



NORTH WALES SAFEGUARDING BOARD

SUICIDE PREVENTION PROTOCOL

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		Review	

Suicide Prevention Protocol - North Wales

Foreword

This Protocol has been developed by partner members of the North Wales Safeguarding Board and North Wales Suicide and Self-harm Forum in response to the growing need for a framework to enable agencies to work together to support the safety of individuals at risk of suicide.

Suicide is not inevitable. Most people who experience suicidal thoughts or feelings do not go on to take their own lives. With compassionate support and the right help, there is hope for recovery. Every step taken to pause or prevent suicide can save a life, from a kind word from a stranger or a friend to a professional intervention.

The Vision for Wales, as set out in **Understanding**, the Suicide Prevention and Self-harm [Strategy](#) for Wales is:

The annual rates of suicide in Wales will continuously decrease. People who self-injure, self-poison, who have suicidal ideation or have attempted suicide will feel safe and understood. They will belong to informed and compassionate communities and will be able to access support and services which meet their needs when and where they need them.

This protocol seeks to contribute to Objective 2 in the strategy:

Preventing: We will have a co-ordinated cross-Government and multi-agency response to tackle the risk factors linked with self-harm and suicide

Suicide is complex; there is rarely a single cause or answer, and each individual's experience is different and requires a person-centred response. This protocol seeks to support multi-agency communication and working, providing an additional option where existing offers are not sufficient, and to enable the right support, at the right time, from the right people.

For support: [Get Help Now - SSHP](#)

To learn more about suicide prevention in Wales: [Suicide Awareness e-module - SSHP | SSHP Cymru Training Hub](#)

Contents:

1.	Introduction and Purpose	...	...	...	...	...	...	...	3
2.	Definitions	...	...	...	...	...	...	...	5
	2.1	Suicidal behaviour	...	...	...	...	...	...	5
	2.2	Adult at risk	...	...	...	...	...	...	5
	2.3	Significant Risk	...	...	...	...	...	...	5
	2.4	Responsibility of the lead agency	...	...	...	...	...	...	6
	2.5	Interfaces with individual services	...	...	...	...	...	...	6
3.	Protocol Process	...	...	...	...	...	...	...	7
	3.1	Identifying the individual	...	...	...	...	...	...	7
	3.2	Before the multi-agency Suicide Prevention Protocol meeting...							7
	3.3	During the multi-agency Suicide Prevention Protocol meeting...							8
	3.4	After the multi-agency Suicide Prevention Protocol meeting	...						8
4.	Contingency	...	...	...	...	...	...	...	8
	Appendix 1 - Flow Diagram	...	...	...	...	...	...	...	9
	Appendix 2 - Service Contacts	...	...	...	...	...	...	...	10
	Appendix 3 - Existing multi-agency processes for preventing suicide (Adults)								11
	Appendix 4 – Language	...	...	...	...	...	...	...	12
	Appendix 5 - Agenda Template	...	...	...	...	...	...	...	14
	Appendix 6 - Action Log Template	...	...	...	...	...	...	...	15
	Appendix 7 - Checklist for closure	...	...	...	...	...	...	...	16
	Appendix 8 - Confidentiality and Wellbeing Statement	...	...	...	...	...	...	...	17
	Appendix 9 - Potential Partners List	...	...	...	...	...	...	...	18
	Appendix 10 - Safety Plans	...	...	...	...	...	...	...	19
	Appendix 11 – References	...	...	...	...	...	...	...	20

1.0 Introduction and Purpose

- 1.1** This Protocol can be referred to where an **adult**¹ is believed to be at risk of suicide. An individual may be considered as at risk of suicide where they are:
- Demonstrating escalating suicidal thoughts and behaviours (See Definitions)
 - Unable to access professional support through the usual avenues
 - Unable to engage with the usual avenues of support, or with a safety plan
 - Do not have a network of support

- 1.2** The **aim** of the protocol is to prevent serious injury or death of individuals by suicide, by ensuring that:
- There is a protocol to follow when individual's needs do not fit exactly with the typical service offers
 - There is shared, multi-agency understanding and recognition of the issues
 - There is effective multi-agency working and practice
 - Concerns receive appropriate prioritisation
 - Agencies and organisations uphold their duties of care (with a what we 'can' do, rather than what we 'can't' do perspective)
 - There is a proportionate response to the level of risk to self and others

The Protocol refers to existing processes and procedures which should be explored in the first instance to bring relevant partners together to keep an individual safe. Where existing processes and procedures have not led to the desired outcome, or where none exist, this protocol provides a structure to enable multi-agency discussion and a plan to prevent suicide. This is especially useful when there are barriers to engaging the individual, or barriers for the individual to access support. It is expected that the protocol will be used in exceptional circumstances.

See the flowchart in Appendix 1.

- 1.3** This aim is achieved through:
- Promoting a **person-centred** approach which supports the right of the individual to be treated with respect and dignity, and to be in control of, and as far as possible, to lead an independent life
 - Aiding recognition of **suicide risk**
 - Increasing knowledge and awareness of the different **powers and duties** provided by legislation and their relevance to the particular situation and individual's needs, including the extent and limitations of the 'duty of care' of professionals

¹ This protocol is regarding adults. Guidance on responding to issues of self-harm and suicide in young people - [Responding to issues of self-harm and thoughts of suicide in young people | GOV.WALES](#)

- Promoting adherence to a standard of reasonable **care** whilst carrying out duties required within a professional role, to avoid foreseeable harm
- Promoting a **proportionate approach** to risk assessment and management
- Promoting the '**right help at the right time from the right people**'
- Clarifying different **agency and practitioner responsibilities**, and in so doing, promoting transparency, accountability, evidence of decision-making processes, actions taken and promoting an appropriate level of intervention through a multi-agency approach.

1.4 Principles²

Empowerment - Presumption of person-led decisions and informed consent.

Protection - Support and representation for those in greatest need.

Prevention - It is better to take action before harm occurs.

Proportionality - Proportionate and least intrusive response appropriate to the risk presented.

Partnership - Local solutions through agencies working with their communities. Communities have a part to play in recognising risk of suicide and signposting to support

Accountability - Accountability and transparency in preventing suicide.

1.5 Empowering individuals (Mental Capacity)

Building a positive relationship with individuals who are experiencing suicidal thoughts and behaviours is critical to achieving change for them, and in ensuring their safety and protection. Consideration needs to be given at an early stage, to determining if the individual has the mental capacity to understand and make informed decisions about their responses to concerns. If the person is thought to lack mental capacity to make a relevant decision, then the principles of the Mental Capacity Act (2005) must be used to guide planning, within this protocol.

2 Definitions

2.1 Suicidal Behaviour

Suicide is complex; there is rarely a single cause or answer, and each individual's experience is different and requires a person-centred response³.

For this protocol, suicidal behaviour is defined as the transition from feelings and thoughts about suicide towards acting on them.

² Adapted from the NWSB Hoarding and Self-neglect Protocol

³ [Myths about suicide - SSHP](#)

Further information on the transition can be found in the Integrated Motivational Volitional (IMV) Model [The IMV Model – Suicidal Behaviour Research Laboratory](#).

2.2 Adult at risk

An adult at risk is a person over 18 who is:

- Experiencing or is at risk of abuse or neglect*,
- Has needs for care and support (whether or not the authority is meeting any of those needs), and
- As a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it

*The Wales Safeguarding [Procedures](#) guidance states that self-neglect can be a type of neglect, and gives the following examples (not exhaustive):

- lack of self-care to an extent that it threatens personal health and safety
- neglecting to care for one's personal hygiene, health or surroundings
- inability to avoid self-harm
- failure to seek help or access services to meet health and social care needs
- inability or unwillingness to manage one's personal affairs

There are circumstances in which risk of suicide will be identified as a safeguarding concern. Responses should be person centred, engaging with individual circumstances, and including the reasons for the suicidal ideation and the presenting risks.

See Point 10 for more information: [Understanding what constitutes a safeguarding concern: FAQs | Local Government Association](#)

2.3 Significant Risk

These factors are known to increase the risk of suicide

- previous suicide attempt, or history of crisis incidents with life threatening consequences
- access to means of suicide
- alcohol or substance use
- relationship conflict
- reduced coping skills
- feeling isolated
- bereavement by suicide
- perpetrator or survivor of domestic violence
- unmet mental health needs
- the individual has little or no choice or control over vital aspects of their life, environment or financial affairs

This list is not exhaustive.

2.4 Responsibility of the lead agency

The lead agency could be any partner agency of the Safeguarding Board, or other agencies with statutory duties and responsibilities, which first identifies that an individual may come under the scope of this protocol.

Suicide prevention work has been agreed as a multi-agency priority and there is an expectation that:

- All partner agencies signed up to this protocol will engage and support the process when this is requested by the lead agency as appropriate or required.
- The lead agency take responsibility for coordinating multi-agency partnership working.
- Lead agencies should be advised by their designate safeguarding lead or team

It is likely that that the individual at risk of suicide will not clearly meet the criteria for any one or a number of agencies or organisations. Previous experience of attempting to engage may have had limited or no success. These factors increase the risk and should be identified as risk indicators that will prompt action under this protocol.

Principles in

Understanding, the [Wales Suicide Prevention and Self-harm Strategy](#):

- Leadership, ownership, and accountability
- Suicide and self-harm are everybody's business
- Focus on inequalities and at risk groups
- Multi-sectoral collaboration

2.5 Interfaces with individual services

This protocol is to be used when other avenues of support by individual agencies have been exhausted, and where other multi-agency processes have not or cannot be effective.

See **Appendix 2** for key contacts of existing support, and **Appendix 3** for a summary of existing multi-agency processes.

3. Protocol Process

Please refer to the flowchart in **Appendix 1**

3.1 Identifying the individual

This protocol can be used for any individual where there is a concern that they are at risk of suicide, and where the usual routes of support or prevention are not effective. Examples include:

- An individual who is not engaging or acknowledging they are at risk
- An individual who is asking for help, but who does not fit into any individual service criteria, and it is therefore not clear who should support them.
- An individual whose needs and risk are greater than what the individual service(s) supporting them are able to provide

Please refer to the adult at risk definition in 2.2.

It is important to be aware of the possible associated risk and protective factors, and the changing nature of risk⁴.

3.2 **Before** the multi-agency Suicide Prevention Protocol meeting

Establish first:

- whether the individual has already accessed any existing support from individual services
- whether the individual has already been the subject of an existing multi-agency discussion to manage risk

(if the answer to the above is no, *these avenues should be explored first before proceeding to use this Protocol* – See **Appendix 3**)

Information gathering should include:

- any previous engagement with the individual
- approaches that appeared to disengage the individual
- an insight into the individual's wishes and feelings
- the views of anyone who has or has had contact with the individual including relatives and neighbours
- existing professional reports, assessments or plans (including safety plans)

A note on **information sharing**:

The All Wales Safeguarding Procedures include [Pointers for Practice](#) on Information Sharing. Under the [GDPR and Data Protection Act 2018](#) you may share information without consent if, in your judgement, there is a lawful basis to do so, such as where safety may be at risk.

3.3 **During** the multi-agency Suicide Prevention Protocol meeting

See **Appendix 5 and 6** for template agenda and action log.

Response Plan

The outcome of a Suicide Prevention meeting will be a multi-agency Response Plan. This will be as a result of an agreement and shared understanding between agencies of the situation and nature of the risks. Agencies will bring what they can do to the discussion, and this may require imaginatively adapting service criteria to meet the individual's needs.

The plan should include:

- Immediate actions to ensure the safety of the individual in the short term, and who is responsible for the actions

⁴ <https://www.cdc.gov/suicide/risk-factors/index.html>

- Identified lead agency to undertake a full assessment of the individual's needs – (for example, Mental Health Act Assessment / Care and Support Needs Assessment)
- Identified lead to work with the individual to agree a person-centred safety plan (See **Appendix 10** for principles and examples)

Agree monitoring and review arrangements.

Please note: Where there are concerns that the individual lacks or appears to lack the mental capacity to fully understand the risks related to their behaviour a mental capacity assessment must be considered in relation to their ability to make informed decisions regarding the risks identified.

3.4 **After** the multi-agency Suicide Prevention Protocol meeting

Record keeping

The case record will include a summary record of the efforts and actions taken by all agencies involved. Individual agencies will also need to keep their own records of their specific involvement. Accurate records will be maintained, and locally agreed case recording policy and procedures should be followed.

Actions by individual agencies

Individual agencies to complete the actions agreed at the Protocol meeting.

Monitoring / review

The lead agency should call a review meeting on the basis of the agreement during the protocol meeting, to:

- Review actions completed
- Review risk
- Make a decision to continue monitoring

See Appendix 6 for a checklist for closure.

4. Contingency

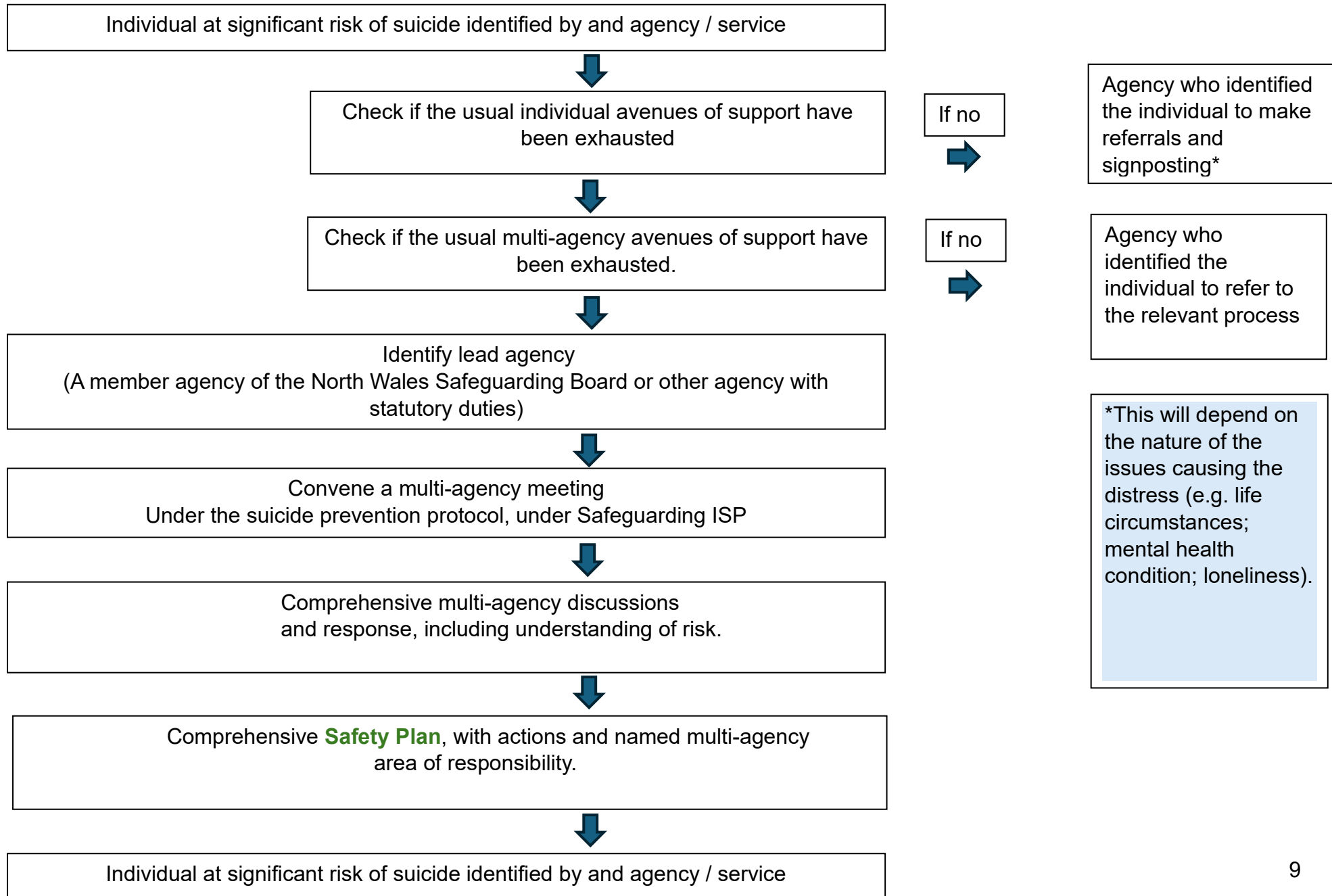
If there is any sense of imminence to the concerns about an individual, call 111 Option 2 for advice.

If this protocol does not achieve a satisfactory outcome, this should be escalated to the senior leadership of the lead agency, and key partner agencies.

If a partner agency is not engaging in the process, this should be escalated to the North Wales Safeguarding Board⁵.

⁵ Useful reference: [NW-Protocol-for-the-Resolution-of-Professional-Disputes-Eng.pdf](#)

Appendix 1 – Flow Diagram



Appendix 2 – Service Contacts

Service		Link
Mental Health 111 Press 2	24/7 urgent mental health support to people of all ages across North Wales. Free to call and bilingual	111 Press 2 - Mental health support for all - Betsi Cadwaladr University Health Board
Social Services Safeguarding	If you are concerned about an adult or a child at risk.	Day time and out of hours details for the six local authority Social Care Services North Wales Safeguarding Board – Safeguarding children and adults across North Wales
North Wales Police	For immediate concerns around risk to life	Contact us | North Wales Police
Local Community Based Support: C.A.L.L. Helpline	Mental Health Helpline for Wales, also holds a directory of local support	C.A.L.L. Mental Health Helpline - Community Advice and Listening Line

Appendix 3 – Existing multi agency processes for preventing suicide (Adults)

Process	Lead Agency	Description
Adult Protection Conference (Safeguarding multi-agency strategy meeting)	Local Authority Safeguarding	Under the Social Services and Wellbeing Act 2014, and Adult Protection Conference is called by Social Services in response to safeguarding concerns regarding an Adult at Risk. More information on the process - Safeguarding Wales
Complex Case meetings	North Wales Police	Complex case meetings can be arranged by any lead agency aware of a person with Mental Health needs, and has a number of services attached to their care, but the services are not well connected to one another. The person may be regularly coming to the attention of police officers, but they may not be the most effective agency to deal with the crisis. The complex case meetings will often result in a “6 point plan” to be created by a MH led service and the patient. The plan is shared with NWP and placed on the RMS system for officers to follow during a MH related event. It encourages the involvement of the person themselves, to offer direction and advice to officers about solutions, and secures the involvement of key services, and what they can offer a person particularly out of hours.
135/136 Monitoring Group	BCUHB and North Wales Police	Purpose of the meeting is to enhance and develop communication and improved processes between NWP and partners in BCUHB, WAST, CAMHS, Adult Statutory Services and the Third Sector, linked to Mental Health services. For key decision makers from partnership agencies to shape strategic working processes and improve the patient’s experience. The meeting enables dialogue to take place directly within a multi agency forum when an adverse event has occurred or when there may be learning from an event that went well or required a follow up / review. Frequency of meetings is monthly.
Vulnerability And Risk Management Meeting (VARM)	North Wales Police	VARM / ASB meetings are an amalgamation of VARM (Vulnerable Adult Risk Management) issues and wider community and neighbourhood policing matters and concerns which often overlap and are therefore ideally placed to be discussed in the

		one meeting with a wide range of partner agencies sitting on the panel. Frequency of meetings is monthly
Demand Reduction Meetings	North Wales Police	Demand reduction meetings operate across the North Wales region on a monthly basis. They are not exclusively to address mental health needs, but to address the ongoing social needs of individuals who are frequently coming to the attention of local officers. Officers work with partner agencies to discuss individuals and decide on multi-agency actions. Whilst a number of the police led initiatives are connected to Anti Social Behaviour orders, the Demand Reduction meetings also produce community protection notices, and Problem Orientated Policing Plans (POP plans).
Prevention of Future Deaths meetings	Conwy Social Care	In response to Coroners duty to issue Prevention of Future Deaths, Conwy Social Care (Vulnerable People Service), call Multi Disciplinary Team meetings to look at what work has been done to date, to ascertain if the MDT is satisfied that all appropriate action has been taken and that we will be confident if called to account. If not, the MDT will agree what is necessary going forward to ensure all preventative action is undertaken.

Appendix 4 - Language

Use of Language - SSHP

The language that we use when talking about mental health, mental illness and suicide and self harm can elicit a number of reactions in other people, particularly those who are immediately affected, and care needs to be taken to avoid offence, judgement, sensationalism, exaggeration, or the perpetuation of stigma.

Key points to consider when talking about suicide are:

say	instead of	because
‘died by suicide’ or ‘ended his/her/their own life’	‘committed’ or ‘commit suicide’	To avoid association between suicide and ‘crime.’ Suicide was decriminalised in 1961 in the UK
‘took their own life,’ ‘died by suicide’ or ‘ended their own life’	‘successful suicide’	To avoid presenting suicide as a desired outcome
‘non-fatal’ or ‘made an attempt on his/her/their life’	‘unsuccessful suicide’	To avoid presenting suicide as a desired outcome or glamorising a suicide attempt
‘concerning rates of suicide’	‘suicide epidemic’	To avoid sensationalism and exaggeration of the risks

Choosing our words carefully is about more than avoiding stigmatizing terms. The language we use can also have a positive effect, which makes choosing the right words just as important as avoiding the wrong ones. Avoid anything that:

- reinforces stereotypes, prejudice, or discrimination against people with mental illness or suicidal ideation
- implies mental illness makes people more creative, fragile, or violent
- refers to or defines people by their diagnosis

We know that talking to someone about suicide won’t cause or increase suicidal thoughts or cause the person to act on them. It can help them feel less isolated and scared.

Be hopeful. People can and do get better. Encourage people to seek help

Appendix 5 – Agenda Template

	Item	Lead
1	Introductions	Chair (Lead Agency)
2	Confidentiality and Wellbeing Statement	Chair
3	Summary of Concerns	Lead agency
4	Summary of actions to date	All partners
5	Multi-agency person-centred safety plan	All partners
6	Agree monitoring and review arrangements	Lead agency
7	Any lessons learned to inform future work (to be fed back to NW Safeguarding Board)	

Appendix 6 – Action Log Template

Action Log for Suicide Prevention Protocol Meeting

Meeting date		
Those present at first call/meeting		
Date action log last updated		
Date action log closed		Signed off:

Actions

	Description of the risks or concerns	Actions required to mitigate further harm or manage risks	Who is responsible for the action (name and agency)	Date of follow up

Appendix 7 – Checklist for closure

Checklist for closing a Suicide Prevention Protocol group (standing down)

Date of final meeting/call		
Consensus to stand down reached	YES	NO
Signed off by Chair		

Criteria for ending Suicide Prevention Protocol group

1	All actions in the action log have been completed	✓ / ✗
2	Any outstanding issues, that could not be addressed or resolved through the Protocol, have been communicated, or escalated to other agencies/levels for attention (with evidence)	✓ / ✗
3	Any new resources or response packages, for different sectors, communities or groups, have been shared through the Regional Lead for suicide prevention	✓ / ✗

Appendix 8 – Confidentiality and Wellbeing Statement

Please be aware that those present at the meeting should adhere to this statement. This meeting has been called under the Suicide Prevention Protocol (Safeguarding). The meeting is strictly confidential, and discussions should not be shared outside of the meeting.

Action notes agreed at the meeting are circulated on the strict understanding that they will be kept confidential and stored securely. The action notes should not be photocopied or shared without the agreement of the Chair and must be kept in a restricted or confidential section of the agency files.

During the course of the meeting, you may hear information which you may find difficult or upsetting. Relevant support and debrief should be provided by your agency as a matter of routine. If you would like the opportunity for independent debrief or a listening ear, this link will be shared at the meeting.

[Get Help Now - SSHP](#)

[Debrief service | Papyrus](#)

Appendix 9 – Potential Partners list

Any partners who are working with the individual currently, or should have a role to play in supporting the individual in future should be invited to the multi-agency meeting

- **Local Authority**
Social Care / Safeguarding
Any other relevant department (e.g. Housing; Wellbeing Services)
- **North Wales Police**
Protection of Vulnerable People Unit
Local policing team
- **Betsi Cadwaladr University Health Board (BCUHB)**
Safeguarding
Any other relevant department, including primary care, substance misuse services, mental health and learning disabilities
- **Other agencies who have regular contact with the individual**
For example:
DWP / Job Centre
Third sector and community organisations
Housing Association
Probation Service
Domestic Abuse Service
Substance misuse services
Homeless services
Response services (e.g. Coastguard; North Wales Fire and Rescue Service; Wales Ambulance Service)

North Wales Safeguarding Board member agencies

[Introduction to the North Wales Safeguarding Adults Board – North Wales Safeguarding Board](#)

Appendix 10 – Safety Plans

Principles to follow for a quality safety plan:

- Person-centred
- Co-produced with the individual and other agencies supporting (and carers if appropriate)
- Strength based and empowering
- Accessible and user friendly
- Tailored to the person and to various situations and locations (including online)
- Addresses risk areas directly
- Informed by previous self-harm and suicide behaviours
- Realistic and achievable
- Flexible – providing options
- Detailed
- Hopeful
- Shared / communicated
- Dynamic / fluid, with regular reviews
- Peer reviewed / supervision

Templates:

4 Mental Health - [Home | Staying Safe](#)

Papyrus - [Suicide safety plan | Papyrus](#) (bilingual)

Every Life Matters - [Safety Planning - Every Life Matters](#)

Samaritans - [Creating a 'safety plan' | Samaritans](#)

Example 6 Point Plan:

1. Objective of the plan
2. Describe the risks
3. Can we better understand the person from their perspective?
4. How can we respond? (Multi-agency)
5. Existing assessments, or which assessments are needed?
6. Summary of person-centred safety plan

Appendix 11 – References

Mental Health Act

[**Mental Health Act - NHS**](#)

Social Services and Wellbeing Act

[social-services-and-well-being-wales-act-2014-the-essentials.pdf](#)

All Wales Safeguarding Procedures

[**Safeguarding Wales**](#)

Wales Suicide Prevention and Self-harm Strategy: Understanding

[**Understanding: a suicide prevention and self-harm strategy | GOV.WALES**](#)

With thanks to the following agencies for their support in drafting this Protocol:

BCUHB Safeguarding and Mental Health Service; Flintshire Social Care;
North Wales Police; Probation; Women's Aid; Clwyd Alyn Housing
Association and members of the North Wales Suicide and Self-harm
Forum.