

**2018  
HERMAN GOLDSTEIN AWARD  
FOR EXCELLENCE IN PROBLEM-ORIENTED  
POLICING SUBMISSIONS**



**Reducing Suicide: a Problem Solving and Partnership  
Approach between British Transport Police and the  
Rail Industry**



## **Section 1: Summary of Application**

In Great Britain, suicide had been rising after many years of decline. In 2013 the number increased to an unprecedented 5.914 deaths, before reducing during the following three years.

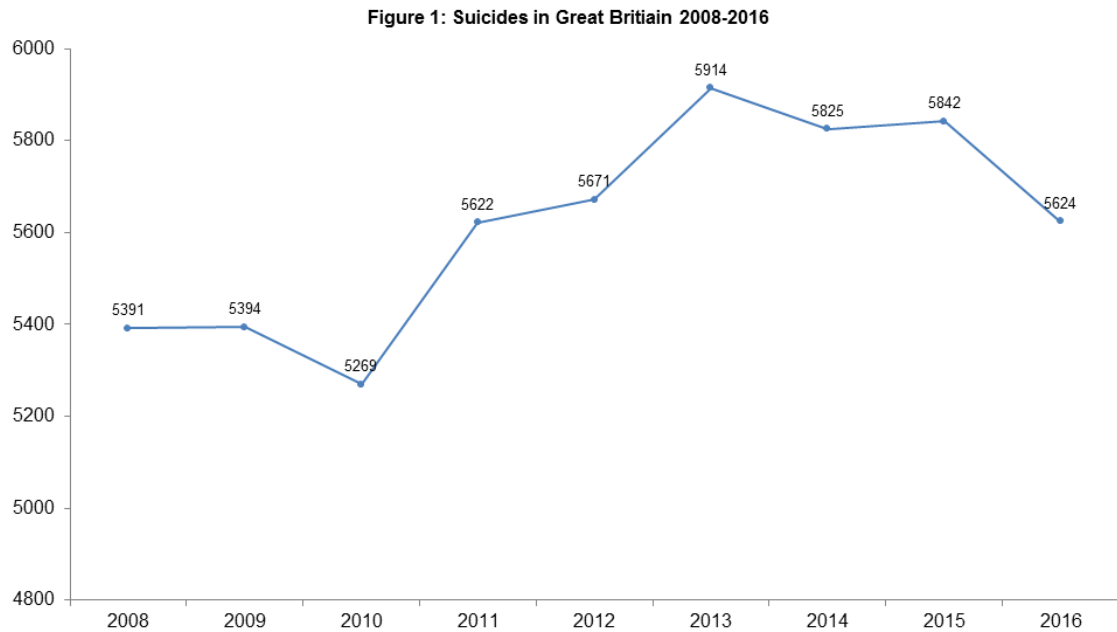
Such deaths are a tragedy for family members, friends and colleagues. For those professionally charged with dealing with the consequences, they can also be highly traumatic experiences.

Suicide was never a criminal offence in Scotland and was decriminalised in England and Wales in 1961.

Research conducted in the 1970s and 1980s reported how the denial of opportunity (when 'coal gas' was replaced by methane for domestic energy consumption in the United Kingdom), led to the all but elimination of that modus operandi in committing suicide.

It is often presumed that those denied one means of completing suicide are in some manner displaced. However, research indicates that 'Suicidal Ideation' is highly method specific and the overwhelming majority of those prevented do not choose another means.

Nevertheless, many suicidal people wrongly perceive the rail network to be an easy and always lethal method of taking their lives.



Since 1830, British Transport Police (BTP) has been responsible for policing the railway network of Great Britain (see Appendix A).

As part of a problem solving strategy, in 2009 BTP established the first cross rail industry suicide prevention working group. This was later amalgamated with a new Network Rail and Samaritans partnership programme in 2010. In 2013 BTP established (with rail industry support and funding), its central Suicide Prevention and Mental Health (SPMH) unit to record, analyse and reduce suicides. SPMH has been instrumental in forging further partnerships with the National Health Service and other statutory and non-statutory agencies, with the aim of reducing lives lost across the rail network.

Key partnership responses detailed and assessed in this submission include:

1. Creation of the Suicide Prevention and Mental Health unit
2. Data harvesting, analysis and sharing
3. Identification of suicide hotspot locations and the escalation process

4. The sponsoring of academic research of suicide
5. Suicide prevention training for rail employees, frontline officers and police staff
6. Crisis interventions by police officers, police staff, rail employees and the public: 5,673 pre-suicidal and mental health incidents producing 1,917 life-saving interventions in 2017/18
7. Highly effective Suicide Prevention Plans for those contemplating the rail network as a means of death
8. Post event scene examination by Designing Out Crime Officers whose recommendations draw heavily on CPTED methodology.

## **Section 2: Description**

### **1.0 Scanning**

#### **1.1 Suicide in Great Britain**

Figures maintained by the Office for National Statistics (2018) and Samaritans (2017) chart the increase in suicide over the past decade and recent downturn (see Figure 1). Nevertheless, suicide remains the leading cause of death for men aged between 16 and 49 and in 2013 accounted for four out of five suicides in Great Britain.

#### **1.2 The rail network**

There are some 9,817 miles (2016) of standard gauge railway lines in Great Britain, together with 251 miles on the London Underground and 300 miles of Light Rail and Tram lines. These networks include 2,564 passenger stations, 28,000 thousand bridges and numerous other rail facilities such as level crossings, freight depots, marshalling yards and signalling control centres.

#### **1.3 The role of British Transport Police**

British Transport Police (BTP) operates across the rail network of England, Scotland and Wales. Consequently, its remit relates to that of Great Britain.

#### **1.4 Fatalities on the rail network of Great Britain**

BTP classifies fatalities on the railway network under separate headings:

- a. Homicide
- b. Fatal Accident

- c. Sudden Death
- d. Suspected Suicide

In addition, there are separate classifications relevant to this subject area:

- e. Injurious Attempts – a suicide attempt where physical injuries are sustained
- f. Non-Injurious Attempt – a suicide attempt where physical injuries are sustained (many of these relate to life saving interventions whereby the suicide attempt is interrupted).

### **1.5 Decriminalisation of suicide**

In Great Britain, suicide was never a criminal offence in Scotland and was decriminalised in England and Wales in 1961.

### **1.7 Psychiatric concept of ‘Suicide Ideation’**

Mayhew et al (1976) and Clarke and Mayhew (1988) reported how opportunity was especially important amongst those intent on taking their own lives. Indeed, during the changeover from coal gas to methane, between 1958 and 1977 total suicides in England and Wales reduced by more than 25 per cent.

Similarly, the psychiatric concept of ‘Suicide Ideation’ (Klonsky et al, 2016; RISSG, 2017; Pedersen, 2018) maintains that potential suicides are method specific and that restricting the means of taking their lives can prevent such actions.

## **1.7 Responsibility for suicide prevention and the protection of life**

As part of the *BTP Safeguarding Strategy 2015-2019, From Crisis to Care: A strategy for supporting people in mental health crisis and preventing suicide 2016-2019*, sets out the police response. A primary function of the police is the protection of life, including responding to people in crisis and in referring vulnerable people to support services.

## **1.8 The legal case**

- The duty to protect life and property, as set out 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 stipulate police data will be recorded, stored and used to support public protection.

Failure to comply with these duties and responsibilities can lead to sanctions at individual and organisational level. It can also lead to a loss of public confidence or sanction by the Coroner (Procurator Fiscal in Scotland).

## **1.9 The economic case**

Mental ill health costs the UK economy £105 billion each year. Attempts to quantify the economic and social costs of suicide have been undertaken in both national and international research, providing the following estimates:

Scotland – £1,290,000 per case in 2004 (Platt et al, 2006)

England – £1,450,000 per case in 2009 (Knapp et al, 2009)

Dealing with the full range of suicidal behaviour and crisis-related incidents places a significant demand on police resources. Consequently, any reduction in suicide can only be beneficial, both in cutting the personal cost to individuals, their families and friends, and in relieving the financial burden on public services – such as health, social care, the police and rail transport operators.

## **1.10 The ethical case**

A mental health crisis and the desire to take one's own life may be a temporary condition, induced by extreme stress, anxiety, depression or social distress. Research points to known aggravating and protective factors affecting suicidal thought. In many cases, people who have had access to the right help and support are able to recover from such a crisis.



Police, rail staff and the public are advised that suicide is not inevitable and may often be a decision made at times of crisis when normal decision-making is compromised, and the person is extremely vulnerable.

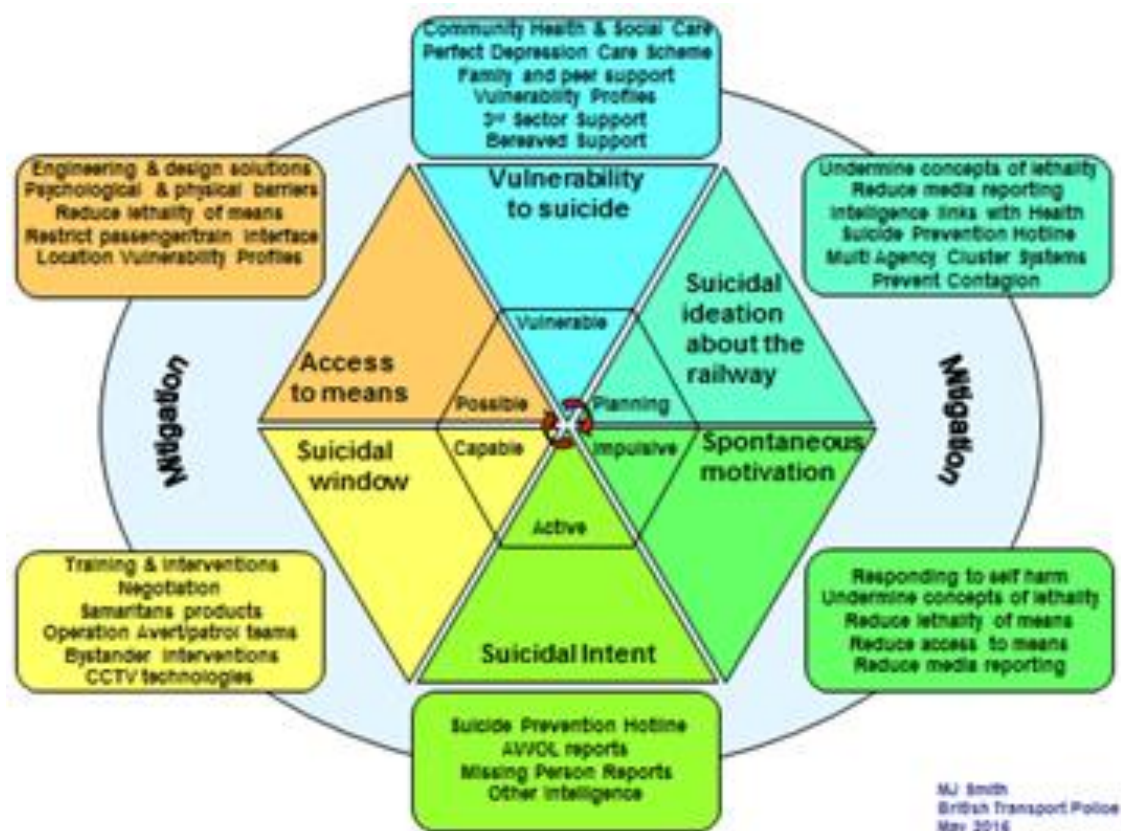
Supporting those in mental health crisis and preventing suicide is about helping some of the most vulnerable people in society and also preventing the consequences of suicide. This will include the devastating impact on the bereaved family and friends, and increased risk to suicide that this creates amongst them.

The police service is committed to protecting vulnerable people and so there should be no distinction between those who are at risk to harm from others and those who are a risk to themselves.

### **1.11 The problem**

Those who take or attempt to take their lives on the rail network, are a fraction of the many thousands with mental health issues who each year deliberately target the rail infrastructure with such intent (see Figure 5). In addition to the human and medical costs of dealing with so many tragedies, there are the economic costs associated with the aftermath: delayed and cancelled trains, repairs, cleaning, passenger congestion and inconvenience. It is the responsibility of BTP and the rail industry to deal with many of these issues and thus the value of problem solving and partnership working.

## 2.0 Analysis



### Suicide Analysis Model

#### 2.1 Suicide Analysis Model

Because suicide is no longer a crime anywhere in Great Britain and as its motivations and potential mitigations are complex, the Problem Analysis Triangle was considered unsuitable. Instead, the Suicide Analysis Model was developed by SPMH with specific reference to the rail network.

This model is based on six considerations:

1. Vulnerability to suicide (vulnerable)
2. Suicidal ideation about the railway (planning)
3. Spontaneous motivation (impulsive)
4. Suicidal intent (active)

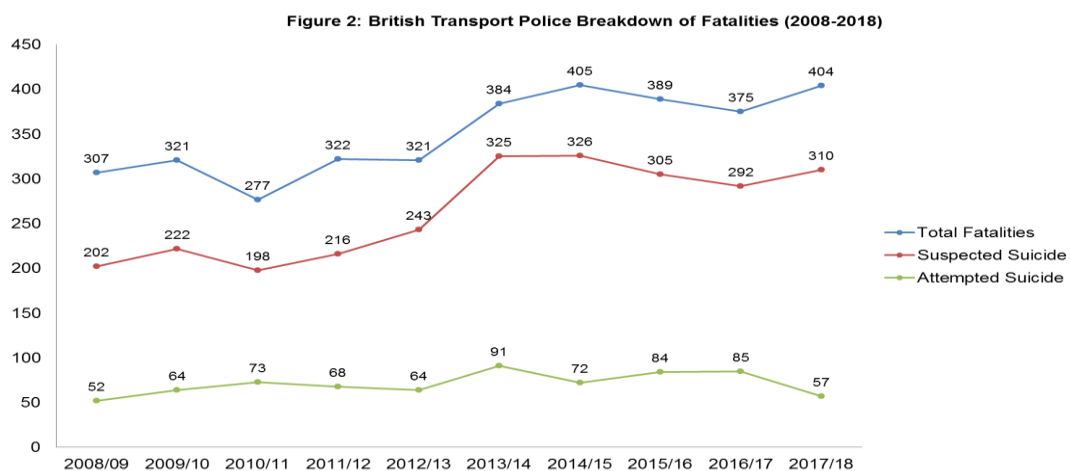
- 5. Suicidal window (capable)
- 6. Access to means (possible)

Six mitigation categories relate to each of the above considerations and each contains a menu of realistic tactical interventions that can (and have been) implemented.

## 2.2 Mental Health Incidents

In 2017/18 BTP dealt with some 5,673 mental health crisis and suicide-related incidents and with its partners, directly prevented 1,917 people from taking their own lives on the railways. These people were removed from a place of danger and in most cases detained under Section 136 of the Mental Health Act 1983, or Section 297 of the Mental Health (Care and Treatment) (Scotland) Act, 2003.

## 2.3 Suicide on the railway network of Great Britain



Almost since its inception, the rail network has attracted those who wish to take their own life. Over the past decade, suspected suicides on the rail network increased by more than 50 per cent between 2008/09 and 2014/15. Over two years they reduced by 10 per cent, before increasing to 310 in 2018/18. Attempt suicides increased from 21 in 2008/09 to 91 in 2014/15 before reducing to 57 in 2017/18. However, a number of warnings need to be given in relation to these statistics.

First, many of these figures are relatively small and consequently suffer insufficient statistical resilience. Second, the advent of the SPMH and its force-wide mandate meant that new (and ongoing) changes in the capture, defining and analysis of data took place. Similar changes took place in the figures recorded by the ONS.

#### **2.4 Great Britain Railway Fatalities in 2017/18**

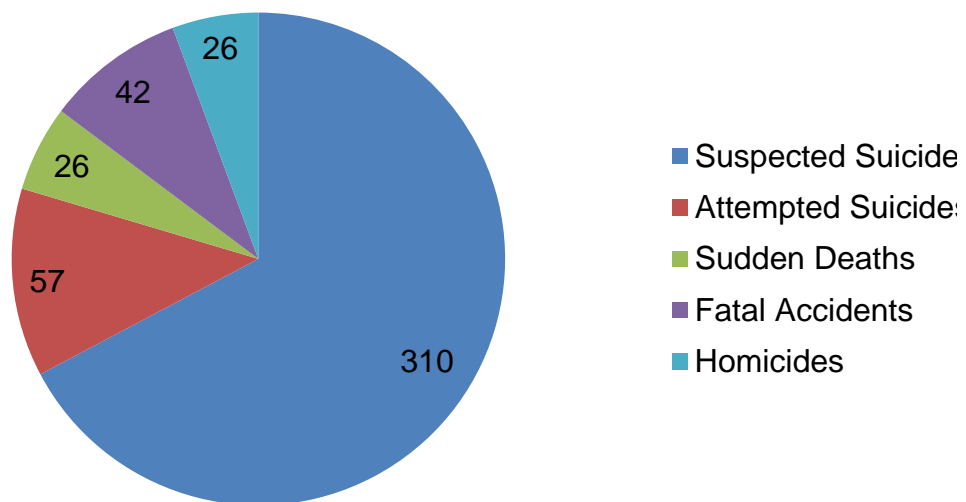
In 2017/18 the total recorded fatalities that took place on the rail network was 404. This figure includes 42 fatal accidents, 26 sudden deaths and 26 homicides. Moreover, because BTP polices the venue, this last figure includes the 22 victims of the Manchester Arena terrorist attack in May 2017 (amongst whom the suicide bomber is included).

A geographical breakdown of the remaining 310 suspected suicides and 57 injurious attempts now follows.

Scotland witnessed a reduction in the number of suspected suicides, down to 16 from a figure of 24 in the previous year. Injurious attempts also reduced. In Wales, suspected suicides decreased by four to 8, whilst injurious attempts reduced by two.

London and the South of England witnessed reductions in the number of injurious attempts, down from 38 to 34 in total, and suspected suicides down from 148 to 139.

**Figure 3: Breakdown of Great Britain Railway Fatalities and Attempted Suicides (2017/2018)**



In the West of England, injurious attempts reduced from nine to zero, whilst suspected suicides increased from 20 to 22. The English Midlands witnessed injurious attempts reduce by three. However, suspected suicides increased from 36 to 50. In the north of England (Pennines), injurious attempts went down from 19 to 13. But suspected suicides increased from 52 to 75. Total fatalities increased from 65 to 112, when compared to 2016/17.

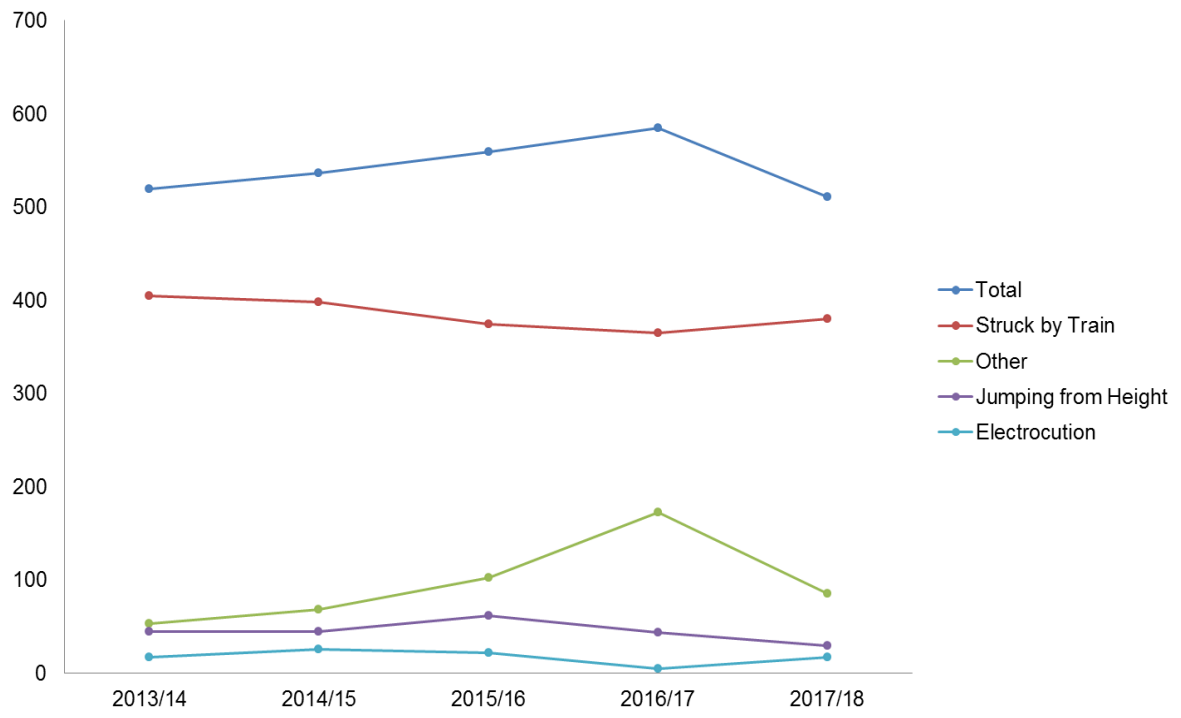
## **2.5 Fatality causes and suicide methodologies**

Over a five year time period, fatality causes and suicide methodologies have remained relatively constant (see Figure 4). 'Struck by Train' accounts for in excess of 70 per cent of all fatalities in any given year. 'Struck by Train' is not further categorised, although it will be detailed in the investigation for the Coroner (Procurator Fiscal in Scotland) and in the Post Incident Site Report (see 4.7 and Appendix D).

'Jumping from a Height' (most often a bridge) makes up approximately 8 per cent of all suspected suicides and 4% by 'Electrocution'. 'Other' largely consists of homicides, fatal and non-fatal accidents and sudden deaths. However, 'Other' also includes 'Hanging', 'Overdose' and 'Vehicle Collisions' none of which measure more than five incidents in any year.

The term 'suspected suicide' is deliberately used as it is not always possible to provide a definitive explanation for the cause of death. In a similar vein, the nature of the Coronial (England and Wales) and Procurator Fiscal (Scotland) inquest systems means that the most recent statistics available from the ONS are for 2016. Whereas SPMH maintains a more immediate (April-March) rolling database, where results are updated as necessary e.g. following an inquest verdict.

Figure 4: Fatality Causes and Suicide Methodologies 2013-2018



### **3.0 Response**

In addition to the menu of tactical interventions detailed within the Suicide Analysis Model on page 10, BTP's response to suicide taking place on the rail network builds on existing partnership arrangements and includes:-

#### **3.1 Statement of purpose**

In *From Crisis to Care (2016)* BTP sets out its Statement of Purpose. A primary function of the police is to protect life and BTP will ensure:

- Policies, procedures and activity support this function
- Compliance with existing legislation
- Local activity complements national strategies to prevent suicide
- Links are maintained to exchange information and good practice
- BTP will support partners in developing and standardising our approach to those in mental health crisis and vulnerable to suicide
- Support for the key themes of Mental Health Crisis Care Concordats.

#### **3.2 Strategic aims**

BTP police officers and staff will work with partners to:

- Prevent suicide occurring on Great Britain's railways
- Support vulnerable people and those in mental health crisis
- Effectively manage the impacts of suicide on the railway.

#### **3.3 Strategic alignment – 6 million passengers each day**

Complements and supports national and force level strategies, objectives, duties and responsibilities across England, Scotland and Wales including:



- The aim to ensure the 6 million passengers who use the railway system each day get home safe, secure and on time
- Strategic objectives for 2014-19
- 2017/18 Policing Plan
- Safeguarding Strategy 2015-2019
- Rail Industry Suicide Prevention Duty Holders Group Strategy
- National Suicide Prevention Strategies in England, Scotland and Wales
- 5 year forward view for mental health – Mental Health Task Force, reduce suicide by 10 per cent by 2020/21
- Statutory safeguarding
- Mental Health Crisis Concordat National Action Plans

### **3.4 Delivery through collaboration**

Partnership strategy is delivered through an action plan aligned to the key elements of the national suicide prevention strategies. A common thread is the need to maintain effective partnerships and relationships with a range of organisations and groups such as:

- Rail industry partnership, including Network Rail, Train and Freight Operators, Association of Train Operating Companies, Rail Delivery Group, Rail Safety and Standards Board, London Underground and Transport for London
- Third sector suicide, mental health and bereavement organisations e.g. Samaritans, MIND, CALM, Papyrus, If U Care Share, SOBS, CRUSE
- National Health Service in England, Scotland and Wales
- Local Authorities and Public Health in England, Scotland and Wales

- National Police Chiefs' Council and Police Scotland
- College of Policing
- All Party Parliamentary Group on Suicide and Self Harm Prevention
- National Suicide Prevention Strategy Advisory group
- National Crime Agency
- Academic institutes and research bodies
- National Suicide Prevention Alliance and Alliance of Suicide Prevention Charities
- National Mental Health Crisis Care Concordat in England and Wales.

### **3.5 National strategies and BTP action and support**

#### **3.5.1 Data and analysis**

- SPMH captures and analyses relevant data to understand the vulnerability of people, places and times
- Provides regular internal and external reporting
- Maintains the data hub to provide regular data sharing with Mental Health Crisis Care Concordat Groups, LAs, Public Health and National Health
- Supports and learns from academic research and development.

#### **3.5.2 Upstream prevention**

- Works with local partners as a signatory to the Mental Health Crisis Care Concordats in England and Wales
- Works with LAs to contribute and support local Suicide Prevention Plans

- Identifies and provides support to high risk groups
- Promotes use of the Suicide Prevention Hotline to highlight suicide risk
- Promotes effective primary care for depression, anxiety and personality disorders
- Supports local Zero Suicide schemes
- Supports the promotion of positive mental health messages and campaigns and provides contact numbers for support services.

### **3.5.3 Restricting access to means**

- Provides post-event site visits to advise on preventive location-based options
- Works with the rail industry to identify national priority locations for suicide prevention engineering and community outreach activity
- Conducts intelligence-led deployments based on the analysis of people, places and times
- Encourages target hardening the most vulnerable parts of railway and engineering solutions for new builds to 'design out' opportunity
- With local partners, exploits learning in recent Public Health England guidance to prevent suicide hotspots
- Works with partners to exploit technology that may reduce access to and lethality of means.

### **3.5.4 Safeguarding and crisis care**

- Provides effective intervention and case management through use of statutory powers, BTP Suicide Prevention Plan process and joint BTP and Health Suicide Prevention and Mental Health teams
- Provides relevant referrals to partner agencies, including statutory safeguarding referrals where relevant
- Continue to develop BTP's third party referral scheme with Samaritans
- Promotes and actions data sharing with partner agencies to better understand risk
- Promotes the rail industry safeguarding communications framework
- Promotes new solutions for effective crisis care including better detention and assessment provisions
- Promotes changes/clarification to existing legislation re detention under the Mental Health Act and Adult Safeguarding in England.

### **3.5.5 Managing the consequences**

- Provides a professional response to suicidal incidents, which aims to protect life and minimise disruption
- Ensures BTP staff benefit from trauma management arrangements
- Developed and published a 'Charter for the Bereaved' (2018 - see Appendix A) that sets out service delivery standards expected of BTP
- Provides effective investigations for the Coroners (England and Wales) and Procurators Fiscal (Scotland)
- Identifies and supports members of the public traumatised by suicidal incidents in a timely manner

- Ensures the vulnerability of those bereaved by suicide is understood, identified and effective support provided.

### **3.5.6 Tackling suicide contagion**

- Operates a joint escalation process with the rail industry at locations with multiple events within given timescales
- Highlights relevant anniversary dates to police and rail industry
- Works with local authorities, Public Health, rail industry and other partners to tackle suicide clusters
- Works with our investigators to tackle effects of social media following a suicide on the railway
- Supports the rail industry and partners to produce public messaging that does not reinforce the railway as a lethal means of suicide
- Supports local suicide surveillance groups with relevant data
- Supports Samaritans and other partners in influencing the media to report suicide within terms of national guidance.

### **3.5.7 Enabling and education**

- Provides effective training for BTP officers and staff through a suite of its own and external products
- Works with the College of Policing to provide Approved Professional Practice in relation to Mental Health and Suicide Prevention
- Learns from those with lived experience so as to improve BTP's service and better understand the nature of crisis
- Explores and exploits technology

- Promotes joint accredited training with health and social care
- Promotes use of online learning tool by BTP and other police forces, through online training packages
- Promotes good citizenship and works with industry partners to provide the public with tools to support BTP's preventative work
- Supports national publications and guidance through the provision of advice and feedback.

## **4.0 Assessment**

### **4.1 SPMH**

Unique within UK policing, the Suicide Prevention and Mental Health (SPMH) unit has been the primary element in co-ordinating BTP's activities in preventing suicide on the rail network. It has worked with partners across the railway industry and beyond, most especially Network Rail and Samaritans.

### **4.2 Data harvesting, analysis and sharing**

SPMH provides the analytical and intelligence function for BTP in relation to fatalities and attempted suicides on the rail network. It analyses this information, has refined its recording over time in pursuit of accuracy and readily shares data with partners, in pursuit of reducing suicides and injurious attempts.

### **4.3 Suicide location hotspots and escalation process**

SPMH identifies suicide location hotspots – those locations that have suffered at least three suicides and/or injurious attempts within a rolling 12 month period.

This triggers the 'escalation process' whereby a meeting is convened locally of public and local health representatives, together with those from the police, rail industry and Samaritans.

To support the process, the central SPMH team creates a local profile with personal data of the deceased and those alive and considered at risk, which is shared with statutory agencies.

An Action Plan is devised and successful measures have included:

- Erecting mid-platform fencing and gates to separate 'fast' lines (carrying non-stopping trains) from 'slow' lines where trains stop at that platform
- Employing security guards to patrol the train station and specific, high risk platforms
- Biometric CCTV alert systems (currently being evaluated).

There are at present 26 escalated suicide locations in Great Britain – 24 in England and 2 in Scotland.

#### **4.4 Suicide prevention training**

Working with BTP's Learning and Development department and Samaritans, SPMH has ensured that frontline police officers and staff are trained in identifying persons at risk and suicide prevention.

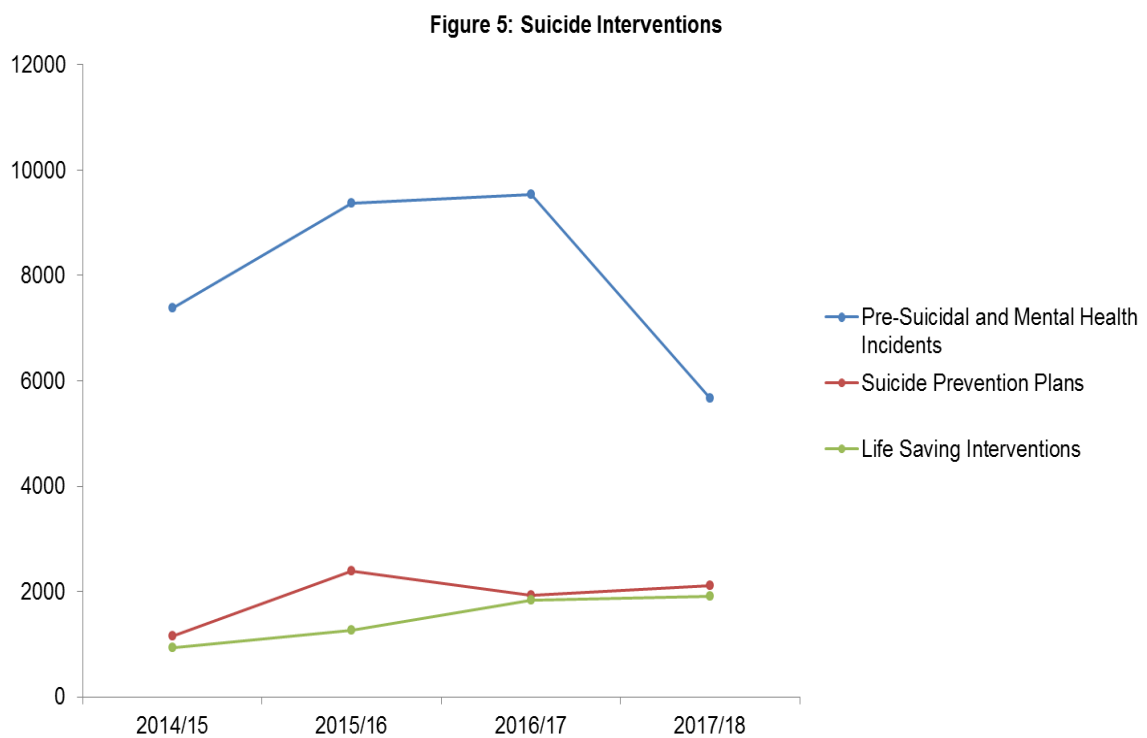
#### **4.5 Crisis interventions by police officers, staff and rail employees**

Since 2014, SPMH has recorded crisis interventions by police officers, staff and rail employees. As Figure 5 below demonstrates, 'pre-suicidal and mental health incidents' rose from 7,387 in 2014/15 and to 9,546 in 2016/17, before



falling back to 5,673 in 2017/18. This last reduction is attributable to a more accurate definition adopted by SPMH.

Of seminal importance, in successive years 935, 1,269, 1837 and most recently (2017/18) 1,917 life-saving interventions were made by BTP frontline staff, rail employees and members of the public.



#### **4.6 Suicide Prevention Plans**

Since the SPMH was first established, a particularly effective initiative in preventing suicide on the rail network has been the referral of those at risk from self-harm into Suicide Prevention Plans (SPP). Each SPP is a bespoke variant designed to meet the requirements of the individual in question.

As an indication of the effectiveness of the SPP process, since it was extended across the whole BTP force area in 2014, in successive years 1,156, 2,397, 1,928 and most recently 2106 (in 2017/18) individuals have been referred into these plans. Most importantly, those in SPPs known to have subsequently taken their lives numbered:

- 2014/15 – 0
- 2015/16 – 15 (7 on the rail network)
- 2016/17 – 12 (6 on the rail network)
- 2017/18 – 10 (5 on the rail network)

These figures suggest minimal displacement and a massive diffusion of benefits (in terms of individuals diverted away from suicide).

#### **4.7 Site visits by Designing Out Crime Officers (DOCOs)**

Beginning as a pilot project on the London North sub-division in 2011 and subsequently extended across the whole force area in 2014, BTP Designing Out Crime Officers (DOCOs) are tasked with attending and surveying the scene of each suspected suicide or injurious attempt that takes place on the rail network. They then submit a Post Incident Site Report (see Appendix D).

The latter is a narrative document, which also includes a list of recommendations about how the opportunities for suicide might be reduced at that location. These recommendations are drawn from a menu of measures (see Appendix C), largely based on Crime Prevention Through Environmental Design (CPTED) concepts and will include:

- Physical security ‘target hardening’ measures (e.g. platform end gates and fencing; raising bridge and wall parapet heights)
- Technological innovations (e.g. lighting, CCTV, biometric alert systems)
- Environmental elements (e.g. enhancing defensible space, natural surveillance, territoriality, reducing access/movement/permeability)
- Symbolic barriers (e.g. pegamoids/‘witch’s hats’ at platform ends, hatched markings). See Holt and Spencer (2005) and warnings of Shaftoe and James (2004) regarding effectiveness
- Accreditation under Secure Stations scheme
- Samaritans signage and posters (see Appendix E)
- Removal of memorials (to reduce ‘suicide contagion’).

Many of these recommendations will have an international application: see Florentine and Crane (2018); CRISE (2018). They are also now included in the Rail Industry Suicide Stakeholder Group (2017) document, *Measures Employed by the Rail Industry to Prevent Suicides on the Network* (see Appendix B).

The DOCOs’ reports are of great benefit to the rail industry and are especially valued by the Coroners (in England and Wales), Procurators Fiscal (Scotland) and ORR (Office of Road and Rail).

DOCOs are also members of rail industry bodies e.g. the Station Design Task and Finish Group, which for the first time has a remit to incorporate mandatory anti-suicide measures in rail station design briefs.

As an indication of the success of their role and unique amongst their fellow DOCOs across the UK, visiting the scene of each suicide and injurious attempt and compiling Post Incident Site Reports, now dominates their work activity.

#### **4.8 Sponsoring Academic Research**

BTP has also commissioned academic research into suicide prevention, most recently that of Marzano et al (2016). The latter investigated media (terrestrial and online) reporting of suicide, how this encourages such acts and how it can be influenced to reduce suicide ideation. As a result, audible announcements on trains and stations have been changed. And a media campaign is planned, to highlight how the rail network does not provide the guaranteed means of death that those who wish to take their lives imagine.

#### **4.9 Future suicide prevention/identification technology**

In addition to the use of Biometric CCTV alert systems referred to in 4.4 above, the use of 'blue light' has been trialled – most notably at the hotspot location of Romford station in Essex. The theory is that 'blue light' has a calming effect and is associated with the emergency services. However, and as the Japanese have discovered with its use on the Yamanote line in Tokyo, electrically-operated platform barriers are a far more effective solution.

Indeed, platform barriers are in use on the eastern section of the Jubilee Line, London Underground, where they have proved to be especially effective.

#### **4.10 Conclusion**

The increase in recorded suicides on the rail network after the SPMH unit was created reflects the national trend – and may also demonstrate how a new initiative will (by proper recording and analysis) reveal the true extent of an identified problem. Furthermore, as the sheer volume of ‘life-saving interventions’ and ‘Suicide Prevention Plan’ statistics detailed in Figure 5 demonstrate, without the SPMH and its strategy of multiple interventions, the number of suicides and injurious attempts would almost certainly be far higher than currently being recorded. In conclusion, by adopting a problem solving approach to suicide prevention, BTP and the rail industry have delivered considerable benefits for everyone using the network.

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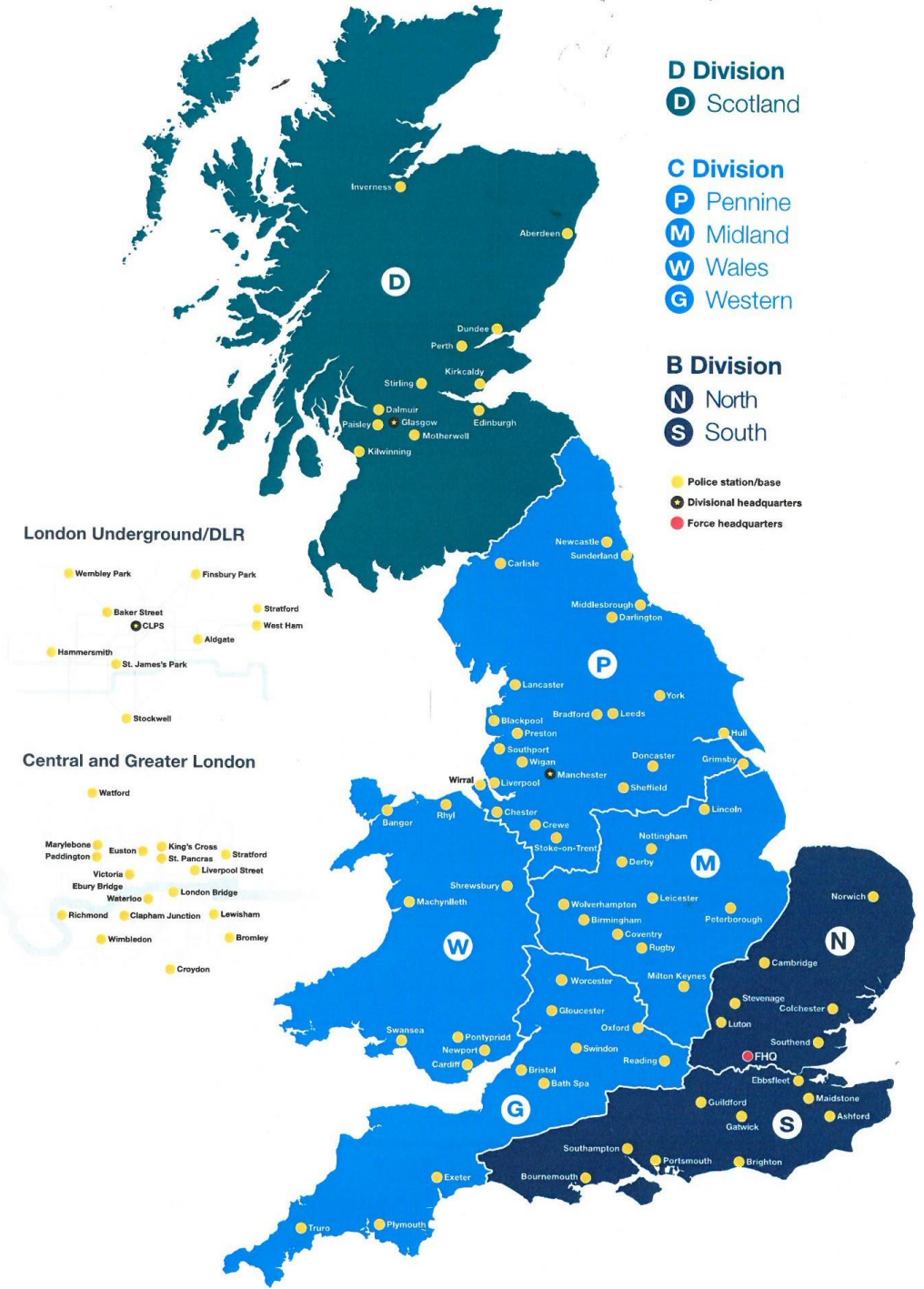
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# Appendix A



# What happens next when someone close to you dies on the railway





## Appendix C



Measures employed by the rail industry to prevent suicides on the network



## Post Incident Site Report

General Information			
CRU Report Reference		BTP Control Works Reference	
Incident Location and Date		Miles & Chains	
Incident Reason/Type		Primary Operators Affected	
Survey Date		Report Author	
Train Operating Company			
Primary TOC Affected		TOC Representative Report To Be Sent To	
Network Rail Route			
Primary/NR Route Affected		NR Route Representative Report To Be Sent To	
Previous Reports			
Has previous post fatality reports for the same location been submitted by a BTP DOCC in the past 12 months?		Details of previous reports if applicable	
Have recommendations from previous reports been implemented?		Confirm copies of previous reports are attached	

**Please note:**

The author of this report is not an expert in Health and Safety, railway level crossing or foot crossing legislation or requirements. The data in this report will be used for analysis purposes and these recommendations are made from a British Transport Police perspective as part of our on-going commitment to fulfil the primary police function, which is to protect life.

## Appendix D

Appendix E

**TALK TO US**  
if things are getting to you.

**08457 90 90 90\***

**SAMARITANS**

## References

- British Transport Police (2015) *BTP Safeguarding Strategy 2015-2019*. London: British Transport Police.
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