

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

## A postvention framework

"An important resource ...The checklist of actions is extremely useful and supportive."

- *Baroness Finlay of Llandaff*

"This is a timely addition to the support needed for health care staff and organisations when one of their colleagues takes their own life. The document provides an excellent step by step guide as to what to do if this rare but traumatic event happens to a member of staff at work. A vital piece of work and I congratulate the authors."

- *Dr Clare Gerada*



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## INTRODUCTION

The sudden death of any work colleague can be shocking, distressing and destabilizing. When the death is unexpected and deliberate, as with a death by suicide, emotional reactions can be extreme, and can have a major impact on the wellbeing and functioning of staff members. A compassionate and supportive approach is needed to help people recover. The term 'suicide postvention' refers to the actions taken within an organisation to provide support after a death by suicide in an effective and sensitive way. The general goals of postvention are shown in Box 1 below, but flexibility is needed to accommodate different circumstances. Some useful guidance on suicide postvention is available but it tends to be targeted at larger organisations that have dedicated human resources and other employee support functions<sup>1</sup>. While postvention guidelines are available to support groups of healthcare practitioners (such as doctors in training and anaesthetists), they typically focus on raising suicide awareness and highlight opportunities for intervention<sup>2,3</sup>. There is little information to support primary healthcare organisations in coping with the aftermath of the death by suicide of a colleague.

The death by suicide of a colleague may be particularly challenging in general practices and other primary care settings. These organisations are generally staffed by small stable teams and employees will often have cultivated close working relationships or personal friendships. Even if a practice is part of a larger group, a relatively small team will typically be responsible for the day-to-day delivery of care. Moreover, patients may have forged a personal connection with the colleague who has died, whether they are a clinician or any other team member. Administrative staff are also key members of the practice team, although they may be less well known to patients. Whatever the professional role of the person who has died, primary care practices (particularly those who lead the practice) will find it challenging to cope with the aftermath of a death, as staff will not only need time and space to process what might be intense emotional reactions and provide mutual support, but also be required to meet the continuing needs of patients and address their distress. It should be acknowledged, therefore, that the death by suicide of a colleague is likely to cause considerable disruption to the organisation that can last for some time and the investment of time and resources will be needed.

### 1 THE GOALS OF SUICIDE POSTVENTION

First used in 1981<sup>4</sup>, 'suicide postvention' refers to the provision of crisis intervention, support and assistance for those affected by a death by suicide. Its aims are:

- To provide appropriate information about the death of a colleague and avoid misinformation or rumours.
- To offer support to employees who are bereaved by suicide and help them deal with grief and any difficult emotions and trauma they may experience.
- To address the stigma that is associated with a death by suicide.
- To stabilise the environment, restore some semblance of order and routine and support employees to return to a state of normality.

People will respond to the death of a colleague in different ways, but postvention guidelines can help people and organisations recover by enabling timely and appropriate support to be put in place. There is little evidence in the literature to inform suicide postvention frameworks. To determine what might be helpful, we have examined the views and experiences of people who have experienced the death by suicide of a co-worker. These guidelines draw on information gained from in-depth interviews with such people, with contributions from other stakeholders, to highlight the challenges that can arise in primary care organisations after the death by suicide of a colleague and the support and actions that are needed at different stages. The issues explored in the interviews are shown in Box 2.

## 2 ISSUES EXPLORED IN THE INTERVIEWS

- The circumstances surrounding the death and breaking the news to staff.
- How staff were affected by their colleague's death immediately and over the longer-term.
- Breaking the news of the death to patients.
- Liaising with the family and the funeral arrangements.
- The support that was provided to staff members and by whom.
- The type of support that was most relevant and useful at different stages after the death.
- How support might be improved, particularly from external sources.

The interviews were recorded and analysed by the two researchers independently. A grounded theory approach was used where themes were initially identified and expanded until saturation was reached<sup>5</sup>. The findings indicate that lack of guidance following the death of a colleague by suicide means that primary care practices are required to improvise on what to do next. This can intensify the emotional reactions to the traumatic event and potentially disrupt the service they provide to their patients. While the people we interviewed were generally satisfied with the support they received from colleagues, they highlighted the strong need for primary care organisations to have more input from external bodies to help them cope with the aftermath of such an event – as one interviewee observed: “we needed somebody to put an arm around the practice”. It is envisaged that these guidelines will inform the development of a flexible crisis management strategy that can provide the information and support that is needed by primary care practices at different stages to help them to mitigate the impact of the death. The guidelines may also be useful to similar small organisations.

It is useful to approach the response to the death by suicide of a co-worker in three phases: immediate, short term and longer term<sup>6</sup>. These guidelines, therefore, identify the likely effects and the actions and support needed:

- a) on the first day;
- b) in the first week;
- c) during the first month and
- d) over the longer term.

## The first day: disclosure, shock, communication and support

### 1. Hearing the news

The team can learn of the suicide of a colleague in many ways. They may hear the news during the working day, or when the surgery is closed. There may be a phone call from a family member or a friend, or the information may be obtained from a posting on social media, or a report in a newspaper. The most immediate need is to acknowledge that the death by suicide of a colleague is likely to have an impact on the psychological wellbeing of people within the organisation and their ability to function. The immediate aftermath is a time of shock, confusion and intense emotion, so the provision of accurate information and making plans for support are crucial.

*"There was absolutely no pre-warning at all, at least not that I was aware of, or her colleagues were aware of. It was very shocking when it happened".*

### 3 COMMON FEELINGS AND BEHAVIOURS FOLLOWING THE DEATH OF A COLLEAGUE

- Denial, disbelief and shock
- Profound sadness
- Emotional lability, or emotional outbursts
- Helplessness and loss of control
- Guilt over things left undone or unsaid
- Anger and irritability
- Feeling unprepared for the situation
- Feeling overwhelmed by everyday tasks
- Automatic behaviours, or feelings of dissociation from reality
- Poor concentration, due to intrusive emotional reactions and memories
- Changes in sociability, such as wishing to withdraw from others or an increased need to talk
- An inability to 'switch off' from thinking about their colleague at home during evenings and weekends
- Physical symptoms, such as shortness of breath, nausea, rapid heartbeat, or aches and pains
- Altered eating and sleeping habits
- A strong need to tell other people about the event; to be with people who knew the person who had died; a drive to reach out to the family

### 2. Breaking the news to staff

The person who first hears the news is likely to be responsible for informing their colleagues. Someone in the practice, ideally not a person who is intensely emotionally affected by the news, must decide when and how to tell the other members of staff. This will usually be one or more of the practice partners, or the practice manager. Our interviewees indicated that it is best to break the news as quickly as possible, before rumours and misinformation start circulating. That a death has occurred will need to be shared immediately, but decisions about how much information to share and with whom will usually be taken after consulting the family. Family members may not want people to know that it was a death by suicide, or they may not wish the details to be shared outside a few key people. There might also be some uncertainty about the cause of death and suicide may not be formally established for some time. Where there is any doubt, care should be taken not to pre-empt formal confirmation. It may be necessary to tell staff that the family do not wish to discuss the cause of death. There may also be media interest. If the practice wishes to release a statement or photograph, this will also need to be discussed and agreed with the family.

*"We sat in silence for over half an hour, then took out pen and paper and began to work out what to do about breaking the news".*

*"We made the pragmatic decision that all our staff would be told explicitly that this was a death by suicide, but we would not share this information with patients, especially as we were not clear about the wishes of the family."*

It may be possible to gather the staff together at the end of the surgery to break the news but making some people aware of the circumstances before a larger meeting would be helpful. If possible, there should be no external interruptions when breaking the news. The news should also be communicated to staff who are not at work that day to prepare them before they are next on duty. If the news is broken at the weekend, it may be necessary to telephone staff at home. In larger practices, a small team might be able to divide the phone calls between them to avoid overloading a single person.

*"The partners divided the team between us. Some of the team leaders also did some news breaking. By the end of the weekend all our staff knew the sad news."*

## The first day: disclosure, shock, communication and support

### 3. Managing the distress of staff members

Supporting the people affected is one of the priorities in the immediate aftermath of a colleague's death by suicide. Grief reactions are influenced by several factors such as an individual's previous life experiences (especially prior experience of death by suicide), their coping skills, their cultural beliefs about death, as well as their personal relationship with the colleague who has died and the circumstances of their death. Although people will react to the death in different ways, it should be recognised that in a small practice every team member is likely to be emotionally destabilised<sup>7</sup>. Box 3 (previous page) highlights some common feelings and behaviours experienced after the death of a colleague. Some are likely to occur soon after the event, whereas others may be experienced later. In addition to the shock, disbelief and sadness that follows the news of any sudden death, members of the team (especially those who knew the person well) might also feel guilty about not spotting signs of distress and taking action. Opportunities to talk over what has happened and vent feelings of sadness or guilt with a trusted person who can listen without judgement can assist with the recovery process.

*"People had a profound shock and to carry on doing the day job was rather hard – but the day job didn't go away."*

*"We needed to be allowed to lay down our tools, at least for 24 hours, but we were told we had to keep going."*

*"There was much space for discussion in the back offices during this time between members of the team. Mainly sharing knowledge, sharing a sense of shock and numbness."*

Staff, especially clinical staff, may experience dissonance between the role of being a doctor (or other healthcare professional) who is responsible for the wellbeing of others and the need to respond to the death as a human being, and a colleague and friend of the person who has died.

*"Essentially it was something I had to get through. We aren't expected to show that these things affect us badly. It is called 'behaving professionally'. It did affect me, but I didn't really have an outlet to discuss it. People just expected me to carry on."*

*"I was absolutely blown away, but we had to support others."*

During the first day and the next week or so, it is important to be mindful of any member of staff who might be too distressed to continue to work safely as the practice has a duty of care to patients. Risk may be hard to establish, as people who are experiencing emotional shock might appear to carry on as normal (even to those who know them well) but can be profoundly distressed. The cognitive deficits associated with extreme shock and grief, such as concentration and memory problems, means that performance at work can be compromised.

The emotional effort required when people try to behave 'professionally' after experiencing trauma can be exhausting and compound grief reactions. Moreover, healthcare professionals frequently struggle to be self-compassionate and often find it easier to comfort others than attend to their own emotional needs. Staff members may, therefore, need to be given 'permission' to take care of themselves; they may be unable to recognise that they need time off to process the news or to have some time away from patient-facing work, and may need to be told kindly and firmly that cover will be found. At this stage, it might be useful to consider what types of workplace concessions could be made available in the first few days and weeks for staff members who are struggling. Cover may need to be found at short notice, so it would be helpful to have people on standby if possible.

*"I could see when I was getting dangerous. I could see that I was not concentrating."*

## The first day: disclosure, shock, communication and support

### 4. Maintaining 'business as usual'

It is both a strength and a weakness of the general practice setting that people in leadership roles have considerable authority and flexibility. They do not have to consult others when making decisions but carry a heavy responsibility for ensuring the decisions are the 'right' ones. Leaders play a key role in the immediate response to a colleague's death, but the demands they face can be extreme; they might feel the impact of the death as profoundly as others, if not more so, yet be obliged to provide support to others and keep the practice going. There might be concerns about maintaining continuity of service that may continue until the situation has stabilised and any cover required has been put in place. The people we interviewed emphasised the importance of having people available who can take appropriate action without being asked in order to share the load.

*"The trouble was that business had to go on as usual as the patients weren't going to go anywhere. We found ways of managing it though – one of the more senior managers took over the front door. We closed for an hour or so immediately after and then reopened."*

*"The keeping going was really hard. We struggled on and struggled on. We needed to stop."*

Ideally managers should meet their own emotional needs before attempting to care for colleagues, but this can be very challenging. In traumatic situations, people often want someone to 'take charge' as they feel helpless and overwhelmed; they typically look to leaders to set the tone in responding to such events. Although leaders can be powerful role models for 'healthy' grieving by openly acknowledging their feelings about the loss of a colleague and providing advice on effective coping strategies, this can be an additional burden for them to carry. Worrying about the psychological effects of the death on team members and feeling responsible for their wellbeing can be stressful; it was of major concern that the people we interviewed often struggled to get support from their professional networks although when available this could be helpful.

*"It was a case of trying to be normal and keep the show on the road. I didn't have anybody to talk to about it."*

*"It was very surreal – I had to deal with all of this, and I just acted on instinct. There was no help or guidance given to me. Suddenly I was in charge of everybody else's feelings and just expected to carry on as normal."*

*"One of the local GPs, said 'I'm coming to see you' and they were very helpful. I had a couple of sessions with them of my own, really just to talk and then I felt I was OK."*



### THE FIRST DAY: KEY ACTIONS

- Arranging a coordinated discussion on the information that should be provided to staff; liaising with the family if appropriate.
- Breaking the news to all members of staff in a quiet environment and ensuring that people not on duty are also aware.
- Dealing with the distress of staff members.
- Ensuring there is time and space to debrief and for staff to support each other.
- Identifying any member of staff who is too distressed to continue working and encouraging them to take time out if required. This may require probing questions and/or asking other staff members for their opinions on the wellbeing of colleagues.
- Assessing the staffing situation; reallocating work or finding cover if required to ensure service is not disrupted.
- Identifying the concessions that could be made available in the first few days and weeks if staff members are struggling.
- Identifying potential sources of support for the future.

## The first week: communication, coordination and continuing support

### 1. Informing external bodies

Several external bodies will need to be informed, depending in part on the role of the person who has died. These may include the Medical Director and cluster lead of the CCG, the Local Medical Committee, the chair of the Primary Care Network and, for a doctor, the Responsible Officer. Our interviews highlighted the difficulties that practice leaders experience when determining who to inform of the death and how to contact them.

*"The other thing that I found really hard, was that I didn't know who to tell. I didn't know the procedures. The CCG were absolutely useless. Maybe they didn't know. Nobody knows these things."*

### 2. Breaking the news to patients

After colleagues have been informed, patients will need to be told. This should be done in the same way as any other death of a staff member, but the situation will be more sensitive and potentially ambiguous. As mentioned in the previous section, it may not be certain that the death was by suicide and whether the family wishes the 'true' cause of death to be communicated widely may be unknown.

When communicating with patients, it may be appropriate not to be specific about the cause of death, but to refer to the staff member 'dying suddenly' or, if they have been on sick leave, 'following a short illness'. Patients might ask staff members about the cause but can reasonably be informed that this is not yet known. The exception would be if the cause of death was very public, and the circumstances had already been posted on social media or reached the local or even national press.

As the reception team will bear the brunt of patient's responses, they need to be involved in discussions about when and how the news should be communicated to patients and other stakeholders. If the death is not already in the public domain, it may be advisable to wait for 24 or 48 hours to allow staff some time to process the news. It is important that the information provided by different members of staff is consistent to avoid confusion and further queries. The practice may know of patients who have a particularly close relationship with the colleague who has died. Some may be emotionally unstable and been receiving support from them. It may be helpful if somebody from the practice could break the news to such people personally and offer support if required, rather than wait for them to find out indirectly or via rumours.

*"One of the partners arrived early and met with all the reception staff working that morning. There were expressions of sadness. Some people wept. It was agreed that the news would not be broken to patients until the following day, to allow staff time to begin to come to terms with the loss and their distress."*

*"After discussion, we came up with a form of words which was basically "she has been terribly ill, and she died". This helped the staff to pass the news on and they didn't need to go into detail and tell patients and others that she died by suicide."*

*"We made the pragmatic decision that all our staff would be told explicitly that this was a death by suicide, but we would not share this information with patients, especially as we were not clear about the wishes of the family."*

*"Our manager partner telephoned a few of the patients who we knew had a strong relationship with our colleague. This was very helpful."*

### 3. Providing a memorial

At this stage, it can be comforting for staff and patients to prepare posters and place flowers in reception. A poster could include a photograph of the colleague, provide her date of death and highlight the contribution the person had made to the practice. Practices could also provide a memorial book in reception and online for patients to write their tributes. This book can be a tremendous source of comfort for staff and eventually may be given to the family. If a book is placed in reception, creating a separate queue to write in the book has the added value of enabling patients to talk to each other about the death, while allowing others to reach the reception desk. Practices may also wish to communicate the loss of a valued member of staff on their website.

*"We made a poster and got a condolence book for both premises. One of the team put flowers in our colleagues' room, and this custom continued for many weeks."*



## The first week: communication, coordination and continuing support

### 4. Dealing with the continuing distress of staff members

Patients are likely to be understanding if staff become upset when discussing the death of a close colleague. Nonetheless, everyone in the practice should be ready to support someone who becomes emotionally overwhelmed. It should be emphasised that stepping away from the reception desk or out of the office for a period is entirely understandable and acceptable. Arranging additional front desk cover for such situations in the first week or two might therefore be helpful. Staff should also be vigilant for colleagues who attempt to 'carry on as usual' without seemingly processing the news; they are also at risk and may benefit from a gentle conversation to help them connect with their feelings in a safe and healthy way. Colleagues who work together could be encouraged to watch out for each other and provide mutual support.

*"There was an accommodation that happened in that first week, that life has to go on, that work has to go on. And the way we got through it was by supporting each other.*

*"Knowing the support was there was very helpful and reassuring."*

*"We had a functional team and we did a good job of supporting each other."*

It can be challenging for individual clinicians who are themselves bereaved to be required to deal one to one with a patient's distress about the death. Planning responses to patients in advance can help, but clinicians need to be able to indicate if they do not feel able to talk about the situation, and to look to colleagues for support if required.

*"There was a discussion, and the use of the phrase 'did you know that our colleague suffered from depression' was useful for some. If asked if she died by suicide, it was confirmed that she did. Most patients who asked responded with silence then calm acknowledgement. There were of course a few emotional outbursts."*

Interviewees reported that some patients can be very supportive of doctors and the practice.

*"She baked some cakes. I'll never forget, they were fairy cakes, and the message she put to me was 'you always look after us, it is now time for us to look after you.'"*

Box 4 provides examples of how leaders can support staff members. This guidance is relevant not only at the early stages following a colleague's death by suicide, but during the weeks and months following.

## 4

### HOW LEADERS CAN SUPPORT STAFF AFTER THE SUICIDE OF A COLLEAGUE

- Maintain open communication with all colleagues.
- Be sensitive to the needs of individual members of staff; do not make assumptions about people's relationship with the colleague who has died.
- Ensure that staff know who they can talk to (in the workplace and externally) if they feel the need to do so.
- Designate a place where people can go if they need time out and, if necessary, ensure someone can go with them.
- Provide opportunities for staff to meet over coffee or lunch to discuss their feelings and offer mutual support.
- Determine when staff need breaks, time off, or relief staff to cover their work.
- Check in with each staff member regularly and offer help at an early stage if their performance suffers.
- Watch out for signs such as a lack of concentration or outbursts of anger and offer support and help.
- Ensure that a list of organisations who can provide support following suicide or bereavement is available in a prominent area, or on the practice intranet.
- Finally, it is crucial that leaders look after themselves: share the burden with others and receive support.

## The first week: communication, coordination and continuing support

### 5. Providing opportunities for mutual support

Bereavement following suicide is often prolonged and complicated. Staff, particularly those who were close to the person who died, often feel emotional distress and may also experience physical reactions to grief, such as fatigue, insomnia and nausea. Such symptoms are likely to recede in time, but grief reactions that are handled improperly or ignored can be destructive and disruptive. At this stage, members of staff will continue to need opportunities to give and receive support to help them come to terms with the loss, while ensuring that the day-to-day running of the practice and the impact on patients is contained. It can be particularly helpful for staff to meet informally, perhaps over lunch, to share memories and feelings. It was suggested that spending some time in silence during the working day can help people get some space to process the loss and remember the person who has died in their own way. A more structured approach, where people are invited to share their most important memories in turn, can also be effective<sup>7</sup>. A meeting after the practice is closed may be more appropriate if staff may feel too upset to continue working afterwards.

*"All the staff met at lunchtime. There was space for people who wished to say a little about what the doctor meant to them."*

### 6. Communicating with the family

Opening up lines of communication with the family is important to set the boundaries of what can be disclosed to others and to find out about the funeral arrangements. Colleagues might be reluctant to make initial contact with the family, as they do not wish to intrude during such a difficult time. It can be helpful for the team to nominate a key person who will maintain contact with the family over the first few weeks and, hopefully, develop a relationship of mutual trust. The family may choose to be in close contact with the practice and may be very willing to talk to members of the team. Other families may prefer to avoid contact with the workplace. They may hold the practice responsible for their relative's death if, for example, workload pressure was felt to be a contributing factor. As death by suicide can be heavily stigmatised, it is not unusual for a family to be in denial that their relative died this way, or they may not wish it to be known outside a few key people. Such situations need to be handled sensitively to avoid further distressing the family or the staff members.

### 7. The funeral

A death by suicide can intensify the emotional reactions to a bereavement, so being able to attend the funeral or a memorial event can be particularly important. It can allow colleagues to offer their condolences and express their grief to family and friends of the person who has died, share memories and start the process of recovery. Some families may welcome all members of staff at the funeral or memorial event, whereas others may prefer that only one or two representatives of the practice attend. A colleague may be asked to speak - it can be positive for people to learn how much their family member was appreciated and valued as a colleague and a friend. The family might also be happy to invite patients to the funeral and may ask the practice to pass on the details. The best way to find out their wishes is to have an open and honest conversation.

*"We invited patients to the funeral, because I was absolutely certain that he would have wanted that, and his wife also was very happy with that."*

Although the family may welcome colleagues to the funeral, not everyone may be able to attend. A key consideration is how close the funeral is to the practice. Assuming the funeral is local, and all colleagues are invited, the practice will need to seek the agreement of the Clinical Commissioning Group (CCG) to close for a half-day. In some cases, highlighted in our interviews, the CCG may require the practice to maintain a service to patients so it will be unable to close. This can have repercussions. Our interviews indicated that there can be a high cost for those who 'volunteer' to remain at work and feeling obliged to do so can cause considerable distress and resentment. As practices are permitted to close for a half-day for protected learning, it seems appropriate that they should be able to do so for the funeral of a current member of staff who has died, whatever the reason. There is usually enough notice of the funeral arrangements to allow a half-day closure, without any negative impact on patients.

## The first week: communication, coordination and continuing support

*"One thing that helped me was that pretty much every member of staff was able to go to the funeral. We were lucky as it was held in the middle of the day and very local, so we had the luxury of going during lunchtime rather than disappear from surgery."*

*"If the funeral had been during surgery time, most of us wouldn't have gone as you must be available when you are supposed to be there. We would have felt very guilty for not going and been concerned about what people would think. It is an impossible position, as you would always have to let somebody down."*

*"The CCG allowed us to close for routine appointments that afternoon but required us to maintain a duty doctor and walk in service. One of our medical team, and our two registrars, offered to stay to behind to run the service. New members of the reception team ran the desk, so about 30 of us were able to attend the funeral, which was some 20 miles away. This was important for us and for her family. Most of the partners returned to the practice direct from the funeral to ensure that everything was under control, which it was."*

If it is not possible for all members of the team to attend the funeral, a memorial event could be held at work. This should be done in an inclusive and sensitive manner. Staff might bring in some food or drink for a buffet-style lunch where colleagues can say a few words about their person who has died or offer up a favourite memory. Staff and patients may also wish to contribute to a charitable cause in the name of the colleague who has died, which could be agreed with the family, or as a separate arrangement coordinated by the practice.

### 8. Dealing with personal belongings

The workplace will have many subtle reminders of the person who had died. Their name might be on their office door, or their personal belongings may remain on their desk or workspace. If possible, the workstation should be left untouched for a few days. If personal belongings are cleared away too quickly colleagues may feel angry or resentful, but it may not be possible to leave the working space untouched and the desk unused for long. Colleagues may be reluctant to clear away the personal possessions of a colleague who has died, so this job might be best shared, to ensure people are supported during what can be a distressing task. It might also be helpful to offer to deliver the colleague's personal belongings to their family or assist them in their collection.



### THE FIRST WEEK: KEY ACTIONS

- Identifying relevant external bodies to inform of the person's death and making contact.
- Involving all relevant staff in deciding how to break the news to patients.
- Breaking the news to patients, dealing with their distress and determining who might need additional support.
- Dealing with the continued distress of staff and identifying anybody who is struggling.
- Ensuring there are continuing opportunities and a physical space for staff to get mutual support.
- Nominating a person to liaise with the family about the funeral arrangements and deciding who should attend.
- Liaising with the CCG if the practice is to close for a half-day for the funeral or, if this is not possible, to provide cover so colleagues can attend.
- Organising a memorial event for all staff, if required.
- Dealing with personal belongings and returning them to the family, if required.
- Placing a memorial in reception: e.g. flowers, a poster and a memorial book for patients to write their tributes. Deciding whether to provide a memorial on the practice website.

## The first month: getting the 'right' kind of support, working towards recovery

### 1. Dealing with continuing distress and emotional responses in the team

Team members may continue to be distressed for some time and can also experience complex emotional reactions over the longer term. Staff will continue to need an outlet to express their sadness about the death of a close colleague and their continuing sense of loss. Everyone in the practice should remain alert to the needs of team members and time and space should be available for people to share their feelings if this is required. Staff could also be encouraged to identify and share information on what can nourish and replenish them (e.g. rest, relaxation, exercise, or other diversions). An understanding of the Kubler-Ross Grief Cycle<sup>8</sup> may be helpful and its key principles are shown in Box 5. It is a useful framework to identify people's likely emotional reactions and support needs at different stages following a bereavement or any significant personal loss.

It may become apparent at this stage or earlier, that some members of the team were closer to the person who has died than their colleagues had realised. People might find that the death invokes memories of past bereavements, or other distressing experiences. It is common to feel guilty in the aftermath of a death by suicide; colleagues may regret not noticing their colleague's distress, or wish they had phoned or visited them, or asked how they were feeling. People who work in the 'helping' professions can be particularly prone to feelings of guilt after a suicide, as they may feel they should have spotted the signs. It is natural for people to feel that doing something differently might have helped avoid the death, but excessive self-blame can be damaging. Colleagues might also speculate about why the person took their life – was it a work situation, relationship problems, or a mental health crisis? It is important to realise, however, that the reasons for a death by suicide are complex and multifactorial and often poorly understood even by those who knew the person best.

*"He was thinking 'I should really have done something; I should really have noticed' and we had a long conversation about it."*

## 5

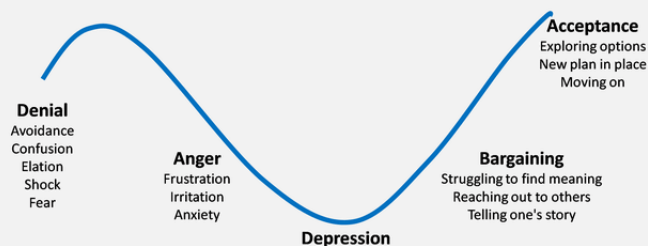
### THE KUBLER-ROSS GRIEF CYCLE

This is a useful framework to identify people's likely emotional reactions and support needs at different stages following a bereavement or any significant personal loss. It should be emphasised, however, that the grief process is highly personal so a flexible approach to support and recovery is needed.

The initial reaction to hearing the news is likely to be shock, denial and emotional numbness; at this stage communication is key, particularly the need to reiterate the situation to allow it to 'sink in'. People may subsequently experience anger and depression when they accept that the death has really occurred. As these emotions can be difficult to express, support and reassurance that such feelings are shared and understandable can be particularly helpful. At the stage of bargaining and acceptance, people often feel the need to reach out to others and find meaning as a way of coming to terms with their loss.

### KUBLER ROSS CHANGE CURVE

Kubler - Ross Grief Cycle



## The first month: getting the 'right' kind of support, working towards recovery

As mentioned above, death by suicide can be a potent cause of anger and, while understandable, this can be destructive and disruptive. Staff may become angry with each other and those who hold responsibility in the practice. Partners may become angry with each other, the CCG, or the medical practitioners who were caring for their colleague. Partners or close colleagues may also be blamed for not previously disclosing information about the person who has died, such as long-standing mental health problems or previous self-harm, even if this was disclosed to them confidentially. It would be even more difficult, both for the practice and the family, if the person who has died has been the subject of serious accusations, for example of malpractice or fraud, which may not necessarily be known to both parties.

The wider medical community may express anger about a 'failure' of the practice to support the person who died, especially if they were well known locally. Those involved may find themselves displacing their frustration and anger onto their families or the patients. Although anger is a common emotional response to grief, angry feelings can be difficult to disclose to others. If a death by suicide follows a complaint or an error in patient management, whether real or perceived, it will add to the complexity of the reactions experienced. People expect to feel sadness after the death of a person who is close to them, but anger can cause confusion, anxiety and shame as it may be considered an inappropriate response.

It is important to find a way to express angry feelings in a safe, trusted space, otherwise they can intensify. There are techniques that can help people lessen their feelings of anger after a bereavement, such as writing a letter to the person who has died or releasing angry emotions by exercising<sup>9</sup>.

*"One of our staff who knew her quite well became very angry and uptight. She thought that the situation hadn't been handled properly, people weren't supportive enough. This was a very disruptive influence – it was a pity."*

*"Some of the salaried team and other team members became angry with the partners for 'not being supportive enough' and seeming remote."*

### 2. Talking about a death by suicide with patients.

The point at which it feels right or necessary to indicate that a colleague died by suicide will vary. As discussed earlier, sometimes the need is immediate (for example, if it has been mentioned in social media). It might also become clear that the family wish the cause of death to be known more generally and it may be openly discussed at the funeral. In some circumstances, it may never feel appropriate to discuss the cause of death with patients, but this decision may need to be reconsidered. For example, a rumour that a death was due to cancer or heart disease might result in patients suggesting fund raising activities, which would indicate the need for a change of policy. One approach is for doctors, rather than receptionists, to discuss the cause of death with patients if they are asked. A line such as "it may help you to understand that our colleague suffered from depression" can be effective. Most patients are well able to understand the complexities of life. Moreover, information can be disseminated rapidly in a community; once a few patients become aware of the circumstances, it is surprising how quickly questions about the death fade away. It should be acknowledged, however, that doctors might disagree about how to break the news to patients, and some may feel unhappy about being expected to discuss their colleague's death by suicide. Any discomfort should be discussed openly and honestly between the team to avoid ambiguity and confusion. For example, any discussion of the method of suicide would usually be inappropriate. Some members of the team may find it helpful to be made aware of resources about conversations about suicide<sup>10</sup>.

*"Sometimes we disagreed with each other about what should be done, especially with respect to talking about the cause of death."*

*"We told people she had been ill since September, agreed her death was unexpected, but did not speak of the cause of death. Our reception team coped professionally and effectively, externally at least. If they were visibly upset at times, it did not matter."*

*"It became clear that the family wanted to be open with everyone about the cause of death, and the tragedy of it. They wanted it to be spoken of and the struggle of depression to be better understood."*

## The first month: getting the 'right' kind of support, working towards recovery

### 3. Practical risks to running the practice

As with any death in a practice, steps must be taken to maintain the everyday care of patients. The risks and the actions that are needed will, to some extent, depend on the role played by person who had died, and the size of the practice. For larger organisations, ensuring the level of service to patients is maintained may not be insurmountable. Locums may need to be arranged, but partnership and managerial responsibilities can usually be covered by others. It is important, however, to assess the risk of placing additional pressure on staff members during a time that will be unusually emotionally demanding and stressful.

If a single-handed practitioner dies, the CCG takes on the responsibility of running the practice and making decisions about its future. Small practices are at greater risk. If one partner in a two partner practice dies, or if a single-handed doctor loses a manager they depend on, it can be close to impossible to continue to maintain the necessary service. A remaining partner may have little knowledge about managing the financial situation. They may not feel able to take time off when they need to. They may be overwhelmed by anxiety for themselves, their patients, and the staff they employ. The risks of burnout are very high for people in this position, especially for those who lack practical or emotional support.

*"Of course, if you are a single-handed GP, who will do the work? Nobody is doing prescriptions; nobody is doing anything. I had a medical certificate, but I just tore it up as I had to carry on working anyway."*

### 4. Getting external support

Teams who have suddenly lost a valued member may struggle to meet their support needs over what can be a protracted period. It is crucial to identify individuals who are experiencing intense or ongoing difficulties and offer additional help. Some of the people we interviewed were showing signs of continuing trauma several years after the suicide of a colleague. People in a leadership role might be particularly vulnerable to long-term adverse effects; they may only be able to support others by dissociating from their own feelings and can find it difficult to find the necessary time and space to grieve themselves. As discussed earlier, relationships within the team may deteriorate in the aftermath of their colleague's death and people may disagree about key issues, such as discussing the cause of death with patients. Fortunately, doctors who are struggling can refer themselves to NHS Practitioner Health (NHS PH)<sup>i</sup> and should be encouraged to do so. This is a free, confidential NHS service for doctors and dentists across England. It can help with issues relating to a mental health concern, including stress or depression or an addiction problem, with a particular focus on issues that might affect work. They can also offer support to a doctor leading the response to a death by suicide in their practice, which may not be well known. The BMA also offers a confidential 24/7 counselling and peer support helpline for all doctors and medical students, as well as their partners and dependents<sup>ii</sup>.

Someone from the practice may be required to give evidence at a coroner's enquiry, and they may need support in preparing. Our interviewees found that being able to discuss their situation with an external person who had experienced a death by suicide in their practice was very useful, even if this was a while after the event. It is important to ensure that support is not obligatory or intrusive. Some individuals or teams will cope well without external input. No one should be considered 'unfeeling' or 'uncaring' if they are managing well and do not feel themselves to be significantly affected.

*"In terms of support, the right person is needed at the right time in the right place. They need to recognise that people's reactions are different so different input is needed."*

i. <https://www.practitionerhealth.nhs.uk/>

ii. <https://www.bma.org.uk/advice-and-support/your-wellbeing>

## The first month: getting the 'right' kind of support, working towards recovery

For non-medical members of the team, the local Improving Access to Psychological Therapies (IAPT)<sup>iii</sup> service can be helpful. As well as offering individual support, they may be willing to offer a group session to members of the practice. If the practice has an Employer Assistance Programme, this may be able to provide access to counselling and support. There may be a minister of religion who knows the family and the practice and who can offer individual support if required. It is important to bear in mind, however, that members of staff will have diverse religious and spiritual beliefs.

The external bodies mentioned above (e.g. the Medical Director and cluster lead of the CCG, the Local Medical Committee, the chair of the Primary Care Network and, in the case of a doctor, the Responsible Officer) will have to be informed of the death. Although it might be assumed that these bodies would be able to provide practical guidance and other types of support, our interviewees expressed frustration and concern at the reluctance of anyone to take responsibility or offer assistance. As Primary Care Networks develop and practices collaborate more, this may improve.

The bodies that were approached by staff following a colleague's death by suicide in their practice did not seem to know what to do or what to say, apart from to express sympathy. This left practices obliged to cope alone in spite of being very vulnerable. To be effective, support needs to be timely and appropriate to the needs of the practice and the people working within it.

*"We had no external connections. I got my help from my personal connections and friends. Thank God I rang my ex medical director and she told me what to do next. Thank God I went to see my ex course organiser who helped me with my budgeting.*

*"I had one phone call from the CCG, but it came to nothing – there was just a pat on the back 'are you OK, get on with it'. I have to be honest; I did not find them supportive at all. I wasn't expecting anything from them, to be truthful, but no help came."*



### THE FIRST MONTH: KEY ACTIONS

- Assessing the risks to the short-term and longer-term functioning of the practice.
- Ensuring opportunities for the team to continue to meet and offer mutual support.
- Dealing with continuing distress and emotional responses such as guilt and anger in the team.
- Recognising that staff will have different emotional experiences at different stages, so an individually than a collective approach to support will be required.
- Referring people who may be experiencing protracted, more serious emotional distress for external support.
- Agreeing on a consistent approach to ongoing communications with patients.

iii. <https://www.england.nhs.uk/mental-health/adults/iapt/>

## Longer term effects and actions: vigilance, continued support, remembrance

### 1. Continuing support among the team and meeting the needs of individuals

During the initial acute phase after the death by suicide of a colleague, people are likely to find it difficult to maintain focus and be productive. Most people will recover their ability to function in a fairly short time, provided they receive support from others if this is required and are compassionate towards themselves. After the first few weeks or so, it is common for people to want to start getting 'back to normal' and they will try to find a way to continue grieving while being able to meet their other responsibilities. Over the longer term, team members may not need to meet up regularly to discuss their loss, but this could be arranged on an ad hoc basis if required. Nonetheless, unrealistic expectations of oneself and others to 'move on' should be avoided and people may be reluctant to disclose that they are not coping well. The impact of a death by suicide in the workplace can take a long time to manifest itself and some colleagues may continue to feel the loss intensely or experience more complex emotional reactions. Existing vulnerability factors may be stress related to the job or personal life, health problems, a limited social support network, or a previous bereavement by suicide.

Some team members may express their reactions behaviourally, through absenteeism or problem drinking, or through psychological reactions such as negativity and cynicism. Others may work excessively long hours to distract themselves from feelings of loss and negative emotions. In a small organisation, such as a primary care practice, such reactions will impose additional pressure on other team members so discussions and additional support (both emotional and in terms of cover for absence) may be needed. Managers may continue to experience challenges as they need to balance the need to care for and support staff with providing the essential services to patients. They must also practice self-compassion and prioritise their own recovery.

### 2. Remembering the colleague who has died

Decisions about memorials are best made collectively, with the input of all team members. Some months after the death, a memorial event involving patients as well as staff can be a source of comfort for all involved.

*"Her family were all there, as well as local colleagues, and practice staff. We paid tribute to our friend, as a doctor and a colleague. Her husband spoke about what the practice had meant to his wife. Depression was spoken of. Members of the team read out tributes from the condolence book. Others made cakes, organised flowers and served refreshments."*

Marking the first anniversary of the colleague's death and at key milestones thereafter may be appropriate. Planning memorial activities to honour them can be a great source of comfort and help people derive a sense of meaning from the loss. Members of staff may decide to come together to do something symbolic, such as releasing balloons. Colleagues may wish to plant a tree or place a memorial bench in the grounds of the practice, or in a local beauty spot that may have been a special place for the person who has died. They may also decide to hang a photograph or create a memory board, with a selection of photographs and other meaningful items to mark the person's life. Continuing to mark their contribution to initiatives and projects can also be comforting and help keep their memory alive. It is also helpful to plan ahead for 'grief triggers' such as birthdays, or activities and traditions that the person particularly enjoyed.



### THE LONGER TERM: KEY ACTIONS

- Ensuring there are opportunities for continuing support among the team that meets the needs of individuals.
- Being aware of how distress might manifest itself over the longer-term and remaining vigilant for signs of difficulty.
- Balancing the loss with the need to resume 'business as usual', while ensuring that expectations of the team are not unrealistic.
- Highlighting the need for self-compassion and self-care for all team members, including leaders.
- Deciding how to remember the colleague who has died over the longer-term.



## CONCLUSION

The death by suicide of a colleague is an intensely stressful and disruptive event that can be long-lasting and affect every aspect of life and work. The fundamental importance of mutual support was highlighted in our interviews, as teams that 'pulled together' during the crisis helped practices recover and heal. Larger practices were generally able to find resources internally, but this did not prevent those who led the process showing signs of unresolved distress some years after the death. Our interviews indicated that small practices are more likely to struggle at every stage. A single individual may be left to manage major practical tasks, as well as cope with the emotional impact of losing a close colleague. This can place both the individual and the practice at high risk. A sudden death for other reasons, including a death from Covid-19, is likely to have a similar impact on a practice and create similar difficulties. The same recommendations would apply in many respects.

Our interviews have highlighted the actions and support from within the practice that is likely to be helpful for people in primary healthcare organisations who have experienced the death by suicide of a colleague at different stages. Based on their personal experiences, our interviewees made several recommendations for the type of external support that would be appropriate and beneficial following such an event. These suggestions encompass practical and emotional support, some of which should be in place for some time after the event.

- Receiving guidance on what to do at the different stages following the death; not a rigid set of 'rules', but a framework that covers how to deal with various aspects of the event that might arise over the short and longer-term.
- Somebody external to the practice to arrange locums and other cover to enable staff to come to terms with the event in the short-term and avoid exacerbating distress and potentially unsafe practice. Access to 'crisis' funding to pay for this cover.
- A helpline to give people the opportunity to talk through the situation with an external person, who could provide guidance on different aspects of the situation.
- An external, experienced coordinator that can provide a personal, rather than a 'corporate' service to a practice that has experienced a colleague's death by suicide. This could be a role performed by a trained team or task force of volunteer GPs who know the actions that are required and the support that is needed.

- Access to an experienced counsellor who can be contacted for personal support, if required.
- A national mentorship scheme where people working in primary care can talk to another person who has had a similar experience.
- A support group that encourages open and honest discussion.

*"Big organisations may have somebody (possibly in HR) who is responsible for managing situations like this – whether it is effective I don't know. But it isn't anything that we ever anticipate or plan for in general practice."*

*"What I most needed was to talk to somebody who had been through a similar experience. But of course, nobody talks about such things, so you have nowhere to go. It makes you realise that there isn't very much support available at all – no network of support to help during challenging times."*

*"A helpline that offers sympathetic, helpful advice from somebody with some experience in the field might be useful. I can't exactly describe what that support might necessarily entail, but you never know until you use it. Maybe somebody to talk it through with, that could include the practicalities."*

Unfortunately, many of the needs identified are not easily met because of a lack of available resources. In the absence of any guidance, our interviewees were obliged to 'ring round' desperately hoping to receive help which was not forthcoming. This clearly intensified their distress and the difficulties that practices, especially small practices, experienced.

*"There are clear cut protocols for emergency situations, such as if our phone lines go down, there is an electrical failure, or if a building gets flooded etc. There should be a recognition that when you have somebody dying by suicide this is a major incident and needs to be treated as such."*

## RECOMMENDATIONS

The framework we are offering should be widely disseminated so it is available when needed. There should be a single point of contact where the practice can obtain support for team members and help to maintain the practice by right soon after a death by suicide, (and other sudden and traumatic deaths). Someone external needs to advocate for the practice and help them resolve immediate practical issues, as well as signpost the appropriate bodies to inform and where to seek assistance. As a death by suicide in a practice is a relatively unusual event, we suggest that this needs to be a commissioned service.

Opportunities for ongoing support are also crucial during the year following the death to support the practice in identifying staff who are not coping well, and ensuring appropriate emotional support and cover is in place. At present, the Practitioner Health Programme offers support only to doctors. Resources for other staff need to be established.

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ACTIONS NEEDED: SUMMARY TABLE					
Action	First day	First week	First month	Ongoing	Action by whom
Contacting external coordinator/task force to receive guidance on who to inform and to receive ongoing support					External support needed
Access to a helpline to talk through key issues					External support needed
Deciding what to say to staff/liasing with family if appropriate; breaking news to team					Internal
Ensuring there is time and space to de-brief and offer initial support; dealing with distress of staff					Internal
Arranging immediate locums/cover for staff, possibly on an ad hoc basis in future					External support helpful
Access to the crisis fund to meet the costs					External support needed
Identifying anybody who is unable to continue working and ensuring they take time out; reallocating work or finding cover if required					Internal External support helpful
Deciding what to say to patients, breaking the news and dealing with their distress; managing ongoing conversations consistently					Internal
Providing a memorial e.g. flowers and a book of remembrance in reception					Internal
Liaising with the family about the funeral/memorial and finding out their wishes					Internal
Arranging to close the practice for the funeral or getting cover if this is not possible					External support needed
Organising an informal and inclusive memorial, if required					Internal
Identifying practical risks to running the practice (short-term and longer-term) and how they can be managed					Internal
Dealing with personal belongings					Internal
Dealing with ongoing distress among staff and being aware of how it can manifest itself; deciding if external support is needed and where it can be found					Internal External support helpful
Access to an experienced counsellor for personal support, if required					External support needed
Ensuring opportunities for the team to continue to meet and offer mutual support.					Internal
Remaining vigilant for signs of difficulty and referring on if required					Internal External support helpful
Deciding how to remember the colleague who has died over the longer-term.					Internal
Ongoing external support: a national mentorship scheme and support group for people to share similar experiences					External support needed

## SPECIFIC RESOURCES

### National Health Service Practitioner Health

<https://www.practitionerhealth.nhs.uk/>

NHS PH is a free, confidential NHS service for doctors and dentists across England. The service is accessed by self-referral. It can help with issues relating to a mental health concern, including stress or depression or an addiction problem, with a focus on issues that might affect work. The service can also offer support to a doctor leading the response to a death by suicide in their practice, which may not be well known. They also host a regular bereavement group for families of health professionals who have been lost to suicide.

### British Medical Association

<https://www.bma.org.uk/advice-and-support/your-wellbeing>

The BMA offers confidential 24/7 counselling and peer support for all doctors and medical students, as well as their partners and dependants, on 0330 123 1245.

### Doctors in Distress

<https://doctors-in-distress.org.uk/>

A charity committed to reducing the prevalence of burnout and suicide among doctors in the UK. Their primary goal is to reduce stigma, change behaviours and cultures and promote the value of good leadership.

### Survive and Thrive Virtual Doctors' Mess

[contactdoctorsmess@gmail.com](mailto:contactdoctorsmess@gmail.com)

Confidential weekly groups facilitated by medical educationalists and coaches, providing space for doctors to share and offload. Wednesdays 18.30-19.30. To register, e-mail the link above with your name and GMC number.

### Improving Access to Psychological Therapies Service (IAPT)

<https://www.england.nhs.uk/mental-health/adults/iapt/>

IAPT services are offered by all clinical commissioning groups across England, so are locally responsive. The service offers a range of talking therapies, delivered by fully trained and accredited practitioners, matched to the mental health problem and its intensity and duration and designed to optimise outcomes. They may be willing to come into a practice and work with a group of staff.

## RESOURCES FOLLOWING A DEATH BY SUICIDE

### Help is at Hand

<https://supportaftersuicide.org.uk/resource/help-is-at-hand/>

A leaflet resource for people bereaved through suicide or other unexplained death, and for those helping them, supported by Public Health England and the National Suicide Prevention Alliance.

### Mind

<https://www.mind.org.uk/information-support/guides-to-support-and-services/bereavement/bereavement-by-suicide/>

Provides information on bereavement by suicide and links to further resources.

### Support After Suicide Partnership

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

Brings together suicide bereavement organisations and people with lived experience to give practical and emotional support for anyone bereaved by suicide.

### Survivors of Bereavement by Suicide

<https://uksobs.org/>

<https://uksobs.org/for-professionals/>

Offers a national helpline for people bereaved by suicide and professionals who work with people affected by suicide. A range of resources, a forum and virtual support groups are also available.

### Samaritans

<https://www.samaritans.org/about-samaritans/research-policy/bereavement-suicide-services/>

Policy briefing on the support needed by people who are bereaved by suicide that highlights the need for prevention strategies, quality standards for services and training for frontline professionals.

“Death by suicide is thankfully an uncommon event in General Practice – but what happens when it is one of your own? How do individuals and practices cope, and what support should be available to help them through the difficult time following the death by suicide of a member of the practice team?

Building on the experiences of individuals who have been through this devastating scenario, this new report describes the difficulties faced and presents a framework of actions. It highlights several challenges for those diverse organisations who commission, represent and support practices, and who should be able to assist, for both the short and long term. These challenges must be addressed.”

*- Dr Alex Freeman, General Practitioner and Chair, The Louise Tebboth Foundation*