Dear Practice Managers 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. Nationally the rate is about 10 deaths per 100,000 population: with males comprising 75% of cases. Whilst suicide rates are higher in middle age overall, suicide is the commonest cause of death in young people.

The majority of people who die by suicide have been seen in primary care during their final year, and commonly even in the final month of life.

Bereavement by suicide is a risk factor for suicide in the survivor. This might be an imitation or copycat suicide or simply an act of despair due to the deep distress and complex grief. Postvention is an intervention that supports those bereaved by suicide. It is more than grief counselling as it includes secondary prevention of suicide.

The aim of this document is therefore to help the practice navigate the difficult aftermath of a suicide and in particular to raise awareness of the postvention interventions now available.

The current worldwide context of a pandemic adds significance to this topic. Surveys show an undoubted increase in the emotional distress population, yet early evidence has not found a rise in actual suicide rates to date. However, this could change, and we know that COVID-19 has not played out equally across communities. Preventing suicide in England: Fifth progress report of the cross-government outcomes strategy to save lives (publishing.service.gov.uk). With this in mind it is welcome news indeed that the government has launched its COVID-19 mental health and wellbeing recovery action plan (publishing.service.gov.uk).

After the death by suicide of a registered patient, there is typically a sadness and shock in the primary care team as they seek to understand what has happened and how to respond to the event. GPs and practice managers have expressed to me a desire to have a simple pack available to help them know the procedural steps they should follow in the aftermath of a suicide, in particular how to access specialist postvention support for the bereaved. The trauma is of course not limited to the immediate family, and so empathy and support should be offered to anyone who feels 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, finally, links to key National Organisations that offer resources to organisations including 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 may provide a stimulus to revaluating the practice policies and training program for staff.

So, whilst the focus of this booklet is suicide postvention, I would like to promote the offer of free Suicide Awareness and Prevention Training for GPs and Primary Care Staff.

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

**Sohrab Panday**
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JUCD Primary Care Mental Health Clinical Lead
General Practitioner Clay Cross Medical Centre
Suicide Prevention Trainer for Primary Care Derbyshire
National Suicide Prevention Alliance: Strategic Steering Group
A postvention is an intervention conducted after a suicide, largely 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 suicide survivor is anyone who experiences high levels of self-perceived psychological, physical and or social distress after the suicide regardless of the social relationship with the person.

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

NEW SERVICE: DERBY AND DERBYSHIRE NOW HAVE FREE ACCESS TO SPECIALIST POSTVENTION SUPPORT.

Acknowledgments
I would like to thank all the esteemed colleagues from the Derby and Derbyshire Self Harm and Suicide Prevention Partnership Forum, Derby & Derbyshire Local Medical Committee and Royal Colleges of Psychiatry and General Practice who have kindly offered their invaluable advice in producing this booklet.

Declarations of Interest
Salaried GP Clay Cross Medical Centre
Clinical Lead Derby and Derbyshire CCG
Suicide Prevention Trainer & Training Lead for Primary Care Staff in Derbyshire
INTRODUCTION

FIGURE 1: OVERVIEW FLOW CHART

(A) IMMEDIATE ACTIONS REQUIRED AFTER A SUICIDE

1. Serious Incident Report Form: Derby & Derbyshire Clinical Commissioning Group
2. GP Practice Management and Clinical Group Meeting and Response
3. Postvention & Support for the Bereaved Family & Friends

(B) SHORT TERM ACTIONS: REPORTS

1. Report for the Coroner
2. Information for the Mental Health Secondary Services Investigation Report

(C) MEDIUM TERM ACTIONS: PREPARING FOR THE INQUEST

1. Significant Event Audits: Suicide Prevention & Safe Prescribing
2. Postvention and Psychological Support for Clinicians
3. The Coroner’s Inquest

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

1. Suicide Prevention Training for Primary Care Teams & GPs
2. The Derbyshire Self-harm and Suicide Prevention Partnership Forum (DSSPPF)
3. Suicide Prevention Training for Primary Care Teams & GPs
4. Suicide Clusters & Response
5. The National Suicide Prevention Alliance NSPA
6. The Support after Suicide Partnership UK
7. Organisation Postvention after the death by suicide of a GP or work colleague

APPENDIX A: Serious Incident Notification Form

APPENDIX B: List of Resources that Support Primary Care Clinicians and Staff
**FIGURE 1: OVERVIEW FLOW CHART**

**KEY:**
- Immediate Actions
- Short Term Actions
- Medium Term Actions
- Longer-Term Actions
- LMC

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**Suicide or suspected Suicide Death**

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**Coroner**

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**Primary Care Immediate Actions**
- Small group meeting
- Serious Incident Form: Notify CCG within 72 hours
- Staff postvention
- Address System Concerns

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**Next of Kin and Family**
- Condolences
- Flag notes
- Appointment
- Refer for Specialist Postvention

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**Practice Audits**
- Practice Policy
- Staff Training
- Safe Prescribing

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**The Coroner’s Inquest**
- Preparation
- Attendance at Court
- Preparation & Support

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**Support for Clinicians Postvention**
- Inquest Preparedness

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**Longer-Term Actions: Ensuring a ‘Safer from Suicide’ Practice**

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**Mental Health Specialist Secondary Services Investigation:**
- GP input to report

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**Support for Clinicians Postvention**
- Inquest Preparedness

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**The LMC** has an integral part to play whenever the Coroner is involved and calls an Inquest – whether it be for a suicide or some other reason LMC alert practices to the case offering advice and support before during and after the inquest. See Derby & Derbyshire LMC: Coroner’s Inquest Advice for GPs.
1. Serious Incident Report Form: Derby & Derbyshire Clinical Commissioning Group

Every death by suicide should be reported to Derby and Derbyshire Clinical Commissioning Group (DDCCG) as per the requirements of the DDCCG Serious Incident Policy.

The aim of the Serious Incident Policy is to ensure that reportable incidents are appropriately managed within the CCG’s commissioned and co-commissioned services. This is so that they can maximise learning, prevent reoccurrence, remove unwarranted variation, improve services, address the concerns of patients, and promote public confidence.

Upon notification of a suicide, the CCG patient safety team will liaise with the practice to review care of the patient in the preceding months to identify if further investigation is needed. The practice needs to provide information to the CCG as below.

Practices should report suicide or self-inflicted death to the CCG patient safety lead within 72 hours of the notification of the suicide.

Serious Incident Notification Form (Appendix A) should be submitted to ddccg.patientsafety@nhs.net

The existing Serious Incident Framework is likely to be changing over the next couple of years (probably 2022) into a Patient Safety Response Framework (PSIRF), and so the information above will need amending when this happens.

Website link: https://www.england.nhs.uk/patient-safety/serious-incident-framework/

2. GP Practice Management and Clinical Group Meeting and Response

In conjunction with the creation of the above report a meeting should take place within a few days that includes the practice manager and those 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. This meeting can quickly glean information about what happened and establish what further information needs to be sought. It is an opportunity to share the understandable emotional shock and sadness that may be felt, and to agree on the next steps and support that can be offered.
It is important to have a non-judgemental approach to individuals, whilst being open to learning ways in which the organisations can be improved. Most commonly, where improvements are identified, it is in the ways in which organisations communicate with each other. If any system errors are identified immediate corrective action is essential.

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 experience of suicide in a family member, relative or someone close to them socially.

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

3. Postvention & Support for the Bereaved Family & Friends

It is usually a good idea to reach out to the family when they are registered at the practice. This is a sensitive issue 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, but also consider offering appointments to those who feel they need psychological support. Remember that bereavement from suicide leads to complex grief and is sadly a risk factor for suicide itself. It is important to mitigate the risk of an ‘imitation’ or ‘copycat’ suicide. So, it is important to think about the risks and safety of those most affected both immediately after the event and particularly around the time of birthdays, holiday periods and key anniversaries.

A memo of the bereavement by suicide and date on the notes keeps staff alert during contact.
Resources and Support for those bereaved by a suicide include the following:

**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.

**The Tomorrow Project - for immediate and follow up help**
This Project provides a variety of support to help someone manage their loss up to one year after the death. There is no age restriction to access the service. A suicide bereavement support officer will make contact and arrange to meet for on-going emotional and practical support. The Project provides support and information during and at the Inquest. The CCG have commissioned this service for any resident of Derby and Derbyshire.

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

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

**Referral:** Any person can self-refer, or referrals can be made professionals.

**e-mail:** bereavement.derby@tomorrowproject.org.uk

**Phone:** 0115 88 00 280 / 01246 541935
(9:30 am to 5 pm; Monday to Friday)

**Help is at Hand Booklet**
This excellent free PDF document is freely downloadable for immediate guidance to people bereaved by suspected suicide.

**Website link:** [HIAH_Booklet_2021_V5-1-2.pdf](supportaftersuicide.org.uk)

**Cruse Bereavement Care**
This is a free, confidential bereavement support service available to the public.

**Helpline:** 0808 808 1677
**Website link:** [Coping when someone dies by suicide | Cruse Bereavement Care](https://www.cruse.org.uk/how-to-help/coping-when-someone-dies-by-suicide)

**Hope Again – Cruse Bereavement Care for Young People and Children**
This is a website created for young people, by young people. It offers an online support, advice, and signposting, specifically to young people who have lost a loved one.

**Website link:** [Hope Again](https://www.cruse.org.uk/how-to-help/hope-again-for-young-people-and-children)

**Winston’s Wish**
Winston’s Wish provides support to children and young families bereaved by suicide, as well as to the professionals who help them.

**Helpline:** 0808 802 0021 National Freephone
(9am to 5pm; Monday to Friday)

**e-mail:** ask@winstonswish.org

**From Grief to Hope**
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*.

**Website link:** [From-Grief-to-Hope-Report-FINAL.pdf](supportaftersuicide.org.uk)

**Survivors of Bereavement by Suicide (SOBS)**
SOBS specialise in provision of peer support specialist suicide support for those bereaved by suicide and can be accessed through support groups, a national helpline, e-mail, and online forums. People refer themselves by contacting their local support group.

**e-mail:** email.support@uksobs.org

**Helpline:** 0300 111 5065
(9am- 9pm; Monday to Sunday)

**Website link:** [https://uksobs.org/we-can-help/local-support-groups/find/](https://uksobs.org/we-can-help/local-support-groups/find/)

**PAPYRUS**
has developed a guide to suicide prevention, intervention and postvention in schools and colleges, aimed specifically at teachers as well as school or college staff. It aims to equip teachers with the skills and knowledge necessary to support schoolchildren who may be having suicidal thoughts.

**Website link:** [#SaveTheClass | Papyrus UK | Suicide Prevention Charity](papyrus-uk.org)
1. Report for the Coroner

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.

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.

As part of this review, **DHCFT may ask the GP if they would like to contribute to the process.** This usually involves an invitation from the lead reviewer to share any information that the GP may consider relevant to the person’s care.
1. Significant Event Audits: Suicide Prevention & Safe Prescribing

After reviewing a **Serious Incident** or ** Significant Event** concerned 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 can prove supportive when presenting evidence at the subsequent **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. **Significant Event**
- **Non-Suicidal Self Injury (NSSI)**: self-injury without suicidal intent.

Practices can contact the DDCCG Patient Safety Team on the email address [ddccg.patientsafety@nhs.net](mailto:ddccg.patientsafety@nhs.net) with any queries; for example, if uncertain about how to proceed with any investigation or for general enquiries linked to patient safety.

Firstly, it would be 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. The essence of prevention is therefore about awareness of risk and risk mitigation.

**‘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 under any mental health specialist care preceding their death by suicide. These include polypharmacy of psychotropic, hypnotic, and analgesic medication; 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.

Thus, opportunities exist within Primary Care Teams to ensure psychotropic medication is only prescribed after a documented diagnosis and offer of psychological talking therapy. Increasing frequency of attendance was related to risk of suicide so could be a useful warning to clinicians to proactively enquire about suicide.

**Website links:**

Primary care contact prior to suicide in individuals with mental illness | British Journal of General Practice ([bjgp.org](https://bjgp.org))

SuicideinPrimaryCare2014.pdf ([manchester.ac.uk](https://manchester.ac.uk))
Audits related to Suicide Prevention by Safe Prescribing

Poisoning is the second most common cause of death by suicide. Whilst there are other methods by which one may attempt suicide, overdose by prescribed medication is directly influenced by the prescriber. The prescribing of benzodiazepines, Z- drugs, tranquillisers, antidepressants, and opiates always come with some degree of risk.

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.

Medicines and Suicide Visual Aid
• Created by DHCT this simple visual aid aims to support effective conversations between clinicians and patients or carers. It comprises a visual aid demonstrating clinical benefit versus suicide risk. Website link below:
  Medicines_and_suicide_professional_aide_memoire.pdf (derbyshirehealthcareft.nhs.uk)

Careful dynamic risk assessment is required and continuous mitigation of risk. Check the regularity of recorded risk by GPs and staff and practice 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.

Resources:

NICE Pathways
Common mental health disorders in primary care overview - NICE Pathways

NICE DO NOT DO Guidance
Do not use risk assessment tools and scales to predict future suicide or repetition of self-harm. I NICE

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

Items which should not be prescribed in Primary Care:
NHS Clinical Commissioners
Website link: items-which-should-not-routinely-be-prescribed-in-primary-care-v2.1.pdf (england.nhs.uk)

Suicide Risk Mitigation:
BMJ Best Practice
Website link: https://bestpractice.bmj.com/topics/en-gb/3000095
Audits related to Practice Protocols and Staff Training Audits

Ensure there is a practice protocol for dealing with people who are distressed and expressing thoughts of suicide when they present requesting help. This should include requests for help from concerned members of the family or friends. Reasonable adjustments should be considered to enable access to healthcare for people with a mental condition.

Look at the freely available accredited suicide prevention website [www.stayingsafe.net](http://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 might reasonably consider creating their own personal safety plan especially with the added stressors caused by the COVID-19 pandemic. Doctors and nurses are known to be in at higher risk for suicide and no one is immune from thoughts of suicide when faced with significant emotional distress.

NB The use of the Stayingsafe.net Website is free to all staff and patients.

Staff Training Audit

Regular training appropriate to the role of their staff should be kept under review.

To obtain free training for GPs or staff simply contact via email on dhcft.primarycareeducation@nhs.net

SAFETool Triage Toolkit Audit

If a Primary Care Team has received training from using the Connecting with People Training (CWP) Modules, then clinical staff are able to use the SAFETool Triage Toolkit.

NB SAFETool should only be used to assist staff who have received CWP training.

SAFETool is available as a Template on SystmOne Pathfinder (F12).
2. Postvention and Psychological Support for 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 A3 above for details).

**Coroner’s Inquest support**

Section C3 below describes the Support and Advice for GPs regarding a Coroner’s Inquest. It includes a flowchart illustrating the key processes pertaining to an inquest.
**The impact of suicide on clinicians**

Suicide can have a profound impact on Health Care Professionals.

**Psychiatrists**

A booklet for and about psychiatrists who are dealing with a patient’s suicide has been created by Professor Keith Hawton and the Centre for Suicide Research, University of Oxford, 2020.

It can be found at the following weblink: [when-a-patient-dies-by-suicide-a-resource-for-psychiatrists-2020.pdf](rcpsych.ac.uk)

It is a qualitative study of the human responses and emotions described by psychiatrists after a suicide.

Feelings of responsibility are quite common and normal and include the following:
- Sadness
- Anxiety
- Guilt
- Shame
- Anger
- Fear
- Feeling blamed by others for the death
- Feeling responsible for the death

The booklet offers psychiatrists advice on how to self-care after a patient has died by suicide.

**General Practitioners experiences of dealing with parents bereaved by suicide.**

A qualitative study interviewed GPs who were involved in discussing the suicide of a young person with the person’s parents.

Website link: [https://bjgp.org/content/66/651/e737/tab-article-info](https://bjgp.org/content/66/651/e737/tab-article-info)

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 guilt following a suicide and a 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 refer parents to, GPs also require formal support and supervision around significant events such as suicide. Results from this qualitative study have informed the development of evidence-based suicide bereavement training for health professionals.

Please see below the website link to PABBS Training on Postvention relevant to GPs.

[Postvention Assisting those Bereaved By Suicide (PABBS) Training - Now CPD Accredited - Suicide Bereavement UK](https://suicidebereavementuk.com)
3. The Coroner’s Inquest

The process of an Inquest can be rather a 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, in undertaking that act, had the intention of suicide. Where there are contributory factors that need to be explained, 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.

The Support for the Bereaved Family & Friends is covered in Section A3 above.

The PDF documents for The Coroners Inquest Advice for GPs and also The Coroners Pathway can be accessed from the following link:

Derby & Derbyshire LMC: Coroner’s Inquest Advice for GPs

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 are invaluable in helping with preparing statements and being prepared fully to attend the coroner’s court.

The Coroners Courts Support Service (CCSS) is an independent voluntary organisation whose trained volunteers offer emotional support and practical help to bereaved families, witnesses and others attending an Inquest at a Coroner’s Court.

This is available to both bereaved family, friends and clinicians called to witness.
Website link: Home - Coroners Courts Support Service
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. The Connecting with People (CWP) approach

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 skills.

NB: 4 Mental Health Limited is the parent company of CWP.

The Suicide Prevention for Primary Care Module comprises two sections which are usually delivered together consecutively over 3 hours, face to face. Delivery has changed to online training during the pandemic restrictions.

Part 1 Suicide Awareness (for all grades of staff) 1.5 hours
Part 2 Suicide Response (for clinical staff of all types) 1.5 hours

The CWP Training for Primary Care Teams in Derbyshire began in 2017 and by early 2021 over 600 staff and GPs had received face to face training within their practice teams. Locally, the training has been delivered by small group of Derbyshire GPs. It is free to practices and commissioned by Public Health.

The feedback so far has been overwhelmingly positive. Participants report the training and materials used were much needed, relevant to everyday practice, and increases their confidence and knowledge significantly. Furthermore, feedback has shown that the peer-to-peer approach has been popular and added credence to the training. It was recognised nationally as an example of good practice by the Health Service Journal Award - finalist in 2018 (Innovation in Primary Care Section).

COVID-19 restrictions have led to the training being adapted, so that virtual online modules are now also available. The aim remains to train the entire primary care workforce in Derby City and Derbyshire County.

To book free CWP training please contact e-mail: dhcft.primarycareeducation@nhs.net
To discuss training feel free to contact Dr S Panday; e-mail: spanday@nhs.net
1b. Health Education England Resources

Website link: Self-harm and suicide prevention | Health Education England (hee.nhs.uk)

Topics include:
- Self-harm and suicide prevention frameworks
- Learning resource: ‘We need to talk about suicide’
- e-Learning for Healthcare and MindEd resources:

‘Postvention Support for Staff and Organisational Response’
In this session learners have the opportunity to deepen their understanding of the impact of bereavement by suicide on family, colleagues, and friends, by following the story of two people affected by a suicide.

Three existing sessions cover issues related to self-harm, making an assessment, and therapeutic consultation competencies. A further 2 sessions on assessment and formulation, and structured care and intervention, including safety planning will be available soon. (Information from HEE Website: 02.03.2021)

1c. Derbyshire County Council Suicide Prevention Website and Training

Derbyshire County Council hosts a suicide prevention website which has a wealth of useful information and resources and training opportunities can be found here.

Website link: Suicide prevention - Derbyshire County Council

**General Information on Suicide Prevention**
- Crisis Help Links
- What you can do to help someone who is feeling suicidal
- Spot the signs
- Conversation starters

**Training Opportunities for the Public and Practice Staff**
Overall Guide: Website link: Mental health training - Derbyshire County Council

- Mental health awareness: staff and volunteers who are in public-facing roles.
- Website link: Mental health awareness course (derbyshire.gov.uk)
- Mental health first aid: staff in contact with vulnerable people; youths or adults.
- Website link for Adult MHFA: Mental health first aid (derbyshire.gov.uk)
- Website link for Youth MHFA: Youth mental health first aid (derbyshire.gov.uk)
- Suicide Awareness and Prevention: provided by Rural Action Derbyshire for staff likely to be in contact with vulnerable people or people who suffer mental illness.
- Website link: Suicide awareness and prevention course (derbyshire.gov.uk)

1d. The Zero Suicide Alliance 20-minute online training available to all NHS staff

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

Website link: ZSA Full Training (relias.co.uk)
1e. Psychological First Aid (PFA) digital training module e-learning

Website link: Psychological First Aid (PFA) digital training module for Adults

This course has been updated by Public Health England and is aimed at all frontline and essential workers and volunteers. The course teaches the key principles of giving psychological first aid in emergencies and aims to increase awareness and confidence to provide this support to people affected by COVID-19. PFA is a globally recognised training in emergency situations and PHE has been developed this new course as part of their national incident response, and in partnership with NHS England, Health Education England, FutureLearn and others.

The course is free, and no previous qualifications are required. By the end of the course, outcomes will include understanding how emergencies like the COVID-19 pandemic can affect us, recognising people who may be at increased risk of distress and understanding how to offer practical and emotional support. The course takes around 90 minutes to complete and is also available in 3 sessions for the learner to complete at their own pace.

Website link: (PFA) digital training module for supporting children and young people

This is written specifically for those who work with or come into contact with children and young people. The course is available for all frontline workers such as teachers, health and social care workers, charity and community volunteers and anyone who cares for or is regularly in contact with children and young people aged up to 25, including parents and caregivers. It is free, takes about 3 hours to complete (split into three sessions that the learner can complete at their own pace) and no previous qualifications are required.

1f. Postvention Training for Health Care Professionals

See Section 6 below on training by the SAP 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 I Health Education England (hee.nhs.uk)

**NEW & LOCAL**

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 effectively explore and understand the following:
- The magnitude of suicide bereavement
- Suicide loss as a unique form of complex bereavement
- ‘Complicated grief’, trauma, and other individual responses to suicide
- The wider impact of bereavement on those exposed to or affected by suicide
- The stigma and shame associated with suicide and bereavement
- Bereavement by suicide as a unique risk factor for suicide
2. The Derbyshire Self-harm and Suicide Prevention Partnership Forum (DSSPPF)

The DSSPPF 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 Health Suicide Prevention Team, e-mail: ASCH.Suicide.Prevention@derbyshire.gov.uk

3. Public Health Real Time Suicide Surveillance

In Derbyshire we have a system to monitor 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.

A report on Deaths From Suicide and Injury of Undetermined Intent is produced annually. The link to the Derbyshire Observatory is as follows: https://observatory.derbyshire.gov.uk/life-expectancy-and/suicides/

Public Health are working towards more frequent and locality reports on suicide and self-harm data to assist Primary Care Networks in mitigating the risks.

Information on suicide prevention in Derbyshire can be found here: Derby & Derbyshire - Emotional Health & Wellbeing (derbyandderbyshireemotionalhealthandwellbeing.uk)
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.

A potential suicide cluster is usually detected by the public health real time surveillance of the Derbyshire Observatory (Section D3). It is then the responsibility of the Suicide Prevention Multiagency Partnership (Section D2) to respond via a Cluster Response Core Group. The response will be based on a preprepared plan of action.

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 (publishing.service.gov.uk)
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: https://www.nspa.org.uk/

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)

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.

Website link: https://supportaftersuicide.org.uk/ which 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-FINAL.pdf (supportaftersuicide.org.uk)

PABBS evidence-based training which equips professionals including General Practitioners to deal with postvention effectively and confidence. See below website link: Postvention Assisting those Bereaved By Suicide (PABBS) Training
7. Organisation Postvention after the death by suicide of a GP or work colleague

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

Sadly, although suicide is rare overall, there is an increased risk in doctors and nurses. The impact is of course profound and being prepared helps.

‘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.pdf](Responding_to_the_death_by_suicide_of_a_colleague_in_Primary_Care.pdf)

‘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 and it can be found here: [Crisis Management In The Event Of A Suicide: A Postvention Toolkit For Employers](Crisis_Management_In_The_Event_Of_A_Suicide:_A_Postvention_Toolkit_For_Employers)
APPENDIX A

Serious Incident Notification Form

The Serious Incident Notification Form is illustrated below.

The Word Document version can be obtained in one of several ways as follows:

1. Downloading it from the secure DDCCG Intranet site for Practice Reporting of Incidents accessible only from authorised NHS computers. The link is here: http://intranet.derbyandderbyshireccg.nhs.uk/practice-area/reporting/incident-reporting/

2. E-mailing DDCCG Patient Safety at: ddccg.patientsafety@nhs.net

3. Contacting James Barker: Patient Safety Lead
   NHS Derby and Derbyshire Clinical Commissioning Group
   M: 07826 951 915 during workdays 08:00 - 16:00 hours
   E: jamesbarker@nhs.net

The completed form needs to be e-mailed back to the DDCCG Patient Safety Team at: ddccg.patientsafety@nhs.net within 3 working days if possible.
APPENDIX B

Comprehensive list of support options available to Clinicians

Joined Up Care Derbyshire
A range of resources for the general wellbeing of Primary Care Staff can be found on the JUCD website.
Link: Your wellbeing during the pandemic:: Joined Up Care Derbyshire

Professional Indemnity Organisation
e.g. MPS MDU offer support to doctors who face criticism or complaint. They are invaluable in helping with preparing statements and being prepared fully to attend the coroner’s court.

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

Local Medical Committees (LMCs)
The local LMC provide an excellent list of available help including access to the GP-S Mentoring Support Scheme
Website: Derby & Derbyshire LMC: Wellbeing & Support

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 and treatment for doctors addicted to alcohol or other drugs and helps with the 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
The British International Doctors’ Association (BIDA) was established in the United Kingdom with the sole objective of promoting equality and fairness for all doctors and dentists working in the UK. BIDA’s mission is to achieve equal treatment of all doctors and dentists based on their competence and merit 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)