Responding to, and learning from, incidents at an organisational level

Responding to a suicide

An ability to provide guidance and support for all employees affected by a person's suicide
An ability to maintain services and to provide stability and appropriate information to staff, other service users and their families and carers
An ability to appoint appropriate individuals to investigate the circumstances leading up to the death
An ability to offer support to individuals and teams who worked with the person who has died, aimed at helping them review the death, discussing their reactions and feelings and receive help if necessary
An ability to communicate with other service users involved and affected by the death (e.g. providing clinical follow-up and support)

Family and carer engagement and communication

An ability to ensure that the terms of reference of any investigation explicitly include arrangements for engaging and communicating with the family or carers of the person who has died
An ability to ensure that the people making contact are suitable to take up this role (e.g. have the appropriate communication skills and an appropriate level of authority)
An ability to ensure that information is provided to the family or carers of the person who has died in a timely and compassionate manner (in line with the duty of candour)
An ability to put in place appropriate support for family or carers of the person who has died
Where a person's family includes children and young people, an ability to signpost or to put in place developmentally appropriate support for them, and to support the family or carers to care for them

Establishing an independent review

An ability to identify an independent team with relevant experience, expertise and authority, including external membership where appropriate, which is empowered to:	
	investigate the circumstances of the death
	compile a record of a person's care and service use
	write a clear report
An ability to ensure that reviews are set up, completed and disseminated in as timely a manner as is practicable	

Competences for the investigating team

An ability for the investigating team to:
review relevant documentation
identify the agencies and services with which the person was in contact
interview members of the staff teams with whom a person was in contact
review and evaluate the course and quality of care or service provided
review legal and ethical matters, particularly those concerning sharing of information within and between services
seek the views of the person's family, carers and significant others
An ability to review the degree to which the service is operating in line with national and local guidance designed to reduce the risk of suicide, such as:
maintaining safe staffing levels
maintaining a consistent staff group who are familiar with the people in their care (by minimising staff turnover)
putting in place appropriate training for staff carrying out critical tasks (such as direct observations, search and restraint)

Clinical policies relating to the management of self-harm and suicide

An ability to review policies relevant to the safe management of people who self-harm or are suicidal, such as:
care planning
risk assessment
routine search
use of restraint
use of seclusion
use of observation
An ability to determine the ways in which these policies are implemented in practice (including arrangements for regular staff training)

Use of information and reporting systems

An ability to draw on knowledge of the information systems used in the workplace and the reporting arrangements used locally and nationally to record and flag serious incidents
An ability to examine information and reporting systems to ascertain the degree to which:
staff in the organisation routinely and systematically record information and particularly information potentially relevant to the management of self-harm and suicide (e.g. risk assessments, communication with other parts of the service or with other services)
the organisation follows up and acts on reports of adverse events and potential areas of concern (e.g. use of seclusion and restraint)
reporting of serious incidents to national external bodies is appropriate (e.g. CQC, NHS Improvement)

Effectiveness of leadership

- An ability to identify how information about potential adverse events or areas of concern is considered by senior leaders in the organisation, for example:
  - whether, how and at what level the organisation receives, takes account of and responds appropriately to information about serious incidents, unexpected deaths and previous incident reports
- An ability to assess the quality of reports of previous investigations (such as serious incidents), for example, considering:
  - the standard of investigation
  - the quality of the report
  - the appropriateness of the actions it recommended
- An ability to determine whether and how recommendations from previous investigations have been implemented

Dissemination

- An ability to draw on knowledge of the ways in which reports can be disseminated so as to be helpful to front-line staff and those close to the person (by giving them access to the report, by presenting its findings or otherwise providing a full account of the circumstances leading up to the death)
- An ability to report both in writing and to present information verbally to relevant parties
- An ability to recommend that reports are disseminated in a timely manner to:
  - all staff who can potentially learn from them, for example:
    - managers
    - staff (including front-line clinical staff, particularly those with whom the person was in contact)
    - other partners (such as local services or local agencies)
  - the person's family or carers

Providing support for staff after a death by suicide

This section focuses on the competences associated with supporting individuals and teams after a person has died by suicide. Separate sections detail competences associated with the formal inquiry that constitutes an organisational response to suicide.

Because the response to suicide is as much institutional as individual, the competences in this section refer both to the response expected of an organisation and the individual competences of those offering support to staff.

An ability to ensure that all relevant staff are informed after a suicide and that support is offered in a timely manner
An ability to ensure that working arrangements are adjusted so that all staff who wish to attend meetings are able to do so
An ability to identify a moderator (a neutral expert with experience and expertise in working with suicide postvention, with either individuals or groups)
An ability for the moderator to establish boundaries to any discussions and ensure that there is clarity about confidentiality

Working with individuals and teams

An ability to provide information about the 'normal' consequences of a suicide	
An ability to help staff discuss their emotional reactions to the death, and to:	
	identify and discuss the breadth of emotions evoked by a suicide (e.g. sorrow, guilt, anger, disappointment, compassion, relief)
	identify and discuss emotions related to their sense of the role they played in the person's treatment (e.g. a sense of failure, incompetence, fear, shame)
	discuss the ways in which they are managing feelings about the death (e.g. denial of feelings or feeling overwhelmed)
	discuss (and so recognise) limits to the control that they had over the person's behaviour
	recognise that (at least in the short term) the death is likely to affect their work and their sense of professional identity
	verbalise fears of disciplinary or legal action
An ability to help staff reconstruct the known circumstances and behaviour of the person before suicide, and to discuss:	
	how they understand the person's decision to die
	their sense of involvement with the person and their view of themselves after the suicide (including, for example, potential feelings of guilt or a sense of failure)
	accusations of blame towards individuals or groups seen as responsible for the person's welfare
	an ability to contain accusations of blame against others (e.g. by distinguishing between feelings of guilt and actual responsibility for the person)
Where a staff member has found the body, an ability to organise or provide appropriate support (e.g. where there is evidence of trauma)	

Working with teams

An ability to draw on knowledge that the reactions of different members of the team will vary and be influenced by their:	
	relationship with the person
	understanding and knowledge of the person
	understanding and anticipation of the event
	personal traits and life experience
	professional experience
An ability to draw on knowledge that because different team members will vary in the extent and depth of their reactions, the support offered (to the team as a whole and to individual members) needs to reflect this, for example:	
	by offering individual as well as group support
	by being sensitive to what each team member knows, and what level of detail they need to know (e.g. if detailing the manner of the death is potentially traumatising, or where the family has indicated a wish to restrict information about the manner of death)
An ability to extend support to staff (such as administrative staff or cleaners) who had no formal role in caring for the person who has died, but whose duties brought them into regular contact with them	