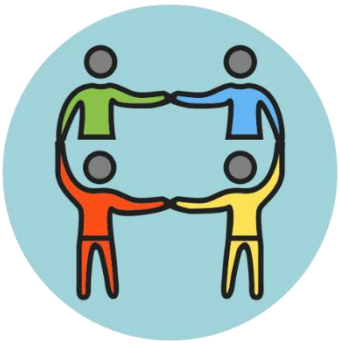
Hammersmith and Fulham Suicide Thematic Review

Executive Summary



Independent Reviewer: Dr Rosie Buckland

Contents

1. Overview of the SAR process

2. Overview of the findings

3. Analysis

4. Recommendations

1. Overview of the SAR process

1. A Safeguarding Adult Review (SAR) was commissioned by the London Borough of Hammersmith and Fulham (LBHF) Safeguarding Adults Board (SAB) in accordance with the Care Act 2014 in early 2025 as an opportunity to consider and review themes across multiple deaths by suicide within LBHF.

2. Statistical information indicated that LBHF has a higher rate of deaths by suicide than both the London average and the national average and this SAR forms part of the LBHF Suicide Prevention strategy 2024-2027, with funding from LBHF Public Health.

3. An independent reviewer with a practice and academic background in mental health services and no connection to any individuals or agencies in Hammersmith and Fulham was appointed.

4. The SAR panel met four times and included members from the following agencies:

- LBHF Public Health
- LBHF Adult Social Care
- NHS North West London ICB
- Metropolitan Police Service
- British Transport Police
- West London NHS Trust
- Imperial College Healthcare NHS Trust
- Chelsea and Westminster NHS Trust
- Turning Point (Drug and Alcohol Wellbeing Service)
- London Ambulance Service

5. Additional expertise and the review of documents was also sought from members from the following agencies:

- LBHF Violence Against Women and Girls Lead

6. A half day learning event, open to practitioners and managers from all relevant agencies in LBHF was held in November 2025 and was attended by members from the following agencies:

- Imperial College Healthcare NHS Trust
- Turning Point drug and alcohol services
- Adult social care commissioning (mental health)
- Two GP practices
- Public Health
- Met police
- Mind bereavement service

7. The deaths of 11 very different people who lived and died by suicide in LBHF were considered within the thematic SAR. They were all adults with care and support needs who were in some contact with services, who were living in the community, who died

between January 2023 and May 2024 and had their deaths ruled as suicide by a coroner's inquest. Despite their differences, the SAR sought to understand commonalities in their experiences.

8. Where details were available for family members of these 11 people they were contacted and invited to participate in the review however they wanted to. 2 people chose to be involved in the SAR. All family members were contacted again to inform them about publication.

9. In addition to panel meetings and a learning event, the SAR process involved:

- A consideration of LBHF demographics and suicide statistics;
- National learning and statistical information about suicide;
- A review of all existing single agency reviews previously undertaken into the deaths of the 11 people;
- A consideration of existing service provision;
- Conversations with family members who chose to participate in the review process.

10. Panel members and other agencies were also asked to provide information about the SAR for people using services and their families so that they could contact the author if they wanted to confidentially share any experiences that might inform the process of the review.

11. A 44 page full report was agreed by panel members and the SAB in early 2026 and will be available to agencies as relevant. Pseudonyms are used in the report but for reasons of sensitivity, confidentiality and differential levels of family involvement, a decision was taken to publish only this Executive Summary (which contains no personal information about any individuals), a Learning Brief and an Action Plan demonstrating how the recommendations will be implemented.

2. Overview of the findings and analysis

1. Findings and analysis were structured by Key Lines of Enquiry (KLoE) under the areas of:

- Individual Characteristics and Life Circumstances;
- Identity, Inequality and Overrepresentation;
- Mental Health, Diagnosis and Dual Needs;
- Risk, Safeguarding and Multi-Agency Practice;
- Access, Engagement and Disengagement;
- Family and Community Support;
- System-Wide Learning.

2. Within and across the existing reviews that the SAR considered, good practice was highlighted in relation to: treatment adherence to NICE guidelines; positive relationships

with staff; regular reviews; proactive attempts to contact family by drug services; safety and service information about rough sleeping given by drug services; timely care being provided.

3. Within and across the existing reviews that the SAR considered, scope for improvement was highlighted in relation to: the quality of care co-ordination; timeliness of care; a lack of safeguarding, Care Act and domestic abuse referrals; limited curiosity and exploration in relation to the assessment of diagnosis and risk and the use of outdated tools for assessing risk; insufficient involvement of family and friends as a source of information and a safety resource; inadequate recording of contact information for family and friends; inaccuracies in recording and inadequate record keeping; insufficient supervision of people in Emergency Departments; adherence to care plans; safety information provided; clarity around frequency of contact at and in between appointments; handover policies and transfer of care from Talking Therapies to MINT; the use of multiple IT systems creating barriers to communication within and across agencies and teams; how care was experienced by people and their families; how people and their families were supported to be involved in decisions about care and to understand clinical decisions made by professionals.

4. Conversations with family members involved in the SAR highlighted issues including: poor quality supported accommodation and the impact of this for people; a lack of creative involvement of family members; insufficiently trauma-informed and culturally-informed understandings of people and of risk factors; a lack of good knowledge about the person; poor communication across different parts of the system when someone presented in crisis; people and their families not feeling listened to and excluded from decisions made about diagnosis and treatment; insufficient information given to families about practical ways of supporting someone in distress; information from families about risk not being taken sufficiently seriously; practical requests from family not being followed.

5. The learning event that was held supported in the development of the recommendations. Concerns raised by attendees around suicide prevention related to: difficulties referring to mental health services; difficulties supporting people with co-occurring substance use and/or physical health difficulties and mental health difficulties; knowing what services are available and how to refer to them; mental health stigma; difficulties in communication across agencies and across professions; difficulties in busy Emergency Departments; difficulties on discharge from hospital; understanding how best to learn from each other; frustrations around seeing the same issues repeated; consent to share information; difficulties in supporting people where engagement with services is an issue.

3. Analysis in relation to the KLoEs

1. Analysis in relation to the KLoEs of (i) Individual Characteristics and Life Circumstances; (ii) Identity, Inequality and Overrepresentation and (iii) Mental Health, Diagnosis and Dual Needs highlighted:

- Potentially missed opportunities around Care Act safeguarding referrals and Care Act assessment of need referrals
- Greater scope for considering risk and resilience in strengths-based ways; greater scope for naming both poverty and self-neglect
- Commonalities around social isolation and difficulties in family, intimate or friend relationships
- Inter-relationships between these issues and problematic drug and alcohol use. As is reflected nationally, deaths by suicide amongst men are higher in LBHF than amongst women. Intersectionality was explored in terms of meeting differing needs around social isolation and the range of community groups and non-statutory sector provision in LHBF was explored.
- There was also exploration of the LBHF suicide prevention campaign targeted at men and the need to recognise greater diversity and intersectionality amongst men and men's needs.

2. Analysis in relation to the KLoEs of (iV) Risk, Safeguarding and Multi-Agency Practice; (v) Access, Engagement and Disengagement; (vi) Family and Community Support and (vii) System-Wide Learning highlighted:

- Learning around transitions between services on discharge
- Good practice and areas for development in joint working between mental health and drug and alcohol services
- Reducing access to means of suicide
- Challenges to multi-agency working presented by the use of multiple IT systems
- A need to strengthen multi-agency risk sharing forums around suicide and self-neglect
- The value of shared training spaces
- Scope to strengthen the use of Care Act assessments of carer's needs.
- Gaps were identified in the recording of accurate ethnicity data and contact information for family members.
- Greater scope for working with families and someone's wider social network was identified and current barriers to this were considered.
- Learning around compassionate support for people's loved ones when someone has died by suicide was discussed.

12. Four themes were identified and recommendations made relating to each of these themes: Working with the person in their intersectional context; Improving multi-agency working, inter-agency working and service provision; Improving people's experience of care, support and service delivery; Understanding suicide prevention as a safeguarding issue.

4. Recommendations

Theme 1: Working with the person in their intersectional context

1. The SAB should collaborate with the Health and Wellbeing Board to seek assurance on how all partner agencies are recording demographic data and mechanisms for auditing compliance, including ethnicity data, to ensure consistency and enable improved tracking of patterns in relation to suicide prevention, risk and completion.

2. LBHF's Public Health should review the current suicide prevention strategy and associated campaigns in relation to the findings of this SAR, to:

a. Consider how to engage with men's suicide risks in a more intersectional way, seeking representations from the SAB and its partners.

b. Ensure that the local Suicide Prevention Strategy incorporates within it the Department of Health and Social Care Men's Health Strategy, published in November 2025, 'Men's health: a strategic vision for England'. This review should also incorporate other up to date learning about men's mental health, including the 2025 Equimundo's/Beyond Inequality 'State of UK Men' referenced in the SAR analysis.

3. West London NHS Trust should continue to develop peer support workers and others with lived experience of using services, with development of training to support staff to understand better how to deliver care that is experienced as compassionate and kind.

Theme 2: Improving multi-agency working, inter-agency working and service provision

4. LBHF Public Health to consider how it might co-ordinate network meetings for AMHPs and professional leads across services, with consideration from all partner agencies on the provision of leads at a practitioner level i.e. carer's leads, substance use leads, mental health leads, suicide prevention leads etc.

5. The SAB should review the current provision of multi-agency safeguarding panels and multi-agency participation in existing forum spaces (such as MINT partnership meetings), the promotion of these to all services and the relationship or potential relevance of each of these to suicide risks. This would ensure that all relevant staff understand how to refer into each of these and that they are better used as a resource by all agencies.

6. The SAB should highlight learning from this review to DHSC in relation to the integration of all IT systems, so that this can be mapped and continued plans made to address this as an ongoing barrier to good safeguarding practice. As part of this, consideration should be given to multi-agency dashboards.

7. For partner agencies to review discharge practices to ensure timely information sharing and liaison with other services (including primary care and drug and alcohol

services), including discharge from secondary services and inpatient mental health services, and discharge from hospital.

8. West London NHS Trust should seek to review of SPA triage processes to understand if referrals are regularly rejected or downgraded, with a view to better understanding referral information patterns and improving relationships between referring agencies and West London NHS Trust. This should include clarification for partner agencies on escalation processes where referrals are rejected or not responded to.

Theme 3: Improving people's experiences of care, support and service delivery

9. All agencies should review how and where they record information about family, friends and significant other professionals, so that there is improved recording across services of phone numbers, addresses, email addresses and information about the nature and strength of the relationship and improved clarity around consent to share information (including upon discharge). Where someone's social networks are limited this should be highlighted as a specific area of vulnerability and consideration should be given about how to respond to this.

10. The SAB and its partner agencies should consider the development of multi-agency resources promoting key referral pathways and the importance of working with people's social networks.

a. This should include an understanding of professional curiosity, strengths-based practice, genograms, understanding important anniversaries, ecomaps, confidentiality and consent and convening multi-person meetings.

b. This should also include clear signposting to other relevant local and national services and sources of support such as the Listening Place and the Carers Network, and highlight the role of advocates (inc. IDVAs and non-statutory advocates)

c. Promotion of the Family Group Conference model

11. All agencies should review their processes to ensure that all relevant staff understand how and when to refer for an assessment including:

a. A carer's assessment under the Care Act.

b. An assessment under the Care Act to consider an individual's care and support needs.

12. The Combatting Drugs Partnership and commissioners should jointly consider at a strategic level how to meet the identified gap in support for people using drugs and/or alcohol and experiencing mental health difficulties who won't access drug or alcohol services.

Theme 4: Understanding suicide prevention as a safeguarding issue

13. The SAB should share the learning from this report with NHSE/DHSC highlighting the need to consider governance processes around the PSIIRF process and safeguarding referrals, including S42 enquiries. This is to ensure that patterns in the use or omission of safeguarding processes can be better understood.

14. All agencies should review their processes to ensure that all relevant staff understand how and when to refer to safeguarding. The relationship between internal safeguarding procedures and the Local Authority safeguarding procedures should be understood by all staff. The relationship between safeguarding, self-neglect and suicide prevention should be explicitly considered.

15. LBHF Public Health should consider, in line with other London Boroughs, the development of a Suicide Response Protocol and a Multiple Suicide Response Protocol to ensure consistency of approach across agencies when people die by suicide, with consideration of role of regional networks in this work.

16. The Hammersmith and Fulham Suicide Prevention Strategy steering group and its associated working groups should consider how to work more closely with the acute Trusts to strengthen their involvement.

17. The use of police data to track the increased risk of suicide (and domestic homicide) post-separation following domestic abuse, particularly where there have been Clare's Law disclosures made or MARAC involvement, should be reviewed, to ensure that it is being utilised as effectively as possible.

18. Learning should be shared with relevant regional leads to allow for consideration of the need for any additional work around the provision of physical safety and suicide prevention measures in local public spaces commonly associated with suicide e.g. bridges, train stations and tube stations, as well as the provision of promotional material for helping agencies in identified places. This should also involve a review of agencies responsible for specific areas and engagement with them where necessary.

19. All partner agencies should review their suicide prevention and awareness training offer to all staff, on an ongoing basis, ensuring that this incorporates suicide risk indicators, recognising links with self-neglect, understanding trauma-informed approaches, working with friends and family and navigating consent and confidentiality in adult safeguarding.

a. Specific assurance should also be sought that suicide awareness and prevention training is made available and undertaken by clinicians responsible for management of chronic pain, with consideration of the impact on mental health.

b. The Public Health review of the impact of training provided by the Listening Place due to take place in March 2026 should incorporate learning from this SAR into considerations about ongoing training across agencies.