Suicide and bereavement response

This page is from APP, the official source of professional practice for policing.

First published 4 July 2016 Updated 30 January 2026
Written by College of Policing
39 mins read

This guidance has been produced to enhance the knowledge of officers and police staff on both suicide prevention and response. The purpose of this module is to support police forces and individual officers in offering crisis intervention to individuals who are at risk of suicide and respond professionally and effectively when suicide occurs.

This guidance will also help officers to:

- understand why suicide prevention is an important part of the role of a police officer or member of police staff
- identify people who may be at risk of attempting or completing suicide, (including colleagues or other staff members)
- approach suicide prevention in a standardised way, increasing awareness of potential vulnerabilities of persons involved in any incident or police enquiry
- manage risk and record data accurately so the potential for suicide can be effectively managed, monitored and analysed
- assist those considering suicide and those bereaved by suicide, (for information on referral to support services see **Sources of support**)

Definitions and terminology

Definition of suicide

Suicide may be defined as, 'the action of killing oneself intentionally' (**Oxford English dictionaries**).

The Office of National Statistics (ONS) defines suicide (within their analysis of Suicide data) as, 'a death (categorised by coroner’s verdict) caused by:

- intentional self-harm
- injury/poisoning of undetermined intent
- sequelae of intentional self-harm/injury/poisoning of undetermined intent'

Definition of self-harm

Self-harm may be defined as intentional self-injury or self-poisoning, irrespective of type of motivation or degree of suicidal intent (**NICE Self-harm** and **Hawton and others 2003**).

This definition (which is used widely in a similar way in countries in Europe and elsewhere) encompasses both suicide attempts and acts with other motives or intentions. This reflects the often mixed nature of intentions associated with self-harm and also the fact that suicidal intent has many dimensions.

Self-poisoning

Self-poisoning is defined as the intentional self-administration of more than the prescribed or recommended dose of any drug (for example, analgesics, antidepressants), and includes poisoning with non-ingestible substances (for example, household bleach), overdoses of recreational drugs, and severe alcohol intoxication where clinical staff consider such cases to be acts of self-harm.

Self-injury

Self-injury is defined as any injury that has been deliberately self-inflicted (for example, self-cutting, jumping from a height).

Classification of suicide and suspected suicide

It is the role of HM coroner to carry out a formal inquiry into the cause of death, this is called an inquest. Where appropriate, the coroner will provide an official finding of suicide or may allude to suicide within a narrative finding. This information will be collated and published annually by the Office of National Statistics (ONS).

However, to allow for an effective and fast, intelligence-led response by the police and local authorities there is often a requirement for an initial judgment to be made on whether a case is potentially suicide. When the police are able to categorise a sudden death as an apparent suicide this information can be shared efficiently across agencies to provide appropriate support to the

bereaved and community. This data may also be used in analysis of emerging hotspots, clusters or suicide methods.

Officers should use their professional judgment – based on all the known facts – and supported by the **national decision model (NDM**), to record whether a fatality is a suspected suicide. Witness accounts, CCTV material, the presence of a suicide note and other available evidence will help in this determination. The **'Ovenstone criteria' (Ovenstone 1973)** may be used as a tool to support decision making on whether a death was more likely to have been suicide than not. Any judgement made in the first instance must be reviewed as further information becomes available.

The Ovenstone criteria

Dr Irene Ovenstone introduced a set of criteria in 1973 which may be used to make judgements as to whether a death is more likely to have been suicide than not. Dr Ovenstone used this methodology during a review of the verdicts of procurators fiscal and crown counsel in Edinburgh. (Her study revealed a potential under-reporting of suicide by crown counsel in Edinburgh of 40.67%.)

The Ovenstone criteria may also be applied when classifying suspected and attempted suicides and potential life-saving interventions. The criteria suggest that each of the following, on its own, may be treated as sufficient evidence of suspected suicide (unless, of course, there is positive evidence that the fatality was accidental or due to homicide).

Direct evidence

- the presence of a suicide note
- a prior statement of suicidal intent
- the behaviour demonstrates suicidal intent (for example, selecting lethal means)

Indirect evidence

- previous suicide attempts
- a marked emotional reaction to a recent stress situation
- failure to adapt to a more remote stress which may be characterised by depression or withdrawal, and may include resorting to alcohol or drugs (where no such behaviour existed previously) or increased intake.

For further information, see **Irene M. K. Ovenstone – A Psychiatric Approach to the Diagnosis of Suicide and its Effect upon the Edinburgh Statistics – BJP July (1973) 123:15-21.**

Preliminary judgments of this type are for analytical and managerial purposes and should not be shared outside of the statutory partner organisations. Official statistics will always be derived from coroner's findings.

The verdict of the coroner will also inform this judgment however it will not necessarily always change the force classification for the purpose of risk management.

Definition of attempted suicide

Note: The references made to criminal law below are not intended to criminalise suicide or attempted suicide. The basic legal concepts have simply been used as a platform on which to construct a workable test that can then be applied to the relevant circumstances.

The Criminal Attempts Act 1981 (1) defines the concept of an 'attempt'. It requires the actions of the subject to be 'more than merely preparatory to the commission of the offence,' but will also include a subject who changes their mind after the act is sufficiently 'proximate' (in this case in time and place to the lethal means).

In the case of an attempt to complete suicide, the key issue is that there must be an act that goes beyond preparation, even if the person changes their mind or their actions are not fatal. An example of an attempted suicide would a person walking onto a train track with suicidal intent who subsequently jumps out of the way of the oncoming to avoid injury, or who remains on the track and is hit by the train but survives the impact.

Definition of suicide prevention

The World Health Organisation (WHO) guidance is based on the premise that suicide is preventable, and that 'the ultimate aim of 'suicide prevention' is to reduce deaths by suicide. However, it is equally important to reduce the frequency and severity of suicide attempts.

Identifying vulnerability to suicide

Suicide is often the end point of a complex history of risk factors and distressing events. Most people who choose to end their lives do so for complex reasons. Life events do not necessarily need to be of a serious nature but merely a trigger for emotional or behavioural distress building from a number of risk factors for suicide in the individual's life.

Risk factors for suicide

Risk factors indicate whether an individual, community or population is particularly vulnerable to suicide.

Factors may relate to the individual, be social or contextual in nature. These risks may become apparent to police officers or staff during a range of interactions and circumstances (for example, during a police response to an incident, during or after an investigation, during witness care and liaison, and while a suspect is in police custody).

Where risk factors are present there is a greater likelihood of suicidal behaviours. The **WHO Public Health Action for the Prevention of Suicide 2012** has provided the following (non-exhaustive) list of risk and protective factors for suicide.

Individual	Situational	Socio-cultural

• previous suicide attempt • mental disorder • alcohol or drug abuse • hopelessness • sense of isolation • lack of social support • aggressive tendencies • impulsivity • history of trauma or abuse • acute emotional distress • major physical or chronic illnesses, including chronic pain • family history of suicide • neurobiological factors	• job and financial losses • stressful life events (including divorce/separation) • relational or social losses • easy access to lethal means • local clusters of suicide that have a contagious influence	• stigma that may prevent a person seeking help • barriers to accessing healthcare, particularly mental health and substance misuse treatment • certain cultural and religious beliefs (for instance, the belief that suicide is a noble resolution of a personal dilemma) • exposure to suicidal behaviours, including through media and influence of others who have died by suicide

The following additional factors have also been significantly associated with suicide (**Hawton and others 2013**):

- male gender (See the **Men, suicide and society report**)
- previous self-harm
- family history of psychiatric disorder
- more **severe depression**

Protective factors

Protective factors help reduce a person's vulnerability to suicidal behaviours and increase an individual's capacity to cope with particularly difficult circumstances. These include:

- a strong connection to family and community support, namely social connectedness

- skills in problem solving, conflict resolution and non-violent handling of disputes
- restricted access to the means of suicide
- seeking help and easy access to quality care for mental and physical ill health
- personal, social, cultural and religious/spiritual beliefs that support the self

Suicide risk response at an organisational level

Health and social care services are responsible for the delivery of preventative care to people who are self-harming and suicidal. However, a primary function of the police service is to protect life and the police will often have a role to play in responding to people in crisis and referring vulnerable people to support services.

The police also have a responsibility to support local authorities' multi-agency work to manage risk of suicide, dealing with threats, attempts and completed acts of suicide. Police forces may also be able to support partners in their efforts to prevent suicide by standardising the approach to the recording, managing and sharing of data on suicide.

Legal obligations for police response to suicide

The police have various legal obligations to become involved in suicide prevention and response.

1. 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).
2. The duty to protect life, reinforced by Article 2 of the European Convention of Human Rights (ECHR) (the right to life), and how this extends to people at risk of suicide (Keenan V United kingdom 27229/95 [2001] ECHR 242).
3. The duty of care that might exceptionally arise when the police assume responsibility towards a particular member of the public. (See **When do the police have a duty to respond?**)
4. When considering the requirement to keep and analyse data for preventing suicide, the **Police information and records management Code of Practice** stipulates that police data will be recorded, stored and used to support public protection.

Note: Incidents where a person dies or is seriously injured after police contact, including deaths from suicide, must be referred to the Independent Office for Police Conduct (IOPC) for investigation. For further information see **Deaths in custody**.

Suicide prevention strategy

National strategy

Separate national suicide prevention strategies exist for England and Wales and are available here:

- **Preventing suicide in England: a cross-government outcomes strategy to save lives (2012)**
- **Talk to me 2: Suicide and Self Harm Prevention Strategy for Wales 2015-2020**

Regional and local strategies

Public Health in England and Wales provide expert public health advice and support for local areas to develop multi-agency partnerships, suicide prevention strategies and plans. Police forces and health services and social care partners are able to direct and promote activity within their communities through involvement in the creation and management of their local suicide prevention strategy.

The **All-Party Parliamentary Group on Suicide and Self-harm Prevention Inquiry into local Suicide Prevention Plans in England** was published in January 2015.

Strategic considerations for police forces

Police forces are able to support local health and suicide prevention partnerships by recognising their role in suicide prevention activity at a strategic level. The following are recognised as key considerations for police activity in both the English and Welsh national strategies.

- Collecting and monitoring data – real-time data collection and suicide surveillance groups (SSGs) work in partnership with public health teams within their local authorities and coroners (see **Suicide surveillance groups**).
- Routinely identifying people who are vulnerable to suicide, referring those people to support services and working to reduce risk by:
  - referring to multi-agency safeguarding arrangements
  - placing warning markers and information locate markers on the Police National Computer (PNC)
  - removing/reducing access to the means (including removing firearms license).

- Identifying locations and places that are being repeatedly used for suicide or suicide attempts and working in partnership with other agencies to:
  - target suicide hotspots (geographic locations, see **Preventing suicide in public places**)
  - respond to clusters
  - identify emerging methods
  - conduct intelligence-led proactive patrol or neighbourhood policing techniques.
- Understanding the unique requirements of different vulnerable groups (including offenders involved in child sexual exploitation and creating or possessing indecent images of children), and diverse cultural reactions to suicide.
- Safeguarding, using a multi-agency risk management referral process, sharing information to help deal with people in crisis (for example, via multi-agency safeguarding hub (MASH)/multi-agency risk assessment conferences (MARAC)/Care plan, see also **Referral for assessment of needs under the Care Act 2014**).
- Training officers and staff (including control room staff) to be aware of suicide and self-harm, in particular providing guidance on contact and intervention with suicidal people.
- Understanding risks to the bereaved and providing support with partner organisations (see **Sources of support**).
- Appropriate use of public protection powers (MHA s 136) and better coordination with partners as part of the **Mental Health Crisis Care Concordat**/**Mental Health Crisis Care Concordat for Wales**.
- Providing support mechanisms for the mental health and welfare of police officers and staff.
- Encouraging appropriate reporting in the media in accordance with national guidelines.

Suicide prevention activity

The WHO suggest that suicide prevention activity should be guided by national and local strategy and pursued by all agencies with a responsibility for the protection and care of the public. For further information see:

- **WHO (2012) Public Health Action for the Prevention of Suicide**
- **WHO (2009) Department of Mental Health and Substance Abuse: Preventing Suicide a Resource for Police, Firefighters and other first line responders**

Detailed information is available within the **WHO (2009) guidance** to support police forces to plan and execute their strategic and operational approach to suicide prevention at a local level via their multi-agency suicide prevention groups (see below).

Case study: British Transport Police suicide prevention plan

The British Transport Police (BTP) report that, of the 1,334 people who tried to take their own lives on the railway in 2014/15, 327 were killed and 72 survived with serious injuries. However, 935 people were physically prevented from taking their own lives by police, railway staff and/or the public.

The disruption caused by suicides on the railways costs over £60 million per year.

BTP has operated a suicide prevention strategy and standard operating procedure since 2010, which has evolved over time and contains a number of core elements. These include the following.

- Multi-agency training – a partnership with the rail industry and Samaritans which provides suicide awareness training to front-line staff and situational preventative techniques to vulnerable locations.
- Data gathering and analysis – a central suicide prevention and mental health (SPMH) team which records real-time data in relation to suicidal incidents and provides analysis, policy and strategic partnership support.
- Joint police/healthcare response – divisional SPMH teams which are staffed by BTP personnel as well as NHS community psychiatric nurses (funded by NHS England and the rail industry). These joint health and policing teams provide real-time health information to officers involved in incidents on the ground and also apply joint health and police decision making for ongoing management of high-risk subjects through individual suicide prevention plans (see Street triage).
- Individual suicide prevention plans – placing people subject to suicide prevention plans on PNC with an information or locate marker so that officers in other forces will be aware of the suicide risk should they check on someone.
- Intelligence-led response and patrol – the use of an operational tactic, driven by analysis which deploys visible resources to vulnerable locations at vulnerable times to proactively seek out people in distress, remove them from danger and gain effective multi-agency support.
- A Suicide Prevention Hotline – this telephone number (0300 123 9101) has been provided to health services (especially mental health trusts), frontline rail staff and volunteers. The hotline

provides an emergency BTP police response to immediate concerns for the safety of a person who has expressed suicidal intentions toward the railway. BTP control room operators answering this line will be aware of the necessary actions and procedures they need to adopt and communicate in order to minimise the risks to life. (A total of 289 calls were made to the Suicide Prevention Hotline in 2014/15 (BTP data)).

Multi-agency suicide prevention groups

Each local authority area are encouraged to have an established multi-agency suicide prevention group (MSPG), headed by the public health suicide prevention lead or their equivalent and overseen by the local health and wellbeing board. (Public Health England (PHE) has issued **guidance on setting up MSPG groups**.)

MSPGs are responsible for developing suicide prevention action plans, which should include a Community Action Plan (CAP) for responding to possible suicide clusters (see **Identifying suicide clusters**).

There are already multi-agency processes in place for reviewing and responding to any sudden death, including suspected suicides, of young people under the age of 18 years (local child death overview panel rapid response team (RRT)) and these should be tied in with the CAP. Suicide contagion is not confined by age boundaries. It is essential that the MSPG establishes links with local bodies responsible for safeguarding children (in England these are local safeguarding children boards) and the local child death overview panel, and is familiar with the **guidance for working together to safeguard children**.

Suicide surveillance groups

Suicide Surveillance Groups (SSGs) are small multi-agency suicide prevention teams that may be assembled by the local MSPG as and when necessary to monitor a potential suicide cluster.

SSG members should be guided by the **PHE (2015) Identifying and responding to suicide clusters and contagion: A practice resource** document.

PHE suggests that SSGs should have a small membership, and include a:

- police suicide prevention lead
- public health suicide prevention lead

- mental health trust suicide prevention lead
- local expert in reviewing mortality data

Police forces should liaise with and support the work of their local SSG.

It may be appropriate for SSG meetings to be held regularly to review real-time data on local suspected suicides and self-harm. One member of the group may take responsibility for a regular review of data. Plotting suicides episodes and also connections (both geographical and social) between them on a map is a valuable method of identifying possible links or contagion.

Each SSG should foster links with similar groups in neighbouring areas to enable a regional overview to be developed, and the early identification of possible increased suicides. This may help to ensure that multi-agency community action plans (CAPs) can be developed and activated quickly and appropriately.

Using the internet and media

The internet is dynamic and driven by its users. It also provides opportunities for the police and healthcare services to target interventions at those who may be vulnerable and in need of support services.

By using the internet, social media (and also traditional media outlets such newspapers, the radio and television) police forces may be able to effectively support vulnerable people by providing links and contact information for support organisations (see **Sources of support**).

Police forces may also be able to use their own social media channels and profile to raise awareness of the criminal nature of online harassment offences (often referred to as ‘cyberbullying’ and ‘trolling’) to prevent crime, self-harming and potential suicide.

Suicide risk response at an individual level

Police officers can be a key point of contact for people at risk of self-harm and suicide. Where such people have mental ill health or learning disabilities, communication may be a particular problem. Dismissing self-harming or suicidal behaviour as some form of manipulation or attention seeking act is dangerous.

Where possible the police response should be supported by:

- a trained police negotiator
- someone who knows the individual (where practicable)
- mental health professional

First response to people who are considering or threatening suicide

Guidance on police interaction and communication style, the assessment of vulnerability, and mental capacity will be available using the following links.

- **Decision making**
- **Communication**
- **Assess threat and risk, and develop a working strategy**
- **Mental capacity**
- **When is police intervention appropriate?**

The **WHO (2009) Department of Mental Health and Substance Abuse: Preventing Suicide a Resource for Police, Firefighters and other first line responders** is a guidance resource for the police service and partners in suicide response.

This document provides the following advice for police officers, firefighters and other responders who believe someone is suicidal.

- Approach all situations involving someone who is suicidal as a psychiatric emergency and act accordingly. (Never assume that suicidal ideas or gestures are harmless bids for attention or an attempt to manipulate others.)
- Clear the scene and keep yourself and others who may be present safe.
- Give physical space, don’t get too close to the person too soon. (Sudden movements, attempts to touch the person, or the introduction of others into the scene, may be misunderstood.)
- Express acceptance and concern. (Avoid sermonising, arguing, problem-solving, giving advice, or telling someone to 'forget about it'.) It is important to convey an attitude of concern and understanding.
- Engage the individual and encourage the person to talk. (Most suicidal people are ambivalent about dying, asking someone if they are suicidal or otherwise talking about suicide will not tip them over the edge, but will provide a sense of relief and a starting point for a solution.)

- To assess intent, ask if the individual has a plan, access to lethal means, or has decided when to act.
- Remove access to all lethal means of self-harm, particularly firearms, and toxic substances (such as large supplies of psychotropic medications, or pesticides).

Note: Officers should avoid leaving a potentially suicidal individual alone based on their promise to visit their mental health worker or the hospital, and should seek to ensure that family members or significant others are on the scene and accept responsibility for help seeking.

Suicide may be averted if people receive immediate and appropriate support. Options for intervention should be carefully considered, and the best course of action will depend on an assessment of the immediate risks to the individual, risks to others, the needs of the individual, and their location.

Response officers should consider using the following options:

- **detention for assessment under the Mental Health Act (MHA) s 136**
- obtaining a **warrant under the MHA s 135** for assessment within a private premises
- use of the **Mental Capacity Act 2005** (see **When is police intervention appropriate?** and **Removal to hospital and deprivation of liberty**)
- Police protection order(s) for children (see **Children and the use of the Mental Health Act 1983 s 136)**
- **referral for assessment of needs under the Care Act 2014**
- referral to charity support services (see **Sources of support**)

Specific communication tools

The information provided here is a summary of the **WHO (2009) Department of Mental Health and Substance Abuse: Preventing Suicide a Resource for Police, Firefighters and other first line responders** guidance.

When officers establish first contact with somebody who may be self-harming or suicidal, communication needs to be initiated. It is important for police officers to allow the person to feel free to speak about the way that she or he feels. Officers should allow the individual to guide the communication and provide clues as to how to understand and help.

Officers may feel that it is appropriate to ask about a number of topics, starting with more general questions and gradually focusing on more direct ones, depending on the answers provided. This must be done with respect, sympathy and sensitivity. Open-ended questions should be asked, such as, 'how do you feel?'

When officers establish first contact with somebody who may be self-harming or suicidal, communication needs to be initiated. It is important for police officers to allow the person to feel free to speak about the way that she or he feels. Officers should allow the individual to guide the communication and provide clues as to how to understand and help.

When assessing an individual's current suicide potential, healthcare professionals have been advised to explore the following list of issues with their patients. While these questions are designed for use by healthcare professionals within a clinical setting, they may provide useful 'indicators of concern' for police officers when communicating with vulnerable and suicidal people and assessing their plans and the level of risk that they may pose to themselves or others (**Hawton and others 2013** in **Assessment of suicide risk in people with depression; A clinical guide**).

- Are they feeling hopeless, or that life is not worth living?
- Have they made plans to end their life?
- Have they told anyone about it?
- Have they carried out any acts in anticipation of death (for example, putting their affairs in order)?
- Is there any available support, such as family, friends or carers?

Also consider – do they have the means for a suicidal act? (For example, access to pills, firearms or other lethal things.)

Guilty feelings

An important element that needs to be taken into account is guilt. The person can feel guilty because of conflicts they may have been experiencing. In this context, professionals who intervene should be careful of what they say in order to avoid making the person feel more guilty.

Officers should avoid:

- accusing statements
- criticising the person's behaviour
- disapproving of what they hear or encounter

Response to a non-immediate risk of suicide

Police officers should refer to the following resources when considering what services are available to support a person who seems vulnerable to suicide but does not seem to be presenting an immediate risk.

- **Assess threat and risk, and develop a working strategy**.
- **Recognising mental vulnerability in children and young people**.
- **Recognising mental vulnerability, learning disabilities and other needs**.
- **Referral and risk management**.
- **Referral of offenders within the criminal justice system**.
- **Referral for assessment of needs under the Care Act 2014**.
- Obtaining a **warrant under section 135 MHA** for assessment within a private premises.
- **Sources of support**.

After a suicide attempt

The WHO provides **guidance** for police officers, firefighters and other responders. The following advice is based on their recommendations.

First interveners are responsible for responding to a crisis in the most adequate and efficient way. In doing so, they need to go through various stages.

If the person is unconscious or may be physically unwell

1. Check the person's vital signs following the suicide attempt and apply resuscitation, as appropriate (they need to remain calm to be able to make the right decisions in a situation dominated by emotional stress and anxiety). In cases of hanging, where there are signs of life, cut and loosen the ligature, call an ambulance and apply first aid as appropriate.
2. Consider the use of CPR – where a person is found hanging, consideration should be given to the possibility that the person may be in cardiac arrest. In such cases CPR should be administered.
3. Contact emergency health care – depending on the nature of the suicide attempt, and mental health care needs (in many situations, it will be important to identify the drugs or toxic substances used in the attempt and determine the amount ingested, it will be helpful to take unused pills and empty bottles to the hospital or mental health unit so that healthcare

professionals can verify the substances that have been ingested).

If the person is unconscious or badly injured, those present also may be a valuable source of information (such as the drugs ingested or past history of suicide attempts). If significant others are not present, it may be necessary to establish contact with them in order to obtain this information.

If the person is conscious and seems physically well

1. Establish the first contact with the person who attempted suicide, (the relationship must be relaxed, non-threatening, empathic, and friendly).
2. Communication should be initiated (see forthcoming authorised professional practice (APP) on Mental Health: Specific communication tools).
3. (If transfer to a medical facility is not warranted) remove further lethal means.
4. Refer the individual to appropriate treatment and follow-up services (where possible ensure that the individual has a family member or close friend to oversee their recovery and manage treatment referrals).
5. Support all of those present. If family, friends or others are present, they may be emotionally distraught, confused, angry, or overwhelmed by the circumstances – first responders need to exercise tact, compassion, and sensitivity.

The **APP on Sources of support** provides information and contact details for a range of support services for distressed and suicidal people and the bereaved.

After an apparent suicide

First response

Police response to sudden death should be guided by standard operating procedures, critical incidents, and fatality management (as applicable). In addition to this, practitioner experience suggests that when responding to an apparent suicide incident, police officers and response staff should:

- be particularly aware of the impact on witnesses and those personally affected by the incident – people bereaved by suicide are themselves at increased risk of suicidal behaviour
- seize any note showing an intention to complete suicide as potential evidence together with any available documents which contain sample copies of the deceased's handwriting for comparison

- consider whether domestic abuse or coercive and controlling behaviour may have contributed to or caused the death
- recover any relevant communication evidence that may be held on mobile phones and other electronic devices for potential investigation (when reviewing this evidence on electronic devices, officers should consider using key word searches such as ‘suicide’, ‘hanging’, ‘knot’)
- exercise caution when releasing information to the media, see **Reporting self-harm and suicide in the media**
- seek personal welfare and emotional support as necessary, see **Protecting police officers and staff**, and **Sources of support**.

Additional considerations for police response to apparent suicides

Hanging

- in the event that a ligature has been used and the person is dead, officers should keep the knot intact where possible
- the ligature should be transported with the body as it will be required for the subsequent post-mortem examination
- officers should note the position of the body to determine whether the body was suspended completely or supported
- the crime scene investigator (CSI) should measure the length of the ligature, in order to establish the feasibility for the body to have been suspended from where it was discovered or described to have been discovered

Poisoning or volatile substance abuse

Apparent suicides or attempted suicides by carbon monoxide poisoning or other poisons can pose extreme hazards to police officers, police staff and medical personnel. Even if a source of gas is stopped, it may still be dangerous to enter an enclosed space where there has been a build up of toxic gas. When responding, officers should:

- always conduct a dynamic risk assessment (using the **NDM**) before taking action and document their decisions accordingly
- ensure that any source of the gas is stopped before attempting any emergency treatment

- always use protective equipment if CPR is necessary (as build-up of carbon monoxide in the body may be transferred)

When investigating apparent suicides in which poisoning is suspected, advice should be sought from the force incident manager.

A CSI should attend the scene, along with chemical, biological, radiological and nuclear (CBRN) trained staff if necessary.

Officers and staff should also search the scene for any signs of volatile substance abuse (VSA). VSA occurs when volatile substances, normally intended for household use, are inhaled through the mouth or nose. The most commonly used substances are butane gas and solvents.

When safe to do so, officers and staff must take anything which may have contained harmful matter (for example, medicines, paper wrappings or labels and objects which may have been used in administering any drug or poison) to the mortuary for the information of the pathologist. They should carefully preserve all drugs, sediment or unconsumed substances.

Suicide pacts or assisted suicide

If the investigating officer believes or suspects that a death may be attributed to a suicide pact or other criminal activity, they must:

- treat the death as suspicious in the first instance
- recover all computers, mobile telephones and media devices so that they can be examined for communication and social networking site activity, which may contain evidence or information relevant to the investigation (officers should also consider obtaining all relevant passwords from the next of kin)
- inform a detective inspector (in cases of suicide involving more than one person, the matter should be referred to a crime investigations department for investigation)

Where a person survives a suicide pact, the enquiry will be dealt with as a criminal investigation, with due consideration being given to offences under the Suicide Act 1961. It is an offence for a person to aid, abet, counsel or procure the suicide or attempted suicide of another.

See:

- **cases of planned assisted suicide**
- **cases of completed assisted suicide**

Use of firearms

When responding to suicides and attempted suicides in which a firearm has been used, officers should:

- be aware that weapons may still pose a risk, and should not be moved or handled unnecessarily
- consider the use of authorised firearms officers (AFOs) in all cases
- take any weapons held or potentially used by the deceased into police possession for safekeeping and the firearms department should be notified

For further information concerning provoked shootings that involve armed police responders see **Provoked shootings**.

Apparent suicide in, or following release from, police custody

The **National Police Chiefs' Council (NPCC) (2016) Interim Guidance Suicide Prevention Risk Management** document provides information on the management of the risk of suicide and self-harm in perpetrators of child sexual exploitation and indecent images of children (IIOC) following police contact.

The **APP on Detention and Custody** provides guidance on **risk management** in custody, **detainee care** and **deaths in custody**.

Apparent suicide as a result of online harassment bullying or trolling

If there is reason to suspect that online harassment, bullying or trolling may have contributed to a person’s decision to take their own life, investigating officers should refer to the NPCC guidance in relation to investigating offences of assisting or encouraging suicide.

This document is available to police investigators via the POLKA mental health community. Please note that this document was produced in 2012 and its content is classified as Official-Sensitive.

The **CPS policy guide for encouraging/assisting suicide** is also available to support prosecutors and investigators.

Conveying the message

When conveying the news that someone has taken their own life to their next of kin, police officers are required to provide the appropriate degree of factual information in a professional and dignified manner. When investigating a suicide, the police are trained to consider the circumstances and individuals involved with the case with suspicion until this can be dispelled.

Police officers are also required to seize materials and belongings to assist in formally identifying the body and investigating the sudden death. Given the differing nature of these roles, there is a natural tension between offering empathy and support, and sometimes being required to view the bereaved as a potential suspect.

The following considerations are based on police experience and feedback from bereaved families and charities. (This information is based on qualitative research into patient experiences led by experts at the University of Oxford and supported by the Department of Health.

Further information is available at **Healthtalk.org – Bereavement due to suicide**.)

See also **College of Policing (2022) Delivering a death message**.

Considerations when conveying the message

Officers should not:

- use police jargon or insensitive language or terminology as this may upset or confuse the bereaved further
- refer to the deceased as ‘the body’ or ‘the deceased’ and should use their name
- leave without signposting support (where available, they should provide a bereavement leaflet with useful and relevant information and contact details – see **Sources of support**)
- make promises that cannot be kept
- rush (receiving this message may have just changed someone’s life forever)
- leave a bereaved person alone (family members, family friends or even neighbours may be able to help)

Officers should consider the religion, faith and culture of the bereaved (there may be contacts that can offer support, such as a rabbi, imam, priest or others) and also consider relevant faith/culture undertakers if applicable as they may be able to assist with explaining procedures to the family.

Note: The bereaved may react in a range of different ways, however, officers should record any reactions that might be considered suspicious.

Finding the right words to use

Poor use of language may cause ongoing distress for families. Where possible, officers should try to say:

- decision, not choice
- survivor, not victim, for the bereaved
- died by… or ended own life, not committed suicide
- coping strategies, not moving on or closure

Officers and staff should not refer to ‘committing suicide’ although this expression has remained in public usage long after suicide legally ceased to be considered a criminal act (1961). It is preferable to refer to ‘apparent death by suicide’ and state that the deceased may have ‘taken’ or ‘ended’ their own life.

Explaining the role of the coroner

Officers may describe the role of the coroner in this way:

'A coroner is a government official who confirms and certifies the death of an individual within a jurisdiction. A coroner may also conduct or order an investigation into the manner or cause of death, and investigate or confirm the identity of an unknown person who has been found dead within the coroner’s jurisdiction.'

Explaining the role of the coroner's officer

Officers may describe the role of the coroners officers in this way:

‘Coroner’s officers are employed by police forces to deal with the coroner’s enquiries. The coroner’s officer acts on behalf of the coroner. They:

- speak to families and relatives
- arrange identification where appropriate
- take statements
- assist the coroner in any investigation'

See **Ministry of Justice, Guide to coroner services.**

Training

It is important that police officers are trained to convey the bereavement message professionally and with care. Key aspects of training that should be considered are:

- managing the investigation professionally with empathy
- understanding the risks associated with bereavement through suicide, including the risk of further suicides
- guidance on referrals to community support locally (see **Sources of support**)

Informing agencies in the community

Forces should give relevant partners and media organisations factual, non-sensationalised information about suicides, in order to keep people informed and stop inaccurate rumours developing.

If there are clear concerns that a suicide cluster may be underway, forces should share information across relevant professional groups, subject to appropriate confidentiality. It is important that families are consulted and advised with sensitivity, so they understand what information is to be shared and why. There may be certain facts families do not want to be shared and this should be respected as much as possible.

Reporting self-harm and suicide in the media

In circumstances in which a suicide has occurred, forces should carefully consider the detail and content of information released to the media. There is research to indicate that reporting details surrounding suicide and suicide methodology may sometimes cause further incidents of a similar nature (**Pirkis and Blood 2010** in **WHO 2008**).

Samaritans has produced **media guidelines** aimed at police forces and any other body reporting suicide in any media (from factual description to dramatic portrayal). It is recommended that these guidelines are used to inform the reporting on suicide, self-harm and potential suicide and when dealing with the media in relation to incidents of this nature.

Case study – multi-agency management of the release of a suicide-related movie

In 2013, a film production company approached Bridgend County Borough Council to explain that they were shooting a film in the area. The Danish feature film production was then filmed on location in the Pontycymmer and Blaengarw areas of Bridgend County Borough in 2013 under the title of ‘The Suburbs’. The film was based upon the story of a cluster of teenage suicides that had happened in the Bridgend area of Wales.

Local reaction to the forthcoming release of the film was mixed, but largely negative in the media and social media. Some head teachers contacted the council to report their concerns as pupils and some parents were talking about the film and its trailer. A Bristol resident has also started a petition on Change.org calling for the UK release of the film to be cancelled.

Risks identified included:

- potential harmful impact on those members of the community that had been directly and indirectly affected by real-life suicide incidents that had occurred in Bridgend (those potentially connected, and those unconnected with the storyline of the film)
- fears of further suicides among vulnerable people influenced or prompted by the portrayals within the film
- fears associated with a potential ‘internet death cult’ on the basis of a local press news article on the subject

How was this managed?

Production of the film went ahead, but Bridgend County Borough Council worked proactively with the police and other partner organisations to manage reports and information on the Bridgend suicides in the local and national media. Decisions were taken by the Local Service Board (LSB), a multi-agency committee made up of senior representatives drawn from:

- Abertawe Bro Morgannwg University Health Board
- Bridgend Association of Voluntary Organisations (BAVO)
- Bridgend Business Forum
- Bridgend College
- Bridgend County Borough Council

- Natural Resources Wales
- South Wales Fire and Rescue Service
- South Wales Police
- Valleys to Coast Housing
- Wales Probation
- Welsh Government

Messages from local services and the police were channelled through a single point of contact (the council press office) to control the flow of information and ensure that consistent messages could be conveyed. The messages were issued in the name of the LSB to prevent any one agency being singled out by the press.

An official statement and response was drafted in a way that sought to deflect attention away from the film and towards local support services instead.

Additional template statements were prepared and issued to local councillors in case the media approached them as community representatives, and a series of general statements were drafted covering a range of scenarios, then adjusted accordingly when required. The statements took account of a number of key messages, the most relevant one being that help was available for anyone suffering from mental distress.

See **Reporting self-harm and suicide in the media** for more information on reporting suicide in the media.

Investigating suicide

Officers may use the term ’apparent suicide’ while investigating a potential suicide until such times as the verdict of suicide has been confirmed by the coroner. Officers should treat all ‘apparent suicides’ as suspicious deaths in the first instance. Forces should be guided by local coronial requirement for investigating sudden deaths.

When investigating offences of assisting or encouraging suicide, forces should be guided by NPCC (formerly ACPO) guidance in relation to investigating offences of assisting or encouraging suicide. This guidance is available to police investigators via the POLKA mental health community. Please note that this document was produced in 2012 and its content is classified as Official-Sensitive.

Deaths following police contact

Article 2 of the European Convention on Human Rights (ECHR) places a positive duty on the state to investigate any death (or serious injury) at the hands of the state. All suicides that occur in police custody and following police contact must be referred to the relevant independent investigative authority for investigation. See **Deaths in custody,** and **Armed policing**: **Post-deployment**.

Identifying suicide clusters

Response to possible suicide clusters must occur rapidly in order to prevent further deaths. Therefore identification of apparent suicides must take place at the earliest possible stage, see **Classification of suicide and suspected suicide**. However, determination of whether a death is to be registered as a suicide is made at a coroner's inquest, which may take place a considerable time, sometimes months, after a sudden death.

Initial awareness of possible suicide contagion usually comes through concerns raised in the community by, for example, schools, healthcare services, community-based services and the media. In the case of under-18s, deaths by suicide will be picked up by the child death overview panel.

PHEs (2015) Identifying and responding to suicide clusters and contagion: A practice resource document provides detailed guidance on multi-agency response to suicide contagion. Responses to suicides and suicide clusters should be directed by a multi-agency suicide prevention group (MSPG), which will designate a focused suicide response team (SRT) when required. The SRT will be responsible for developing and implementing a tailored CAP as required.

MSPG organisations/individuals

The following bodies and individuals may be required to contribute to the response of the MSPG and the SRT (not all of these parties will have responsibility for direct delivery of the CAP):

- public health consultant responsible for suicide prevention (lead)
- adult and children's safeguarding boards, including a representative from the child death overview panel
- NHS and local authority commissioners

- police
- coroner’s service
- healthcare (primary care, mental health services, acute general hospitals, substance misuse services)
- local expert in reviewing mortality data (including, if possible, suicide deaths)
- schools, colleges and universities
- media communications lead, who should be a consistent communications representative from either the local authority or police
- local non-statutory agencies (for example, counselling agencies, bereavement charities, Samaritans and other suicide prevention charities)

Protecting police officers and staff

Sometimes people decide to die by suicide regardless of whether the police or others have tried to prevent them doing so. If this happens, it is very important that the police officers and staff who have responded in a professional way don’t blame themselves.

Officers should remember that they have tried to help in the best way they knew, or could at the time. No-one has the power to change another person’s mind. Others can offer to support them when they are distressed or in pain but only the person themselves can change their mind. However, positive intervention can give a mentally vulnerable or emotionally distressed person an opportunity to consider the options (NHS Scotland 2005).

Cultural barriers have been recognised within the police service related to mental health and wellbeing. Line managers and organisational leaders can have a positive impact on the wellbeing of their own officers, staff and colleagues by looking out for signs that a member of staff may require mental or emotional support and helping them to access appropriate services.

Forces should provide officers and staff with access to emotional support via occupational health, staff associations and outside organisations. See **Sources of support**, and specifically, **Support for police officers and staff experiencing mental illness or distress**.

Resources for suicide prevention and response

The following documents provide reference material to support coordinated multi-agency suicide prevention activity.

- **National Suicide Prevention Alliance (NSPA)** – the NSPA are a cross-sector coalition committed to reducing the number of suicides in England and improving support for those bereaved or affected by suicide.
- **Preventing Suicide in Public Places** – the University of Exeter has produced this best practice guide for the National Institute for Mental Health to support effective multi-agency collaboration in identifying locations that are ‘hot spots’ for suicide and taking appropriate steps to improve safety and deter acts of suicide at these locations.
- **Suicide Prevention Fingertips Tool** – this tool has been produced to help develop multi-agency understanding and support an intelligence-driven approach to suicide prevention. It collates and presents a range of publicly available data on suicide, associated prevalence, risk factors and service contact among groups at increased risk.
- **National Suicide Bereavement Support Partnership (SBSP)** – the SBSP is the hub for those organisations and individuals working across the UK to support people who have been bereaved by suicide.
- **NPCC (2016) Interim Guidance Suicide Prevention Risk Management** – Perpetrators of Child Sexual Exploitation and Indecent Images of Children (IIOC).

Useful web links

- **Care Act 2014**
- **Mental Health Act 1983**
- **Samaritans website**
- **Papyrus website**
- **Mind website**
- **APP on Detention and custody**

Relevant publications

- **Preventing suicide in England: A cross-government outcomes strategy to save lives (2012)**
- **Talk to me 2: Suicide and Self Harm Prevention Strategy for Wales 2015-2020**
- **Choose life: National strategy and action plan to prevent suicide in Scotland**

- Protect Life: A shared vision. The Northern Ireland Suicide Prevention Strategy and Action Plan (2012- March 2014)
- HM Government (2014) Mental Health Crisis Care Concordat
- Welsh Government and Partners (2015) Mental Health Crisis Care Concordat for Wales
- The Welfare of Vulnerable People in Custody (2015)
- Equality and Human Rights Commission (2015) Preventing Deaths in Detention of Adults with Mental Health Conditions.
- World Health organisation (2008) Preventing Suicide: A Resource for Media Professionals
- World Health organisation (2009) Department of Mental Health and Substance Abuse: Preventing Suicide a Resource for Police, Firefighters and other first line responders
- World Health organisation (2012) Public Health Action for the Prevention of Suicide
- Guidance for developing a local suicide prevention action plan: information for public health staff in local authorities

Resources for reporting suicide in the media

Samaritans has developed the Media guidelines to promote sensitive reporting of suicides, protect families, support the bereaved and limit suicide contagion. The following fact sheets are also available.

- 10 things to remember when reporting suicide – a summary of the key points.
- Best practice for broadcast reporting of suicide.
- Best practice for reporting on suicide using digital media.
- Drama portrayals of suicide.
- Reporting murder-suicides.
- Reporting rail suicides and attempts.

See also:

- National Institute for Mental Health in England (2007) What's the Story? Reporting Mental Health and Suicide: A Resource for Journalists and Editors
- National Institute for Mental Health in England (2007) Sensitive Coverage Saves Lives: Improving Media Portrayal of Suicidal Behaviour
- APP on Communication and engagement
- Independent Press Standards Organisation

- Ofcom

Academic publications

Beck A, Schuyler D and Herman J. (1974). Development of suicidal intent scales. In The Prediction of Suicide (eds Beck A, Resnik H and Lettieri DJ), pp. 45 -56. Bowie, MD: Charles.

Becker K and others. (2004). Parasuicide online: Can suicide websites trigger suicidal behaviour in predisposed adolescents? Nord J Psychiatry 58: 111–114.

Collings SC and others. (2011). Media influences on suicidal behaviour: An interview study of young people in New Zealand. Auckland, New Zealand: Te Pou o Te Whakaaro Nui, The National Centre of Mental Health Research, Information and Workforce Development.

Daine K and others. (2013). The power of the web: a systematic review of studies of the influence of the internet on self-harm and suicide in young people. PLOS ONE, 8, e77555.

Harriss L, Hawton K and Zahl D. (2005). Value of measuring suicidal intent in the assessment of people attending hospital following self-poisoning or self-injury. The British Journal of Psychiatry, 186 (1) 60-66.

Hawton K and others. (2013). Risk factors for suicide in individuals with depression: A systematic review. Journal of Affective Disorders, 147, 17-28.

Hawton K and others. (2003) Deliberate self-harm in Oxford, 1990-2000: a time of change in patient characteristics. Psychol Med 2003; 33: 987-96.

Hawton K and Williams K. (2002). Influences of the media on suicide. Researchers, policy makers, and media personnel need to collaborate on guidelines. BMJ 325: 1374–1375.

Hawton K and others. (2002). Deliberate self-harm in adolescents: self report survey in schools in England. BMJ 325: 1207–1211.

Gunnell D and others. (2005). The epidemiology and prevention of suicide by hanging: A systematic review. International Journal of Epidemiology. 34 (2): 433–42.

Knapp M, McDaid M and Parsonage M (eds). (2011). Mental Health Promotion and Mental Illness Prevention: The economic case. PSSRU, LSE and Political Science.

Lo?nnqvist J. (2000). Psychiatric aspects of suicidal behavior: depression. In **Hawton K and Van Heeringen K. (Eds.). (2000). The international handbook of suicide and attempted suicide. John Wiley & Sons.**

Madge N and others. (2011). Psychological characteristics, stressful life events and deliberate self-harm: findings from the Child & Adolescent Self-harm in Europe (CASE) Study. Eur Child Adolesc Psychiatry 20: 499–508.

O'Connor RC, Rasmussen S, Hawton K (2012) Distinguishing adolescents who think about self-harm from those who engage in self-harm. Br J Psychiatry 200: 330–335.

Irene MK. (1973). Ovenstone – A Psychiatric Approach to the Diagnosis of Suicide and its Effect upon the Edinburgh Statistics – BJP July 1973 123:15-21.

Pirkis J and Blood W. (2010). Suicide and the news and information media. A Critical Review.

Platt S and others. (2006). Evaluation of the first phase of Choosing Life: The national strategy and action plan to prevent suicide in Scotland: Annex 2 – The Economic Costs of Suicide in Scotland in 2004. Edinburgh: The Scottish Government.

Roberts S, Jaremin B and Lloyd K. (2013) High Risk Occupations for Suicide. Psychological Medicine 43(6).

Tags

Mental health