Dr Catherine Millman &
Áine McAnuff
Health Intelligence
Linum Chambers

Evaluation of the SD1 and CRP processes in Northern Ireland as a response to suspected suicide

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Glossary of terms

C&V	Community and Voluntary sector
CRP	Community Response Plan
FMO	Forensic Medical Officer
HSC	Health and Social Care
HSCB	Health and Social Care Board
HSCT	Health and Social Care Trust
NISRA	Northern Ireland Statistics and Research Agency
NOK	Next of Kin
OCMT	Occurrence Case Management Team
PHA	Public Health Agency
PLIG	Protect Life Implementation group
PSNI	Police Service of Northern Ireland
RSG	Regional Steering group
SAI	Serious Adverse Incident
SD1	Sudden Death (form)
Support Services	Support services are provided by HSC Trusts and C&V organisations following a death by suicide.

Acknowledgements

Special thanks go to the individuals bereaved by suicide who gave up their time to talk to the evaluation team about their experiences about the support processes in Northern Ireland. Their input is crucial to help inform how support is provided in the future to ensure that services meet the needs of people bereaved by suicide.

We are also grateful to the PSNI officers who gave up their time to discuss their experiences when responding to suspected suicide. Finally, we would like to thank the support services based in the C&V sector who talked to the evaluation team about the work they do to help and support bereaved individuals and communities in their areas.

Executive Summary

Background

The process in Northern Ireland to report and react to suspected suicide involves the completion of a 'Sudden Death' form by police officers (known as the SD1 form). The SD1 form triggers support for anyone bereaved by suicide. Information captured on the SD1 form is also used to determine whether a Community Response Plan (CRP) is activated to provide a greater level of support into communities. Ultimately, these processes aim to reduce the number of suicides in Northern Ireland.

The SD1 and CRP processes have been subjected to ongoing evaluation which has included:

- Desktop analysis of SD1 data (Apr-12 to Mar-14 and Apr-Sep '17);
- 13 interviews with support services (5 HSCTs & 8 C&V organisations);
- 11 interviews and one focus group with families bereaved by suicide;
- 12 interviews with PSNI officers;
- Engagement work with PHA Health Improvement staff (n=7);
- Desktop review of CRP debriefing papers (n=8).

Findings

<u>SD1 data and processes</u>

- SD1 processes are viewed as a positive step in offering postvention support.
- PSNI officers have some training to respond to sudden death but training is not consistent across the region and further training was welcomed.
- Responding to a suspected suicide can be difficult for PSNI officers to manage in relation to their professional roles and the need for self-care.
- SD1 forms completed to a high standard but some of the data collected may be inconsistent and unreliable if difficult to obtain (eg involvement of alcohol/drugs, whether the deceased was known to mental health services).
- PSNI officers felt they were most suitable to offer support to bereaved families but were unsure about the processes triggered by the SD1 form.
- Delays were reported earlier in the implementation period regarding HSC Trusts receiving SD1 forms from PSNI but delays have since been rectified. Occasional delays may still occur but are appear to be due to the complexity of cases.
- Evidence of strong partnership working and effective communication between the PSNI and Trusts.
- Strong links between PSNI and HSC Trusts helped to ensure suspected suicides were responded to in timely manner. Also effective in responding to rumours.

<u>Providing support to individuals and communities bereaved by suicide</u>

- The timing and type of support provided to individuals bereaved by suicide varies depending on their need. Individual circumstances mean there are no standardised packages of care.
- Substantial effort is made by support services to identify anyone requiring care and this includes family, friends, work/school colleagues and the wider community who may be impacted by suspected suicide.
- Most bereaved families were able to access support that met their needs and described the support they received as 'lifesaving'.

- Receipt of an SD1 form prompts HSC Trusts to determine whether the deceased had accessed mental health services in the year before death. If the deceased had accessed mental health services, the Adverse Incident process is initiated.
- Trusts play important role in monitoring SD1 data and this may trigger a CRP.
- Activation of a CRP requires multi-agency partnership working across a wide range of groups.
- Actions implemented during the CRP process includes providing support for individuals and raising awareness of support available, having a vigilant response team and media engagement.
- Debrief sessions occurs after a CRP has been deactivated and the success of the CRP and identifies learning for going forward.
- The CRP process was challenging and demanding for individuals involved but is considered to save lives.

Key considerations

- There is opportunity to consider the information required following a suspected suicide and amend the SD1 form accordingly.
- If required, data capture processes could be formally recorded to monitor processes more robustly (eg timing of receiving information, individuals accessing support and types of support provided).
- The process introduced during the evaluation to check that information is held consistently between PSNI and HSC should be maintained going forward.
- Consider providing training to all stakeholders responding to suspected suicide (including the SD1 and CRP processes and self-care).
- Standardisation of the processes for offering support would ensure the same services are offered region-wide.
- There should be regionally agreed protocols for contacting individuals who declined support and protocols should ensure individuals rights are protected and should not risk any further trauma.
- Roles and responsibilities should be clarified when responding to suicide and providing support to individuals and communities.
- There is opportunity to share learning following the activation of CRPs to ensure responses to suicide are more effective in future.
- There may be some opportunity to include a greater number of stakeholders, particularly from the statutory sectors, to contribute formally to the SD1 and CRP regional groups.
- There is an opportunity to address gaps in service provision which include:
  - Providing support to the person who found the deceased if this is not the NOK;
  - Providing support when a person dies outside of NI but their relatives live in NI;
  - Provide support to parents and raise awareness of the support available for children following a death by suicide.

1 Introduction

Each death by suicide will impact on the deceased's family, friends, wider social circle, community and potentially strangers, depending on the circumstances of death. Whilst there is no agreement about the number of people impacted by a single death, estimates suggest from at least six individuals[1] and can depend on a range of factors (eg age, relationship to those bereaved, employment situation etc[2]). In 2016, 297 individuals in Northern Ireland died by suicide which conservative estimates therefore suggest the number of those impacted is 1,830 individuals in a single year.

The impact of suicide on those bereaved is vast, impacting their physical, psychological and social lives. Impacts include confusion, loss of sleep/insomnia, lack of energy, numbness, nightmares, feelings of unreality, loss of control, fear, blame, anger, guilt, social isolation, stigma, unemployment, anxiety and depression[3-5]. There is also evidence of suicide contagion whereby exposure to suicide can normalise the behaviour and increase the risk of imitation behaviour. Those bereaved by suicide are considered at particular risk of contagion[5].

Several authors argue that the impact of suicide on those bereaved is distinctly different and more intense than the normal grieving process by other means of death[5-6]. There is potential for those bereaved by suicide to become 'stuck' in their grief, unable to move on and the symptoms of grief do not wane over time.

Research suggests that postvention strategies can help to meet the needs of those bereaved by suicide by helping individuals with their grief [2,7]. The timing of support can have an impact on effectiveness with earlier support considered most appropriate and effective with a need for ongoing support in the long-term[8].

In Northern Ireland (NI), the refreshed suicide prevention strategy *Protect Life*[9] listed several evidence-based actions for delivery[1]. These include:

- The provision of early access to local information to allow for early identification of suicide and self-harm;
- Develop mental health services which reach out proactively and assertively to vulnerable people at times of emotional crisis, and to develop 'places of safety' for people at risk of suicide.

To meet the needs of those bereaved by suicide and contribute to the *Protect Life* actions, the current SD1 and CRP processes were introduced in April 2012. The process in place in NI to report and respond to sudden deaths starts with the completion of a 'Sudden Death' (SD1) form by PSNI officers. This form triggers support for the family that has been bereaved and informs decisions about how communities can be supported. If appropriate, a Community Response Plan (CRP) may be initiated.

It is hoped that the SD1 and CRP processes will help to identify those most at risk from suicide at an early stage. Early identification of those at risk provides an

[1] The strategy is currently being updated by DoH and the new strategy (*Protect Life 2*) is anticipated to be announced in 2018.

opportunity for localised support to be available where, and when, it is needed most. It is hoped that this process will ultimately help to reduce suicides in Northern Ireland.

1.1 The SD1 process

When a sudden death is notified to police and it is a suspected suicide, PSNI officers are the first responders to attend the scene of death. Based on the guidance of the Forensic Medical Officer (FMO), PSNI officers record information about the deceased and their next of kin (if consent is provided) on a SD1 form. The form captures basic information about the deceased (including demographic information and prior involvement with mental health services), the circumstances of suicide and contact details of family members who provide their consent to be contacted by support services.

The Occurrence Case Management Team (OCMT) within PSNI manages all coronial correspondence in relation to all unexpected deaths including the SD1 process. The completed SD1 form is sent via secure electronic transfer by OCMT to key Health and Social Care Trust (HSCT) and Public Health Agency (PHA) representatives within 48 hours.

1.2 The CRP processes

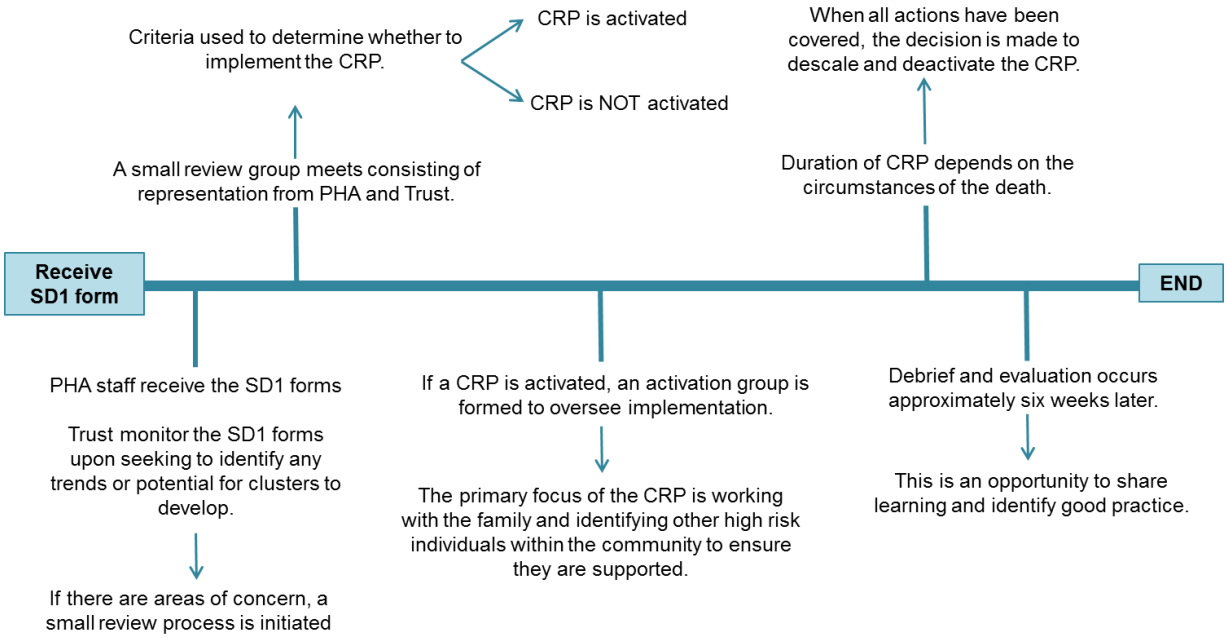
The primary focus of the CRP is to facilitate early detection of a cluster to ensure timely support is provided across the community and to prevent further deaths from occurring. Key individuals within each HSCT monitors information received on SD1 forms to ensure that bereaved individuals and communities receive timely support following a death by suicide. If there are concerns about the impact of a death on the wider community, a review process is initiated to review whether a CRP should be activated. Initially this review group consists of representation from HSC organisations and local C&V organisations but wider representation will be sought depending on the needs of the community following the death. The review group oversee implementation of the CRP including the rationale for the CRP, the scope of the CRP, any actions identified and progress, and decision-making processes around descaling and/or deactivating a CRP. A debrief and evaluation occurs approximately six weeks after the decision to deactivate the plan. This provides an opportunity for all members involved to share learning and identify good practice. Progress on these actions is reported on at HSCT Protect Life Implementation group (PLIG) meetings where the CRP is a standing item[2].

It is important to note that activation of a CRP is not required in all instances whereby someone dies by suicide. However, each death is carefully assessed to determine the extent of response required following a suspected suicide.

Figure 1 provides an overview of the processes which are followed when determining whether to implement a CRP. In some occasions, community intelligence presents ibefore the SD1 form and this may be the catalyst for the small review process to be initiated.

[2] The implementation of the *Protect Life* strategy is managed by the Implementation Group, chaired by the PHA and Community and Voluntary sector. The chair of Trust Protect Life Implementation groups varies across Trusts

Figure 1: CRP processes



1.3 Management groups

Chaired by the Public Health Agency, a Regional Steering Group (RSG) meets biannually to oversee the SD1 and CRP processes. The group includes representatives from PHA, PSNI, HSC Board, HSCTs, Families Voices, and Ulster University. The purpose of the group is to continue to monitor the implementation and develop the SD1 and CRP processes where appropriate, monitor SD1 data for emerging trends and to share best practice and learning. Information from the RSG is fed back to the local PLIGs, as appropriate.

2 Evaluation approach and methodology

The SD1 and CRP processes have been subjected to ongoing evaluation from April 2012 to February 2018 with a central aim:

> *to review the processes and implementation of suicide surveillance and the community response plan processes*.

Five objectives presented in Table 1 were devised to meet the aim of the evaluation work. The approach and methodology used to evaluate the SD1 and CRP processes are outlined against each of the objectives in Table 1. Interim findings during the evaluation period have been reported via the Regional Steering Group when available.

Table 1: Evaluation approach

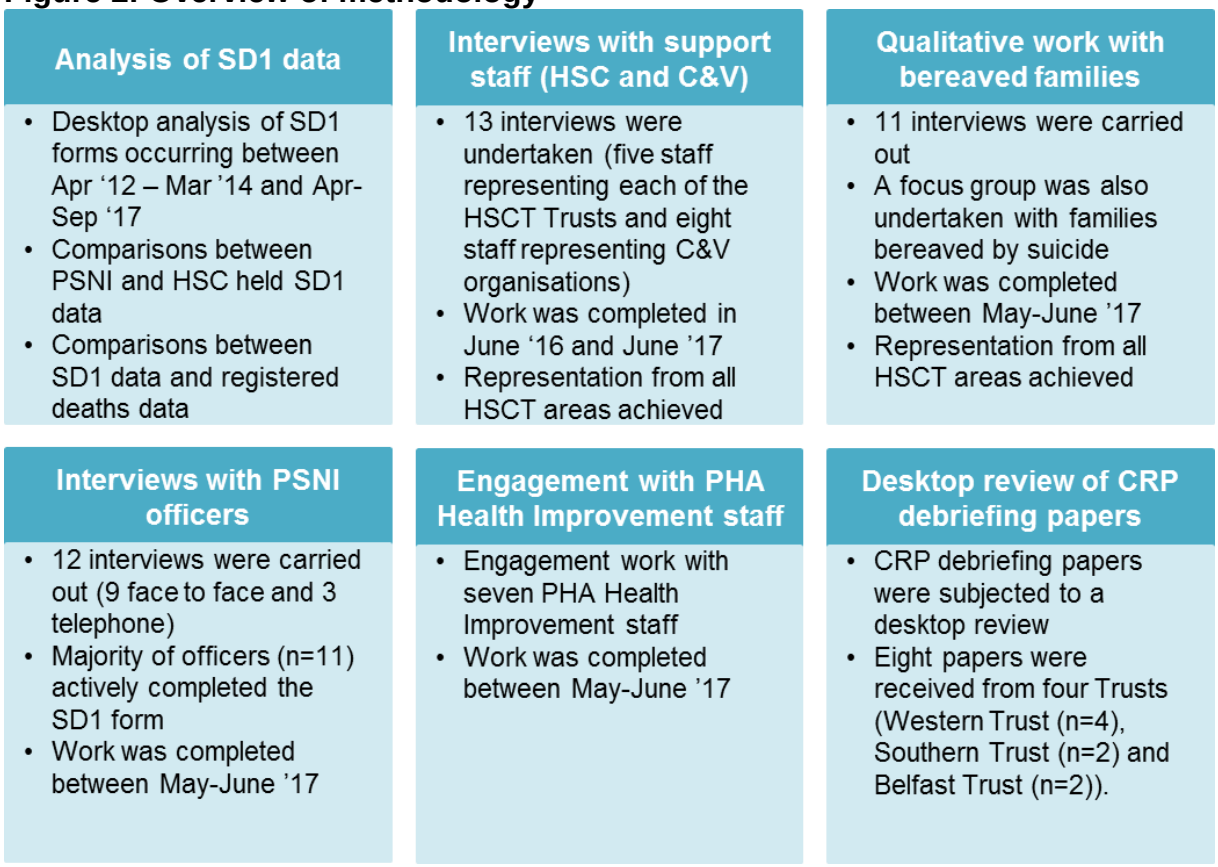
Objective	Approach	Data sources
To review the SD1 data collection form and processes	Analysis of SD1 forms completed between April 2012 and March 2014; analysis of data in the first two quarters of 2017/18 financial year Understanding of purpose of SD1 form and questions	SD1 database from PSNI and HSC records PSNI interviews
To review consistency, accuracy and timeliness of SD1 data	Comparison of PSNI and HSC records, and comparison with suicide deaths occurring in 2013	SD1 database Deaths database Support Services interviews
To review the communication processes between relevant PSNI and HSC bodies	Feedback from relevant stakeholders to examine processes	PSNI interviews HSC interviews
To review the impact on families and their reaction to the process and subsequent uptake of support	Feedback about reactions to support following death Uptake of support services by bereaved families	Bereaved families interviews Support Services interviews
To review the use of the SD1 data regarding the CRP processes	Use of the data captured on the SD1 form to inform the CRP processes	Support Services interviews PHA engagement work
To assess the impact of the CRP processes	Outline resultant action of CRP processes Identify consistent best practice	Support services interviews Review of CRP debriefing papers

2.1 Methodology

The methodology used to evaluate the SD1 and CRP processes included (see Figure 2):

- Analyses of SD1 data;
- Interviews with those providing support to bereaved individuals and communities;
- Interviews and focus group with families bereaved by suicide;
- Interviews with PSNI officers;
- Engagement work with PHA Health Improvement staff; and
- Desktop review of CRP debriefing papers.

Figure 2: Overview of methodology



2.1.1 Analysis of SD1 data

Desktop analysis of SD1 data for deaths occurring between April 2012 and March 2014 was completed. Data were analysed to ensure that data were complete, consistent, accurate and timely in terms of the overall SD1 and CRP processes (completed June 2016). To monitor changes in completeness, the analysis was repeated for key pieces of information for SD1 forms received Apr–Sep 2017. Comparisons between PSNI and HSC held SD1 data were conducted along with comparisons between SD1 and registered deaths data[3].

[3] Comparisons with registered deaths data was based only on deaths occurring in 2013. Caution is advised in terms of the comparisons between SD1 and deaths data due to methodological issues and potential delays in death registrations.

2.1.2 Interviews with support staff (HSC and C&V)

Support services are provided and coordinated by staff in the HSC and C&V sectors. Representatives from support services provided insight into how support is provided following a suspected suicide. In total, 12 interviews were undertaken with representatives from support services. This included five staff representing each of the HSCTs and eight representatives from C&V organisations providing support in the Belfast, Northern, Southern, and South Eastern Trust areas[4]. Interviews focused on the processes occurring upon receipt of the SD1 forms to providing support. The interviews also explored any impacts on the support services, staff and recipients of support.

2.1.3 Qualitative work with bereaved families

At the centre of the SD1 and CRP processes, are the families that are bereaved following the death of their loved one to suspected suicide. To assist with the evaluation, 11 interviews were carried out along with one focus group with family members who had been bereaved by suicide within the implementation period of the current processes (ie April 2012 to date).

Given the sensitive nature of this work, care was taken to ensure that participation did not have a negative impact on those who participated. To ensure this, the following criteria were applied so that all interviewees:

- were family members or friends of the deceased;
- were adults aged 18 years and above;
- the death had occurred at least one year prior to the interview but not before April 2012 when the current SD1 and CRP processes were introduced;
- the death occurred in Northern Ireland;
- were fluent English speakers.

Potential interviewees were identified and approached by the support services who had worked with them following their bereavement. The support services approached individuals they considered to be in a state of readiness to participate. Potential interviewees were asked to initiate contact with the research team (directly or via the support service) and express their interest in participation.

Interviews were carried out face-to-face, arranged for a suitable time and venue for interviewees and lasted for approximately 45 minutes (ranging 15–60 mins). The majority of participants were female (n=9; male, n=2) and all HSC Trust areas were represented. Where information was available, participants were bereaved on average for 2.6 years (ranging 1.5–4 years) and had been bereaved by family members (incl. children, siblings or partners).

Interviews were focused on identifying the support received and interviewees' perceptions about the support they received. To avoid causing distress, interviewees

[4] HSC staff in the Northern and Western Trust areas provide support directly to those individuals and communities impacted by suicide. HSC staff draw on support from C&V organisations in the Northern and Western areas to help provide support in those areas. In the scope of the evaluation, it was not feasible to include all C&V sector organisations that are linked to the SD1 and CRP processes.

were not asked about the circumstances around the death of their loved one but this was discussed if initiated by interviewees.

2.1.4 Interviews with PSNI officers

In the case of a suspected suicide, PSNI officers are first responders and their role is to preserve the scene, liaise with public and statutory bodies (eg Coroner's office), and complete relevant paperwork. Twelve interviews were carried out with PSNI officers in May-Jun '17 (nine face to face and three telephone interviews)[5]. The majority of officers (n=11) had attended the scene of a suspected suicide and completed the SD1 form. In total, eight males and four females were interviewed and interviews lasted for approximately 25 minutes on average (ranging 20–40 mins). Interviews focused on the role of PSNI officers at the scene of a suspected suicide and the processes they follow, understanding of the SD1 and CRP processes, and the impact on officers (professionally and personally).

2.1.5 Engagement with PHA Health Improvement staff

Seven PHA Health Improvement staff engaged in the evaluation due to their involvement in the SD1 and CRP processes. This work was to establish the processes for activating a CRP, to gain an insight into implementation processes and to understand how partnership working with other stakeholders has contributed when dealing with suicide.

2.1.6 CRP debriefing papers

Eight CRP debriefing papers were reviewed to identify best practice. Papers were received from the Western HSCT (n=4), Southern HSCT (n=2) and Belfast HSCT (n=2)[6].

2.1.7 Reporting on evaluation work

As the evaluation has been ongoing from April 2012, interim findings have been reported to the RSG. Earlier reporting was to ensure that learning could be considered in a timely way. However, this final evaluation report presents findings from all of the evaluation work carried out (previously outlined in Figure 2).

[5] Representation was achieved in all HSCT areas with the exception of the Belfast HSCT due to constraints within PSNI when fieldwork was ongoing.

[6] Both Northern and South Eastern Trust were contacted and asked to provide copies of CRP debriefing papers but none were available. There were no CRP activations in the Northern Trust and it was not possible to access CRP debriefing papers written prior to recent staffing structures for the South Eastern Trust.

3 Findings

This section includes the findings from the evaluation work outlined in Table 1.

3.1 Objective: to review the SD1 data collection form and processes

PSNI officers follow specific processes when attending the scene of a suspected suicide to ensure that SD1 data is collected. When the SD1 form is completed, a copy of the form is sent to representatives in the HSCTs and PHA. Findings relating to the processes from collection to liaising with HSCTs are presented in the sub-sections below.

3.1.1 Attending the scene of a suspected suicide and completing the SD1 Form

All stakeholders participating in the evaluation viewed the SD1 form as a positive first step in offering postvention support to those impacted by suicide. PSNI officers attending the scene of a suspected suicide are required to complete the SD1 form along with two other forms used for the purposes of PSNI and the Coroner's office (the P1 and Form 19).

Officers felt that responding to suspected suicide is a part of their job and they reported having some relevant training including District Training (n=8), Family Liaison Officer Training (FLO, n=2) and communicating death messages and investigations (n=2). A small number had training in suicide prevention (ASIST, n=1; generic, n=1), mental health awareness (n=2), mental illness (n=2), and training on appropriate language to use (n=1). Officers felt they had received little training on suicide prevention/mental health and this type of training was not consistently available across the region.

More training was welcomed by officers, including training on the SD1 and CRP processes (and support provided), how to communicate with the bereaved next of kin, mental health and/or suicide prevention training, and FLO training. Officers suggested that resources that can be left with the bereaved family about support would be useful.

> *We are coming across more and more incidents [involving mental health issues]. It seems to be a bigger part of our job all of the time.* **PSNI officer**

> *I've actually had to prevent people from harming themselves by jumping or cutting.* **PSNI officer**

> *Every officer in here is not trained to deal with the aftermath of suicide.* **PSNI officer**

Whilst the majority of officers felt comfortable completing the necessary paperwork, some felt that there was duplication between the forms and this made form completion intensive and burdensome. Duplication appeared to be between the Form 19 and P1 forms. Some officers suggested the forms should be completed

electronically at the scene. This would allow for the information to be input once only but forwarded to the relevant departments and would minimise burden on officers.

> *[There are] countless forms to fill in... There are a lot of forms, too many I think. A lot, I find, is duplication.* **PSNI officer**

> *Maybe fill them [form] in on your phones now. I think it's daunting when you go to someone who has just killed themselves and whip out all these forms so maybe if you just have a few questions and you could type the answers into the phone so it's not as obvious it's a form we are completing.* **PSNI officer**

The majority of officers (8 out of 12) reported completing the SD1 form at the scene whilst others completed the form at the station immediately after attending the scene (n=2). Officers reported gathering information quickly and efficiently and some emphasised the need to do this discreetly to minimise any distress for those bereaved at the scene. Officers felt it was easier to obtain information for the SD1 form if they established rapport with the bereaved.

> *Whenever you go to a sudden death, a lot of people are very upset and traumatised by what has happened…it [building rapport] is just a matter of taking your time…and trying to empathise with the family.* **PSNI officer**

Officers discussed how they managed the challenges to their role as evidence gatherers when attending the scene of a suspected suicide. Whilst understandably upset by the scene and death of a loved one, the emotional reactions of those bereaved by suicide was reported as being difficult at times for some officers to cope with. Officers reported that the grief and shock experienced by those bereaved could be further confounded by the time taken for investigative processes to be completed.

Officers recognised that responding to a suspected suicide could impact on them professionally and personally. Whilst responding to the needs of those bereaved at the scene, officers were required to balance compassion and protecting themselves psychologically. The nature of the death could affect officers and the processes (eg gathering information, completing forms etc) they followed could be used as a protective barrier and help them to remain detached. Officers reported having little time to deal with the impact of exposure to suicide on a personal level and this raised concerns around their self-care.

> *I am there to do a job and I do it to the best of my ability and I do it professionally. I have to remain detached…because tomorrow I come back to work and I might be met with a similar situation and I have to be fit to deal with everything that I meet.* **PSNI officer**

> *I don't particularly like them [suicide deaths] and you do wonder about the long term effect that it would have personally.* **PSNI officer**

However, all officers were aware that support was available if needed to help them cope if they felt impacted by deaths by suicide they had responded to. Support

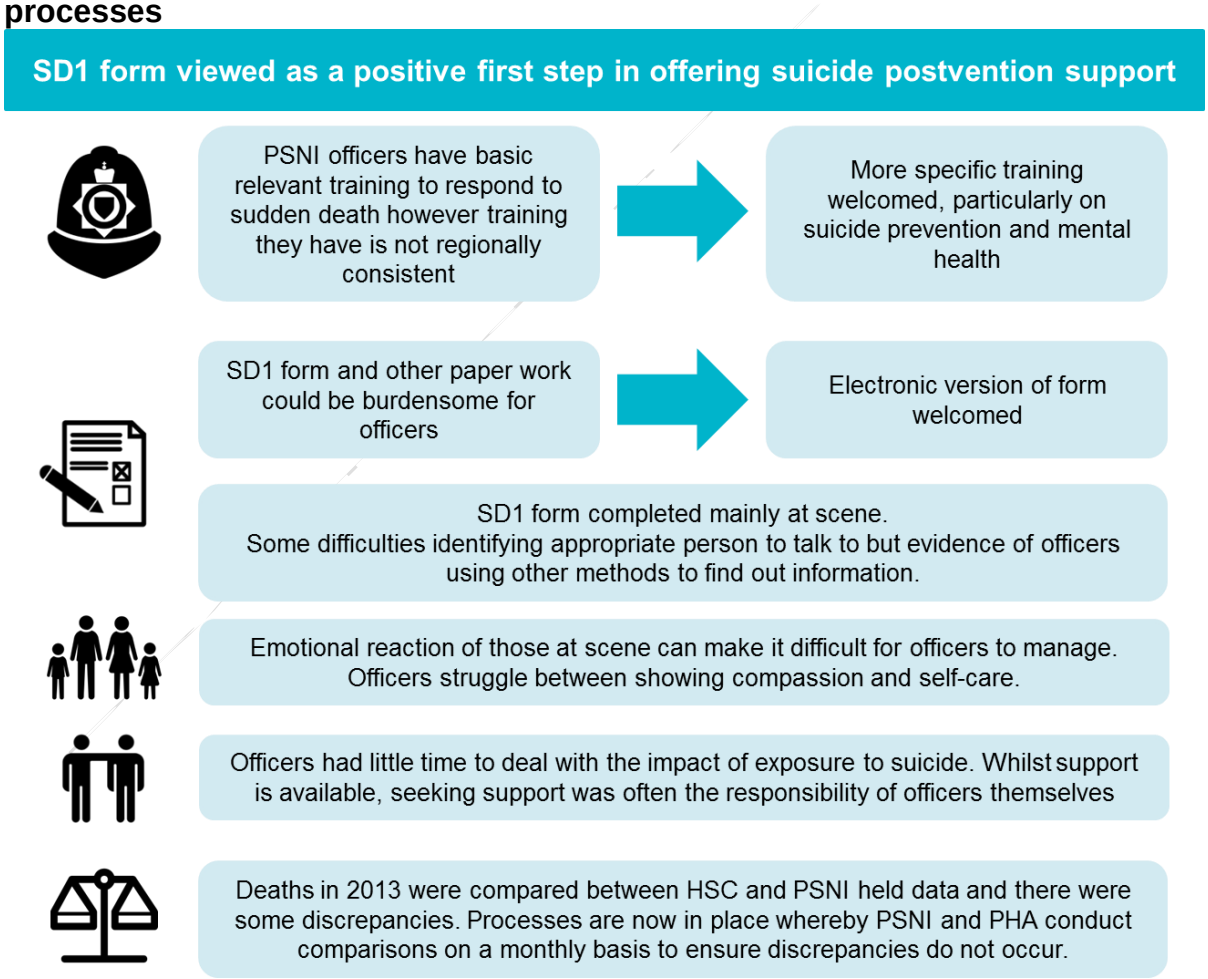
available included a referral to their occupational health and general wellbeing support/clinical support and some mentioned they could speak with their line managers. Seeking support was viewed as the responsibility of officers themselves which they were often reluctant to do.

3.1.2 Transfer of SD1 data from PSNI to HSC

When officers complete the SD1 form, they submit it to an internal department known as Occurrence Case Management Team (OCMT) who then forward the forms to HSC and PHA.

To examine the process of transferring SD1 data from PSNI to HSC, data for deaths occurring in 2013 were compared[7]. In total, 18 records held by PSNI were not held in HSC records. In nine cases, the SD1 form had not been completed and the remaining nine were sent to the Coroner's office in error. This interim finding was communicated to the RSG and processes have since been introduced to rectify this. The PHA and PSNI now compare data on a monthly basis to identify and rectify discrepancies as soon as possible.

Figure 3: Key messages for reviewing the SD1 data collection form and processes



[7] At the time of analyses, this was the first full year period of data available.

3.2 Objective: to review the consistency, accuracy and timeliness of SD1 data processes

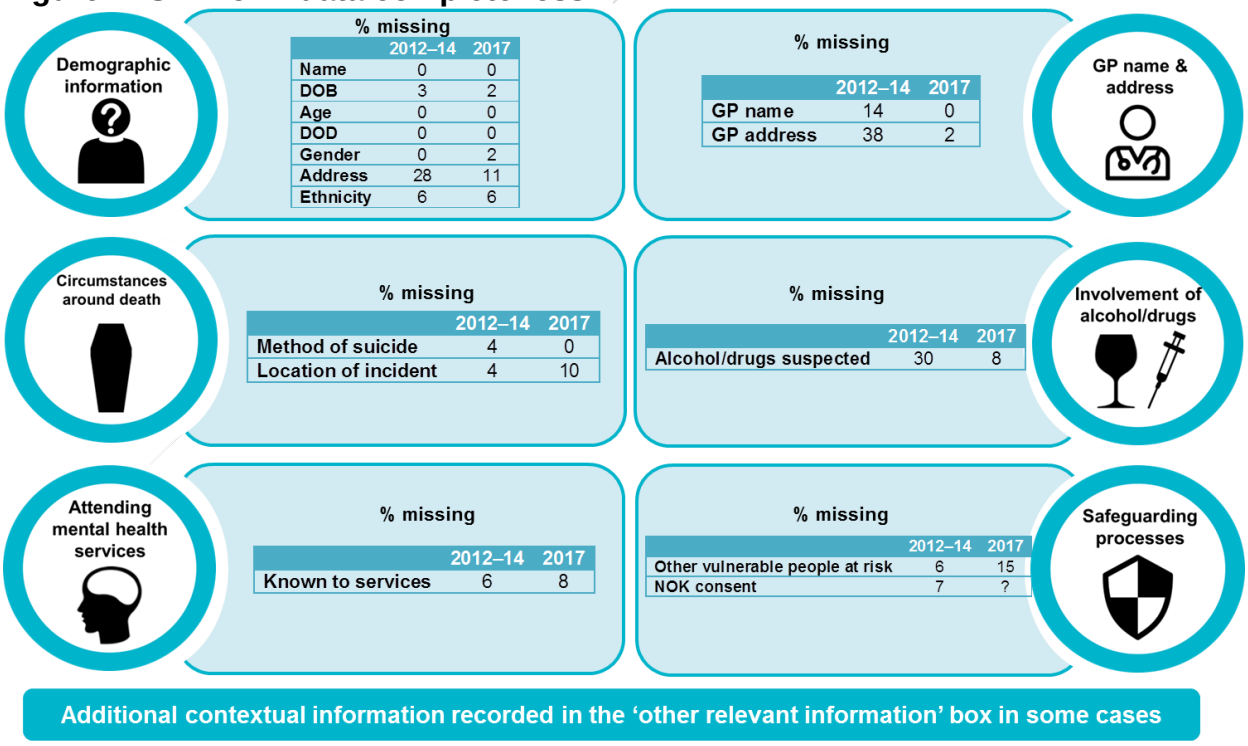
Information collected via the SD1 processes is used by support services to target postvention support for bereaved individuals and communities. It is important that information captured on the SD1 forms are completed to a high standard and that the information captured is consistent and accurate. The data captured for deaths occurring between April 2012 and March 2014 were analysed to assess the consistency and accuracy of information collected. Data completeness was also carried out on SD1 data for deaths occurring to date in 2017 (April to September). Perceptions around data completeness, accuracy and timeliness were explored through interviews with support services and PSNI.

3.2.1 Consistency and accuracy of SD1 form data

Overall, SD1 forms were completed to a high standard indicating that PSNI officers were making every effort to complete the forms. The extent of missing information for key sections of the SD1 form is outlined in Figure 4.

Over the course of implementation, steps have been made to improve areas of concern relating to missing information. This includes an improvement in the completeness of fields such as the deceased's address, the GP information, the method of suicide, and whether alcohol/drugs were suspected. The remainder of this sub section will focus on discussing each section of the information captured on the SD1 form.

Figure 4: SD1 form data completeness



3.2.1.1 Deceased's demographic information

PSNI officers stated that capturing information on the SD1 form was part of their role as information-gatherers:

> *That is the bread and butter of policing… they are always obtained by police officers so getting that information is what comes second nature*. **PSNI officer**

Analyses of data for 2012–14 showed data quality issues in particular relating to the deceased's address (missing in 29% of cases) and ethnicity (6% of missing cases but more typically impacted by inconsistent and unreliable recording). PSNI officers usually obtained the deceased's demographic information from those bereaved at the scene. Whilst the majority of officers (10 out of 12) reported no difficulties in obtaining demographic information, this information could be more difficult to obtain if the bereaved family were in shock as this could impact on their ability to recall specific details. Difficulties were also reported if the deceased was single or died in a public place with no documentation available that included their identification. In these instances, officers relied on searches of PSNI databases or gathering intelligence from the local community.

Despite officers making efforts to obtain accurate information for the SD1 form, some issues around data quality remained. Support services highlighted how these data quality issues could impact on their responses to SD1 information:

> *Sometimes I need clarity around an address, a telephone number and I go back to OCMT. On one occasion there wasn't a telephone number, or a digit missing. There was one [form received and] I was going to send the letter to a completely different address. It was as well I phoned the [next of kin beforehand].* **Support services**

Since the time of this interview, the SD1 form was amended to provide the names of attending PSNI officers. This has allowed for support services to clarify details recorded on SD1 forms more easily.

3.2.1.2 Information relating to the deceased's GP

In 2012–14, the name of the deceased's GP was missing for 14% of cases and there was no address for 38% of cases. How this information was used differed across HSCT areas among services providing postvention support. Some support services used the information in an outreach attempt if the next of kin (NOK) had declined the offer of support initially made by PSNI (see section 3.4.1 for full discussion on obtaining consent for support services). Some support services felt that the shock experienced by the NOK may have impacted their decision to decline consent. Other support services disagreed, arguing that the deceased's GP may not have contact with the NOK and that it was unethical to do so as individuals have the right to decline support:

> *Some people use the GP information to get to [access] relatives but I'm not sure that's the most effective way to get to the family members because they may not be the same GP.* **Support services**

Approximately half of PSNI officers felt they had no difficulty obtaining the deceased's GP information. The other half reported difficulties if the deceased's family did not know this information which could result in officers phoning local GP practices. Whilst officers were trying their best to source this information, they were unaware of the potential for inaccuracies of these methods or recording partial information (eg more than one GP with the same name).

3.2.1.3 Circumstances around the death

Information relating to the circumstances around the death (location and method) was completed to a high degree with improvements noted between the two periods of analyses (2012–14 and 2017). As PSNI officers were recording information about the scene they were attending, it is not surprising that this information was accurately recorded. Some officers tried to obtain wider contextual information through speaking to family and/or friends and also made efforts to capture this on the SD1 form.

3.2.1.4 Involvement of alcohol and/or drugs

In 2012–14, there was a high degree of missing data recorded on the SD1 form relating to the involvement of alcohol and/or drugs for the deceased which improved by 2017 (30% to 8% missing information). However, the recording of this information lacked consistency as a result of different forms being used that asked for different information, whether drugs and/or alcohol were found at the scene, or whether the deceased was known to have misused drugs and/or alcohol in the past. This finding was corroborated by interviews with PSNI officers who were reluctant to make interpretations on the role of alcohol/drugs without toxicology results:

> *Drugs and alcohol, it may be physical evidence there; you know if you are finding drugs paraphernalia present you would certainly consider that and alcohol, again you are looking around the house to see lifestyle things there or talking to family.* **PSNI officer**

> *Without a toxicology report you cannot be sure so it is always going to be a suspected alcohol or suspected drugs overdose, we are not in the position to say otherwise but I think there will always be sufficient evidence on a scene to say it is suspected alcohol or drugs.* **PSNI officer**

Information about the involvement of alcohol and/or drugs was used by support services to help tailor responses to suicide. For instance, if there was a suspected link between deaths as a result of a lethal new drug (but not necessarily between individual deaths), the appropriate responses could be put in place to deal with this issue (eg warnings about specific drugs, increasing accessibility to specific organisations etc).

3.2.1.5 Attending mental health services

Analyses of SD1 data showed a high degree for completeness relating to whether the deceased was attending mental health services, with missing data accounting for 6% of cases. Half of the PSNI officers felt they were able to obtain this information without any difficulties during their investigative processes. Others (n=4) described

difficulties obtaining the information with particular concerns about the reliability of information.

When an SD1 form is received, all HSCTs check their HSC records to see if the deceased was known to mental health services. This is completed regardless of the information recorded on the SD1 form. This initiates a review process within HSCT, if the deceased accessed mental health services in the twelve months before their death. The review provides opportunity for the HSCT to help contribute to understanding about the circumstances before the individual took their own life, learn lessons in an attempt to reduce the risk of future suicides (if appropriate), and share examples of good practice. The review process is known as the Adverse Incident process.

3.2.1.6 The next of kin (NOK) and consent for support

Currently, it is the role of PSNI officers to ask the deceased's NOK if they consent to being contacted for support (see section 3.4.1 on reactions to this). This is one of the most important pieces of information collected via the SD1 process. Along with accessing services for themselves, the NOK is also a gatekeeper through whom other family members, friends or colleagues (work/school) impacted by the death can avail of support offered:

> *The information that is crucial is when the [PSNI] officer has had a conversation with the next of kin about whether they want support.* **Support services**

The majority of PSNI officers said that obtaining consent was part of the processes they were required to follow. Most officers (n=7) believed they were the most suitable people to approach the NOK to ask for their consent for their details to be passed to support services. Officers noted they may be the only point of contact with those bereaved and felt that it may be more difficult to make contact with the NOK at a later stage.

Furthermore, officers felt their role in obtaining consent meant that they were able to offer something to people in distress. This, in turn, helped officers to deal with the situation they faced. A few officers also felt that their role in this aspect of the SD1 process offered more compassion as the NOK would not be cold contacted by a stranger which they perceived to be more difficult for the NOK.

> *We are the one going to their house and saying 'Your son is dead' but you can sort of take the good with the bad. You can say 'if you need help to deal with this, we can pass your details on'. I don't think it would be right to say 'your son is dead' and then leave and wait for some other randomer [sic] to come.* **PSNI officer**

> *I feel very positive about it, you are there to do a job but we also want to support the relatives and the people left behind.* **PSNI officer**

Officers also felt that PSNI involvement in the SD1 process demonstrated partnership working with other agencies, and had a positive impact on their reputation in the wider community. However, some officers suggested other

organisations that could also make the offer of support (eg Coroner's office, GPs, paramedics).

In most cases, officers noted that the NOK may be at the scene they were attending and, as such, there are unlikely to be problems in recording their information on the SD1 form. Some officers reported difficulties if the NOK was not on site, if there were complex circumstances surrounding the death, or if there were difficulties in identifying the deceased. Officers then relied on their own searches (eg PSNI databases, electoral records) to obtain this information.

There was evidence that PSNI officers gave consideration to who would be the most appropriate person to be recorded as the NOK. Officers acknowledged that the legal NOK may not always be the most appropriate person (eg if there were complex family circumstances). In such cases, they made efforts to identify who required support but sometimes relied on the Coroner to make this determination. This decision-making process is lengthy resulting in the information not being available for the submission of the SD1 form.

> *[We thought] the next of kin was an ex-partner …but (the deceased) had been divorced and it wasn't amicable…in that instance I would put the deceased's parent's down because the ex-partner didn't really want anything more to do with them.* **PSNI officer**

> *The only problem would be if they were still legally married but separated but the family would maybe dispute who the next of kin is, that can be tricky. That wouldn't be something that would be completed on the SD1 form, a lot of the time the coroner would actually help you make that decision when they are releasing the remains so they would help you decide, they would know who had precedent.* **PSNI officer**

PSNI officers suggested that consent for support could be extended beyond the NOK. In particular, they observed that the person who found the deceased may require support.

> *A (person) walking his dog came across (deceased). They were obviously quite shocked…it's hard, you can't really label one experience and say everybody who finds a stranger dead will react in the same way… asking that person for their permission to pass their details on to a support agency…I suppose I can't see any problem with that as long as the person gave permission.* **PSNI officer**

3.2.1.7 Additional information

There is a space at the bottom of the SD1 form to capture additional information. This information was completed in a small number of cases in 2012–14 (47 out of 452) which support services found useful. The information captured included contextual information about the deceased (eg history of suicidal behaviours, complex family circumstances), additional information about the circumstances around the death (eg method or notes left), and additional information about the NOK (contact information, support needs, reasons for refusal). Support services said that additional information helped them when contacting the NOK or extending the

offer of support to the wider family/friends/social circle, particularly if there were complex family circumstances.

3.2.1.8 PSNI understanding of the role of the SD1 form

There was limited awareness about processes following submission of the SD1 form among PSNI officers. Nine (out of 12) officers did not know what happens after the SD1 form is submitted. Some showed limited awareness of support being offered:

> *I'm completely oblivious if I'm being honest, I know [the SD1 form] serves a purpose but I'm not sure [what happens].* **PSNI officer**

> *Once that goes we do know that support services will be in contact but as to what services there are I am unaware.* **PSNI officer**

3.2.2 Comparisons between SD1 data and official deaths data (2013)

For deaths occurring in the 2013 calendar year, a comparison was undertaken between SD1 records and official deaths data held by the NISRA[8]. There were 62 deaths by suicide recorded on official deaths data that were not matched with SD1 records. This meant that in 2013, 22% of deaths by suicide were not picked up by the SD1 process and support was not offered in these cases. The majority of these deaths (90% of 62 deaths) occurred at the deceased's home address and occurred as a result of self-poisoning.

3.2.3 Timeliness of SD1 form submission by PSNI to HSC

Although the accuracy of data regarding suspected deaths by suicide is important, support services stressed that the timeliness of the SD1 form being received by HSC was of utmost importance to ensure prompt support is offered to those who need it. Although occurring less frequently, there were reports in the first years of the processes being implemented that SD1 forms were not being sent within the agreed 48 hours to HSC. This delay presented challenges and in some instances timely support could not be offered to the NOK. These examples have been reported to be occurring less frequently as the SD1 and CRP processes became more embedded but monitoring data does not allow for the timing of forms being sent and received to be analysed further.

> *Whatever form you use, you are going to get some people out there who are able to fill out the form fully. You will always get discrepancies on the quality of the information on the form. The timeliness of it all is the key.* **Support service**

> *There seems to be different officers – the form wasn't filled in or they've gone off [eg on leave] and haven't sent the form through. I would phone OCMT and they say they know but they haven't received the form. There's a problem there in keeping to the timescales set out in the first place.* **Support service**

[8] It should be noted that the official deaths data does not include full personal information that would allow for matches on an individual's name and address. Consequently, matches were based on limited information (including gender, DOB, DOD, and postcode). It is possible to get a reliable match on this information. It is possible for errors to have occurred based on a limited match and these findings should be treated with caution.

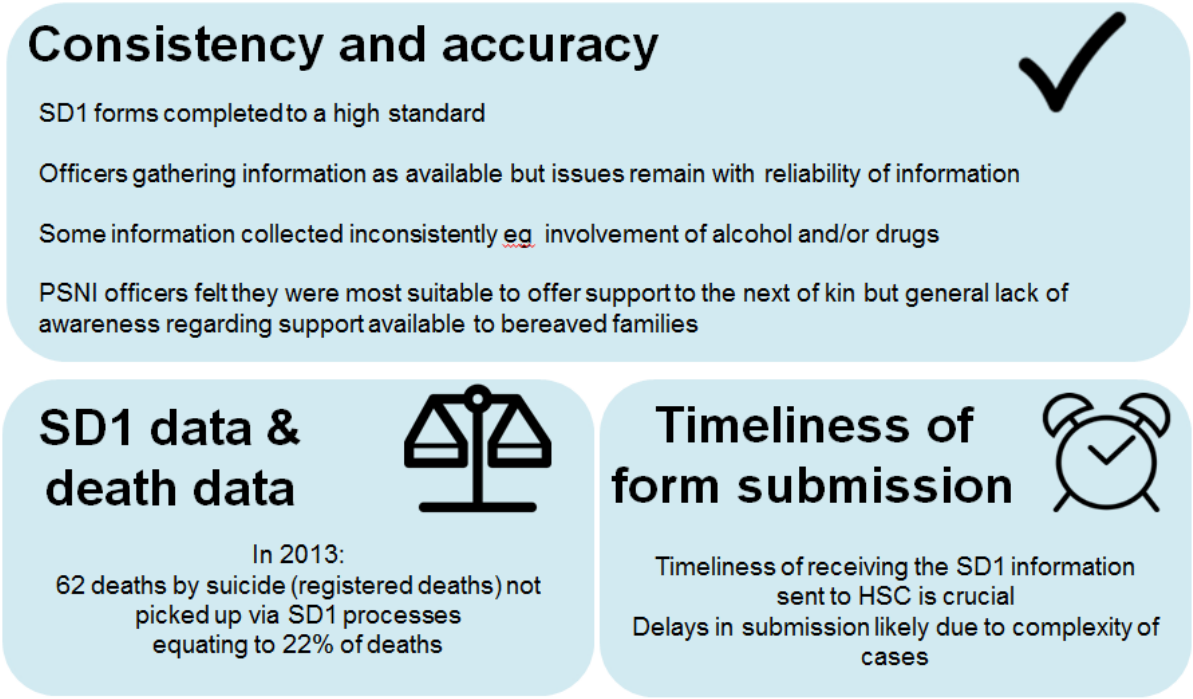
On some occasions, it was felt that delays in the SD1 form being received could also be due to the complexity of cases. For instance, if the deceased died in hospital:

> *There's this issue where people die in hospitals from their injuries at a later stage. We wouldn't get the SD1 but the next of kin would still be in need of support…There's a gap there.* **Support service**

Support services also highlighted a gap in service provision when a death occurs outside of NI (ROI or in another part of the UK) but the deceased's loved ones live in NI. In these instances, the bereaved family will only access support if they proactively look for it and approach services. Whilst it is currently not possible to determine how many people this is likely to impact, more partnership work would be necessary to respond to such cases to ensure that all NI residents are offered support.

> *We have many families here who's loved ones have died across the border so the SD1 process doesn't work for them …It's a lengthy time, the SD1 couldn't follow it because it was in the south that the death occurred, the inquest is going to be in the South of Ireland.* **Support service**

Figure 5: Key messages for the consistency, accuracy and timeliness of SD1 processes data



3.3 Objective: to review the communication processes between relevant PSNI and HSC bodies

When an SD1 form is completed, it is transferred between PSNI and HSC via OCMT. Support services said they were able to contact OCMT to clarify SD1 data.

Recent to the time of writing, the SD1 form has been updated to include the name of the responding PSNI officer. Although not subjected to evaluation, this change should simplify communication processes between HSC and PSNI.

In addition to the process for transfer of SD1 data, effective communication between PSNI and HSC was perceived as paramount to ensuring support was provided to individuals and communities. Some difficulties in the communication processes were reported early in implementation of SD1 and CRP processes. Regional changes in policing structures were considered to have temporarily interrupted partnership links. Support services reported trying to identify appropriate PSNI officers to work with and effort was required to establish new working relationships and obtain buy-in for the SD1 and CRP processes.

> *There is a lot of work required to get PSNI on board with changes in policing structures causing setbacks…Some officers are not aware of the importance of processes or attending meetings but when fully explained, full buy-in is achieved.* **Support service**

Some support services felt that buy-in for the SD1 and CRP processes could be achieved by explaining the importance of SD1 data and the resultant processes. Although challenging, strengthening partnership links and obtaining buy-in from PSNI officers was perceived by support services to be crucial.

> *I went to a [bereaved] family who has a strong family background in the police. They asked us how we came out so quickly and we told them we got the SD1 form. They said they wondered where that form went to...[As police officers] they were filling in this form and not realising what would happen from completing that form. They said 'gosh, I'll look at that form differently now'.* **Support service**

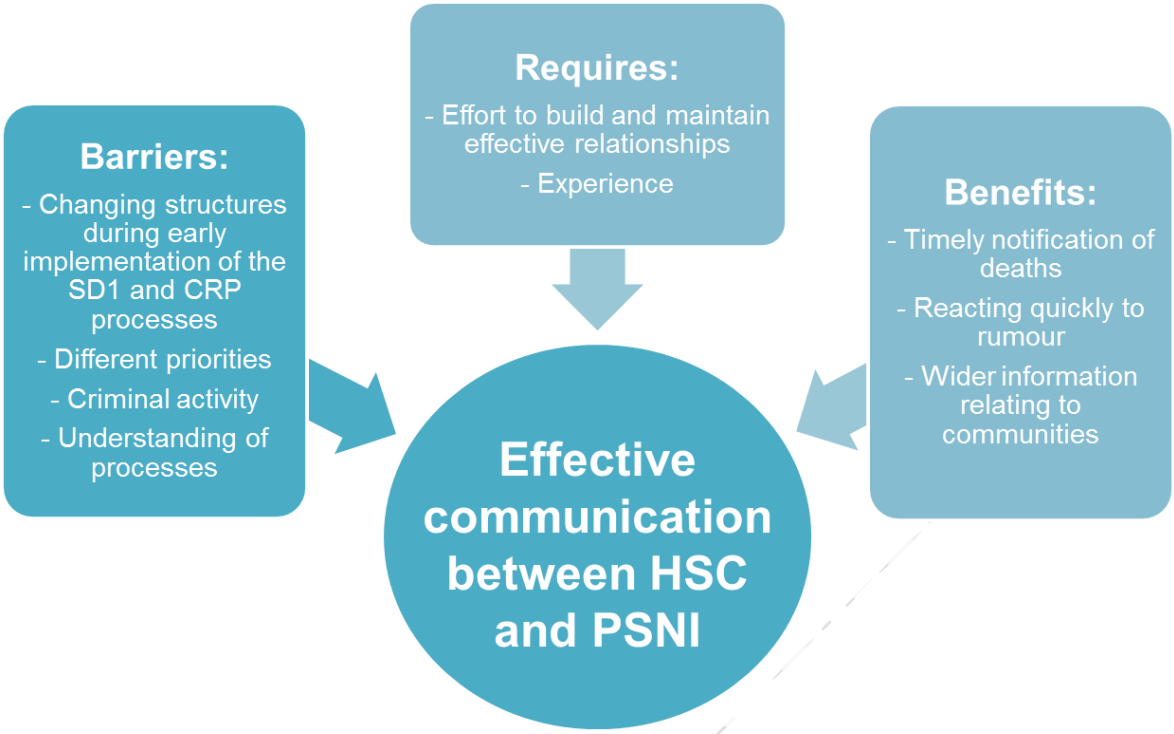
Support services described the effort required to strengthen partnership links with PSNI. Strong links between PSNI and support services was useful when addressing rumours about suicide within a community. However, these informal links took considerable resource (time and effort) to establish and was not consistent across the region.

> *We have a very good relationship with PSNI…When rumour mill hits, [PSNI] will ring me and confirm whether there have been deaths. [The PSNI] know and see the benefit of our service and it helps them.*
> **Support service**

> *If we hear of a death, we phone them and because we know officers in the area, they've given us their mobile number and they check it out for us. It does benefit a police officer because they have something to offer the family.* **Support service**

Strong partnership links were perceived to be mutually beneficial for PSNI officers as it helped strengthen their links with other organisations and provide them with greater community intelligence that might help in their wider roles.

Figure 6: Key messages for the communication processes between relevant PSNI and HSC bodies



3.4 Objective: to review the impact on families and their reaction to the process and subsequent uptake of support

3.4.1 Obtaining consent as part of the SD1 processes

The SD1 and CRP processes begin when families bereaved by suicide are approached by PSNI at the scene of death to ask if they consent to their information being passed to support services to be contacted at a later stage. It is important to understand the context under which bereaved families are asked to consent to support which usually occurs under extreme distress. Families talked about the circumstances around the death and some described finding the body of, and potentially trying to resuscitate their loved one. This experience had a lasting and profound impact on the bereaved with some being diagnosed with PTSD as a result.

> *Here I am. My son has just died…I can barely get out of bed…I was just a zombie…Some days I would just sit all day and relive that event all day in my mind. It would only feel like 5 minutes to me but it was the 8 hours that they were gone…I woke up that morning and I went to bed that night a different person and that person that woke up that morning will never come back.* **Bereaved family member**

> *I just couldn't go out at all for a few months after it… I was having nightmares of dead bodies coming around my room and all.* **Bereaved family member**

All stakeholders said that the circumstances around the death meant that the deceased's NOK was in a state of shock. Some PSNI officers felt that the shock

experienced by families meant that they were able to obtain consent more easily. However, other officers felt that the timing was not appropriate.

> *I always describe it as a bit surreal. It is probably the best time to get the details because it hasn't sunk in yet – what has actually happened.* **PSNI officer**

> *I don't think we should be asking them at that time…I think it could be too soon. They are going to have so much going through their mind about what has happened…it could be a few days down the line that support services could be introduced.* **PSNI officer**

The majority of bereaved families could not recall providing consent for their details to be passed to support services. All of those bereaved described being in psychological shock which impacted their ability to recall what they perceived to be minor events at the time of the death.

> *I had to find out through [the support service] that the police asked me the question on the SD1 because I didn't know. There's certain things you remember and you'll never forget from that day and that wasn't one of them.* **Bereaved family member**

> *I said I wasn't asked [for consent]… [The person at the support service]… confirmed I was asked. I never knew I was asked because you're in such a daze.* **Bereaved family member**

SD1 data indicates that approximately half of the deceased's NOK provide their consent for their contact details to be forwarded to the support services (2012–14, 57%; 2017, 50%). Support services said that the shock experienced by families could be contributing to the high refusal rate of approximately half of those bereaved.

In addition to shock, the lack of information available to the NOK at the time consent is asked for also contributes to the refusal rate.

> *I don't think they [PSNI] explained what kind of support and at that time my mummy just said 'yes' but I don't think my mummy knew what she was saying 'yes' to. I don't think you are in the right state of mind to know what you're agreeing to.* **Bereaved family member**

When the NOK declines the offer of support, some support services used other methods to try and reach out to the NOK to offer support (eg via the GP). This approach was not consistent across support services with some saying refusals were a clear indication that contact should not be made with the NOK.

> *The crucial bit [of information] is that the family want or don't want contact. If it comes through 'definitely not' that's very useful. It gives you a very clear idea that you shouldn't touch it.* **Support Service**

Despite providing consent to the PSNI, bereaved families also declined support when the support services made contact. In consequence of not recalling providing

consent to PSNI, one interviewee talked about perceived suspicion around being contacted by the support service. This person's initial refusal was attributed to the suspicion felt by them and their family.

> *I got a phone call from [the support service who]…explained that the police had given him my number but I said 'no, no. I don't need anybody'. My family were suspicious because they didn't know that this happened either…It was after…two or three months before I couldn't stick it anymore and went to the doctor.* **Bereaved family member**

When support services contacted the NOK to provide support, the NOK could refuse support at this stage. Support services would then ask for permission to follow up with individuals at a later stage or leave their contact information with the individual should they wish to make contact in the future. It was hoped that this would provide the individual with options in the future if the current timing of offer of support did not meet the needs of the bereaved individual.

> *Rather than close that referral…I say 'I understand you are ok for now, are you ok if I phone you in a month or six weeks?' Based on their reply, I put a date in my diary, I end the conversation by saying that 'if you feel you need my support in the meantime, you have my number give me a call'.* **Support service**

Whilst the right to decline support was acknowledged by all support services, there was concern that the NOK acted as a gatekeeper for other family members and/or friends who may need support. If the NOK declined support, other people affected by the death would need to seek support themselves.

> *If the next of kin says 'no' there may be a whole raft of other people who may have said 'yes'.* **Support Service**

3.4.2 Accessing appropriate support

It is intended that support services make contact with the NOK listed on the SD1 form to offer them support. There was clear consensus among support services that there was no 'right time' to make contact with the NOK but that care should be taken to ensure that support meets the needs of the NOK. This timing of support varied between support services but ranged from 48 hours after the deceased's funeral to two weeks after the death. In some instances, support services met with the bereaved family before the funeral to provide support at an earlier stage. The timing of support varied depending on what the bereaved family wanted and the specific circumstances of the death or relating to the deceased (eg public profile of the deceased).

> *When we get [the NOK's] contact details, we ring the family and arrange to go out and see them at a time to suit them. It could be three hours [after the body has been discovered]…it's whatever suits the family.* **Support service**

The reality is some families want that immediate support, others want it weeks, months, years down the line. I think it is very important we are all mindful of that. **Support service**

In relation to therapeutic engagement, there was consensus that providing support at the 'right time' was perceived to be crucial. However, there was no consensus about what the right time was. Some felt a delay is required before providing support to allow time for families to grieve. It was felt that many families receive support from family, friends and the community immediately after the death but this wanes over time.

They are in shock and are not in therapeutic place: they're so busy. It's after that they need the support…a bit of a delay is needed. **Support service**

People get an awful lot of support from family members, friends, neighbours and then by the time I kick in that support is beginning to wane…I will phone and arrange our offer of a support visit. **Support service**

It would be really important that people have space to get the funeral over…there are a lot of people around at the time of the funeral and I don't think that is the right time to go out… I think within communities you would have a lot of neighbours who would call in but the reality is after a couple of weeks that all stops. **Support service**

When support services make contact with the NOK, they use significant resources to identify anyone who may be impacted by the death to offer them support. This includes other family members, friends, work/school colleagues of the deceased and the wider community.

[Support services] do a huge amount of work in terms of identifying other people who may be at risk…[they] would have a family tree of who they're involved with. That is difficult as…where do you stop? **Support service**

Support services felt the SD1 process was limiting as the NOK captured on the SD1 form may not be the most appropriate person to contact to offer support. This was particularly so in cases whereby family relationships were complex. This was viewed as problematic as the NOK acts in this gatekeeper role for other family members or friends to access support. For example, the NOK may be someone who is estranged from the deceased and therefore the wider family circle of the deceased. If the NOK declines the offer of support, other family members/friends/colleagues will not be offered help via this process.

In some cases, there isn't the full picture in terms of the next of kin because at the scene, it could be a wider family connection that you can't identify until you make that connection with the family. So the next of kin in some cases could be a brother, father, daughter, aunt. But when you connect you find out there is maybe a significant number of

people who were close to the deceased as well that needs the support. **Support service**

In addition to the limitations associated with the NOK details captured on the form, there was concern that the SD1 form does not capture the details of the person who discovered the deceased's body, if that person was not the NOK.

We never get the information about the person who found them and that concerns me because they are left with this trauma and there is no one there to support that. **Support service**

The other people who may need support are the people who found the person. **Support service**

Half of the bereaved families interviewed (6 out of 11) accessed support because the support service contacted them. The other half sought help themselves (n=3) by visiting their GP or responding to a poster advertising support services or a family member helped them access support (n=2). One person interviewed had not received formal support.

[The support service] heard about me and they came to the house. I know they do that quite a lot. **Bereaved family member**

[I saw a] poster [for the support service]…and I just thought 'I need something'…I emailed [the support service]…and then [someone from the support service] came out to [visit] me. **Bereaved family member**

At the end of the [public] meeting [about suicide in the area] we exchanged numbers with someone from [the support service] and then he gave me a call and I ended up going to the group. **Bereaved family member**

The doctor recommended [bereavement support], they gave me two phone calls and said they would contact me in six weeks again. That was nearly a year ago and the doctor put me in touch with [the service provider]. **Bereaved family member**

Support available to those who were bereaved included letters and information, practical support, complementary therapies, therapeutic interventions, peer and social support. Support services emphasised that the support provided was tailored to meet the needs of those receiving support. Consequently, there was no standard package of support provided.

Some support services initially contacted those who consented to support by letter and all support services left information booklets with bereaved families. Recall for receiving information was generally high among bereaved families with some saying that they read the information.

[The person from the support service] told me about everything that's available there and left me leaflets and stuff to do with their service. **Bereaved family member**

Initially, [the person from the support service] had brought around a wee pack…and sometimes I'd flicked through it. **Bereaved family member**

However, the majority of bereaved families said they did not look at this information and some were unhappy with the information sent.

I believe we got something through the mail from the [support service] but I wasn't even opening the post in the house…I didn't know about it. **Bereaved family member**

I remember reading literature…[that] said you shouldn't seek help until after six months. And I just remember reading thinking…if I had to wait six months, I wouldn't have been here. That really put me off. You could need it from day one. **Bereaved family member**

Families could receive practical support as part of the service offered. This included help with completing forms (eg to apply for benefits), advice about the Coroner's process and the funeral, advice and support through legal processes, and family support. This type of support was positively received by bereaved family members.

Initially I…try to normalise what they are feeling. Tell them about what's going to happen, when their loved one is going to come back, information about the birth certificate, personal belongings – a bit of knowledge, knowledge about an inquest. **Support service**

[The person from the support service] helped me fill out the paperwork to get some money because it's [funeral] very expensive. **Bereaved family member**

I got everything that I needed from [the support service]…going through courts and stuff, [the support service] gave me advice for solicitors and help writing letters and stuff. **Bereaved family member**

Complementary therapies could be provided in conjunction with other support provided to those bereaved. Those who received them explained that complementary therapies were able to help them relax or to help them move on to talking therapies.

I actually thought I was going to die that day and I called [the support service]…they told me on the following Monday to come for this massage and then I had the counselling on the Wednesday. I was lying there crying my eyes out when she was giving me this massage. I tell you, it helped because I went back the next week and the next week. **Bereaved family member**

I'd never tried reflexology…I have to say, I had never relaxed so much for so long, you're so uptight. All you're thinking about is your loved one and is everybody else ok. **Bereaved family member**

There was also a range of therapeutic interventions (eg counselling, CBT, art therapy, play therapy etc) offered to those requiring support. Most of the bereaved families who talked about therapeutic interventions specifically mentioned receiving counselling. Those who received counselling talked about using the sessions to process what had happened and dealing with their emotional response to the death.

Through the counselling I decided that I would ask [my son] to forgive me and I'd forgive myself…They helped me put it into words – will you forgive me?…You just have to process it. For me it was going to the counselling that helped me go through all of that. **Bereaved family member**

I spoke to [the support service] and I said I would love a one-to-one with a counsellor because I just felt that I really wasn't coping… I could actually get my anger out at her. It was as if she was in the room and I could say 'how dare you do that to us?' It was really nice and it's very therapeutic. **Bereaved family member**

I've been getting counselling…[what helped most was] being able to…get my feelings out and get the anger out. I really felt so angry for months…That's starting to subside a good bit now. **Bereaved family member**

Counselling was reported to be needed at an earlier stage in the grief process as it was additional one-to-one support. Many of those who received counselling reported that it had a beneficial impact on their own mental wellbeing and they disengaged when ready. Notably, those receiving counselling commented that other individuals may need one-to-one support and they were mindful of taking up valuable resources. All of those receiving this type of support were aware that they could contact the support services again if needed.

The one-to-ones [counselling] I did need more at the start. Not so much now but [the support service] has always said I can have one-to-one at any time I wish but I feel stronger now. **Bereaved family member**

It was definitely beneficial. I suppose just to remember that everything you're going through is alright…the counselling was good and the amount of sessions was probably right because then you need a bit of time to go and do a bit of healing yourself. **Bereaved family member**

The counselling helped me to open up. I was carrying a burden that didn't belong to me… They helped me with everything, [the support service] normalised everything for me…made me feel like a human again. **Bereaved family member**

However, counselling was not a positive experience for a minority of the bereaved families interviewed (n=2). One interviewee felt the counselling style did not suit her and the other interviewee described an inappropriate method of counselling. In the latter instance, the counsellor was described as being distracted when attempting telephone counselling on two occasions. The perceived distraction eroded the confidence of the individual receiving the service.

> *I just felt like I was repeating the story over again and how the week went…I wasn't really up for that… I just lost interest…it was like being back in school.* **Bereaved family member**

> *The first time she [counsellor] was offering counselling she was walking to go up to [a university], she was doing some postgraduate or evening degree course. The second time she was in the car, driving. I'm not a stupid woman, I'm an intellectual woman but I would never offer that service to anybody…you might ring up and say you want to make an appointment but that's it. The service was diabolical.* **Bereaved family member**

The final type of support individuals could receive was peer and social support. This included support groups that could be facilitated by peers or support services and residential weekends. This type of support was perceived to be invaluable for long-term ongoing support by those accessing this. The format of support groups differed in that some groups run indefinitely on a weekly basis, whereas others were for a set number of weeks. It was important that the support groups were specific to those bereaved by suicide. In bereaved by suicide support groups, meeting other people in similar situations helped to normalise the experiences of group members as they did not get this elsewhere. It should be noted that support groups were not accessible across the region.

> *I like that you're not the only one. I used to go out and it used to be terrible. People wouldn't stand with me at the bus stop…When people can tell you their experiences. It makes it more normal because it's a very abnormal thing to happen to you.* **Bereaved family member**

> *They understand and that's all you want, especially somebody that's been through that. It makes all the difference, big time.* **Bereaved family member**

> *It was bereavement counselling but it wasn't specific… But I felt that once people find out it's a suicide loss, you get the pity look and then I just felt completely switched off. I don't need the pity.* **Bereaved family member**

Many of those who had received support commented that the support had been 'life saving' indicating how valuable they perceived it to be.

> *I would say going to [the support service] that day did saved my life. Not just that. It's made things so much easier.* **Bereaved family member**

It's helped me a lot. I always know that if I do feel low that I can come in here any time. It's helped me grow. When I came in here I was in a dark place and I just didn't think there was going to be a life for me after [my loved one] dying. But you know, I have hope now. **Bereaved family member**

My life has changed and I can see light now at the end of the tunnel. I came here and I was low in confidence and my confidence has grew. **Bereaved family member**

Them dark days are gone because of these people [support service]. **Bereaved family member**

[The support service] treated you like a person…If you get uptight or anything then they're there for you…I would recommend anybody to them. **Bereaved family member**

[The support service] being able to tell me I was normal, and everything was OK and this was going to happen, it was brilliant. It was a weight lifted off my shoulders. I didn't feel like a freak. **Bereaved family member**

3.4.3 Breakdown in the processes

Whilst support provided was generally perceived positively by bereaved families, there were instances whereby the current SD1 and CRP processes were not effective. In one instance, the NOK acted as a barrier to the wider family accessing support due to familial conflict. Consequently, the interviewee described trying to access support for other children in the family and reported finding the process very difficult.

[My children] got some support but it's what I've tried to find for them… I was looking it up online. I was going around places. The GP did give me the numbers of one or two places and I had to self-refer my son and my daughter… I would've loved somebody to come along and talk me through the stages that we were going to go through and what was going to happen. What to look out for in the children. **Bereaved family member**

The quote above also highlights a perceived gap in service provision for children. This gap was also perceived by other bereaved family members.

There are [some] girls in [my child's class in school] and their fathers have taken their own lives. Their mothers have asked me if there is counselling…they were asking me 'where did you go?' And I was saying there was nowhere for my girls to go…I told them to call [the support service] but there really is a lack for children. **Bereaved family member**

3.4.4 Other potential statutory partners

Family members who participated in the evaluation felt that other statutory organisations could improve their response in relation to those bereaved by suicide. These statutory organisations included Social Services, the Education Authority and the NI Housing Executive.

> *My [other children] did not return to school [for a short while]…The Education Board wanted a letter from the doctor to explain their absence. The school was very helpful and said they were really sorry but this is what they want because they said a bereavement doesn't warrant that much time off school.* **Bereaved family member**

> *The Housing Executive… wanted to know when I was going to hand the keys in. [My daughter] wasn't even buried. I had been to Citizen's Advice because I fill in forms in my house but my brain was mush so Citizen's Advice filled in forms for me. I said about the Housing Executive and they rang them and asked if we could get it sorted in four weeks. But the Housing Executive then told us two weeks.* **Bereaved family member**

> *I still hadn't heard from the Housing Executive but the Housing Executive then sent me a letter about a year later – 'do you still want to move?' I mean are you serious? I wanted to move long ago so I never even replied to them. They weren't very sympathetic. They didn't understand the situation. I was in a house that I couldn't really be in. I couldn't be on my own in it.* **Bereaved family member**

> *When someone is a victim of suicide, I feel that there should be a task team put in place that they all link in. Whether it's a home care team, whether there's elderly involved there, if there's a counselling, specialist counselling team and also the GPs linking into that as well to ensure the support network is there for that family.* **Bereaved family member**

Figure 7: Key messages for the impact on families and their reaction to the process and subsequent uptake of support

3.5 Objective: to review the use of the SD1 data regarding the CRP processes

Support services and PHA Health Improvement staff described that the SD1 data was primarily used to support those bereaved by suicide. The SD1 data were also used to initiate the Serious Adverse Incident (SAI) processes if the deceased was known to statutory or HSCT mental health services. All interviewees emphasised the importance of the role of SD1 processes in monitoring whether a community response plan should be implemented.

3.5.1 The Adverse Incident process

When Trusts receive an SD1 form, they check whether the deceased was known to statutory or HSCT mental health services and whether the SAI process should be initiated. The initiation of the SAI process was considered to be beneficial as it provided greater engagement with the bereaved family and provided another opportunity for therapeutic support to be provided:

> *The SAI process…means that we would have contact with the family. We have an obligation to carry out that process if someone was known to us within the last year – even if they had been seen once 11 months ago. The SAI process has a counselling and supportive element to it.*

We have seen people move from very angry to people who are fully accepting of the SAI report. **Support services**

3.5.2 Supporting the community: the Community Response Plan

3.5.2.1 CRP Levels

The CRP processes are intended to be led by HSC Trusts with support provided from PHA and other agencies as appropriate. Previously there were three different levels to the CRP processes which were intended to illustrate different responses depending on community need in response to a death by suicide. The processes and differentiations in levels (as originally intended) are illustrated below:

CRP level	Trust considerations
Level 1	Concerns about death to be raised and evidence reviewed. If no further action required, continue monitoring. If further action required, move to level 2.
Level 2	Increased surveillance and promotion of support. If evidence of cluster/risk, move to level 3. If no further evidence, notification to DoH (formerly) DHSSPSNI on activation and deactivation.
Level 3	Full implementation of local plans with notification to DoH (formerly) DHSSPSNI on a daily basis. Stand down and evaluation to end.

Support services agreed that a CRP is activated as a result of the information gathering and sharing between agencies. However, there was confusion about the differentiation of CRP levels. Understanding of CRP Level 1 was roughly comparable across most Trust areas, involving monitoring, evidence gathering and information sharing between agencies. There was greater confusion about the differences between Levels 2 and 3 and this was raised at the RSG meetings. Consequently, in an attempt to simplify the process, there are now two CRP levels: 1) information sharing and 2) CRP activation. This change has not been subjected to evaluation.

3.5.2.2 CRP activation & implementation

All interviewees discussed their role in monitoring SD1 data and the work involved in assessing whether there are connections between deaths and whether CRP activation is necessary. SD1 data was monitored to identify potential clusters. All Trusts discussed monitoring:

- Demographic information (age and gender);
- Connections and associations with previous deaths;
- Connections between methods;
- Connections between families and communities;
- Levels of family support;
- Geographical associations (via mapping); and
- Public profile (leadership, membership of clubs or sports teams).

In some areas, support services had a strong role in monitoring SD1 data and reacting to deaths.

> *We take notification, we log it on our system (name, next of kin) check our own internal database to see if the named next of kin are known to us. I then look at my separate database where I log the gender, method used, location and part of that is to look at potential clusters. We look at new methods if they are used if that is evident.* **Support service**

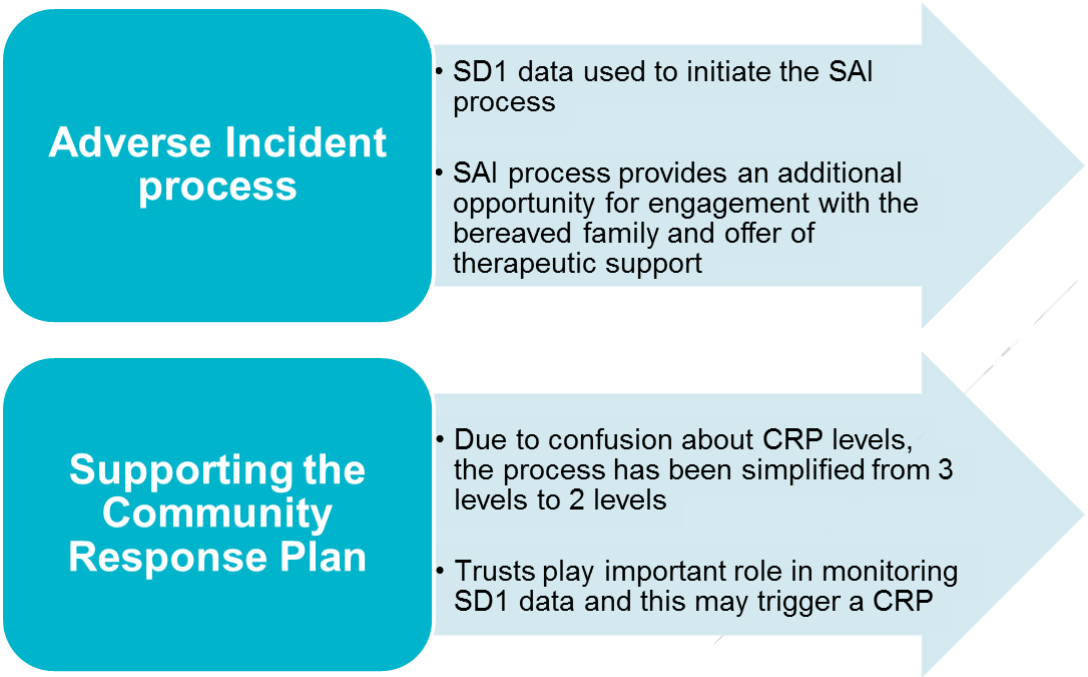
Community Response Plans may be activated to provide support to communities to minimise the likelihood of more deaths. However, on some occasions, decisions about activating the CRP are not solely made based on data monitoring but are also influenced by individual cases in the area and wider factors (eg non suicide cases such as accidental overdose).

> *Last week we had a single suicide of a young girl but the significance of her death in the way that it happened has been enough for us to decide that there needed to be at least a meeting.* **Support service**

The activation of a CRP requires strong multi-agency partnership working to take forward demanding time-pressured work. Who is involved in responding to each CRP is tailored to the needs within the community and the situation surrounding the death. Those implementing a CRP acknowledged that the timing of implementation of CRPs was also important.

> *There is an issue about moving in too quick. Communities need to grieve together, they need to band together and support each other…Let them know there is support there and then move in later.* **Support services**

Figure 8: Key messages for the use of the SD1 data regarding the CRP processes



3.6 Objective: to assess the impact of the CRP process

Following Trust monitoring work, if there are areas of concern, a small review process is initiated. The small review group consists of representation from Trust and PHA staff. This group determines whether the CRP plan is initiated. If a CRP is activated, an activation group is formed to oversee implementation. Representation on this group is dependent on the circumstances surrounding the death (see section 1.2 for an overview of the CRP processes).

When all actions have been covered, the decision is taken to descale and/or deactivate the CRP and debrief occurs approximately six weeks following deactivation. This provides an opportunity for all members involved to share learning and identify good practice. Progress on these actions is reported on at Trust Protect Life Implementation group (PLIG) meetings where the CRP is a standing item (see section 1.2).

Eight CRP debriefing papers were available for review to assess the impact of the CRP processes and to identify best practice. The remainder of this sub-section will focus on findings from this review.

3.6.1 Content of the CRP debriefing papers

There was variation in the content and quality of CRP debriefing papers with some papers containing a high degree of detail and structure, providing clear indication of how the CRP was implemented. Papers that clearly outlined the CRP processes included the following elements:

- Background and purpose of a CRP;
- Outline of who was involved in the CRP;

- Rationale for determining whether to activate a CRP;
- Identification of vulnerable individuals;
- Overview of implementation of the CRP;
- Rationale for descale/deactivation;
- Identification of communication issues during implementation of CRP;
- Review/debrief (interactive or desk based);
- Conclusion and recommendations;
- Acknowledgements
- Other relevant information included as appendices (eg overview of membership of Trust/PHA monitoring group; overview of membership of local response group for each district council area; notes of CRP meetings; and media statements used).

3.6.2 Decision-making processes for CRP activations

A rationale for activating the CRP is included in most of the reviewed papers (6 out of 8). Similarities in the information included in these sections were:

- Non-identifiable information relating to the deceased including gender, age and date of death;
- Contextual information relating to the deceased; and
- Detail on other concerns raised in the wider community (eg concerns about other individuals).

Three debriefing papers provided a clear rationale for activating CRPs by outlining the criteria and the decision-making processes. Reasons for activating included media interest in response to a death (n=3), the deaths being linked to alcohol and/or drugs (n=2), multiple suicide attempts among the deceased's peer group (n=1), and the deceased's public profile (n=1).

3.6.3 Who was involved

If a CRP is activated, an activation group is formed to oversee implementation. Representation on this group is dependent on the circumstances surrounding the death but may include Trusts, PHA, C&V organisations, community leaders (eg local sports clubs and local clergy), schools and Education Authority, housings associations, PSNI and local councils.

3.6.4 Identification of vulnerable individuals

Most papers (6 out of 8) noted that vulnerable individuals were identified by the CRP activation group and offered/signposted to appropriate support. Half (n=4) were able to quantify the number of vulnerable individuals which ranged between 10–48 individuals. Three papers included a summary table which outlined the relationship between the vulnerable individuals identified and the deceased and details on the support offered and the organisation who provided the support.

3.6.5 Implementation of the CRP

All papers outlined the actions implemented as a result of the CRP but differed in terms of the detail provided to outline the rationale for activations. Furthermore, five (out of 8) papers included a summary table of key actions and outputs as a result of the CRP which was deemed a good summary of what was put in place.

There were similarities in the actions which were implemented during the CRP process in all debriefing papers. Typical actions included:

Provision of support for individuals Providing support to vulnerable individuals was a key element of CRP activations. Support was offered through local community groups, statutory services and supported accommodation units. Local services and venues also extended their opening hours to allow those affected to obtain support.

Awareness raising for support available All CRP activations emphasised raising awareness of support available to vulnerable individuals. Six papers signposted available support services (eg Lifeline) at local venues especially if the venues had a connection to the deceased (eg local sports clubs and schools). Information about services was also distributed on a door-to-door basis where necessary.

Vigilant response teams Two debriefing papers noted liaising with the Emergency Department, primary care and crisis response teams to ensure they were extra vigilant and that individuals who were affected would be treated as priority if they presented in need of support.

Engagement with the media Due to evidence demonstrating a link between increased media attention and increased risk of suicide, media responses to suicide was a concern for some of the debriefing papers. To minimise potential harm and ensure consistent messaging, media statements were prepared and shared at local and regional levels.

3.6.6 Descale, deactivate and debrief

In most cases, it was decided to deactivate the CRP once the activation group were satisfied that all actions were completed. Following deactivation, debrief occurred and this was facilitated by someone independent from the CRP process, when possible. Debriefs were interactive (workshop/questionnaire) and/or desk based and examined what had worked well, challenges faced and recommendations. CRPs ensured that support was available at the earliest opportunity for anyone requiring it. It was concluded that the CRP activations saved lives as they prevented further suicides.

Partnership working between agencies was viewed as instrumental to the success of the CRP. Members stressed the importance of the role of local groups and organisations in providing support due to their knowledge of local communities. There was positive feedback from the C&V sector that the process helped build relationships and establish links with other agencies. It was also identified in one debriefing paper that the role of the Trust in chairing the CRP process was key to ensuring relevant links were made with statutory services for individuals.

Whilst the CRP process could be resource intensive and demanding for the individuals involved, one debriefing paper noted that members of the activation group felt supported in their role and spoke positively about training they had received (eg safeTALK and ASIST).

Challenges in the CRP process were identified. This included:

Roles and responsibilities	On some occasions, there was a limited awareness regarding what the CRP process involved and the level of input required from organisations, particularly if there were changes in personnel within organisations. This included difficulties for organisations to be involved in the CRP process during unsociable hours. There was also some confusion around specific organisational roles during CRP implementation. Clarifying roles and responsibilities during the implementation process was time consuming for the activation group and it was thought this time could have been better spent addressing actions which needed to be implemented during the CRP process.
Working with the media	Media interest in deaths could add to the communities' sense of anxiety and the importance of working with the media to ensure accurate information was reported to try and minimise any additional distress was emphasised.
Data protection	During CRP implementation, a number of different organisations could be part of the activation group. There was some concern about the level of detail of the information which was shared during the meetings. It was suggested that the activation group should seek advice from data protection and information colleagues in moving forward around information sharing during similar processes.
Demands on staff	A large amount of work that is required when investigating the circumstances of a death, connections with other deaths and consideration of community need. The CRP can be an exhausting process and self-care was viewed of the utmost importance.
Timing of follow up work	Learning from CRPs was viewed with the utmost importance. However, on a few occasions, a full review and debrief (questionnaire and workshop) could not be completed due to time (eg summer holidays).

Table 2 provides a summary of the recommendations made in the CRP debriefing papers to prevent similar issues in the future. There were similarities in the challenges faced and areas which needed clarification across all debriefing papers. Actions and outcomes following CRP debrief are assigned to be carried out by individuals/organisations during the debrief session. In some debriefing papers, it is unclear who was responsible for taking forward recommendations. However, four papers outlined the lead organisations who were responsible for implementing the recommendations. Progress on these actions is reported on at Trust Protect Life Implementation group (PLIG)[9] meetings where the CRP is a standing item.

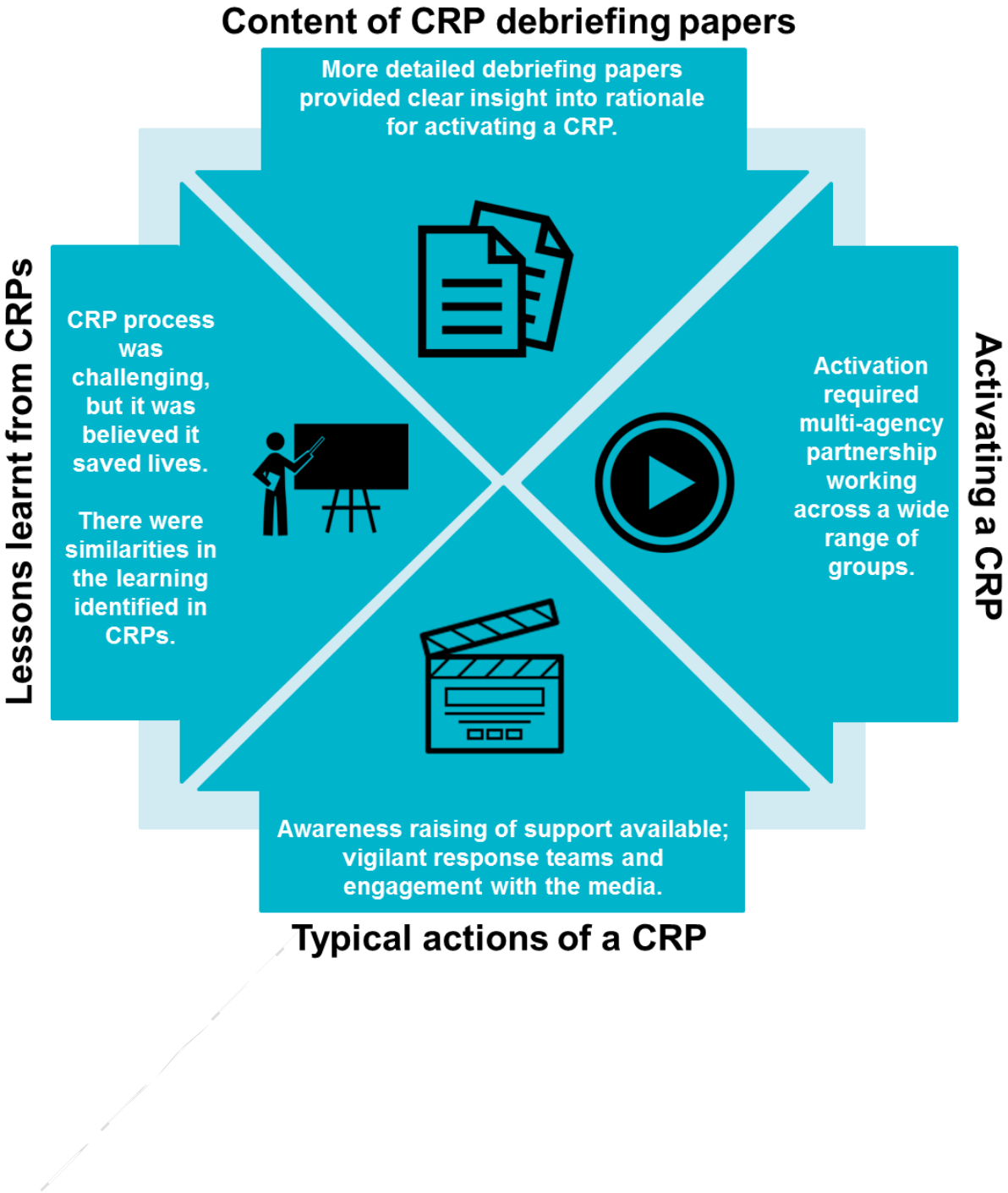
[9] The implementation of the *Protect Life* strategy is managed by the Implementation Group, chaired by the PHA and Community and Voluntary sector. The chair of Trust Protect Life Implementation groups varies across Trusts.

Table 2: Summary of recommendations from CRP debriefing papers

Theme	Detail on recommendations
Training	• Awareness raising among local C&V groups, PSNI, councils and local political parties regarding the SD1 and CRP processes. • Housing Associations should consider that all staff working in sheltered accommodation should undertake gatekeeper training on mental health and suicide prevention to ensure they are equipped to support people in the event of a sudden death.
Representation on CRPs	• CRP implementation requires prompt reaction from all those involved to ensure that the activation group is formed quickly to oversee implementation, contact details of appropriate representatives for local organisations should be updated and maintained.
Roles and responsibilities	• Clear roles and responsibilities of lead agencies should be identified during CRP implementation. • Develop regional and local protocols for handling media which includes roles and responsibilities. It was believed this would ensure meetings are action focused and that this would also help ensure there is clear and consistent media messaging.
Local services	• C&V sector were important element when implementing a CRP. It was recommended that local services should be promoted for people feeling vulnerable or in distress. • All local services should have their own postvention protocols. Community organisations, PHA and Trusts were responsible for taking this forward.
Information sharing	• Improved management of confidential information between organisations to ensure confidentiality is maintained at all times. • More formal information sharing processes with the Health Services Executive in the Republic of Ireland, especially when a CRP is activated along the border counties or when there are concerns around particular drugs. • There was some concern about the level of detail of the information which was shared during meetings (eg people's details). It was recommended that PHA and Trusts seek advice from data protection and information colleagues around information sharing.
Media work	• Media interest in deaths could add to the communities' sense of anxiety. It was recommended that further work needs carried out with local and regional media in terms of following The Samaritans Media Guidelines[10].
Debrief	• A date and time should be agreed for the debrief after deactivating the CRP, ensuring commitment by all members to attend
Shared learning	• Learning from CRP should be shared regionally so experience can influence other related processes.
Self-care	• It was recommended that PHA/Trust should provide greater clarity on what self-care is and how staff are looking after themselves when the CRP process is active as well as when the group has been stood down.
Planning events	• It was recommended that in planning of any major event/festival it would be advantageous that PHA are part of that process, particularly where there is a risk of drugs and/or alcohol.
Using CRP model elsewhere	• Colleagues in the drugs and alcohol profession should consider the development of a CRP model to address community concerns.

[10] Samaritans. (2013) Media Guidelines for reporting suicide. Dublin: Samaritans Ireland.

Figure 9: Key messages for the impact of the CRP process



4 Conclusions and considerations for going forward

4.1 The SD1 form and processes

The SD1 form is completed by PSNI officers attending the scene of a suspected suicide. Officers are working to their best abilities to complete the form as accurately as possible and send it to OCMT within the required timeframe. Analyses of SD1 data shows that data completeness improved over time with issues around data quality remaining. Data quality issues result from ambiguity around the information requested (eg involvement of drugs/alcohol) and information not being available or known by the deceased's NOK. There is potential to make improvements to the quality of data by amending the SD1 form to remove unnecessary data fields or improve the clarity of information required (see section 3.2). Despite changing the SD1 form, it is likely that some issues with data quality will remain given the difficult circumstances under which information is gathered.

Currently, there have been four iterations of the SD1 form that are in use across the region. The four forms differ in the information collected, impacting on the regional collation and analysis of SD1 data. Care should be taken to minimise the number of form revisions going forward and effort is required to ensure all PSNI officers are using the most up-to-date version only.

By amending the SD1 form, it is hoped that data quality will be improved and also that other more pertinent information can be collected. When determining any future changes to the form, consideration should be given to the following aspects:

- Demographic information relating to the deceased and information about the method and location of death should be retained as this information is used to monitor deaths and make decisions about the extent of response required following a death. However, either the 'date of death' or the 'date when life declared extinct' should be retained. Consideration should also be given to the inclusion of 'marital status' as this is not used in the SD1 or CRP processes. Furthermore, the data quality for 'nationality/ethnic background' is poor. This piece of information is not used for SD1 or CRP monitoring and consideration should be given to removing this data field.
- Information about the deceased's GP is used in some but not all HSC Trust areas as a means to access and offer support to the deceased's family and friends if consent was not provided at the time of death. It would be beneficial to consider the appropriateness of this approach and to standardise the use of this information across the region. The outcome of these considerations will determine whether this information is retained on the form.
- Recording the involvement of alcohol and/or drugs in the death was problematic for officers who felt uncomfortable in making this a determination without a toxicology report. SD1 data showed that different interpretations where made about this information with some officers recording whether the person was known to misuse alcohol/drugs, whether they had a prior history, or whether drugs/alcohol were found at the scene. The information was captured in various detail also with some including the names of drugs/alcohol and the categories of drugs (eg legal highs, illicit drugs, prescription drugs). There was evidence that this information was being used as an early indicator about problematic drug use in a local area. Consideration should be given as to whether this information is best collected on the SD1 form or if this can be

garnered during the community intelligence gathering phases used by support service providers when responding to suspected suicides. If this is to be retained on the form, the wording of the data field should be reframed to improve clarity and remove ambiguity in interpretation.
- Whether the deceased was attending mental health services should be deleted from the form as checks are made within HSC Trust processes regardless of the information captured on the form.
- Any space made on the form should be used to incorporate information that would be useful in providing support to those who might require it. This could include information relating to the person who found the deceased if they are different from the NOK.

Having completed the SD1 form, it is sent via OCMT to the HSC Trusts and PHA within 48 hours. Whilst there are no formal mechanisms currently in place to monitor the timing of this process, the timescales are reportedly adhered to in the majority of instances. Earlier in implementation of the SD1 and CRP processes, support services reported delays in receiving the SD1 forms and this coincided with changing policing structures resulting in changing staff and weakening partnership links. However, these delays appear to have been rectified with any delays being minimal and associated with complex cases. Going forward, it would be beneficial to formalise data capture processes so that timing issues can be monitored more robustly, if required.

Earlier evaluation work indicated some discrepancies in the records relating to SD1 data held by PSNI compared to those held by HSC. Consequently, a process was introduced whereby SD1 data are regularly cross-checked and this is reported to have had positive results. This process is necessary to ensure support is offered to anyone requiring it and this should be maintained going forward.

4.2 Staffing and training

Consideration should be given to training all stakeholders who are responding to suspected suicide. Training would help individuals working in this area to deal with their experiences on a professional and personal level. Consideration could be given to the following:

- Few PSNI officers attending the scenes of suspected suicides were aware of the wider SD1 and CRP processes resulting from the SD1 form being submitted. Training focusing specifically on the SD1 and CRP processes that would be cascaded to all current officers and new officers would be beneficial. This could be developed using mandatory e-learning. Furthermore, officers said that training around mental health and suicide prevention and communicating distressing information such as sudden death/suspected death of a loved one would be beneficial.
- All of the individuals in PSNI, HSC and C&V sectors reported feeling well supported in their roles as responders to suicide. However, training for self-care would be beneficial for all individuals working in this area with refresher training being available.

4.3 Consenting to support

PSNI officers ask the deceased's NOK to consent for their details to be passed to support services so they can offer formal support to help the NOK and the wider

circle of family and friends to deal with the loss of their loved one. Obtaining consent was viewed by PSNI officers as a positive aspect of attending the scene of a suspected suicide. In the context of a difficult situation, officers felt that it was beneficial to be able to offer support. However, the NOK is typically in psychological shock which is evidenced by their later inability to recall this offer of support being made.

Approximately half of the bereaved families provide their consent for their details to be passed support services whilst the other half decline. It is important to acknowledge that those who declined support were not approached to participate in the evaluation for ethical reasons. Caution is advised when speculating about why these individuals declined support. However, anecdotal evidence suggests that individuals declined support due to a lack of understanding (impacted by shock) and information about what the offer of support was for. This was corroborated with PSNI officers who lacked awareness about the processes triggered by submission of the SD1 form.

Consideration should be given to the timing of this offer of support as the shock experienced by those bereaved may result in people declining support. This is likely to result in a delay in support being offered which may concern some services who offered support at an early stage. However, it may not be necessary to provide support at an earlier stage as is evidenced by the support services who felt a delay in contacting the NOK was appropriate. Standardisation of these processes would ensure the same services are offered region-wide. If the timing of the offer of support is deemed appropriate, training PSNI officers about the wider SD1 and CRP processes becomes more critical as this may be vital in reducing the refusal rate.

Consideration should also be given to the appropriateness of processes followed when attempting to contact anyone who has declined support. Anecdotal evidence from support services suggested that some individuals who initially declined but later took up support and found it to be beneficial. This benefit should be weighed up against the ethical issue that individuals have the right to decline the offer of contact by support services. There is a risk that contacting individuals who have declined support may cause further trauma. This is especially so if they do not accept that the death of their loved one was due to suicide or if they are trying to deal with their grief on their own, or cope in other ways.

4.4 Providing support

Support services tasked with identifying and providing support following a death by suicide invest extensive resources to ensure that support is provided to as many individuals as possible. The process of identification and gathering community intelligence itself was reportedly demanding for all involved and resource intensive.

Ultimately, all of those who had accessed support[11] and who participated in the evaluation said that the support they received was of a very high standard and had helped them psychologically, socially and physically. All support services providing support ensured that support was tailored to meet the needs of the individuals

[11] Note that whilst some individuals reported that some aspects of the support they received was not as beneficial as other aspects, all individuals were happy overall with the support they received.

involved and delivered at a pace that suited them. The types of support provided varied from letters and information, practical support to therapeutic interventions and peer support.

It was clear that it would not be appropriate to standardise the support provided to the family and friends of the deceased or the wider community. This was evidenced by some of those who had accessed support expressing dissatisfaction with some elements of the support they received. For instance, some individuals did not feel comfortable with counselling but felt well supported by methods of peer support.

The process of providing support was intended to be as a result of the support services contacting the NOK. Among those who participated in the evaluation, half sought help themselves and did not associate this with the SD1 and CRP processes. As there are no formal monitoring processes, it was not possible to assess how all individuals accessed support services.

4.5 The community response

In conjunction with providing support via the NOK, support services monitor the information relating to each death to determine whether additional support is needed within communities. Information that is used in the decision-making process includes the deceased's demographic information (eg age, gender), whether there are any connections to other deaths, connections between methods used, connections between families and communities, levels of family support, geographical connections, and the deceased's public profile.

The organisations who lead this early investigative work differ across the region. In some areas this is led by HSC Trusts whilst in other areas it is led by PHA or by C&V sector organisations. Whilst this is an excellent example of multi-agency partnership working, it would be beneficial to consider the roles and responsibilities in leading this work. The lead organisation would have responsibility and accountability for all CRP activity in the local area. This would also help to make it more accessible to share learning of CRP activity and ensure the same service is available region-wide.

The organisations and individuals leading the CRP activity will also work with other organisations from a wide range of stakeholders from the statutory, community and voluntary sectors. This work is often resource intensive and demanding for individuals and is often time-bound. Thus, requiring strong leadership to ensure communities are provided with accurate information and effective support.

There appears to be ambiguity in terms of what is meant by 'CRP activation' and this resulted in confusion, especially when there were three levels of activation. As a result, the levels required for each activation level differed across the HSC Trust areas resulting in the inability to compare reported activations. During the evaluation period, the three activation levels were reduced to two in an attempt to standardise reporting. Going forward, it would be beneficial to assess whether this process has been useful in reducing ambiguity and increasing clarity.

It was envisaged that following a CRP activation, a debrief session would take place with the aim of evaluating the success of the CRP and identify any learning that could be used going forward. This approach differs across the region with some

areas adopting formal workshops objectively-led by individuals not involved in the CRP activity. However, in other areas the process of debriefing was unclear. Importantly, the learning gathered from CRP activations is not shared region-wide.

It would be worthwhile to formalise the processes for which CRP activations and resulting debriefings should take place. Consideration should also be given to having regional oversight of CRP debriefing papers to ensure that learning can be shared to others not involved in the CRP but who may be involved in others. This could help make CRP responses more effective going forward.

4.6 Perceived gaps in service provision

There were some gaps in service provision identified through the course of the evaluation. Some gaps identified by some participants in the evaluation were only perceived but highlight the need that further work is required. Going forward, the following gaps should be given consideration (some may already be covered earlier in this section):

- Support services and PSNI noted that if the person who found the deceased is not the NOK, their details are not captured and support is not offered. If changes are made to the SD1 form, this would be a beneficial addition.
- If there are complex family relationships, the NOK can act as a barrier to other family members and/or friends accessing support.
- One in five suicide deaths in 2013 were not picked up by the SD1 process. The deaths not picked up were usually as a result of self-poisoning and occurring at home. It should be noted that this data may now be outdated and given other improvements in the SD1 processes, this may have also improved. It would be worthwhile to monitor this going forward but should be borne in mind that real-time monitoring is not possible due to delays in suicide death registrations in Northern Ireland.
- When a person dies outside of Northern Ireland but their relatives live in this country, they are not covered by the current SD1 and CRP processes. Without coordinated effort between Northern Ireland, England, Scotland, Wales and the Republic of Ireland, it is unlikely that support can be offered to the deceased's relatives through the SD1 and CRP processes. It is not possible to determine how many people this may affect as there are no formal monitoring processes in place to identify who this might apply to. However, consideration could be given to raising awareness of the support services among the general public.
- Bereaved families perceived a lack of support services specifically for children or information to help guide conversations with children following suicide. Services that were available were reported to limited support for a six month period and this was not felt to be suitable. This issue could be explored regionally to determine how children and their parents can be better supported following suicide.
- Although this report provides evidence of the impact support following bereavement by suicide has had on individuals in Northern Ireland, this relates to a small number who participated in this work. There are currently no formal region-wide mechanisms in place to monitor the impact of support for those receiving it and this would benefit from greater exploration.
- Consideration should be given to improving monitoring data for the SD1 and CRP processes. These include the timing of receipt of SD1 forms by HSC,

details of those who are receiving support, duration and types of support received by individuals, how support is accessed, contact attempts and methods to the NOK by support services, and outcomes demonstrating the impact of support on individuals receiving it.

- There may be some opportunity to include a greater number of stakeholders, particularly from the statutory sectors, to contribute formally to the SD1 and CRP regional groups. This may help to improve how other services respond to individuals bereaved by suicide.

References

1. Cerel, J., Padgett, J.H., Conwell, Y., & Reed, G.A. (2009). A call for research: the need to better understand the impact of support groups for suicide survivors. *Suicide and Life Threatening Behavior, 39*(3), 269–281.
2. Andriessen, K., & Krysinska, K. (2012). Essential questions on suicide bereavement and postvention. International *Journal of Environmental Research and Public Health, 9*, 24–32.
3. Begley, M., & Quayle, E. (2007). The lived experience of adults bereaved by suicide: a phenomenological study. *Crisis, 28*(1), 26–34.
4. McKinnon, J., & Chonody, J. (2014). Exploring the formal supports used by people bereaved through suicide: A qualitative study. *Social Work in Mental Health,* 12(3), 231-248.
5. Pitman, A.L., Osborn, D.P.J., Rantell, K., & King, M.B. (2016). Bereavement by suicide as a risk factor for suicide attempt: a cross-sectional national UK-wide study of 3432 young bereaved adults. *BMJ Open, 6*, e009948.
6. Andriessen, K. (2009). Can postvention by prevention? *Crisis, 30*(1), 43–47.
7. Ali, F. (2015). Exploring the complexities of suicide bereaved research. *Procedia – Social and Behavioral Sciences, 165*, 30–39.
8. Trimble, T., Hannigan, B., & Gaffney, M. (2012). Suicide postvention; coping, support and transformation. *The Irish Journal of Psychology, 33*(2-3), 115-121.
9. DoH. (2012). Protect Life: A Shared Vision. The Northern Ireland Suicide Prevention Strategy 2012 – March 2014. Belfast: DoH.

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