rcpsych.org/content/123/572/15
3. We need much better capability and capacity in primary care to treat acute stress, anxiety, depression and personality disorders in order to provide more effective upstream prevention.

4. Family, friends and patients themselves should be able to make direct referrals for assessment under the mental health act, again as a more effective means of upstream prevention.

5. Health Based Places of Safety should be deployed against a robust demand based modeling process and the concept of emergency assessment centres should be explored to provide a true multi agency approach to all aspects of vulnerability.

6. Each local area should have joined up multi agency support arrangements for the bereaved and bereaved communities.

7. Real time data capture systems should be developed to ensure there is always an up to date and reliable source of suicide related data, for each local suicide prevention group and public agency to work from.

8. The burden of proof for Coroners should be moved to the standard civil requirement of the balance of probabilities.