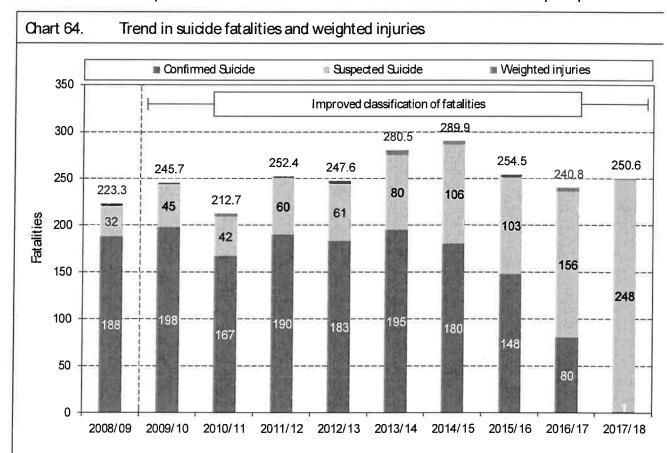
9.2 Trend in suicide fatalities

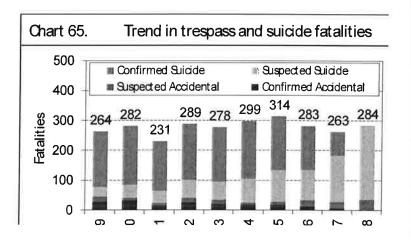
Chart 64 presents the trend in harm from suicide and suspected suicide for the past 10 years. The dark bars represent the number of events with a coroner's confirmed verdict. The light bars represent the number of verdicts that were open, narrative, or not yet returned, which are currently dassed as suspected suicide, based on application of the Ovenstone criteria.

The discontinuity resulting from greater information being available from 2009/10 onwards is reflected in the chart. Later years have greater proportions of unconfirmed categorisations, while coroners' inquests or verdicts are still awaited. Note that due to capacity constraints RSB have not reviewed coroners reports for most 2017/18 fatalities and this will be carried out post-publication.

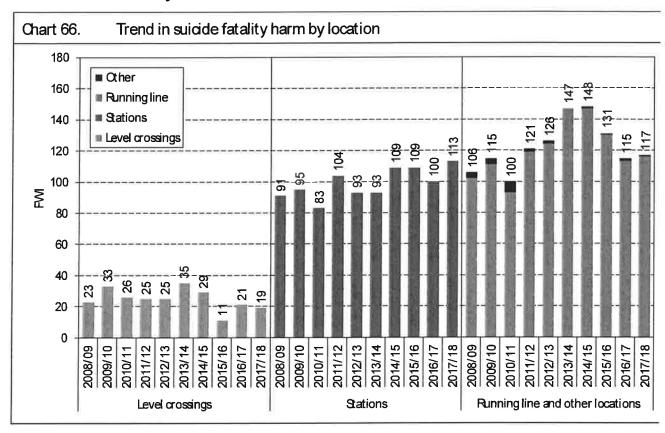


Note: For 2009/10 onwards, the classification of open, narrative and unreturned coroners' verdicts has based on an improved amount of information.

- Given the proportion of cases that are open, narrative or unreturned, which is where judgement needs to be applied, it is useful to look at the trend in trespass and suicide fatalities as a whole.
- Chart 65 shows that although up to 2014/15 there has been a generally increasing trend in fatalities due to trespass or suicide, numbers have



Trends in suicide by location



- Since 2008/09, around 50% of suicides have occurred on the running line. In 2017/18 there was small increase in suicide events at these locations.
- Since 2008/09, around 40% of suicides have occurred in stations. The number of suicides in stations for 2017/18 increased to the highest in the reporting period.
- The number of suicides at level crossings decreased this year and remains below the annual average for the reporting period. Over the past 10 years, around 10% of suicides have occurred at level crossings. The remaining small percentage of events have occurred in other locations.
- The occurrence of suicide on the railway is likely to be influenced by wider societal trends, as we as by initiatives the railway takes to prevent suicide attempts.

9.3 Suicide prevention initiatives

Rail Industry partners (including Network Rail, the train operating companies, trades unions, BTP, Samaritans, and RSSB) under the banner of the Rail Industry Suicide Stakeholder Group (RISSG) have been working together since 2010 to reduce suicide on the railway and to support those involved or who witness such an event. In 2015 the contractual partnership agreement between Samaritans and Network Rail on behalf of the rail industry was renewed until 2020.

The industr suicide prevention programme involves the roll out of a number of prevention and post-incident support initiatives. These include multi-agency partnership working at national and local level, bespoke training of rail industry staff, a national public awareness poster campaign, the implementation of physical mitigation measures at railway locations, post-incident support at railwa stations provided by local Samaritans volunteers and work to encourage responsible media reporting of suicides. Increasingly important are the relationships being forged with local authorities and MPs as collectively there is recognition that the rail industry is but one player in addressing the societal issue of suicide.

LOEcomment

We don't alwa know what has led someone to consider suicide. But what we do know is that if take the time to talk to someone at risk of harming themselves, usen't make it worse, and you may actually save their life.

On 15 November, this started to be put into practice when the industry, in partnership with Samaritans, launched its first national bull ander campaign, 'Small Talk Saves Lives' which seeks to gain the support of customers and the public in preventing suicide not only on the railway, but also in their own communities.

Driven by examples of rail staff, and members of the public who have intervened to help someone in crisis, the campaign's overarching aim is to encourage people to trust their instincts and take action if the see someone the concerned about.

The award-winning campaign has been launched country-wide, across many multi-media outlets. It features role model behaviour, showcases the work of the rail industry at large, and equips the public with a belief that suicide is preventable and that a simple conversation can be all that's needed, along with guidance on what to look out for, and what action to take.

In short, it humanises suicide for rail passengers, it focuses on driving intent and removing barriers that prevent action, making it easier by simplifying the ask and giving people the confidence to act and a belief that they can make a difference.

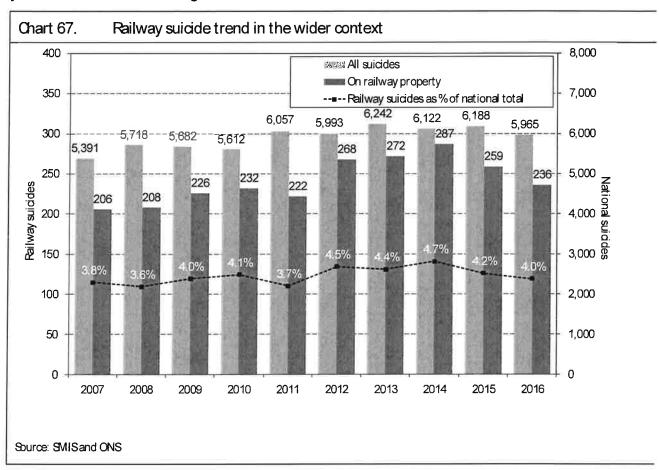
Deliver national guidance emerging from event reviews

3. Suicide Prevention Champions and Coordinators in place within each organisation Continued partnering with dedicated Samaritans and British Transport Police suicide prevention teams Smplified version of the Programmes strategy published Production of guidance documents Provision of core data sets for industry and third-party use Working with Department for Transport to development a transport sedor suicide prevention strategy Working with Public Health England to validate industr approach to suicide prevention Hosting suicide prevention conferences and parliamentary receptions Promoting national awareness activities with Samaritans Sharing expertise with foreign rail agencies Prevention activities Commissioning bespoke research to identify new ways to meet the suicide prevention challenge on the railway societ al issues at high risk locations Design and delivery of suicide prevention awareness campaigns such as Shall Talk Saves Lives Overlailing the industr⊞ escalation process to high-risk locations Provision of suicide prevention training Monitoring of press and social media outputs Suicide prevention arrangements built into franchise agreements. Looking at new and emerging technologies to prevention activities with local MPs Lidentification of the industr⊞s of prevention strategy Completion of location reviews to determine approlevels of suicide prevention activities Identifyication of 'at risk' locations Prevention activities Prevention activities Identifying at risk locations Palsing awareness amongst staff of the industr⊞s prevention measures and getting them to become actively involved Coordinating prevention activities with local author and other third-party with public prevention activities Industributing to and leading power the programmes are suicides and the prevention activities Commissioning bespoke research to identify new ways to beploy the programmes are suicided prevention activities Identifying at risk locations Palsing awareness anongst staff of the industr⊞s		Summary of programme activities	
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learning

9.4 Railway suicides in the wider context

Suicides on the railway represent by far the largest proportion of railway-related fatalities, but they represent a relatively small percentage of suicides on a national level. National suicide figures are not available as recently as railway figures, being published on a calendar year basis; the chart shows the latest available calendar year comparisons. The national figures used for the UK are based on the year when the death was registered.



- Over the period shown in the chart, the average number of national suicides has been 5,897 per year. The years 2011-2016 have seen a sustained higher level of national suicides. This increased number of suicides at a national level has been in line with an increased number seen on the railway. The number seen in 2016 is the lowest in five years, but remains higher than historic figures.
- The proportion of the national total occurring on railway property has been 4.1% over the analysis period; the most recent available year for comparison has shown a slightly lower proportion.

9.5 Key safety statistics: suicide

Suicide	2013/14	2014/15	2015/16	2016/17	2017/18
Fatalities	275	286	251	236	249
Struck by train	265	281	243	228	242
Not train related	10	5	8	8	7
Injuries to others	292	243	213	186	88
Major injuries	0	0	0	0	0
Minor injuries	0	1	0	1	3
Shock and trauma	292	242	213	185	85*

^{*} The apparent reduction in shock and trauma is due to a change in the way such incidents are reported in SMIS