Public Health England

Protecting and improving the nation's health

Identifying and responding to suicide clusters

A practice resource

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Foreword

A cluster of suicides is a rare event, but when it happens it can affect more than families and friendship groups. The impact can be widespread. Any suicide is shattering, but a suicide cluster can cause distress in whole communities.

The profile of suicide prevention has increased nationally since the first version of this guide published in 2015. In response to increasing concern over suicide in young people studying at university and the possibility of a cluster in this population we have included a section specifically focussing on this setting.

We have also developed a greater understanding of the role of the media, in particular social media and how it can be used to promote suicide prevention messages to vulnerable groups during a cluster.

Preparation is key. Agencies may be faced with several pressing priorities: dealing with the devastating aftermath of a suicide, protecting vulnerable or impressionable individuals and trying to prevent a cluster from expanding. In the early stages of the response possible opportunities for prevention may be missed as community leaders search for answers.

The authors of this guidance have outstanding expertise and they draw on the extensive experience of people across the suicide prevention field, including families bereaved by suicide who are determined to contribute to the safety of others.

We recognise the critical role Local Authorities have in providing suicide prevention leadership; with all Local Authorities in England now having a suicide prevention plan in place and multi-agency groups established.

This guide provides a framework for action, together with some step-by-steps, that we hope Local Authorities will adapt to their own needs, resources, and strengths complementing the work already taking place.

Professor Louis Appleby
Co-chair of the National Suicide Prevention Strategy Advisory Group

Executive summary

This document is intended for those with responsibility for suicide prevention in local authorities and their partner agencies. Whilst this guidance focuses on identifying and responding to suicide clusters it is important to note that appropriately responding to single suicides can reduce the risk of further suicides. The information within this guidance will be of relevance following single as well as multiple suicides.

Suicide clusters understandably cause great concern, especially as they predominantly occur in young people, and may lead to hasty and potentially unhelpful responses. It is important that plans for such occurrences are prepared in advance, to ensure a measured and effective response. Authorities need to remain vigilant for potential clusters and possible contagion between deaths, and put strategies in place to forestall this.

This resource has been developed as a contribution to the National Suicide Prevention Strategy for England. It complements the PHE guidance on developing local suicide action plans:
www.gov.uk/government/publications/suicide-prevention-developing-a-local-action-plan

Addressing suicide clusters is the responsibility of Multi-agency Suicide Prevention Groups, generally led by local authorities, which should build preparing for clusters into their local suicide prevention plans. These groups should include relevant organisations that might be affected, including mental health services, schools, colleges and universities.

The guide includes: the meaning of the term ‘suicide cluster’, the identification of clusters, suggestions for who may be at risk of suicidal acts due to the influence of other people’s suicidal behaviour, the likely mechanisms involved, and the effects of suicide (including suicide clusters) on other individuals. The steps that need to be taken at local level to respond to a suicide cluster are described. This necessitates the development of a Suicide Cluster Response Plan and identification of individuals and agencies that will deliver such a plan. The need for close collaboration between organisations and groups involved in a Suicide Cluster Response Plan and those with responsibility for community wellbeing and safeguarding is highlighted.

Identifying possible suicide clusters can be difficult. Early indicators are described, together with the need to carefully establish the facts and avoid premature and possibly unhelpful responses.

This document suggests specific aspects of responses to possible suicide clusters, including preventing unhelpful media reporting, supporting those bereaved or directly

affected, identification of individuals and groups who may be particularly vulnerable, advice regarding social media and practical interventions to reduce the risk of a spread of suicidal behaviour.

In this age of instant information sharing it is possible for a cluster to be widely geographically dispersed. Local groups will need to alert other local authorities if this looks possible.

The issue of how to follow up a response to a suicide cluster is also outlined, with emphasis on the fact that localities which have had clusters may be at heightened risk of further clusters.

The guide includes general guidance on addressing suicide clusters in community settings. This is followed by sections focussing on organisations and institutions known to be vulnerable to suicide clusters, namely mental health services, schools and colleges, and universities. The guide does not address the issue of suicide clusters in prisons.

It should be noted that whilst this document is based on the best available evidence, this is an emerging field and all of the recommendations are based on good practice, informed by expert opinion and various examples of practical experience.

Summary of changes to the original guide

This guide is a revision of the original 2015 guidance for identifying and responding to suicide clusters. Whilst the description of what constitutes a suicide cluster remains the same as in the original guide, this updated version has been informed by further experiences of responding to suicide clusters. This has enabled us to create a more practical resource. The main differences are:

Terminology: this revised guide refers to a **Suicide Cluster Response Plan** and associated suicide cluster response group. These terms replace those used in the first version of the guidance (Community Action Plan; Suicide Response Team) and provide greater clarity for the reader.

Leadership guidance: Experience has indicated that there can be confusion around leadership responsibility in responding to clusters, particularly when concerns are within a specific institution such as a school, university or mental health setting. In practice it has been necessary to have internal leadership supporting community-based public health leadership and this document provides guidance accordingly.

Structured components to a response: surveillance; information sharing; media issues; bereavement support; prevention; monitoring and reviewing. These components

provide structure to a cluster response, which experience suggests is helpful at a time when anxiety is high and during a process that might involve multiple agencies. The components are derived from experience and are central to this resource, informing all sections.

Institution-specific sections: mental health services; schools and colleges; universities. The mental health and schools sections have been fully revised. A new section on universities is now included. These settings, known to be vulnerable to suicide clusters, have their own governance and ways of working. However, experience has shown that basing a response on the model in this guide can help these organisations and public health adopt a systematic approach to responding to a potential or actual suicide cluster.

How this guide is organised

The first section of this document (pages 15 to 20) explains what a suicide cluster is, which populations might be particularly vulnerable, mechanisms involved in clusters, the role of the media and the contribution of bereavement by suicide to clusters.

The second section (pages 21 to 27) outlines how multi agency partnerships should prepare in advance for a suicide cluster. This is key to ensure that in the early stages of response possible opportunities for support and prevention are not missed.

It is important to note that identification of suicide clusters can be difficult in practice. In reality, clusters are more likely to be suspected or there are concerns that one may occur because of the nature or circumstances of a specific suicide or suicides. Conclusively identifying a cluster should not stand in the way of responding to concerns. In groups particularly vulnerable to imitation (for example those in schools, further education colleges, universities or inpatient psychiatric wards), attention should be paid to possible contagion after even a single suicide.

The main body of this resource provides guidance on addressing suicide clusters. It is divided into responding to suicide clusters in general, followed by responding to clusters in specific institutional settings, namely mental health services, schools/colleges and universities.

Community suicide clusters – page 28 to 42
Mental health services – page 43 to 47
Schools/colleges – page 48 to 54
Universities – page 55 to 63

The key components of a suicide cluster response, which have been derived from experience, are:

- **surveillance** – to identify and monitor occurrence of suicidal acts
- **information sharing** – between relevant agencies to ensure consistency of response
- **media issues** – to ensure responsible reporting
- **bereavement support** – to help those bereaved and affected by suicide
- **prevention** – to reduce risk of further suicides
- **monitoring and review** – to assess the impact of the response, what has been learned and to inform future plans

Readers concerned with a possible suicide cluster in an institutional setting are advised to read the section of the guide on responding to suicide clusters in general before reading the section relevant to their specific setting.

Public Health England has several other resources relevant to suicide prevention that are referred to in this guide. It is important to consult these where relevant.

Overview: suicide cluster response and links to relevant resources and guidance

Being prepared for a suicide cluster

Build cluster response and identification into local authority led multi agency suicide prevention groups and plans

Establish mechanisms for local real time suicide surveillance

Identify membership of a Suicide Cluster Response Group

Develop a Suicide Cluster Response Plan:

- surveillance
- information sharing
- media
- bereavement support;
- prevention
- monitoring and reviewing

Link with child death overview panel regarding deaths of under-18 year olds

Identification of a possible suicide cluster

Concerns about a possible suicide cluster should arise when there are:

More suicides than expected within a time period within a specific location

More suicides than expected within a time period which are geographically widespread

Suicides involving particular methods of suicide

Suicides occurring in the same location as previous clusters but after some time

Single suicides in groups vulnerable to imitation (for example, within a school, college, university or inpatient psychiatric unit) are of particular concern and require a preventative response

To determine appropriate level of concern it is important to establish the facts around suspected suicide/s. Conclusively identifying a cluster should not stand in the way of responding to concerns. If in doubt go straight to ‘Response’.

Response to a possible suicide cluster

Continue or establish local **surveillance,** including links with Coroners

Convene **Suicide Cluster Response Group**

Agree **leadership** and **information-sharing** arrangements

Establish a single point of **media** contact. Work with **media** to facilitate understanding of role in prevention

Identify groups and individuals requiring **bereavement support**

Identify vulnerable groups and individuals and target **prevention** measures

Establish whole population wellbeing and suicide **prevention** awareness

Establish **monitoring and review** processes

Key PHE resources to support a suicide cluster plan and response

PHE Local Suicide Prevention Planning Guidance:
www.gov.uk/government/publications/suicide-prevention-developing-a-local-action-plan

Thames Valley Real -Time Surveillance System Resource Pack:
www.nspa.org.uk/wp-content/uploads/2017/10/Thames-Valley-Real-Time-Suicide-for-website-FINAL-with-links.pdf

Suicide Prevention: Suicides in Public Places:
www.gov.uk/government/publications/suicide-prevention-suicides-in-public-places

Support after a Suicide: A Guide to Providing Local Services:
www.gov.uk/government/publications/support-after-a-suicide-a-guide-to-providing-local-services

Preventing Suicide: Lesbian, Gay, Bisexual and Trans Young People:
www.gov.uk/government/publications/preventing-suicide-lesbian-gay-and-bisexual-young-people

What is a suicide cluster?

The term “suicide cluster” describes a situation in which more suicides than expected occur in terms of time, place, or both. It is difficult to precisely define a cluster. A suicide cluster usually includes 3 or more deaths; however, 2 suicides occurring in a specific community or setting (for example a school) in a short time period should also be taken very seriously in terms of possible links and impacts (even if the deaths are apparently unconnected), particularly in the case of young people. It is important to establish at a very early stage if there are connections between suicides. However, it is also important to recognise that there do not have to be clear connections for multiple deaths to constitute a cluster. Multiple unconnected deaths in a community can have similar consequences to a cluster in which links between deaths are apparent, such as media response, heightened local concerns and speculation, and influence on methods used for suicide. Also, there may be unrecognised connections between deaths.

Some people dislike the terms ’suicide cluster’ and ‘contagion’ because they find them anxiety provoking and they might also be seen as insensitive to bereaved families. However, these are the terms generally used by people working in the suicide prevention field. We have therefore used them in this guide. It is important, however, that agencies which prefer to use other terms ensure consensus and consistency in their use.

Different types of suicide clusters are described in **Box 1**. Attention is usually focussed on point clusters, such as the cluster of suicides that occurred in the Bridgend area of Wales in 2007/8[1]. However, with suicidal behaviour increasingly spreading via the internet and social media[2-4] the incidence of geographically spread mass clusters may be increasing, but these can be difficult to recognise. There can also be clustering in terms of methods of suicide (for example specific types of gas poisoning[5], overdose or injury). This might occur within a point cluster or a mass cluster.

Box 1: Types of suicide clusters

Point clusters (or spatial-temporal clusters)
A greater than expected number of suicides that occur within a time period in a specific location. This might be in a community or an institution (for example school, university, psychiatric inpatient setting)

Mass clusters (or temporal clusters)
A greater than expected number of suicides within a time period which are spread out geographically

Clusters involving a specific method of suicide
Sometimes clustering can involve a particular method of suicide. This can occur in both point and mass clusters

Echo cluster
A cluster occurring in the same location as a previous cluster, but some time later

While the focus of this guide is mainly on suicides, it is essential to recognise that self-harm can also occur in clusters[6], as can mixed clusters of both suicide and self-harm[7]; indeed, linked episodes of self-harm may be a precursor to a suicide cluster[8]. While the term 'suicide cluster' is used throughout most of this guide, much of what is covered could apply equally to clustering of self-harm.

It is difficult to ascertain how many suicides occur in clusters and the extent to which clusters contribute to overall suicide rates[9]. Approximately 5% of all suicides in New Zealand appeared to occur in point clusters[10] and 2.4% of suicides in Australia[11]. Data from England and Wales suggest that possibly as many as 10% of suicide deaths in people who are in contact with mental health services in the year prior to their death may be related in time and setting[12]. Estimation of such figures is approximate. It is not known how many suicides occur in mass clusters because accurate identification of those affected may be impossible as they tend to be geographically remote; sometimes linked deaths occur in different countries.

Identification of suicide clusters can be difficult in practice. For the purposes of establishing a community suicide cluster response, identification is best based on local impressions, although this needs to be done with caution. However, it is worth

emphasising the importance of taking preventive measures after even a single suicide in a group vulnerable to imitation (for example in a school, further education college, university or inpatient psychiatric ward).

In England, determination of whether or not a death is officially a suicide depends upon a coroner's inquest. Unfortunately, inquests usually occur a considerable time, often many months, after deaths. Response to possible suicide clusters must occur rapidly in order to prevent further deaths, and therefore identification of deaths in which suicide is the likely cause must take place at the earliest possible stage, without awaiting coroners' verdicts. For clarity, such 'suspected suicides' will usually be referred to in this guide as 'suicides'.

Areas which have suffered a suicide cluster may be at increased risk of it happening again (echo clusters). This could be related to particular characteristics of the area/population which increase vulnerability to suicide more generally (for example high levels of socio-economic deprivation).

The term **'multiple suicides'** is often used to describe a situation where more than one suicide occurs in close temporal (time) and geographical proximity, although this may not be viewed as amounting to a cluster. Establishing any connections between such deaths can be important and will help to identify possible risks of **suicide contagion,** i.e. spread of suicidal behaviour, (see **Mechanisms involved in suicide clusters,** page 18) and offer appropriate support and interventions. However, as noted above, apparently unconnected multiple suicide deaths in a locality can have some similar consequences to clearly connected deaths.

Whilst most suicides occur at a person's place of residence, certain locations may be frequently used for suicide (for example particular bridges, cliffs, remote areas). Separate PHE best practice on taking action to prevent suicide in public places is available to support local multi-agency suicide prevention groups address concerns about particular locations. See: www.gov.uk/government/publications/suicide-prevention-suicides-in-public-places

Individuals who may be involved in suicide clusters

Some population groups are particularly vulnerable to suicide clusters, including young people[13], people with mental health problems[14], and prisoners[9]. Clusters of suicidal behaviour are more common in certain settings, including schools[9], universities[15], psychiatric facilities[14], prisons[9, 16] and work-places[17]. People who share similar characteristics or identify psychologically with individuals who have taken their lives may be vulnerable to the contagious effects of suicide, which may contribute to the development of clusters[18].

Mechanisms involved in suicide clusters

Suicide clusters may result from **'contagion'**, whereby one or more than one person's suicide influences another person to engage in suicidal behaviour or increases their risk of suicide ideation and attempts (see **Box 2**). A variety of mechanisms may be involved, such as modelling and vulnerable individuals tending to come together in social groups[13]. The people involved are likely to already be vulnerable, perhaps because of existing mental illness and thoughts of suicide, or factors such as severe family discord or previous bereavement. However, it is also possible that exposure to suicidal behaviour may make a person contemplate a suicidal act for the first time; it can also provide information about possible methods.

There are often several complex issues at play in individual suicides. It is also important to note that not all suicides that occur in clusters are the result of contagion (for example when shared environmental stressors, such as job loss, or lack of adequate service provision occur).

Box 2: Suicide contagion is more likely to occur where:

A suicide involves a person with similar characteristics (for example gender, age, social circumstances) to other people who have died. Such deaths may have occurred within an individual's social network or in people they became aware of through media or other influences. This is sometimes termed **'horizontal transmission'.**

New or unusual methods of suicide are publicised, including through social media

There is a death of a celebrity by suicide (or other cause)[19-21]. This is sometimes referred to as **'vertical transmission'**.

A suicide involves a young person

The role of media

Media may be a significant influence in the development of a suicide cluster. This includes traditional media, such as print, newspapers and television, as well as, increasingly, the internet through social media and online platforms. The latter have become increasingly influential, especially as these can spread both inaccurate and harmful information[3, 22, 23], while also being an important potential source of help and advice[3, 22].

The way suicides are reported can be very important in determining whether contagion will occur[24]. A US study of newspaper reports associated with suicide clusters in 13-20 year-olds[25] showed that reports of suicides which were followed by clusters differed from isolated (single) suicides in terms of:

- appearing more frequently/repetitive coverage
- being more often on the front page
- having headlines which included the word ‘suicide’ or a description of the method used for suicide
- providing more detailed descriptions of the individuals and their suicide acts

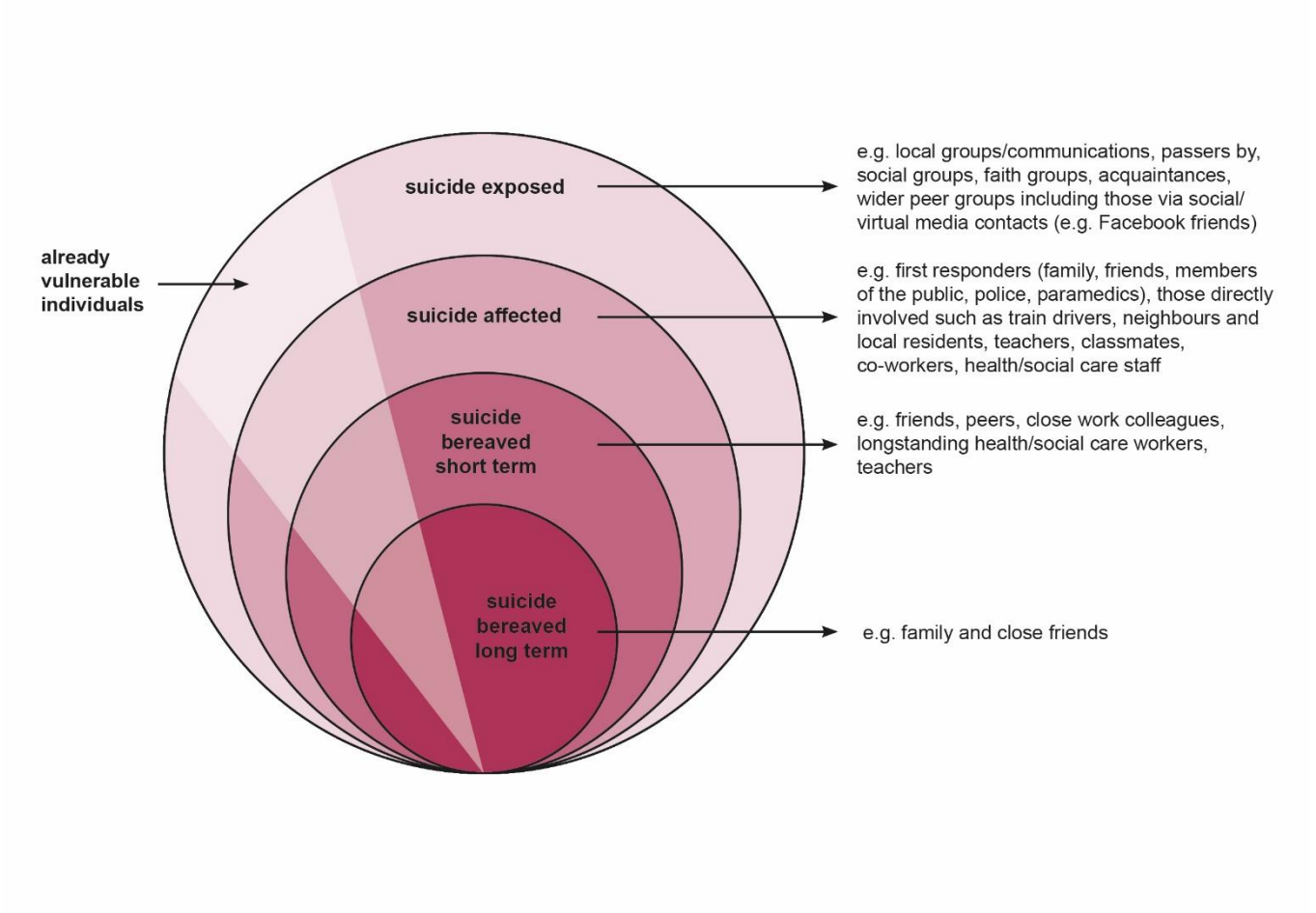
Such characteristics may also be relevant to the potential influence of online news.

Conversely, it has been suggested that more positive media coverage such as reports of individuals who experienced suicidal ideation and overcame it may be associated with preventing suicide. This has been termed the ‘Papageno effect’[26]. Digital media in particular has the potential to provide crisis support, reach a broad range of people during a cluster including more marginalised groups, deliver therapy and give information about sources of support and advice[3].

The contribution of bereavement by suicide to suicide clusters

Suicide can be devastating for families, friends, work colleagues, teachers and others and any suicide usually affects a large number of people[27]. These will not just be close family or friends (see **Figure 1**). Suicide bereavement can itself increase suicide risk[27]. While this may apply especially to people close to the person who died, there may be particularly vulnerable individuals across all categories of those who are exposed to suicide due to mental health problems, isolation, history of self-harm, and other psychological, psychosocial or environmental factors (see **Figure 1**). These individuals may be known or unknown to the deceased and known or unknown to services.

Figure 1: The range of individuals who may be affected by suicide[28] (modified with permission)



Being prepared for a suicide cluster

Multi-agency Suicide Prevention Group

Each local authority area should have an established **Multi-agency Suicide Prevention Group,** led by the public health suicide prevention lead. Public Health England has issued guidance on developing local suicide prevention plans and setting up local multi-agency groups to deliver on these plans. See: www.nspa.org.uk/wp-content/uploads/2016/10/PHE_LA_guidance-NB241016.pdf

Multi-agency Suicide Prevention Groups are responsible for developing local suicide prevention action plans. These should include a plan for responding to possible suicide clusters**.** In this document this plan will be referred to as the **Suicide Cluster Response Plan**. The aim of the plan is to support those affected by suicide and to prevent further suicides. Local authorities may wish to use their own term. Feedback from organisations facing suicide clusters has shown that a Suicide Cluster Response Plan should be in place before a cluster occurs; lack of such a plan can result in a haphazard response when a cluster is suspected. While use of the term **Suicide Cluster Response Plan** implies that a cluster has definitely been identified, in reality clusters are more likely to be suspected or there are concerns that one may occur because of the nature or circumstances of a specific suicide or suicides. The plan should be reviewed periodically to ensure it continues to reflect current agencies and partnerships.

Public Health England has a major role in suicide prevention and should usually be informed when local authorities are dealing with a suspected cluster. This should be done via the local Public Health England lead in the first instance.

PHE Regional and Local Centres

PHE Centres are the front door for most of PHE's local services across health improvement, healthcare public health and health protection. They:

- support local areas to deliver their health and wellbeing strategies
- co-ordinate PHE's local activities to improve health outcomes for local populations
- work across local and national strategies, policies and actions that affect the health of their populations

They can help to facilitate national support if required.
Contact details:
www.gov.uk/guidance/contacts-phe-regions-and-local-centres

Young people under 18 years

There are already processes in place for reviewing and responding to any sudden death, including suspected suicides, of young people under the age of 18 years (via the **Local Child Death Overview Panel Rapid Response Team**) and these should be tied in with the Suicide Cluster Response Plan. There should be links between the Multi-agency Suicide Prevention Group and local bodies responsible for safeguarding children (in England these are Local Safeguarding Children Boards) and the local Child Death Overview Panel: 'CDOP'. See: www.gov.uk/government/publications/working-together-to-safeguard-children.

Developing a Suicide Cluster Response Plan

A plan is best developed by a small core group comprising the public health suicide prevention lead and other relevant members of the Multi-agency Suicide Prevention Group. In this guide this group will be termed the **Suicide Cluster Response Group.** The group might include:

- public health suicide prevention lead
- police
- coroner
- healthcare (eg primary care, mental health services)
- CDOP lead
- local authority media communications lead

The Suicide Cluster Response Group should try and seek input from an expert in suicide prevention – this contact could be facilitated by the local Public Health England Centre lead. The Group may wish to involve their local Public Health England Centre Lead at this stage, but should at least ensure that mechanisms for reporting and liaison are in place as part of the plan.

All areas will have local settings that may be vulnerable to suicide clusters (notably schools, colleges and universities). Involvement of representatives of these settings in developing the Suicide Cluster Response Plan should be considered.

Leadership

Leadership responsibility for a local Suicide Cluster Response Plan rests with the local public health lead for suicide prevention. It should be noted that where there are concerns about suicide clusters in educational or mental health settings, the organisations concerned should have their own internal policies for responding to

suicides or unexpected deaths. Ideally these should include addressing the possibility of contagion. In these cases close collaboration between the responsible organisational lead and the local Public Health England Centre Lead can help ensure that any response is in keeping with local policies and that implications for the local community are addressed. It is important to recognise that a cluster which occurs in an institutional setting may be part of a wider problem of suicidal behaviour in the local community. In such cases it is essential that clarity around the roles of the public health and organisational leads is established at a very early stage to avoid confusion or duplication and to manage anxiety. Suggested public health and organisational leadership roles are provided in **Appendix 1.**

When developing a Suicide Cluster Response Plan there should be consideration of local agencies which may have a role in responding to a suicide cluster. The agencies and personnel to be involved should reflect the nature and circumstances of the cluster. For example, a cluster involving young (<18 years) people will necessitate involvement of the local Children Safeguarding Board or Children's Social Care, and may require Child and Adolescent Mental Health Services (CAMHS) and child bereavement charity involvement. Response to a cluster of suicides in adults in the community may benefit from involvement of a local police community support officer, who will have an in-depth knowledge of the community; where drugs or alcohol feature in the deaths substance misuse services should be included; where deaths involve members of specific faith communities relevant faith leaders should be included.

Suicide clusters may not be confined to local authority areas. Therefore there usually needs to be close collaboration with other potentially affected areas such as neighbouring authorities and clinical commissioning areas.

Components of a Suicide Cluster Response Plan

The following structure is used throughout the guide, including in the sections on clusters in specific institutional settings. It is based on growing experience of addressing clusters in both community and institutional settings.

Surveillance

Suspected suicides: as part of the local authority multiagency suicide prevention action plan, strategies for real time monitoring and surveillance of suspected suicides may be in place. An example of this is the Thames Valley Suicide Surveillance System. See: www.nspa.org.uk/wp-content/uploads/2017/10/Thames-Valley-Real-Time-Suicide-for-website-FINAL-with-links.pdf.

Further guidance is also available in Section 3 of PHE's suicide prevention planning guidance: www.gov.uk/government/publications/suicide-prevention-developing-a-local-action-plan

If not it will be necessary to establish links with local police and coroners to obtain information about recent suspected suicides and be alerted to any additional incidents that might indicate growing evidence of a possible cluster.

Non-fatal self-harm: suicide clusters may also be associated with increases in non-fatal self-harm. While monitoring of self-harm at the community level is challenging, surveillance could include monitoring of self-harm which results in hospital presentation. This may include detecting increases in use of specific methods of self-harm. Mechanisms for emergency departments, ambulance services, mental health services and police departments to report observed significant increases in self-harm incidents should be considered as part of the plan.

Information sharing

Agencies that need to be informed: Organisations that may be affected and who might be responsible for provision of support, such as general practitioners, should be informed about concerns regarding a possible suicide cluster. Those developing the Suicide Cluster Response Plan will need to balance an appropriate level of information sharing with containment of anxiety. Previous experience of managing responses to suicide clusters have shown that including too many people in Suicide Cluster

Response Plans can escalate anxiety due to spreading of news and fear, which might increase the risk of contagion.

Confidentiality: This must be considered when planning and implementing Suicide Cluster Response Plans. Although it is important for multiple agencies to work together and share information, it is also crucial that confidentiality and data protection are considered at all stages. However, it is important that key information about people dying by suicide is shared (for example name and address; whether in receipt of mental health care; name of school, university or workplace).This should be overseen by the public health suicide prevention lead. Organisations will need to be guided by their own confidentiality and data-sharing policies. There should be care about terminology used in emails and other messages, for example the term ‘suicide cluster’ might generate anxiety in administrative or other staff not directly involved in the procedures.

Public information: Depending on the nature of the possible suicide cluster it may be necessary to provide public information (for example if the suspected suicides concerned involve students at the same school, college or university). Processes for providing public information should be agreed at the planning stage and must be developed in partnership with the institution involved. Samaritans Media Guidelines (see **Box 3**, page 31) may be helpful in preparing this information. These are available at: www.samaritans.org/media-centre/media-guidelines-reporting-suicide

For further information on information sharing, see page 32 of Section 3 of PHE’s suicide prevention planning guidance.

Media issues

Media communication leads: A Suicide Cluster Response Plan should identify a consistent media communication lead and ensure that there is close liaison between the communications teams of affected agencies. It is expedient that the leadership of media communications rests with the local authority; however, there may be circumstances where it is appropriate that the affected organisation takes the lead (for example if a cluster is within a mental health service or university).

Planning an early and consistent response to media interest: There may be no media interest, but in case of enquiries a consistent response should be agreed at an early stage.

Vigilance for potentially harmful social media communications: It is not possible to monitor individual social media use; however, police will look at internet activity following incidents of suspected suicide and it may be possible to monitor memorial sites (which in some cases might glamourise suicide). Where suspected suicides of school age young people occur, schools should be advised to alert students and

parents about responsible social media use and encourage students to report any concerns to teaching staff.

Advice for families: such as warning about possible media interest, how to respond to this (for example selecting an agreed photograph of the deceased, their right to check a media report before it is published) and advice around managing social media (for example removal of a Facebook page).

Further information is provided in the Independent Press Standards Organisation's guidance on reporting suicides: www.ipso.co.uk/member-publishers/guidance-for-journalists-and-editors/guidance-on-reporting-suicide

Bereavement support

The term 'Postvention' is now often used to describe bereavement support. In this guide the latter term has been used as the meaning of this is clearer, especially for those less familiar with the field. Postvention (i.e. Bereavement Support) has been described as 'activities developed by, with or for people who have been bereaved (or affected by suicide) to support their recovery and to prevent adverse outcomes, including suicide and suicidal ideation'[29]. When planning a Suicide Cluster Response Plan it will be necessary to consider:

- identification of individuals and groups needing early support
- interventions for individuals needing more intensive help
- identification of services that can provide support
- ensuring first responders and those involved in providing support are themselves supported

Use of the groups who may be affected by a suicide shown in **Figure 1** (see page 20) is a helpful approach to help identify individuals and groups who may need support.

Prevention

Prevention should include both bereavement support and measures to improve broader community mental wellbeing. Bereavement support is concerned with helping people bereaved and affected by suicide, which will include those who may be more vulnerable to suicide ideation or attempts due to their exposure to suicide. Prevention is concerned with promoting wellbeing and help-seeking and preventing self-harm and suicide. It is also important to consider wider and longer-term needs of the local community in relation to prevention. See: www.gov.uk/government/publications/prevention-concordat-

for-better-mental-health-consensus-statement/prevention-concordat-for-better-mental-health

Further information on community-based approaches to suicide prevention can be found on page 54 of PHE's suicide prevention planning guidance.

A suicide cluster may flag-up community issues such as a lack of service provision (for example for supporting those in debt, men in crisis, or people who are lonely) that can be addressed in future suicide prevention and wellbeing action plans. Those designing the Suicide Cluster Response Plan will need to consider:

- identification of individuals and groups at risk (the Circles of Vulnerability (see **Figure 2**, page 35) can assist with this)
- interventions at community and individual levels

Monitoring and reviewing

The plan should include monitoring and review, for example:

- frequency of meetings: these should be frequent, especially in the early stages, with dates agreed and prioritised
- administrative support: it will be necessary to identify and resource administrative support to assist regular communication and organisation of meetings
- record keeping: this should include identified issues and concerns, agreed actions, responsible individuals and progress and next steps. Templates to assist record keeping are shown in **Appendix 2**
- following up the plan by ensuring support provision is sustained where required and that relevant agencies are aware of how to direct future concerns
- evaluation of progress and overall impact of the plan, including a follow-up strategy

Community suicide clusters

Identification of a possible suicide cluster

Initial awareness of a possible suicide cluster usually comes through concerns raised within the community. Whatever the source, the facts around the concerns must be established as soon as possible. At this point the local public health suicide prevention lead should consider arranging a meeting of the Suicide Cluster Response Group. A possible agenda for the first meeting of the Suicide Cluster Response Group is provided in **Appendix 3**. This first meeting is extremely important. If not planned carefully it can lead to premature assumption that a suicide cluster is occurring, which may exacerbate anxieties, leading to unhelpful panic and other negative consequences.

Establishing the facts

To make a judgement about possible occurrence of a suicide cluster the Suicide Cluster Response Group should:

- review available data to understand the timing and circumstances of the suicides. It is useful to record characteristics of the individuals involved and the nature of their deaths in a template covering potentially important factors (See **Appendix 4**)
- identify any similarities and possible links between the deaths (for example in terms of method used, possible contagion through exposure to other suicides, community issues, occupation, social connections). Plotting information about suicides on a map can also help identify potential connections (both geographical and social) (example in **Appendix 5**). Mapping can be carried out with the assistance of local public health analysts and/or local police
- establish a timeline of events surrounding suicides. Timelines can incorporate factors such as geography, police and healthcare data, coroner's information and anniversaries of previous suicides

Responding to a possible suicide cluster

Surveillance

If a possible cluster has been identified through local surveillance (see page 24), this surveillance will need to continue. If not, it is advisable to establish a local surveillance system and build close links with local coroners.

Information sharing

Relevant community agencies should be given factual, non-sensationalised information about suicides, in order to keep people informed and stop inaccurate rumours developing.

If there are clear concerns that a suicide cluster may be occurring, information should be shared across relevant professional groups, subject to appropriate confidentiality. It is important that families are consulted, and advised with sensitivity, so they understand what information is to be shared and why. There may be certain facts families do not want to be shared and they may be uncomfortable about inference that a death has been a suicide before a coroner's inquest has been completed; this should be respected as much as possible.

Media issues

It is essential that there is a single point of media contact. This should be the Media Communications Lead of the Suicide Cluster Response Group. The members of the Suicide Cluster Response Group should carefully consider a media communication strategy, including making statements to the media. Reporting is more likely in the event of suicide clusters, where a suicide involves a young person or where an unusual method is used[30].

There may be concerns about how a suicide is reported in the media. To support appropriate reporting, the Independent Press Standards Organisation (IPSO) provides media guidance on reporting suicide:
www.ipso.co.uk/member-publishers/guidance-for-journalists-and-editors/guidance-on-reporting-suicide/
In addition Samaritans publishes guidance for media on how to report suicide responsibly: *Media Guidelines for Reporting Suicide*:
www.samaritans.org/media-centre/media-guidelines-reporting-suicide
Samaritans' Media Advisory Team can be approached for advice on dealing with the press in the aftermath of a suicide by emailing: mediaadvice@samaritans.org or by phone: 020 8394 8377. The team has extensive experience in working with the press in

relation to reporting suicide. They can provide confidential briefings to media to help encourage safe reporting, and can offer training to local media outlets on how to appropriately cover this topic in the news.

Coroners' inquests are a key time point with regard to media reporting. There may be a flurry of press coverage when an inquest is opened and adjourned, and then often a lengthy period before the full inquest occurs.

It can be helpful to work proactively with coroners ahead of inquests, including sharing the Samaritans' *Guide for Coroners.* Copies of the guide can be obtained by contacting: mediaadvice@samaritans.org

Coroners should be reminded of the risks associated with media reports containing too much detailed information following an inquest, and encouraged to remind press of their responsibilities regarding sensitive reporting. In cases where there is a suspected cluster, Samaritans' Media Advisory team can liaise with the coroner's office and provide a bespoke confidential briefing, to be shared with any media attending the inquest hearing.

If there are concerns about press harassment of members of the public (such as bereaved family members), individuals can contact IPSO for advice. In some situations, IPSO can send out a notice to industry passing on a specific request (for example, to stop phoning a member of the public). IPSO can be reached on 0300 123 2220 or in an emergency out of hours or at weekends on 07799 903929. Alternatively, email: inquiries@ipso.co.uk

Box 3 provides some key points for media reporting.

Box 3: Key points for media reporting (from Samaritans)

Media should be encouraged to:

- refer to Samaritans' Media Guidelines for Reporting Suicide and supplementary factsheets to avoid the risk of reporting influencing imitational behaviour. Copies of the guide can be obtained by contacting: mediaadvice@samaritans.org
- refrain from reporting detailed descriptions of suicide methods.
- avoid including method of suicide in headlines
- avoid re-running the details of each death in every news report**,** including publishing picture galleries of others who have died. Such repetition may cause alarm in the community and increase risk of contagion
- avoid making unsubstantiated links between separate incidents of suicide.
- not give undue prominence to a story, such as making it a lead news item or front-page story with dramatic headlines, extensive use of photographs and memorials of people who have previously died
- avoid speculation about a 'single trigger' for a suicide. Suicide is complex and seldom the result of a single factor, it is likely to have several inter-related causes and this complexity should be portrayed in news reporting where possible
- encourage others who may be struggling to cope to seek help by publishing articles which include messages of hope, such as real life stories of people who have managed to come through a difficult time because they were able to reach out for help and work through their problems
- avoid reporting which may deter vulnerable people from seeking help (for example stories highlighting waiting times in a hopeless way which implies there is no help available)
- sensitively portray the devastation left behind for families, friends and communities following a death by suicide
- be wary of over-emphasising community expressions of grief (for example romanticised comments and montages of images of floral tributes), as this can inadvertently glorify suicidal behaviour to others who may be vulnerable to suicidal contagion
- avoid dramatic language, such as 'suicide epidemic' and 'hot spot', and sensationalist pictures or video (for example of a suicide location)
- avoid the use of witness comments, such as 'in a better place', 'found peace' and 'heaven has gained another angel'
- refrain from publishing the content of suicide notes

Samaritans' Media Advisory Team is available to give advice on reporting suicide. Contact details are: email: mediaadvice@samaritans.org Tel: +44 (0)20 8394 8300, out-of-hours: 07850 312224

Bereavement support

The local authority-led Multi-agency Suicide Prevention Group should have bereavement by suicide as a priority in their local action plan, in line with the National Suicide Prevention Strategy for England. Public Health England has developed guidance for local authorities in providing services for people who are bereaved.

PHE Guidance for provision of services for people bereaved by suicide

A guide to providing local services:
www.gov.uk/government/publications/support-after-a-suicide-a-guide-to-providing-local-services

Developing and delivering local bereavement support services:
www.nspa.org.uk/wp-content/uploads/2017/01/NSPA-postvention-framework-20.10.16.pdf

Evaluating local bereavement support services:
www.nspa.org.uk/wp-content/uploads/2017/01/NSPA-postvention-evaluation-24.10.16.pdf

People bereaved by suicide should be given information about available support at the earliest opportunity. Ideally this should be provided by the police who attend the scene of a suspected suicide and followed up by bereavement support agencies. Information should include contact details for Survivors of Bereavement by Suicide (SoBS), local and national bereavement organisations, Samaritans and other relevant local voluntary organisations.

For more information see:

Support after Suicide
http://supportaftersuicide.org.uk/

The booklet **Help is at Hand: Support after someone may have died by suicide** www.gov.uk/government/news/you-are-not-alone-help-is-at-hand-for-anyone-bereaved-by-suicide should be given to bereaved relatives and close friends as soon as possible. Where parents have died it is important to consider the support needs of the wider family, including, for example, children who are not living at home.

A short **Z-card** is available for first responders:
www.orderline.dh.gov.uk/ecom_dh/public/saleproduct.jsf?catalogueCode=2901503

Specific aspects of bereavement support to consider in relation to suicide clusters include:

- possible connections between bereaved individuals (for example through workplace, educational establishment or local community)
- collective anger towards an organisation (for example towards a workplace, university, psychiatric service) regarding its perceived contribution to the deaths and the organisation's response
- the possibility that an individual's death is seen as losing identity because of being part of a cluster
- increased risk of media interest and invasion of privacy
- increased risk of inaccurate information and false rumours

Prevention

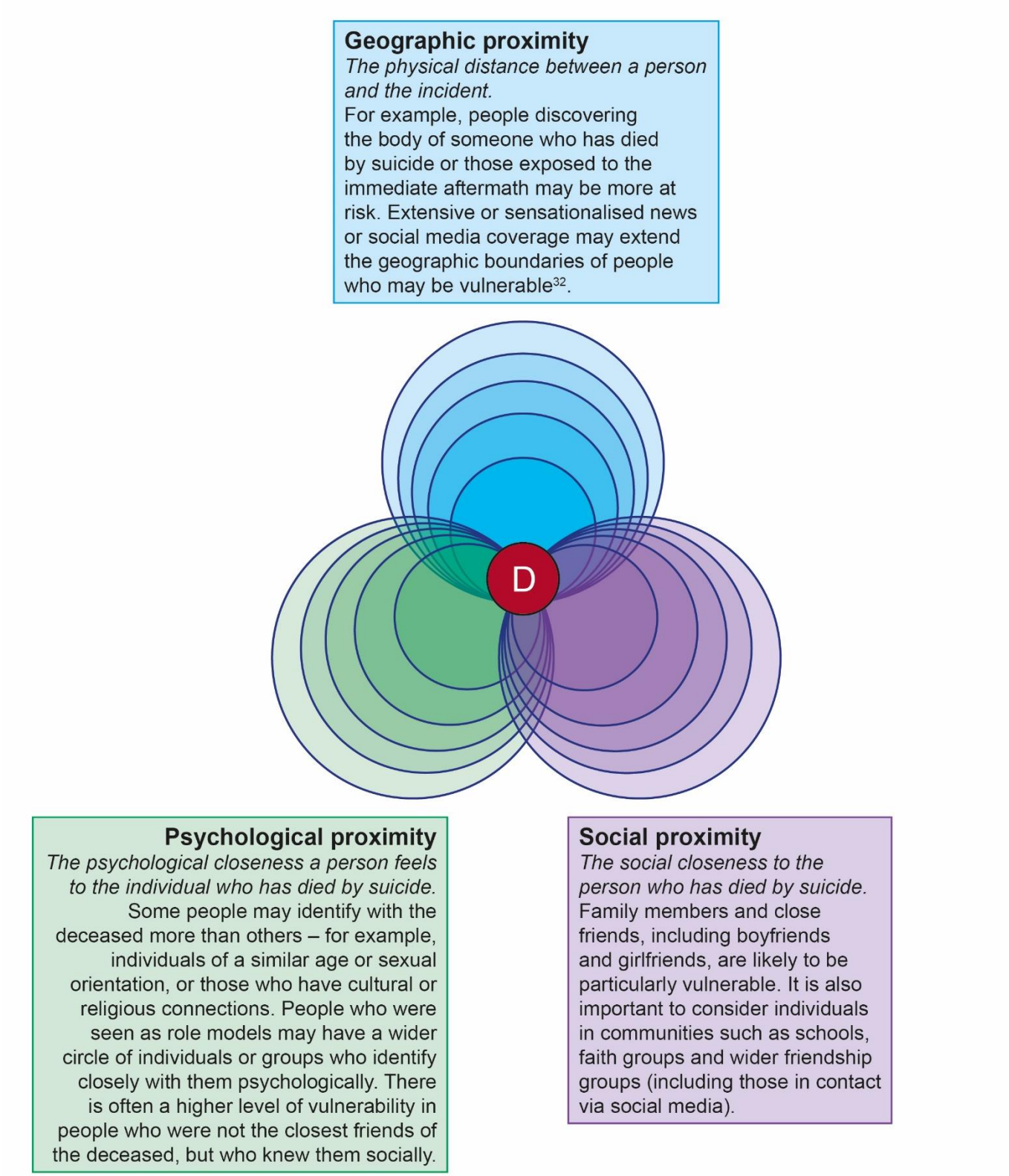
While bereavement support will include measures that may be preventive, prevention initiatives primarily focus on the broader community that may be affected and influenced by suicide. The Circles of Vulnerability Model (see **Figure 2** – page 35) can help to identify people who may be vulnerable and at risk following a suicide. The model is based on the idea that every suicide is like a stone cast into a pool of water – ripples spread out across the pool all the way to the edge, but the effects are larger closer to the point of impact[31]. Vulnerability can be thought of in terms of concentric circles and, more specifically, in terms of interlocking circles representing 3 axes: geographical proximity (the physical closeness or distance to the incident), social proximity (the social closeness or distance to the person who has died by suicide) and psychological proximity (how close or distant someone relates psychologically to the person who has died by suicide).

It will not be possible to identify everyone who may be at risk following a suicide, however the Circles of Vulnerability will help the Suicide Cluster Response Group consider where there may be individuals and groups at possible risk. Individuals who may be at increased risk include those who:

- are suffering from depression or other mental illness, substance abuse or who have a sense of hopelessness
- engage in self-harming behaviour
- feel responsible for the death, or who may be subject to allegations as a result of the death
- feel a sense of closeness to or psychological identification with the deceased
- already have experience of suicide or self-harm in family or friends
- lack family or social support
- have a history of adverse childhood experiences

Figure 2: Concentric Circles of Vulnerability

The central red circle (D) represents the person who has died by suicide. The 3 overlapping groups of concentric circles show varying vulnerability according to closeness to the deceased (D) in terms of geographical and psychological and social proximity.



A **vulnerability matrix approach** based on the Circles of Vulnerability is a practical approach that can be used to identify and prioritise at-risk individuals and groups and identify appropriate interventions and support. These matrices can be populated by the Suicide Cluster Response Group members to help map and record interventions. This will reduce risk of duplication and help to identify gaps and ongoing need. The vulnerability matrix should be seen as a live document which can provide real-time information about bereavement support and prevention activities. Vulnerability matrices can also be used to identify and support community resilience and protective factors, such as informal social support networks.

It should be noted that risk of contagion applies to each category. In the example below it is noted where risk may be particularly high.

Examples of completed vulnerability matrices As well as template vulnerability matrices for ready use can be found in **Appendix 6.**

Interventions

Interventions provided when responding to a suicide cluster will vary depending on the nature of the suicides concerned and related cultural, faith and circumstantial issues. Approaches will also be influenced by the agencies involved, in that certain suicide prevention charities may have particular styles of outreach work (see **Box 4,** page 38, and **Box 7,** page 50, for examples).

To ensure the needs of all identified vulnerable groups are met it might be useful to consider the following 3 tiers of intervention:

Whole population approaches

Whole population approaches should aim to raise community suicide prevention awareness and help-seeking behaviour. This might involve local outreach, for example through drop-in sessions and distribution of posters, leaflets, cards and beer mats. It could also involve using print and online media to share stories of people who have sought help and come through difficult periods in their lives, along with signposting to sources of support. Involving charitable organisations (for example Samaritans or Campaign Against Living Miserably) may be helpful in reaching and engaging particularly vulnerable people. To facilitate the contribution of local primary and social care, education and other services (for example benefit or housing agencies) to whole population approaches it may be necessary to provide relevant training in suicide prevention. Such training may already be delivered as part of the local suicide prevention plan. It may be appropriate to consider extending this training to the general public. Further guidance on reaching vulnerable people as well as suicide prevention

training is in section 5.2 ‘tailoring approaches to improve mental health’ in PHE’s Local Suicide Prevention Planning guidance.

Targeted approaches

Targeted interventions should focus on specific groups identified as being vulnerable – for example those from particular residential areas, educational establishments, workplaces, health centres, faith, minority or community groups. Interventions may include talks, drop-in clinics, provision of counsellors and more specific literature on the emotional and psychological impact of traumatic incidents, suicide and depression.

Individual approaches

Individuals who are recognised as being at possible risk following a suicide should be approached by an identified individual and offered time to talk about their thoughts and feelings. Psycho-education regarding grief and trauma responses can be provided in both verbal and written form (see: https://www.england.nhs.uk/london/our-work/help-and-support/). It may be helpful to consider establishing rapid referral pathways to mental health services, including community psychological treatment agencies (such as Increasing Access to Psychological Therapies (IAPT)). Such an arrangement will necessitate involvement from the local mental health service and possibly associated clinical commissioning groups.

Those bereaved should be supported as discussed above (see page 32) and availability of support for people bereaved or affected by suicide should be communicated sensitively across the community.

Examples of Interventions

Box 4 below provides an example of tiered interventions delivered in response to a suicide cluster in Nottingham and **Box 5** outlines an approach called “Kitchen Table Talks” that has been used in the Netherlands.

Box 4: The Nottingham experience of delivering tiered interventions

Harmless is a Nottingham-based organisation that provides support, information, training and consultancy around the issue of self-harm and suicide prevention www.harmless.org.uk. In 2013 Harmless developed the Tomorrow Project www.tomorrowproject.org.uk in response to a local suicide cluster. This includes a three-tier model:

1) Relevant and accessible information resources, designed to be wide-reaching across all strands of the community. These include posters, beer mats, and leaflets.

2) A range of community meetings to inform different groups about the risk of suicide, warning signs, how to respond and where to go for help, facilitated in conjunction with community leaders to ensure uptake. This includes contributing to personal, social and health education (PHSE) within the local school, where appropriate, and offering information sessions with GP's, healthcare providers, teachers, community members, families and faith groups.

3) Clinical support delivered by therapists following self-referral.

Community feedback following the 2013 suicide cluster response indicated that the Tomorrow Project significantly raised local awareness of suicide and helped to tackle stigma. Self-report evaluation indicated that clinical support reduced suicidal planning and suicidal thinking and that satisfaction with the intervention was very high.

Box 5: Kitchen Table Talks - an approach to reaching and supporting peers after a young person's suicide

A project in Westfriesland, an area in the North West Netherlands, offered "Kitchen Table Talks" with young people after they had experienced the suicide of a friend. The aim of these talks was to validate distress and strengthen solidarity, empathy and empowerment within the friendship group. The sessions were facilitated by mental health nurses, but were not therapy, and they were held at a location the friends chose for themselves.

The KitchenTable Talks helped the young people share their experiences. Three key questions facilitated this:

- how did you hear about it? what did you do when you heard that your friend had died?
- how are you getting on now? (can you sleep, eat, go to school?)
- what are your future plans?

Young people reported that after the talks they felt a sense of relief that they had been able to talk and not feel judged. The friends said they felt closer to each other and more confident that they were all there for each other.

Use of social media

During a cluster, social media can be a way to reach a huge number of people, including vulnerable people, and promote a sense of social connection and support. It is likely that communities affected by a cluster will use social media to inform people about the death, create virtual memorials and post messages often of sympathy but sometimes blaming people for the death, particularly if bullying is suspected. This can all cause a lot of anxiety. At this time it is useful for those involved in responding to suicide clusters to work with communities or organisations to:

- use social media to let people know where they can go for help and support (see **Box 6,** page 40)
- use social media to promote suicide prevention messages
- issue advice on how to intervene or who to contact if people are aware of, or concerned about, messages they see online in the aftermath of a suicide. These could include rumours, suggestions that suicide was a positive outcome for an individual, bullying or publicly blaming people, or messages from individuals who are at risk and expressing their distress online. In these situations it may be appropriate: to speak directly to those involved; request that

the offensive content be removed by the person or the service provider; report the content to the service provider; dispel rumours; contact the police or emergency services when information posted online may indicate a risk to an individual's or another's safety or is threatening

- organise an appropriate member of staff or other professional within an organisation/setting to meet with key individuals to discuss what is being shared online
- let people know that memorial pages often elicit negative comments but acknowledge that these sites are often created to honour individuals who have died. Issue advice to avoid including details of the method of suicide, report concerning posts and to try to avoid giving the impression that the death was a positive outcome. Organisations can consider creating a safe memorial page where offensive or negative comments can be removed. Samaritans have developed guidance on social media use and memorials for students and parents which may also be helpful for other organisations (see: www.samaritans.org/stepbystep)

Box 6: Sample response to social media posts that cause concern

If you or someone you know is feeling desperate help is always available. The best way to honour [*person's name*] is to seek help if you or someone you know is struggling. If you're feeling lost, desperate or alone please get in touch.

Samaritans 116 123 jo@samaritans.org

Papyrus Call: www.papyrus-uk.org Tel: 0800 068 41 41 Email: pat@papyrus-uk.org Text: 07786 209697

Childline www.childline.org.uk 08001111

Young Minds https://youngminds.org.uk/ Parents helpline: 0808 802 5544

Campaign Against Living Miserable (CALM) www.thecalmzone.net 0800 58 58 58

Monitoring and review

Suicide Cluster Response Plans should remain active while concern regarding a suicide cluster is current. The monitoring and review arrangements (see page 27) should be considered. The longer-term impact of a suicide cluster on organisations and communities should not be underestimated. Some affected institutions have reported that there can be significant long-term changes following a cluster in terms of organisational culture and ways of working. The possible risk of echo clusters in affected communities should also be remembered. When current needs have been identified and adequate ongoing support measures are in place a follow-up strategy should be agreed. This should include:

Surveillance

Maintaining local monitoring of suicides as part of the local authority suicide prevention plan with vigilance around anniversaries of suicides within clusters, especially in institutional settings such as schools.

Agreeing reporting mechanisms for observations of significant clusters of self-harm presentations to the emergency department.

Feeding back relevant community issues identified as part of the Suicide Cluster Response Plan to the Multi-agency Suicide Prevention Group (for example lack of substance misuse, befriending or bereavement services; gaps between substance misuse services and mental health services).

Information sharing

Providing a summary of interventions delivered as part of the Suicide Cluster Response Plan, ongoing community/organisational vulnerabilities and longer-term prevention work to relevant bodies (for example Multi-Agency Suicide Prevention Group, Safeguarding Boards, Health and Wellbeing Boards, Clinical Commissioning Groups) in order to help ensure a consistent approach and provide information relevant to the local authority Suicide Prevention Action Plan.

Media issues

Maintaining and developing positive relationships with local media and planning for protective reporting such as stories of overcoming suicidal ideation and responsible reporting of suicides. This might include offering training for journalists.

Bereavement support

Maintaining promotion of bereavement support agencies and resources within the community.

Providing support and debrief opportunities for staff within affected organisations.

Planning support for significant dates and anniversaries.

Prevention

Maintaining whole population prevention measures and continuing targeted and individual preventative interventions as indicated.

Ensuring organisations are aware of how to report future concerns.

Reviewing the plan within the Multi-Agency Suicide Prevention Group

Reviewing the plan to identify areas of strength and need. This should include providing individuals involved in the Suicide Cluster Response Plan with the opportunity for reflection and shared learning. Where possible, feedback from those who received interventions should be sought.

Identifying development needs and planning strategies to meet these needs.

Ongoing assessment of available interventions to respond to suicide clusters to ensure preparedness in case of future concerns.

Given that suicide clusters are relatively uncommon, organising external peer review by a public health and organisational lead with experience of a cluster may help in reviewing local responses. In addition, sharing experiences with neighbouring local authority areas will help to support the spread of good response and prevention practice.

Appendix 7 provides a checklist of core actions of the Suicide Cluster Response Group that might be used to assist the public health and organisational leads.

Mental health services

Mental health services should be represented on the local authority Multi-agency Suicide Prevention Group. A suicide cluster involving mental health service users will affect members of the local community (family, friends, colleagues, healthcare staff etc.) and collaborative working between public health and the mental health service is important to ensure that support needs are met and community prevention work is undertaken.

Possible suicide clusters in mental health service users may be identified by clinical teams or mortality review groups. Concerns might arise in circumstances where there are 2 or more patient deaths within a community team, ward or day care setting within a short time scale, or where there are multiple deaths involving a particular suicide method.

Where there are concerns about a suicide cluster or risk of one developing, an organisational lead should be identified at an early stage to head the internal response and link with the public health lead in convening a **Suicide Cluster Response Group**. This group should be kept as small as possible.

Suicide Cluster Response Plan

Surveillance

Internal monitoring of suspected suicides should be continuous to ensure that increases in incidents within a particular group, team or geographical area are picked up at an early stage. Noting significant increases in self-harm should be part of surveillance.

Where a cluster is suspected or there are concerns that a patient suicide may have an impact on the wider community, liaison with the public health suicide prevention lead should take place to consider whether a local suicide cluster response is required.

Information Sharing

Mental health trusts will have polices in place regarding information sharing in the event of the death of a service user.

If a cluster is suspected or risk of such is identified it may be necessary to share information with public health, safeguarding, police, the Clinical Commissioning Group, and affected organisations such as workplaces. The organisational lead should link with

relevant internal managers and the public health lead to identify who should be requested to attend a Suicide Cluster Response Group meeting. It may be advisable to link with the information governance lead and/or Caldicott Guardian regarding information sharing.

If a death of an inpatient, day patient or a patient of a therapy group occurs, other patients will need to be informed of the death. Details of the method of suicide should be kept to a minimum and staff should discuss in advance what information they need to convey.

Clinical teams should consider whether there are other internal or external agencies that may need to be informed (for example other wards/clinical teams, workplaces, third sector organisations, substance misuse services, supported housing establishments)

Media issues

Mental health trusts will have policies regarding media enquiries which will be applicable in relation to suicide clusters. In addition, the media section on page 25 will be relevant. It is important to recognise that any media coverage may cause distress for families, fellow service users and staff.

It will be necessary to promote safe and responsible social media use within connected service user groups (see page 39 for advice regarding social media).

Bereavement support

Family and friends

All mental health services should have procedures in place for communicating with and supporting families and close significant others following suspected suicides of service users. This should include:

- providing a copy of **Help is at Hand**
- informing families about local Survivors of Bereavement by Suicide (SoBS) groups and other local bereavement support agencies
- identifying any immediate additional psychological support needs
- advice to see their GP for monitoring of health and wellbeing
- agreeing ongoing communication channels

Where a suicide cluster is suspected there will be additional considerations (see page 33).

Fellow service users

Fellow service users are likely to be affected by the suspected suicide of a peer and where there are multiple suicides the effect will be greater. Service users who were on the same ward or in the same therapy group and those who also knew the deceased outside of mental health services (for example through families, school or work) might need additional attention and support. Individuals who have a history of self-harm and suicidal ideation may be particularly affected and possibly vulnerable to contagion (see prevention section below).

After all suicides group and individual support should be offered to fellow service users to allow them to talk about their responses and feelings. In cluster situations support groups will be more complex but where deaths occur within a socially connected group it may be appropriate to consider offering therapist-facilitated support groups specific to the social network concerned. Whatever the mode of support, it is important to ensure that minimal information about the circumstances of the deaths is relayed.

Ongoing opportunities to talk with named clinicians and/or pastoral support services and concise written information about common grief reactions should be made available.

Help is at Hand and information about local bereavement support agencies should be made available.

Where appropriate and if service users are agreeable it may be helpful to inform carers of the situation in order that they can support individuals at home.

Staff

Mental health staff can be significantly affected after patient suicide. Responses include emotional reactions, stress, trauma, and professional practice changes such as anxiety and hypervigilance when assessing suicidal individuals[33]. Where there are multiple suicides the impact on staff is likely to be intensified. Mental health services should have staff support mechanisms in place following individual suicides. Where a cluster is suspected there will be additional considerations:

Teams should be offered opportunities to come together and share their thoughts and feelings around the cluster. Some staff may require additional practical clinical support and supervision, particularly if they are dealing with other suicidal patients.

Support should be available on an ongoing basis and stepped up at significant points such as funerals, following media reporting and coroner’s inquests. Written or online information outlining available support should be provided to affected staff.

Prevention

Suicide prevention is fundamental to mental health care and is a key component of day-to-day clinical practice. In the event of a possible suicide cluster clinical teams should consider service users who may be vulnerable as a result of the suicides and potentially at a higher risk of suicide or self-harm themselves. This will include service users under the care of different teams who had a strong social connection with the person who has died. Communication with other teams is therefore an important aspect of prevention of contagion. The Circles of Vulnerability (see page 35) can assist in this process:

- geographical proximity – Service users who were closely involved in the suicide(s) (for example those who witnessed the incident or who had contact with the patient concerned shortly before the incident)
- psychological proximity – Service users who may identify with the deceased (for example in the same therapy group, on the same ward, through sharing similar problems)
- social proximity – Close friends and family of the deceased and service users who were close to the deceased

Service users with existing suicide risk and others who might be particularly vulnerable after suicides (see list on page 33) may need increased monitoring and support. While staff should try to identify particularly vulnerable patients, it is important to recognise that use of traditional risk factors for suicide may be misleading and it is not possible to accurately predict who may or may not be at risk of suicide. Rather, there should be a focus on risk reduction across the exposed patient population. Where particularly vulnerable service users are identified, however, care and safety plans should be reviewed, clearly documented and implemented.

If there are immediate concerns about the safety of a service user it will be important to consider sharing information with their family or carer. The Department of Health Consensus statement on this provides helpful advice. See: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/271792/Consensus_statement_on_information_sharing.pdf

Responses to multiple suicides of service users should be considered and contained. Notwithstanding the adverse impact a patient's suicide may have on other service users it is important to recognise that contagion is relatively rare and over-anxious responses may exacerbate rather than alleviate risk. **Appendix 8** provides an example of guidance for mental health staff where there are possible concerns about suicide contagion.

The **Monitoring and Review** section above (see page 40) is also relevant to mental health services. In addition, specific organisational serious incident review processes

should be implemented following suicide clusters, which should include reviewing incident reports from the individual suicides. These reviews will help gain an understanding of any systems issues which may have contributed to suicide clusters and thus inform ongoing suicide prevention work.

Schools/colleges

Suicide in school students will have profound effects on the school community. Both individual students and student groups are likely to be affected. This will especially include students from the same year as the person who died, those in friendship groups and clubs, and students with pre-existing vulnerability (such as due to mental health issues or other experience of bereavement).

Following the sudden death of a young person under the age of 18 years there is a nationally agreed process in England. It is overseen by a county-wide **Local Safeguarding Board** and its **Child Death Overview Panel**. The immediate response is co-ordinated by a **Rapid Response Team**, whose role is to gather information, support the family, identify those at risk and aim to prevent future child deaths.

After every sudden death of a young person under 18 years the designated professional identified as the single point of contact with responsibility for co-ordinating the Rapid Response Team is contacted immediately. This person ensures rapid communication to all agencies and professionals involved with the individual. The school/college head must be informed as soon as possible. A meeting of the Rapid Response Team should be convened within 72 hours. Where a death may be due to suicide it is likely that the public health suicide prevention lead or a nominated deputy will be present at Rapid Response Team meetings.

Definition of a suicide cluster in schools is extremely difficult due to the generally low rate of suicide in children and adolescents. Consideration of student welfare is paramount after a single suicide. More than one death in a school over even a protracted time period should raise concerns of possible contagion or a cluster.

Schools and colleges should have a written policy in place regarding action in the event of a suicide – or suspected suicide – of a student. In the case of multiple suicides, an early **Suicide Cluster Response Group** meeting should be convened, involving the Rapid Response Team, school or college head, public health suicide prevention lead and representatives of relevant agencies – for example social care, education, police and Child and Adolescent Mental Health Services (CAMHS) – to share information and plan an appropriate response. An identified school/college suicide response lead should be identified as the first point of contact for internal staff and external agencies.

Responding to student suicide can be very challenging. It is important, however, that the response is designed to achieve a balance between recognising and responding to the impact on other students and on the school/college community, and at the same time trying to maintain a positive and forward-looking community culture.

Surveillance

The school/college should maintain a register of deaths and serious suicide attempts.

Staff should be alert to occurrences of suicidal behaviour, including self-harm. Internal reporting mechanisms should be agreed.

Staff should be alert to possible contributory factors (for example increase in bullying behaviour, student reports of potentially harmful social media use etc.) and internal reporting mechanisms should be agreed.

Information sharing

The school/college should maintain a close link with the Rapid Response Team, which will co-ordinate communication with the family and the response across agencies.

Establishing rapid links with relevant services such as primary care, CAMHS, educational psychologists, social care, Samaritans and local bereavement services will be essential.
Any information sharing will need prior discussion with the family.

Minimal information should be shared about the cause of death, particularly as a coroner's verdict of suicide may not be confirmed immediately. Consideration should be given to language used and it may be appropriate to use the term 'sudden unexpected death'.

Within the school or college, teachers and other staff should be informed first.

Students close to the deceased should be identified and informed by a familiar member of staff.

Other students should be informed in classroom groups rather than a large assembly.

Guidance for teachers should be prepared. Key points to cover are:

- pertinent facts about the death (not the details) – as discussed with the family. Details of method of suicide should not be disclosed
- normalisation of the emotions experienced in response to the death i.e. acknowledging that responses will be different and wide ranging (including anger and blame) and will change with time
- encouraging caring for each other and letting staff know if anyone has concerns about other students
- encouraging positive ways of managing distress/stress

- letting students know that support is available
- sharing useful print and online resources with the students (it may be helpful for students to be able to physically take information away with them)

Following agreement with relevant agencies and the Rapid Response Team, letters should be sent out to parents giving information and details of contacts and agencies for support (see **Box 7** for suggested content). The school/college must check with family of the deceased first before sending out any details about the death.

Details on how to access support should also be posted on the school/college website.

Box 7: Suggested content of letter for parents following the suicide of a student

Brief pertinent information about the death(s), including what year the student was in

Confirmation of when and what the students were told

Encouragement to parents to let their son/daughter know that the letter has been received and that they (parents) will listen to concerns

Acknowledge any parental concerns about son/daughter's reaction to the news, and normalise grief reactions

Guidance on how to talk to the young person

Encouragement to parents to discuss positive strategies to cope (for example sharing feelings; maintaining usual routine, such as hobbies and sports; getting sufficient sleep)

Advice to keep connected to the young person and support them in a general sense

Advice to contact their GP if they or their child would like further support

Information on how the school/college is responding and supporting students, including provision of drop-in support and specific counselling to those that need it

Details of staff member to contact if there are any specific concerns/questions

Acknowledgement that the school will be carrying on their normal routines as far as possible

Add link to relevant website for parents and young people (for example PAPYRUS). Samaritans Step by Step service also has information and resources for young people and their families/ parents

Media issues

Media interest should be considered as part of the Rapid Response Team Meeting.

The school/college suicide response lead should link with the public health suicide prevention lead and relevant local authority communications representative to agree action in the event of media contact, including content of a media statement.

For consideration of other media aspects of the response see page 29.

Bereavement support

Support for students

Staff should be aware of the impact that student suicide will have on other students and the fact that students will need to talk about the event(s) and express feelings. Specialist advice for different cultural and religious groups may need to be sought.

Samaritans Step by Step Service offers practical support, guidance, information and resources to schools, colleges and other youth settings for responding to and recovering from a suspected suicide. See: www.samaritans.org/stepbystep
Box 8 provides an example of such an intervention.

Local child bereavement charities may offer in-reach support to school and college communities following suspected suicides. They may also help facilitate occasions of reflection and remembrance.

Forums should be set up to provide opportunities for students to talk in a group led by a facilitator (for example a child bereavement counsellor or mental health practitioner), such as through a Kitchen Table Talk approach (see **Box 5,** page 39).

Drop-in sessions/hotlines/information leaflets/a support room should be made available. Some schools have found that students respond to having an identified safe space where they can ‘hang out’, listen to music and be with each other, remembering the deceased individual without necessarily talking about the death.

Individual/group counselling should be provided to those at risk or considered vulnerable either by school/college counsellors or local child bereavement counsellors.

Referrals may be made to local CAMHS where appropriate.

Every effort should be made to continue school/college routines as usual.

School or college staff should be aware of longer-term issues that may arise for some students (for example development of depression, anxiety or self-harm). The anniversary of the young person’s death may be a particularly difficult time for some students.

Box 8 Samaritans Step by Step case study

When support was requested by a school that had experienced a suspected suicide of a student, Samaritans Step by Step service initially offered support by phone and sent the bereavement support guide '*Help When We Needed It Most'*. The death had occurred during school holidays although Year 10 students were popping in and out for revision sessions. Samaritans provided guidance to the Leadership team, including posting messages of support, signposting sources of help and ensuring staff were present and available.

Samaritans also provided support for the staff who needed help during these early days. Telephone support, providing reassurance and guidance for the Head continued over the weekend before the students returned, including planning practicalities such as what to do with the deceased student's locker and seat in class and how to reduce rumour and speculation. Samaritans talked to the year group the following week. This was carried out in small groups, ensuring students were made aware of ways to cope with difficult feelings, how to support one another and where to go for help and information. Difficult questions were addressed honestly and responsibly. Samaritans' attended the school again the following week. Advice was given to the leadership team on the range of support services available to offer to the family. Samaritans' volunteers attended the funeral and provided support to staff, parents and carers. Samaritans offered to continue to support the school - the weeks and months following such a tragic incident can be a roller coaster for the whole community.

Link to Samaritans Step by Step programme:
www.samaritans.org/your-community/samaritans-education/step-step

Social media

See the Social media section on page 39.

It will not be possible to monitor all social media coverage of a student's death but it is important to educate the school/college community about safe and responsible online messaging following the death of a peer, including what to do if messages of concern are posted and where to go for support. Samaritans have developed guidance on social media use and memorials for students and parents. See:
www.samaritans.org/stepbystep

Where possible the activity of any Facebook page of the deceased or memorial page set up by students following the suicide should be monitored, being aware of the potential for increasing risk in other students. The Rapid Response Team and the school/college suicide response lead should decide who is responsible for monitoring this site. If comments are posted which indicate risk in any other young people, their

family and relevant professionals should be contacted with some urgency, although diplomacy and sensitive use of language are required.

Samaritans advise that schools/colleges could consider establishing an online memorial on their own website, which they can then moderate and remove after an agreed time.

Support for school/college staff

Staff should be given the opportunity to meet in groups for information sharing and review to ensure they are aware of the Rapid Response Team plan and what support is available for students and families. Staff should also be given information regarding risk factors and warning signs for suicidal behaviour to help them spot students who may be at risk.

The impact of student suicide on school or college staff may be profound and long-lasting. Consideration should be given to short- and longer-term support for staff as well as for the school community. Staff should be given opportunities to come together to talk about their feelings and emotional responses in a safe environment facilitated by an appropriately trained individual. Staff should be signposted to relevant support agencies.

Individual support should be offered to school/college staff, including head teachers/college heads.
Support should be available on an ongoing basis and stepped up at significant points such as funerals, following media reporting and coroner's inquests. Written or online information outlining available support should be provided to affected staff.

Staff who have pre-existing mental health problems, a history of self-harm or other experiences of bereavement may be in need of support or more intensive help.

Prevention

Pastoral heads of each year should consider who might be at risk for suicide or self-harm, taking account of the Circles of Vulnerability (see **Figure 2**, page 35). These will include:

Geographical proximity

Those who were closely involved in the suicide(s), (for example witnessed the event or its aftermath, or discovered the body) or exposed to such details through social or other media.

Psychological proximity

Students who may identify with the deceased (for example same class, similar interests, same clubs or sports team; or those who perceived that they were similar to the victim in some way).

Social proximity

These are:

- close friends of the deceased
- current or recent partner(s) of the deceased
- relatives of the deceased

For an indication of individuals who may be at increased risk see page 33. It is advisable to discuss strategies for managing and supporting individuals who may be at risk with the local CAMHs service.

Schools/colleges should promote a caring, positive and supportive school environment, facilitating appropriate discussion and help-seeking. The PAPYRUS guidance **Building suicide-safer schools and colleges: a guide for teachers and staff** provides helpful information to promote supportive environments. See: www.papyrus-uk.org/repository/documents/editorfiles/toolkitfinal.pdf

The resource **Young people who self-harm: a guide for school staff,** which is available from The Charlie Waller Memorial Trust, provides useful information about helping students who self-harm, including addressing contagion. See: www.cwmt.org.uk/resources?lightbox=dataItem-jmfzb026

The **Monitoring and Review** section above (see page 40) is also relevant to schools.

A decision will need to be made at some stage about stepping down the response in terms of ending the Suicide Cluster Response Group. The appropriate timing of this will be difficult to determine in the school setting because, fortunately, even within a suicide cluster, deaths are uncommon.

Universities

Given the specific vulnerability of young people to self-harm and suicide, in areas with a university there should be university representation on the local authority Multi-agency Suicide Prevention Group. Universities which have had the experience of responding to suicide clusters have highlighted the importance of membership in these groups in order to:

- understand what a suicide cluster is and know when to be concerned that one may be emerging
- understand the leadership role of public health and how the university can benefit from public health involvement
- ensure a rapid and appropriate response in the event of a possible suicide cluster

Universities generally have policies in place for responding to the aftermath of individual student deaths. These usually include information on effectively managing communications and offering support to family, friends, staff and the wider student community. However, these policies may not include specific advice on suicide deaths or what to do should multiple suicide deaths occur. It is important to review such policies to incorporate identification and responses to suicide clusters.

Where concerns arise regarding a possible suicide cluster there should be immediate communication with the local authority public health suicide prevention lead and close collaboration in the development of a response plan.

Identification of a possible suicide cluster

A senior member of the university should be responsible for on-going monitoring of student deaths, including suspected suicides (the template in **Appendix 4** might help with recording). This ‘real time’ monitoring can help identify multiple events, such as 2 suicides in a relatively short period of time (for example one term), which may indicate a suicide cluster.

If a possible cluster is identified or suspected a **Suicide Cluster Response Group** meeting should be organised immediately. This group should be relatively small. Membership might include:

- senior Members of the University responsible for Welfare and Wellbeing (for example Pro Vice Chancellor and Director of Student Services)
- senior member of the communications/media department of the university
- local authority Public Health Suicide Prevention Lead

- staff member leading response to individual student deaths
- head of university counselling service (or equivalent)
- local police
- at an early stage the group should include a senior Student Union representative, such as the CEO or one of the executive officers

The primary task of the Suicide Cluster Response Group is to assess the situation and agree the right balance of response, aiming at responses which are reflective and proactive rather than solely reactive, and maintaining vigilance without increasing institutional anxiety. The initial objective is to decide the level of concern and appropriate interventions. In the early stages it is important that Suicide Cluster Response Group meetings occur frequently (either in person or virtually), possibly even daily, to ensure new information is captured and, if necessary, plans are revised.

The initial meeting of the Suicide Cluster Response Group is particularly important in terms of deciding leadership and planning of the response. Experience of suicide clusters at universities has shown that levels of anxiety will be considerable. There may be confusion of roles and leadership, together with uncertainty about what should be done. It is important to decide leadership of the response group at the outset. Close collaboration between university and local public health is essential (joint leadership is likely to be the most effective. See **Appendix 1**). The local public health lead can provide wider community intelligence and vital links with the police and local coroner; the university lead can offer contextual information about individual deaths and the university community.

A possible draft agenda for the first meeting of the response group can be based on the one provided in **Appendix 3**. It is essential that there is a clear record of what was discussed in the meeting and agreed actions, including by whom and by when. This and organisation of meetings will require administrative support.

Based on the circumstances of the suicides and identified needs of the student community the Suicide Cluster Response Group should consider who else may need to be involved with the response and when. **Not all those involved will need to attend meetings; some agencies will just require information and updates**. It is important that the Suicide Cluster Response Group does not become too large; experience from universities which have responded to suicide clusters suggests that over-inclusive groups can reduce effectiveness. Possible agencies and personnel who might need to be included in the extended group or with which/whom there should be links, depending on the circumstances, include:

- Vice Chancellor’s Office
- Registry (Registrar)

- Head of Counselling or Wellbeing (it is key that a clinical member of the university support services is involved)
- Head of Student Health Service/Representative of Primary Care
- Security Service (Head of Security)
- Head of Academic Department or Division
- Estates (Director of Estates or Campus Facilities)
- President of Student Union (Student Representative)
- Other student representation, including from specific cultural groups (perhaps via International Student Office)
- Director of Human Resources (because of impact of suicides on staff)
- Director of Accommodation
- Chaplaincy
- Director of IT Services
- University medical practice or appropriate GP practices
- NHS Mental Health Service
- Clinical Commissioning Group
- other educational institutions, especially other local universities

A student suicide is likely to result in significantly increased demand for student pastoral care services. Experience at one university indicated a 60% increase in referrals to the student counselling service. It will be important for universities to have contingency plans to draw on additional counselling and bereavement support resource, which could include local mental health and voluntary services. This will probably be the responsibility of the local Clinical Commissioning Group. Local voluntary agencies providing such support (for example Samaritans) do not generally need to be part the response group, although they should be informed of the situation. There may be instances, however, where the leaders of the Suicide Response Group consider it appropriate to involve representatives from these agencies as group members. In such cases appropriate confidentiality and information sharing protocols must be in place.

Surveillance

This will include:

Monitoring possible further deaths within the university. This should include investigation of possible connections between individuals, their circumstances and their suicidal behaviour. The template in **Appendix 4** will assist with recording this information. Multiple suspected suicides may not be connected, but their occurrence can nonetheless have consequences within the institution which may affect vulnerable individuals. For example, it may cause feelings of insecurity; it may even contribute to thoughts of suicide as a way of dealing with problems in some individuals.

If possible, monitoring should include identification of apparent increases in self-harm, especially self-harm leading to hospital referral. This might be part of a more general increase in suicidal behaviour, indicating particular student vulnerability and further highlighting the need for a very active response. Monitoring of self-harm might also be done through collection of information from student support services and student health services, together with data from emergency departments and ambulance callouts.

As well as numbers of events, the characteristics of the individuals concerned and the circumstances in which incidents occur may be important in determining the appropriate nature of the response. For example, the suicide of a relatively high profile student who was involved in several extra-curricular clubs will necessitate communication and extension of support within these clubs; if a novel method of suicide is used, attention should be paid to possible increased communication about it and ways of reducing this.

Investigating the apparent impact suspected suicide deaths have on the student community. This might be done through regular discussions with student union representatives, chaplaincy teams (who often have links with diverse areas of the academic community), and monitoring of student newspapers and social media. This will help inform student well-being strategies, including the need for psychological first aid and bereavement support. This responsibility should also include attention to the welfare of affected staff.

Identification of a possible suicide cluster should incorporate awareness of suicides in the wider community, including other local educational institutions. This underlines the importance of university membership of the local Multi-agency Suicide Prevention Group and early and close collaboration with the local public health suicide prevention lead.

Information sharing

University policy on student deaths will include guidance on family liaison following a student death. In relation to information sharing around a suicide cluster the Suicide Cluster Response Group should assess what information needs to be shared, at what point and with whom. This should include consideration of **possible** communication with:

- students
- university staff in contact with students
- other local educational institutions
- Local Adult Safeguarding Board
- local health services (GPs, emergency departments, psychiatric service). It is important to ensure that there are clear and, where necessary, rapid referral pathways to key services and guidance on how services can be accessed out-

of-hours, especially at weekends. If this involves changes to usual service provision it may be necessary to discuss this with local clinical commissioners
- embassy or consulate staff if a student is from outside the UK
- parents (for example of students in close proximity to the person who died, and vulnerable students)

Where a decision is taken to communicate with the wider student body the information should include:

- pertinent facts about the death(s) (not the details)
- explanation of normal responses to news about student deaths
- encouraging students to support each other and advice to let staff know if anyone has concerns about other students
- encouraging positive ways of managing distress/stress
- letting students know what support is available from the university support services
- providing a link to **Help is at Hand**
- signposting to other support agencies and resources

Minimal information should be shared about the cause of death, particularly as a coroner's verdict of suicide may not be confirmed immediately. Consideration should be given to language used and it may be appropriate to use the term 'sudden unexpected death'.

Media issues

There should be special attention to media responses in the event of multiple student deaths. General guidance about media reporting is provided **Box 3** (see page 31). There should be a single point of contact (usually the communications/media department member of the Suicide Cluster Response Group). The media response should include:

- monitoring of media response, including local and university media
- preparing a draft media statement (in case this should this be required)
- liaison with university / student media, including highlighting the need for care and sensitivity in articles and other communications from student news reporters (meeting with them pro-actively can be important)
- awareness of the possibility of harmful social media communications. It will not be possible to monitor all social media coverage of a student's death, but it is important to educate the university community about safe and responsible online messaging following the death of a student, including what to do if messages of concern are posted and where to go for support. Also, see page 39 for advice regarding social media

- consideration of positive media initiatives (for example promoting well-being and help-seeking; highlighting stories of recovery from emotional problems)
- consideration of giving advice to students and staff if approached by the press to contact or refer journalists to the university press office or named lead
- advising students and staff that there may be more media interest around the time of an inquest (which may occur a number of months after a death)
- linking with the Samaritans Media Advisory Team (see page 31) for advice

Bereavement support

The Suicide Cluster Response Group should consider individuals within the university who may suffer significant bereavement following a death and those affected in other ways:

Students who may need early support (for example living in the same accommodation as the individual who died, close friends, individual(s) who found the body). Both individual and group support and/or counselling should be made available. Small groups and forums are very helpful for friends and colleagues to provide an opportunity for students to talk in a supportive group facilitated by a counsellor or clinically trained member of the support services.

Staff who may need early support. This will include non-academic as well as academic staff. There might be key staff members who need greater support, for example those from accommodation or security who may have found the body of the student, the student's academic tutors or supervisors, departmental administrators or other members of staff who knew the student.

Students and staff who may be in need of support or more intensive help (for example, those who have pre-existing mental health problems, a history of self-harm or other experiences of bereavement).

Sources of support within the university (for example student counselling service; student-delivered support such as Peer Support, Nightline, NUS Welfare).

Local and national bereavement support agencies which can help affected individuals (for example Samaritans, Cruse, Survivors of Bereavement by Suicide, Papyrus).

Dissemination of information about sources of support (both within the local community and on-line support) to students and staff.

Prevention

The Suicide Cluster Response Group should consider identification of individual students who may be at increased risk following a suicide. This may be difficult in the university setting, especially given the size of the population and the fact that such information is largely personal. However, the Circles of Vulnerability (as described on page 35) may be helpful in identifying those students who might be particularly vulnerable. These may be characterised by:

Geographical proximity

Those who were closely involved in the suicide(s), (for example witnessed the event or its aftermath, or discovered the body) or exposed to such details through social or other media.

Psychological proximity

Students who may identify with the deceased (for example same academic group, similar interests, same clubs or sports team; or those who perceived that they were similar in some way to the person(s) who died.

Social proximity

These can be:

- close friends or housemates of the deceased
- current or recent partner(s) of the deceased
- relatives of the deceased.

For an indication of individuals who may be at increased risk see page 33.

Possible interventions include:

- communication with the student body about the occurrence of multiple deaths (an example of a possible draft message is included in **Appendix 9**)
- dissemination of information throughout the university about the factors that may make certain students particularly vulnerable and sources of help (for example student media, websites and social media)
- encouraging self-care (for example sleep hygiene, healthy diet, exercise, maintaining social contacts) and avoiding harmful coping strategies (for example excess drinking, drug use)

- assisting students who are particularly vulnerable to recognise their likely need for help and facilitating easy access to appropriate care (for example specific interventions for PTSD)
- increased resources for students with mental health problems
- facilitated support groups for students who feel they need help
- understanding and responding to students with specific cultural needs and beliefs
- supporting the student body about memorials of student deaths, but at the same time trying to avoid institutionalisation of grief. The Samaritans Step by Step programme offers advice regarding memorials (see: www.samaritans.org/stepbystep).
- consideration of reducing academic stress on affected students
- instillation of hope through dissemination of positive messages about available help, recovery from depression and coming to terms with bereavement

Staff, particularly personal tutors or those with a pastoral role, may also benefit from some of the above interventions. They may also need specific help, such as through staff support groups, debriefing sessions, educational sessions about suicide and self-harm including bereavement by suicide. Non-academic staff, including catering, administrative, library and staff in student accommodation, on or off site, should not be overlooked.

The Universities UK/Papyrus guidance **Suicide-safer Universities** provides useful information to promote safety in universities: www.universitiesuk.ac.uk/policy-and-analysis/reports/Documents/2018/guidance-for-sector-practitioners-on-preventing-student-suicides.PDF

Monitoring and review

This will include:

- ongoing surveillance of deaths and, if possible, self-harm
- uptake of support offered to students
- assessment of responses of involved organisations to the plan

It might also include:

- surveying students regarding how supported they felt
- assessing the impact of interventions for staff
- in the longer term a review to inform lessons learned and review procedures and provision of well-being services

A decision will need to be made at some stage about stepping down the response in terms of ending the Suicide Cluster Response Group. The appropriate timing of this will be difficult to determine in the university setting because, fortunately, even within a suicide cluster, the number of deaths are usually few.

It is important to remember that this is a difficult time for everyone involved, with potentially high levels of anxiety across the institution. Even if the best procedures are implemented one cannot always control or anticipate every eventuality. However, the experience of universities and communities which have had to respond to student suicide clusters is that from such tragedies there can eventually be positive developments, including enhanced provision of student wellbeing policies and resources, training, relationships with partner organisations and local agencies (for example public health, other educational institutions, third sector organisations).

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Resources to inform and support Suicide Cluster Response Plans

Preventing Suicide in England: a cross-government outcomes strategy to save lives (2012) The Department of Health national suicide prevention strategy for England
www.gov.uk/government/publications/suicide-prevention-strategy-for-england

Suicide prevention: fourth annual report (2019)
The fourth progress report of the suicide prevention strategy sets out what's being done to reduce deaths by suicide in England.
www.gov.uk/government/publications/suicide-prevention-fourth-annual-report

NICE guideline [NG105] Preventing suicide in community and custodial settings (2018)
This guideline covers ways to reduce suicide and help people bereaved or affected by suicides.
www.nice.org.uk/guidance/NG105

Office for National Statistics
Provides data on suicides in the UK.
www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/datasets/suicidesintheunitedkingdomreferencetables

Suicide prevention: developing a local action plan (2016)
Guidance for developing a local suicide prevention action plan: information for public health staff in local authorities.
This document is part of Public Health England's ongoing programme of work to support the government's suicide prevention strategy.
www.gov.uk/government/publications/suicide-prevention-developing-a-local-action-plan

Suicide Prevention Fingertips Tool
This has been produced to help develop understanding at a local level and support an intelligence driven approach to suicide prevention. It collates and presents a range of publicly available data on suicide, associated prevalence, risk factors and service contact among groups at increased risk.
http://fingertips.phe.org.uk/profile-group/mental-health/profile/suicide

Support after a suicide: a guide to providing local services (2017)
This practical guidance helps commissioners understand why and how they can deliver support after suicide in their local areas.
www.gov.uk/government/publications/support-after-a-suicide-a-guide-to- providing-local-services

Support after suicide: developing and delivering local support bereavement services (2017)
Guidance for local authorities drawn from the practices of existing suicide postvention support services in England, with input from organisations delivering support services and from people bereaved or affected by suicide.
www.nspa.org.uk/wp-content/uploads/2017/01/NSPA-postvention-framework-20.10.16.pdf

Support after Suicide Partnership
Support after Suicide is a network of organisations that support people who have been bereaved or affected by suicide and provide guidance regarding developing local services.
http://supportaftersuicide.org.uk/

Media reporting guidance
Developed and regularly updated by the Samaritans (most recent version 2013) to promote sensitive reporting of suicides in order to protect families and bereaved and limit suicide contagion.
www.samaritans.org/media-centre/media-guidelines-reporting-suicide

Independent Press Standards Organisation (IPSO)
www.ipso.co.uk/IPSO/index.html

IPSO guidance on reporting suicides
www.ipso.co.uk/member-publishers/guidance-for-journalists-and-editors/guidance-on-reporting-suicide/

Ofcom
http://stakeholders.ofcom.org.uk/binaries/broadcast/831190/broadcastingcode2011.pdf

Information Sharing and Suicide Prevention: Consensus Statement (2014)
Designed to promote greater sharing of information within the context of the relevant law, and to clarify that this is a matter of professional judgement for an individual practitioner providing care to an individual person.
www.gov.uk/government/uploads/system/uploads/attachment_data/file/271792/Consensus_statement_on_information_sharing.pdf

Suicide prevention: suicides in public places (2015)
Guidance on suicides in public places, how to identify locations and sharing best practice about interventions.
www.gov.uk/government/publications/suicide-prevention-suicides-in-public-places

Suicide-safer Universities (2018)
This resource, developed by Universities UK/Papyrus, provides helpful information about suicides in universities and guidance on prevention.
www.universitiesuk.ac.uk/policy-and-analysis/reports/Documents/2018/guidance-for-sector-practitioners-on-preventing-student-suicides.PDF

Young People who Self-harm: A Guide for School Staff (2018)
This resource provides advice to school staff about helping students who self-harm. It includes information about contagion.
www.cwmt.org.uk/resources?lightbox=dataItem-jmfzb026

Preventing suicide: lesbian, gay, bisexual and trans young people (2015)
Toolkits to help clinicians understand mental health and suicide risk issues in relation to LGBT sexual orientation and identity in young people.
www.gov.uk/government/publications/preventing-suicide-lesbian-gay-and-bisexual-young-people

Workplaces – Suicide Prevention Toolkits
Developed by Business in the Community and Samaritans

- Reducing the risk: prevention toolkit for employers
- Crisis Management in the event of a suicide: bereavement support for employers.

https://wellbeing.bitc.org.uk/all-resources/toolkits/suicide-prevention-toolkit

National Suicide Prevention Alliance (NSPA)
A cross-sector, England wide coalition committed to reducing the number of suicides in England and improving support for those bereaved or affected by suicide.
www.samaritans.org/about-us/our-organisation/national-suicide-prevention-alliance-nspa

Health Education England Self-harm and Suicide Prevention Competency Frameworks
These competency frameworks describe activities that need to be brought together to support people who self-harm and/or are suicidal.
www.hee.nhs.uk/our-work/mental-health/self-harm-suicide-prevention-frameworks (2018)

Resources for people bereaved or affected by suicide and those vulnerable to suicide

Help is at Hand: Support after someone may have died by suicide or other sudden traumatic death
Provides detailed advice on practical aspects of dealing with the aftermath of suicide and traumatic death, as well as information on the emotional and psychological impact of suicide and sources of help and support.
www.nhs.uk/Livewell/Suicide/Documents/Help%20is%20at%20Hand.pdf

Public Health England also has a Z-Card summary of the content of Help is at Hand. This is a useful resource for first responders to give to relatives and significant others immediately affected by suicide.
www.orderline.dh.gov.uk/ecom_dh/public/saleproduct.jsf?catalogueCode=2901503

Finding the Word: How to support someone who has been bereaved and affected by suicide
Provides helpful advice on how to support someone who has been bereaved by suicide.
http://supportaftersuicide.org.uk/wp-content/uploads/2018/03/Finding_the_Words.pdf

Survivors of Bereavement by Suicide (SoBS)
Self-help support groups and support line facilitated by people who have themselves been bereaved by suicide. Can provide early support for the bereaved.
http://uk-sobs.org.uk/

Child Bereavement UK
Grief support app for young people (11-25) who have been bereaved of someone close to them.
www.childbereavementuk.org

Winston's Wish
Offers support and guidance to bereaved children, families and professionals, with a specific service for children affected by suicide.
www.winstonswish.org.uk

Samaritans
24 hour telephone support, text messaging and email service and time limited drop in facilities available in branches.
www.samaritans.org

Step-by-step service for helping youth settings respond to suicides.
www.samaritans.org/your-community/supporting-schools/step-step

PAPYRUS: Prevention of Young Suicide
Helpline, text and email support for young people and parents.
Suicide prevention training.
Suicide bereavement support for those who have been affected by a young person's suicide.
www.papyrus-uk.org/

Healthtalk.org
Information on a range of illnesses and other health-related issues from seeing and hearing people's real life experiences, including people bereaved by suicide.
www.healthtalk.org/peoples-experiences/dying-bereavement/bereavement-due-suicide/topics

Cruse Bereavement Support
Face-to-face, group, telephone and email support to support people who are bereaved.
www.cruse.org.uk/home

The Compassionate Friends
Provides support and friendship to parents and families after the death of their son or daughter, at any age and from any cause.
www.tcf.org.uk/

The Way Foundation (Widowed & Young)
Aims to support young widowed men and women as they adjust to life after the death of their partner – whether that was a month, a year, or 10 years ago.
www.widowedandyoung.org.uk/

MIND
Provides advice and support for people experiencing a mental health problem, through local groups, networks, advice and training. Information on how to cope with suicidal feelings
www.mind.org.uk

Young people's experiences: depression and low mood
Website on young people's experience of depression, including suicidal feelings and self-harm.
www.healthtalk.org/young-peoples-experiences/depression-and-low-mood/depression-self-harm-suicidal-feelings

Parents and carers of young people who self-harm
Website on parents' and carers' experiences of coping with self-harm in their children.
www.healthtalk.org/peoples-experiences/mental-health/self-harm-parents-experiences/topics

CALM (Campaign Against Living Miserably)
Helping to prevent male suicide in the UK.
www.thecalmzone.net/

NHS Choices
Information from the National Health Service on conditions, treatments, local services and healthy living which includes signposting to support for people who are feeling suicidal or are affected by suicide.
www.nhs.uk

Appendices

Appendix 1: Public health and organisational leadership roles

1.1 Public Health Leadership Role for Suicide Cluster Response Plan

Convene and chair the Suicide Cluster Response Group Meeting in agreement with the institution/community setting.

Interpret the national PHE guidance for local implementation and understand the local landscape for suicide prevention within the county.

Understand the data profile for suicide within the local authority area and have access to intelligence from real-time data surveillance or most recent suicide audit.

Ask attendees to have gathered relevant information in advance for discussion at the response meeting.

Agree terminology to use within the meeting/terms of reference.

Assimilate relevant information from partners in the meeting to decide if there is a cluster or if one might be developing.

Mobilise local organisations which could provide support.

Interpret data/intelligence to provide a community perspective that can be communicated with residents and professionals to allay concerns.

Act as a central point of contact if new information becomes available and decide next steps.

Ensure that next steps are identified and agree actions and date of next meeting/s of the Suicide Cluster Response Group.

Agree regular communication with relevant organisational lead.

Keep external agencies updated:

- Public Health England Centre Leads
- Neighbouring Public Health Suicide Leads if required

- Relevant people within the local authority informed, including Councillors, Children's Social Care, Adult Social Care
- Clinical Commissioning Group
- Public Health commissioned services
- Community Mental Health Services
- Child Death Overview Panel

1.2 Organisational Leadership Role for Suicide Cluster Response Plan

Where an organisation has concerns contact the local public health suicide prevention lead at an early stage to agree process.

With the public health lead agree the individuals and agencies who should be invited to an initial Suicide Cluster Response Group meeting (these meetings should not be too large).

Ask organisational attendees to have gathered relevant information in advance for discussion at the response meeting.
Act as the internal lead in convening the Suicide Cluster Response Group meetings and agree chairing arrangements with the public health lead.

Agree terminology to use within the meeting/terms of reference.

With the public health lead, assimilate the relevant information from partners at the meeting to decide if there is a cluster or concerns that there may be risk of one developing (for example, if there appears to be an increase in self-harming behaviour following a suicide).

Agree support mechanisms for families, those within the organisation (for example, students, staff) and affiliated external agencies that may be affected (for example, sports clubs, music societies). It is important to avoid duplication and support provision should be as systematic as is possible.

Identify a single point of access within the organisation to link with families.

Identify a single point of access within the organisation for internal feedback, concerns etc.
Identify a single point of access for media/external enquiries.

Agree regular internal meetings to monitor concerns and support mechanisms.

Maintain close links with the public health lead to:

- feedback from internal meetings about progress and ongoing concerns
- ensure any new and relevant information is relayed
- request additional support; the public health lead should be able to mobilise and provide contacts through the multi-agency suicide prevention group for local organisations which could provide support both in the immediate and longer term

Appendix 2: Suicide Cluster Response Plan: Template to assist record keeping

Issue	**Action**	**Next steps**	**Responsible lead**	**Monitoring/progress**	**Completed Y/N Additional action required**
Example: Friends of deceased requiring support	Bereavement support (group and 1-1) offered by local bereavement charity	School/college/university to provide parents with information to help them support their child with their loss	Pastoral care lead	Feedback at next meeting and inform organisational lead if new concerns arise	
Example: Concerns about inaccurate rumours spreading within the community	Identify source and nature of rumours	Link with local councillor. Seek advice from Samaritans Consider preparing a public statement	Public health/media communications lead	Monitor media coverage Review if level of concern alleviated	

Appendix 3: Suggested agenda for initial Suicide Cluster Response Group Meeting

1. **Identify an individual to take notes of the meeting and provide ongoing administrative support**

2. **Confirm purpose of meeting is to:**

   - agree leadership/co-leadership of the Suicide Cluster Response Group (see role descriptors in Appendix 1) and clarify working and communication arrangements
   - establish facts surrounding suspected suicides and determine possible links between deaths
   - agree appropriate level of escalation and intervention
   - review membership of the Suicide Cluster Response Group, identify additional members (those required to attend meetings and those with whom links should be established) and clarify roles
   - agree and record actions and timescales

3. **Surveillance**

   - details and circumstances of deaths: data from real time monitoring or Coroners
   - understanding the events in the context of the organisation concerned; for example, is there something going on in the wider community that is affecting the organisation, or vice versa?
   - identify anniversaries of previous suicides
   - identify any reported increases in non-fatal self-harm
   - Systematically record details and circumstances to aid identification of similarities and possible connections between deaths (see **Appendix 4**)

4. **Information sharing**

   - identify further investigations – what additional information is required from whom?
   - identify who needs to be informed of concerns and agree communication processes
   - agree confidentiality and information-sharing processes

5. **Media**

   - identify media communication lead of Suicide Cluster Response Group
   - identify media communication leads within affected organisations

- agree communication strategy between organisations and with internal and external media
- agree content for media/press statement
- identify possible social media concerns
- agree process for monitoring known Facebook memorial sites and responding to concerning posts with supportive statements and signposting

6. **Bereavement support**

- identify bereavement support that is already in place or has been provided
- identify additional support needs (using circles of vulnerability)
- identify bereavement support agencies
- identify any shortfall and make contingency plans
- identify any additional support requirements for bereavement support providers

7. **Prevention**

- identify individuals and groups who may be at risk (using Circles of Vulnerability)
- agree whole population, targeted and individual strategies for support and prevention activity and identify provider agencies

8. **Monitoring of plan**

- agree monitoring (including record keeping and storage) and evaluation strategies
- agree frequency of Suicide Cluster Response Group meetings

Appendix 4: Template to record details and circumstances of deaths and relevant individual characteristics (those shown are examples)

Name	**Person A**	**Person B**
Gender		
Ethnicity		
Date of Death		
Date of birth and Age		
Day of death		
Mode of death		
Location of death		
Home address		
Clubs		
Faith group		
GP		
Previous suicide attempts		
History of self-harm		
In touch with mental health services		
Past mental health problems		
Connections to other decedents		
Possible triggers for suicide		
Social media presence		
Family issues		

Appendix 5: Fictitious example demonstrating use of a map to plot geographic locations of suspected suicides

The small town of Dorborough was rocked by a number of tragic deaths. In February, Lee, a popular teacher at Bluewald school, died by suicide in his home. In March, an 18 year-old woman, Keeley, was found dead by suicide in another part of town. Keeley died by an unusual method of suicide. She was very active on social media and had a YouTube channel showcasing her reviews of recent films. Because of Keeley's age, her family's media connections and her social media presence, her death was widely reported in the media and memorialised in social media. This included some detailed reporting of her method of suicide. In addition, news of her death spread widely on social media.

In July, Mike, a troubled 21-year-old man, died by suicide using a similar method to Keeley. Mike was in a band that was well-known locally. He had been struggling with mental health problems. In October, Mike's young cousin Scarlette also died by suicide. She was a pupil at Bluewald and knew Keeley through her older sister. She had been struggling with her schoolwork and her cousin's death. Shortly after, Mike's friend and bandmate, James, survived a serious self-harm episode involving a different method. James, now working, had been at Bluewald school several years beforehand.

Appendix 6: Vulnerability matrices (example and blank forms)

Partially completed vulnerability matrices

Geographic Proximity Individuals discovering or exposed to the aftermath				
Circles of Vulnerability: Individual or Groups	**Description of risk**	**What has been done to help this person?**	**What remains to be done?**	**Comments**
Individual(s) discovering the body	Psychological trauma, mental health, grief/loss	Psycho-education re: responses to trauma, Help is at Hand and bereavement services, signposting to suicide prevention charities, GP advised	Follow up wellbeing checks. Psychological services if indicated	
Professionals on the scene	Psychological trauma, mental health	Wellbeing checks, psycho-education, signposting or referral to psychological services	Follow up wellbeing check	
Neighbours	Exposure, loss, mental health	Given brief bereavement leaflet at scene, signposting to community resources	Follow up wellbeing check	
Members of household	Psychological trauma, grief/loss, mental health	Bereavement services inc. child bereavement, Help is at Hand, GP advised Close family and extended family visiting to support	Follow up. Consider fast track to psychological or mental health services where indicated	
Local population (through media reporting)	Potential to broaden exposure in community, contagion	Media liaison to support media with sensitive reporting inc. suicide prevention charity contact information	Distribution of leaflets, posters beer mats etc.	
Psychological Proximity Identification with, relationship to or connection to the person who died				
Circles of Vulnerability: Individual or Groups	**Description of risk**	**What has been done to help this person?**	**What remains to be done?**	**Comments**
Spouse or partner, ex-partners	Psychological trauma, grief/loss, mental health	Bereavement support inc. WAY foundation and child bereavement where indicated, Help is at Hand. Widow is close to husband's family Also her parents are with her	Follow up. Consider fast track to psychological or mental health services if indicated	
Peer Group	Loss, grief, mental health, contagion	Distribution of supportive signposting literature with helpline numbers, Step by Step for schools and schools guidance followed	Letter to parents of affected children. Support and awareness posters and literature to be distributed	
Professional staff who had contact	Psychological trauma, loss, stress, mental health	Facilitated psychological support sessions, signposting to ongoing support and resources	Information about psychological first aid. Offer of follow up support	
Social media connections	Contagion	Media liaison lead to post suicide prevention and bereavement charity information on memorial posts. Arrange monitoring of Facebook page	Ongoing	

Social Proximity Identification with, relationship to or connection to the person who died				
Circles of Vulnerability: Individual or Groups	**Description of risk**	**What has been done to help this person?**	**What remains to be done?**	**Comments**
Children within family or local friendship group	Grief/loss, psychological trauma, mental health	Child bereavement services for child and family support	Follow up. CAMHS if indicated	
Close friends and family	Grief/loss, psychological trauma, mental health	Bereavement support, Help is at Hand	Follow up. Referral to psychological services if indicated	
Workmates or college peers	Grief/loss, contagion	Facilitated psychological support sessions, signposting to supportive literature and community resources	Follow up	
Pupils at same school	Grief/loss, psychological trauma, mental health contagion	Schools guidance followed, Samaritan Step by Step services, CAMHS presence	Continuation	
Club or group members	Loss, contagion	Community talks, signposting to resources, awareness posters, leaflets, beer mats	Promotion of community awareness and help seeking	
Social media connections	Contagion	As with psychological proximity	Ongoing	
Individuals who were in recent contact (text messages, social visits that day)	Psychological trauma, loss	Wellbeing checks, psychoeducation, signposting to community resources	Promotion of community awareness and help seeking	

Blank templates for vulnerability matrices

Geographic Proximity Individuals discovering or exposed to the aftermath				
Circles of Vulnerability: Individual or Groups	**Description of risk**	**What has been done to help this person?**	**What remains to be done?**	**Comments**
Psychological Proximity **Identification with, relationship to or connection to the person who died**				

Circles of Vulnerability: Individual or Groups	Description of risk	What has been done to help this person?	What remains to be done?	Comments

Social Proximity Identification with, relationship to or connection to the person who died				
Circles of Vulnerability: Individual or Groups	**Description of risk**	**What has been done to help this person?**	**What remains to be done?**	**Comments**

Appendix 7: Suicide Cluster Response Plan: Checklist of core actions

Core actions	Completed
Convene Suicide Cluster Response Group meeting and if concerns are identified activate the pre-prepared Suicide Cluster Response Plan according to the circumstances of the suicides concerned	
Agree confidentiality and information-sharing arrangements	
Identify organisational leads and agree links between internal response and Suicide Cluster Response Group	
Ensure clear communication, recording and administration arrangements are in place	
Ensure appropriate bereavement support and signposting are offered to family and friends of the deceased	
Identify vulnerable individuals and groups using the Circles of Vulnerability model as a guide.	
Document identified concerns, actions and responsible leads	
Agree monitoring and review arrangements, including ongoing suicide surveillance	
Ensure support is in place for staff providing bereavement support activity	

Appendix 8: Mental Health Services Guidance for responding to contagion risk or concern following suspected patient suicide/ serious self-harm

Service managers should be informed when it is thought that there is possible risk of contagion. In such instances it may be necessary to implement the Public Health England guidance for identifying and responding to suicide clusters. This process should be led by clinical or service directors.

It is important to revisit possible contagion risk at agreed intervals in order to identify whether there is in fact any evidence of contagion.

Such deaths may have occurred within an individual's social network or in people they became aware of through media or other influences". (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/459303/Identifying_and_responding_to_suicide_clusters_and_contagion.pdf)

It is important to note that whilst service users may be susceptible to contagion, occurrence of contagion is relatively rare. It is normal to experience emotional and psychological distress when a friend or peer is involved in an incident and, in vulnerable individuals such as service users, such distress may increase the risk of self-harm or suicide independently of any contagion effect. However it is expedient that clinical teams are mindful of possible contagion risk and identify service users who might be vulnerable. Associated communication with other teams within the organisation who provide care to connected service users is an important aspect of contagion mitigation.

Process for identifying vulnerable individuals:

Team managers/clinical leads, consultants and relevant care co-ordinators should come together at the earliest opportunity after a suspected suicide or act of serious self-harm for mortality or multi-disciplinary review.

As part of this review service users who may by adversely affected by the incident should be identified, support and intervention needs discussed and care and safety plans reviewed where appropriate. When service users are closely socially connected it may be appropriate to inform them of the death before they find out via other means for example, social media. This should be a team decision overseen by the consultant and team manager.

Where the service user involved in the incident is closely connected to service users from other clinical teams, social care or third sector organisations, team managers should communicate accordingly at an early stage.

Appendix 9: Example of a message for students following multiple deaths by possible suicide

Dear Student

I am writing to you about the tragic deaths of [number] students [add any other specific information required] this term. These deaths have been reported in the media over the last [duration]. My colleagues and I have been working with the students' families and friends and with others who are directly affected. Our thoughts are with them and we will continue to respect their privacy as far as we can.

In addition to those directly affected, I want to make sure that everyone in our university community is aware of the support available for them, if needed. Shock, sadness and anger are entirely normal responses following unexpected deaths, and what has happened will affect everyone in different ways and at different times. If you have been affected by these events, it is important to talk to your friends and families about how you are feeling. In addition, you can access support and counselling from [give relevant details of university counselling and student support]. If you are unsure about what to do, your [personal tutor/course director] will be very happy to help you or point you towards someone else who can provide help.

Help is available around the clock, please remember that the following services are available out of normal working hours:

Local:
[if applicable] Hall wardens, deputy wardens and senior residents, who will be on site over the weekend

Insert student support and local support agencies

Samaritans (Available 24/7): phone 116 123, email jo@samaritans.org

HOPELine UK (Text, phone and email) www.papyrus-uk.org/help-advice/about-hopelineuk

If you feel in need of support in the days and weeks ahead, please take a look at university and national online support (for example Young Minds, Student Minds, Students Against Depression) and make use of the information and advice available.

I am sure that you will look out for each other during this difficult time, but if you are concerned about the welfare of anybody following this news, then please tell a member of staff or encourage the student to contact the services listed above and/or contact them yourself for advice.

With best wishes

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