Joined Up Care Derbyshire

SUICIDE POSTVENTION

SUPPORT PACK FOR GENERAL PRACTICE IN DERBYSHIRE - JULY 2023

NHS

The Derbyshire VCSE sector Alliance

Derby City Council

DERBYSHIRE County Council

INTRODUCTION

Dear Practice Managers; General Practitioners and Primary Care Colleagues

In Derbyshire there are approximately 80 deaths from suicide each year. This equates to around 8 deaths per 100,000 population annually. In England and Wales between 2019-2021 there were 15,447 deaths by suicide equating to 10.4 deaths per 100,000 population annually. Males comprise around 75% of cases at a rate of 15.9 per 100,000, though suicides in females under 24 are rising at the fastest rate since ONS records began.
Source - Fingertips - Public Health England

Suicide is the commonest cause of death in young people. The highest rate of suicide is in middle age. Crucially; 41% of middle-aged men who die by suicide had contact with their GP practice in the 3 months prior to death; and 16% in the final week. **Br J Gen Pract 2023; DOI:** https://doi.org/10.3399/BJGP.2022.0589

Bereavement by suicide is an independent risk factor for suicide in the survivor. This might be due to deep despair and complex grief. Postvention is an intervention that supports those bereaved by suicide. It is combines grief counselling with secondary prevention of suicide.

The aims of this document are threefold; to help the practice:

- **Navigate the processes and reporting** that follow a patient suicide.
- **Signpost to bereavement counselling** or **postvention interventions** for the bereaved
- **Create a 'safer from suicide practice' through continual learning**.

The Covid-19 pandemic was the backdrop and stimulus for the creation pack in 2020. Population studies showed an increase in emotional distress in the population. Counterintuitively, suicide rates did not rise post pandemic. However; the data requires very careful interpretation. From 1961, when the Suicide Act decriminalised suicide, until 2018 coroners used the criminal standard of proof; 'beyond reasonable doubt'. In 2018 the standard was changed by a High Court ruling to the civil standard; *on the balance of probabilities*. This has inevitably increased the number of suicide conclusions registered nationally.

Young people and children have certainly been adversely affected by the pandemic with increasing self-harm and possibly a real rise in suicides in young women. In addition, the economic downturn is perpetuating the mental wellbeing of society so there is no room for complacency. New standard of proof for suicide at inquests in England and Wales | The BMJ

After the death by suicide of a registered patient

Such news is invariably met with both shock and sadness by the primary care team as they seek to understand what has happened and how to respond to the event. As part of my role as Clinical Lead for Derbyshire Mental Health and trainer in suicide prevention I discovered the need for GPs and practice managers to have a simple but comprehensive pack describing the

procedural steps they should follow in the aftermath of a suicide, including how to access specialist postvention support for the bereaved. The trauma is not limited to the immediate family, and support needs to be offered to all who feel affected, including members of staff.

The Support Pack

I have presented the appropriate actions a practice should consider after a patient has died by suicide in chronological order and matched these to the simple colour scheme in the document.

Immediate; Short Term; Medium Term & Longer-Term Actions.

Immediate actions should be completed within **3 working days** of the notification of death whilst the timescales for later actions will vary according to the circumstances.

In responding to a death by suicide a non-judgemental, compassionate approach within and across healthcare teams is of paramount importance to promote a learning culture.

I have included information about locally available suicide prevention training, public health strategy, real time suicide surveillance and links to key National Organisations that offer resources such as pastoral support and postvention training for professionals.

Suicide is complex and each suicide is different. Yet it is important we all have the approach that suicides are not inevitable and can be prevented. The event of a suicide should trigger a revaluation of the practice policies and training program for staff.

The Derbyshire Integrated Care System, named Joined Up Care Derbyshire (JUCD) has developed a strategy and key suicide prevention principles which can be found with this link:

https://s3.eu-west-2.amazonaws.com/crstl-assets/health-wellbeing/files/Derbyshire-Suicide-Prevention-Strategic-Framework-2022-25.pdf (outlook.com)

Joined Up Care Derbyshire Key Principles

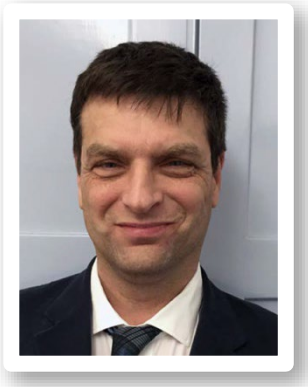
- Self-harm and Suicide are commonly a manifestation of a person's emotional distress; rather than a mental illness in and of themselves
- Suicide is not inevitable
- Everyone in our communities has a role in helping those with distress, those having thoughts of self-harm and in the prevention of suicide
- Suicide is unpredictable; however, some factors may increase the risk
- Conversations about self-harm suicide are based on compassion, validation, & avoid judgment
- It is important to strive to understand the person's story
- The impact of self-harm and suicide extends from close networks to the wider community

These principles underpin future **training of the workforce** which are actively in development.

See link for further information**: www.derbyandderbyshireemotionalhealthandwellbeing.uk**

The information in this pack is aimed at both individual general practice surgeries and I trust would be useful to Primary Care Networks or Federations.

I sincerely hope you find this support pack a useful resource, and I would welcome feedback comments, as they will aid the continual update and improvement of the pack.



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Derby and Derbyshire Integrated Care Board
General Practitioner Clay Cross Medical Centre
Suicide Prevention Training Lead for Primary Care Derbyshire
National Suicide Prevention Alliance: Strategic Steering Group 2019-2022
STORM consultant
Harmless Ambassador
4 Mental Health *stayingsafe.net* expert reference group

Governance and Acknowledgements

To ensure this document is validated for Derbyshire it was important to fully consult with the key stakeholders involved - including the Suicide Prevention Partnership Forum (led by Public Health), the Local Medical Committee, the Clinical Professional Leadership Groups, the local coroner, and the Integrated Care Board Patient Safety Team.

I would like to specifically thank the following for their invaluable support:

James Creaghan Public Health Lead for Derbyshire County Council; for encouragement and provision of necessary resources to create the document. .

Dr James Pumphrey, Suicide and Mental Health GP Fellow in Brighton; for collaborating to convert the Derbyshire document into a generic free resource that other primary care healthcare systems in the country can adapt and adopt for local use.

2023

Postvention is an intervention conducted after a suicide, taking the form of support for the bereaved (family, friends, professionals, and peers).

Suicide has a 'ripple effect' on the community and those most affected are at increased risk of suicide themselves.

A 'survivor of bereavement by suicide' is anyone who experiences high levels of self-perceived psychological, physical and or social distress after the suicide of a person they know regardless of the social relationship.

The dual objectives of suicide postvention are to alleviate the effects of this complex grief, and to prevent suicide in the survivors.

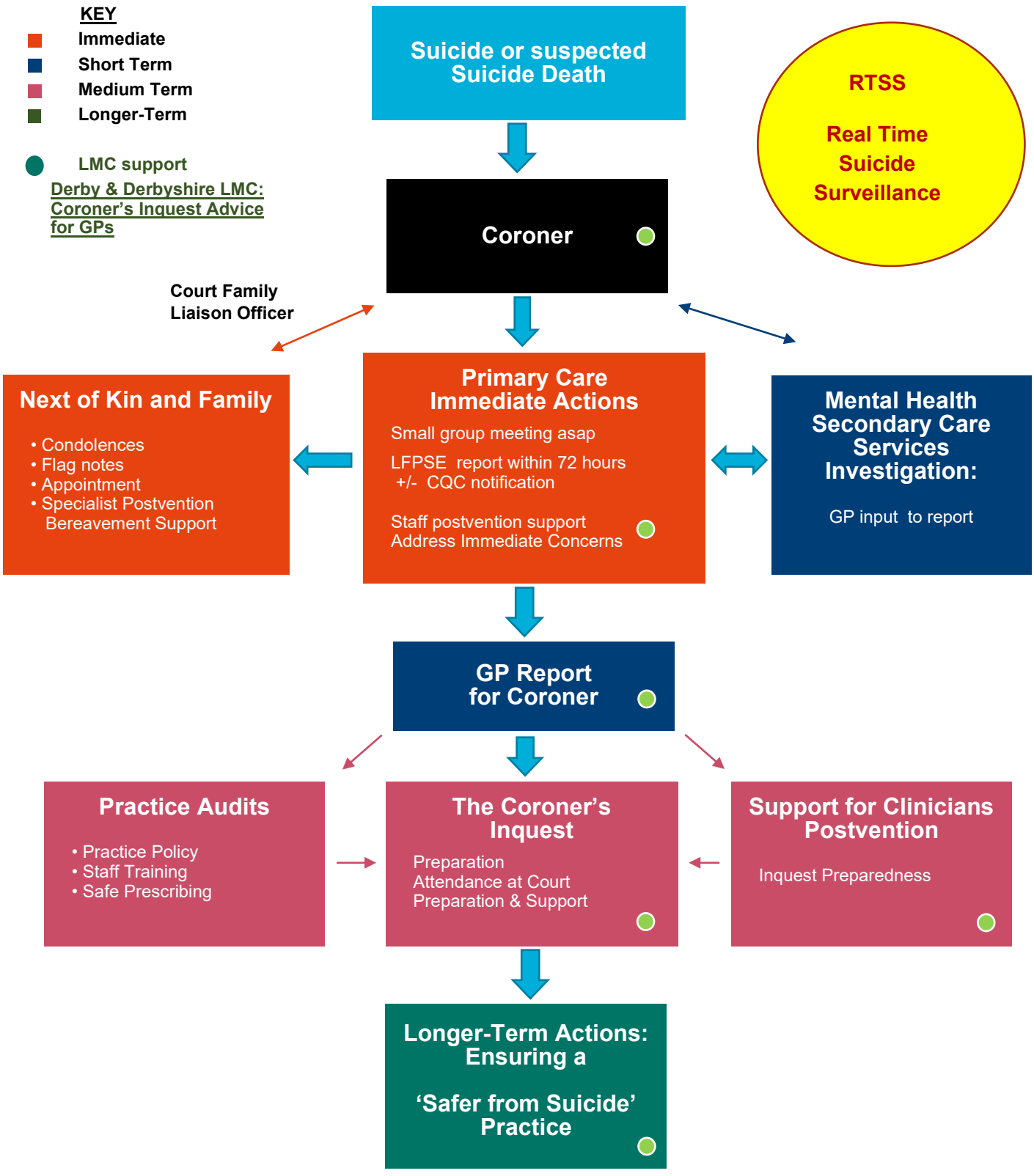
DEDICATED SERVICE:

DERBY AND DERBYSHIRE NOW HAVE FREE ACCESS TO SPECIALIST POSTVENTION SUPPORT
SEE SECTION A PART 4

POSTVENTION ON A PAGE - PRINT & SHARE PAGE 11

CONTENTS

FLOW CHART


KEY
Immediate
Short Term
Medium Term
Longer-Term
LMC support
Derby & Derbyshire LMC: Coroner's Inquest Advice for GPs
Suicide or suspected Suicide Death
RTSS
Real Time Suicide Surveillance
Coroner
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Preparation & Support
Support for Clinicians Postvention
Inquest Preparedness
Longer-Term Actions: Ensuring a
'Safer from Suicide' Practice

(A) IMMEDIATE ACTIONS REQUIRED AFTER A SUICIDE

1. GP Practice Management and Clinical Group Meeting and Response

The Practice may learn of the suicide of a patient in a variety of ways including the Coroner's Officer, a healthcare provider, the police, or even from the family. Sadly, this may be some time after the event.

The Practice Response

It is key for the practice to have an initial meeting as soon as possible. This would include the practice manager and the key primary care staff who were involved in the case. The lead for this meeting should be someone relatively remote from the patient's care to ensure objectivity and balance.

This purpose of this meeting is to rapidly share known information about what happened and establish what further information may need to be sought. It is also an opportunity to share the understandable emotional shock that may be felt, offer support, and agree on the next steps. .

It is essential to have a non-judgemental approach to individuals, whilst being open to learning ways in which the organisation can be improved. The most common identified need for improvement is communication between professionals and organisations. If there are any immediately obvious needs, then do not delay in making essential corrective action.

Specifically, ensure staff know they can approach the manager or lead GP if they need to talk about any aspect of the event at any future time. Silence does not necessarily mean that staff feel 'OK'. Grief reactions are individual, sometimes hidden, and often delayed. Sometimes a whole practice team can be impacted, and in some individuals the impact is compounded because there has been a former close personal experience of suicide.

Real Time Suicide Surveillance RTSS

A recent development is to notify death by suicide through the real-time suspected suicide surveillance (RTSS) system. Police attending a death where suicide is considered a possibility will inform agreed elements of the integrated care system within 24 hours. The aim is to identify and react to patterns and to greatly improve the speed at which targeted support reaches the bereaved. Each area will have its own approach, but generally public health, specialist mental health services, the coroner's office and local bereavement support services are notified.

See Appendix A – Additional Information Section A1 RTSS

See Appendix B - List of Resources that Support Primary Care Clinicians and Staff

2. Report to the Learning from Patient Safety Events (LFPSE) system

It is a national requirement for GP practices to report incidents onto LFPSE. The LFPSE link is:

https://www.england.nhs.uk/patient-safety/learn-from-patient-safety-events-service/

Every death needs to be reported onto LFPSE system within 72 hours. This will automatically be received by the patient safety team at the Integrated Care Board (ICB).

Upon receipt of the above report, the ICB patient safety lead will review the care of the patient in the preceding months using the information provided by the practice via LFPSE.

On occasion, where further information is needed, the ICB will contact the practice to seek it.

NHS England » Patient Safety Incident Response Framework

Primary care information on the new national learn from patient safety events service

The **LFPSE** system is replacing the existing National Reporting and Learning System (**NRLS**) and Strategic Executive Information System (**StEIS**).

This new system is **universal and proactive**. It is managed by NHS England and NHS Improvement, is a major upgrade. It creates a single central national NHS system for recording and analysing patient safety events. It is hoped that the new system will increase reporting and recording of events.

In General; Primary care staff are encouraged to **record any events where:**

- **A patient was harmed**
- **A patient could have been harmed**
- **Future risks** to patient safety have been identified
- **Safe effective care** has been shown to improve safety

A national learning system allows patterns and trends to be picked up more effectively as part of the national picture. This enables the NHS National Patient Safety Team to identify new or under recognised issues and take NHS-wide action. For example, issuing an urgent alert to protect patients.

The LFPSE allows for positive local responses to patient safety events.

This supports effective management, mitigation, and learning activities. Events recorded in LFPSE can be used for significant event analysis. They can also be used for continuing professional development and reflective practice. The ICB will assess the LFPSE report and decide if a SEA is required. The ICB will continue to access GP incident reports but via LFPSE rather than the NRLS.

Practices should report suicide or self-inflicted death to the Integrated Care Board Patient Safety Lead within 72 hours of being aware – use the LFPE system

The Patient Safety Incident Reporting Framework (PSIRF) is the new national strategic approach for providers to know ***how and when to respond*** to the reported safety events

See Appendix A for details on PSIRF

3. Reporting to Care Quality Commission (CQC)

Suicide is not always necessarily a notifiable death to the CQC. However, it will be notifiable in certain deaths in which a **Statutory Notification to CQC** must be made '**without delay**'.

The **CQC** would expect to be notified of a **suicide** in the below circumstances:

- if the person had been in receipt of **regulated activities** within the previous 2 weeks
- if it occurred during the delivery of regulated activities
- if there is police involvement that involves the practice
- if there is the potential that the practice and CQC may be named in a coroner's report

Or, if the deceased is subject to any of the below:

- The ***Mental Health Act***
- A ***Deprivation of Liberty Safeguard***
- A ***Notification to the Local Authority*** of actual or alleged abuse
- A ***Notifiable Safety Incident*** under ***Duty of Candour*** regulations **see Appendix A**
- A ***Never Event*** Never events: analysis of HSIB's national investigations — HSIB
- A ***Healthcare Safety Investigation Branch*** notifiable condition. About HSIB
- If ever a practice is **unsure**, it is advisable to **submit** a notification to the CQC.

For General Information on when to refer to CQC see Appendix A

4. Postvention & Support for the Bereaved Family & Friends

A national survey of 7518 people who self-identified as bereaved by suicide identified 77% as being majorly impacted, including family, friends, or professional colleagues. A third of them had experienced suicidal thoughts and 8% had made a suicidal attempt. Most had not accessed support. There was a disproportionate number represented from ethnic minority and LGBT communities. Disenfranchised grief is when stigma or exclusion is an additional component to complex grief. Link: **McDonnell et al.** Suicide bereavement in the UK

It is a good idea for Primary Care to proactively reach out to the family. This is a sensitive time because they will be in shock or even angry, but they need to know that the practice would like to express their condolences and are available to support them in their hour of need. How this is done is best decided by the clinical staff most familiar to the family, however, a distressed member of the team may not be the right person for this task.

In addition, primary care staff need to be receptive to contact from friends or even professionals affected by grief, and particularly sensitive to people who feel disenfranchised.

Helpful advice & tools on consulting and supporting a bereaved person are in **Appendix A**

Finding the words - NSPA Suicide & Co Support after Suicide Bereavement

Remember that bereavement from suicide leads to complex grief and is sadly the bereaved are at an increased risk of suicide themselves. The risk could be immediate or delayed and is often worse at the time of birthdays, holiday periods and key anniversaries.

An alert on the GP records on the anniversary of the bereavement may be helpful.

POSTVENTION RESOURCES

PRINT & SHARE THIS PAGE

Coroners Liaison Officer

After a death by suicide an inquest is inevitable and a Coroner's Liaison Officer will automatically contact the next of kin and support the family from the time of death until the inquest process is complete.

NEW & LOCAL

TOMORROW PROJECT

- for immediate and follow up help

Specialist commissioned support to help anyone manage a bereavement by suicide.

Any age. Any Derbyshire resident.

A suicide bereavement support officer will make contact and arrange to meet for on-going emotional and practical support.

Note: Available to any health care professional or GP for personal support.

Guidance and professional advice are also available to anyone concerned or caring for someone bereaved by suicide.

Self-referral or Professional referrals.

e-mail or Phone
bereavement.derbys@tomorrowproject.org.uk
0115 88 00 280 / 01246 541935

NEW & LOCAL

Survivors of Bereavement by Suicide (SOBS)

SOBS specialise in provision of peer support specialist suicide support for those bereaved by suicide. A national organisation with online forums as well as in person local groups in many areas (see website).

Self-referral via contacting local support group.

e-mail: email.support@uksobs.org
National Helpline: 0300 111 5065
Link: UK SOBS & local support

Help is at Hand Booklet

This excellent free PDF document is freely downloadable for immediate guidance to people bereaved by suspected suicide.

Link: HIAH Booklet 2021 support after suicide

Cruse Bereavement Care

This is a free, confidential bereavement support service available to the public.

Helpline: 0808 808 1677
Link: Coping when someone dies by suicide

Hope Again – Cruse Bereavement Care for Young People and Children

A website created specifically for young people, by young people. It offers an online support, advice, and signposting.

Link: Hope Again

Winston's Wish

Support for children and young families bereaved by suicide, as well as professionals

Helpline: 0808 802 0021 National Freephone
e-mail: ask@winstonswish.org

From Grief to Hope

An excellent report by The Support after Suicide Partnership

Link: From-Grief-to-Hope-Report

PAPYRUS

A guide to suicide prevention, intervention and postvention in schools and colleges. Equips teachers with the skills and knowledge needed to support young people having suicidal thoughts.

Link: #SaveTheClass | Papyrus UK |

(B) SHORT TERM ACTION:
FURTHER REPORTS

1. Report for the Coroner

The coroner has the power to call any witness that they feel will assist in their investigation to give evidence in person at an inquest, provide a written witness statement or provide documents of evidence in the custody of a person, under **Schedule 5 of the Coroners and Justice Act 200**. It is an offence to fail to comply or attend unless there is a reasonable excuse. As a witness, you play an important role in helping the coroner establish the circumstances of a death, to enable them to reach a conclusion at the inquest hearing.

Attendance at an inquest and cooperation with a coroner is also a requirement of the GMC, as stipulated in **Paragraph 73 of *Good Medical Practice*.**

Being called to give evidence does not automatically indicate that you are going to be criticised for your involvement. You may simply be called to assist the coroner in establishing the facts leading to the death. Clinically complex cases are more likely to have clinical witnesses give oral evidence, as coroners are generally not medical professionals.

Submitting a detailed and comprehensive statement can often negate witness attendance if that person has very limited or peripheral involvement. However, if a person is centrally involved in the circumstances leading to death, or their evidence is contentious, the coroner is likely to call that individual to give oral evidence.

The Coroner will ask for a written report from the patient's usual GP about their medical history including any mental illness, suicide attempts, self-harm or documented expressions of suicidal ideation or signs of suicidal intent. This information will include interventions and medication as well as which other organisations were involved. In some cases, the Coroner requests the GP to attend the inquest to present the findings and answer questions for the coroner and the barristers representing the family or the organisations involved.

In the majority of cases the GP is considered a witness but in uncommon circumstances they may be named as an Interested Person.

Who is an Interested Person?

Broadly speaking, an Interested Person is someone who has the right to actively participate in the inquest proceedings, whether by virtue of relationship to the deceased, involvement in the circumstances of the death or at the discretion of the coroner.

An 'Interested Person' is defined in section 47(2) of the Coroners and Justice Act (CJA) 2009. This includes a long list of classes of people who may be deemed to be an Interested Person in an inquest, including: the deceased's spouse, civil partner, partner, parent, child, sibling, grandparents, stepparents, and half siblings.

Other Interested Persons listed under the Act include:

- personal representative of the deceased's Estate (i.e., the Executor of their Will)
- a beneficiary under a policy of insurance issued on the life of the deceased
- a person who may have caused or contributed to the death of the deceased
- any other person who the senior coroner thinks has a sufficient interest

Occasionally, an organisation with no direct knowledge of the primary facts may be permitted to 'intervene' in an inquest if the coroner deems it to be appropriate. For example, the Care Quality Commission may be present at the inquest of a death in a care home.

If a GP is named as an Interested Person, the GP and their own legal representative may question the other witnesses, address the Coroner, and make submissions at the end of the inquest, to assist the Coroner in reaching his or her conclusion.

Inquests are occasions when either the Coroner or an Interested Person raises concerns with either the police or a regulatory body. Doctors also have a duty to self-report to the GMC if they are criticised by an official inquiry which includes criticism by a Coroner. This means that what happens at an inquest can dictate what happens afterwards.

2. Information for the Mental Health Secondary Services Investigation Report

A request for information about the patient from the usual GP is made by the mental health provider in order that they can do their own Investigation. This information is likely to be provided to the Coroner as well. This may be in the form of a peer review or by a multi-disciplinary two- or three-person review team, comprising professionals with the requisite skills, knowledge, and expertise. The aim of the review is to establish any learning to inform future systems and practice.

If a specialist mental health service were involved in the care of the deceased, they will do an internal review of the death. They may request the General Practitioner to contribute to this review in order to get a fuller picture. This usually involves an invitation from the lead reviewer to share any information that the GP may consider relevant to the person's care.

(C) MEDIUM TERM ACTIONS:
PREPARING FOR THE INQUEST

1. Post or Pre-Event Audits: Safe Prescribing & Safety Planning

After reviewing a Patient Safety Incident, practices may wish to take the opportunity to audit their internal practice with respect to suicide prevention. Audits may be reactive to a significant event, secondary prevention, or proactive to strengthen primary prevention. An audit and review of practice procedures and protocols is supportive evidence at the Coroner's inquest.

Definitions

- **Suicide: self-harm, resulting in death. Serious Incident**
- **Attempted suicide: self-harm with intent to take life, resulting in nonfatal injury.**
- **Non-Suicidal Self Injury (NSSI): self-injury without suicidal intent.**

Firstly, it would worth looking at some of the evidence on which patients are more likely to die by suicide; whilst always remembering suicide can occur in any person. It is also worth remembering that there is **no evidence** that suicide can be predicted using any algorithm, tool, or checklist. Prevention should therefore focus on awareness and the mitigation of risk factors.

'The characteristics of people who die by suicide' within primary care.
Research has shown certain common characteristics of the population who are attending primary care but are not receiving secondary mental health specialist care in the year preceding their death by suicide. Commonalities include polypharmacy of psychotropic, hypnotic, and analgesic medications; comorbidities in particular chronic pain; alcohol misuse and increasing frequency of consultation. There were a significant number of people who had psychotropic medication, had no coded diagnosis of a mental illness on the GP record system and had not been referred to the secondary mental health. Only 8% of those who died by suicide had been referred for specialist mental health care in the preceding 12 months.

Thus, opportunities exist within Primary Care Teams to ensure patients get assessment, diagnosis, coding, evidence-based therapy, safe prescribing, referrals, and structured care.

Where needed referral to specialist care and ideally collaborative care is provided. Increasing frequency of attendance correlated with the rates of suicide and should alert clinicians.

Website links:

Primary care contact prior to suicide NCISH SUICIDES IN PRIMARY CARE 2014

Br J Gen Pract 2023; DOI: GP consultation before death by suicide in middle-aged males

Suicide Prevention through Safe Prescribing

Self-poisoning is the second most common cause of death by suicide. Uniquely overdose of prescribed medication is directly influenced by the prescriber. The commonest medication for a mood disorder is an SSRI which is not without risk especially in younger people. Z- drugs, benzodiazepines, tranquillisers, beta-blockers, opiates, and other antidepressants always come with risk. Importantly, there are certain steps that can be taken to mitigate that risk, including:

- Comprehensive counselling on commencing, especially with SSRIs in young people
- 'Prescription Safety Plans
- Frequent review and limited medication supply when actively suicidal
- Entrusting carers to oversee and dispense
- Prescription Drug Dependency avoidance (QOF Quality Improvement)
- Safe Deprescribing

See Appendix A for More Tips and References for Safe Prescribing

Suicide Prevention through Personal Safety Planning

General Practitioners may read about the role of the GP in suicide prevention & Safety Plans here:
CR229 Royal College of Psychiatrists Self-harm and Suicide in adults 2020

See Appendix A for an extract

Personal Safety Plans reduce suicidal behaviour. The number needed to treat (NNT) to prevent one suicidal act is only 16. The relative risk of suicide is reduced to **0.57**.
Safety planning-type interventions for suicide prevention: meta-analysis

It is good clinical practice to encourage all people who self-harm or express suicidal ideation to create a personal safety from suicide plan. Practices therefore should ensure they have a protocol for dealing with people who are distressed and expressing thoughts of suicide when they seek help. This includes requests for help from concerned family or friends. Reasonable adjustments should be made to enable equitable access for people with mental condition.

www.stayingsafe.net Video demonstration & PDF of co-creation of a **Personal Safety Plan**

HOPELINK Papyrus UK **Unique 2-way digital support** to make a safety plan, 24/7, secure.

Information Sharing Best Practice

Clinicians are rightly duty bound to patient confidentiality. However, often this results in a lack of involvement of family or carers who can support the patient. A consensus statement has been issued by the DHSC, encouraging clinicians to share information more often, but still within the confines of the law. GPs should be fully versed in the below guidance.

Guidance for frontline workers : created by Zero Suicide Alliance

Information sharing and suicide prevention: consensus statement - GOV.UK (www.gov.uk)
SHARE: consent confidentiality & information sharing in mental healthcare & suicide prevention

2. Postvention and Psychological Impact on Clinicians

In all of this it is especially important that we keep in mind that members of the Practice Team may be profoundly affected by the death of a patient or the prospect of an inquest. Postvention support is available to clinicians just as it is available to the public.

Thankfully, there are plenty of resources available to help clinicians and staff in Derbyshire and nationally which are listed in **Appendix B**.

These include general emotional support, postvention support and professional support. The Derby and Derbyshire LMC are a key local support organisation for GPs. The Tomorrow Project is now commissioned to provide specialist immediate and follow up postvention support for any Derbyshire GP or member of staff that feel they would like it. (See **Section A5** for details).

The impact of suicide on clinicians

Psychiatrists

A booklets for psychiatrists dealing with the loss of one of their patients to suicide was created by the Centre for Suicide Research, University of Oxford, led by Professor Keith Hawton; 2020. The booklet offers psychiatrists advice on how to self-care after a patient has died by suicide
When a patient dies by suicide a resource for psychiatrists RCPsych 2020

A qualitative study within this described the emotional responses of psychiatrists:

Sadness • Anxiety • Guilt • Shame • Anger • Fear • Feeling blamed or responsible

The Royal College of Psychiatrists have published **a framework** on how to support staff.

CR234 Supporting mental health staff following the death of a patient by suicide: A prevention and postvention framework December 2022

Weblink: **Royal College of Psychiatry Report CR 234 Staff support following patient suicide**

The key recommendations include that each organisation should have a senior clinical pastoral lead, and a structured proactive response to caring for clinicians following a patient suicide.

Further research has supported the need for postvention support for clinicians

'Reflecting on the death and accessing good support helps clinicians process the emotional impact. It can also increase their resilience in the longer term by giving them a greater understanding of both their own and their patients' limitations, and in this way strengthen their capacity for compassion as clinicians.' Oates & Gibbons **https://doi.org/10.1192/bjb.2021.106**

'Actively supporting psychiatrists, by addressing the stigma they face and the sense of blame they feel, is extremely important for their mental health and well-being, and ultimately their capacity as professionals' Tamworth et al: **https://doi.org/10.3390/ijerph192114507**

In 2023 a support booklet for all mental health professionals was created which is an excellent guide on how to manage the emotional impact and disenfranchised bereavement experienced.
If a patient dies by suicide for mental health professionals RCPsych 2023

General Practitioners

There is as yet no comparable study of the impact of a patient suicide on the general practitioner and such research would be welcome. Despite the obvious differences between psychiatry and general practice, the guide for mental health practitioners is very valuable and relevant ;since in both cases it is about a human professional who has lost a patient for whom they were caring and had a relationship. There is a bereavement but often it is hard for oneself or others to validate that sense of loss; hence the term disenfranchised bereavement is used.

If a patient dies by suicide for mental health professionals RCPsych 2023

In 2016 a highly relevant qualitative study interviewed GPs who were involved in discussing the suicide of a young person with the person's parents.

Website link: **GPs' experiences of dealing with parents bereaved by suicide**

Authors: E Foggin, S McDonnell, L Cordingley, N Kapur, J Shaw & Chew-Graham

Suicide prevention is an NHS priority in England. Bereavement by suicide is a risk factor for suicide, but the needs of those bereaved by suicide have not been addressed, and little is known about how GPs support these patients, or how they deal with this aspect of their work.

GPs described mental health as 'part and parcel' of primary care but disclosed low confidence in dealing with suicide and an unpreparedness to face parents bereaved by suicide. Some GPs described feeling guilt and reluctance to initiate contact with the bereaved parents. GPs talked of their duty to care for the bereaved patients but admitted difficulties in knowing what to do, particularly in the perceived absence of other services. GPs reflected on the impact of the suicide on themselves and described a lack of support or supervision.

Conclusion:

GPs need to feel confident and competent to support parents bereaved by suicide. Although this may be facilitated through training initiatives, and accessible services to which bereaved parents can be referred; GPs also require formal support and supervision around significant events such as suicide.

After Death Reviews in Primary Care

Clearly there are unmet needs in Primary Care that to be addressed. In some localities, this has prompted the development of After Death Reviews (ADR) being offered to the primary care teams involved. An ADR is led by a GP from outside the practice and primarily focuses on non-judgemental reflection on the suicide and compassionate support for staff.

See Appendix A for more on ADRs in Primary Care

3. The Coroner's Inquest

The process of an Inquest can be rather a rather daunting one for the family and the health care professionals involved. It also can take some time to take place; so, there is a need to understand the emotional difficulties of revisiting the tragic event again to help the Coroner establish how the person died; the relevant circumstance and any other contributory factors. The inquest is a fact-finding court process. It is not meant to be a fault-finding mission, although it may feel like that to some. Support is helpful for many and being prepared makes the process easier to handle.

Suicide has not been unlawful since 1961, however, it is only recently in 2017 that the burden of proof or threshold required for a conclusion of 'suicide' was lowered from the criminal threshold of 'beyond reasonable doubt' to the civil threshold of 'on the balance of probability'.

To reach a **conclusion** (previously known as a **verdict**) the coroner must find on the evidence that the deceased undertook a **deliberate act,** ***and*** the suicide was the **intention** of said act.

Where contributory factors need explanation, the coroner may return a **Narrative Conclusion**. Inquests are public hearings, and the press are entitled to attend. High profile cases are likely to attract media attention, and this will understandably add to the anxieties of inquest attendees.

Most media nowadays are aware of the Samaritans Guidance on how to report suicide responsibly and without creating the risk of sensationalism or attract the attention of vulnerable readers. Information and conclusions shared during an inquest can offer an opportunity to aid understanding of some of the issues surrounding suicide.

Guidance for reporting on inquests for England, Wales & Ireland Samaritans

The Support for the Bereaved Family & Friends is covered in **Section A5** above.

The Support for GPs: Derby & Derbyshire LMC: Coroner's Inquest Advice for GPs

The Coroner's Inquest Advice for GPs
The Coroners Pathway

Once a Coroner decides an Inquest is needed the LMC are informed directly, and they send a support pack to the GP practice. They proactively offer support via the GP-S Mentor Scheme. If following the Conclusion of the Inquest there has been any criticism of the GP by the Coroner, the LMC will contact the GP & guide them on self-referral to the GMC & NHSE and support available throughout any investigation done by the local NHSE Performance Advisory Group (PAG).

Professional Indemnity Organisations

For example, the **MPS** or **MDU** offer invaluable support to doctors who face criticism or complaint. They provide expert help with preparing statements and inquest preparedness. Example Link: **https://www.medicalprotection.org/uk/protection-in-practice/coroner.html**

The Coroners Courts Support Service (CCSS)

This independent voluntary organisation offers emotional and practical help to bereaved families, friends and clinicians called to witness at a Coroner's Court Inquest.
Website link: **Home - Coroners Courts Support Service**

A Guide to Coroner Services for Bereaved People created by The Ministry of Justice

This guide is for the bereaved family, or anyone called to witness, whatever the cause of death.

Link: A Guide to Coroner Services for Bereaved People (publishing.service.gov.uk)

The Local Medical Committee is a source of support and advice always worth consulting

Coroner's Inquest support

Support and Advice for Derbyshire and Derby GPs regarding a Coroner's Inquest.

It includes a flowchart illustrating the key processes pertaining to an inquest.

https://www.derbyshirelmc.org.uk/coronersinquestadviceforgps

NHS RESOLUTION

Inquests: A guide for health providers Supporting staff to prepare for an inquest

Inquests-films-and-guide.pdf (resolution.nhs.uk)

(D) LONGER-TERM ACTIONS:
ENSURING A 'SAFER FROM SUICIDE' PRACTICE

The regular engagement with some of the following resources will support the practice maintains a high standard of suicide prevention and postvention.

1. Suicide Prevention Training for Primary Care Teams & GPs

1a. Organisations specialising in Suicide Prevention Training

There are various organisations that offer training courses in suicide and self-harm prevention.

Training can be provided in various formats; different modules suit different needs.

Examples of familiar training courses include:

STORM® Skills Training - Suicide Prevention

4 Mental Health Training

Mental Health First Aid Training

ASIST Applied Suicide Intervention Skills Training UK

Papyrus UK Prevention of Young Suicide

The Ollie Foundation: One Life Lost Is Enough Includes Prescription Safe Plan Training

Grassroots -Suicide Prevention, Mental Health, Self-Harm Training Courses

Harmless & Tomorrow Project Training Courses

The above list is not fully comprehensive and not to be taken as a recommendation. The important thing to remember is that there are many training modules which differ in their target audience, ranging from general awareness to deeper knowledge and even to fine tuned skills. Therefore, the choice depends on the role of the trainee and what previous training they have had.

Health Education England Training Hubs

Contact your local HEE training hub to see what training is available in your locality.

Derbyshire Emotional Health and Wellbeing JUCD website hosts all the information for public and professionals alike on mental health and suicide prevention support and training offers

Derby & Derbyshire - Emotional Health & Wellbeing (derbyandderbyshireemotionalhealthandwellbeing.uk)

A note about Derbyshire and Suicide Prevention Training

In recent history Derbyshire Primary Care have been provided with training using 4 Mental Health (Connecting with People) Materials. This is an organisational response to tackling suicide and self-harm. The approach combines compassion and clinical governance. It challenges stigma and enhances awareness, knowledge, and confidence.

Initially the training was delivered by a small group of passionate Derbyshire GPs and this peer-to-peer approach was a catalyst for change in primary care. Training switched to online once the pandemic developed.

The 4 mental health training for Primary Care Teams in Derbyshire began in 2017 and by early 2023 around 1000 staff and GPs had received training within their practice teams. Most sessions were delivered during the practice QUEST sessions (protected learning).

The feedback from sessions was very positive in terms of meeting a huge unmet need, the materials used and the peer delivery. It really helped to have local clinicians deliver the training. The work was a finalist in the Health Service Journal Awards 2018 (Innovation in Primary Care).

The training is no longer funded by the Derbyshire ICB as each provider organisation has been tasked with creating a more bespoke and flexible model to meet the particular roles of their workforce. The ICB and Health Education Derbyshire are working together to develop a range of training options which will be compatible with Primary Care Networks, the extended primary care teams, and the transforming community mental health services.

1b Health Education England Resources

Website link: **Self Harm & Suicide Prevention Health Education England**

Modular 'e-learning for healthcare' or E-LFH is a HEE programme created in partnership with NHS organisations which includes **MindEd** as one of its resources.

MindEd is a free e-learning resource funded by HEE, the Department of Health & Social Care with the Department of Education. It is aimed at equipping professionals and the public with evidence-based information about the mental health of all age groups.

MindEd is part of the **National Suicide and Self Harm Prevention programme (SSHP)**
https://www.gov.uk/government/publications/suicide-prevention-cross-government-plan

It aims to help everyone involved to understand how to approach all ages from children and young people through to adults, in such situations. This includes front line staff in care or services, first responders, teachers, social workers, volunteers, carers, and parents

MindEd SSHP skills building scenarios and knowledge sessions teaches ***the dos and the don'ts*** in these difficult situations. All sessions can be used in workshop or single learner settings.

Here is the link for the HEE resources **HEE e-learning for healthcare**

Access to MindED Options

Register with MindEd **MindEd Hub**

Access via existing e-lfhc account **MindEd - eLearning for healthcare (e-lfh.org.uk)**

Go to the Programme: MindEd Suicide and Self Harm Prevention There are 3 Courses

1 Suicide and Self Harm Prevention, Skills for Schools (6 modules)
The *Post Suicide Bereavement and Postvention* which covers breaking bad news

2 Suicide and Self Harm Prevention, Young People (25 modules)
A very comprehensive list of modules for *Dealing with Young People*

3 Suicide and Self Harm Prevention, Skills for Adults (4 modules)
The Postvention Support for Staff & Organisational Response explores the impact of family, colleagues, and friends, by following the story of two people affected by a suicide.

HEE Competency Frameworks

HEE worked with the National Collaborating Centre for Mental Health (**NCCMH**) and **UCL** to make competence frameworks for self-harm & suicide, bringing together evidence-based suggestions for best practice. There are 3 parallel frameworks and documents freely available via the below link:

- working with children and young people (from 8 years upwards)
- working with adults and older adults (from 18 years upwards)
- working with the public (community and public health)

Self-harm and Suicide Prevention Competence Framework UCL

Choosing a training package for staff: it is important to match the role of the member of staff to the competency framework and check an appropriate training package is selected.

1c The Zero Suicide Alliance provide free online training for all NHS staff

Supported by the Department of Health, the Zero Suicide Alliance offers a free e-learning training session, called **Suicide - Let's Talk**, which takes around **20 minutes** to do online. This training aims to enable staff, whatever their role, to identify when someone is presenting with suicidal thoughts or behaviour, to speak out in a supportive manner and signpost them to support.

ZSA Suicide Awareness Training (frank-cdn.uk)

1d. Psychological First Aid (PFA) digital training module e-learning

UK Health Security Agency (UKHSA) has 2 free courses on PFA available on Future Learn

CYP Psychological First Aid online course - FutureLearn

COVID-19: Psychological First Aid Training Course - FutureLearn

Psychological first aid is an evidence-based approach to providing humane and practical help during a crisis. Both modules were initially created in relation to the Covid-19 pandemic and cover effective listening practices and recognising common signs of distress across different age groups.

1e. Suicide Postvention Training

PABBS | Postvention Support Training | Suicide Bereavement (suicidebereavementuk.com)

Postvention Assisting those Bereaved by Suicide (PABBS) is an evidence-based postvention support training, which is open to everyone, not just clinicians or even healthcare staff. This is a one-day course, delivered in person at an array of locations around the United Kingdom.

See also section D6 for more information on the Support After Suicide Partnership (SASP).

1f. Derbyshire County Council Suicide Prevention Website

Derbyshire County Council hosts an excellent website which has a wealth of useful information and resources on emotional health, wellbeing, suicide prevention and postvention. Training opportunities are posted here too.

Website link: Derby & Derbyshire - Emotional Health & Wellbeing

GPs and Primary Care staff using SystmOne can access this information using the Mental Health Pathfinder on the intranet by pressing F12 on the keyboard.

1g. Postvention Training for Health Care Professionals

See Section 6 below on training by the SASP or select the weblink below.
Postvention Assisting those Bereaved By Suicide (PABBS) Training

Also see **Section D1(b)** for HEE e-learning in postvention or select below weblink:
Self-harm and suicide prevention | Health Education England (hee.nhs.uk)

Derbyshire

FREE suicide bereavement training BY HARMLESS FOR STAFF

https://www.eventbrite.co.uk/o/harmless-lets-talk-training-14795237737

This course is designed to enable participants to explore and understand the following:

- The magnitude of suicide bereavement
- Suicide loss as a unique form of complex bereavement
- Complex grief, trauma, and other individual responses to suicide
- Wider impact of bereavement on those exposed to or affected by suicide
- Stigma and shame associated with suicide and bereavement
- Bereavement by suicide as a unique risk factor for suicide

2. The Self-harm and Suicide Prevention Partnership Forum

The Derbyshire Forum comprises multiple organisations from across the county who work in partnership to deliver the strategic aims as set out by public health. It enables oversight and coordination of various pieces of work, including training, bereavement support and community outreach.

The Chair is James Creaghan, Public Health Lead for Mental Health and Suicide Prevention, Derbyshire County Council.

Practices, Primary Care Networks. GPs, healthcare workers and patient participation groups are welcome to contact the Forum with information, concerns, or to become involved.

Contact the Public Heath Suicide Prevention Team, e-mail:
ASCH.Suicide.Prevention@derbyshire.gov.uk

3. Public Health: Real Time Suspected Suicide Surveillance RTSSS

In Derbyshire we have a system to monitor suspected suicide related incidents in 'real time'. This enables us to identify and respond to trends as they happen with a view to implementing preventative or mitigation measures. This could be a location, a cohort of the population or a method of suicide.

Derbyshire Observatory
Data and statistics for Derbyshire

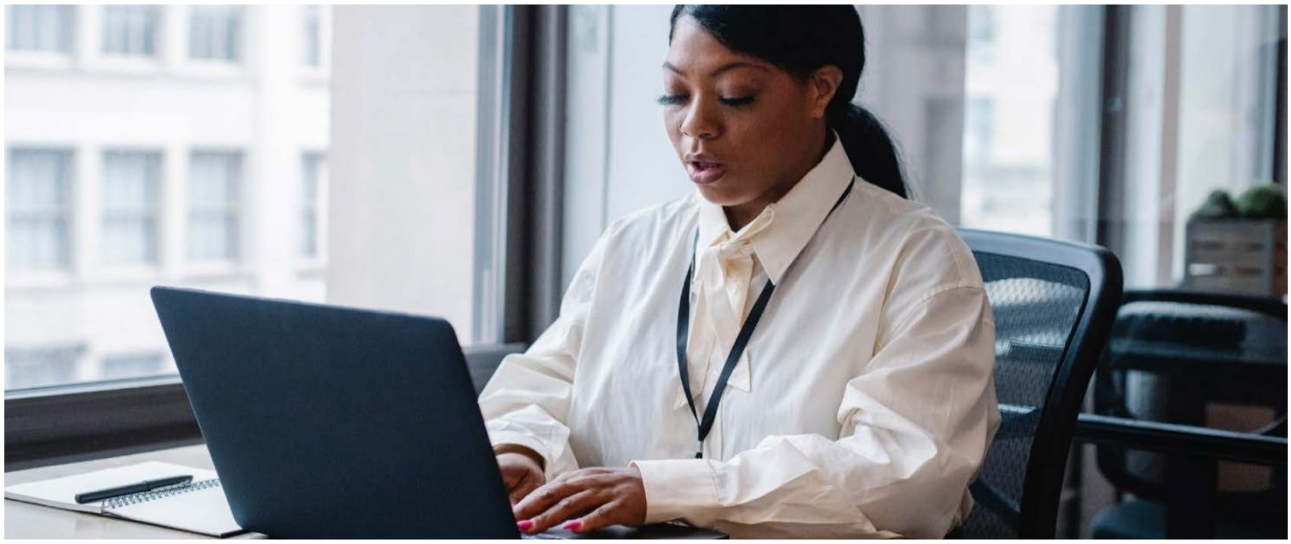
A report on Deaths From Suicide and Injury of Undetermined Intent is produced annually.

Link: https://observatory.derbyshire.gov.uk/life-expectancy-and/suicides/

Frequent local reports on suicide data assist Primary Care Networks in mitigating the risks.

This can include evolving methods of suicide and geographical places of high frequency.

Information on suicide prevention in Derbyshire can be found here:
Derby & Derbyshire - Emotional Health & Wellbeing



4. Suicide Clusters & Response

The term “suicide cluster” describes a situation in which more suicides than expected occur in terms of time, place, or both. It is difficult to precisely define a cluster. A suicide cluster usually includes 3 or more deaths; however, 2 suicides occurring in a specific community or setting in a short time should also be taken very seriously in terms of possible links and impacts, particularly in the case of young people. It is important to establish at the earliest stage possible if there are connections between the suicides. There do not have to be clear connections, however, for multiple deaths to constitute a cluster.

Multiple unconnected deaths in a community can have similar consequences to a cluster in which links between deaths are apparent, such as media response, heightened local concerns and speculation, and influence on methods used for suicide. Also, there may be unrecognised connections between deaths.

It is also important to respond to concerns around suicide clusters and to pay attention to groups vulnerable to imitation and at risk of contagion in the case of a single suicide.

Types of Clusters

Point Clusters (or spatial-temporal clusters)
A greater than expected number of suicides that occur within a period of time in a specific geographical location. This might also be in a community or an institution (e.g. school, university, workplace, psychiatric ward)

Mass Clusters (or temporal clusters)
A greater than expected number of suicides within a period of time which are spread out geographically.

Method Clusters
Sometimes clustering can involve a particular method of suicide. This can occur within point and mass clusters.

Echo Clusters
Two or more clusters occurring in the same location but separated by time.

Suicide clusters may result from ‘contagion’, whereby one or more than one person’s suicide influences another person to engage in suicidal behaviour or increases their risk of suicide ideation and attempts. A variety of mechanisms may be involved, such as modelling and vulnerable individuals tending to come together in social groups. The people involved are likely to already be vulnerable, perhaps because of existing mental illness and thoughts of suicide, or factors such as severe family discord or previous bereavement.

There are times when Primary Care Teams may need to be alerted to the presence of a possible cluster by the Response Group in order to facilitate greater awareness and prevention. Examples might include practices that support University Students or practices that have a geographical location where suicides are frequent.

Source: **Identifying and responding to suicide clusters**

5. The National Suicide Prevention Alliance NSPA

This is a vibrant thriving alliance of small and large organisations as well as individuals who are committed to preventing suicide and mitigating the harmful impact of suicide on others.

It is jointly led by the Samaritans and Public Health England. It has a small steering group which support its function and guide the strategic direction.
Website link: **NSPA website**

One pivotal document that has been produced is called From Grief to Hope and is a study of over 7000 people bereaved by suicide and can be found here:
McDonnell-et-al.-2020.-From-Grief-to-Hope.pdf (nspa.org.uk)

Derbyshire NSPA members 2021

6. The Support after Suicide Partnership UK

'Our vision is that everyone bereaved or affected by suicide is offered timely and appropriate support.' SASP

The Support After Suicide Partnership is a special interest group of the National Suicide Prevention Alliance (NSPA) based at Samaritans. The group is a UK wide network of over 70 members and supporters. Founded in 2013, it brings together national and local organisations that are involved in delivering suicide bereavement support across the UK to address the need for formal, multi-agency, proactive suicide bereavement support.

Support After Suicide (link) has useful resources and training offers.

Here is a link to a video from their annual conference including a poem about loss to suicide.
Suicide Bereavement UK - Jenny Berry - Poem 'In It Together' - YouTube

For a deeper insight into the impact of suicide on family and friends, please refer to the excellent report by The Support after Suicide Partnership called ***From Grief to Hope***
From Grief-to-Hope Report

PABBS evidence-based training which equips professionals including General Practitioners to deal with postvention effectively and confidently. See below website link:
Postvention Assisting those Bereaved By Suicide (PABBS) Training

7. Organisation Postvention after the suicide of a GP or work colleague

GP Practices, Primary Care Networks, Federations, Alliances and GP Practices are small businesses and employers. Along with larger NHS organisations such as ICBs and Provider Trusts, they should be prepared in the event of the suicide of one of their colleagues or staff.

Sadly, although suicide is rare overall, there is an increased risk in doctors and nurses.

'Responding to the death by suicide of a colleague in Primary Care: A Postvention Toolkit'.

The Society of Occupational Medicine and The Louise Tebboth Foundation recently published an excellent guide for primary care to navigate through the aftermath of such a tragic event. I think it would be invaluable for any practice manager and it can be found here:

Responding to the death by suicide of a colleague in Primary Care

'Postvention Guidance for the Ambulance Service'

An evidence based postvention guidance toolkit aimed at ensuring excellent support after a suicide within the paramedic community, to help prevent further deaths.

Samaritans Postvention Toolkit June 2021

'Crisis Management In The Event of a Suicide: A Postvention Toolkit for Employers'

This resource provided by Business in the Community is a guide for any employer, NHS or otherwise, wishing to create organisational readiness:

A Postvention Toolkit For Employers - Business in the Community

Universities UK guidance on ensuring Suicide – Safer Universities

Our postvention guidance was created to help guide universities with what to do in the immediate aftermath of a death by suicide. This practical guidance offers recommendations, an extensive checklist, and resources to help institutions define their response to a student suicide.

Responding to a suicide: advice for universities (universitiesuk.ac.uk)

APPENDIX A
ADDITIONAL INFORMATION

Section A1 GP Practice Management and Clinical Group Meeting and Response

Real Time Suicide Surveillance (RTSS)

Real time suicide surveillance was originally set up by the British transport police and has completely revolutionised our ability to respond to suicides in a timely fashion.

Thrive London LDN Thrive LDN is the largest developed RTSS system in the UK.

- Designed & implemented the only whole region RTSS, covering 9 million people
- The RTSS provides a system to securely share information on suicide for multiple agencies
- Included: Metropolitan Police, British Transport Police, the NHS & 33 London local authorities
- The system is all online and has been developed with QES, a data solutions company
- The Thrive LDN system is part of the national pilot for RTSS
- The System was launched in 2019 on World Suicide Prevention Day
- RTSS has been integral in London's Covid-19 response
- RTSS shares information quickly & securely enabling vital services e.g., bereavement support
- RTSS allows greater understanding of suicide prevention input into prevention strategies

The RTSS takes data from the police and other sources above about suspected suicides and now extending to include attempted suicide and self-harm. Work is done to identify clusters and ensure postvention is offered within 48 hours in the vast majority of cases. The GP is involved in terms of having the postvention services and training are offered.

Courtesy of Dr Phil Moore Deputy Chair (Clinical), NHS Kingston Clinical Commissioning Group.

Section A2 Report to the Learning from Patient Safety Events (LFPSE) system

The Patient Safety Incident Response Framework (PSIRF)

The new **PSIRF** is replacing the **Serious Incident Framework (SIF) (2015)** and **Route Cause Analyses (RCA) ,** as the way in which we respond to patient safety incidents in the hope of learning from them. In some areas deaths by suicide must be reported under this policy.

PSIRF makes **no distinction between Patient Safety Incidents and Serious Incidents** hence negating the threshold for the latter. The aim is to achieve a **Just Culture**, whereby an investigative approach is replaced with a compassionate, proportionate response involving those people affected by the incidents. It allows for greater data informed system learning.

The Patient Safety Investigation Response Framework (PSIRF) supports the development and maintenance of an effective patient safety incident response system that integrates **four key aims**:

1. Compassionate engagement & involvement of patients, families, and staff
2. A pro-active strategy for Learning from Patient Safety Events (LFPSE)
3. Considered proportionate responses
4. Supportive oversight to strengthen responses & encourage continual improvement

PSIRF advocates an encompassing, data-driven approach to responding to incidents in healthcare. The framework moves away from defining a serious incident and focuses on patient safety incidents, to embed patient safety incident responses within the wider improvement culture.

The aim of the policy is to ensure that reportable incidents are appropriately managed within the Integrated Care System's (ICS) commissioned and co-commissioned services.

PSIRF is compulsory for providers of Acute, Community and Mental Healthcare as it is a contractual requirement under the NHS Standard Contract.

Primary Care Services in England and Wales do not have to adopt the PSIRF at present but may either choose to, or be mandated to, in the future as this new framework develops.

Website link: **NHS England » Patient Safety Incident Response Framework**

Organisations that are signed up to PSIRF will have specific National and Local Priorities on which they must report. The information is held nationally and shared with the ICS Safety Lead.

Section A3 Reporting to Care Quality Commission (CQC)

Reporting to Care Quality Commission (CQC)

General Information on when to refer to CQC

When: Notification to the CQC should be ***without delay***

Who: Providers and managers of NHS GP need to notify CQC if:

The death occurred actually **during, or within two weeks of, regulated activity** being provided
AND
The death was or may have been **the result of the regulated activity** or how it was provided
AND; *IF IN YOUR REASONABLE OPINION*
The death **could not be** attributed to the course which the illness or medical condition would **naturally** have taken if the deceased had been receiving appropriate care and treatment.

CQC Regulated Activities are those a provider must register in order to perform them.

Scope of registration: Regulated activities - Care Quality Commission (cqc.org.uk)

For **GP services** these would be mainly

- Treatment of disease, disorder, or injury
- Surgical procedures
- Diagnostic and screening

Practices that are linked up to the CQC provider portal can use this to notify the CQC alternatively the link below will direct them to what they need to do to make the necessary notification.

CQC Guidance for Providers on Notifications

GP myth buster 21: Statutory notifications to Care Quality Commission

'Notifiable safety incident'

A ***Notifiable Safety Incident*** is a specific term used in the ***Duty of Candour*** regulations.

It should not be confused with other types of safety incidents or notifications.

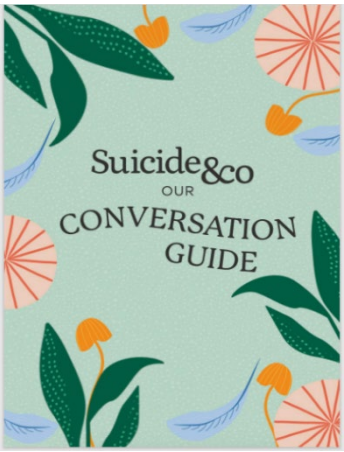
A notifiable safety incident must meet **all 3 of the following criteria:**

1- It must have been **unintended or unexpected**.

2- It must have occurred during the provision of an **activity CQC regulates.**

3- It already has, or might, result in **death, severe or moderate harm** to the person.

Section A4 Postvention & Support for the Bereaved Family & Friends

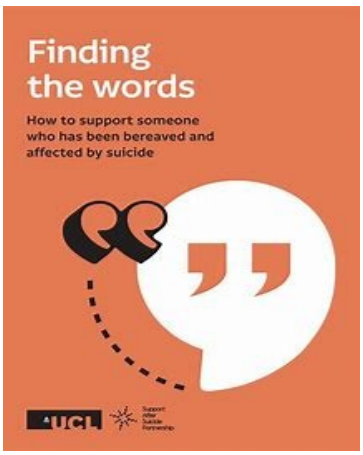


Suicide & Co: Support after Suicide: Our Conversation Guide

Helpful advice & tools on consulting and supporting a bereaved person.

Organisation set up in 2020 with a mission to support bereaved individuals and open the conversation around suicide-related grief.

Conversation guide has suggestions around language choices and collates experiences of those bereaved, both positive and negative.



Link: **Finding the words**

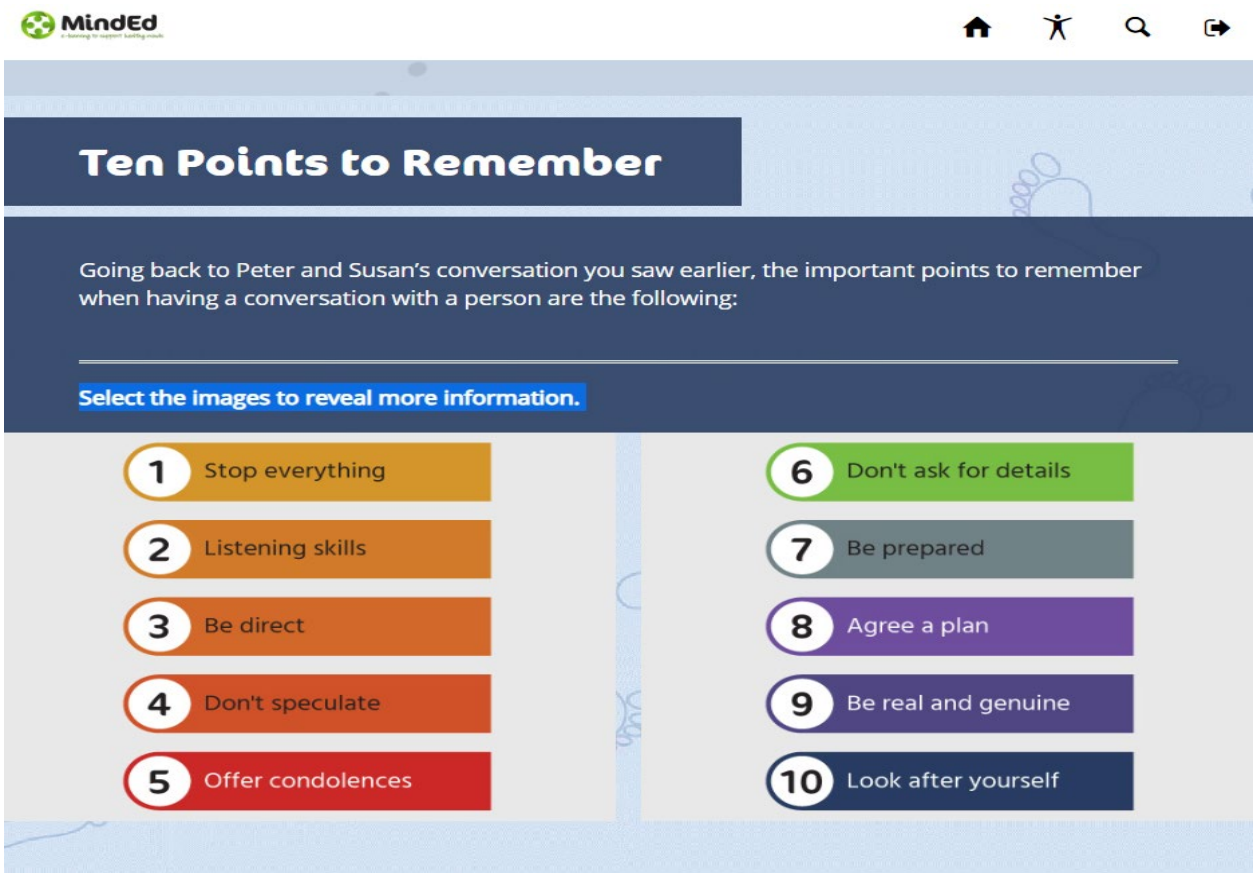
Link: **Judi Meadows Memorial Fund**

'Finding the words' was created by the Judi Meadows Memorial Fund alongside **UCL** and contains useful advice on how to communicate sensitively with anyone bereaved or affected by a suicide. Useful for public and staff alike.

TEN POINTS to remember during a conversation with someone bereaved by suicide

The below is taken from the **MindEd** module on Postvention and was an attempt to distil the views and learning of the authors. The 10 points provide a good framework for approaching a first conversation with someone after bereavement.

Reproduced with the permission of the authors.



1 Stop everything

2 Listening skills

3 Be direct

4 Don't speculate

5 Offer condolences

6 Don't ask for details

7 Be prepared

8 Agree a plan

9 Be real and genuine

10 Look after yourself

The plan should of course include an offer of specialist bereavement counselling.

After death reviews (ADR) in Primary Care

This process was established in Brighton & Hove in 2019 to try and improve the support offered to GPs in the immediate aftermath of a suicide. Deaths of this nature can often leave us with unanswered questions, and in primary care there aren't always easy opportunities to discuss the case or debrief with secondary care colleagues. This can potentially leave clinicians working feeling isolated and vulnerable, and risk missing the chance to capture any potential learning.

Using the real time surveillance data we proactively reach out to practices in the days following a suicide, initially to offer condolences and signpost to some of the resources contained in this leaflet. We then offer to meet with a member of the clinical team to go through the patient story together in a safe, non-judgemental fashion. Sometimes this debrief and timeline construction is enough, but sometimes we identify other stakeholders and try to arrange a more comprehensive review meeting with the wider team.

The concept has been discussed with the coroner who has endorsed it as good practice, so long as the meetings take place after any statements for the coroner's court have been submitted. There is no obligation, and some practices may well have their own process but where it has been taken up, staff have generally found it supportive and valuable. Although the primary aim is to support the staff involved, once the ADR is completed any relevant learning is anonymised and can be fed back to the System-wide Suicide Prevention Group by the practice as deemed appropriate.

There is evidence that Primary Care reviews of this type can be useful so long as the process is not a fault-finding exercise.

See: General practice critical incident reviews of patient suicides: BMJ Quality & Safety

Conclusion: Practices were willing to hold critical incident reviews, including seeking the views of the next of kin, and appreciated the potential positive value; but need reassurance that they will not be blamed for suicides, and that the cost in time and resources will be recognised.

It would be for each locality to consider implementing this approach if system resources allow.

(Courtesy of **Dr James Pumphrey**; Suicide Prevention Fellow, Brighton & Hove)

Section C1 Post or Pre-Event Audits: Safe Prescribing & Safety Planning

Preventing Suicides through Safe Prescribing

The following advice is consistent with NICE Guideline NG225
Self-harm: assessment, management and preventing recurrence Published: 07 09 2022

The Key Messages for any person starting an antidepressant include:

- Antidepressants are widely used across the world as medication to treat depression and the benefits usually outweigh the risk of any unwanted or unpleasant symptoms.
- People can have an adverse reaction (ADR) to any medication including all antidepressant medications.
- Antidepressants have many side effects, some more serious than others. Some of the adverse side effects listed in the 'Patient Information Leaflet' (PIL) include deepening depression, worsening anxiety, thoughts of self-harm or suicide; especially for people with previous suicidal thoughts or aged below 30 years.

SSRI Medication and Suicides

SSRI drugs are the commonest antidepressants used today, and whilst much safer than the older generation of drugs. Overall, they benefit in lifting mood and reducing suicide behaviour and alongside talking therapies are widely used. However, there are concerns that especially in young people, they may increase the risk of suicidal thoughts, at least anecdotally. Therefore, it is imperative that whenever they are prescribed a clear warning is issued to the patient by the GP and reinforced by the pharmacist. This should alert the patient to be aware that they may feel worse before they feel better, and that if they feel worried or suicidal to contact the GP again immediately. The Ollie Foundation have created some supportive materials and training on this specific topic. See below.

My *Prescription* Safe Plan **The Ollie Foundation** The Ollie Foundation Facebook Page

This charity supports others to reduce the risk of suicide and has a particular focus on young adults and students. The Foundation has developed novel pathways for supporting those who are prescribed medication with side effects that include deteriorating wellbeing and or suicidal thoughts. A concern for all is that such side effects may increase distress and reduce hope in the person if they interpret it as a deterioration of their presenting condition. It is therefore imperative the prescriber has clearly communicated the possibility of side effects to the person with clear advice to get back in touch for a medication review without delay if they feel their wellbeing is deteriorating.

To support that conversation the Foundation created a **Prescription Safe Plan**, an innovative key addition to the personal safety plan. The NICE Guidelines support this approach.

Choice of Medication

- The appropriate prescribing for common mental health conditions reduces the risk of suicide by effectively treating the mental illness and also reducing access to means.
- Avoiding venlafaxine or tricyclic antidepressants as higher risk of death in overdose.
- Avoiding benzodiazepines or antipsychotics to manage anxiety.
- Beware of concomitant use of analgesics or opiates especially if alcohol misuse present.
- Use of Consultant Connect service for GPs to get rapid advice on psychopharmacology from a specialist mental health pharmacist or psychiatrist where this is commissioned.

Medicines and Suicide Visual Aide Memoire

This visual too, kindly created by Derbyshire Healthcare Foundation Trust, can be used to support effective conversations between clinicians and patients or carers. It seeks to demonstrate the balance between clinical benefit and suicide risk.
Website link: **Medicines and suicide professional aide memoire**

Careful dynamic risk assessment is required and continuous mitigation of risk.
Medication reviews should include risk benefit assessments which should be recorded in the notes by GPs, and Mental Health workers and pharmacists.

Practical Tips for prescribers concerned about risk of suicide

- Changing from repeat to acute medication.
- Frequent review and limited supply.
- Entrusting carers to oversee the medication of patients who are actively suicidal.
- Close liaison between GP and pharmacist.
- Close liaison between GP and psychiatrist.
- Doses, quantities, medication reviews, and judicious use of 'repeat' prescribing are all areas which require practice policy but also individual tailoring to a patient's risk.
- Beware of stockpiling medication whether prescribed, bought or accessed from a family member. The latter may be deceased, particularly from suicide which raises the risk of an imitation suicide.

Safe *Deprescribing* (planned discontinuation) of Antidepressants

There is growing evidence that some patients find it very hard to discontinue antidepressants, and that the discontinuation effects can be debilitating and alarming. Therefore, it is vital that the person is fully informed by the GP and pharmacist on what to can happen and advised to get in touch with them if concerned. In some cases, very careful slow tapering is needed.

Studies show an increased risk of suicide in patients after initiation of an SSRI, but also following changes in the dose, and after discontinuation of an SSRI. Therefore, particularly close monitoring is needed during these periods.

Prescription Drug Dependency

In 2019 the Quality Outcomes Framework introduced Quality Improvement components including Safe Prescribing. The Prescription Drug Dependency QI module was introduced in 2022/23. There is concern that prescribing of certain medications in non-cancer patients causes prescription drug dependency . Patients on high doses of certain medications including opiates, gabapentinoids, benzodiazepines, and Z-drugs, need review. The primary aim of the QI PDD is to mitigate against dependency and adverse drug effects.

However, this group of patients, with pain and comorbidities, are also at high risk of depression, and many will also be on antidepressants. They are therefore vulnerable to suicide or accidental death by overdose particularly where alcohol is misused.

The GP and pharmacist use the medication review as an opportunity to assess the patient's mental health; and proactively enquire about any suicidal thoughts or plans.

References for Safe Prescribing

Common mental health problems: identification and pathways to care | Guidance | NICE

Preventing suicide in community and custodial settings | Guidance | NICE

Overview | Depression in adults: treatment and management | Guidance | NICE Overview | Self-harm: assessment, management and preventing recurrence | Guidance | NICE

Overview | Self-harm: assessment, management and preventing recurrence | Guidance | NICE

Suicide prevention: optimising medicines and reducing access to medicines as a means of suicide. NICE Key therapeutic topic KTT24
Link: www.nice.org.uk/guidance/ktt24

NHS Clinical Commissioners
Link: items-which-should-not-routinely-be-prescribed-in-primary-care

Suicide Risk Mitigation: BMJ Best Practice
Link: https://bestpractice.bmj.com/

Antidepressant discontinuation & risk of suicide attempt: a retrospective, nested case-control study

Withdrawing from SSRI antidepressants: advice for primary care | BJGP 2023

An introduction to quality improvement in QOF | QI Ready Learning Network (rcgp.org.uk)

C1 continued

Preventing Suicides through Personal Safety Planning

CR229 Self-harm and suicide in adults July 2020 College Report

Self-harm and suicide in adults (CR229) (rcpsych.ac.uk)

The role of the general practitioner

Along with emergency department staff the general practitioner is the professional most likely to be the first point of contact for those who have self-harmed or experienced suicidal thinking. Often the GP will have a good knowledge of the patient and their family background. The GP should aim to put the person at their ease, take an initial history and carry out mental state and appropriate physical examinations. The NCISH (2014) noted that mental illness was often recognised in primary care patients who later died by suicide. Indicators of risk in these patients include frequent consultations and prescription of multiple psychotropic drugs. The self-harm/suicidal ideation may be an indicator of a psychiatric disorder including depression, substance misuse and, less commonly, psychotic illness. In some individuals, the self-harm may be associated with psychological and social factors such as current or past sexual or physical abuse, relationship problems or financial concerns.

The GP must also be mindful of the potential risk to children being exposed to adults who self-harm. If the person presents with self-cutting the GP should establish when this started, its frequency, the parts of the body involved, and the effect on the patient, including its purpose in the control of painful emotions.

The GP should ask about specific triggers and whether the self-harm is becoming more frequent or escalating in severity. They should enquire about other self- damaging behaviours such as misusing alcohol or drugs. The patient should be asked for the key symptoms of depressive illness i.e., anhedonia, loss of energy, impaired sleep, appetite and concentration, and negative patterns of thinking. The GP should enquire about key relationships, those in whom the patient can confide, and how the person has coped at in previous times of distress.

On mental state examination it is important to assess the level of depression, your objective view as well as the person's subjective view. The GP should check the level of self-esteem, the presence of guilt, hopelessness, and suicidal ideation.

The consultation should conclude with an agreed follow up plan. This is likely to include a review by the GP, advice on how to obtain help, if necessary, before the review. For less severe cases, there may be a referral to counselling. If there is evidence of a mental illness, a prescription of medication may be appropriate.

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The importance of Safety Plans

A Safety Plan should be co-produced with the patient, who will identify most of the elements; if the patient is unable to articulate their wishes, or when their psychological pain and wish to die prevents them from effectively engaging safely, the clinician may have to take a more directive role. The Royal College of Psychiatrists believe that every person with suicidal thoughts or who has engaged in self-harm should have a Safety Plan.

Making a Safety Plan

A Safety Plan should be co-produced, is owned by the person, and comprises:

- Individualised strategies/activities to instil hope
- Calming/distracting activities
- Restriction of access to common means of suicide
- Contacts for social and crisis support

StayingSafe.net is an innovative digital solution to equip people to make a Safety Plan.

- Reasons for living and/or ideas for getting through tough times
  Reminders of positive aspects of life: photos of people, pets, or special places, favourite music

- Making your situation safer
  Remove things that could be used for self-harm or suicide - make it safer or store less

- Identify and avoid distress triggers

- Things to lift or calm mood – a calming activity is anything relaxing
  Meditation, yoga or looking at a photo of a great view or someone you care about
  Writing down feelings in a diary or a letter
  Calming thoughts such as about a special place or happy memory

- Distractions
  Anything that 'takes your mind away' from distressing feelings
  Distracting activities 'keeping you busy' (e.g., exercise, cooking, art, chores, connecting with meeting someone in person, via email phone call or text or on social media)
  Distracting via thinking 'keeping your mind busy' (e.g., music, puzzles, TV, YouTube, Films)

APPENDIX B
List of Resources that Support Primary Care Clinicians and Staff

SELF CARE

Personal Safety Plans for staff

There is always a need for self-care and self-compassion; and more so after a bereavement or loss of a patient or colleague to suicide.

Look at the freely available accredited suicide prevention website **www.stayingsafe.net.**

This website aids the creation of a **Personal Safety Plan** and is worth sharing, as a precaution, with every person who has suicidal thoughts as well those who have been bereaved by suicide.

Each individual healthcare worker is encouraged to create their own personal safety plan BEFORE any point of crisis or despair arises. This is especially true now with the added stressors caused by the current workforce and NHS critical pressures . Doctors and nurses are known to be at higher risk for suicide and no one is immune from thoughts of suicide when faced with significant emotional distress and repeated moral injury. It is not a sign of weakness, and it is vital to seek and find support from family, friends, and professionals.

The personal safety plan is a vital guide in times of despair.

Guide for staff

In 2023 a support booklet for all mental health professionals was created which is an excellent guide on how to manage the emotional impact and disenfranchised bereavement experienced.
If a patient dies by suicide for mental health professionals RCPsych 2023

Whilst there is as yet no comparable study of the impact of a patient suicide on the general practitioner and such research would be welcome. Despite the obvious differences between psychiatry and general practice, the guide for mental health practitioners is very valuable and relevant ;since in both cases it is about a human professional who has lost a patient for whom they were caring and had a relationship. There is a bereavement but often it is hard for oneself or others to validate that sense of loss; hence the term ‘disenfranchised bereavement’ is coined.

General Practitioners, clinical staff & managers may well find this resource very helpful.

LOCAL ORGANISATIONS

JUCD Joined Up Care Derbyshire

The Integrated Care System provides a range of resources to support the general wellbeing of Primary Care Staff can be found on the JUCD website.

Link: Staff support » Joined Up Care Derbyshire

Wellbeing - Your Self Care Pack » Joined Up Care Derbyshire

Local Medical Committees (LMC)

The local LMC provide an excellent list of available help including

Guidance for **Inquests** and access to the **GP-S Mentoring Support Scheme**

Website: **Derby & Derbyshire LMC: Wellbeing & Support**

Inquest support: **https://www.derbyshirelmc.org.uk/coronersinquestadviceforgps**

Specialist Commissioned Suicide Postvention and Bereavement Counselling

NEW & LOCAL

TOMORROW PROJECT

NEW & LOCAL

- for immediate and follow up help

Specialist commissioned support to help anyone manage a bereavement by suicide.

Any age. Any Derbyshire resident.

A suicide bereavement support officer will make contact and arrange to meet for on-going emotional and practical support.

Note: Available to any health care professional or GP for personal support.

Guidance and professional advice are also available to anyone concerned or caring for someone bereaved by suicide.

Self-referral or Professional referrals.

e-mail or Phone
bereavement.derbys@tomorrowproject.org.uk
0115 88 00 280 / 01246 541935

NATIONAL ORGANISATIONS

Professional Indemnity Organisations

The **MPS, the MDU** support doctors who face criticism or complaint. They are invaluable in helping with preparing statements and being fully prepared to attend a Coroner's inquest.

NHS Practitioner Health

Practitioner Health (PH) is a confidential NHS service for doctors in England and can help with issues relating to a mental health concern, stress or depression, or an addiction problem, where these might affect work. PH is not a service for individuals with mental health problems which require specialist psychiatric input though we can help provide additional support. PH is provided by health professionals who have additional expertise.

Telephone: 0300 0303 300 – 8am to 8pm Monday to Friday and 8am to 2pm Saturdays.
Website: **http://www.practitionerhealth.nhs.uk/**
Email: **prac.health@nhs.net**
Text: NHSPH to 85258 for the out-of-hours crisis text service

BMA wellbeing support services

This is a confidential, nationwide, non-stop 24/7 advice, counselling and peer support and relevant signposting service for doctors and medical students regardless of BMA membership, plus their partners and dependants. Provides help for doctors in difficulty, especially in relation to mental health problems and misuse of alcohol and/or drugs.

Helpline telephone: 0330 123 1245
Websites: **www.bma.org.uk/advice/work-life-support/your-wellbeing**
www.bma.org.uk/advice/work-life-support/your-wellbeing/counselling-and-peer-support

Support 4 Doctors – now hosted by the Royal Medical Benevolent Fund
Telephone: 0208 540 9194
Website: **www.rmbf.org**

DocHealth

A specialist paid for psychotherapeutic service for doctors supported by the British Medical Association and the Royal Medical Benevolent Fund. Self-referring doctors can access up to six face to face sessions with the service and further care can be advised. All doctors in the UK can self-refer to this service.

Website: **https://www.dochealth.org.uk/**
Telephone: 0207 383 6533
Email: **enquiries@dochealth.org.uk**

Doctors' Support Network

This network aims to provide support, reduce stigma, and campaign for better services for doctors with a range of mental health problems. "As doctors we are used to supporting patients' health and wellbeing, but we often neglect our own. Doctors have among the highest rate of mental health problems of any profession, but often feel isolated and unsupported."

Email: **info@dsn.org.uk** or complete online form confidentially.
Website: **www.dsn.org.uk**

The British Doctors' and Dentists' Group

This is a mutual support society for doctors and dentists who are recovering, or wish to recover, from addiction to or dependency on alcohol or other drugs. It provides venues to meet for confidential, mutual support and encouragement.

Telephone: 07825 107970
Website: www.bddg.org

The Sick Doctors Trust

This is a wholly independent and confidential organisation which offers support and help to doctors and medical students suffering any degree of dependence on drugs or alcohol. It offers early intervention, treatment, recovery and rehabilitation of affected doctors and their families

Helpline number: 0370 444 5163 (24 hrs)
Website: www.sick-doctors-trust.co.uk
Email: help@sick-doctors-trust.co.uk

Alcoholics Anonymous

Telephone: 0800 917 7650
Website: www.alcoholics-anonymous.org.uk

Narcotics Anonymous

Helpline telephone: 0300 999 1212 – 10am to midnight
Website: www.ukna.org

British International Doctors' Association

BIDA was established in the UK with the sole objective of promoting equality and fair treatment of all doctors working in the UK irrespective of race, gender, sexual orientation, religion, country of origin or school of graduation.

Telephone: 0161 456 7828
Website: www.bidaonline.co.uk (complete online contact form)

Samaritans

The Samaritans provides confidential non-judgemental emotional support, 24 hours a day for people who are experiencing feelings of distress or despair, including contemplating suicide.

Telephone: 116 123 (freephone for callers in UK)
Website: www.samaritans.org
Email: jo@samaritans.org (for emotional support)

Mental Health at Work

Advice and support for small businesses – relevant to GP partners and Practice Managers

Home – Mental Health At Work

Samaritans Helpline for Health and Social Care Staff

Wellbeing support line for health and social care workers | Samaritans (Wales only)

Joined Up Care Derbyshire

NHS

The Derbyshire VCSE sector Alliance

Derby City Council

DERBYSHIRE County Council