

# Families Bereaved by Suicide:

The Right to Timely and Appropriate Support



The  
SAFER  
Campaign

*“Because there were so many people involved with the funeral of my daughter –some 600 - I couldn’t get any information or support for the young people – I had to go out to the bus stop and try comfort the young people myself – and I had my own issues, my own family at the time – such a traumatic time for me to take it on .. and try to comfort other people. If there had have been something else in place – I wouldn’t have had all that running about... it added pressure on me which I could have done without it.’*

Bobby Duffin,

**Mental Health Rights Campaign**

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## **The SAFER Campaign: The Right to Timely and Appropriate Support**

### *Executive Summary*

The Mental Health Rights Campaign (MHRC) and PPR have campaigned successfully for improvements to the mental health services. Changes made include improvements in follow up appointment systems at Emergency Departments (Card Before You Leave) and the inclusion of mental health information in the governments public information campaign Choose Well.

For those affected by suicide, proper post-bereavement support can be vital to improving their mental health, and so decreasing the likelihood of further suicide.

However, the MHRC have identified several ways in which the current bereavement support model is falling short. This report identifies the problems as including difficulties with referral, lack of information on support available, lack of referral for those who die in hospital, and time delays in receiving support.

The report was compiled following 3 focus groups with people bereaved by suicide including

the Belfast Mental Health Rights Group (BMHRG), the Safe Together Group and Survivors of Suicide in Spring 2016 on the issue of post-bereavement care. They identified from their own experience the Sudden Death 1 (SD1) Form as a key measure that should be improved. Subsequent research, discussions with key support workers with in-depth knowledge of the impact suicide has on a family, and the mental health system also pointed to a need for change in this area.

The report offers simple solutions identified by focus/group participants such as:

- An automatic referral for the SD1 process. An automatic referral policy already exists with Victim Support and so the principles (and solutions to obstacles such as data protection) can be applied here.
- A newly formulated referral process comparable to an automatic SD1 referral process for deaths in hospital following admission following a suicide attempt.

These recommendations will strengthen the Department for Health and its agencies' human rights obligations, especially in regards to proactively protecting the right to life by putting in measures to prevent suicide.

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## 1. Who we are

Participation and the Practice of Rights (PPR) is a human rights organisation located in Belfast, Northern Ireland. Established in 2006 by human rights activist and trade unionist Inez McCormack, PPR supports marginalised groups to use human rights tools to realise their social and economic rights. In 2012, PPR's unique approach was recognised by the United Nations Office of the High Commissioner for Human Rights as a good practice example of how communities can claim their rights.

The Mental Health Rights Campaign is a group of people affected by mental health issues, their carers and families bereaved through suicide who campaign for improvements in mental health services and the realisation of our right to the highest attainable standard of mental health.

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## 2. The SAFER campaign

This report marks the launch of the campaign which asks our decision-makers to ensure **Support Automatically For Everyone Referred (SAFER)**. To achieve this we call for the recommendations in this report to be implemented.

Through our research and our own experience, we have identified post-bereavement support as vital to improving the mental health of those impacted by suicide.

We have also identified several ways in which the current bereavement support model is failing. This report identifies the problems as being

- difficulties in referral,
- lack of information on support available,
- lack of referral for those who die in hospital, and
- time delays in receiving support.

The report offers recommendations, such as an automatic referral process and the use of a similar automatic SD1 process for those who die in hospital.

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### 3. Mental Health and Suicide in Northern Ireland

*“The former Special Rapporteur on the right of everyone to the highest attainable standard of mental and physical health has stated that mental health is one of **‘the most grossly neglected elements of the right to health.’**”*<sup>1</sup>

Mental health and suicide are an increasing problem in Northern Ireland. Rates of mental ill health and suicide are higher than in other jurisdictions of the United Kingdom, with the Department for Health estimating that the prevalence figures for mental health in Northern Ireland are 25% higher than in England. In 2014 the rate of suicide in Northern Ireland was 16.5 per 100,000 compared to 9.2 per 100,000 in England. Just over three quarters of those who died were male. Since the 1998 Good Friday/Belfast Agreement more people have taken their own lives in Northern Ireland than were killed in the conflict.<sup>2</sup> Despite this, investment in mental health

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1 ‘The right of everyone to the highest attainable standard of mental health: Developing the normative framework for a population-approach to mental wellbeing’ Essex Human Rights Clinic (<http://www.essex.ac.uk/hrc/documents/human-rights-clinic/Right%20to%20mental%20health.pdf>)

2 ‘Suicide kills as many as the Troubles’ *The Detail* 10 February 2014 (<http://www.thedetail.tv/articles/suicide-kills-as-many-as-the-troubles>)

services in Northern Ireland is between 10-30% lower than per capita spend in England.

Those areas most impacted upon by the conflict continue to experience higher levels of inequality and social deprivation, including in relation to the provision of mental health services. Rates of suicide in the most deprived areas are over three times (29.9 per 100,000) those for the least deprived areas (9.3 per 100,000). Between 2005 and 2009, 30.7% of all deaths occurring in the 25 to 34 years age bracket were attributable to suicide.<sup>3</sup> Suicide figures in Northern Ireland are currently the highest on record, with 318 deaths recorded in 2015.<sup>4</sup>

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### 4. Impact of suicide on family members and friends

An individual’s suicide has far-reaching impact on those around them, and has a long-term effect on the mental health of family members and friends.

*“In 2011 it was suggested the numbers of people ‘profoundly*

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3 *Protect Life The Northern Ireland Suicide Prevention Strategy: A Shared Vision 2012 - March 2014 (Refreshed June 2012) Department of Health p32* ([http://www.setrust.hscni.net/pdf/Refreshed\\_Protect\\_Life.pdf](http://www.setrust.hscni.net/pdf/Refreshed_Protect_Life.pdf))

4 ‘Suicide deaths in Northern Ireland highest on record’ *The Detail* 29 July 2016 (<http://www.thedetail.tv/articles/suicide-deaths-in-northern-ireland-highest-on-record>)

*affected' following a suicide were; in cases up to 80 for children, 60 for a spouse, 45-50 for siblings and friends."*<sup>5</sup>

Studies also show that people who die by suicide often know someone who did the same recently and that *"those who are affected or bereaved by suicide have themselves an increased risk of suicide or mental disorder."*<sup>6</sup>

As part of the Knowledge Exchange Seminar Series (KESS) – Evidence of Bereaved by Suicide Support needs for NI31 a 'Grief Study' found that:

*"Over the study period bereaved persons were 40% more likely to experience poor mental health compared to people who had not been bereaved. The likelihood of poor mental health is further increased in the case of sudden bereavements, including following accidents and suicide"*<sup>7</sup>

Studies show that bereavement by suicide is different than that from other forms of loss by death,

<sup>5</sup> Berman, A. L. (2011). Estimating the population of survivors of suicide: Seeking an evidence base. *Suicide and Life-Threatening Behavior*, 41(1), 110- 116., cited in 'A death like no other: dealing with the aftermath of suicide. Supporting loved ones who are bereaved by suicide', Karen Lascelles Oxford Health NHS Foundation Trust

<sup>6</sup> *Preventing suicide A global imperative World Health Organisation (WHO) 2014 p40* ([http://www.who.int/mental\\_health/suicide-prevention/world\\_report\\_2014/en/](http://www.who.int/mental_health/suicide-prevention/world_report_2014/en/))

<sup>7</sup> *BEREAVED BY SUICIDE SUPPORT N.IRELAND Background Paper for Proposed Service Model June 2015 p10* ([http://www.publichealth.hscni.net/sites/default/files/Background%20Paper%20-%20Bereaved%20by%20Suicide%20Support\\_0.pdf](http://www.publichealth.hscni.net/sites/default/files/Background%20Paper%20-%20Bereaved%20by%20Suicide%20Support_0.pdf))

relating to, for example, the stigma around suicide. Bereavement by suicide is known to have "long term health outcomes"<sup>8</sup>

Children are particularly vulnerable to loss of a family member, and subsequent lack of support:

*"Children bereaved through suicide are at significant risk for a range of issues including anxiety, depression and social problems"*<sup>9</sup>

As a result, the importance of timely and appropriate post bereavement care cannot be underestimated.

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## 5. International Human Rights Context

The United Kingdom, and consequently the Northern Ireland Executive, its department, agencies and trusts have undertaken human rights obligations in regards to mental health services.

The United Kingdom is a party to the International Covenant on Economic, Social and Cultural Rights<sup>10</sup>. Article 12 of this treaty, and the corresponding General

<sup>8</sup> Pitman, A., Osborn, D., King, M., & Erlangsen, A. (2014). Effects of suicide bereavement on mental health and suicide risk. *The Lancet Psychiatry*, 1(1), 86-94., cited in 'A Death Like No Other'

<sup>9</sup> *BEREAVED BY SUICIDE SUPPORT N.IRELAND p9*

<sup>10</sup> International Covenant on Economic, Social and Cultural Rights, 16 December 1966, (<http://www.ohchr.org/EN/ProfessionalInterest/Pages/CESCR.aspx>)

Comment No. 14 (2000)<sup>11</sup> contains the most comprehensive description of the nature of this right.

Article 12 (1) of ICESCR states:

*“The States parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.”*

This is interpreted as the right not only to “timely and appropriate” health care, but also to underlying determinants of health, including water, sanitation, food and health related education and information.<sup>12</sup>

The General Comment further sets out the nature of the health care which governments are required to deliver:

*“The creation of conditions which would assure to all medical service and medical attention in the event of sickness” (art. 12.2 (d)), both physical and mental, includes the provision of equal and timely access to basic preventive, curative, rehabilitative health services and health education; regular screening*

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<sup>11</sup> CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12) Adopted at the Twenty-second Session of the Committee on Economic, Social and Cultural Rights, on 11 August 2000 (Contained in Document E/C.12/2000/4) <http://www.ohchr.org/Documents/Issues/Women/WRGS/Health/GC14.pdf>

<sup>12</sup> CESCR General Comment 14, Para 11

*programmes; appropriate treatment of prevalent diseases, illnesses, injuries and disabilities, preferably at community level; the provision of essential drugs; and appropriate mental health treatment and care.”<sup>13</sup>*

General Comment 14, paragraph 12 (b) highlights the importance of services reaching particularly vulnerable groups and individuals:

*“Health facilities, goods and services have to be accessible to everyone without discrimination... especially the most vulnerable or marginalised sections of the population.”*

While governments are under a duty to ‘progressively realise’ the right to health, some elements place an unconditional and immediate obligation on the state, including:

*“To provide education and access to information concerning the main health problems in the community, including methods of preventing and controlling them.”*

<sup>14</sup>

Notably for the SAFER campaign, the UN underlines the importance of participation of groups in decision making around the way in which the right to health is given

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<sup>13</sup> CESCR General Comment 14, Para 17

<sup>14</sup> CESCR General Comment 14, Para. 44(d)

effect. Essentially, people affected should have a say.

Under international human rights law;

*“The right of individuals and groups to participate in decision-making should be an integral part of any policy, programme or strategy developed to discharge governmental obligations under Article 12.”<sup>15</sup>*

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## 6. The Current Suicide Prevention & Post Bereavement Care Framework in Northern Ireland

Suicide prevention has been a long-term policy aim of the Northern Ireland Executive, featuring explicitly in the 2008-2011 previous Programme for Government (PfG) which set a target of reducing suicide by 15% by 2011 from a baseline of 12.6 deaths per 100,000 of population.<sup>16</sup> The 2011-2015 PfG states it will aim for “cross-departmental work to reduce suicides” as part of its health Priority<sup>17</sup>, and suicide prevention can be found implicitly in the

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15 CESCR, General Comment No.14, para 54

16 Programme for Government, 2008-2011, NI Executive p37 (<https://www.northernireland.gov.uk/sites/default/files/publications/nigov/pfg-2008-11.pdf>)

17 Programme for Government, 2011-2015, NI Executive p36 (<https://www.northernireland.gov.uk/sites/default/files/publications/nigov/pfg-2011-2015-report.pdf>)

current PfG in Indicator 4 pertaining to reducing preventable deaths<sup>18</sup>. It is a key aim of the Department for Health’s Promoting Mental Health Strategy and Action Plan 2003-2008 which also stated:

*“The traumatic impact of suicide on families, relatives, friends and communities warrants a specific focus by those involved in promoting mental health and emotional wellbeing.”<sup>19</sup>*

The Ministerial Forward of *Protect Life, the Northern Ireland Suicide Prevention Strategy (2012 – 2014)* states:

*“From the Government’s perspective, the Executive has agreed that all departments should play a pro-active role in determining actions in support of suicide prevention.”<sup>20</sup>*

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### 6.2 Bereavement Care

Northern Ireland also has a strong policy framework for bereavement care. It is rightly recognised that proper bereavement care is a desirable good in its own right,

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18 Draft Programme for Government, 2016-2021, NI Executive p52 (<https://www.northernireland.gov.uk/sites/default/files/consultations/newnigov/draft-pfg-framework-2016-21.pdf>)

19 *PROMOTING MENTAL HEALTH Strategy & Action Plan 2003-2008 Jan 2003 Department of Health p26* ([http://cain.ulst.ac.uk/victims/docs/agency/dhssps/menhealth\\_0103.pdf](http://cain.ulst.ac.uk/victims/docs/agency/dhssps/menhealth_0103.pdf))

20 *Protect Life The Northern Ireland Suicide Prevention Strategy p4*



as well as its potential to improve mental health, and as a measure to reduce further suicide. If implemented fully, the principles here could play a strong role in creating the structures that are currently missing.

Northern Ireland Health & Social Care Services Strategy for Bereavement Care 2009<sup>21</sup> sets out the pathway for bereavement care in Northern Ireland. One of the key objectives of the strategy is:

*“to ensure that systems are in place within the Health and Social Care services for the identification of those most likely to need specialist support”*

The Quality Standards for Health and Social Care (2006) notes:

*“People in receipt of services should be actively involved in all decisions affecting their lives and should fully contribute to any planning for, delivery and evaluation of services”<sup>22</sup>*

A number of standards have been developed around key themes to assist Health and Social Care services in the delivery of services to people who are dying and their

families, friends and carers and for those services coming into contact with them at other times. Six principal standards exist including Standard 5.2 on Promoting Safe and Effective Care which states:

*“Interventions to support dying and bereaved people should be provided by individuals who have appropriate training and supervision”*

and continues:

*“a pathway for sudden death should be developed where this does not already exist”<sup>23</sup>*

Standard 5.3 on Communication, Information and Resources states that:

*“Information should be communicated verbally and reinforced/supported by written information”*

*“Interventions should be timely and accessible, and should be organised in advance where death is foreseen”*

*“Arrangements for immediate support should be in place when death is sudden or due to traumatic circumstances”<sup>24</sup>*

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<sup>21</sup> Northern Ireland Health and Social Care Services Strategy for Bereavement Care, June 2009, Department Of Health (<https://www.health-ni.gov.uk/publications/northern-ireland-bereavement-strategy-2009>)

<sup>22</sup> Quality Standards for Health and Social Care (2006) cited in Northern Ireland Health and Social Care Services Strategy for Bereavement Care, p10

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<sup>23</sup> Northern Ireland Health and Social Care Services Strategy for Bereavement Care., p13-14

<sup>24</sup> Northern Ireland Health and Social Care Services Strategy for Bereavement Care., p15

## 6.3 Positive bereavement care and its connection to suicide prevention

Research for the Public Health Agency has highlighted the importance of bereavement support in relation to suicide. In their 2015 paper “Bereaved By Suicide Support N. Ireland: Background Paper for Proposed Service Model” they define bereavement support as

*“emotional, practical and information support services provided to individuals and / or groups of individuals who have been bereaved by suicide to assist in the grieving process and recovery.”<sup>25</sup>*

It further states that:

*“The unique experience and diverse needs of every person and family affected by bereavement should be respected, ensuring that care is holistic, appropriate and timely. As such it is necessary to put in place services to provide individuals and communities with timely and appropriate bereavement support intervention to help and support survivors grieve and to reduce the risk of further suicide.”<sup>26</sup>*

25 BEREAVED BY SUICIDE SUPPORT N.IRELAND p6

26 BEREAVED BY SUICIDE SUPPORT N.IRELAND p6

## 7. The Current Process for SD1

A principal way that families can access support services following a suicide is through the SD1 referral process, which is administered by the Police Service for Northern Ireland (PSNI) and described below:

*“The Police Service of Northern Ireland (PSNI) has responsibilities when people die in sudden and unexpected circumstances. In circumstances where death is suspected to be as a result of suicide, the investigating officer will complete form SD1 and will forward this to the designated officer in the relevant health care trust. If there is permission from the family, they may then be contacted by the health care trust to be offered support”.<sup>27</sup>*

According to the Department for Health’s draft Protect Life strategy (August 2015)<sup>28</sup> a Sudden Death Notification (SD1) Form is defined as below:

*“The Sudden Death Notification form (SD1) is used by the PSNI to notify relevant statutory agencies about a sudden death. Prompt notification of a sudden death*

27 ‘Police Service Northern Ireland’, HSCNI Bereavement Network (<http://www.hscbereavementnetwork.hscni.net/guidance-2/guidance/psni/>)

28 Copy shared with PPR by Family Voices Forum

*helps to determine the possible emergence of a suicide cluster [emphasis added] and also ensures that early support is provided to bereaved families.*

*A surveillance process is in place for SD1 forms to be sent to the local Trust and the PHA who both monitor the information. This is supported by information that the local Suicide Prevention Coordinator will pick up from the family or that staff may obtain from community links. SD1 forms are completed by the doctor at the scene of death and include a note on whether they consider if the death was probably a suicide. An arrangement is also in place by which the Coroner's Office provides the PHA with monthly anonymised data - date of birth, gender, locality and known methodology. This information is used by the PHA to cross reference the SD1 data."*

Information received by PPR in March 2016 relating to the Belfast Trust in response to a Freedom of Information request, showed however that in 2014, 41 SD1 forms were received and 25 requests for support were made. In 2015, 55 SD1 forms were received and 30 requests for support were made. Overall just over 50% took up the offer of support through the SD1 process. This does raise concerns

that families are not receiving support given the associated risks.

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## **8. What is not working**

A range of issues with the SD1 process were highlighted by the group from their own experiences. For example, families have raised the issue that this support is offered just after the death, when they may not be in a frame of mind to accept it. In addition, families report that when asked, the PSNI could not always explain the type of support on offer.

Also, police and social services can be perceived negatively in some communities in Northern Ireland and thus people might not want to take the support. Indeed research advises for a careful approach following suicide noting "the secondary trauma investigations can cause"<sup>29</sup>. Finally, there is no current process akin to SD1 where a family member attempts suicide but later dies in hospital, and therefore families are missing out on support referrals.

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<sup>29</sup> 'A death like no other: Dealing with the aftermath of suicide. Supporting loved ones who are bereaved by suicide' Oxford Health NHS Foundation Trust.

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## 8.1 Lack of Information on Support

*'I didn't know what to do ... where to turn...I didn't think there was that much help for me – who to turn to'<sup>30</sup>(Group member)*

Research carried out by the Mental Health Rights Campaign shows that bereaved families have trouble accessing support and having access to information about what services are available. Surveys showed in 2015 that 100% of carers highlighted access to information for someone in mental health crisis as being problematic/core issue for them.<sup>31</sup>

Further studies show<sup>32</sup>:

- Most people don't receive formal help despite many wanting help
- People bereaved by suicide describe "shocked detachment" indicating that it will be difficult for them to seek help early on

As a result of their increased risk of suicide then, it becomes imperative that information and support can be easily accessed in a timely way.

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**30** Group member SOS Focus Group April 2016

**31** Surveys conducted by Mental Health Rights Campaign in Spring 2015 with 104 service users/carers across Northern Ireland

**32** 'A death like no other: Dealing with the aftermath of suicide. Supporting loved ones who are bereaved by suicide' Oxford Health NHS Foundation Trust. p9

NHS Oxford notes importance of families being given:

*"signposting literature where it is suspected a death may be a suicide"<sup>33</sup>.*

Support group members from both Survivors of Suicide (SOS) and SAFE Together felt that the PSNI could not identify the support that was on offer, and this was a factor in not giving permission to receiving support. One worker said:

*"If families do remember being asked - when asked what that support might look like the police aren't able to tell them- so why are any families who suffered this trauma going to say yes to this support when they don't know what it is this could be ... that could be social services coming if there's kids in the house"*

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## 8.2 Timing of SD1 completion and delays in support

*"they should know people are not going to look for help at that time – it's the last thing you are thinking about – it's about getting through the next couple of weeks..."*

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**33** 'A death like no other: Dealing with the aftermath of suicide. Supporting loved ones who are bereaved by suicide' Oxford Health NHS Foundation Trust. p10

Focus groups with families bereaved by suicide in Belfast further elaborated on the nature of the problems post bereavement. One group member explained how it is difficult to know if you need help so close in time to the bereavement as it is such a traumatic time. Next of kin are usually asked this by a police officer about whether they want support within a short period of time of the death.

*“I don’t think you know in your head if you need support – you think in your head you need to do this, do that – down the line you think I need to deal with myself – something is not right – not feeling right and that’s probably when you go down that line and god knows when that would be when you go looking for help”*

*“People don’t realise the situation – the way it affects you”*

Even when families take up support, there are time delays. Support should be offered in 48 hours. However, very few people get this.<sup>34</sup>

Further, the Families Voices Forum, a regional voluntary forum of individuals and families bereaved by suicide, noted in their briefing paper that:

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<sup>34</sup> One worker noted that out of 12 families she worked with, only 3 had received support within 48 hours.

*“The Sudden Death process (SD1) in Northern Ireland provides the initial contact for those bereaved by suicide. Presently the PSNI do not receive training in the completion of this document (PSNI, 2014). What does exist is guidance to officers entitled Police Investigations into Unexpected, Unexplained or Suspicious Deaths and Human Tissue Retention, in relation to SD1 (Appendix 1). These instructions are brief and procedural and do not give guidance on the needs of those who have been bereaved or how the issue should be addressed. Furthermore, this process does not take into consideration complex family dynamics and as such only allows for one named person whom may be impacted by the suicide.”<sup>35</sup>*

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### **8.3 Deaths in hospitals**

Family members also raised the issue of lack of post bereavement support when an individual dies in hospital following a suicide. There is no SD1 process of support referral, as PSNI guidelines do not mandate them to investigate deaths in hospitals (even suicides) except

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<sup>35</sup> Briefing paper, The Families Voices Forum ([www.families-voicesforum.com/downloads/BriefingPaper27thMayMrHamilton.doc](http://www.families-voicesforum.com/downloads/BriefingPaper27thMayMrHamilton.doc))

in exceptional circumstances. However there are positive steps such as the introduction of “Coping with Bereavement” (2011) booklets given by staff to families, as well as the role of Bereavement Co-ordinators, who are based in each of the 5 Health and Social Care Trusts in Northern Ireland.<sup>36</sup>

*“The Bereavement Coordinator is responsible for the establishment of bereavement care standards across the trust and will liaise with colleagues and service users to ensure that relevant policies and procedures meet national and regional requirements and reflect the delivery of an efficient and compassionate service to bereaved people.”<sup>37</sup>*

The Southern Trust ‘Policy for the Management of The Death of a Patient or Client’ (2014) aims:

*“to ensure Trust staff involved in the care of dying and deceased patients and bereaved relatives deliver a safe, effective and sensitive service whilst performing their duties and obligations.”<sup>38</sup>*

It further acknowledges that:

*“the care that bereaved relatives receive at this time can have a*

*significant impact on the grieving process”.*

Dr Patrick Loughran, a current non-executive director to Belfast Health and Social Care Trust, said in 2011 that;

*“Providing information and support to families and carers following a death and during the grieving process is very important.”<sup>39</sup>*

Suicide is recognised as being particularly difficult on families, and that the bereavement from this is unique to other forms of death. Given the mental health implications and increased risk of suicide, extra measures are needed. While deaths in hospitals following a suicide present unique difficulties, being in the hospital setting before deaths means that Trust policies on End of Life Care, which:

*“identifies bereavement care as a key part of palliative and end of life care,”<sup>40</sup>*

allow the Trust the opportunity to start the support process as soon as is possible/suitable, giving the family extra resources to cope.

However, while staff are able to

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<sup>36</sup> Bereavement Network, HSCNI (<http://www.hsbereavementnetwork.hscni.net/>)

<sup>37</sup> Policy for the Management of The Death of a Patient or Client, March 2014, Southern HSC Trust p3 ([http://www.southerntrust.hscni.net/pdf/DeathOfA\\_PatientOrClient.pdf](http://www.southerntrust.hscni.net/pdf/DeathOfA_PatientOrClient.pdf))

<sup>38</sup> Policy for the Management of The Death of a Patient or Client p2

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<sup>39</sup> ‘Coping with Bereavement booklet’ 22 June 2011 Southern HSC Trust (<http://www.opportunitiesforall.org/news/item/27/coping-with-bereavement-booklet/>)

<sup>40</sup> “Living Matters; Dying Matters: A Palliative and End of Life Care Strategy for Adults in Northern Ireland” March 2010 Department of Health [www.ncpc.org.uk/sites/default/files/8555\\_palliative\\_final\\_0.pdf](http://www.ncpc.org.uk/sites/default/files/8555_palliative_final_0.pdf)

provide some information of where to go for help, as with deaths in the home this is not enough. Group members have identified the need for a referral process, and as with the recommendations for the SD1, that this process be automatic.

*“The SDI process is about ensuring we get appropriate and timely support to people bereaved by suicide. however in cases where the death occurs within a healthcare setting the process isn’t followed. Given this gap in the system, stories have emerged of families struggling to cope without support, and desperately searching online for help. At best some make connections to agencies and groups that are regulated care giving professionals and are following the guidelines to support people bereaved by suicide. Others not so fortunate get overwhelmed by “others stories”and spiral into a place of insecurity and doubt about recovery and healing. This falls far short of what we know about supporting recovery, reducing stigma and giving hope. As a worker in this field I want to be assured that all people bereaved by suicide can be identified in a sensitive and confidential manner.”*

**Roberta Coates**

Community Suicide Liaison  
Coordinator, Extern

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## 9. What needs to change

The work of MHRC along with the support groups strongly calls for the need for a system of automatic referral for bereavement support. Below are some suggestions for how this could happen. The current SD1 process could be amended to be in line with the Victim Support model of automatic referral unless the family actively declines. For deaths in hospital, a system mirroring (but not necessarily linked to) the SD1 process, amended to be automatic, would be in line with HSC Bereavement objectives. Finally, automatic referral to the coroner’s office as a place to manage bereavement support has been proposed by the group and has found success in other jurisdictions.

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### 9.1 Recommendation 1: *Automatic referral to bereavement support through SD1*

As highlighted throughout this report, the current model for referral to bereavement support is not working sufficiently well for families. Data released through Freedom of Information showed that in 2014 and 2015 almost 50% of families were not opting

for referral when the police were completing the SD1 forms. As we have stated, many families have shown how that the offer of support is coming too soon and that police often cannot fully explain what is on offer.

Yet families do want support, and thus have suggested automatic referral to be used instead. This could simply mean PSNI officers informing families that their details are being passed on. As with other automatic referral services, families can state they do not want support at the time, and can opt out at a later stage.

Making SD1 an automatic referral would bring it in line with support offered to others who have been through a traumatic experience – namely victims of crime.

If you have been a victim of a crime;

*“The police will automatically pass your details to Victim Support NI and other criminal justice organisations, so you can be offered information on additional services (including support services). They can advise on medical support or alternative accommodation should this be required as a result of the crime.”<sup>41</sup>*

Further to this the PSNI Victims

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<sup>41</sup> ‘Information for victims of crime’ Department of Justice p2 (<https://www.justice-ni.gov.uk/sites/default/files/publications/doj/information-for-victims-of-crime.PDF>)

Charter states that:

*“You are entitled to have the police pass your details to a victim support service provider (unless you object) so that you can be offered information on what support services, including specialist support services, are available to you. You do not have to use these services.”<sup>42</sup>*

The automatic referral to support services may potentially raise data protection issues. However, within the Trust’s current Family Support Guidelines<sup>43</sup> regarding SD1 referrals, it already emphasises the importance of keeping families information private, and requires that staff only use a person’s initials when Family Support Plan is forwarded to community representatives involved.

Additionally, as we are arguing that the PSNI extend their automatic referral used in Victim Support to the SD1 process, they can use their already developed data protection methods here.

The Data Sharing Code of Practice, which covers activities such as police passing on information and

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<sup>42</sup> Victim Charter Summary, A Charter for victims of crime, Understanding your entitlements and the support you can get Department of Justice p8 ([https://www.psni.police.uk/global-assets/advice--information/victim-support/n-i\\_victims\\_charter\\_summary.pdf](https://www.psni.police.uk/global-assets/advice--information/victim-support/n-i_victims_charter_summary.pdf))

<sup>43</sup> Trust’s Current Family Support Guidelines, VG Guidelines Comm’ Pathways, December 2014, Belfast HSC Trust, obtained in Freedom of Information Request (12 Feb 2016)



GPs sharing patient information with a hospital, emphasises that:

*“under the right circumstances and for the right reasons, data sharing across and between organisations can play a crucial role in providing a better, more efficient service to customers in a range of sectors – both public and private.”<sup>44</sup>*

The Code also highlights situations:

*“of when, or whether, it is acceptable to share information without people’s knowledge or consent or in the face of objection”.<sup>45</sup>*

Given the noted effects of poor or delayed bereavement support following a suicide, introducing automatic referrals will help Trusts meet the Protect Life objectives of all departments playing a proactive role in determining actions in support of suicide prevention.

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## **9.2 Recommendation 2:** *Automatic referral for deaths in hospital*

An additional area in which bereavement support was not meeting families’ needs was around deaths in hospitals following a suicide attempt. Group members

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<sup>44</sup> Data sharing code of practice, Information Commissioner’s Office, May 2011, p4 ([https://ico.org.uk/media/for-organisations/documents/1068/data\\_sharing\\_code\\_of\\_practice.pdf](https://ico.org.uk/media/for-organisations/documents/1068/data_sharing_code_of_practice.pdf))

<sup>45</sup> Data sharing code of practice p7

stated that the choice of support referral (for example through the SD1 process) when a death happens outside of hospital was not open to them. The Trust guidelines around sudden death and bereavement in general would support the introduction of an automatic support referral process, in line with our above proposed changes to SD1. Because the PSNI only rarely investigate deaths in hospitals (even suicides),<sup>46</sup> the Trust will need to create their own automatic referral policy (but can be modelled on SD1).

Our suggestion is situated in general bereavement guidelines, which notes that the majority (three quarters) of deaths in Northern Ireland are in a hospital setting. It also notes the seriousness of sudden/violent deaths. Therefore it is highly problematic having no clear systems/guidelines for automatically linking families into post bereavement support if their loved one dies in hospital following an attempt to take their own life. Current guidelines say bereavement support should start even before death – this is possible with people coming in after suicide

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<sup>46</sup> Memorandum of Understanding. Investigating patient or client safety incidents (Unexpected death or serious untoward harm): Promoting liaison and effective communications between the Health and Social Care, Police Service of Northern Ireland, Coroners Service for Northern Ireland, and the Health and Safety Executive for Northern Ireland. ([www.hscbereavementnetwork.hscni.net/wp-content/uploads/2014/05/memorandum-of-understanding\\_investigating\\_patient\\_or\\_client\\_safety\\_incidents.pdf](http://www.hscbereavementnetwork.hscni.net/wp-content/uploads/2014/05/memorandum-of-understanding_investigating_patient_or_client_safety_incidents.pdf))

attempt. While Trust guidelines have many positive aspects such as informing families of help available, as with the SD1 process this needs to be automatic (unless the family expressly opts out).

Allowing for deaths in hospital which follow a suicide attempt to be put through an automatic referral process will allow Trusts to fulfil current HSC Bereavement Care policy (2009) aims. This policy stresses the need to

- *“improve the quality of care delivered in the Health and Social Care services for family, friends and carers of people who are dying*
- *create a holistic, co-ordinated approach to bereavement care, which applies during the ‘journey’ of bereavement (i.e. prior to, at the time of, and following the death).”*<sup>47</sup>

And to heed by these principles:

*“Communication, information and resources: That people who are dying and those who are affected by bereavement will have access to **timely, accurate and consistent information***

*Working together: That good communication and co-ordination will take place within and between*

<sup>47</sup> Northern Ireland Health and Social Care Services Strategy for Bereavement Care pp 4-10

*individuals, organisations and sectors,*

*Arrangements for immediate support should be in place when death is sudden or due to traumatic circumstances”*<sup>48</sup>

Families of people who enter hospital after a suicide attempt also should avail of bereavement support as soon as possible, and not necessarily only after their family member passes away. This will help fulfil Trust policies on End of Life Care which:

*“identifies bereavement care as a key part of palliative and end of life care.”*<sup>49</sup>

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### **9.3 Recommendation 3:**

***A long term goal of automatic referral to coroner’s officer for bereavement support***

Support group members highlighted the positive experience they had of the role that the Coroner’s office played in bereavement support. Suicides must be reported to the Coroner’s office<sup>50</sup>.

<sup>48</sup> Northern Ireland Health and Social Care Services Strategy for Bereavement Care pp10-14

<sup>49</sup> Living Matters Dying Matters A Palliative and End of Life Care Strategy for Adults in Northern Ireland March 2010 [www.ncpc.org.uk/sites/default/files/8555\\_palliative\\_final\\_0.pdf](http://www.ncpc.org.uk/sites/default/files/8555_palliative_final_0.pdf)

<sup>50</sup> Coroners Service for Northern Ireland, Courts NI (<https://>

This includes deaths in hospital.

A Memorandum of Understanding (MOU) between the PSNI, HSC and the Coroners' office states that

*"There is a general requirement under section 7 of the Coroners Act (Northern Ireland) 1959 that any death must be reported to the coroner if it resulted, directly or indirectly, from any cause other than natural illness or disease for which the deceased had been seen and treated within 28 days of death....For example...deaths associated with the misuse of drugs (whether accidental or deliberate); any apparently suicidal death; [etc]"*

Therefore, as all suicides should be reported to the coroners office, this provides an opportunity for them to be involved in overseeing the bereavement support. This model has worked in other jurisdictions:<sup>51</sup>

A recent piece of research examined a similar model which works successfully in Australia. In the Coroner's office for New South Wales the forensic counsellors (social workers):

*"make initial contact to the next of kin within a day or two of the death being reported to the Coroner, providing psychosocial support and information about the autopsy and the Coronial process."*

*"The team work with the Coroner's office and police to facilitate supported access to post mortem and Coronial reports, and viewing the body."*

As the forensic counsellors, who provide information, support and counselling to families in the aftermath of suicide, are part of the Coronial system, they can contact the next-of-kin immediately following a death to provide support, working alongside Police. While there is a high rate of complaints about processes when people die in hospital in the United Kingdom, a team which was the focus of a study reported:

*"that they have never received a complaint about their proactive approach from anyone contacted immediately following a death."<sup>52</sup>*

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[www.courtsni.gov.uk/en-GB/Publications/UsefulInformation-Leaflets/Documents/Coroners%20Service%20for%20Northern%20Ireland/Coroners%20Service%20for%20Northern%20Ireland%20\(HTML\).htm](http://www.courtsni.gov.uk/en-GB/Publications/UsefulInformation-Leaflets/Documents/Coroners%20Service%20for%20Northern%20Ireland/Coroners%20Service%20for%20Northern%20Ireland%20(HTML).htm)

<sup>51</sup> *Developing Psychoeducation Bereavement by Suicide Groups (Australia & New Zealand) Anne Embury, The Rank Foundation, 2014*

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<sup>52</sup> *Developing Psychoeducation Bereavement by Suicide Groups pp9-10*



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