I am writing to you under the Freedom of Information Act 2000 to request the following information on your Authorities' suicide audit and action plan.

Please provide answers to the following questions, including information on the documents we refer to in this request.

1.	Has your authority undertaken a suicide audit in the last five years (2019 -2023)? Yes or No. (If yes please see 1.a, If no please see 1.d)	Yes. Suicide audits are typically undertaken annually.
a.	If yes, is this available in the public domain? Yes or No. (If yes please see 1.b, if no please see 1.c)	1a Not currently available in the public domain.
b.	If yes, please provide a web link to the report for us to access.	1b N/A
c.	If no, please attach the latest report from your authority.	1c 2021 Suicide Audit – see attached document
d.	If you have not undertaken a suicide audit in the last 5 years please provide the reasons for not undertaking the audit? E.g., lack of capacity, lack of expertise, difficulty in accessing data, lack of cooperation from the Coroner's office (i) (ii) (iii) (iv)	1d A suicide audit was not completed during 2020/2021 due to covid restrictions.
2.	Has your authority developed a suicide action plan in the last five years (2019 -2023) based on the suicide audit? Yes or No. (If yes please see 2.a, if no – no further action needed)	Yes
a.	If yes, is this available in the public domain? Yes or No. (If yes please see 2.b, If no please see 2.c)	2a Not currently available in the public domain.
b.	If yes, please provide a web link to the action plan for us to access.	2b N/A
c.	If no, please attach the latest action plan from your authority.	2c Strategy and Action Plan attached (see attachments)

Wigan Suicide Audit - 2021

Wigan Council has responsibility for health surveillance of the population of the Borough, and this includes the monitoring of mortality rates due to suicide. As part of this surveillance and to help underpin and shape the development of a proactive, targeted and collaborative local Suicide Prevention Strategy and Action Plan Wigan Council Public Health Team undertake annual audits of all available Coronial files relating to suicide and circumstances surrounding instances of suicides.

Key Headlines from 2021 Audit

Numbers of instances of death by suicide and suicide rates

35 deaths due to suicide or injury of undetermined intent were registered in Wigan in 2021, compared with 33 in 2020 and 50 in 2019.

32 of these cases had records available at Bolton Coroner's Court and have been included in this audit report. Of these, the coroner recorded a verdict of suicide in 21 (66%) cases, a narrative verdict for 16 (16%), an open verdict for 16 (16%) and 1 verdict of misadventure.

Gender

Of the 32 cases audited, 27 (84%) were male and 5 (16%) were female. This broadly reflects the national picture for 2021 (Males are 2.9% more likely to die by suicide than females) and is similar to the gender split of the overall rate of Wigan audits since 2011.

Age

The overall most common age range was 40-49. The most common age range for males was 40-49 (33%), and for females (figure supressed due to the low number). 34% of all deaths included in this year's audit were under 40. Coronial files were audited for young people 18 and under.

Method

Hanging was the most common method for Males (63%) and Overdose for Females (60%). The next most common methods identified in 2021 were multiple injuries as a result of contact with a train.

Location

The highest proportion of deaths took place within the home (56%) of the deceased; this is in line with previous audits and national results. There were 4 deaths in hospital, with the remainder occurring elsewhere (31%). No obvious links between cases or evidence of clusters were identified.

Living situation and Marital Status

As seen in previous years, people most commonly lived alone in their own home, followed by living with other and their parents. Living status recorded as being homeless and temporarily residing in a hotel. The highest proportion of people were married (47%), single (41%) and divorced (12%). As with previous audits, people recorded as single were in relationships or separated.

Risk factors, Issues and Previous Self-Harm

All cases described multiple issues and risk factors, with 59% having 5 or less and 41% having 6 or more.

[redacted]
Senior Public Health Analyst – Joint Intelligence Unit
Update - October 2023
[redacted]

Suicide Prevention is Everybody's Business

Our ambition is that Wigan is a supportive place to live, work and visit where people receive support as and when they need it. As a Borough we are committed to preventing people dying by suicide and have set ourselves an ambitious target to have zero suicides. Although the number of suicides locally is small compared to other causes of death, we recognise that every suicide has a significant impact on the families, friends, colleagues, community and workers associated with the victim. Suicide is not inevitable. We want to ensure that no resident will think that suicide is their only option, by tackling the stigma associated with suicide, building resilient communities, and encouraging people to seek the right help and support. To achieve the ambition of zero suicides we will:

· Build capacity and capability within organisations and communities to talk openly and routinely about suicide.

· Maximise the opportunities provided by national and regional suicide prevention programmes to benefit local people, including Shining A Light on Suicide and GM Bereavement Service.

· Ensure routine crisis de-escalation and case management is implemented to help prevent suicide by people in mental health crisis and/or emotional or social crisis.

· Support those who have been affected by suicide.

· Work in partnership by recognising that we all have the right to good wellbeing, no one organisation can do it alone, and the answer lies in collaboration and co-production.

· Collaborate with those with lived experience to drive change in the suicide prevention agenda.

Intended Outcomes

- Reduce the risk of suicide in high-risk groups
- Tailer approaches to improve mental health in specific groups
- Reduce access to the means of suicide
- Provide better information and support to those bereaved by suicide
- Support the media in delivering sensitive approaches to suicide and suicidal behaviour
- Support research, data collection and monitoring
- Reduce rates of self-harm as a key indicator of suicide risk

Strategic Enablers

Whole System Approach	Targeted Approach & Intelligence Led	Workforce Development	Estates and Infrastructure Across the Place	Communication & Community Engagement
• Chair and support an effective boroughwide multi agency strategic suicide prevention group (SPG)/ subgroups overseeing the delivery of the Suicide Prevention Strategy • Identify funding, commissioning resources and opportunities for related suicide prevention activity and insight • Ensure that SPG members advocate on behalf of suicide prevention and have targeted activity in their local work plans including world suicide prevention day • Maintain strong links to the Adult and Children's Safeguarding Boards, Mental Health Transformation Board, Health and Wellbeing Board, GMIC Boards, and relevant Children, Young People & Adult strategic groups • To collaborate with regional networks, partners and colleagues to share best practice in suicide prevention	• Establish a Borough real time surveillance group with relevant partners • Development of real time surveillance systems both for the Borough and at a Greater Manchester level ensuring appropriate intelligence is shared in a timely/ sensitive manner. • Expand and improve the systematic collection of and access to data on suicides through working with local and regional partners (e.g. Children and Young People's Services, Coroner's office, Network Rail and Samaritans) • Undertake annual suicide audits of the coronal files	• Roll out of e-learning and face to face training • Improve the knowledge/skills of those working front-line to identify those at greatest need and have the confidence to talk about suicide and direct individuals and families to support services • Development of level 1 offer; to improve population mental wellbeing and resilience (pre-IAPT), including a person-centred approach with range of options • Promotion of Shining a Light on Suicide Campaign, website, and resources • Ensure that frontline staff have appropriate support in the workplace to protect their personal wellbeing & mental health • Embed Trauma Informed and connect 5 training across place	• We will continue to monitor and respond to emerging high-risk locations by working with our partners to lead the "suicide safer communities" approach • We will identify sites where suicides occur and install appropriate signs for local crisis services and support • Access to high-risk areas will be secured to reduce risk at that location to include Rail Networks and Waterways • Reduce risk of suicide on the railway by working with British Transport Police, Network Rail and Samaritans • Promote an awareness of suicidal risk among property and housing developers, planning and other agencies to aid the designing out risk from new structures and buildings	• Engage with local media to ensure responsible reporting and portrayal of suicide and suicidal behaviour in the media • Monitor and review media reporting in relation to specific incidents of suspected suicide and more general commentary around suicide, mental health and crisis care • Raise awareness of the risks presented by inappropriate social media content and potential harm to the general emotional wellbeing of children and young people arising from excessive, un-moderated access to social media • Develop a communications plan for the delivery of reports, messages, and updates to ensure that the Suicide Safer Community brand is recognised and visible • Invite local media to participate in this strategy and its key messages • Promotion of World Mental Health Day; Mental Health Awareness Week; and Suicide Prevention Day • Engage with residents to share their stories and suicide prevention messages

Suicide Prevention Strategic Priorities

Integrate suicide prevention into a broader framework for promoting population mental health and wellbeing	Reduce attempted suicide and self-harm especially amongst children and young people	Reduce the risk of suicide in our most complex, high-risk groups	Learn from those who have died by suicide or attempted suicide	Provide better information and support to those bereaved or affected by suicide
• To embed suicide prevention opportunities across the life course from Start Well to Age Well, using the family approach. • Promote awareness of suicide among community groups, including Connect 5-and suicide prevention training. Encourage local people with personal experience of suicide to share it appropriately in their communities. • Collaborate with individuals and groups to develop innovative ideas to prevent suicide in their communities. • Develop and support effective suicide prevention activity within primary and secondary care, increasing knowledge and awareness of those at risk of suicide. • Promote information about good practice in mental wellbeing and suicide prevention in key settings • Increase the use of Safety Plans within key pathways. • Help build community resilience to improve mental wellbeing including the promotion and use of resources such as LLTTF, Connect 4 etc.	• To ensure a strategic response to building resilience and mitigating the impact of social media on young people's emotional wellbeing. • Gain a better understanding of self-harm by analysing and utilising local data; to shape recognition and understanding of self-harm in young people's settings • Testing of incident alert system in Start Well • To influence and raise awareness among front line staff of the complex issues contributing to self-harm and a greater understanding of the role of safeguarding • Identify a strategic lead for self-harm and work with lead to develop the appropriate pathways for self-harm. • Collaborate with others to ensure children who are looked after and those who have had trauma, receive the support and treatment they need. • Embed safety plans within the psycho-social assessments and ensure they are offered where appropriate to those presenting in crisis • Influence an effective recording system within primary care in relation to self-harm. • Review recording of self-harm by education settings. • Collaborate with key settings (e.g. Colleges) and encouraging them to develop their own Suicide Prevention Strategy.	• Examine the specific needs of those attending A&E who have attempted suicide, self-harmed, or who are in mental health crisis. • Ensure effective crisis de-escalation and case management tools are used in place. • Map the current crisis referral pathway, identify and escalate gaps via the appropriate governance routes and make the results available. • Utilise the Live Well model developments to support local interventions and solutions in relation to working with specific complex and high-risk groups at risk of suicide • Target interventions to cohorts who are known to be at higher risk of suicide e.g. men, those who are economically vulnerable, LGBTQ+ community, those in care of mental health services, those in contact with criminal justice services and those who self-harm. • Collaborate on Greater Manchester's annual suicide prevention priorities. • Embed suicide prevention strategies into key priority programmes, including harmful gambling, welfare and reform, criminal justice system, veterans. • Ensure '10 ways to improve patient safety' is adopted locally to support those in the care of local mental health services. • Consult with residents to inform suicide prevention plans. • Ensure that appropriate support is in place for Neurodiverse people and consider the results of NIHR funded study – published 2024.	• Agree an information sharing protocol which enables services to identify near misses and provide rapid support interventions where death has occurred. • Develop a local proactive, real-time suicide surveillance system. • Collate a shared risk log that highlights emerging intelligence in relation to suicide, including new and emerging methods of suicide and at-risk locations. • A sharing of intelligence from across partner agencies to populate a local suicide dashboard which will help inform workplan priorities. • Learn from the safeguarding assessments and interventions for vulnerable and temporarily vulnerable adults. • Implement the learning and recommendations from Safeguarding Adult Reviews, Child Death Overview Panel investigations and Brief Learning Reviews. • Collaborate across GM to further develop an early alert process to prompt sharing of appropriate information by the police and coroner's service, referral to support services and multi-agency response • Encourage a multi-agency approach to serious incident reviews and lessons learned procedures, ensuring that resulting information is disseminated appropriately. • Collaborate with Network Rail on their post incident support processes.	• Establish a central resource hub to support delivery and access to bereavement services. • Local Postvention pathway developed (in line with Bereavement Support Strategy and GM offer). • Ensure specific interventions are in place to support key cohorts as reference in national SP Strategy • Collaborate with first responders and local funeral directors to promote 'Help is at Hand'. • Ensure appropriate resources are available in settings such as libraries, primary care and through bereavement support organisations. • Map current provision of bereavement support services available across the system, and at different stages of bereavement (including long term grief & PTSD), identify gaps and collaborate with others to build community assets • Child Death Oversight Panel to ensure that there is dedicated professional liaison with each family to support them during the multiagency review of any unexplained death. • Raise awareness of the work by bereavement, community & faith-based organisations that offer support to those bereaved or affected by suicide. • Promote the establishment of a local peer led support group of people and families who have been bereaved through suicide. • Erect a permanent memorial for those who have died by suicide across the borough


Mental Health Transformation Board
Wigan Adult Safeguarding Board
Wigan Childrens Safeguarding Board
Health and Wellbeing Boared
Wigan Suicide Prevention Group
Tactical Subgroups

Wigan Suicide Prevention Action Plan 2024

Strategic Priorities:

1. **Integrate suicide prevention into a broader framework for promoting population mental health and wellbeing.**
2. **Reduce attempted suicide and self-harm especially in children and young people.**
3. **Reduce risk of suicide in our most complex, high-risk groups.**
4. **Learn from those who have died by suicide or attempted suicide.**
5. **Provide better information and support to those bereaved or affected by suicide.**

Objective 1: Whole Systems Approach			
Key Actions	**Responsibility**	**By When**	**Expected Outcome(s)**
Establish a central resource hub to support delivery and access to bereavement services, co-ordinated by Bereavement Support Strategy Group			
Map the current crisis referral pathway, identify and escalate gaps via the appropriate governance routes and make the results available.			
Collaborate with key settings (e.g. colleges) and encouraging them to develop their own Suicide Prevention Strategy.			
Collaborate on GM's annual suicide prevention priorities.			
Ensure a strategic response to building resilience and mitigating the impact of social media on young people's emotional wellbeing.			
Collaborate with others to ensure children who are looked after and those who have had trauma, receive the support and treatment they need.			
Establish a short-term Training Subgroup to document local and national training offer including target group. - Follow up includes commissioning any future gaps in provision			

Joint accountability and collaboration from all Board members. They will within their organisation: • Undertake lead advocate roles for the SP Strategy • Ensure respective leadership teams are sighted on the strategy, including their role in assisting to deliver outcomes • Collaborate with system partners where there are joint actions • Ensure learning that has or will benefit to the overall strategy and work is conveyed back to the Board.			
Objective 2: Targeted Approach & Intelligence Led			
Key Actions	**Responsibility**	**By When**	**Expected Outcome(s)**
A sharing of intelligence from across partner agencies to populate a local suicide dashboard which will help inform workplan priorities.			
Agree an information sharing protocol which enables services to identify near misses and provide rapid support interventions where death has occurred.			
Influence an effective recording system within primary care in relation to self-harm.			
Examine the specific needs of those adults attending A&E who have attempted suicide, self-harmed or who are in mental health crisis.			
Examine the specific needs of children and young people attending A&E who have attempted suicide, self harmed or who are in mental health crisis			

Identify the needs on physical health wards for support around patients who are experiencing mental health crisis, and how we can support staff to support and signpost to appropriate services.			
Collate a shared risk log that highlights emergency intelligence in relation to suicide, including new and emerging methods of suicide and at-risk locations.			
Collaborate across GM to further develop an early alert process to prompt sharing of appropriate information by the police and coroner's service, referral to support services and multi-agency response.			
Embed suicide prevention strategies into key priority programmes including harmful gambling, welfare and reform, criminal justice system, veterans.			
Provide support via VCSFE to determine quality assurance framework for the sector who provide targeted interventions for key cohorts - men, those who are economically vulnerable, LGBTQ+ community, those in care of mental health services, those in contact with criminal justice services and those who self-harm.			
Gain a better understanding of self-harm by analysing and utilising local data to shape recognition and understanding of self-harm in young people's settings.			
Objective3: Workforce Development			

Key Actions	Responsibility	By When	Expected Outcome(s)
Develop and support effective suicide prevention activity within primary and secondary care, increasing knowledge and awareness of those at risk of suicide.			Connect 5 Zero Suicide Alliance GMMH
Utilise the Live Well model developments to support local interventions and solutions in relation to working with specific complex and high risk groups at risk of suicide.			
Collaborate with first responders and local funeral directors to promote 'Help Is At Hand' book via Bereavement Support Strategy Group.			
Local Postvention pathway developed in line with Bereavement Support Strategy group.			
Child Death Oversight Panel to ensure that there is dedicated professional liaison with each family to support them during the multiagency review of any unexplained death.			
Identify a strategic lead for self-harm and work with lead to develop the appropriate pathways for self -harm.			
Objective 4: Estates and Infrastructure Across The Place			

Key Actions	Responsibility	By When	Expected Outcome(s)
Collate a shared risk log that highlights emerging intelligence in relation to suicide, including new and emerging methods of suicide and at-risk locations.			
Objective 5: Communications and Community Engagement			
Key Actions	**Responsibility**	**By When**	**Expected Outcome(s)**
Promote awareness of suicide among community groups, including Connect 5 and suicide prevention training. Encourage local people with personal experience of suicide to share it appropriately in their communities.			PH Comms to undertake Connect 5 Connect initially. PH Campaigns Lived experience
Help build community resilience to improve mental wellbeing including the promotion and use of resources such as LLTTF, Connect 5 etc.			
Map current provision of bereavement support services available across the system and at different stages of bereavement, identify gaps and collaborate with others to build community assets via Bereavement Support Strategy Group.			
Promote the establishment of a local peer led support group of people and families who have ben bereaved through suicide.			

Erect a permanent memorial for those who have died by suicide across the borough.			
Ensure appropriate postvention resources are available in settings such as libraries, primary care and bereavement support organisations.			