



Suicide Prevention Themed SAR

(Incorporating recommendations for Havering's Safeguarding Children Partnership)

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Havering Thematic Safeguarding Adults' Review: Suicide Prevention

1. Introduction

Under the Care Act 2014, Safeguarding Adults Boards (SABs) have a statutory duty to commission a Safeguarding Adults Review (SAR) when:

- An adult with care and support needs dies or experiences serious harm, and
- Abuse or neglect is suspected, and
- There is concern about how agencies worked together.

In October 2024, the Independent Chair of the Havering Safeguarding Adults Board (HSAB) reviewed two cases referred from the Case Review Working Group: John (45) and Trevor (21), were both white British males, whose deaths were as a result of suicide or suspected suicide. The Chair agreed that both cases met the criteria for a discretionary SAR. Given the thematic similarities and the national rise in suicide-related SARs, the Chair recommended that the cases should be examined together under a single thematic review focused on '**suicide prevention**'.

In August 2025, the Havering Safeguarding Children Partnership (HSCP) agreed that a third case, Richard (17), a black African British Zimbabwean, who survived an apparent suicide attempt should be included to strengthen learning around transitions and early intervention.

This review aims are to:

- Extract learning from these tragic events
- Strengthen suicide prevention approaches across Havering
- Align with the development of the Havering All Age Suicide Prevention Strategy (2025-30)
- Draw on insights from previous local SARs and national reviews

2. SAR Methodology

2.1 Purpose of SAR

A SAR is not an enquiry into the cause of death or any culpability. That is the function of the coroner and any official complaint or criminal investigations. The aim of a SAR is to:

- Identify lessons for multi-agency working.
- Consider safeguarding policies and protocols.
- Improve local safeguarding practices.
- Produce actionable recommendation.

2.2 Methodology

Havering Public Health are responsible for the production and oversight of the implementation of the Havering All-Age Suicide Prevention Strategy¹ (2025-30). Given the focus of this review was suicide prevention, it was essential that Public Health worked with the SAB in informing this review.

A case review group was formed to support the review and met on two occasions.

The following action has been undertaken in the preparation of this report:

- A table audit of primary cases.
- An audit of suspected suicides in Havering during a fixed period undertaken by Public Health.
- Focus group
- Review previous local SAR's and other area SARs
- Research national suicide prevention reports
- Hear the voice of Richard

3. Family Involvement.

It is good practice for any review to liaise with family members. For this review, family members of the primary individuals have been contacted and have either failed to respond or declined to be involved.

Further attempts will be made and if successful, amendments to the report will be made.

4. Background Pen Picture

As the theme of this review is suicide prevention, a detailed clinical examination of the lives of these three individuals was not undertaken. What was required was an overview of the lives of the individuals to identify reoccurring factors. Multi agency chronologies were produced.

The following are short pen pictures of the three primary cases. They provide an overview of the individual's life journey and highlight their involvement with differing statutory agencies.

4.1 John

John was a 45-year-old white British male who took his own life at his home in June 2024. The Coroner concluded the cause of death was suicide. During 2022, police attended a number of alcohol related domestic incidents. His wife and 3 children left him in October 2022. He had no contact with his children post this time. Incidents of domestic abuse appear to have been fuelled by his use of

¹ London Borough of Havering. (2025). *Havering Suicide Prevention Strategy*. London Borough of Havering

substances. The ending of his marriage appears to have resulted in John having significantly increased contact with agencies during 2022 and 2023, the majority being with police and the hospital between June 2022 and 2024.

During December 2022 John made five emergency calls raising concerns of suicidal ideation. Police detained him under section 136 Mental Health Act 1983. Police notifications (MERLINS) were submitted to the Multi Agency Safeguarding Hub (MASH). Police had no further contact after December 2022.

Adult Social Care assessed the MERLINS and concluded that there was no indication of John being subject to abuse or neglect, and he was in contact with mental health services. A referral was made to mental health to ensure that his care and support needs were formally assessed under the Care Act. There is no indication that this took place.

The London Ambulance Service (LAS) had fifteen contacts with John which included the calls he made to the 999 and 111 phone lines. On several occasions he called to cancel the ambulance before its arrival. This activity led to him being transferred to hospital on five occasions. Most calls were in relation to his mental health, seizures and chest pain. During most contacts he was recorded as intoxicated.

On most occasions he either declined to go with LAS to hospital or declined follow up appointments when discharged from hospital.

The LAS made a safeguarding referral in January 2023 due to clutter in his house, and the presence of dog faeces. Housing was not informed.

He was assessed by North East London Foundation Trust (NELFT). On one occasion in 2022 he was referred to HABIT². He was not offered any medication or services as his alcohol misuse had not been addressed.

In March 2023 John self-referred to ³CGL for support with his use of alcohol. He was assessed as having a high level of alcohol dependency. His attendance at support groups was infrequent. No other agency contacted CGL to inform them of their involvement with John.

In March 2023 John was served with an eviction order having breached his tenancy agreement. His case was presented to LBH Housing's Vulnerable Person's Panel. It is notable that had Housing been aware that one of their clients was involved with services such as CGL, they could have considered delaying the eviction by twelve months. They were not aware of CGL's involvement.

In September 2023 John commenced work with TfL as a bus driver. He then appears to have minimal contact with agencies between September 2023 and the time of his death nine months later.

³ **Aspire Havering is an integrated service delivered by CGL.** We offer a free and confidential support service for individuals and their families affected by drug and alcohol problems.
<https://www.nhs.uk/services/service-directory/cgl-aspire-havering/N10992566>

4.2 Trevor

Trevor was a 21-year-old white British male who died near his home in March 2024. Whilst it was established that there was no third-party involvement, the coroner was unable to establish Trevor's state of his mind at the time of his death, so did not conclude that this was a deliberate act.

Trevor had been known to several agencies in both Havering and Kent since his childhood. He moved to education at an Alternative Provision in Havering.

In 2016/17 there were concerns about Trevor's speech and language development. He had been drawn into possible criminal exploitation and substance use. Whilst support was identified by Early Help Services, agencies were unable to maintain consistent engagement or produce a positive change.

Between 2018/19 Trevor's level of violence escalated, and it was during this time he was referred to NELFT. No mental health disorder was clinically diagnosed. He was also referred for specialist speech and language therapy sessions.

Following his arrest for grievous bodily harm (GBH) and the theft of a motor vehicle, he became a client of the youth justice service, and his case was closed to Children's Services and NELFT.

During 2020-2022 Trevor was arrested and charged with supplying drugs and having weapons; he was detained in prison on remand. He became dependent on nitrous oxide and was being treated at a local health centre, for degenerative effects of substance use and resulting chronic pain and paralysis. He was last seen at the centre on 21/03/24. He suffered from depression and was using anti-depressants.

Trevor was known to the Probation Service in Kent until January 2024, following a 12 month community order for affray. The requirement of the order was 10 days Rehabilitation Activity of which he attended 12 of the 17 appointments offered. On 30.11.23 he received a Conditional Discharge for possession of cannabis.

Trevor's condition went into decline once all services were withdrawn.

4.3 Richard

The requirement to consider undertaking a review involving persons under 18 is set out in Working Together 2023. As highlighted in the introduction, the HSCP agreed that Richard's case should be included in this review. A pen picture has been produced to provide life context, and because the suicide attempt was not fatal, the review had the opportunity to speak with Richard to capture his valuable observations.

Richard was a 17-year-old Black British male who survived a non-fatal suicide attempt in June 2024.

In 2013, Richard was placed into foster care following allegations of physical abuse by his father. He left care a couple of months later following allegations he made against his carer. He became subject of a Child In Need plan.

From 2013 to 2015 Richard was known to NELFT Child and Adolescent Mental Health Service (CAMHS) owing to behavioural concerns. At secondary school, he was popular with both staff and his peers. Whilst in Year 8, he had sessions with a school counsellor following concerns for self-harm and maintaining friendships.

In 2019 his GP referred him to CAMHS. This referral was not progressed due to his father's intervention. His father was a registered mental health nurse. CAMHS did not speak with Richard.

In December 2021 LAS transported Richard to hospital after he had collapsed at a bus stop due to intoxication.

In March 2022, as a result of Richard assaulting two pupils, he was allocated an alternative schooling provision. He was also at this time exploring his sexuality but felt that he could not confide in his parents. He disclosed that he was also having dark thoughts.

In June 2023, his GP again referred Richard to CAMHS following his disclosure that he had low mood and urges to harm himself. He also informed the GP that his half-brother had sexually assaulted him, several years ago.

In August 2023 Children's Social Care undertook an assessment in respect of his allegations of abuse by his stepbrother. The case was closed as he was a current patient of CAMHS.

The GP referred Richard to MASH in November 2023. The MASH assessment identified that Richard was being bullied at school, was using cannabis and alcohol, and was having daily suicidal thoughts, although he did not disclose that he had made any specific plan. He was worried that he was a paedophile and was avoiding places where children were. Safeguarding concerns were not identified, and his case was closed as he had been referred to CAMHS and Tigerlight⁴ which provides support around sexual assault.

His college pastoral team were not made aware of Richard's mental ill health and experience of trauma until May 2024. Richard was provided with counselling by the college but was informed that this was only a stop gap until Tigerlight commenced providing support.

Although he was referred to CAHMS and Tigerlight in November 2023, the case was not allocated until May 2024 as there were delays in establishing contact with his mother.

⁴ Tigerlight Early emotional support for children and young people, aged 3-18 (and their families), who have disclosed sexual abuse. <https://www.barnardos.org.uk/get-support/services/tiger-light-nel>

In June 2024, following the allocation of his case in May, an initial meeting was undertaken, two days before he attempted to take his own life. The day before the incident Richard had been informed that his counselling support at college was going to end.

4.4 Richard's Voice

Richard agreed to be interviewed for this review and provided the following valuable information.

Reflection on Past Support and Services

Social Work Support (Pre-Incident)

Richard reported that prior to his recent incident, there was a lack of consistent and effective social work support. He experienced frequent changes in assigned social workers and felt that his mental health was not prioritised. Communication was poor, and no support plans were implemented with his family. He noted a lack of progression during visits, which contributed to his frustration.

Mental Health Support (CAMHS and Inpatient Services)

During his time in the 18–25 CAMHS service, Richard participated in group therapy. However, he found the sessions inconsistent and not always helpful. Positive support came instead from informal conversations with staff on the ward, which he found more beneficial. Richard was open about his mental ill health and willing to accept help.

He previously accessed therapy while in secondary school but chose to stop attending sessions due to concerns about confidentiality, specifically the possibility of information being shared with his family.

Views on Local Services in Havering

Richard believes that whilst the range of services available in Havering is adequate, the delivery by professionals lacks passion and genuine care. He feels that staff often do not demonstrate the motivation or empathy required for meaningful support.

5. Observations

John

It is evidenced from John's recorded contact with agencies, following his relationship breakdown and substance use, led to increased contact with several agencies, especially Health.

In September 2023 he commenced a job and from that point in time until his death, nine months later, he had minimal if any, significant contact with agencies including Health.

There is no single easily identifiable factor that led John to fatally harm himself- he was facing relationship breakdown, issues of contact with his children, substance use and housing insecurity- he had been issued with an eviction notice.

Trevor

Trevor was a young man who had been involved with statutory agencies for many years. At one time he was subject to a Child Protection Plan. His increasing violent/criminal conduct transferred him into the criminal justice system, whose agency became the lead agency for the last few years of his life.

There is no evidence that suicidal thoughts or self-harm incidents were noted by any agencies. There are indications that he may have been subject to criminal exploitation as a young person. This will be subject to further comment later in this report.

Whilst John and Trevor's life circumstances are different there are several commonalities.

When reviewing these cases, several organisational factors were presented that have been highlighted previously in both local and national reviews.

These include:

- Complex Case handling
- Transitional Safeguarding
- Information Sharing between agencies
- Multi agency risk assessments
- Safeguarding referrals

Whilst the focus of this SAR is 'suicide prevention' there are several issues that should be subject to comment.

5.1 College Experience and Support

A college staff member noted that there was a lack of information shared by the previous education setting, prior to Richard joining the college, which affected the quality of his transition. He initially presented with low mood and was supported through 1-to-1 sessions with the Senior Mental Health Lead, as well as counselling. The staff member stated that there was lack of communication between the social worker and college and believes if they had been given a full handover, they would have been able to support Richard to their best ability.

The college's pastoral team is extensive and includes well-trained staff with strong knowledge of mental health. Exit interviews are offered to all students leaving the setting, to ensure feedback and continuity of care.

Recommendation 1

HSCP to consider issues raised in Richard's feedback in relation to information sharing, consistency of services and services in relation to transitions to adulthood.

Housing

In relation to John, there is a reoccurring observation by Housing that they were not aware of the case but needed to be directly involved in early discussions to advise on major issues, such as his accommodation. Housing will often be a significant issue for vulnerable individuals. For a treatment/safety plan to be effective, stability of accommodation is a significant factor in the individual's life.

It is therefore important that Housing is consulted at an early stage and considered to be part of the multi-disciplinary support team.

Recommendation 2

As part of any planning or assessment, LBH Housing and Housing Associations, as relevant, should be consulted by MASH / other agencies to establish if they have had any involvement with an individual or could provide early involvement. LBH Housing to ensure other agencies are drawn into their work with vulnerable people and to review the membership of their panels.

5.2 Risk v Safeguarding.

In Trevor and other cases, referrals were made to Adult Social Care under Section 42 of the Care Act 2014. When a referral is not accepted by ASC, future planning and coordination of support by agencies often becomes difficult. When there are too many referrals in the system, safeguarding concerns may be missed. There is no uniform practice of agencies following the Pan London LSCP Matrix of Need and ensuring referrals to MASH for children with suicidal ideation and / or in hospital treatment for self-harm concerns.

A clearer understanding of risk versus safeguarding in respect of self-harm and suicide attempts is important, for adults and children's systems.

Knowsley SAB Feb 24 Guidance for Managing Risks v Safeguarding in relation to Mental Health / Self Harm /Suicidal Ideation⁵ has the following observation:

Generally, the term 'safeguarding' is used to describe a situation of risk, or where a person may need support (or more support than what is in place) however, this does not mean that the statutory safeguarding duty laid down in s42 Care Act 2014 is met. The term 'Safeguarding' is often used to refer to concerns or circumstances of risk such as self-harm, suicidal ideation, mental health crisis/deterioration and substance misuse. Sometimes 'Safeguarding' is used to describe someone who has care and support needs and requires help with their day-to-day tasks, as they are unable to meet their care needs and consequently there is a 'risk' (perhaps not eating enough or neglecting personal hygiene) that needs 'Safeguarding'. However, this signals someone who requires an assessment of their needs to manage the presenting issue rather than a statutory safeguarding response.

Recommendation 3

HSAB and HSCP should examine how to elevate understanding of risk versus safeguarding across agencies, particularly in relation to self-harm and mental health concerns.

Richard

Richard was still only 17 when he caused serious harm to himself. He was approaching adulthood (18 years) and therefore transitioning to adult services. He

⁵ <https://knowsleysafeguardingadultsboard.co.uk/wp-content/uploads/2024/03/Mental-Health-Self-Harm-Suicidal-ideation-Guidance-February-2024.pdf>

was subject to a Children Social Care (CSC) assessment, but the case was closed as he was under CAMHS at the time.

There is evidence that he might have been subject to interfamilial abuse over several years. There is no indication that this was progressed.

From both Richard's feedback and review of actions taken, it appears that he was not listened to. There is evidence that the views of his father (a Mental Health worker) were overriding his son's expressed needs, and the inability to contact his mother was given for the significant delay between referral and meaningful action.

6. Impact of Culture/Ethnicity

The Office for National Statistics⁶(2025). Ethnicity and suicide in England and Wales. The report summaries findings as follows:

Of the 31,644 suicides recorded between January 2012 and March 2019 in England and Wales, 11% were in individuals from a minority ethnic group. Suicide rates were lower in almost all minority ethnic groups compared to the White British group, except for individuals who identify as being from Mixed-heritage backgrounds and White Gypsy or Irish Travellers.

Among males, suicide rates in these two groups and in White Irish individuals were similar to those in the White British majority. Among females, rates were 79% higher in those of Mixed White and Caribbean heritage, and more than double among White Gypsy or Irish Travellers. The higher suicide risk seen in some minority ethnic groups appears to be driven by descendant populations (minority ethnic individuals born in the UK), rather than migrants.

Experiences such as discrimination, racism and cultural stigma can contribute to suicidal ideation and should be considered when reviewing individual circumstances. National statistics would suggest being of white British ethnicity puts a person at increased risk.

"It's Silent", March 2025, the thematic review commissioned by the Child Safeguarding Practice Review Panel to explore how race, racism and racial bias influence how professionals identify, understand and respond to the safeguarding needs of Black, Asian and Mixed Heritage children and their families, underlines the learning in this review. The report affirms that all Black families will have faced racism and discrimination in the UK.

Agencies working with Richard and his family, referred to their ethnicity as "Black African". There was no understanding of their identity, their experiences and history, and what this meant to them. There was no evidence that those working with the family reflected on the intersectional disadvantages they may have faced, such as poverty, racism or discrimination relating to any other of their protected

⁶ https://www.adruk.org/our-work/our-impact/ethnicity-and-suicide-in-england-and-wales/?utm_source=copilot.com

characteristics. There was no understanding of the community around them or the dynamics in their own family.

Trevor and John's experiences were not considered in relation to any protected characteristics and the higher rates of self-harm and suicide for White British people.

Recommendation 4

HSAB should examine how to elevate understanding of race, ethnicity, intersectionality approaches, and protected characteristics in safeguarding.

7. Emerging Themes Across Local and National Reviews

As identified at the start of this report, there has been an increasing number of SARs nationally linked to suicide. It is therefore important to examine a wider cohort of cases to establish if there are linking factors present that could provide insight into the possible future prevention strategies.

To that end this review has also considered:

- Havering case reviews
- National case reviews

7.1 Havering SAR's

Between 2017 and 2023 Havering commissioned several SAR's /Learning Reviews where the death was recorded as suicide or suspected suicide. They are as follows:

2025 Daniel ¹⁶SAR. Daniel died by suicide at an incident in 2023 in Havering, aged 36 years. In the 12 months prior to his death, Daniel became increasingly mentally unwell. After a fire at his home address, he experienced accommodation instability followed by homelessness and rough sleeping, which affected the continuity of the care and treatment he received. He began presenting to various agencies with suicidal ideation, paranoia and apparently fixed delusional beliefs. There were also indicators that he could have been the victim of exploitation.

2023 River ⁷SAR. River, 22 years old, took their own life in Romford in 2022. River was looked after for the whole of their life in Essex and came to Havering as a care leaver. River received support for mental health concerns and had some learning needs. They were gender fluid. They were financially and sexually exploited. There is learning around gender identity, and how services work with someone who is gender fluid.

⁷ <https://safeguardinghavering.org.uk/adultsboard/wp-content/uploads/sites/3/2024/02/HSAB-SAR-River-report-final-revised-030823-pdf.pdf>

¹⁶ [Havering-Essex-SAR-Daniel-Executive-Summary-_compressed-1.pdf](#)

2023 Kasey ⁸SAR. Kasey took her own life in 2020. Kasey had significant support around mental ill-health and substance use. There is learning around coordinating and sharing information between professionals.

2022 Q and Y ⁹SAR. Q and Y were white British males, who had been known to children's and adult social care, mental health, and drug support services. Both had a history of presenting with very complex needs including substance misuse and suicidal ideation. They also had a history of adverse childhood experiences. Q died from an unintentional overdose and Y died from an intentional overdose in 2020. There is learning around transitions to adulthood.

2022 Simon ¹⁰SAR. Simon had long standing difficulties with alcohol, had attempted suicide, had periods of rough sleeping and relationship breakdowns. He died from the effects of liver damage.

2020 SW ¹¹SAR. SW took her own life in 2017. She had a long history of mental health concerns and housing difficulties.

7.2 National Reviews

Similar themes were identified in a SAR into the death of 3 males reviewed by Devon & Cornwall

Torbay and Devon Safeguarding Adults Partnership ¹²(2024) *Thematic Safeguarding Adults Review: Three men with care and support needs who died as a result of self-harm/suicide during the pandemic.*

The Devon & Torbay review concluded:

Whilst the three men had different individual circumstances, there were a number of parallel themes. These are summarised as trauma, mental health condition (more than one), poor and relapsing mental health, expressed thoughts of suicide, depression, anxiety, history of self-harm and suicide attempt, and excess alcohol use. Other connecting themes was that of communication difficulties at times of high levels of distress, difficulty or declining to engage with treatment or services, and two men had supported living placements where there was a breakdown of this placement with escalating risk. Two men described how they would end their lives and made an earlier attempt shortly before death.

7.3 Integrated Analysis

To facilitate the best analysis of this review's primary cases against both other local and national cases, an integrated analysis of the following has been undertaken:

⁸ <https://safeguardinghaverling.org.uk/adultsboard/wp-content/uploads/sites/3/2023/07/HSAB-Executive-Summary-Kasey-July-2023-002.pdf>

⁹ <https://safeguardinghaverling.org.uk/adultsboard/wp-content/uploads/sites/3/2022/09/Final-QY-Discret.-SAR-7-Minute-Briefing.pdf>

¹⁰ <https://safeguardinghaverling.org.uk/adultsboard/wp-content/uploads/sites/3/2022/07/Final-Simon-SAR-7-Minute-Briefing.pdf>

¹¹ <https://safeguardinghaverling.org.uk/adultsboard/wp-content/uploads/sites/3/2023/04/Haverling-SAB-7-minute-briefing-SW-SAR.pdf>

¹² <https://www.devonsafeguardingadultpartnership.org.uk/document/thematic-safeguarding-adults-review-sar-three-men-with-care-and-support-needs-who-died-as-a-result-of-self-harm-suicide-during-the-pandemic/>

- LGA¹³ & ADASS (2023) Analysis of Safeguarding Adult Reviews
- Havering suicide-related SARs (2017–2023)
- NHS North East London (n.d.). Thematic Review of Teenage Suicide Across BHR, Dr Sarah Luke. NHS North East London:
- National suicide-¹⁴prevention evidence
- This current Havering Suicide Prevention Thematic SAR

It reveals a highly consistent set of vulnerabilities and systemic issues. These patterns demonstrate that the challenges identified locally are not isolated but reflect national trends in safeguarding and suicide prevention.

Mental Health Needs Not Met Early or Consistently

Across all sources, mental health need is the most prominent theme. The LGA/ADASS national analysis identifies mental health as one of the most common factors in SARs, often characterised by fluctuating crises, inconsistent engagement, and gaps in service provision. This mirrors the Havering SARs (River, Kasey, Q & Y, Simon, SW), the BHR review, and the three individuals in this thematic SAR, most of whom experienced long-standing emotional distress, self-harm, suicidal ideation or untreated mental health concerns. National suicide-prevention evidence (NCISH, NSPCC Learning) reinforces that mental health needs are frequently recognised but not addressed through sustained, coordinated intervention. However, over half of people who die by suicide do not have a diagnosed mental health condition at the time of their death.

Substance Misuse as a Compounding Risk Factor

The LGA/ADASS review highlights substance misuse as a recurring theme in adult safeguarding deaths. This is strongly reflected in Havering's SARs, particularly Kasey, Q & Y, Simon, John and Trevor where alcohol or drug use increased vulnerability, reduced stability, and complicated engagement with services. National suicide-prevention research similarly identifies dual diagnosis as a high-risk factor requiring integrated, multi-agency responses. Recent changes to mental health treatment pathways mean that it is no longer a requirement to be free from substance use in order to access mental health services.

Cumulative Adversity and Trauma

The LGA/ADASS analysis emphasises the cumulative impact of trauma, adverse childhood experiences, exploitation, and chronic instability. This aligns with the Havering SARs, where individuals experienced childhood abuse, exploitation, domestic abuse, bullying, identity-related stress, or chronic pain or other health issues. The BHR review found similar patterns among adolescents, with trauma, family conflict, and disrupted education contributing to vulnerability. **The ¹⁵NSPCC**

¹³ Local Government Association & Association of Directors of Adult Social Services. (2023). *Analysis of Safeguarding Adult Reviews: April 2019 – March 2023*. LGA

¹⁴ Department of Health and Social Care (2023). *Suicide Prevention Strategy for England: 2023 to 2028*. Department of Health and Social Care

¹⁵ <https://learning.nspcc.org.uk/research-resources/learning-from-case-reviews/suicide>

Learning (2024) *Suicide: learning from case reviews*: reinforces that suicide risk emerges from layered adversity, rather than isolated incidents.

Disengagement from Services Not Treated as Risk

Nationally, the LGA/ADASS review identifies disengagement as a critical warning sign that is often misinterpreted as non-compliance. This theme is echoed across Havering's SARs, the BHR review, and this thematic SAR. Individuals frequently disengaged shortly before their deaths, yet services often closed cases or reduced contact rather than escalating concerns or using assertive outreach. National suicide-prevention guidance stresses that disengagement should trigger proactive, relationship-based responses to change practitioners' methods of engagement.

Fragmented Multi-Agency Working and Poor Information-Sharing

The LGA/ADASS report identifies multi-agency fragmentation as one of the most persistent systemic failures in SARs. This is mirrored across Havering's SARs, where agencies held isolated pieces of information but did not always form a shared understanding of risk. Housing, mental health, social care, education and criminal justice services often worked in parallel rather than jointly. The BHR review identified similar issues, with inconsistent communication and a lack of shared risk formulation. National suicide-prevention strategies emphasise the need for co-ordinated, whole-system responses.

Housing Instability and Insecure Living Situations

Housing instability is a major theme in the LGA/ADASS national analysis, often linked to increased vulnerability and reduced safety. This is reflected in Havering's SARs (Simon, SW, River, John, Daniel), where unstable accommodation, eviction or homelessness contributed to escalating risk. National evidence recognises stable housing as a key protective factor in suicide prevention, and deprivation as a risk factor.

Recommendation regarding Housing engagement has been previously set out on page 10.

High-Risk Transitions Between Services

The LGA/ADASS review highlights transitions, particularly between Children's and Adult Services, or between hospital, prison and community settings—as high-risk periods. This is strongly reflected in Havering's SARs (River, Q & Y, Richard, Trevor), where transitions were poorly planned or lacked continuity. The BHR review found significant gaps in transitional care for 17-year-olds. National suicide-prevention evidence identifies transition as one of the most vulnerable points in a person's journey.

A recommendation regarding Transitions' engagement is set out on page 17 below.

Identity, Belonging and Social Connection

The LGA/ADASS analysis notes the importance of social connection and identity in safeguarding outcomes. Havering's SARs show similar patterns: River's gender identity-related stress; Richard's struggles with sexuality and bullying; John's isolation after family breakdown; and Trevor's disconnection after prison. The BHR review and national evidence highlight loneliness, discrimination, stress and lack of belonging as significant contributors to suicide a rise in suicidal ideations.

Exploitation and Safeguarding Complexity

The LGA/ADASS review identifies sexual, financial and criminal exploitation as a recurring theme in SARs. This is reflected in Havering's SARs (River, Daniel, Trevor, Q & Y) and in Richard's disclosures of historical abuse. These cases highlight the overlap between safeguarding, exploitation, mental health and suicide risk. Involvement in criminal gangs also significantly increases risk of death by suicide (1 in ten gang-affiliated males). [The mental health needs of gang-affiliated young people](#)

A recommendation re Risk v Safeguarding has previously been made on page 10.

These shared themes reinforce the need for a **whole-system, trauma-informed, relationship-based approach** to suicide prevention in Havering, with strong multi-agency co-ordination, assertive outreach, and early identification of cumulative harm.

8. Young People (16-25)

Whilst the previous integrated analysis included Richard and Trevor, it is important to highlight that the young people up to the age of 25, especially those transitioning across services, face specific challenges.

NHS North East London (n.d.). Thematic Review of Teenage Suicide Across BHR, Dr Sarah Luke. NHS North East London: stated

Risk factor evidence review

Suicide in teenagers is usually the outcome of a complex interaction between factors including those identified in the literature review: biological, genetic, psychiatric, cultural, social and psychological factors.

Dr Luke's report highlights similar factors identified in this review and in the NSPCC report. It made recommendations which resonate with this report.

Recommendation 5

HSCP to be assured that recommendations in the NEL report, *Thematic Review of Teenage Suicide Across BHR, prepared by Dr Sarah Luke*, are being progressed.

The NSPCC Learning (2024) *Suicide: learning from case reviews*:

is a national analysis that can be considered against Richard and Trevor's life circumstances.

This NSPCC report identified several risk factors:

- *abuse or neglect, including non-recent abuse*
- *mental health problems*
- *conflict within key relationships*
- *drug or alcohol use*
- *bullying*
- *lack of stable or consistent care*
- *social isolation*

The NSPCC report highlights the significance of **abuse, neglect, and instability** as risk factors. Richard's history of alleged interfamilial abuse, bullying, and identity-related stress exemplifies this pattern. Similarly, Trevor's experiences of exploitation, criminal involvement, and chronic health issues reflect the NSPCC's emphasis on the cumulative effect of adversity.

The NSPCC emphasises the importance of **stable, consistent care and trusted relationships**. Richard comments about changes in social workers, delays in CAMHS allocation, and a lack of continuity across transitions. Richard's experience is particularly illustrative: despite multiple referrals, he waited months for CAMHS involvement; his college was not informed of his risks; and his counselling ended abruptly the day before his crisis event. These gaps reflect the NSPCC's conclusion that instability in care environments and the absence of sustained, trusted relationships significantly heighten vulnerability.

The NSPCC highlights the critical importance of **hearing and believing the voice of the child**. Richard's disclosures about low mood, self-harm urges, and historical abuse were not consistently acted upon, and his father's views were often prioritised over his own. This aligns with the NSPCC's finding that children's voices are frequently overlooked, minimised, or overshadowed by adult narratives. The consequences of this were evident in Richard's escalating distress and eventual crisis.

Taken together, the NSPCC findings reinforce the emerging themes of this review: that suicide risk is shaped by cumulative adversity, unmet mental health needs, disengagement, fragmented multi-agency working, and failures to listen to and act upon the voice of the individual. Integrating this national learning strengthens the case for a **trauma-informed, relationship-based, and assertively coordinated approach** to suicide prevention across Havering.

8.1 Transitions & Sexual Abuse

Richard and Trevor underscore the heightened vulnerabilities associated with **transitioning from children to adult services**. The BHR review identified systemic weaknesses where three of the eight adolescents were aged 17 and experienced

significant gaps in transitional care. National evidence consistently identifies the 16–25 age range as a high-risk period, particularly when service thresholds change abruptly, or continuity of care is lost.

Transitions and Transitional Safeguarding have been subject of several Havering reviews. This has led to the Local Authority setting up a transition working group looking at the findings of reviews and national recommendations.

Recommendation 6

Havering Local Authority Transitions Group to respond to and action the findings of this review.

8.2 Sexual Abuse

The Child Safeguarding Practice Review Panel (2023) *I wanted them all to notice: A thematic analysis of multi-agency responses to intrafamilial child sexual abuse*, highlighted areas of concern about agencies' responses to interfamilial abuse including:

Not hearing children's voices and understanding their needs

- *Children who are sexually abused by someone in their family are frequently not being identified by practitioners.*
- *Uncertainties about what can and cannot be said to children which have dominated practice for many years.*
- *Over-reliance on the criminal justice system to confirm whether a child has been sexually abused.*
- *Practitioners have been led to believe that they need children to approach them to speak about sexual abuse.*
- *When children did tell someone, as they did in nearly three-quarters of the reviews looked at, they were often not listened to or were disbelieved.*
- *Practitioners were not always clear about the need for joint social work/police child protection investigations.*
- *A lack of consistency in the identification and response to sexual abuse.*
- *Lack of an appropriate response to parents and carers.*
- *Practitioners not taking sufficient account of parents' contexts and vulnerabilities, particularly for those subject to domestic abuse.*
- *An unrealistic over-reliance on parents and carers to protect their children.*
- *Parents and carers were often left feeling that practitioners did not believe them, blamed them.*

This comprehensive report covers two other areas:

- Understanding parents' and carers' contexts, vulnerabilities and needs;
- Challenges in identifying signs, understanding risk and raising concerns.

Richard was reporting abuse, but it is not clear if he was believed. There is evidence that his voice was not being heard and there was an overreliance on his parents, especially his father.

There are suggestions that Trevor was being criminally exploited, it is not clear if this was sexual, but the principal of hearing his voice applies.

In relation to suicide prevention, responses to disclosures or indications of abuse especially interfamilial abuse, will have a major impact of a child's long-term actions including self-harm.

Applying trauma informed practice is essential when looking to prevent suicide.

Child Sexual Abuse is explicitly linked as a risk factor for chronic suicidality (especially where the disclosure is not believed). This review highlights the missed opportunities where:

- *Richard's disclosures were not progressed;*
- *Over-reliance on the father influenced professional judgement.*

Recommendation 7

"I wanted them all to notice"

HSCP to review the national panel report to ensure that issues highlighted have been or are being addressed by partners.

9. Havering Public Health.

To help inform this review Public Health Havering undertook an audit of all suspected suicides in Havering reported during 2024 to identify any notable patterns and to illustrate to the SAR process the variety of scenarios, sociodemographic characteristics and factors that contribute to a person dying by suicide.

On average there have been 19 registered deaths by suicide per year amongst Havering residents over the last decade; the equivalent of 1 death every 3 weeks – emphasising the importance of collective and coordinated action to prevent suicide.

It was identified through the consultation process in preparing the Havering All-Age Suicide Prevention Strategy that there was variation across practices of the perceived role of General Practice in suicide prevention. During the past year, the Designate Nurse for Safeguarding Adults NEL ICB, has ensured local GPs had a teaching session on suicide prevention.

Recommendation 8

Havering Public Health and NEL ICB to continue to work to increase GP awareness of suicide prevention.

9.1 Suicide Prevention

The aim of this review is to inform the suicide prevention work being undertaken in Havering. The strategic lead for this work sits with Havering Public Health with multi-agency involvement in the delivery of actions.

The opening paragraph of the ***London Borough of Havering (2025) Havering Suicide Prevention Strategy 2025–2030*** states:

A death by suicide is often the culmination of a complex interplay of risk factors and distressing life events, and results in a profound and long-lasting impact on families and friends. The effects extend beyond immediate circles, rippling through communities to affect neighbours, workplaces, schools and other social networks. Bereavement by suicide increases the risk of those affected taking their own lives.

The phrase ‘complex interplay of risk factors’ fairly describes the conclusions of this review and should support a **trauma-informed, relationship-based, and assertively coordinated approach** to suicide prevention across Havering.

The strategy is complemented by a suite of resources to support suicide prevention and self-harm prevention across Havering; these resources have been formed with help from the Steering Group and Lived Experience Advisory Group (LEAG). They include:

- Havering Suicide Prevention Toolkit (for anyone working or living in Havering)
- Factsheet for those engaging in self-harm (and an easy-read version)
- Understanding Self-Harm: Toolkit for Education Staff and Schools
- Understanding Self-Harm: Guide for Parents and Carers
- A comprehensive [webpage](#) that includes local and national support.
- [Preventing Suicide Factsheet](#) for frontline staff
- [Self-Harm Factsheet](#) for frontline staff
- [Mental health and Wellbeing Factsheet](#) for frontline staff
- [Children and Young People’s Mental Wellbeing Factsheet](#) for frontline staff
- [Bereavement Support Factsheet](#) for frontline Staff
- [Perinatal Mental Health Factsheet](#) for frontline staff

These resources will help the understanding of suicide and self-harm and supports improved suicide prevention.

Recommendation 9

Havering Public Health to consider these review findings against their actions taken to deliver the current borough-wide multi-agency Strategy.

9.2 Department of Health and Social Care (DHS) (2024) *Staying safe from suicide*

The *Staying Safe* guidance sets out a national framework for how health professionals should assess, understand and respond to suicide risk. It moves away

from traditional “risk prediction” models and instead promotes a **holistic, person-centred, trauma-informed approach** to safety.

The ‘low-risk paradox’ – that most people in contact with mental health services who die by suicide have been assessed as being at low or no risk of suicide – shows that suicide prediction tools, scales, and stratification (for example, into low, medium, or high risk) don’t work. This has been [well established by research](#). And yet the use of static risk stratification persists. It is supported by myths, including the belief that it minimises liability or standardises care. In some areas, a tick-box culture has developed, using forms and checklists that are unvalidated and have no predictive value.

This approach supports the findings of this review.

Recommendation 10

HSAB to establish if the DHS Staying Safe report has been reviewed by Mental Health providers and commissioners.

10. Practitioner Event

A practitioners’ event was held by the Partnership. Unfortunately, attendance was limited. The participants worked with children and were discussing issues that they were seeing in schools. Anecdotally, they reported that there had been an increase in children seeking support from schools for emotional distress, low self-esteem and issues at home.

They had noticed that children were self-harming, and they often did not know if this was being discussed outside school, because they were noticing the same people harming themselves. They stated that as schools they were doing the best they could to support these children, as they awaited CAMHS involvement.

11. Conclusion

It must be acknowledged that any SAR is always a result of a set of tragic events. In this case, the untimely deaths of John and Trevor, and the serious injuries suffered by Richard.

The findings of this thematic Safeguarding Adults’ Review sit firmly within a wider pattern of learning emerging both locally and nationally. Although the three individuals at the centre of this review John, Trevor and Richard had distinct life histories, their experiences reveal a set of recurring vulnerabilities that mirror those identified in previous Havering reviews, the Barking, Havering and Redbridge (BHR) Review, and national suicide-prevention research.

Factors identified include mental health need, substance misuse, disengagement, fragmented services, housing instability, transition risk, cumulative adversity, and identity-related challenges are not isolated or unique. They represent systemic issues that require coordinated, trauma-informed, multi-agency responses.

This review reinforces the need to continue to strengthen partnership working, improve information-sharing, develop proactive engagement, and a whole-system approach to suicide prevention across Havering.

Summary of Recommendations

<p>Recommendation 1 HSCP to consider issues raised in Richard’s feedback in relation to information sharing, consistency of services and services in relation to transitions to adulthood.</p>
<p>Recommendation 2 As part of any planning or assessment, LBH Housing and Housing Associations, as relevant, should be consulted by MASH / other agencies to establish if they have had any involvement with an individual or could provide early involvement. LBH Housing to ensure other agencies are drawn into their work with vulnerable people and to review the membership of their panels.</p>
<p>Recommendation 3 HSAB should examine how to elevate understanding of risk versus safeguarding across agencies, particularly in relation to self-harm and mental health concerns.</p>
<p>Recommendation 4 HSAB should examine how to elevate understanding of race, ethnicity, intersectionality approaches, and protected characteristics in safeguarding.</p>
<p>Recommendation 5 HSCP to be assured that recommendations in the NEL report, <i>Thematic Review of Teenage Suicide Across BHR, prepared by Dr Sarah Luke</i>, are being progressed.</p>
<p>Recommendation 6 Havering Local Authority Transitions Group to respond to and action the findings of this review</p>
<p>Recommendation 7 “I wanted them all to notice” HSCP to review the national panel report to ensure that issues highlighted have been or are being addressed by partners.</p>
<p>Recommendation 8 Havering Public Health and NEL ICB to continue to work to increase GP awareness of suicide prevention.</p>
<p>Recommendation 9 Havering Public Health to consider these review findings against their actions taken to deliver the current borough-wide multi-agency Strategy.</p>
<p>Recommendation 10 HSAB to establish if the DHS Staying Safe report has been reviewed by Mental Health providers and commissioners.</p>