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"Quite simply they don't communicate": a case study of a National Health Service response to staff suicide

Ann Luce , Georgia Turner, Lauren Kennedy, Reece D Bush-Evans

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Department of Communication and Journalism, Bournemouth University, Poole, UK

Correspondence to
Dr Ann Luce, Bournemouth University, Poole, BH12 5BB, UK; aluce@bournemouth.ac.uk

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ABSTRACT

Workplace suicide can have significant knock-on effects within an organisation, yet research has shown within the healthcare profession, not all staff receive suicide prevention training, and few employers take the time to reflect on the need to change workplace policies or practices following the death of a staff member to suicide. How staff suicide is communicated across an organisation and to family members is important. Effective crisis communication is critical for effective management for a timely and sensitive response to a staff suicide within an organisation. By doing so, workplaces can help to reduce the significant emotional trauma suicide can have on an employee, and support good mental health across its workforce. This study aimed to explore and understand the communication processes around staff suicide across a National Health Service (NHS) Trust and to provide recommendations based on these findings. Semi-structured interviews were conducted with 29 participants, each lasting approximately 90 min. The Consolidated Criteria for Reporting Qualitative Research (COREQ) guidelines were followed. Thematic analysis was used to analyse the data, resulting in seven themes being identified based on communication. Findings indicated that the Trust had no clear communication strategy in place for tackling staff suicide. Each suicide was handled differently, training across staff roles was lacking and operational procedures were deemed insensitive. This paper aimed to provide insight into the communication strategies used in the aftermath of a staff suicide. These findings highlight the inconsistency of the communication, lack of clear policy and guidance and the negative impact this had on staff. Further research is needed across NHS Trusts nationwide to gain insight into the current communication strategies in place to develop a national approach to clear communication following the death of an NHS worker to suicide.

Tweetable abstract: Effective communication is critical in the aftermath of an NHS staff suicide. By doing so, NHS Trusts can help to reduce the trauma suicide can have on an employee and support good mental health across its workforce @stann2.

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BACKGROUND

Globally, around 700 000 people die by suicide each year, according to WHO (2021). Suicide rates and suicidal ideation among clinicians and healthcare workers are higher than in the general population (Patel, Swift, and Digesu 2021, 1055–59). Healthcare professionals have been found to have an elevated risk compared with other occupational groups (Alderson, Parent-Rocheleau, and Mishara 2015; Office for National Statistics 2021, 91–101). Based on these rates, the National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH), the UK's leading research programme into suicide prevention in clinical service, recommended the development of a dedicated mental health service for nurses and frontline healthcare professionals across organisations (NCISH 2021).

Research on the impact of suicide has largely focused on family members, however Cerel *et al*. (2014) found over 80% of studies reported an increased suicide risk in non-family members exposed to suicide. There is also growing evidence that exposure to suicide in a workplace is associated with significant emotional trauma and poor mental health (Aldrich and Cerel 2022, 23–37). Maple *et al*. (2018, 275–82) highlighted the need for postvention services to stay alert to the needs of non-family members such as friends and colleagues.

Despite the development and early implementation of guidance and workplace toolkits when dealing with staff suicide, Waters and Palmer (2022) found employee suicides are still largely treated as individual mental health problems that have no direct relevance to work or the workplace. Given this, this study aimed to investigate, using semi-structured interviews, how an NHS workforce in the South of England communicated with staff in the aftermath of 11 suspected staff suicides. Specifically, the timeline of the communication processes, alongside the effectiveness or limitations of existing communication strategies, will be explored. An output of the study was to create a Postvention Communication Strategy Model (online supplementary appendix A).

Communicating a suicide

One of the highest priorities for an organisation in a suicide response, like any critical incident, is to contain the crisis. Crisis communication is the communication process used to address those affected following a crisis, typically involving informing staff of the incident and providing details of available help and guidance (Millar and Heath 2004). Effective organisational communication in response to suicide stands to bridge the gap between management and employees; however, poor communication can result in misinterpretation and uncertainty (Kim 2018, 451–75). Clear communication strategies are crucial for a timely and sensitive response to a staff suicide within the healthcare workforce.

Taking a constitutive approach, communication within a workplace is what underpins the

organisation itself, rather than acting as a function developed by the organisation (Putnam and Nicotera 2009). In these terms, organisational communication should be recursive in nature, an evolving process encompassing the impact of the workplace, individuals and interests of an organisation (McPhee and Zaug 2009, 21). When considering crisis management, communication strategies should be at the core of any policy development (Seeger 2006, 232–44). According to WHO (2017), it is important that suicide is not discussed or communicated about dramatically or sensationally, and it should never focus on the means or location of death. Stigmatisation and negative perception around mental health have been found to negatively impact how a person is viewed and can act as a significant barrier to seeking mental health treatment, consequently putting them at greater risk of suicide (Sickel, Seacat, and Nabors 2014, 202–15; Oexle, Feigelman, and Sheehan 2020, 248–55). Those bereaved by suicide have also reported feelings of associated-stigma and self-stigma (Sheehan *et al*. 2016, 330–349). Inappropriate or careless use of language can sensationalise, depersonalise or glorify death, as well as cause harm to those bereaved by suicide (Luce 2019).

Where research does explore workplace responses to suicide, it is repeatedly noted that open communication helps to destigmatise suicide, reduce feelings of isolation and can provide a space for workers to voice their grief-related needs (Ting *et al*. 2006, 329–41). Miller *et al*. (2017, 563–570) identified compassionate communication within the workplace as beneficial to staff members. The use of compassionate language, understanding the emotional needs of the workforce and appropriately structuring the work environment was beneficial. Workplaces can also benefit from encouraging and supporting interpersonal activities such as group communication following suicide loss (Levi-Belz *et al*. 2014, 74–87). Importantly, leadership in times of crisis can reinforce and build trust, confidence and workplace cohesiveness. Feeling cared about and supported in the immediate aftermath of a traumatic event is important in the healing and recovery process (Harrington-LaMorie *et al*. 2018, 143–54). In contrast, an unsupportive and unstructured workplace response that lacks clear communication can result in feelings of increased distress (Finlayson and Simmonds 2019). Consequently, by not responding appropriately, the overall impact of the traumatic event is magnified (Suicide Prevention Resource Center n.d).

Suicide communication within an NHS Trust

When considering what an organisation needs to provide in terms of communication following a staff suicide, research has highlighted various necessities. Waters and Palmer (2021) identified that organisational responses to suicide were inconsistent, with no set protocol for employers to follow. A lack of management mental health training, understanding and sensitivity to mental health issues following a suicidal death, the actual support provided as well as communication, employer response and employer responsibility were all criticised for being unsupportive and lacking clear protocols, following the suicide of a colleague. Similarly, Gorton *et al*. (2019) found pharmacy staff reported receiving little to no training about suicide prevention, relying on personal experience to support patients, further highlighting the need for evidence-informed training programmes to develop strong communication strategies, and understanding of mental health and suicide. Experiencing the suicide of a friend or colleague can result in associated trauma or reopen past feelings (Pitman *et al*. 2017). Given the vital role organisations and management teams have when dealing with the aftermath of a suicide, running training programmes, reflective events and understanding the knock-on effect a suicide has in a workplace can be particularly beneficial (Gerada 2019).

Given the associated impact of suicide, supportive crisis communication within a workplace is essential. Healthcare organisations are situated within critical sectors and often operate during crises (Chen *et al*. 2022), therefore ensuring healthcare organisations use crisis management models in times of crisis is essential. Such models are founded based on crisis communication, essentially what an organisation's response is following a crisis (Coombs 2010, 17–53). When developing crisis management models, a workplace needs to ensure it has sound guidelines that consider what message is being delivered and the organisation's reputation and the emotional impact and intentions of those receiving the communication (Coombs and Holladay 2023, 165).

In recognising the importance of addressing the high suicide rates among NHS staff and increasing the support available for healthcare staff within NHS Trusts (a healthcare organisational unit serving a specific geographical area of function, eg, mental health/acute care), both prevention and postvention strategies have become one of the top priorities for workplaces. In the UK, the Office for Health Improvement and Disparities (OHID, formerly Public Health England (PHE)) and national mental health charities have created a series of policies and workplace toolkits aimed at reducing deaths by suicide and to provide postvention support guidance (Office for National Statistics 2021; Public Health England 2016; Mental Health Taskforce to the NHS England 2016; Business in the Community 2022). Based on these prevention strategies, NHS services have already increased staff access to well-being support through counselling or advice on well-being, however, this access can vary greatly across different NHS trusts (Pagel and Palmer 2021). Even recently, an NHS-commissioned report looking into suicide among nurses suggested that staff need to be provided with education about sources of support, alongside a standardised communication strategy to be used across organisations following a staff suicide (Lascelles, Groves, and Hawton 2022).

Given the frontline work required by healthcare professionals, they must have the support of their profession and healthcare organisation to maximise their ability to care for themselves and their patients (Lemaire and Wallace 2017). This support needs to be communicated following a crisis and should emerge from a strong communicative underpinning held within the structure of the organisation (Coombs and Holladay 2023, 165). Having an effective workplace response following a suicide, using a public health framework for postvention service delivery, designated support teams and protocols providing accurate information about the death of a colleague and an understanding of the continued emotional needs required across multiple areas of an organisation is required (Kinman and Torry 2021, 171–73).

As part of an organisational response to a staff suicide, this seminal study aims to explore and understand the communication processes in place following suspected staff suicide within an NHS workforce. Specifically, the timeline of the communication processes, alongside the effectiveness or limitations of existing communication strategies, will be explored.

METHOD

This study was commissioned following the death of 11 Trust employees and/or former employees between 2019 and 2021. This number was provided to the researchers by the Trust's Human Resources department following a wider consultation of

key stakeholders across the Trust. A suspected staff suicide was linked to each of the five Directorates within the Trust, which included both frontline medical staff, as well as professional and administrative services.

Research question: What were the communication processes around staff suicide across the Trust?

Data collection

Participants were recruited using both purposeful sampling, a non-probability sampling method where the researcher relies on personal judgement when choosing members of a population to participate (Benoot, Hannes, and Bilsen 2016) and snowball sampling, where one participant recommends another until the sample snowballs to a large number of respondents (Naderifar, Goli, and Ghaljaie 2017). Participants included senior members of staff and a variety of teams affected by suspected suicide within the Trust, including mental health nurses, consultants and allied health professionals.

Twenty-nine participants (20 females, 9 males) were recruited from an NHS Trust in the South of England. Semi-structured interviews were conducted via Microsoft Teams, each lasting approximately 90 min. The interviews were audio recorded and transcribed. Participants were initially informed about the aims of the study and were informed of their right to withdraw. The interviews took place between June 2021 and December 2021. Data were collected until saturation had occurred. Data saturation is reached when no additional data are being found, whereby the researcher can develop properties of the category (Bernard and Ryan 2009). It is generally believed in social science that most themes are identified within 10 in-depth qualitative interviews, and no new themes are identified after about 20, with the saturation of categories occurring within 15–30 interviews (Hagaman and Wutich 2017, 23–41). Based on the aims of this project, the researchers became empirically confident that saturation of categories was reached.

Data analysis

Following the interviews, reflective thematic analysis (Braun and Clarke 2019, 589–97), an inherently flexible interpretive approach to qualitative data analysis for applied research (Byrne 2022, 1391–1412), was used to explore and understand the communication processes around staff suicide in the Trust. Based on the six stages set out by Braun and Clarke (2019), the principal investigator and research assistant initially familiarised themselves with the data by immersing themselves in the transcripts and becoming aware of meaningful units of text. Second, initial codes were generated by each researcher independently. Once all the data were coded, initial codes were reviewed and interpreted to develop themes and subthemes. Construction of these themes was based on the main issues as informed by emergent issues raised by participants highlighted through the coding process, and recurrent points seen through the interviews. Following best practice within qualitative research, coded transcripts were then compared by the researchers for reliability (Thomas and Harden 2008) with any disagreements discussed thoroughly. Once themes had been reviewed, named and defined, the analysis was written up to show the analytic narrative and data extracts.

Ethics

Participants approached for interviews were informed they could decline to be interviewed. Each participant was sent a participant information sheet outlining the nature of the research and to reassure participants of confidentiality and anonymity, as well as asked to sign and date a participant agreement form. Participants' well-being throughout the process was the priority, and as such, they were informed of their right to withdraw and were provided with details of support services if they felt this was needed. All participants agreed to have the interview recorded for transcription purposes. Patients or the public were not involved in the design, or conduct, or reporting, or dissemination plans of our research.

This manuscript has been prepared under the Consolidated Criteria for Reporting Qualitative Research guidelines (Tong, Sainsbury, and Craig 2007, 349–57) (online supplementary appendix A).

Table 1 Years of experience within the Trust, and occupational backgrounds

Years of experience	
<10	13
10–19	7
20–29	6
>30	3
Role/Profession	
Mental health nurse	9
Other staff groups (advanced practitioner, healthcare assistant, occupational therapist, physiotherapist)	10
Human resources, information technology, organisational development, pensions and payroll	10

RESULTS

The occupational backgrounds of participants are shown in table 1.

From the interviews conducted, seven themes emerged based on staff experiences of the communication processes in place and workplace handling following a suspected staff suicide:

- Hearing about a staff suicide
- First steps in the communication process
- Social media and WhatsApp
- Operational processes and procedures
- Communicating with family
- Communicating with patients
- Training

Overall, the interviews conducted highlighted the lack of a clear communication strategy for tackling staff suicide within the Trust.

Hearing about a staff suicide

Staff within the Trust reported multiple ways in which they heard about a suspected staff suicide. Some were called at home, some received voicemails with limited information and others left messages on their desks. Some team leaders took it on themselves to ring each team member individually, which was appreciated by their staff, although emotionally taxing for the manager.

> I came into the office and on my desk was just a written hand note saying to cancel XXX's diary and that XXX would explain more. P7, L55–57.
>
> … it had been quite a convoluted trail to come through before I learned about it, and I'm a senior leader in the Trust. P25, L127–128.

Some staff received information from their deceased colleague's best friend, family members and relatives. Some members of staff, like the Pensions team or Human Resources team, often learnt of a suspected staff suicide through email from a manager,

a member of the senior leadership team or the 'Leaver's Form' (an employee leaver form is a detailed form completed by line managers when an employee leaves their post).

> I've probably found out about it via various kind of routes. So sometimes I've been contacted, by the manager, kind of directly, or sometimes it's been fed up, or fed down to me by more senior colleagues, so perhaps kind of more the Executive have been notified and had awareness, and then it's got kind of filtered down? P24, L190–193.

Interview participants critiqued the lack of clear communication structure around a staff suicide:

> Quite simply they [the Trust] don't communicate. There's a little bit that comes in dribs and drabs with the teams, it's localised to the teams that find out either through personal connections outside of work or dribs and drabs in the workplace. It's hashed up. P6, L188–196.

First steps in the communication process

At this point in the communication process, the Trust now knows that a member of staff has died by suspected suicide. Team leaders indicated that what came next was panic. That was not always helped by Service Managers who also were at a loss as to what to do. Having no guidance or process to follow from the Trust caused additional stress and anxiety in an already difficult situation.

> We were a bit blindsided. We didn't know what to do, but we supported each other, and we both spent that morning in the office with XXX teams and with the XXX teams just letting people know. P25, L140–142.
> … there clearly isn't a process, there clearly isn't a way that we should all be doing this…, but it's about knowing where you stand and what needs to happen. P28, L338–341.

There was no single point of contact in all but one of the staff deaths resulting in the perception among interview participants that this suspected staff suicide was 'more important' than others. Some also felt too many '*people jumped on the bandwagon*', and that not all the people who attended coordination meetings for this particular staff death should have been there. Participants report that the process did not run as sensitively as it should have and at times did not consider the attendees' emotional states in supporting others with the death of their colleague. Interview participants support the creation of a clear strategy plan:

> But when things go wrong and when something as I suppose, emotionally charged as a suicide is at the centre of it, people who are really, really well-meaning start piling in and there needs to be some coordination of that support and message, and I think, you know there should be an identified person who does that in the organization. P8, L422–426.

Participants also had an issue with how a suspected staff suicide is more widely communicated throughout the workplace, highlighting the need for refinement and further consideration as to what the Trust wants that communication to look like. All participants in the study reported problems with the communication process; non-managers did not like what was said in emails because the message was inconsistent. Managers, however, really felt at a loss as to what to write:

> We need standard paragraphs that one could use in this environment, in this sort of situation. But again, 'cause of individual circumstances, individual people are different, you might tweak it, but it gives you something on which to base some communication, so you don't have to think of it from scratch. P3, L768–772.

Social media and WhatsApp

As with most organisations, the Trust appears to still be finding its feet with social media usage by staff (Scragg *et al*. 2017, 235–41). While most healthcare professional codes of practice guide the best usage of social media in the treatment of patients, there does not appear to be a clear social media policy for employees of the Trust, specifically as it relates to the death or suspected suicide of a colleague.

What has further complicated this is changing working practices because of COVID-19. Staff across the Trust have adapted to working from home and now use technology and social media as an additional way to communicate with colleagues, be it in their teams, or previous teams, or for general socialising among friendship groups formed at work. Many participants shared that more guidance is needed from the Trust.

> … it spread like wildfire, and it was only maybe a couple of weeks later we got the message, 'Please don't share it with teams, so please don't discuss it'. So, I think if we hear of a staff death, I think having clear guidance from either the family member, the partner or the Trust like you know, if we're not to talk about it, we're not talking about it. P17, L672–676.
> It's really, I think for the organization to be really clear about what expectations and boundaries are, so an example might be, we all know that there are staff WhatsApp groups—they happen, but what is the guidance around staff WhatsApp groups? P1, L87–102.

Operational processes and procedures

Once managers heard of a suspected staff suicide and got through initial communication barriers, the next issue were the Trust's own policies and procedures. Many of the operational processes or policies that needed to be followed were deemed *'urgent'*, but, caused significant stress, angst and worry. Interview participants described them as '*mechanical', 'awful', 'horrendous'* and '*callous'*.

The 'Leaver's Form', and pensions and payroll were discussed at length by interview participants. It was perceived by managers that except for notifying payroll that a staff member had died, the rest could wait, or should and could, in most cases, be carried out by someone else. The 'Leaver's Form' came under scrutiny as the questions it asked were deemed insensitive and there was also no place to indicate that someone had died by suspected suicide. This was seen by several interview participants as '*shameful*' and creating more stigma around suicide. Some service managers stepped in to carry out the more business-focused roles, but they, too, reported that it was '*just too much*'.

> We need you to come let payroll know, we needed to let the pensions people know. I was very cautious about it. Sounded quite callous to have a conversation about the pensions, but what I didn't want was for anybody to contact family in the wrong way. P25, L168–170.

Through analysis it was found that managers need a systematic proforma checklist and/or guidance on how to manage a suspected staff suicide, or otherwise, they are acting on instinct, or what they think is best. This leads to an inconsistent approach in communication, and in postvention.

> A crisis team or something like that to come in quickly, but I do think there needs to be more there where you do close, and you should

close your department down for a period of time [for the safety of staff and patients]. P27, L1080–1082.

Communicating with family

When it came to communicating with family members about a suspected staff suicide, it was clear from managers that this was also a difficult process to navigate. Some managers felt it was outside the remit of their role while others felt it was expected of them to support the family as well. There was also the collection of personal items from the Trust that needed to be organised, as well as the collection of Trust property from the deceased's home.

> I suppose it's just something about who's responsible for doing what when it actually comes down to communicating with the family? It's not necessarily the line manager, or the manager's manager who is the best person placed to do that, because actually, it's who's got the closest relationship with the family and feels comfortable to do it? P25, L375–378.
>
> I think there should be a better process in place in regard to communicating with the family because I think we should be protected from that a little bit. P9, L371–373.

Having a single point of contact and communication for families is a crucial part of postvention support within an organisation, and it also will help with supporting teams, team leaders and service managers who have also been bereaved. This could also help support several processes, such as payroll and, more importantly, pensions where that team needs to contact family members (although not immediately), and has a high risk of traumatisation itself because of that.

> … we want to be prepared in case a family member comes to us straight away and says right, 'I know this person was my relative, whomever was in the pension scheme; What do I do? And then?' You know, we never really want to be floundering. Of course, where it is a sensitive situation, the more we know about it beforehand, the better, but it's more about trying to, I don't know, respond appropriately if we end up talking to the family members…. if there was somebody whose role was to go and speak to and then to pass that information on and put them in contact with us when they're ready, then yes, that would be OK, great. P2, L45–53.

Communicating with patients

Another area where communication support and guidance are needed is when staff need to communicate with patients that their caregiver has died. Staff members who are often overlooked across the Trust are those who work in administrative roles or as receptionists. Little thought has been given to how to support this group of employees who are also grieving a colleague, but most times deal with the brunt of suicidal calls from patients, calls from family members who have been bereaved by suspected suicide or the trauma of having to cancel diaries and reschedule patients, the latter of whom, are not always pleasant about this fact.

> … they cancelled XXX's patients for the day…. They didn't give any reason to the patients for doing that and so we [team leader and service manager] had a conversation with XXX and XXX, the administrators. We both agreed, you know that they just wouldn't get into a major conversation. They both did an excellent job of keeping themselves together and just got through those phone calls and cancel it and then they kind of did a big sigh of relief. And that's when they both sort of cried and went home. P268, L268–275.

The clinical staff also struggled what to tell patients:

> Unfortunately, you know the service users are gonna think well, 'Blimey, XXX was a [clinician] and [they've] gone and killed [themselves], 'what does that mean for us?' sort of thing, so that's another little difficult scenario, and I think that was something that certainly we were struggling with in terms of, 'what do we say?' P22, L377–380.

Training

Team leaders and service managers who have experienced a suspected staff suicide were clear on what they want, need and expect from the Trust as it pertains to future training in this area. Those managers and employees that had not experienced a staff suicide felt that '*mandatory training was not needed*' and was a '*step too far*'. They also believed that more senior members of the Trust would know what to do and they would be supported through the process, especially with paperwork.

> I think it's about how does it fit into that broader conversation about, 'how do we talk about suicide and then how do we support staff around suicide?' and then kind of layering it on. P23, L202–204.
>
> I think that there's line managers out there that are probably ill-equipped to talk about those topics, so they don't feel confident to have that conversation. P11, L156–157.

Staff in non-clinical roles also addressed the need for training to help provide support and appropriate communication.

> I think part of our mandatory training should be about bereavement and how that affects people, you know just the stages that you go through because that actually affects so many patients as well. P18, L723–725.

DISCUSSION

The study aimed to investigate how the Trust communicated in the aftermath of 11 suspected staff suicides and what processes, if any, were followed. It is clear from the interviews conducted for this project, that the Trust does not have a clear communication strategy for tackling staff suicide. By not having a clear communication process, the research showed that each of the suspected staff suicides between 2019 and 2021 was handled differently. There was no single point of contact in all but one of the staff deaths and the lack of a clear communication process also meant that how staff learnt about a colleague's death was not systematic and grounded in Trust policy. Communication from team leaders and service managers to staff about the loss of a colleague was inconsistent and they felt unsupported in their roles. The wider communication across the Trust was problematic and led to problems within WhatsApp groups and on social media, indicating no real organisational social media policy that encompasses guidance regarding suicide. This is problematic when it comes to respecting the dignity and privacy of the deceased, allowing for gossip and misinformation to spread more quickly.

There are serious issues about how bereaved family members are communicated with and the level of engagement team leaders and service managers feel is expected of them at a time when they are vulnerable themselves. There are issues around communicating with patients about the death of their caregiver and the impact this has on staff. Team leaders and service managers pointed out problems with operational communication policies around payroll, pensions and the 'Leaver's Form'. There were additional problems around operational procedures, or the lack

of them in most cases, around what to communicate, to whom and when, using what language and how to do it.

Based on these findings, communication within the Trust cannot be viewed as constitutional in nature (McPhee and Zaug 2009, 21). Rather than being the backbone of the organisation, communication was sporadic and inconsistent across all areas. To engage with a constitutional perspective, communication strategies should be fully integrated into the decision-making processes for crisis management (Coombs 2010, 17–53). By doing so, any subsequent communication issues will be apparent sooner, whereas if communication issues are only considered after the fact, the effectiveness of crisis communication is typically reduced (Seeger 2006, 232–44).

Given the impact of suicide, how suspected suicides are communicated within a workplace can influence the phenomenon itself within the organisation, therefore we have developed the seminal Postvention Communication Strategy Model (online supplementary appendix A) to support organisations in creating underpinning communication strategies that support postvention. Similar to the findings of Finlayson and Simmonds (2019), participants called for more open communication in the workplace, alongside the development of a clear strategic plan. Having a clear communication strategy is essential for effective and appropriate communication following a suspected staff suicide (Kinman and Torry 2021, 171–73; Lascelles, Groves, and Hawton 2022; Samaritans UK 2022). This strategy should include a clear timeline for communication interventions defined in the communication recommendations. Considering the most recent postvention guidance for staff impacted by suicide provided by NHS England (2023), calling for Trusts to formulate and use a trained postvention team available to respond in the event of a suspected suicide, it is hoped that this communication postvention strategy could work alongside a core postvention strategy to ensure the use of effective communication within postvention support.

The current data found that in the instances where staff members first heard about a suspected staff suicide, the inconsistent way in which the information was disseminated resulted in uncertainty, confusion and distress. Participants perceived there was no coordinated plan in place to communicate information, leading to convoluted and confusing communication channels which were not always effective. Any postvention communication strategy needs to be based on a clear, tiered approach centred around who needs to know, who communicates this information and how they communicate. Having a clear communication plan in place can be beneficial to both the organisation and staff, as it can be useful for staff members to know how their employer will respond following a suspected suicide (Austin and McGuinness 2012). By integrating this plan within a pre-existing constitutive approach, a workplace can ensure communication acts as a solid building block for workplace effectiveness and positive relationships (Coombs 2010, 17–53).

As part of this communication strategy, all communication with members of staff, family or patients of the deceased must use appropriate language and terminology. Our data found that those in managerial roles felt uncertain about how to communicate with other staff or family members, receiving no guidance on what to say and how to say it. This was also the case for members of staff tasked with informing clients, alongside staff in non-clinical roles such as payroll and pensions, who often felt underqualified to be talking to family members of the deceased. As research has shown, the language used to discuss a suicide can hurt those bereaved (Sickel, Seacat, and Nabors 2014, 202–15; Oexle, Feigelman, and Sheehan 2020, 248–55), with Padmanathan *et al*. (2019) finding that the impact of inappropriate language can be damaging, and circumstantially impact individuals in different ways. Within any organisation's response to a suspected suicide, the language used and how and where information is communicated needs to be considered, with reflective, compassionate communication at the forefront of policy (Miller *et al*. 2017, 563–570). While some participants noted the possible benefits of having a script to aid this communication, it is just as important not to dehumanise the deceased. Trusts would benefit from providing scripts with suggested wording, incorporating compassionate and sensitive language (Samaritans UK 2020). It is important to note that provided scripts are not ridged in content. Scripts should remain flexible to enable users to adjust to differing circumstances and allow for input from those working in different functions. The protocol for this should be set out clearly within a communication strategy, ensuring future responses address the criticisms found by participants in the current study.

This communication strategy also needs to extend to an awareness of how to protect staff's well-being in the aftermath of a suspected suicide. The interviews highlighted that when team leaders were expected to communicate information regarding the suicide, they were faced with a variety of emotions from staff members as well as themselves, with little guidance on how best to manage the situation. McDonnell *et al*. (2022, 887–97) propose that any staff providing postvention support needs to be equipped to recognise the complex trauma of those bereaved by suicide, therefore, when discussing ideas for future organisational response following an incident, identifying a suicide response team leader, responsible for a small suicide response team was viewed by participants as a beneficial method for organisations to use. Roles within this need to have clearly outlined responsibilities (online supplementary appendix A). Supporting those in these roles is also needed, as good supervision tailored around support and protecting staff well-being was important for those providing continuous postvention support (Kinman and Torry 2021; Maple *et al*. 2010, 171–73).

The process of reporting a suicide, along with completing the necessary paperwork following a suspected suicide also came under the umbrella of problematic communication within the workplace. Participants reported the lack of appropriate or sensitive language used within required paperwork resulted in unnecessary distress, further supporting the need for a dedicated response team and improved understanding of appropriate language about suicide. Addressing the various operational processes and procedures is also recommended. While the 'Leaver's Form' was used across this NHS Trust for this study, similar alternatives would benefit from clarity in terms of when this should be completed, as well as ensuring all forms about a staff suicide use appropriate terminology, considering the dignity of the deceased. Crisis communication literature highlights the importance of communicating the message needed, and to ensure an emphasis on community, content and dialogue (Ruck and Welch 2012, 294–302).

Similarly, the payroll and pensions department would benefit from clear policies for staff to follow. Having a clear point of contact for the completion of these forms is deemed to be beneficial to members of staff (Waters and Palmer 2022). Social media policy would also benefit from further assessment, providing staff with guidance on appropriate social media and WhatsApp use as it pertains to suspected staff suicide. This is supported within the toolkit for employers, developed by Public Health England (2016), Office for National Statistics (2021), the NHS employee suicide postvention toolkit (Samaritans UK 2022)

and the NHS report 'Suicide Among Nurses' (Lascelles, Groves, and Hawton 2022). They suggest a key step for organisations is to develop a communications strategy for suicide, including a policy around social media.

Finally, the lack of training provided to members of staff was repeatedly mentioned across the interviews, with the consensus that providing training to staff members would improve communication following a suspected suicide and general awareness and a better understanding of mental health, suicide stigma and accessibility to available support. Overall, existing research points to a lack of training around suicide awareness for healthcare staff (Gorton *et al*. 2019; Miller *et al*. 2017; Waters and Palmer 2021). Rebair and Hulatt (2017, 44–51) suggest that organisations provide staff with suicide awareness training that provides guidance on suicide prevention and helps to reduce stigma and developing to compassion about suicide. Additionally, support from senior staff and clear guidelines are needed when applying this training (Chan, Chien, and Tso 2009, 763–69). Participants in the current study presented the view that there were no guidelines for senior staff to follow when first communicating the suicide to staff, nor when subsequently supporting staff. Those in managerial roles reported having no clear communication guidelines, which resulted in differences in how each suspected suicide was handled. Similarly, staff in non-clinical roles such as payroll, pensions and human resources believed mental health training, communication training, and normalising mental health conversations would be beneficial within their roles. In line with previous research suggestions, providing senior and managerial staff with necessary suicide prevention and postvention training may help to improve the support received by staff, as well as provide confidence for those in managerial positions in the ability to support staff and follow communication guidelines.

While training is essential, this needs to be provided as part of a communication strategy and alongside postvention. Training could be incorporated into onboarding processes when new staff join the organisation. Further mandatory training around mental health awareness and suicide prevention could be required each year as part of continuing professional development for all staff across the organisation. Bespoke senior leader and manager-focused suicide prevention training could also be provided on an annual basis, with specific role play and training exercises to simulate a crisis response, so managers feel better prepared should they ever need to engage in a postvention crisis response. Previous research found that providing suicide risk-assessment training to mental health professionals can serve as a protective factor when assessing clinicians' stress reactions after a patient's suicide. However, this training alone only lessened this stress partially, whereas the combination of support and appropriate training had stronger protective effects (Dransart *et al*. 2015). These findings can be transferred to how workplaces can provide a well-rounded approach to dealing with staff suicide. Ensuring staff are offered postvention support can help to mitigate some of the emotional trauma felt following a suicide (Dransart 2017, 994–1005), with both training and postvention workshops following a suicide found to be beneficial to a workplace (Gerada 2019, 12290). Training and postvention would also benefit from addressing the stigma around mental health and suicide, as when more stigma is experienced by those bereaved by suicide, the greater the need for postvention support (Feigelman and Cerel 2020). Peters *et al*. (2015, 353–59) found that when a postvention programme addresses stigma and opportunities to discuss personal experiences, those participating felt a larger sense of community. Participants in the current study also indicated that normalising conversations around mental health and sharing experiences would be beneficial in the aftermath of a suicide. However, when implementing training and postvention support, workplaces need to ensure staff providing these have also received appropriate training and are equipped to recognise the complex trauma of those bereaved by suicide (McDonnell *et al*. 2022, 887–97).

Study limitations

There were some limitations to the current study. Due to COVID-19, all aspects of this project were carried out online. While best practices for online interviews about suicide were followed, it is recognised that conducting work on suicide prevention is always best face-to-face (Brown *et al*. 2005, 2847–49; Mousavi *et al*. 2016). Another impact of COVID-19 meant the workforce was on heightened alert. Coupled with personal reactions to this transnational trauma, it is possible that responses to interview questions were amplified. Additionally, as interview participants had mostly been bereaved by suicide, there was a range of emotions presented in interviews which aligned with common responses to suicide, which include: guilt, confusion, shame, anger and stigma (Sheehan *et al*. 2016, 330–349). Some participants self-disclosed that they were experiencing post-traumatic stress disorder and major depression, and others were experiencing complicated grief. This lived experience is valuable in research projects around suicide and can be difficult to deconstruct in the coding process because of the emotional intensity of the responses. However, the decision was made that these experiences provided valuable information about the impact following a suspected suicide, and steps were taken to ensure safety and well-being of both the participants and the interviewer. Finally, the purpose of this study was to explore personal experiences of suicide communication among NHS staff; however, it is recognised that these findings are not generalisable across all NHS Trusts.

CONCLUSION

This study aimed to gain insight through staff experiences into the current communication strategies used within an NHS Trust in the South of England, following several suspected staff suicides. The lack of consistency in how each suspected suicide was dealt with, paired with the lack of clear communication strategy within the Trust resulted in staff experiencing the aftermath of a suicide in different ways. In recognising that effective communication needs to be an integrated and ongoing process, the Trust needs to ensure successful communication underpins the entire organisation. From the moment the Trust learns of a suspected suicide, a communication strategy must be employed as it serves as the underpinning guidance for the communication and interventions of postvention support. This must be driven by the Trust's communication team, who must be comfortable working in suicide prevention, are clear on the WHO international guidance available around responsible and safe messaging as it pertains to suicide prevention and actively take ownership of the communication strategy for suicide prevention which is reviewed at least quarterly. Serving as an umbrella to all these problems is the serious issue of mental health stigma that prevails and permeates through every aspect of the Trust, regardless of the Directorate. The need for a clear communication strategy, alongside training to address mental health awareness and stigma, is evident. It is hoped that by improving communication in response to a suspected suicide, future suicides can be stopped. While the UK has made significant improvements in postvention

policies, further research is needed across NHS Trusts nationwide to gain further insight into the current communication strategies in place to cope with the suspected suicide of a staff member in the workplace.

Twitter Ann Luce @stann2

Contributors AL was the main contributor responsible for the overall content. AL was the lead planner for the study and conducted the Interviews. AL and LK carried out the analysis of the data. GT wrote the report, with additional input from AL and RDB-E. AL is the guarantor.

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ORCID iD

Ann Luce http://orcid.org/0000-0001-7366-6805

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Appendices

Appendix A.

Postvention Communication Strategy Model

Suicide communication strategy	
Suicide prevention communication strategy	1) Timeline for communication interventions i) Immediate crisis response (First day) ii) Acute response (24-48 hours) iii) Initial actions (1-2 weeks) iv) Ongoing communication (2 weeks – 6 months) v) Longer term communication (6 months – 2 years) 2) Hearing about a staff suicide i) Tiered approach: who needs to know and at what step in the process? ii) What is allowed and what is not (home visits?) iii) How and where is it communicated (ie. email, face-to-face, staff intranet) iv) When is it communicated? v) Who communicates? vi) What do they communicate? vii) How widely do they communicate? viii) For how long do they communicate? ix) Who is responsible for monitoring social media? 3) Types of communication i) Reflect on the language being used a. Is it Destigmatising? b. Is it Sensitive? c. Is it Responsible? d. Does it follow WHO international guidelines? ii) What information is to be shared? a. Take guidance from Family Liaison re: staff death b. Use postvention support resources c. Follow WHO international guidelines iii) Provide sample texts/scripts for emails and phone calls a. From Executives to Trust b. From Trust to Managers c. Teams to Patients (clinical and administrative) d. Wider Comms across the Trust e. External Comms 4) Crisis checklist/proforma for team leaders and managers i) Process for managing a staff suicide a. How to activate suicide response team + next steps

	ii) Identify a Suicide Response Team (SRT) Leader iii) Create a small but effective Suicide Response Team including: a. Crisis Team Leader b. Communication Lead c. Postvention Intervention Lead d. Family Liaison Lead
Review/Create Policy/Forms	1) 'Leavers' form: Amend and create clear policies and procedures i) Rephrase questions so they are more sensitive to suicide ii) Include suicide as an option on the form iii) Create internal database to track number of staff suicides across Trust iv) Clarify at what point in the process this needs to be completed v) Clarify who is responsible for completing this form 2) Payroll: Create clear policies and procedures i) Is a 'Leavers' Form required to be able to carry this out? ii) Is it possible to have another process in place? 3) Pensions: Create clear policies and procedures i) Link in with Family Liaison and work together to provide information to family ii) Family Liaison should be point of contact in supporting and preparing Pensions Team for all communication with family 4) Social media policy i) Guidance on appropriate social media use as it pertains to a staff death/suicide ii) Guidance on appropriate messaging use as it pertains to staff death/suicide
Training	5) Training for Managers as part of annual mandatory training package for Team Leaders, Service Managers and anyone with line management responsibility (clinical or administrative) across the Trust. i) Mental Health first aid ii) Suicide First Aid iii) ASIST iv) Having difficult conversations around staff mental health and wellbeing v) Managing a service/department in the aftermath of a suicide vi) Managing internal processes, ie. Leaver's Form, Pensions, Payroll in the aftermath of a suicide vii) Writing Coroner's Reports and Statements viii) Awareness and management of emotional states in self and others in the aftermath of a suicide ix) Stages of bereavement and what you can expect with suicide bereavement; engaging with family bereaved by suicide (for pensions) x) Supporting a patient in suicidal distress/crisis (for receptionist/admin teams) xi) How to communicate to a patient their carer has died (for clinical/receptionist/admin staff) 6) Training for Communication Team

	i) Understand and can apply international WHO guidance on safe messaging ii) Understand the topic of suicide iii) Understand what postvention is
Suicide Prevention and Mental Health	1) Create internal awareness campaign(s) prevention i) Consider using "Small Talk Saves Lives"—Samaritans ii) Consider using "It's OK to not be OK"—Samaritans iii) Source already evaluated national campaigns through local partnerships on suicide prevention 2) Destigmatising suicide and help-seeking behaviours through internal campaign(s) prevention i) Source already evaluated national campaigns through local partnerships on suicide prevention ii) Include lived experience of staff already working in Trust iii) Include lived experience of senior leaders working in Trust iv) Include lived experience of senior leaders working outside of Trust v) Consider highlighting mental health champions vi) Consider highlighting lived experience group vii) Consider lanyards signposting willingness to talk about mental health viii) Consider badges signposting willingness to talk about mental health ix) Consider 'Wellbeing Wednesdays'—a time to check in, take a break and talk about mental health