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Transport related Suicide prevention

Over the last 12 months research carried out in Sweden has highlighted the misclassification of transport related suicide. The research carried out by Anna-Lena Andersson (Special Adviser, PhD Swedish Transport) challenged the official statistics of 6% of fatalities on the transport network being suicide. Her team concluded that this figure is 4 or 5% higher, highlighting that the problem is significantly greater than first thought.

In Wales collaboratively we are working with key stakeholders to strategically plan ahead to reduce the risks on our network. Over the next few months the first All Wales Fatal review board will meet and one of the terms of reference will be to identify collisions that are caused by suicide. The Fatal review Board is a first of its kind for the UK, it function is to bring all emergency services, local authorities, NHS, coroners and 3 sector partners together to review all fatal collisions in Wales. This will allow all parties to learn from good/bad practices, identify common themes and collectively make really changes throughout Wales to save lives.

Wales Government Transport department has set up a working group with the Police to identify opportunities to prevent transport related suicide. The group have identified that there must be a multi-agency approach share date of bridges, buildings, costal area that members of our community are using to attempt/commit suicide. Upon identify these locations in Wales we could take a collaborative approach to put preventative measures in place to reduce the risk. This could be for example an engineering solution, signage signposting individuals to charities and so on.

In Wales we have started to work with our partners in British Transport Police to learn from the outstanding work their doing to reduce suicide on the rail network. BTP and partners have taken a 9 point approach to reducing suicides on the network, these are the 9 points -

1. Leadership and resources:

a. Working in partnership and allocating resources appropriately across the railway industry such as tasking local officers and embedding officers within route teams.

2. Identifying 'priority/at risk' locations:

- a. Employing geographical and temporal analysis to identify locations, regions or routes with proportionally higher numbers of incidents.
- b. Compiling a list of National Priority Locations based on incident numbers and disruption. c. Introduction of the Escalation Process to address locations that have seen three or more suspected suicides and/or injurious attempts within a 12 month period.
- d. Engaging with local authorities to address suicidal activity and enhance the support for those in mental health crisis.

3. Physical mitigation measures:

a. Restricting access to the means by methods such as; securing bridges, lineside fencing, mid platform fencing and restricting access to unused platforms.

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b. Introduction of more CCTV cameras, security lighting, platform hatchings and enhancing security and patrols at high risk locations.

4. Promoting life-saving interventions:

a. Promoting and supporting life-saving interventions using suicide prevention materials and the BTP Suicide Prevention Hotline.

5. Training staff to intervene in suicide events:

a. Introduction of the Managing Suicidal Contacts (MSC) course for frontline staff and the related Learning Tool DVD.

6. Promoting help seeking behaviour:

- a. Using campaign material such as Samaritans posters to promote help seeking behaviour and introducing crisis signs at high risk locations.
- b. Raising awareness of suicide both nationally and locally and using third-party referrals for potentially vulnerable individuals.

7. Trauma management support and resilience.

8. Trauma support training.

9. Emotional support.

In Wales our goal is to introduce a similar approach to the road network, together with the fatal review board we believe that Wales make a significant step towards reducing suicides in Wales.