



CENTRE  
FOR  
SUICIDE  
RESEARCH



# **Guidance for mental health organisations regarding staff support following the death of a Patient by Suicide**

## ***A Prevention and Postvention Framework***

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## Purpose of this guidance

*'I felt as though I was deeply wounded' (Psychiatrist)*

The death of a patient by suicide can have a profound effect on the clinicians who have been involved in their care. The consequences of this distress can include burnout, mental health problems, not progressing with training, and in some cases, leaving the mental health sector. Staff support following a death of this nature varies widely across organisations. Some staff report feeling prepared and well-supported, whilst others describe feeling blamed or even scapegoated by the organisation employing them <sup>3,11,17,19,21, 29.</sup>

There are currently no national guidelines for organisations that employ mental health clinicians for the pastoral care of their staff both before these events to help in preparation (prevention), or to aid recovery (postvention). This is important because when organisations provide good support it can mitigate the damaging personal and clinical effects, enables resilience, and facilitates realistic reflection and post traumatic growth <sup>2,19, 23, 28.</sup> A few postvention programs have been suggested and early evidence demonstrates their effectiveness for organisations that use them consistently <sup>3,20,21,27.</sup>

This guidance has been written by the Royal College of Psychiatrists Working Group on the Effect of Suicide and Homicide on Clinicians

(ESH) and the Oxford Centre for Suicide Research. It is endorsed by the Royal College of Nursing (RCN). It outlines best practice recommendations for mental health and training organisations for supportive operational strategies and pastoral care of staff after a patient death by suicide. It is aimed at the organisational board, senior clinical leadership including the medical and nursing directors, suicide leads currently in post, and more broadly as guidance to all clinicians.

Recommendations are based on recent research studies,<sup>12,17</sup> suggested postvention models,<sup>3,20,21,29</sup> and focus groups, as well as examples of good practice currently provided within some mental health organisations. Quotes below are from clinicians in the surveys conducted by Gibbons et al 2018 and Croft et al 2022.

The death of individuals by suicide is a powerful experience encountered by different professional groups in a variety of work settings. The current document provides guidelines for professionals working in Mental Health. Despite the specificity of recommendations we hope they can be of use, to other professional environments where patients, clients, or prisoners also die by suicide.

Members of the Operational Board will need to value, endorse and support the ethos and this guidance for the recommendations to be successfully integrated within their mental health organisations.

There is a managers checklist at the end of this guidance (Appendix 5)

## Aims

- **To recommend evidenced based and best practice interventions:**
  - To mitigate the impact of a patient death by suicide on mental health professionals, improve the sustainability of mental health services and increase staff wellbeing, progression with training, resilience and retention.
  - To assist mental health and training organisations in their legal obligation of duty of care for their employees
- **To increase awareness of the impact that a death of a patient by suicide can have on professionals.**
  - To encourage transparent and open dialogue about the impact on staff of working with suicide risk and death.
  - To facilitate expansion of suicide prevention and awareness training to include preparation for the emotional effects and the processes that follow the death of a patient by suicide.
- **To help support cultural transformation:**
  - from one where individual clinicians can feel isolated and personally held responsible following a death, to a systemic understanding about the uncertainty and complex aetiology of suicide.
- **To improve the quality of patient care:**

- by helping staff feel less anxious working with suicidality and in this way maintain their capacity to think clearly.

- **To increase the possibility of truly learning from these tragic events.**

- To learn takes time, space for reflection and freedom from persecution.

*“Overwhelming sense of guilt and personal responsibility. Grief. Tearfulness. Reduced appetite. Difficulty sleeping. Difficulty Concentrating” (Nurse)*

*“I was helped with my caseload to allow me plenty of time to write the coroner’s report and plenty of support in doing this. When I took a day off for stress following the funeral and coroner’s inquest this was not questioned ...service manager and other staff at the time attended the coroner’s inquest with me. The Trust Solicitor was very empathic and sensitive.” (Occupational Therapist)*

# Executive summary of recommendations

**1. ORGANISATIONAL PASTORAL SUICIDE LEAD ROLE**

**2. PASTORAL SENIOR MANAGEMENT SUPPORT**

**3. SUPPORT FOR THE PROCESSES FOLLOWING THE DEATH**

**4. BUDDY SYSTEMS AND OTHER INDIVIDUAL SUPPORT**

**5. GROUP PSYCHOLOGICAL SUPPORT**

**6. A FAMILY LIAISON ROLE/SERVICE**

**7. TRAINING ON THE EFFECT OF PATIENT SUICIDE ON CLINICIANS AND ON THE PROCESSES THAT FOLLOW**

**8. RESOURCE AVAILABILITY**



## Summary of research

- **Most mental health professionals will experience a patient death by suicide at least once in their career; many will encounter this event several times.**
  - The number of patient suicides can vary but it is estimated that clinicians will experience between 1 and 4 patients dying by suicide during their professional life <sup>1, 10, 11, 17</sup>.
  - Many of these deaths are experienced whilst clinicians are in training <sup>10,21</sup>.
- **The death of a patient by suicide has a significant emotional and clinical effect on clinicians**
  - Mental health professionals are usually unprepared for a patient death by suicide, and this can increase the distress and trauma after the event <sup>3,11,17,19,21, 29</sup>.
  - For some clinicians there is a profound impact that affects all aspects of their functioning with some developing secondary care level mental health problems, including post-traumatic stress disorder, depression, anxiety and adjustment disorders. <sup>2,11,17,17,19,21, 29</sup>.
  - For some staff the effect is long-lasting or experienced sometime after the event. <sup>11,17</sup>

- This effect on mental health professionals is variable due to individual vulnerability linked to personal characteristics, resonance with the patient, as well as clinical involvement. <sup>3,11,17,19,21, 29.</sup>
- The psychological support provided should accommodate differences in need. <sup>3,11,17,19,21, 29.</sup>
- **The Response of the mental health and training organisations matters**
  - If clinicians experience the mental health and training organisations as supportive this reduces the traumatic impact.
  - If clinicians experience the mental health and training organisations as unsupportive it can increase the traumatic impact and recovery becomes problematic. It can also lead to clinicians leaving the team, organisation or profession <sup>3,12,17,19,21, 29.</sup>
- **Mental health staff may need to be encouraged to attend to their own wellbeing after these events**
  - Clinicians find it difficult to acknowledge their vulnerability and may benefit from temporary adaptation to facilitate recovery and a more successful return to full duties. These adaptations may include compassionate leave <sup>12,17.</sup>
- **There can be significant consequences for the mental health and training organisations**
  - ***There is significant attrition of mental health staff following patient deaths by suicide*** <sup>1,17,18.</sup>

- The negative impact on service provision and clinical performance in affected teams can be considerable
- Clinical practice in the organisations can be detrimentally affected
  - Staff tend to become more risk adverse
  - Discharges from services may be delayed
  - The threshold for admission to hospital decreases
  - Patients are referred to alternative teams more frequently.
- **Mental health staff want help and support before and after a patient death by suicide**
  - The different types of help that clinicians want based on two staff surveys (Gibbons et al, ^^Croft et al, ^^) are summarised below. The support is organised in descending order with the most frequently wanted at the top.

<b>Support wanted</b>
A senior clinician with a role as suicide lead who could give confidential advice and support
Support for formal processes following a patient suicide
Personal debrief
Confidential reflective practice group/space specifically for processing the effects of a patient suicide
Information about the process following patients' death by suicide

Information about resources for families affected by suicide
Help in communicating or meeting the family/ friends of the patient who has died (e.g. Public Health England's Help is at Hand)
Access to a general reflective practice group
Organised peer support
A training session about this topic

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# Recommendations in Detail

## 1. Appointment of an Organisational Pastoral Suicide Lead role

The working group recommends that each mental health organisation appoint an Organisational Pastoral Suicide Lead. A suicide lead should be a senior clinician with a pastoral role in the organisation. This is a different leadership role than suicide prevention. The feedback from organisations that have suicide leads is uniformly positive. NHS England is planning to bring in Wellbeing Guardians for all NHS organisations. This is a Board member who has responsibility for staff wellbeing (Ref). The suicide lead role may link well with this development. This clinician needs protected time for the role within their job plan that includes:

- **Leading, overseeing, supervising the organisational response in the pastoral care of clinicians experiencing loss of patients to suicide**
- **Supporting staff and families through the formal processes that follow a death by suicide**
- **Signposting to resources for staff and families**
- **Advocating for clinicians and families after critical events within the organisation**

## 2. Pastoral Senior Management Support

*“Conversation with my manager was helpful, she was empathetic and supportive. She helped to complete some trust paperwork”*

*(Occupational Therapist)*

Most clinicians value the support received from the direct line managers or supervisors. In the surveys they found it helpful to have someone in their workplace to turn to both for emotional assistance and to guide them through the practical tasks that may be required of them following the death, such as internal inquiries and inquests. Managers/supervisors should adopt a compassionate leadership style to support individuals through this traumatic event.

- **Be kind**
  - Send compassionate letters/emails to those clinicians and teams affected. <sup>20,27,29.</sup>
  - Support adjustments to work demands and compassionate leave as appropriate <sup>20,27,29.</sup>

*“I feel after such incidents there should be a push from leadership to strongly encourage a short break from clinical work. Otherwise, I feel often we don't want to let clients down or pass work over to*

*colleagues so are likely to continue as normal.” (Nurse in team that suffered several patient suicides)*

- **Break the news thoughtfully.**

- How the news about a patient's suicide is imparted influences the emotional impact of the death and is therefore very important <sup>12, 20,27,29.</sup>

*“I worked closely with this patient but only found out they had died by accident - I was really shocked that there was no mechanism for informing all staff that a patient had died.” (Nurse)*

- Consider all staff members who have been involved in the patient's care, however peripherally. These may be clinicians who are not currently part of a team, have left, or have come across the patient while on call/duty. Ensure as best you can that everyone is informed in a timely manner. Some staff who have been involved in looking after the patient may have recently left the Team (e.g. students or trainees on placements). Non-clinical staff (e.g. housekeepers, ward clerks) may be particularly vulnerable to being affected by the death because they have less training and preparation for the

possibility of a death by suicide than clinical staff and are often forgotten in provision of support.

*“As I was part of an external company, I didn't feel that I was given any support by the staff at the hospital. They didn't see me as a colleague or member of staff so didn't offer any support or even ask me how I was.” (Advocate)*

- **Intervene on behalf of the clinician if there are any professional sanctions following the suicide of a patient.**
  - Any professional sanctions, such as a referral to the GMC or NMC or HCPC, needs to be carefully reviewed, and intervention on behalf of the clinician by the mental health organisation strongly considered. The specific reasons for suicide in individual patients are unlikely to be known and therefore any conclusions that an individual professional's input had a role in the death is likely to be erroneous, and action taken around this assumption unnecessarily harmful.
  - Advise psychiatrists to contact the Royal College of Psychiatrists Psychiatrist Support Service (PSS) to receive advice and support around this issue.
  
- **Be aware of the different support needs of different clinicians:**



- There is no ideal support that suits everyone as clinicians vary in what they want and need. They do value knowing there is support available and having choices about whether and when they access it.
- Within the NHS people plan there is an ambition for all staff to have a health and wellbeing conversation with their line manager. Part of this conversation would include discussions on support required and how to access it. There is national training available for all line managers on the NHS website. (<https://www.england.nhs.uk/supporting-our-nhs-people/support-now/having-safe-and-effective-wellbeing-conversations/>)

### 3. Support during the processes following a death

*'The suicide was upsetting, however the aftermath, the serious incident investigation and attending the Coroner's Court were very traumatic for me. It made me feel very upset, sad, angry and it felt like people were out to blame us/me/services.'*

*'The sense of shame and responsibility that seems to be accepted in the whole psychiatric community about suicide didn't help.'*

*(Psychiatrist)*

## i. Serious incident investigation

- Serious incident investigations are very important. When conducted well they can generate important learning for the organisation about the services they provide. However, the uncertainty and anxiety resulting from suicide can lead to confusion and disturbance in organisational functioning. Organisations need to ensure that the process does not become persecutory by ensuring that investigators are supervised and that contextual and system factors are appropriately addressed. Persecutory investigations have the potential to re-traumatise staff and families, arrive at unhelpful conclusions and prevent productive learning and recovery.

- **Be clear about the remit of the investigation.**

- The aim of the investigation is to learn from a close examination of the care pathway provided to the patient, to ensure it has been of good quality and has followed local recommendations and policies. The learning from this examination is used to improve the quality of care in the future and guide service development. It is not to identify causes for the death as this is purely speculative. It is the coroner's remit to determine who has died, how they died and where and when they died.

- **Encourage systemic recommendations and not individual clinician responsibility.**

- Try not to use words such as 'fault' and 'blame' within formal processes and reports.
- Investigators can feel that they have failed if they do not generate recommendations. Small imperfections in areas such as note taking can be identified as serious 'failures' and lead to recommendations. This results in meaningless reports, additional detrimental emotional impact on families, and little systemic learning.
- Investigators should also highlight good practice where this is found, to ensure a balanced report is produced.
- It needs to be kept in mind that any problems in care identified cannot be reliably connected with the aetiology of the death. These problems, if identified, need to be considered systemically and not personalised.

- **Family involvement.**

- Involve the family as far as possible in the investigation process but be sensitive to tensions that may exist between the family and the services. Involve a family liaison service if you have one.

- Review the communication and care provided for the family as part of the investigation process.

ii. Support during legal processes; Coroner's Inquest (England, Wales and Northern Ireland), Fatal Accident Inquiry (Scotland)

*I think training on coroner's court would be helpful for clinicians to attend routinely as it will make it a little less daunting, maybe a visit to the actual court at a time when they are not highly emotional. (Psychiatrist)*

- **Encourage clinicians to attend the Inquest/Fatal Accident Inquiry (FAI) with supportive colleagues.**

- Having a supportive colleague attend the coroner's inquest can be very valuable for clinicians.

- **Ensure protected time for clinicians to prepare for the inquest/FAI and to write the report**

- It is vital that clinicians are able to prepare thoroughly for the inquest and have appropriate supervision, support, and protected time to ensure that the coronal process is not frustrated.
- Mental health organisations should provide legal support in cases where this is appropriate to do so. (Guidance from the

MPS is found here:

<https://www.medicalprotection.org/uk/articles/inquests-how-can-we-help>)

- Mental Health organisations should consider training from clinicians with lived experience as a previous witness to guide colleagues on how to prepare as a witness. (See Buddy System below)

- **Encourage a thoughtful return to work after the Inquest or Fatal Accident Enquiry**

- For example for the clinician to have the rest of day of the Inquest/FAI as supported leave.
- For the clinician to have the opportunity to reflect the following day with a supervisor/manager/suicide lead before starting usual duties.

## 4. Buddy systems and other Individual Support

*I feel there is a pressure to bounce back quickly from these incidents, and be 'ok' and to continue our work with high-risk and suicidal patients shortly after these incidents (Nurse)*

- **Consider mentoring from a consultant or mental health professional with lived experience (Buddy system).**

- “Buddy systems’ are starting to develop in different organisations. These systems mean that clinicians who have recently experienced the suicide of a patient are put in touch with a colleague in a different part of the mental health organisation who has been through a similar experience in the past. The ‘Buddy’ can give collegiate support and information, helping to guide the clinician through the processes that follow the death.
- **Provide additional supervision, psychological support and mentoring as required.**
  - See resources in Appendix 1.
- **Encourage use of the Occupational Health service where this is relevant.**
- **Regular reviews of wellbeing as agreed with the clinician by both the line manager and, if involved, Occupational Health.**
  - At certain times, distress may increase, for example during formal hearings, reviews, anniversaries and subsequent deaths. It is important to acknowledge this, as well as possibly increasing or re-instating support at these times.

*“When the case was brought up recently I didn't realise how strongly it would still affect me now; crying, sad.”(Nurse)*

## 5. Group Psychological Support

*“The impact of losing clients to suicide has been vast on our team. It feels each time this happens that it takes away from the great work we do .... I have been grateful for time spent as a team to reflect and support one another following these incidents, having a space to be honest and open about the difficulty of our roles. ...It has been helpful to have an outside clinician providing a space to reflect “ (Psychiatrist)*

- **Reflective spaces embedded within the structures of the teams and organisation can provide an environment where trauma and grief associated with the death of a patient by suicide can be processed.**
  - Access to a general reflective practice group such as a Balint Group, case discussion group and/or group staff support can be very helpful.
  - Many staff find Schwartz rounds helpful for seeing senior members of the organisation modelling openness and vulnerability.
  
- **A separate reflective group specifically to process the effects of suicide.**
  - Some clinicians responding to research surveys (Gibbons 2019, Croft 2022) wanted a confidential, safe, space specifically designed for reflecting on deaths by suicide within the

organisation. Several organisations have such groups running successfully. These groups tend to run on a monthly or bi-monthly basis and cover the whole mental health organisation. Support and commitment from senior management has been essential for these groups to become embedded within practice and the culture of the organisations. Facilitation is an important consideration when planning these groups. The current groups are facilitated by clinicians with training in psychotherapy and vary in whether they are internal or external to the organisation. A model for the group is described in Appendix 3. In some organisations facilitation of suicide groups is being written into the job descriptions of new consultant medical psychotherapists.

## 6. Family Liaison role/service

- Some organisations are now developing family liaison/bereavement support services and/or roles. These services can provide effective support and help bridge the gap that can arise between the organisation, the treating team and the family and friends in the aftermath of a death.
- Family liaison services have an advocacy role and can act as a conduit between the family and the incident investigation team.



- Some organisations invite lived experienced facilitators to hold regular training sessions.
- **Be thoughtful about family contact: take clinician vulnerability and distress into account.**
  - The initial liaison with family and friends of a patient who has died by suicide is very important in establishing the family's immediate needs, their views and concerns on the care of the patient, offer an opportunity for them to ask questions, and provide signposting to bereavement support and counselling services. A distressed member of the team will not be the right person for this task.

## 7. Training on the effects of patient suicide on clinicians and the processes that follow

- **Encourage training institutions to have major role in awareness and pastoral care.** This subject is now in the national curriculum for psychiatrists but not for other professional groups.
- **Formalised training as part of induction**
- **Regular teaching sessions on the emotional effects of patient death by suicide as part of local teaching programmes.**

- **Clinicians to be encouraged to attend an inquest and Serious Incident review as part of training and induction**
  
- **Regular and accessible workshops on:**
  - The effect of patient suicide on clinicians
  - Lived experience. Opportunities for clinicians to talk openly and share their experience of both recent and historical patient deaths, without fear of judgment or censure. This develops the understanding that experiencing the death by suicide of a patient is part of the shared experience of working within mental health
  - The internal and external inquiry processes
  - Working with families
  
- **Inquest and Coroner's Court**
  - The Coronal Process. There has been good feedback when solicitors experienced in these processes have been involved in this training.
  - Report writing.

## 8.Resource Availability

- See appendix 1

# APPENDIX 1

## Resources and further reading for all mental health professionals

### Online

- **When a Patient Dies by Suicide a Resource for Psychiatrists.** Located on the Royal College of Psychiatrists webpage: <https://www.rcpsych.ac.uk/members/supporting-you/if-a-patient-dies-by-suicide>
- **When a Patient Dies by Suicide a Resource for Clinicians.** Located on the Royal College of Psychiatrists webpage: <https://www.rcpsych.ac.uk/members/supporting-you/if-a-patient-dies-by-suicide>
- **The Webpage If a Patient Dies by Suicide.** On the Royal College of Psychiatrists website where there are many resources including videos of clinicians and families talking about their experience following a death by suicide. <https://www.rcpsych.ac.uk/members/supporting-you/if-a-patient-dies-by-suicide>
- **NHS England Mental Health and Wellbeing Hubs** set up to provide rapid access to assessment and local evidence-based mental health The hub offer is confidential and free of charge for all health and social care staff. <https://www.england.nhs.uk/supporting-our-nhs-people/support-now/staff-mental-health-and-wellbeing-hubs/>

- **NHS Scotland Wellbeing Hub**<https://wellbeinghub.scot/>
- **Clinicians as Survivors of Suicide** Located on the website of the American Association of Suicidology. The Clinician Survivors Task Force provides a postvention web resource and opportunity for linking for clinicians who had lost a patient to suicide.  
<http://pages.iu.edu/~jmcintos/basicinfo.htm>
- **Helping Residents Cope with Patient Suicide** Produced by the American Psychiatric Association to support doctors in training who have had the death of a patient from suicide.  
<https://www.psychiatry.org/residents-medical-students/residents/ coping-with-patient-suicide>
- **Finding the Words: How to support someone who has been bereaved and affected by suicide**  
Provides useful simple advice for how to speak to someone who has been bereaved by suicide. Helpful for family and friends of those who have suffered bereavement and also for clinicians. There is a leaflet that can be downloaded.  
<http://judimeadows.com/wp-content/uploads/Finding-the-words-online-version.pdf>
- **Free online CBT resources**  
Computer based self-help for everyone.
  - Living life to the full: <https://lltff.com/>
  - Mood juice: <https://www.moodjuice.scot.nhs.uk/>
- **Healthtalkonline. Bereavement by Suicide**

Thematically arranged clips of interviews with bereaved individuals to show impacts of bereavement by suicide and ways of coping.

<http://www.healthtalk.org/peoples-experiences/dying-bereavement/bereavement-due-suicide/topics>

- **Royal College of Psychiatrists Leaflet: Post-Traumatic Stress Disorder**

Online information on Post Traumatic Stress disorder that can be downloaded, detailing symptoms, treatment and links to sites providing further help.

<https://www.rcpsych.ac.uk/mental-health/problems-disorders/post-traumatic-stress-disorder>

- **Suicide Bereavement UK** Specialises in suicide bereavement research, providing consultancy on postvention and delivering evidence-based suicide bereavement training.

<https://suicidebereavementuk.com/>

- **Support After Suicide Partnership (SASP)** An umbrella organisation of suicide bereavement organisations and people with lived experience. The website provides helpful online information and details of local and national support services.

<https://supportaftersuicide.org.uk/>

- **Improving Access to Psychological Therapy services (IAPT)** Primary care mental health services in England offering a range of evidence-based treatments for common mental health problems via telephone, online and face-to-face services. Accept self-referral. Search IAPT for your local service contact information.

- **Private therapy**

- BABCP accredited CBT therapists:

<http://www.cbregisteruk.com/>

- UKCP accredited psychotherapists and counsellors:

<https://www.psychotherapy.org.uk>

- **Samaritans** Charity aimed at listening to people who are angry, depressed and suicidal any time - night or day.

<https://www.samaritans.org/>

Email: jo@samaritans.org

Tel: 116 123.

- **BMA Counselling** 24/7 helpline, individual counselling and Doctors Advisor Service (peer support). Free telephone support for all qualified doctors and medical students.

<http://www.bma.org.uk/advice/work-life-support/your-wellbeing/bma-counselling-and-doctor-advisor-service>

Tel: 0330 123 1245

- **DocHealth** Independent psychotherapeutic consultation service for medics. Based in London but available to all doctors in the UK. Fees payable.

<http://www.dochealth.org.uk>

Tel: 020 7383 6533

- **NHS Practitioner Health Programme** Confidential NHS treatment service for Healthcare Professionals working in England with mental health or addictions problems. Free. <https://php.nhs.uk/>

Tel: 020 3049 4505

- **Workforce Specialist Service** Confidential, free NHS mental health service for regulated health and social care professionals working in Scotland. Self-referral <https://wellbeinghub.scot/the-workforce-specialist-service-wss/>

- **Health for Health Professionals** Free confidential mental health support for NHS staff and students in wales <https://hhpwales.nhs.wales/>

- **Royal College of Psychiatry Psychiatrists Support Service** Confidential support and advice service for psychiatrists at all stages of their career. Free.

<https://www.rcpsych.ac.uk/members/supporting-you/psychiatrists-support-service>

Tel: 020 7245 0412

- **Sick Psychiatrists Trust** Helpline for Psychiatrists with drug or alcohol issues. Free. <http://sick-doctors-trust.co.uk/>

Tel: 0370 444 5163

- **Cavell Nurses Trust** Helpline for Nurses, midwives and healthcare assistants, both working and retired <https://www.cavellnursestrust.org/>

Tel: 01527 595 999

## APPENDIX 2

### **Resources for family and friends**

- **Help is at Hand** Very useful and widely used resource to provide important information and support relatives and friends after a by suicide. There is a downloadable booklet that is a first line resource used by many Mental Health Trusts and community services.  
<https://supportaftersuicide.org.uk/support-guides/help-is-at-hand/>
- **After a Suicide** A thoughtful and helpful booklet for those bereaved produced by The Scottish Association for Mental Health (SAMH)  
<https://www.samh.org.uk>  
[https://www.samh.org.uk/documents/After\\_a\\_suicide.pdf](https://www.samh.org.uk/documents/After_a_suicide.pdf)
- **The Listening Place** Offers free face-to-face support 7 days a week between 9am and 9pm for those experiencing suicidality. Self-referral by email or phone.  
<https://listeningplace.org.uk/>
- **Healthtalkonline: Bereavement by Suicide**  
Thematically arranged clips of interviews with bereaved individuals to show impacts of bereavement by suicide and ways of coping.  
<http://www.healthtalk.org/peoples-experiences/dying-bereavement/bereavement-due-suicide/topics>
- **Alison Wertheimer (2013). A Special Scar: The Experiences of People Bereaved by Suicide** Routledge: Abingdon. Book with very sensitive



accounts of experiences of bereaved individuals, which psychiatrists will also find informative.

## Support agencies for family and friends

- **Cruse Bereavement Care** A confidential bereavement service.  
<https://www.cruse.org.uk/>  
Tel: 0808 808 1677
- **Survivors of Bereavement by Suicide (SOBS)** Offering emotional help and support to those bereaved by suicide.  
<https://uksobs.org/>  
Tel: 0300 111 5065
- **Scottish Association of Mental Health:** Scotland's national mental health charity offer a range of mental health support and services.  
By post: Brunswick House, 51 Wilson Street, Glasgow, 1 1UZ.  
[www.samh.org.uk](http://www.samh.org.uk)  
By email: [info@samh.org.uk](mailto:info@samh.org.uk)  
Tel : 0141 530 1000
- **The Compassionate Friends** Charitable organisation supporting bereaved parents and their families after a child die.  
[www.tcf.org.uk](http://www.tcf.org.uk)  
Tel: 0845 123 2304
- **Samaritans** Charity aimed at listening to people who are angry, depressed and suicidal any time - night or day.

<https://www.samaritans.org/> or email: jo@samaritans.org

Tel: 116 123

- **The Way Foundation**

Supporting young, widowed men and women under 51 years of age as they adjust to life after the death of their partner.

<https://www.widowedandyoung.org.uk/>

Tel: 01332 869 222

- **Winston's Wish**

A national grief support programme for bereaved children.

<https://www.winstonswish.org/>

Tel: 08452 03 04 05

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## APPENDIX 3

### **Model for a group for reflecting of deaths of patients by suicide**

- Frequency: Monthly or bi-monthly
- Time: 60-90 mins.
- Number of cases discussed: 1
- Type of case: Completed suicide
- Facilitator or Convener: Usually two. One of whom has psychotherapy training and one who has lived experience.
- Boundaries: Same time and same place on each occasion if possible
- Style: Often similar to Balint group.
- Core Membership: Around four core members who commit to attend frequently. It is advisable to start with a pilot group to establish the core members. The core members should have their lived experience of losing patients to suicide which can be starting point for their own reflection.
- Attendance: Clinicians who have had a death by suicide either ask to attend or are invited if a colleague is aware, they have just had a death. They may come once, to tell their story, or more frequently. They can also stay in the longer term and join the group. Quite often individuals can come once after the death and then again at the time of the coroner's court.
- **Functioning or process:**

- When a new member (e.g., Dr X) joins after they lose a patient to suicide, they are first given space to share their story , without notes, while the rest of the group listen. This may take them between 10-20 minutes. They are allowed to talk without any interruption. This is without notes, allowing any emotional responses to be shared.
- Dr X is asked to sit back and listen to the group discuss what they have heard for around 20 mins. The group members share their thoughts and associations to Dr X's story.
- Dr X is then asked to re-join the group and feedback their thoughts. They are then allowed more time, around 10 minutes, to continue the narrative. They are then asked to sit back again.
- The group again discuss the further material for around 20 mins.
- Dr X is asked back into the group, to feedback.
- Further discussion is as a group.

# APPENDIX 4

## **Formal processes following death by suicide in Scotland**

### **Introduction**

1. Mental health services are part of Health Boards/Health & Social Care Partnerships (HSCP)
2. This appendix will describe the different processes and agencies/organisations that could potentially be involved following the death of a patient by suicide.
3. Local Serious Adverse Event Review (SAER) processes are all based on Healthcare Improvement Scotland's (HIS) national framework for reporting, reviewing and learning from serious adverse events although the exact processes can vary between Boards/HSCPs.
4. The Crown Office and Procurator Fiscal Service (COPFS) also referred to as the Procurator Fiscal or Fiscal can also conduct a Fatal Accident Inquiry (FAI) in some cases.
5. The Mental Welfare Commission (MWC) may have a role particularly if the patient was detained under the Mental Health (Care & Treatment) (Scotland) Act (2003).
6. NHS Boards send quarterly review data to HIS.

### **Local SAER processes**

7. All deaths, near misses and serious incidents are reported to the serious adverse event review team via local electronic reporting

systems. The SAER team will usually be led by the senior medical and nurse managers of the organisation.

8. Adverse event reviews are not about apportioning blame. The aim is to be open and honest with people when things do go wrong and offering an apology as soon as an event has been identified. A review of the care provided determines whether there are learning points for the organisation or organisations to improve the service. Organisations then need to implement the improvements identified to support a greater level of safety for all people involved in its care systems.
9. Following an event the senior doctor or clinical manager (where no doctor was involved in the care) will make contact with the deceased's family to offer condolences, advise on avenues for accessing support, inform them of the independent internal review process (and that reviewers will be in touch with them) and offer to meet.
10. The senior doctor/manager will provide a report to the review team.
11. The reviewers will gather data from the case notes and relevant staff interviews as well as any information from the bereaved relatives and use standardised documentation which provides a chronology, identify care & delivery challenges and contributory factors if any, and make recommendations. The commissioners of the review develop an improvement plan based on the recommendations.

## Fatal Accident Inquiries

12. There is no system of coroners' inquests in Scotland unlike England, Wales and Northern Ireland. The investigation of deaths in Scotland is the responsibility of the Crown Office and Procurator Fiscal Service (COPFS), often referred to as Procurator Fiscal. In certain circumstances these investigations will result in the holding of a Fatal Accident Inquiry (FAI). This is the judicial process for the public examination of the circumstances of the death in the public interest.
13. FAIs are an inquisitorial process, which seek to establish the facts surrounding the death. The purpose of an FAI is not to apportion blame for the death. They are mandatory where the death was the result of a work-related accident, or where the death was in custody. Discretionary FAIs can be held where the death was sudden, suspicious, unexplained or occurred in circumstances which give rise to serious public concern, for example a death of a detained patient in hospital. COPFS will make a recommendation if they consider a discretionary FAI ought to be held. FAI's are held in the Sheriff Court
14. The majority of evidence at the hearing is normally lead by the Procurator Fiscal, who presents the Inquiry for the Crown. Other parties involved may include the deceased's family, employer (if the death occurred at work), and any others with a potential interest in the circumstances of the death.

15. After conclusion of the hearing, the Sheriff will issue a Determination.

The findings in the Determination will include the cause of the death, or accident, and reasonable precautions which could have been taken. They may also include recommendations of steps to be taken to avoid deaths in the future. Participants to the FAI may need to respond to these.

16. Importantly, the process is a fact-finding one, not a fault-finding one.

## **Mental Welfare Commission**

17. The Mental Welfare Commission for Scotland (MWC) is a statutory body set up to protect the rights and welfare of people with mental illness and learning disability.

18. The Commission should be notified of instances where a person has died following suicide in an inpatient setting, or within a month of discharge from hospital, or if the person is subject to the Mental Health Act. There is a specific form for the latter event currently available through contacting the Commission (Notification of death form ND1). A list of instances that the Commission requires notification on is here: [Notifying the Commission | Mental Welfare Commission for Scotland \(mwcscot.org.uk\)](#)

19. The Commission has the option through its powers and duties under the 2003 Act to conduct its own review in the case of any suicide where it appears to the Commission that there may have been a deficiency of care and treatment.



## Other resources

20. The Scottish Association for Mental Health (SAMH) has produced an extremely informative guide to support and inform people bereaved by suicide and can be found here <https://www.samh.org.uk/about-mental-health/samh-publications/suicide-publications>

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## APPENDIX 5

### **Checklist for Senior Management Teams (SMT) and Managers of Affected Clinicians**

#### **Prevention:**

Staff well being	Have you provided or delegated regular health and wellbeing conversations with your staff?  ( <a href="https://www.england.nhs.uk/supporting-our-nhs-people/support-now/having-safe-and-effective-wellbeing-conversations/">https://www.england.nhs.uk/supporting-our-nhs-people/support-now/having-safe-and-effective-wellbeing-conversations/</a> )	
Team Training & Information	Have you provided training on:  1. The emotional effects of a patient's suicide, what helps and what is unhelpful  2. The processes that follow including the serious incident inquiry and the coroner's court  3. How to write and present a statement to the coroner  4. How to investigate a serious incident in an impartial way, that is supportive to staff and teams.	

Team culture	<p>Do you:</p> <ol style="list-style-type: none"> <li>1. Foster an open benign team culture.</li> <li>2. Have regular open discussions about serious incidents including normalising emotional responses.</li> <li>3. Encourage your team to access support within and outside the team, when needed.</li> <li>4. Have links with Occupational Health</li> </ol>	
Supportive systems	<p>Have you:</p> <ol style="list-style-type: none"> <li>1. Developed and encouraged staff reflective spaces to be embedded and regularly utilised by staff</li> <li>2. Developed a buddy/network of staff who have experienced patient death</li> </ol>	
Processes	<p>Have you processes:</p> <ol style="list-style-type: none"> <li>1. To notify you following a death</li> <li>2. To the senior management team to come together to discuss and delegate tasks</li> <li>3. For all clinicians involved to be informed in a timely and sensitive manner</li> </ol>	

	<p>4. For all those involved (not just those in the current team) to be notified sensitively.</p> <p>5. Systems for feedback and provision of different staff emotional needs after a death</p> <p>6. to ensure robust challenges to internal investigative processes</p>	
Resources	<p>Have you:</p> <p>1. Identified and provided staff with both local and national information and advice about services that can provide psychological intervention/support</p> <p>2. Identified and provided staff with (national/local) information about resources for families and friends</p>	

**Postvention**

**First few days**

Immediate protocol	<p>Have you met to communicate and delegate tasks including:</p> <p>1. Communication with the family of the deceased (see below)</p>	
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	<ol style="list-style-type: none"> <li>2. Identifying and thoughtfully informing staff members involved</li> <li>3. Offering condolences to staff involved</li> <li>4. Identifying who will liaise with internal and external agencies</li> </ol>	
Immediate support	<p>Have you:</p> <ol style="list-style-type: none"> <li>1. Thought about your own support needs.</li> <li>2. Offered health and wellbeing conversation to staff involved.</li> </ol>	
Liaising & further team support	<p>Have you:</p> <ol style="list-style-type: none"> <li>1. Linked up with trust/organisation Suicide Prevention Lead and identified local support resources available</li> <li>2. Considered, in collaboration with team managers, if any staff needs work adjustment, compassionate leave and /or referral to Occupational Health</li> <li>3. Organised a facilitative pastoral reflective space for all clinicians who have been involved to come and talk</li> </ol>	

	<p>together- both in the first week and the following month.</p> <p>4. Liaised with the GP</p>	
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### Support for Families, Friends

<p>Liaising &amp; external support provision</p>	<p>Have you;</p> <ol style="list-style-type: none"> <li>1. Identified the most appropriate senior professional to liaise with the family after the death.</li> <li>2. Offered condolences to the family</li> <li>3. Signposted the family to appropriate local and national services and resources</li> <li>4. Encouraged the involvement of the family liaison service</li> <li>5. Ensured other people in the community (including fellow inpatients) who might need help are identified by the team or their GP and other agencies (e.g. school for pupils) and signposted to support as needed.</li> </ol>	
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## Longer term support for Staff

<p>Practical support for staff</p>	<p>Have you:</p> <ol style="list-style-type: none"> <li>1. Allocated sufficient time for staff involved in writing statement to the coroner, internal investigations and attending coroner's court</li> <li>2. Ensured a supportive colleague will be present at inquest</li> <li>3. Involved the organisation's legal department for advice</li> </ol>	
<p>Long term input and emotional support for staff</p>	<p>Have you:</p> <ol style="list-style-type: none"> <li>1. Organised regular follow up meetings with management teams to regroup, receive feedback from affected team managers and discuss further task delegation.</li> <li>2. Had another wellbeing conversation with staff involved</li> <li>3. Has the SMT, in collaboration with Affected Team Managers, identified staff who appear to be still affected after the first month.</li> </ol>	

	4. Has the SMT, in collaboration with Affected Team Managers, considered whether work adjustments are needed by affected staff members in medium term.	
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