‘Suicide changes everything’

An exploratory study of the experiences of suicide survivors using a sociological autopsy approach

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Author's Note

In order to maintain confidentiality, names of participants, the deceased and health professionals which appear in the text have been changed.

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Abstract

Background

This thesis addresses a significant gap in suicide prevention research by examining how the experiences of people bereaved or otherwise affected by suicide can contribute to formal systems of learning and prevention. Focusing on Northeast and North Cumbria, it challenges the dominance of medical and psychological accounts by advancing a more socially grounded understanding of suicide and its aftermath.

Methodology

Using a constructivist grounded theory design, the study combined 17 in-depth interviews with bereaved or affected individuals and family groups in Northeast England with secondary suicide-audit data. This methodological design makes an original contribution by extending sociological autopsy beyond retrospective case reconstruction to include survivor testimony as a source of analytic insight into the wider social and structural conditions shaping suicide.

Findings

The findings demonstrate that suicide has profound and enduring effects on survivors' identities, relationships and wellbeing, while also exposing significant limitations in existing support and review systems. They show that suicide is shaped by interconnected social and structural factors, including trauma, domestic abuse, bereavement, deprivation, substance use and stigma, which are insufficiently accounted for in dominant individualised models. On this basis, the thesis develops a novel analytical framework that links audit intelligence with lived experience, generating new knowledge about how survivor-informed evidence can strengthen trauma-informed postvention, earlier multi-agency learning and more socially responsive suicide prevention.

Conclusions

Overall, the thesis shows that losing a loved one to suicide has devastating and enduring consequences for survivors, while the support available to them remains limited, often ad hoc, and insufficiently responsive to their needs. It highlights the underestimated impact on children and young people, the importance of community response in shaping survivors' experiences, and the potential for targeted prevention where familial and social patterns of suicide become visible. As the first study of its kind to extend sociological autopsy through

the integration of survivor testimony with audit data, it offers an original framework for more socially informed suicide prevention, postvention and future research.

Chapter 1: Introduction

This introductory chapter describes the researcher's background and influences, outlines the research question, provides definitions of several key terms, and summarises the structure of the thesis.

1.1 Background and theoretical influences

Throughout my career in public health and the NHS, I have worked predominantly in public mental health and suicide prevention. Consequently, I have developed a strong understanding of the impact of poor mental health and suicide on individuals and communities.

In 2012, I led the development of the local suicide strategy in County Durham, including a suicide early alert system and a process to identify increasing suicide trends and suicide clusters. Since then, the strategy and research developed in Durham have been steadily extended, and by 2024 I was leading this work across the Northeast and North Cumbria Integrated Care Board. The near real-time suicide surveillance system enables an early alert notification process, allowing support services to be notified of a suspected suicide within one to two days of the event. This approach enables preventative action to reduce suicide contagion and shortens the time before postvention support can be offered to suicide survivors.

In 2005, I met a family bereaved by suicide through the loss of their 19-year-old son. They were passionate about suicide prevention and about supporting others who had been bereaved by suicide. Between 2005 and 2011, I worked with the family as a public health commissioner and developed a mechanism to link them with a local Mind charity so that they could learn from and be mentored by Mind. Their ambition was to establish a charity to support suicide survivors, which they did in 2011 with the launch of If U Care Share. The Northeast postvention support service is based on a peer-support model, in which people who have been bereaved by suicide support others who have experienced a similar loss. This service acted as the gatekeeper for recruitment to this study.

Through my work and contact with the suicide survivor community and the suicide audit programme, I became aware of the taboos and stigma surrounding suicide and of how these

differed across communities and families. In some situations, support was readily available and open conversations took place; in others, there was little support and a sense that people avoided talking about suicide because of concerns that it might happen again and spread throughout the community, as though it were a hidden cause of death.

There was little research evidence or practice guidance to help explain these observations, and I struggled to understand what these views meant for those bereaved by suicide and how they affected people's ability to access support. This became my motivation for further study, together with the clear gap in the literature relating to individuals and communities bereaved or affected by suicide and the implications for suicide prevention strategies.

Chapter 2: Research question

The research question was developed in conjunction with my supervisory team and informed by the initial scoping of the study.

'What is the experience of those bereaved or affected by suicide and what role do communities play in providing support?'

The key issues to be explored are:

- Relationship with suicide clusters and other suicide deaths.
- The experience of being bereaved or affected by suicide (suicide survivor).
- What type of support or who is key in providing this support to those bereaved or affected by suicide.
- The role of communities, how communities interact and react following suicide/s.
- What else could be done to assist those bereaved or affected by suicide.

The study may identify the impact of losing a loved one to suicide, highlight any unmet needs of suicide survivors, and explore whether recovery from the impact of suicide occurs and, if so, over what period of time. This is supported by including the time elapsed since the death for each participant.

Chapter 3: Key terms

3.1 Suicide bereavement

Suicide bereavement describes the period of grief, mourning, and adjustment following a suicide death. It may be experienced by, but is not limited to, immediate, extended, or

adoptive family members, foster family, close friends, colleagues, school, college or university peers, teachers, and former partners.

3.2 Bereaved by suicide

Being bereaved by suicide refers to the experience of losing someone close through suicide and the complex grief, emotional distress, and social challenges that follow.

3.3 Suicide survivors

The term ‘suicide survivor’ refers to the behaviour of an individual or group who have lost someone to suicide, and the impact that suicide has on them and others remaining (Jordan, 2001).

3.4 Affected by suicide

Individuals who do not feel personally bereaved by suicide but still feel they have been affected by the death, for example, if you knew a neighbour who has lost their partner, son or daughter; if you were the passer-by who witnessed the death or found the person; if you are front-line staff who respond to an emergency (e.g. ambulance personnel, emergency department staff, police, fire, air ambulance and lifeboat personnel), prison officers, train drivers, health professionals responsible for their care, and other people who may have had regular social contact with the person who died, such as shopkeepers, hairdressers, and other members of the local community (McDonnell et al., 2022).

3.5 Postvention

The term postvention describes activities developed by, with, or for people who have been bereaved by suicide in order to support recovery and prevent adverse outcomes, including suicidal ideation, suicidal behaviour, and suicide (Postvention Support Service Evidence Briefing Paper, 2022).

Postvention is support provided after someone takes, or is suspected of taking, their own life. It may be offered to family, friends, colleagues, and health professionals, with the aim of meeting support needs, enabling longer-term recovery, and preventing contagion. It also encompasses community interventions in response to suicide clusters and increasing trends, with the purpose of reducing contagion, addressing community risk factors, and identifying people at increased risk.

3.6 Community

Community is a multifaceted concept that has evolved beyond geographical boundaries. It is generally defined as a group of people sharing common interests, values, and social ties (Rein, 1997; Wellman, 2005). MacQueen et al. (2001) propose a comprehensive definition emphasising diverse characteristics, social connections, shared perspectives, and joint action. Communities provide sociability, support, information, and a sense of identity (Wellman, 2005; Etzioni, 2000). The concept has shifted from neighbourhood-centric to network-based, acknowledging long-distance ties (Wellman, 2005; Bradshaw, 2008). This 'post-place community' recognises solidarity and shared norms without geographical constraints (Bradshaw, 2008).

3.7 Suicide cluster

A potential cluster is defined as 'a group of suicides, suicide attempts, or both, which occur more closely together in time and space than would otherwise be expected'.

In March 2026 the UK Government released updated guidance and described a cluster as 'a group of deaths, suicide-related activity or self-harm that are linked in some way by time, death, method, location, geography or demography' (Gov.uk, 2026).

In addition to a numerical count of suspected cases, the rationale for determining whether a cluster is developing should also be informed by a series of 'cluster triggers' (McGeechan, 2017). These are:

- When there is one or more death by a young person or adolescent in a community.
- How the individual was perceived by the community i.e. is the individual a high-profile person?
- Whether the death(s) has the potential for media interest.
- Whether there are any unusual circumstances surrounding the death.
- Whether there has been a perception by the community of an increase in suicide.
- Whether cases appear to have increased due to an underlying economic or social problem.

Chapter 4: Literature review

This chapter critically interrogates the theoretical and empirical literature pertinent to the present study. Grounded theory, considered in detail in the following chapter 5, occupies a distinctive methodological relationship to the literature. In its purist form, the approach assumes that researchers enter the field with minimal preconception and generate substantive theory inductively from the data. In practice, however, some degree of prior engagement with the literature is indispensable if a research proposal is to be methodologically credible and capable of meeting ethical and funding requirements. At the same time, grounded theory requires sustained openness to emergent categories, rather than adherence to the deductive logic of hypothesis testing (Charmaz, 2006). In underexamined fields, this tension is most effectively managed through a preliminary theoretical framework that delineates the broad contours of the topic without prematurely constraining theoretical development (Urquhart, 2001). Such a framework presupposes familiarity with the relevant body of scholarship and enhances the theoretical sensitivity that Glaser (1978) associates with immersion in extant ideas. It may then be progressively refined as the analysis advances and new avenues of inquiry become apparent.

The literature examined below provides a foundation for further discussion and exploration in the findings and discussion chapters (Chapters 8 and 9) and sets out the historical and social context of suicide in the UK. This includes the epidemiology of suicide, high-risk populations, suicide survivors, grief, and stigma.

4.1 Epidemiology of suicide

Suicide is a major public health concern, with an estimated 877,000 people taking their own lives worldwide each year, representing 1.5% of the global disease burden (Aini, 2017). Suicide has a devastating impact on society, and the economic costs are also high, estimated at £1.7 million for each life lost among people of working age (Omerov, 2013). These costs include direct costs, such as GP visits, counselling, funerals and insurance payments; indirect costs to society, including time lost from work and lost productivity resulting from absence

from, or exit from, the workforce; and human costs, including years of disability-free life lost in addition to the pain and grief experienced by family and friends.

Suicide rates in England and Wales have fluctuated significantly over time, with consistent gender differences. Males have consistently higher rates than females, although the ratio has varied and is influenced by biological, environmental and social factors. Seasonal variation in suicide is widely reported, with studies identifying a spring peak and winter trough (Mofatteh, 2026). A 35-year population study (1982–2015) in England and Wales found that males accounted for 73.3% of suicides, with a mean male-to-female ratio of 2.64. Seasonal variation in suicide deaths was more pronounced in females (Mofatteh, 2026).

Geographical variations exist, with higher rates in urban areas and a north–south divide emerging by the early 2000s (Gunnell, 2010). The geographical distribution of suicide among 15–44-year-olds in England and Wales shows patterns of higher rates in inner-city and coastal areas, particularly in remote regions (Middleton, 2006).

Economic circumstances, including unemployment and poverty, significantly affect suicide rates. Strategies to mitigate these effects include national policies, employment maintenance, minimum wage levels, infrastructure investment, and positive public health messaging (Sinyor, 2024).

Method availability influences trends, as seen with the rise and fall of domestic gas suicides (Thomas and Gunnell, 2010), showing the impact of policy change on suicide. Similarly, changes in paracetamol deaths followed reductions in packet size and purchasing quantity (Schapira, 2001). Among mental health patients who died between 2005 and 2021, Rivart et al. (2024) confirmed hanging as the most common method while identifying method-specific associations with patient characteristics (e.g. hanging linked to recent self-harm and depression; self-poisoning linked to substance misuse).

Other risk factors include being single, divorced, or widowed, and working in professions with access to lethal means (Schapira, 2001).

The 2008–2010 economic recession was associated with increased suicides, particularly among men in regions with higher unemployment (Barr, 2012). However, early data from the COVID-19 pandemic did not show a significant increase in suicide rates after the first lockdown in 2020 (Appleby, 2021). This contrasts with psychological data: suicidal ideation increased during the early phases of lockdown in UK population surveys, particularly among

young adults, and 31% of survey respondents reported suicidal thoughts in phase 1 (Rathod et al., 2022). Media coverage was often sensationalised, with 39% of articles predicting rises in suicide despite evidence to the contrary (Marzano et al., 2022).

England has had a suicide prevention strategy for 24 years. During that time, national suicide rates have been the lowest on record, with the average rate around 20% lower than in the previous two decades (Department of Health and Social Care, 2023). In August 2023, the UK Government released an updated suicide prevention strategy informed by suicide data, including the impact of a global recession, which increased suicide rates, and a pandemic which, contrary to most expectations, did not increase the suicide rate in England (Department of Health and Social Care, 2023).

The priorities for action of the Suicide Prevention Strategy for England (Department of Health and Social Care, 2023) over the 5 years (2023 to 2028) are:

1. Improving data and evidence to ensure that effective, evidence-informed and timely interventions continue to be developed and adapted.
2. Tailored, targeted support to priority groups, including those at higher risk, to ensure there is bespoke action and that interventions are effective and accessible for everyone.
3. Addressing common risk factors linked to suicide at a population level to provide early intervention and tailored support.
4. Promoting online safety and responsible media content to reduce harms, improve support and signposting, and provide helpful messages about suicide and self-harm.
5. Providing effective crisis support across sectors for those who reach crisis point.
6. Reducing access to means and methods of suicide where this is appropriate and necessary as an intervention to prevent suicides.
7. Providing effective bereavement support to those affected by suicide.
8. Making suicide everybody's business so that we can maximise our collective impact and support to prevent suicides.

Understanding differences in suicide trends is crucial for developing effective prevention strategies. From 1981, over the following 26 years, there was a general downward trend in suicide rates in England, from 15.6 deaths per 100,000 people in 1981 to 10.6 deaths per 100,000 in 2007 (Office for National Statistics, 2023).

The suicide rate in England has not fallen since 2018, with over 5,000 deaths by suicide in England each year and the suicide rate for males remaining three times higher than that for females. The year 2018 saw an increase in suicide rates, and this has continued steadily, with the most recent data, from 2024, showing the highest population rate for England since 1999 (Office for National Statistics, 2025).

The key points from the 2024 suicide data show:

- There were 6,190 suicides registered in England and Wales in 2024, rate 11.4 deaths per 100,000 people. This is similar rate to 2023 with 11.3 deaths per 100,000 people.
- An increase nationally approx. 400 additional deaths or 7.6% increase
- Highest population rate since 1999 (11.4 per 100,000)
- Increases in both males and females
- Lowest rate in London, 8.3 and highest rate in the Northeast of England at 15.1 deaths per 100,000 people
- This equates to 14.5 deaths per 100,000, up from 12.8 in 2022 for the Northeast and North Cumbria.

It is important to note that suicide rates are based on the year of death registration. Because of registration delays, 39% of deaths registered in 2023 had a date of death in the same year, 51% occurred in 2022 and the remaining deaths occurred in 2021 or earlier (Office for National Statistics, 2023).

Traditionally, any death in England and Wales which is a suspected suicide, must be certified by a coroner. The coroner seeks evidence to record a conclusion; however, it is often difficult to be sure whether a person intended to take their own life. In England and Wales, it is customary to assume that most injuries and poisonings of undetermined intent are cases where the harm was self-inflicted, even if there is insufficient evidence to prove that the deceased deliberately intended to kill themselves (Brock, 2002).

The standard of proof required by coroners to conclude that a death was caused by suicide changed on 26 July 2018 from ‘beyond all reasonable doubt’ to ‘the balance of probabilities’. Since this change, the proportion of deaths in England and Wales with an underlying cause of intentional self-harm has increased, while the proportion coded as undetermined intent has decreased. This indicates a change in the conclusions reached by coroners, but, taken as a whole, does not affect the Office for National Statistics suicide rate, because both categories are included in that measure (Office for National Statistics, 2024). The change in the standard of proof therefore does not explain the increase in the suicide rate.

The Office for National Statistics (2024) reported on sociodemographic inequalities in suicides in England and Wales from 2011 to 2021. This population-level analysis compared the risk of dying by suicide across sociodemographic groups in adults. The main findings included:

- Rates of suicide were higher in men compared with women across all ages, with the highest rates in men aged 40 to 50 years
- For men aged 40 to 50 years, the highest rates of suicide were in disabled people, those who have never worked or are in long-term unemployment or are single (never been married or in a civil partnership).
- For ethnicity, rates of suicide were highest in the White and Mixed/Multiple ethnic groups for both men and women.
- People who reported belonging to any religious group generally had lower rates of suicide, compared with those who reported no religion; however, rates were higher in Buddhists and “Other” religious groups.
- Disabled people had higher rates of dying by suicide than non-disabled people.

4.2 Suicide risk

While death from suicide is still relatively rare, it is a devastating event. There is, of course, no single cause of suicide, and the roots of an individual case will often be difficult to understand. Suicide is influenced by a complex interplay of psychosocial and societal factors. Unemployment, social isolation, and economic hardship are consistently associated with increased suicide risk (Kapur and Goldney, 2019; Stack, 2021; Milner, 2013). A number of

risk factors are known; these include childhood trauma, social isolation, certain mental health issues, bereavement, loss of employment, substance misuse, and deprivation. Furthermore, individual characteristics such as ethnicity, religion, gender, and age may influence risk.

Research on suicide risk in England and Wales reveals complex patterns across different populations. The Suicide Prevention Strategy for England (Department of Health and Social Care, 2023) highlights the increase in suicide and self-harm in young people and the risks for those experiencing domestic violence, gambling and issues related to online safety. People on the margins of society because of poverty, ethnicity, disability or prejudice experience higher rates of suicide.

4.3 Suicide in high-risk populations

Cancer patients face an elevated suicide risk, particularly in the first six months after diagnosis, with the highest risk observed in mesothelioma patients (Henson, 2018). Ethnic variations in suicide rates have been observed, with young Black Caribbean and African men, as well as young women from South Asian, Black Caribbean, and Black African backgrounds, showing higher standardised mortality ratios compared to their White counterparts (Hunt, 2021). However, overall suicide rates were lower for South Asian individuals. These studies emphasise the importance of considering both individual- and area-level factors in suicide prevention strategies, as well as the need for improved psychological support and culturally sensitive interventions (Henson, 2018; Turnbull, 2014; Bhui and McKenzie, 2008).

There are, however, variations in the risk factors, which mean men are almost three times more likely to take their own lives than women, with men aged 40–44 representing the most at-risk group (Pitman et al., 2014).

Moral injury, a psychological conflict arising from violations of one's moral code, has been associated with various negative mental health outcomes in military populations. Moral injury is strongly associated with increased suicide risk among veterans and active-duty military personnel (Ames, 2018; Levi-Belz, 2018; Bryan, 2014). Studies have found significant positive associations between moral injury and mental health issues such as Post Traumatic Stress Disorder (PTSD), depression, anxiety, and substance use (Hall, 2021). Moral injury can manifest as transgressions committed by others, transgressions committed by oneself, and perceived betrayal by others, with self-transgressions being particularly associated with more severe suicidal ideation (Bryan, 2014). The combination of Moral

Injury and Post Traumatic Stress Disorder further elevates suicide risk (Bryan, 2018). Mechanisms connecting Moral Injury to suicidality include entrapment, depression, and reduced meaning in life (Levi-Belz, 2018; Kelley, 2021).

Research indicates a significantly higher prevalence of suicide attempts and ideation among neurodiverse populations in the UK compared to the general population. Autistic individuals are particularly at risk, with evidence of autism found in 10.8-41.4% of suicide cases (Cassidy, 2022). Risk factors include being male, history of self-harm, depression, and comorbid mental disorders (McCarthy, 2019; Peters, 2018). Neurodevelopmental difficulties are associated with increased vulnerability to mental illness and self-harm in prison populations (McCarthy, 2019). Suicide risk is also elevated in individuals with ADHD and eating disorders (Curtis, 2022). Schools are considered an acceptable setting for suicide prevention programs, with a need for early intervention and tailored approaches for neurodiverse individuals (Ashworth, 2024). However, challenges exist in identifying suicidal ideation in autistic individuals due to communication difficulties (Richa, 2014). More research is needed to understand protective factors and develop effective interventions (Zahid, 2017).

Suicide among young people is a significant public health concern, with rates increasing in recent decades, particularly for males (Glenn et al., 2019; Bilsen, 2018). Key risk factors include mental disorders, previous suicide attempts, personality traits, genetic predisposition, family dynamics, and psychosocial stressors (Bilsen, 2018; Beautrais, 2000). Recent research (Hink, 2022) identifies additional factors such as exposure to violence, suicidal behaviours, substance misuse, depression, and post-traumatic stress disorder. Specific injuries, including traumatic brain injury and spinal cord injury, have also emerged as risks for adolescent suicide.

Parental factors such as suicide, mental illness, and socioeconomic adversity also contribute to increased risk (Agerbo, 2002). Calderaro (2021) found offspring exposed to parental suicide had a relative risk of 2.97 for completed suicide and 1.76 for suicide attempts compared to offspring of two living parents. While many suicides are preceded by warning signs, a substantial proportion (30%) occur without explicit indicators (Rodway, 2020). Gender differences exist in risk factors and service contact, with girls more likely to experience certain stressors and engage with specialist services (Rodway, 2020).

4.4 Sociology of suicide

A sociological understanding of suicide began with Durkheim's work on suicide (Durkheim, 1966), which laid the foundation for understanding the role of social integration in health. He challenged the view of suicide as a purely psychological, intimate and individual act, and argued instead that suicide follows the 'patterning' of social factors.

The sociology of suicide has been a significant area of study since Durkheim's seminal work, focusing primarily on explaining differences in suicide rates across populations (Atkinson, 1968; Wray, 2011). Researchers have examined various sociological factors influencing suicide, including gender, marriage, family, unemployment, age, and education. Recent innovations in sociological research on suicide have redirected attention towards ethnoracial subgroups, individual-level phenomena, and age-period-cohort effects (Wray, 2011). Carter et al. (2021) conducted stratified logistic regressions examining suicide attempt prevalence across racial and ethnic groups in a nationally representative sample of 36,309 adults, finding differential patterns by race. Suicide clusters with racially distinct patterns were found in a study of youth aged 5–34 across four racial groups (Platt et al., 2022).

4.5 Sociopolitical influences on suicide

Sociopolitical factors influencing suicide involve a complex and multifaceted interplay of psychosocial and societal influences. Economic factors, including unemployment, economic hardship, and low socioeconomic status, are consistently associated with increased suicide risk (Stack, 2021; Kapur and Goldney, 2019; Milner, 2013). Social institutions such as marriage and parenting can be protective, although their effects may be gendered (Stack, 2021). Cultural attitudes, including approval of suicide and traditional male roles, also significantly affect suicide rates (Stack, 2021). Media reporting and access to means contribute to suicide risk (Kapur and Goldney, 2019). Religious beliefs may be protective or permissive, depending on the stance of the faith tradition (Beneshi, 2017), but are generally considered protective against suicide (Norko, 2017). Other influential factors include social isolation, family issues, academic failure, and relationship problems (Yousuf et al., 2023). Rapid economic development and rural–urban migration has been associated with increased suicide risk in some Asian countries (Pirkis et al., 2008). Political factors, such as social welfare policies and firearm restrictions, can also affect suicide rates (Stack, 2021).

The impact of sociodemographic risk factors can be moderated by their prevalence within the population (Crawford, 2009). For adolescents, school problems, a family history of suicidal

behaviour, poor parent–child communication, and stressful life events are significant risk factors (Radde et al., 2018). Historically, conceptualisations of suicide have evolved alongside societal change, emphasising the importance of considering socioeconomic contexts in suicide prevention strategies (Solano et al., 2017). Understanding these sociopolitical factors is crucial to the development of effective suicide prevention strategies.

As noted, the evidence suggests that periods of high unemployment or severe economic difficulty adversely affect population mental health and are associated with higher suicide rates. The global financial crisis of 2008 led to a rise in suicide rates in many countries, including England, and the more recent cost-of-living crisis is also expected to have a negative impact on suicide rates. A number of studies have demonstrated an association between the areas of England most affected by health inequalities, including unemployment during the financial crisis, and increased suicide rates (Department of Health, 2015). The most recent ecological population-based study in England on socio-environmental determinants of suicide, covering 2002–2022 (Gascoigne et al., 2025), found no evidence of a decline in suicide rates in England over the last 20 years and identified community profiles characterised by greater deprivation, isolation, and access to road and rail networks as those at highest risk.

The 2008 financial crisis and subsequent austerity measures led to increased health inequalities in Europe, particularly affecting mental health and suicide rates (De Vogli, 2014; Barr, 2015). Unemployment was strongly associated with declining self-rated health and increased suicide risk, especially in countries with less generous unemployment protection (Nelson and Tøge, 2017; Norström and Grönqvist, 2014). The crisis disproportionately impacted vulnerable populations, widening health inequalities based on education level and employment status (Barr, 2015; Van der Wel et al., 2018). In England, regions with the largest unemployment increases experienced the greatest rises in suicide rates, particularly among men (Gascoigne et al., 2025). While overall mortality remained stable, suicide rates increased in several European countries (Baumbach, 2014; Georgievski, 2016).

Social policies and strong social protections were found to mitigate the negative health effects of economic downturns (Norström, 2014; Van der Wel, 2018). Social factors also play a role, with social fragmentation associated with increased suicide risk even after controlling for individual-level factors (Turnbull, 2014; Congdon, 2012).

4.6 Physiological factors influencing risk of suicide

Suicidal behaviour may occur proximate to negative life events or stressors (Liu, 2014), although individuals will each feel the stimulus of such events differently and so be at different risk of suicide. There are a number of models that attempt to describe the physiological factors influencing this risk, with dysregulation of the hypothalamic-pituitary-adrenal (HPA) axis playing a central role (O'Connor, 2019; Berardelli, 2020). Neuroinflammation and increased inflammatory markers are associated with suicidal behaviour (Bengoechea-Fortes, 2023; Wiebenga et al., 2022). Serotonergic dysfunction, particularly low cerebrospinal fluid levels of 5-hydroxyindoleacetic acid, correlates with violent and impulsive suicidal behaviour (Mann, 1997; Moberg, 2011). Genetic and early life experiences also contribute to suicide risk (Van Heeringen et al., 2014), with adverse childhood experiences, particularly sexual abuse, emotional abuse/neglect, and disrupted attachment, associated with higher suicide risk (Brodsky, 2016). Understanding these physiological mechanisms may lead to improved suicide risk prediction and targeted interventions (Berardelli, 2020; Wisłowska-Stanek et al., 2021).

4.7 Social networks and community

The concept of social networks to explain the behaviour of individuals or groups emerged as British anthropologists (Bott, 1957) found it increasingly challenging to understand behaviours based on traditional categories such as class and residential groups. Social networks provided a way to view the structural properties of relationships among people without the limitations of bounded groups. A group of American sociologists further developed the concept to consider the structure and function of networks from the perspective of the individual, using an egocentric network approach to social network analysis (Cohen, 1985; Perry et al., 2018). Considering this work in relation to suicide would build on the assumption that the social structure of the network is largely responsible for individual behaviour, attitudes, along with constraints and opportunities to access resources and support.

What constitutes a 'community' and the structure of social networks was observed by Bott (2007) who suggested that the structure of community may not conform to preconceived ideas based on geography or kinship, but that the essence of community is its social structure, not its spatial structure (Wellman, 1988). This research considers community in terms of its social structure based on the participants' perception of community.

4.8 Protective factors and suicide prevention

Recent research on socio-political issues related to suicide highlights the complex interplay of factors influencing suicide rates. Political policies, such as increased social welfare expenditures and minimum wage laws, can lower suicide rates (Stack, 2021). Social institutions like marriage and religiousness generally serve as protective factors (Stack, 2021). Cultural definitions of gender roles and societal approval of suicide also impact suicide rates (Stack, 2021). Economic factors, including unemployment and low socioeconomic status, are strong predictors of suicide (Stack, 2021). Sociological perspectives emphasise the influence of social factors like gender, family, and education on suicide (Maloku and Maloku, 2020). Some researchers argue for a social justice approach to suicide, examining issues of inequality and oppression (Marsh, 2019). Others highlight the need to address social attitudes and perceptions of suicide as a solution to problems (Pridmore et al., 2016). Methodological challenges in suicide research include measurement issues and the need for cross-national studies (Stack, 1987).

Protective factors include marriage, parenting, and religiousness, although their effects may be gender-dependent (Stack, 2021). Cultural attitudes, media reporting, and access to means also contribute to suicide risk (Kapur and Goldney, 2019; Stack, 2021). There is evidence that increased personal resilience and coping skills may reduce risk for those bereaved by suicide. Social support consistently emerges as a crucial protective factor and is associated with a decreased likelihood of suicide attempts (Darvishi, 2024). Other protective factors include positive coping skills, life satisfaction, resilience, and purpose in life (Montross, 2005; Ki, 2024). Access to mental health services, religious beliefs, and restricted access to lethal means are also identified as protective (Sher, 2006; McClatchey et al., 2019). Network analysis suggests that interventions targeting depression may be particularly beneficial in reducing suicide risk (Holman and Williams, 2022).

Potential protective factors can include:

- Strong reasons for living
- Physical activity and health
- Family connectedness
- Social support networks
- Supportive schools

- Satisfactory employment

The impact of suicide bereavement can trigger a wide range of mental and physical health issues, including:

- Feelings of overwhelming guilt, confusion, rejection, shame and anger
- Stigma and isolation, which can lead to social exclusion
- Complicated grief or persistent complex bereavement disorder (i.e. when grief severely disrupts someone's ability to carry out normal activities beyond six months of bereavement)
- A depressive episode or post-traumatic stress disorder
- Increased ill health, including complications to existing health problems

Those bereaved or affected by suicide are known to be at higher risk of suicide, mental health problems, and emotional distress (McDonnell, 2022). Research on suicide survivors' difficult emotional experiences is well established and continues to grow, confirming that bereavement after suicide extends far beyond the death itself (McDonnell, 2022; Young, 2012).

Protective factors that may moderate the relationship between moral injury and suicidality include mindfulness, social connectedness, and self-compassion (Kelley, 2019). Understanding the impact of moral injury on suicide risk, separate from PTSD, is crucial for developing effective prevention strategies in military and veteran populations (Bartlett, 2023). Notably, religiosity does not appear to moderate the relationship between moral injury and suicide risk (Ames, 2018).

Suicide prevention strategies for children and young people should focus on early recognition and treatment of mental illness, multi-agency approaches, and addressing socioeconomic factors (Hughes, 2023; Steele, 2007). Continued monitoring of suicide rates and risk factors is crucial for effective prevention efforts. Helplines play a crucial role in suicide prevention for young people (WilColins, 2022). General practitioners face challenges in assessing and managing suicide risk in youth, highlighting the need for specialised training (Michail, 2016). Effective prevention strategies should involve a multi-agency approach, incorporating education, social care, health services, and the third sector (Rodway, 2020; Hughes, 2023).

4.9 Exposure to suicide

Suicide is often the end point of a complex interplay of biological and psychological factors (Department of Health, 2012). Its impact is far-reaching, affecting the close friends and family members of the deceased, who are left vulnerable to long-term psychological morbidity (Omerov et al., 2013) and increased risk of suicide (Pitman et al., 2014) themselves. Suicide can also have a profound effect on the local community. We know from studies of those in suicidal crisis that, in addition to immediate family and friends, many others will be affected in some way (Owens et al., 2011; Cerel et al., 2019). They include neighbours, school friends and work colleagues, but also people whose work brings them into contact with suicide – emergency and rescue workers, healthcare professionals, teachers, the police, faith leaders and witnesses to the incident.

Research indicates that exposure to suicide is prevalent, with lifetime exposure rates ranging from 21.83% to 58% in population studies (Andriessen, 2017; Maple, 2019). Exposure to suicide is associated with increased risk of depression, anxiety, PTSD, and suicidal ideation (Cerel, 2016). The impact of exposure varies, with some individuals experiencing increased suicidality while others become more averse to suicide (Miklin, 2019). Closeness to the deceased is a significant factor in determining the severity of psychological outcomes (Cerel, 2016). The long-term effects of exposure can persist for years, particularly for depression, anxiety, and PTSD (Levi-Belz, 2022). These findings highlight the need for targeted interventions and support for those exposed to suicide (Maple, 2019).

4.10 Suicide survivors

Research estimates that between six and 135 ‘survivors’ are directly affected by any one suicide, meaning that in the UK a minimum of around 36,000 people per year are exposed to suicide and may become ‘suicide survivors’ at risk of psychological harm (Jordan, 2011; Hawton, 2003; Cerel, 2019). Preventative interventions are therefore key in supporting those bereaved by suicide who may be at increased risk of taking their own lives and may also help prevent the development of suicide clusters (Cox, 2012).

Previous studies have identified suicide survivors as a high-risk group for suicide themselves and for mental and emotional distress (Knapp, McDaid and Parsonage, 2011). Research is limited on the perceived needs of those bereaved by suicide, and what is available consistently highlights a significant gap between the need for support and the provision of quality services (Wilson and Marshall, 2010; Dyregrov, 2011). Common themes include the

importance of peer and social support, the need for professional help tailored to individual needs, and the value of group support (Pitman et al., 2018). Barriers to accessing support include stigma, triage processes, and lack of awareness among healthcare providers (Peters et al., 2016). Studies emphasise the need for proactive offers of support, improved training for service providers, and culturally sensitive approaches (Dyregrov, 2011; Provini, Everett and Pfeffer, 2000). The findings from research underscore the importance of understanding the experience of those bereaved by suicide, sustained community outreach, and tailored interventions for the suicide-bereaved population.

Available studies consistently highlight the importance of social and peer support for those bereaved by suicide (Jordan, 2011; Brock, 2003; Qin, 2002).

There is growing evidence of a link between suicide bereavement and mental health problems, including increased risk of suicide (Diekstra, 1989). There is now also mounting evidence that both individuals and communities could benefit from support following a death by suicide. When compared with people bereaved through other causes, those bereaved by suicide are at an increased risk of suicide, psychiatric admission, and depression (Pitman et al., 2014), as well as poor social functioning (Pitman et al., 2016). Providing support for people bereaved by suicide has been a key objective of the suicide prevention strategy for England since the first national strategy in 2012 and the more recent Department of Health and Social Care *Suicide prevention in England: 5-year cross-sector strategy*, launched in 2023 (Department of Health and Social Care, 2023).

The wide-reaching impact of each suicide means that being bereaved or affected by suicide is not an uncommon experience. The England Suicide Prevention Strategy 2023 states that over 5,000 people die by suicide each year, and, using an estimate that 10 people are bereaved or affected by each death, this gives an annual total of around 50,000 people who may benefit from support after suicide. Those who may benefit include close family members, who are the most vulnerable group, but there are also clear risks for wider family, friends, colleagues, and the wider community, including those who discover the deceased.

The *From Grief to Hope* report (McDonnell, 2022) was influential in shaping the priorities of the England Suicide Prevention Strategy and in establishing people bereaved by suicide as a priority group for intervention.

Because of the significant number of people who may be affected following someone taking their own life, consideration should be given to the potential for suicide contagion, particularly in young people (de Leo and Heller, 2008). Support after suicide should be

available to people throughout the individual's social network, as well as to health professionals affected by suicide (Pitman et al., 2016; McDonnell et al., 2022).
Given the number of people who might potentially be affected by any adverse effects of suicide bereavement, it is important to be precise about the associated risks, particularly those relating to suicidal behaviour, and the interventions appropriate to mitigate such risks (Pitman et al., 2016; Andriessen et al., 2019).
Approximately 51% of adults have been exposed to suicide in their lifetime, with 35% experiencing moderate to severe emotional distress (Feigelman et al., 2018). Suicide survivors may face unique challenges, including stigma, isolation, and difficulties in accessing support (Peters et al., 2016; Pitman et al., 2017). They often struggle with finding explanations for the death and may be at increased risk of mental health issues and suicidal behaviour themselves (Pompili et al., 2013; Galway et al., 2017). The bereavement process can be complicated by societal attitudes and a lack of understanding from others. These findings highlight the need for improved support services, education, and awareness to address the widespread impact of suicide bereavement on individuals and communities (Hawton et al., 2003; Pompili et al., 2013).

4.11 Postvention

This term was first coined by Shneidman (1968) at the first conference of the American Association of Suicidology. He used it in contrast to *pre*vention to describe the actions taken after a suicide to support suicide survivors. The American Association of Suicidology (1988) defines suicide postvention as 'the provision of crisis intervention, support and assistance for those affected by a completed suicide'.

The aftermath of death by suicide can be particularly devastating for those left behind and may place survivors at increased risk of physical illness, depression, anxiety, substance misuse, family disruption, work disruption, and further suicide.

While not all those bereaved or affected by suicide will feel they need support, research suggests that among people bereaved by suicide who wanted support, one in five received no support at all or felt they did not need support. Multiple interconnected barriers prevent those bereaved by suicide from accessing desired support, including systematic gaps, information deficits, and psychological obstacles (Gelezelyte et al., 2020; Harrop et al., 2021).

Among those who self-harm in the aftermath of being bereaved by suicide, three-quarters seek no help for this (Pitman et al., 2017). The stigma of suicide is a known barrier to bereaved family members seeking help and to others offering support (Ratnarajah and Schofield, 2011; Sheehan et al., 2018; Evans and Abrahamson, 2020).

There has been growing recognition of the psychological harm that suicide can cause for those left behind, and of the need for effective postvention support. Survivors of suicide have an elevated risk of suicide and are susceptible to psychiatric morbidity and social alienation (Bellini et al., 2018). Evidence suggests that a multi-agency approach to suicide postvention is beneficial, with voluntary sector organisations founded by people who are themselves bereaved by suicide playing a key role in any postvention strategy (McDonnell et al., 2022). There is still very little evidence on the effectiveness of postvention support in preventing future suicides, and although some studies have shown a small positive effect, more robust research is needed in this area (Andriessen, 2009).

4.12 Reducing stigma and social attitudes that stop people accessing support

Research indicates that suicide survivors experience significant stigma, which can complicate the bereavement process and lead to negative psychological outcomes. Although stigma towards mental illness has decreased in recent decades, stigma associated with suicide remains persistent (Sudak et al., 2008). Some studies do, however, suggest a reduction in suicide stigma over time (Witte, Smith and Joiner, 2010). Suicide survivors experience stigma in the form of shame, blame, and avoidance, which can lead to concealment, social withdrawal, and difficulties in grieving (Hanschmidt et al., 2016; Kučukalić and Kučukalić, 2017). This stigma is associated with higher levels of psychological distress, depression, and suicidal thoughts (Feigelman, Gorman and Jordan, 2009; Scocco et al., 2017). Compared with those bereaved by natural causes of death, suicide survivors often face greater stigmatisation and greater difficulty in grieving (Feigelman, Gorman and Jordan, 2009; Hanschmidt et al., 2016). The stigma also extends to families of those who die by suicide and can act as a barrier to help-seeking (Carpiniello and Pinna, 2017).

4.13 Navigating the grief experience of suicide loss

Research on bereavement by suicide highlights the unique challenges faced by those who have lost loved ones in this way. Survivors often experience complex emotions, including shame, stigma, and self-blame (Shields, 2017). The grieving process often involves a search

for meaning and purposefulness (Shields, 2017). Support needs also change over time, with many survivors experiencing difficulties in navigating services and social isolation (Peters et al., 2019). The internet has transformed the bereavement experience by offering new avenues for support and memorialisation (Lestienne et al., 2021). However, responses from agencies and communities are often perceived as insensitive or unhelpful (Peters et al., 2016). Proactive offers of support throughout social networks are therefore crucial, as needs may remain hidden (Pitman et al., 2018). For older adults, bereavement by suicide can significantly affect the experience of ageing (Hafford-Letchfield et al., 2022). Overall, these studies emphasise the importance of tailored and sensitive support for those bereaved by suicide.

4.13.1 The experience of suicide survivors

Suicide survivors, defined here as those who have lost a loved one to suicide, often face a complex and challenging emotional journey. Their experiences are characterised by several key features.

Overwhelming emotions

Survivors of suicide often grapple with intense and varied emotions. They may experience shame, stigma, and self-blame, which are particularly characteristic of suicide bereavement. The early months following the loss are often marked by attempts to “control the impact of the death” (Begley, 2007, Dransart, 2018), indicating the overwhelming nature of their grief.

Quest for understanding

A dominant theme in the grief experience of suicide survivors is the overwhelming need to “make sense of the death” (Dransart, 2018). This process of meaning-making is crucial for survivors as they struggle to understand their loved one's decision (Sands, 2010; Shields, 2016). The journey to find meaning can be described as “a never-ending quest”, suggesting that this aspect of grief may persist long after the loss.

Social challenges

Suicide survivors often face significant social challenges (Peters, 2016). Many experience “social uneasiness” and may feel isolated or rejected by friends and community. They might perceive that “people look down on you when you tell them how he died”, leading to feelings of being blamed, shamed, and judged (Evans, 2020).

Stigma

The stigma associated with suicide can lead to survivors feeling silenced (Peters, 2016). This silencing can complicate the grieving process, as survivors are denied the opportunity to tell their stories. The experience of stigma can have detrimental effects on their relationships and help-seeking behaviours (Hanschmidt, 2016).

Transformation and growth

Despite the challenges, many suicide survivors eventually experience a sense of "purposefulness" in their lives following the death (Dransart, 2018). This suggests that while the grief process is difficult, it can lead to personal growth and transformation. Some survivors find sanctuary in support groups, which can play a crucial role in the meaning-making process (Sands, 2010; Shields, 2016).

Unique aspects of suicide bereavement

Suicide bereavement is often considered unique in its impact. The guilt experienced by survivors is particularly intense, and it's argued that no other type of death is likely to bestow this negative emotion on survivors to the same degree (Bell, 2012). Research to date notes that the experience of suicide survivors is complex and multifaceted, involving intense emotions, a search for meaning, social challenges, and potential for personal growth. Understanding these experiences is crucial for providing appropriate support and interventions for those bereaved by suicide (Peters, 2012).

4.13.2 Bereavement process following suicide

The question of whether suicide bereavement differs from other forms of bereavement has been the subject of substantial research and debate. The evidence suggests that, although there are similarities, suicide bereavement does have some distinct characteristics.

A recurring theme in the suicide-bereavement literature is that survivors' experiences may diverge from other bereavements along (at least) three intersecting domains: (1) the thematic content of grief (e.g., shame, rejection, responsibility, explanatory searching), (2) social processes (e.g., stigma, concealment, withdrawal, altered support), and (3) family-level dynamics (e.g., avoidance or ambivalence within the family system) (Feigelman, Gorman and Jordan, 2009; Bartik et al., 2013; Westerlund et al., 2020). Empirical work simultaneously highlights that many observed "suicide-specific" patterns may overlap with bereavement after

other traumatic, sudden, or stigmatised deaths, making distinctiveness partly contingent on the chosen comparison group and measured outcomes.

Survivors often experience feelings of shame, guilt, and blame, coupled with a heightened search for meaning (Shields, 2017; Hanschmidt et al., 2016). Social stigma and reduced support can further complicate the grieving process (Flynn and Robinson, 2009; Hanschmidt et al., 2016).

Support groups and professional interventions tailored to suicide survivors may be beneficial, although more research is needed to evaluate their effectiveness (Andriessen, 2019). Understanding the distinct nature of suicide bereavement is crucial to providing appropriate care and improving outcomes for survivors (Andriessen, 2019).

Several studies highlight unique aspects of suicide bereavement including the emotional and psychological impact. Suicide survivors often experience more intense grief reactions compared to those bereaved by other causes (Pitman et al., 2016). They may encounter a range of difficult feelings, including blame, guilt, and emptiness (Shields, 2017). Survivors of suicide also report greater feelings of shame compared to those bereaved by accidents (Pitman et al., 2016).

4.13.3 Family impact

Suicide bereavement appears to occur more frequently in vulnerable families. There is also evidence of a greater history of loss among parents bereaved by suicide (Séguin, 1995), suggesting a potential compounding effect of multiple losses.

4.13.4 Thematic content of grief

Comparative longitudinal evidence suggests that some grief reactions are not merely higher in magnitude but are meaningfully patterned around suicide-relevant themes such as rejection, stigmatisation, shame, responsibility, and explanatory searching (Kõlves et al., 2020). In a prospective cohort comparing suicide bereavement with other sudden deaths across 6–24 months, significant group differences were observed over time in rejection, stigmatisation, shame, and responsibility after adjustment for confounding factors (Kõlves et al., 2020). At specific time points, the suicide-bereaved group showed significantly higher

“search for explanation” early in bereavement, alongside elevated shame and somatic reactions at selected assessments.

Cross-sectional and qualitative evidence reinforces the centrality of “why” questions, self-blame, and guilt-related meaning-making efforts, while also warning that generic grief or mental-health measures may fail to capture these thematic distinctions (Feigelman, Gorman and Jordan, 2009). This study speculated that the greater number of prior suicide attempts by the deceased may increase survivors’ guilt and perceived blameworthiness, illustrating how suicide-specific contextual knowledge can shape the content of grief even when broad symptom levels resemble other traumatic losses (Feigelman, Gorman and Jordan, 2009).

Suicide loss is repeatedly described as involving shame about the cause of death, guilt about perceived preventability, blame directed towards the self and others, and feelings of abandonment or rejection by the deceased. Collectively, these form a thematic profile that may be distinct from many non-suicide losses (Hanschmidt et al., 2016).

Understanding these distinctive aspects of suicide bereavement is crucial to the development of appropriate intervention. Implications for postvention and clinical care follow most directly from evidence that suicide bereavement often involves heightened stigma-related experiences, and that interpersonal processes such as disclosure and social support predict complicated grief and depression over time (Hanschmidt et al., 2016). Because stigma may pose a barrier to professional help-seeking, postvention pathways should actively address the concealment and avoidance behaviours associated with it.

Longitudinal evidence that social support and self-disclosure predict lower complicated grief and depression up to six years later implies that interventions may reasonably prioritise facilitated disclosure and support-building as protective mechanisms rather than relying solely on symptom-focused approaches (Levi-Belz, 2023).

Service-planning implications are also evident in large descriptive surveys indicating substantial self-reported need and significant gaps in provision (McDonnell, 2022). In a large UK survey, 40% of participants accessed at least one support service after the death, while local suicide-bereavement provision was viewed as inadequate by 62% of respondents, indicating unmet need at scale.

4.13.5 Social context and support

The bereavement process following suicide takes place within a challenging social context. Both the bereaved and the wider community may struggle to interact in helpful ways (Shields, 2017).

Suicide survivors experience stigma in the form of shame, blame, and social avoidance (Hanschmidt et al., 2016), and this stigma has tangible functional consequences. Peters et al. (2016), in interviews with ten bereaved individuals, identified four recurring themes: feeling blamed and shamed, feeling isolated and rejected, feeling silenced, and feeling burdened by the discomfort of others. Crucially, the study found that stigma deterred help-seeking by denying survivors the opportunity to tell their stories, thereby directly complicating the grieving process.

Feigelman (2024), in an online survey, found that newly bereaved survivors often self-impose isolation, partly to protect themselves from stigmatisation and partly as a form of self-care. This suggests that low levels of observed social support may arise not only from rejection by others, but also from active withdrawal by survivors.

A Korean study by Ahn et al. (2026), drawing on nine years of counselling records, found that children and adolescents tended to experience shame-driven social withdrawal, whereas adults experienced deteriorating economic and health conditions layered onto emotional isolation. This indicates that the social context of bereavement varies substantially according to age and structural position.

4.14 Suicide clusters

In March 2026, the UK Government released updated guidance describing a cluster as ‘a group of deaths, suicide-related activity or self-harm that are linked in some way by time, death, method, location, geography or demography’.

Suicide clusters, although rare, are a significant concern, particularly among adolescents and young adults (Haw, 2013; Hazell, 1993). These clusters can occur in a range of settings, including schools, psychiatric hospitals, and rural communities (Niedzwiedz, 2014; Davies, 1993). Risk factors include male gender, substance misuse, past self-harm, depression, poor

social functioning, previous trauma, and social contagion through peer networks and electronic communication channels, including social media and memorial pages (Hawton, 2013; Robertson et al., 2012).

Evidence-based approaches to cluster management combine crisis intervention, public health responses, and epidemiological investigation. Specific interventions include psychological debriefing, community-based trauma response teams (Hacker, 2008), and coordinated action strategies at universal and community levels (Lai, 2020).

Statistical analysis combined with case studies is recommended for investigating clusters (Niedzwiedz, 2014).

Prevention strategies include identifying at-risk youth, developing youth programs, and implementing media guidelines for reporting suicides (Fowler, 2013). However, more rigorous research is needed to better understand and prevent suicide clusters (Hawton, 2013).

Research has shown that suicide clusters, both mass clusters (media-related) and point clusters (local phenomena), can arise as a result of contagion (Joiner, 1999). However, the underlying mechanisms are not fully understood and may involve complex interactions between individual, relational, and social factors (Martínez, 2023).

4.16 Suicide autopsy

Suicide autopsy can be examined through both sociological and psychological lenses.

4.16.1 Psychological autopsy

The work pioneered by Edwin S. Shneidman has been particularly influential in the development of the psychological autopsy (Leenaars, 2010) and remains valuable for understanding suicide risk factors and prevention (Shneidman, 2018; Abondo, 2008). Shneidman (1993) introduced the concept of ‘psychache’, or unbearable psychological pain, as a central factor in suicide. His work can be categorised into theoretical, clinical, and administrative dimensions, including the analysis of suicide notes and post-intervention strategies (Leenaars, 2010).

Psychological autopsy is described as a crucial method for investigating completed suicides and for providing insights into the factors leading to self-destructive behaviour (Khan, 2005; Brent, 1989). The approach involves reconstructing the events preceding death through interviews with family members, friends, and professionals, alongside examination of medical records (Shneidman, 2018; Cavanagh, 2003). Studies using psychological autopsy have shown that psychiatric disorders, particularly depression, together with stressful life events, are significant contributors to suicide (Conwell, 1991; Khan, 2005). Research consistently indicates that mental disorders are strongly associated with suicide, with a median proportion of 91% in case series and 90% in case-control studies (Cavanagh, 2003). Although psychological autopsy has limitations, including potential recall bias, it remains one of the most effective techniques for examining the relationship between specific antecedents and suicide (Sher, 2013). Sher suggests that future research should focus on high-risk groups and continue to evolve as patterns of suicide change over time.

Psychological autopsy remains an important method in suicide research, providing comprehensive information about the deceased's life, personality, and the circumstances leading to death (Murthy, 2010; Khan, 2005). Studies emphasise the complex interplay of factors contributing to suicide, including gender, life stage, mental health, and social relationships. Although psychological autopsy has proved valuable in understanding suicide, its implementation faces challenges in some countries because of administrative, ethical, and cost-related constraints (Abondo, 2008).

Sociological perspectives on suicide have evolved since Durkheim's foundational work, which emphasised social integration and regulation (Durkheim, n.d.). Durkheim's sociological theory of suicide and its contemporary applications are discussed by Fincham et al. (2011), who introduced the concept of the 'sociological autopsy' to examine individual suicide cases qualitatively. Several studies have tested and extended Durkheim's model, with Wenz (1976) finding support for social integration within social areas, Recker and Moore (2015) applying social capital theory to US county suicide rates, and Cetin (2016) combining Durkheim's approach with ethnography to study suicides in a transnational community. Abrutyn (2018) further elaborates on Durkheim's typology by incorporating socio-emotional factors.

The enduring relevance of Durkheim's work provides an important foundation for continued efforts to understand the social roots of suicide. However, as Manning (2013) notes, it is not

without limitations when applied to the modern world. Mueller et al. (2021) review more recent sociological theories of suicide in order to examine how the external social world shapes individual psychological pain and suffering, and to bridge the divide between sociological and psychological explanations of suicide by identifying those limitations.

- Methodological Limitations: Durkheim's approach fails to adequately address the ecological fallacy of studying suicide rates to understand individual behaviour. He argued that societal-level forces caused individual-level behaviour, but the link between these levels is challenging to document empirically.
- Neglect of Psychological and Cultural Factors: Due to the intellectual climate of his time, Durkheim worked to distinguish sociology from psychology and anthropology. As a result, he could not incorporate social psychological or cultural ideas into his theory. This limited his ability to explain how macro-level social forces translate into individual psychological pain and suicidal behaviour.
- Oversimplification of Social Integration: While Durkheim emphasised the protective role of social integration, recent research suggests a more complex relationship. Too much integration can also lead to suicide in certain contexts, a phenomenon Durkheim termed “altruistic suicide” but did not fully explore.
- Lack of Attention to Power and Inequality: Durkheim's theory does not adequately address how structural inequality, colonisation, and intersecting systems of oppression, privilege, and power shape vulnerability to suicide. This is a significant limitation in understanding suicide in diverse modern societies.
- Limited Focus on Individual Factors: Durkheim's approach falls short in explaining why a particular person dies by suicide and the mechanisms through which external social forces generate psychological pain leading to suicidality.
- Neglect of Cultural Meanings: Durkheim's theory does not account for the role of cultural meanings in understanding and explaining variations in suicidality across time, space, and groups of people. This has been a point of criticism since the 1960s.
- Overemphasis on Societal-Level Analysis: While Durkheim's focus on societal-level factors was innovative, it neglected the importance of meso-level social environments like communities, schools, and workplaces in shaping suicide risk.
- Limited Applicability to Modern Organisational Contexts: Durkheim's theory does not address the role of formal organisations in suicide risk and prevention, which is a

significant limitation given that suicide prevention often takes place within organisational contexts in the modern world.

These limitations highlight the need for more comprehensive, multi-level approaches to understanding and preventing suicide in contemporary societies. Modern sociological theories have built upon Durkheim's foundation while addressing many of these limitations, incorporating insights from social network theories, cultural sociology, and sociological social psychology.

Researchers have challenged aspects of Durkheim's work, including his treatment of altruistic suicide (Stack, 2004) and his emphasis on the protective nature of social integration (Kushner, 2005). Recent studies have extended Durkheim's approach by incorporating socio-emotional factors (Abrutyn, 2018) and by examining the roles of social networks, culture, and emotion in suicide (Mueller, 2021). Critics have also highlighted methodological difficulties in applying Durkheim's concepts to modern phenomena such as suicide terrorism (Zevallos, 2006) and have questioned the reliability of official suicide statistics (Douglas, 1968). Some scholars therefore argue for a more nuanced understanding of individual motives and social meanings in suicide (Douglas, 1968; Mucchielli, 1998). Despite these limitations, Durkheim's work remains influential, and sociological approaches to suicide continue to be refined and expanded (Wray, 2011).

4.16.2 Sociological autopsy

The 'sociological autopsy' method has been used to examine the immediate social context of individual suicides, moving beyond the traditional focus on aggregate rates (Manning, 2013; Tosini, 2013). Recent research has expanded this framework by incorporating social capital theory, cultural sociology, and social psychology in order to better understand the social roots of suicide (Mueller et al., 2021). Studies have found that higher levels of social capital and diversity are associated with lower suicide rates, whereas factors such as divorce and unemployment are associated with higher rates (Recker and Moore, 2015).

Studies have highlighted the importance of gender and the gendered nature of suicide, life course stages and social bonds in understanding suicide, particularly intimate relationships (Fincham, 2011; Fitzpatrick, 2021). Research in diverse settings, from urban slums to rural areas, has revealed the influence of sociocultural factors, including tension, problem drinking, and marital issues (Fitzpatrick, 2021). This sociological approach reveals how specific social conditions, such as job loss or relationship conflicts, contribute to suicidal behaviour. The

findings from sociological autopsy studies have potential implications for suicide prevention strategies (Fincham, 2011). By integrating diverse sociological perspectives, effective suicide prevention strategies can be developed to address rising suicide rates (Mueller, 2021) and offer valuable insights for suicide prevention and mental health promotion.

Overall, these studies demonstrate the value of combining quantitative and qualitative methods to gain a comprehensive understanding of suicide from a sociological perspective. They emphasise the importance of social integration, moral regulation, and contextual factors in understanding suicide (Hossen, 2022).

A review of the literature on the social concepts that influence suicide identifies more than 170 such concepts, including many of the factors outlined above. The complex interplay between these factors, and the ways in which they shape suicidal behaviour, is explored further in this research. For the Northeast and North Cumbria population, a sociological autopsy approach was adopted, and the findings from these data are analysed and discussed in the subsequent chapters.

Chapter 5: Methodology

5.1 Ontological and epistemological positioning

This chapter discusses the ontological and epistemological underpinnings of the research, which are located within a constructivist interpretive paradigm. The rationale for selecting an interpretivist approach as most suitable for this exploratory inquiry is set out. The chapter also discusses the theoretical foundation of the study, which lies in symbolic interactionism. The second part of the chapter details the grounded theory methodology used in this study, including how the data were gathered and analysed.

5.2 Interpretivist paradigm and rationale

This is a qualitative study of suicide and the experience of suicide survivors. It uses evidence about both the social context of suicide and individual suicides to develop understanding. The use of secondary suicide-audit data complements the in-depth interviews with suicide survivors and extends the sociological autopsy approach in order to:

- Identify the social context that influences suicide

- Understand the experience of suicide survivors as a high-risk population of suicide
- Examine the immediate social context of individual suicides
- Understand the experience of those bereaved or affected by suicide
- Understand the role communities play in support and the relationship with suicide survivors and suicide clusters
- Use a qualitative narrative to identify the factors in which suicide survivors reconstruct their lives, or not

5.3 Theoretical foundation of the study

The aim of the inquiry was to explore the experiences of those bereaved or affected by suicide and the role communities play in providing support, drawing on participants lived experience. The exploratory nature of the study called for a qualitative methodology and an interpretive framework.

Symbolic interactionism is a major sociological theoretical perspective and framework that relies on social interaction to construct meaning, self, and society (Belgrave, 2018). The reality constructed through social interaction focuses on how people respond to their environment and then act according to their interpretation of the world (Charmaz, 2006). This research describes the experiences of those bereaved or affected by suicide using grounded theory methods, with the study's theoretical foundation drawn from symbolic interactionism.

Suicide can also have a profound effect on the local community. We know from studies of those in suicidal crisis that in addition to immediate family and friends, many others will be affected in some way (Owens et al., 2011). They include neighbours, school friends and work colleagues, but also people whose work brings them into contact with suicide – emergency and rescue workers, healthcare professionals, teachers, the police, faith leaders and witnesses to the incident.

Those bereaved or affected by suicide are a key priority group within national and local suicide prevention strategies. The Northeast of England has a significantly higher suicide rate than the rest of England. By English region, the highest age-standardised mortality rate was in the Northeast (14.1 deaths per 100,000 people), and this was the case in six of the preceding ten years. The Northeast had statistically significantly higher suicide rates than the overall England rate of 10.5 per 100,000.

An initial review of support services for those bereaved by suicide suggested that many suicide survivors did not access commissioned support in the first instance, with many doing so only some time after the death or not at all. The early literature review also identified a lack of high-quality research on effective ways to support those bereaved or affected by suicide and on the role communities play. The evidence generated by this study will therefore support both local and national suicide prevention strategy.

I conducted an initial-stage literature review of studies investigating the experiences of those bereaved by suicide. Much national and international research on suicide and suicide bereavement has focused on quantitative measures of suicide, which may fail to identify many of the circumstances experienced by family members bereaved by suicide or to capture the unique experience of personal loss. Quantitative methods are not sufficiently sensitive to identify the detail of people's experiences of bereavement. This limited literature therefore directed the study towards understanding how people experience suicide bereavement and how they are affected by suicide.

On reading the methodological literature, it became clear that the study would be underpinned by the principle that the data generated would grow and develop from participants' accounts. The study would examine emerging concepts and themes through an iterative process until a point of saturation was reached; accordingly, the study would be driven very much by the data.

5.4 Constructivist grounded theory methodology

The research methodology was designed around the principles of grounded theory as an approach that examines people's experiences using as many relevant data sources as possible in order to develop a more objective understanding of the subject of the study. The research will inform public health practice, and any resulting theory will be grounded in the data generated from people bereaved or affected by suicide.

Grounded theory methodology was introduced by Glaser and Strauss in 1967 (Glaser and Strauss, 2009) and is described as an inductive methodology with roots in sociology. The approach is based on the philosophical belief that theory can be discovered by examining concepts grounded in data from the perspective of participants who have experienced the phenomenon under study. This contrasts with deductive analysis, in which an existing theory is tested. Starks (2007) explains that it is interaction with others in social processes that

shapes the meanings derived from them. Grounded theory is therefore driven by the data, unlike approaches such as phenomenology, for example, which gather all data before theming and analysis (Piantanida, 2002).

Grounded theory is an interactive method in which the researcher engages closely with the analysis, the data, and the participants, and provides tools for answering 'why' questions from an interpretive stance. It can help address diverse areas such as societal issues, social justice, organisational studies, and social psychology (Charmaz, 2014). Creswell (2013) argued that there are three dominant types of grounded theory design: constructivist, systematic, and emerging design. Systematic design is commonly used in educational research and focuses on data-analysis steps and the development of logical paradigms. Emerging design connects categories, with the researcher developing a theory based on the relationships among those categories.

The research adopted a constructivist approach, which acknowledges multiple realities and the co-creation of knowledge by the researcher and participants, although Mills (2006) warns that this may be criticised for a lack of objectivity. Glaser (2002) explains this view as arising from the mutuality between researcher and interviewee, where the interviewee not only describes what is happening but also indicates how the researcher should view it. This can be described as an epistemological bias, or a bias in the ways of establishing what is real.

This study design is based on the ontological assumption that research is subjective and that there are multiple realities as seen by the subject. It also reflects the epistemological belief that there should be minimal distance between the researcher and the participant, achieved through methods of observation and face-to-face interviewing.

Grounded theory suggests that researchers enter the data as innocents. The work of Charmaz (2014) and constructivist grounded theory challenges this and acknowledges that researchers do not enter the field without their own experiences but instead harness these by being theoretically agnostic rather than theoretically innocent (Slade, 2015). Charmaz moves grounded theory further into interpretive social science, seeking multiple versions of reality and attending to how experiences are constituted and structures enacted, with attention to language as well as action.

Strauss and Corbin's (2008) revision of grounded theory resulted in an approach much closer to Charmaz's constructivist grounded theory. The revision takes grounded theory into organisational contexts and structures and can therefore be used at different levels beyond the

individual. This approach supported my interest in participants' individual experiences of suicide, the wider social context, and the role communities play in supporting suicide survivors.

Constructivist grounded theory, and Charmaz's approach in particular, relies on participants' own descriptions of experience. How language is used, implicit meanings, how language structures action, and how it forms a frame are central to capturing participants' realities. The research therefore represents the language used in the narratives of this study through quotes transcribed in vivo (Saldana, 2021).

This study used the systematic approach advocated by Strauss to collate and analyse the data. This structured process of analysis has been criticised for its reductionist tendencies (Higgens, 2008), reducing phenomena to that which can be observed. Parahoo (2014) describes this as empiricism: only that which can be observed through the human senses is treated as fact. However, Mills (2006) argues that grounded theory has the ability to respond to the research situation by continually searching for evidence that confirms or disconfirms emerging theory.

5.5 Researcher positionality and reflexivity

As the principal researcher, I am aware of the axiological dimension of the study in that I bring my own values to the research and that, as such, an element of bias is inevitable.

Working in the same field as the research topic, I recognise and value the fact that my interactions with participants and the data are influenced by my professional perspective. The research reflects on this, acknowledges the researcher's beliefs and values, and provides access to the data and analysis.

The researcher's tacit knowledge of suicide and the experience of those affected by it has developed through repeated professional exposure and experience (Odel, 1983).

An academic background in health promotion and public health, together with exposure to health-promotion models and theory, has informed these views alongside personal experience.

The view that death by suicide can be prevented, and that it is influenced by the social determinants of health, inequalities in society, and the impact of poverty, is clear. The belief that suicide contagion can be identified in communities, groups, and families is reinforced

through repeated stories from suicide survivors, suggesting that exposure to suicide can, for some, create the perception that suicide is an available option that might not otherwise have been considered.

The researcher is a suicidologist and has worked in suicide prevention for over 25 years as both a public health specialist and an NHS commissioner. Previous research has focused on understanding why people take their own lives and how this may be prevented at a population level and among specific groups and families. Developing an in-depth understanding of suicide prevention approaches and theory from a social-ecological model of suicide prevention has provided a framework for integrating general and population-specific risk and protective factors (Mueller et al., 2021), and this work stems from the foundational contributions of Durkheim (1951) and the social context of suicide.

Durkheim's insights into sociology's role in understanding suicide have underpinned much subsequent work on this social phenomenon. Although there has been considerable debate about the limitations of Durkheim's work, these insights have nevertheless provided an important grounding in suicidology and, more broadly, in sociological theories of suicide. The roles that inequality, intersectionality, organisations, and communities play in suicide provide a lens through which to reflect on suicide survivors' and communities' experiences of loss and suffering, and through which to develop theories of suicide prevention.

There are four major sociological perspectives: symbolic interactionism, social conflict theory, structural-functional theory (functionalism), and feminist theory. Each provides a way of explaining aspects of contemporary society and how it operates. The work of Charles Horton Cooley and George Herbert Mead (1982) contributed to the development of symbolic interactionism (Plummer, 1991). This theory is based on the premise that individuals behave towards situations according to the meanings those situations hold for them. These may include physical objects or institutions and are referred to as symbols. Symbolic interactionism is a micro-sociological theory that focuses on how the meaning of symbols for an individual is derived from interpersonal and social interaction. This contrasts with functionalism; a macro-sociological theory developed from the work of Émile Durkheim. Durkheim's functionalism examined the macro level of social structure and social institutions, including family, government, and religion, in order to explain how these contribute to the stability of society (Taylor, 1992). Durkheim's work in *Suicide: A Study in*

Sociology (Spaulding, 2010) demonstrates his insistence that society is more than the sum of its parts and focuses on how social structures and institutions contribute to social stability.

Symbolic interactionism examines the symbolic meanings people attach to phenomena such as suicide. Suicide loss is a challenging issue that may be more difficult to internalise than some other forms of bereavement. The sudden loss of a loved one can be traumatic and, just as the deceased is unique, so too is the way in which that loss is experienced.

George Herbert Mead (1982) noted that death is an object to which we respond on the basis of the meaning we attribute to it. That meaning emerges out of social interaction and can be used, understood, and mediated through an interpretive process adopted for dealing with the objects we encounter (Plummer, 1991). The empathy central to symbolic interactionism requires us to seek access to a person within their personal context and culture, focusing on empathetic connection and communication in order to open a route to genuine understanding between individuals (*A Framework for Understanding the End of Life*, n.d.).

5.6 Summary

This chapter has set out the methodological approach for the study, including the ontological and epistemological positioning within an interpretivist, constructivist paradigm, and the rationale for using constructivist grounded theory informed by symbolic interactionism. It has also highlighted the role of the researcher, including reflexivity and the influence of professional and personal perspectives on the research process. Chapter 6 now details the methods used to operationalise this methodology, including sampling, data collection and analysis, and ethical considerations.

Chapter 6: Methods

The research methods chosen for this study enable an examination of suicide, an understanding of the context in which suicide takes place, and an exploration of the experiences of suicide survivors, all of which are intrinsic to qualitative research.

Sociological autopsy is a methodological approach in the sociological study of suicide that goes beyond analysing aggregate suicide rates in order to examine the specific social contexts

and conditions surrounding individual suicide cases. This approach was coined by Fincham et al. in their book *Understanding suicide: a sociological autopsy* (2011).

6.1 Key features of sociological autopsy

- Qualitative focus: Sociological autopsy involves a qualitatively driven, mixed methods approach to studying individual suicide cases (Fincham et al., 2011).
- Case file analysis: The method typically involves examining suicide case files to gather detailed information about the circumstances and social factors surrounding each death (Fincham et al., 2016).
- Contextual understanding: By focusing on individual cases, sociological autopsy allows researchers to explore the immediate social context in which suicides occur, such as job loss or spousal conflicts (Manning, 2013).
- Bridging micro and macro levels: This approach helps connect broader sociological theories about suicide with the specific, concrete social conditions that contribute to individual suicides (Manning, 2013).
- Complementing rate-based analyses: While traditional sociological approaches to suicide have focused on analysing suicide rates, sociological autopsy provides a more nuanced understanding of the social roots of suicide (Manning, 2013).

6.2 Themes explored through sociological autopsy

Sociological autopsy allows researchers to delve into various social aspects of suicide, including:

- Gender dynamics: The gendered character of suicidal behaviour (Fincham, 2016).
- Life course factors: The role of the life course in suicide (Fincham et al., 2011).
- Social bonds: The importance of social bonds, especially intimate relationships, in suicide (Fincham et al., 2011).
- Identity and emotions: How social identities and emotions, particularly shame, contribute to suicidal behaviour (Mueller et al., 2021).
- Cultural scripts: The role of cultural beliefs and scripts about suicide in shaping suicidal behaviour (Mueller et al., 2021).

By employing the sociological autopsy method, researchers can gain a more comprehensive understanding of how the external social world impacts individual psychological pain and suffering, ultimately contributing to suicidal behaviour. This approach helps bridge sociological and psychological theories of suicide, offering a more holistic perspective on this complex phenomenon (Mueller et al., 2021).

Through using grounded theory methodology, the study seeks to gain a deeper understanding of the experience of suicide bereavement. Based on the works of Glaser and Strauss (2009), Charmaz (2014) identifies in detail the core processes of grounded theory method:

- Gathering rich data as an iterative process from intensive interviewing with constant comparison
- Textual analysis – constructing analytical codes and categories from the data
- Memo writing describing categories and relationships between them to develop conceptual categories
- Theoretical sampling seeking new specific data
- Completing and reviewing literature

Given the personal and sensitive nature of the topic, individual or family-group interviews were considered the most appropriate method of data collection. The interviewer's role was to encourage discussion, observe, and listen carefully to participants' responses. It was anticipated that suicide survivors would do most of the talking, with prompts from the interviewer used only where necessary or where clarification was required. This approach lends itself to in-depth conversation in a comfortable and safe environment, helping to ensure that participants could share as much detail as they wished.

In-depth interviews, or what Charmaz (2006), drawing on Lofland, describes as a directed conversation, are a useful method for interpretive inquiry because they provide a mechanism for the deep exploration of a topic or area of interest. They can elicit participants' interpretations of their own experiences by allowing interviewees to explain and reflect on their feelings, circumstances, and understanding.

The initial literature review reflected the lack of high-quality research on how best to support those bereaved or affected by suicide and on the role communities play in providing support, with much of the existing research being quantitative in nature, including suicide surveys that focused on the circumstances of the deceased rather than on the bereaved. This informed the key areas to be explored through the interview process, as outlined below.

- What is the lived experience of being bereaved or affected by suicide
- How does the community interact following suicide/s and are there key community members or roles who support
- Are there individuals, services, groups, organisations or agencies with whom individuals and families bereaved or affected by suicide interact
- What information, support or signposting could be provided to help individuals and families bereaved or affected by suicide
- Are there key factors which need to be considered in order to help ensure those bereaved or affected by suicide are able to access support

There were initially three topic guides developed for the three groups identified to be involved in the research (individuals and families bereaved or affected by suicide, service providers and stakeholders). Topic guides can be found in Appendix B.

The topic guides helped ensure consistency in data collection by setting out the key issues that would be explored with each participant. While the topic guide shapes the content of the discussion, it is not an exact prescription of coverage. This means that the order in which issues are covered, and the time spent on different topics, varied. The responsive nature of qualitative research also enabled the interviewer to explore any unanticipated but relevant themes that arose during the conversation.

The initial stage of data collection involved the development of the topic guide and interview schedule, which were submitted at the point ethical approval was sought for the study; approval was granted in 2016. The questions proposed in the topic guide were purposefully open-ended and broad enough to allow wider exploration with the interviewee. The initial interview schedule was subsequently updated to reflect early data analysis, which identified new areas for discussion and exploration in later interviews. Subsequent versions, for example, included questions about participants' experiences of religion and spirituality. The topic guide worked best when items were phrased as short prompts rather than as fixed questions. This encouraged the interviewer to formulate questions responsively and to use language with which participants felt comfortable. The guide included some follow-up questions, probes, and prompts, but decisions about what and how to follow up were made by the researcher in light of the research objectives.

The use of a digital recorder was important in enabling the interviews to be transcribed accurately, but more crucially it allowed the interviewer to give their fullest attention to the

participant, maintaining eye contact and listening actively without the distraction of taking copious notes. The researcher considered this important for building trust and rapport and for encouraging interviewees to share sensitive information.

Systematic data collection through one-to-one interviews was undertaken with individuals and families bereaved or affected by suicide, as well as with service providers and stakeholders. All interviews were conducted by the same interviewer, who had extensive experience of working with people bereaved or affected by suicide and who understood the emotional, sensitive, and complex nature of discussing suicide.

The interviews were transcribed verbatim by the researcher, while a small proportion of interviews (n=4) were transcribed by an independent agency. These transcripts were then checked by the researcher for accuracy.

A Northeast of England charity acted as gatekeeper. The charity had been developed by people with experience of suicide bereavement and supports people bereaved or affected by suicide. It was able to recruit people with experience of suicide bereavement for interviews through the distribution of information leaflets, which can be found in Appendix A. In some cases, suicide survivors were identified through theoretical sampling in order to answer specific questions from their perspective, such as the interview with a medium who had experience of working with suicide survivors.

The gatekeeper was crucial to gaining access to suicide survivors, and a good working relationship was established. The charity had a legitimate interest in the research and was genuinely concerned about the wellbeing of suicide survivors. Trust between the gatekeeper and the researcher, together with mutual respect for each other's expertise, was key to building a relationship in which the gatekeeper felt comfortable sharing information with potential study participants. Gaining insight from the gatekeeper during the planning stage also helped ensure that the research would feel relevant and worthwhile to suicide survivors who might participate. Human-factor variables were considered as part of the recruitment strategy in order to reduce gatekeeper anxiety that might otherwise have impeded the research (White, 2008).

6.3 Theoretical sampling

Theoretical sampling is central to grounded theory. It is a process through which the researcher inductively identifies an emerging concept or theory from the data and then uses further data collection to test, refine, or challenge that theory.

Theoretical sampling can be defined as the process of data collection for the purpose of generating theory, whereby the researcher jointly collects, codes, and analyses data and then decides what data to collect next and where to find them in order to develop theory as it emerges (Nelson, 2017).

There is a clear distinction between theoretical sampling and purposive sampling. Purposive sampling is a non-probability sampling method, and it occurs when participants who are selected for the study are chosen by the judgment of the researcher. Unlike standard purposive sampling, theoretical sampling attempts to discover categories and their elements in order to identify and explain interrelationships between them (Strauss and Corbin, 1998).

Theoretical sampling is associated with grounded theory and analytic induction. Unlike many other sampling methods, it is not intended to produce a representative sample of the population or to test hypotheses; rather, it is aimed at generating and developing theoretical insight.

Theoretical sampling was used in this study to identify participants who would participate in the research from ‘an accessible population’ (Piantanida, 2002). This was done via a gatekeeper with the initial interviews providing data to feed into and build on for subsequent interviews (Cutcliffe, 2000). The researcher moved back and forth between data collection and data analysis and followed this approach through coding data and the formation of initial categories.

Participants were not known to the researcher prior to interview, but they expressed an interest in the study and received study information from the gatekeeper. In some cases, the researcher was asked to contact the potential participant; in others, the participant contacted the researcher directly.

The details of the study were discussed via telephone and, if the potential participant agreed to take part, a time and place for interview were arranged. Consent forms, including contact information, were presented at the start of the interview and completed before the interview began. No interviewee was under 18 years of age. This approach enabled any further queries to be addressed and ensured that informed consent was obtained. All participants who initially expressed an interest in the study consented to be interviewed.

6.4 Interviews

The interviews focused on developing an in-depth understanding of how people think and feel about their experience of suicide and the role communities play in providing support. Broad, open-ended questions were used to enable participants to share their knowledge, experience, and beliefs through a natural conversational style. By creating open-ended and non-judgemental questions, the interviewer encouraged unanticipated stories and reflections to emerge (Charmaz, 2006).

Because the interviewer was genuinely interested in understanding the experiences of those bereaved by suicide, the interviews were conducted in a conversational style and participants were prompted, where appropriate, to explain their perspectives in more depth. Interviews were planned to allow sufficient time for the exploration of experience and for breaks where needed, given the emotive nature of suicide. The confidential nature of the interviews enabled participants to share stories that might not have been discussed in ordinary conversation, including details of a loved one's death, suicide notes, family circumstances, emotional responses, the impact of the death, how life had changed, and their reflections on the present and the future.

The interviewer was acutely aware of the potential for distress when participants discussed their experiences and therefore ensured that the conversation was led by participants in terms of when they felt comfortable moving into more difficult areas. Where the interviewer sensed increasing distress, they would pause, or move the conversation on, until the participant indicated that they wished to continue.

Most interviews took place in participants' own homes, except for two that were held in a community centre at the participant's request. All participants lived in Northeast England and had either experienced suicide or been affected by suicide where the deceased had also lived in the region. Conducting interviews in participants' homes, or in another place of their choosing, helped ensure that suicide survivors felt as comfortable and safe as possible when sharing their stories. Where interviews took place in the home, the setting also gave the researcher some insight into the family environment and enabled participants to share personal items, such as photographs of the deceased and other meaningful possessions.

Online and in-person face-to-face interviewing methods have distinct trade-offs, with no clear superiority. Lobe (2022) systematically evaluated online versus in-person interviews across logistics, ethics, recruitment, research design, and moderating with no clear recommendation.

Davies (2020) found that online alternatives produce shorter responses, less contextual information, and lower relational satisfaction compared to face-to-face approaches. However, Anthony (2025) recently reported no statistical differences in data quality between Zoom and in-person interviews, though participants perceived significantly higher rapport and empathy in face-to-face settings.

A key contradiction emerges while Davies (2020) suggests online methods yield lower-quality data, Anthony (2025) found comparable data quality. This discrepancy may reflect methodological differences or evolving technology. All sources agree that online methods should not be viewed as straightforward replacements for in-person interviewing. Notable gaps include limited guidance on specific best practices and recommendations for researchers choosing between modalities.

The interviews were not planned with fixed time constraints and were allowed to conclude when participants felt they had reached a natural end point. The topic guide included questions that encouraged suicide survivors to share their experiences of bereavement after suicide and the impact this had on their own lives, their families, and their communities. This led to exploration of their perceptions of how communities interact and react following suicide, whether there were key community members or roles who provided support, how services and groups offered support, what was experienced as helpful or unhelpful, and whether more could be done to assist those bereaved or affected by suicide. Interviews concluded with the interviewer thanking the participant, recapping contact details, and signposting to relevant support services where appropriate.

The researcher expected the relational dynamic established during interviews to vary across participants. The interviewer was a white, middle-aged, professional woman who had herself been bereaved by suicide. All suicide survivors asked about the researcher's professional role in addition to requesting information about the study. As expected, the experience of conducting interviews with a range of participants was varied. Interviews with two male participants, however, did not unfold as the researcher had anticipated. One participant questioned the interviewer's beliefs about suicide, her professional experience, and how she could add value to suicide prevention. He was also explicit in his view that the interviewer could not empathise fully with his experience because she had never lost a child to suicide. A second male participant was guarded in his responses and generally vague, adopting a light-hearted tone when speaking about the death of his partner and the family's loss of a wife and mother. He was reluctant to respond to prompts intended to deepen his reflections and instead redirected attention to the positives of his current circumstances; this interview was the

shortest. As Schwalbe (2002) notes, when interviewing men, the male–female dynamic and questions of power and control may affect comfort in a female-led interview context. By contrast, some interviews were carried out with mixed-gender family groups, which lent themselves to in-depth exchanges between participants about their views, beliefs, meanings, and actions following suicide. These interviews provided differing interpretations of the same reality, or of what participants felt and experienced as real at that time. They also enabled focused clarification and deep reflection, and in these circumstances the conversational format required little direction from the researcher beyond occasional clarification.

Each interview was managed in a way that responded to the specific circumstances of the participant, their willingness to engage, and the manner in which the interaction unfolded. In all cases, breaks for refreshments were taken when needed and were led by participants; given the intensity and emotional weight of the topic, these pauses may also have offered useful time for reflection. In some cases, the interview content was painful to revisit, and the interviewer allowed as much time and space as participants needed to tell their stories. When the interviewer felt that the participant had exhausted their account and that repetition had begun to occur, they would ask whether there was anything further the participant wished to share before bringing the interview to a close. The interviewer would then discuss any support the participant might want for themselves or others and signpost to appropriate services.

Interview transcripts were shared with the research team, and the content of interviews was discussed to help ensure that participants' experiences were represented faithfully. This process helped reduce the potential for bias on the part of the researcher, who was also the interviewer. The researcher's scrutiny of their own experience, theoretical position, and transparency throughout the research process reflects a reflexive stance that seeks to represent participants' experiences and stories as accurately as possible.

The value of theoretical sampling lies in its capacity to lead the researcher into areas and topics that were previously unknown or not considered significant before data collection began. It enables the researcher to investigate these areas further and to gather new information and insights that are grounded in the data themselves.

6.5 Analytical process

In total, the researcher undertook seventeen separate interviews involving twenty-four participants; three of these interviews involved family groups. Interviews took place between

May and September 2016. All suicide survivors were bereaved by suicide and had lost either a child, parent, partner, sibling, or other family member, or had otherwise been affected by suicide. As part of the research, an interview was also undertaken with a medium who worked with families bereaved by suicide in Northeast England.

Strauss and Corbin (1998) emphasise the need for systematic data collection methods in order to reach theoretical saturation, or, in grounded theory terms, a point at which no substantially new conceptual insights are emerging. Saturation develops through the continued refinement of concepts and through hearing similar accounts repeatedly across the data. This method requires constant comparison between data fragments, with ongoing analysis to develop concepts as the study progresses until no new concepts emerge, or until the researcher judges that sufficient depth has been achieved, while recognising that the data may warrant further return at a later stage. In some studies, claims of saturation are made after very few cases, which can contribute to the perception that grounded theory is methodologically weak. In practice, the number of interviews undertaken is contingent on whether the research has reached a position of theoretical saturation (Saunders, 2018).

The next stage began with data analysis and the initial coding of the data. Grounded theory coding consists of at least two phases: initial coding and focused coding (Charmaz, 2006). Initial coding of the interview data was undertaken iteratively throughout the data-collection phase of the study. The researcher transcribed the interviews and uploaded the data one interview at a time into Quirkos (Turner, 2018), a qualitative data-analysis software package. This tool supports the management of qualitative data by helping the researcher organise sections of text and categorise them into topics or themes of interest. Quirkos also produces a visual representation of the data, which the researcher found helpful. It aided the identification of important areas within the text, supported constant comparison, and enabled the researcher to review codes and categories and identify additional questions for later interviews. Constant comparison is a common-sense approach to examining qualitative data by comparing interviews, codes, and themes to identify both similarities and differences. Memos and field notes were used to support the initial coding phase. The data were coded line by line for the first two interviews, and the researcher continued this approach throughout the study, coding all subsequent interviews line by line. This approach provided insights that were used to modify questions in later interviews and to identify who might be of interest to interview next, thereby allowing the data to guide further inquiry. As Charmaz (2006) notes, such questions help direct further data collection towards the analytical issues

that are being defined. Applying the same coding method consistently until saturation was reached contributed to the rigour of the study.

The visual functionality of Quirkos enabled the researcher to move data across and between themes, creating new themes or subthemes in order to compare data, processes, concepts, and themes more easily and begin to construct meaning from the data. Quirkos is not an artificial-intelligence tool and does not analyse the data on behalf of the researcher; rather, it supports visual organisation and exploration. The researcher could create quirks, or bubbles, into which text segments were placed for particular codes; the more material assigned to a quirk, the larger it became. Quirks could also be merged, nested, or grouped into broader categories, thereby supporting analytic thinking and the testing of concepts.

The use of memos in Quirkos helped the researcher describe the data and the links between concepts and usefulness of the categories. Writing memos enables the researcher to flag incomplete categories and gaps in analysis.

Focused coding grouped the data into processes and a relatively small set of theoretical categories: circumstances prior to suicide, the suicide itself, the impact of the death, support after suicide, and knowledge of multiple suicide deaths. The data were tested against these early processes by comparing the data with the codes and grouping codes into concepts in order to examine what was actually happening in the data. The researcher used in vivo codes, that is, direct quotations from participants, to name some codes or categories (Quirkos, 2023). This approach keeps the researcher close to the language used by respondents. People's choice of words can reveal their perspectives more directly and helps mitigate the tendency for the researcher to impose their own discourse and meaning onto the text. This can be seen in example codes such as 'manage one day at a time', 'pushing the future you imagined away and live', and 'handling depression'.

Saldana (2006) describes how a read through of the text to create in vivo codes can be a useful process to create a summary of each source. Grounded theory lets codes and theory emerge from the data, looking for unusual or unfamiliar terms which respondents use in their own language (Ryan, 1996).

Further literature review and focused data analysis led to the definition of categories through linking concepts together, clarifying relationships between concepts, and refining themes that gave meaning to the experience and journey of suicide. This process involved making links between concepts in order to create a higher level of abstraction (Bowen, 2006) and a deeper understanding of the experience of suicide and the emerging theory.

Grounded theory provided a systematic framework for data collection and analysis and enabled the researcher to identify themes that ultimately formed the study's conceptual framework.

- reconstruction of suicide and continuing bonds
- the process of sense and making meaning of the suicide
- their feelings at different times following death
- the social context bereavement by suicide
- their perception and knowledge of related suicide
- coping mechanisms
- growth and healing after suicide

Charmaz (2014) stated simply; grounded theory methods consist of systematic, yet flexible, guidelines for collecting and analysing qualitative data to construct theories from the data themselves. Grounded theory begins with inductive data, invokes iterative strategies of going back and forth between data and analysis, uses comparative methods and keeps you interacting and involved with the data and emerging analysis.

6.6 Ethics

Suicide is a highly sensitive topic. During the recruitment process, the researcher ensured that participants were clear about the nature of the topic and the research process. Participants were invited to describe their own personal experiences explicitly and in their own terms.

The researcher was flexible in how participants were able to take part in the research and was always guided by the participant regarding the location of the interview. The researcher drew on a range of skills and experience, including offering breaks where appropriate, remaining participant-led, and managing the pace and dynamics of the interview as far as possible in order to ensure that participant wellbeing remained the priority. Participants often shared information that they had not previously disclosed to anyone, and the researcher reiterated the confidential nature of the discussion at the end of each encounter.

The researcher was mindful of the approach required for this subject area, including the terms that should be avoided and the concepts and wider culture that needed to be considered. Although all participants opted in to the study, the researcher emphasised its voluntary nature both at the recruitment stage and immediately before the interview began. Participants were

also informed that they did not need to answer any questions or discuss any topics they did not wish to address.

The researcher managed the pace and dynamics of each interview so that participants were left in a neutral and safe space and as far as possible, 'as they were found'. The researcher was also clear about the consent process and about the limits to confidentiality, including the action that might be taken if a participant disclosed suicidal thoughts. All participants were offered a leaflet at the end of the interview containing details of tailored support organisations. This included contact details for any organisations with which they were already engaged, as well as other appropriate services for those bereaved or affected by suicide.

The research encounters may also have been distressing for the researcher. However, the researcher conducting this study had extensive experience of working across a range of sensitive subject areas and ensured that support mechanisms were in place for themselves. After each research encounter, the researcher checked in with their supervisor and had the opportunity for a full debrief when this was considered helpful. The interview schedule was planned with the wellbeing of both participants and the researcher in mind.

Consent was obtained from all participants, and no participant was under the age of 18 years. None of the research participants were from groups identified as lacking capacity; it was therefore assumed that all participants had the capacity to consent. Participants were asked to read and sign a consent form agreeing to take part in a face-to-face interview.

No additional ethical issues were identified beyond those raised in the original ethical application, and approval was granted for the research to commence, as shown in the Research Ethics Committee Decision Statement in Appendix A. The committee did, however, request some minor changes to the topic guide and participant information, which were actioned before data collection began.

Any data containing personal details were classified as 'Respondent Confidential'. A range of measures was implemented throughout the project to ensure confidentiality. These included:

- All fieldwork was digitally audio recorded for full verbatim transcription using encrypted digital recorders.
- Personal details were only kept on consent forms which were kept in a secure folder with access restricted to the researcher only.

- As soon as data was transcribed, names and identifiers were removed. Anonymised data was available to the researcher and supervisor only.
- Names and identifiers were removed from transcribed data which were subsequently identified by a serial number. Electronic data were stored on the University of Sunderland main server. The anonymised data were only available to the researcher and supervisor.
- All data will be kept for a period of 5 years after the publication of the PhD thesis. Thereafter electronic data will be deleted, and paper documents shredded.

Participants were reassured that, although their views would be represented in the final outputs from the study, care would be taken to ensure that no identifying features were revealed. Where quotes or case-study examples were used, any potentially identifying information would be removed or changed. The researcher and supervisor were responsible for implementing and maintaining the security arrangements required to preserve confidentiality. The researcher involved in this project had also completed enhanced DBS checks.

Ethical approval for this study was obtained through the University of Sunderland. This required a detailed account of the rationale for the study, the research process and sample population, how the sample would be contacted, the feasibility of the study, and any anticipated ethical issues.

6.6.1 Inclusion criteria

To be eligible for inclusion in the research, participants had to meet the following criteria:

- A person bereaved or affected by suicide aged 18 years or over.
- A service provider or community member who supports those bereaved or affected by suicide.

6.6.2 Exclusion criteria

- Those with no experience of suicide bereavement or being affected by suicide.
- Those aged under 18 years of age.

Chapter 7: Northeast and North Cumbria suicide autopsy

Suicide autopsy can be explored through both sociological and psychological lenses. The concept of ‘sociological autopsy’ has emerged, combining qualitative and quantitative

methods to study individual suicide cases within their social contexts (Fincham et al., 2011; Scourfield et al., 2012). This approach highlights the gendered nature of suicidal behaviour, the role of the life course, and the importance of social bonds, particularly intimate relationships (Fincham et al., 2011).

The autopsy method for investigating suicide has evolved to include social and technological aspects. The "social-mobile autopsy" incorporates analysis of digital communications and social media profiles (Aquila et al., 2017) and may include research on method of suicide and influences. Interviews with family members and professionals offer valuable insights into individual suicides (Shneidman, 2018). This research combines qualitative data from interviews with those bereaved or affected by suicide with data sourced through agencies and services including coroner records. The research emphasises the complexity of factors which contribute to suicide, including gender, life stage, mental health, social relationships and social context.

This chapter draws on secondary autopsy data from deaths of people who were resident in Northeast and North Cumbria geography at the time of death. Data from a 10-year case study from a specific local authority area, County Durham, is analysed covering deaths from 1st January 2005 to 31st December 2015. This data set includes the suicide deaths from the survivors who were subsequently interviewed about their experience of suicide.

The autopsy then goes on to examine more recent suicide and suspected suicide data from 1st November 2024 to 31st October 2025 which covers the whole of Northeast and North Cumbria and generates themes from the data which are compared over time.

7.1 Northeast and North Cumbria 10-year case study

During the researcher's employment in County Durham, she led the 10-year study and analysis of deaths by suicide and undetermined injury that occurred in the County Durham area from 1 January 2005 to 31 December 2015 (Durham County Council, Health and Wellbeing Board, March 2017). Data were collected throughout an 11-year period and an in-depth analysis undertaken, identifying common themes, trends and suicide clusters. This initial study led to the development of the Northeast and North Cumbria Near Real Time Suicide Surveillance System and subsequent data collection, alongside which the 12 months' data from November 2024 to the end of October 2025 are provided as a comparison. These data, alongside the qualitative data from suicide survivors, develop a picture of deaths by

suicide in the Northeast and North Cumbria. Where available, socio-political factors are identified and are then further explored in the discussion chapter.

Data on deaths by suicide was collected via the coroner's office from 2005 and this data was used to establish any relationships, including clustering, between those deaths determined as suicide. Data was collected from a range of agencies including coroners, which includes records from families of those deceased, police, prison, social services, mental health services and substance misuse services.

There were 445 deaths by suicide or undetermined injury in County Durham by residents of County Durham between 1st January 2005 and 31st December 2015. This report is based on the analysis of 445 deaths.

Of the 445 deaths, 79% were male (352) and 21% were female (93).

67% (298) of all cases were people under the age of 50.

Just under a third of cases were employed at the time of death: 30% (134) were employed, a further 25% (134) were unemployed, 9% (42) were retired and 7% (14) were long-term sick or disabled.

In 34% (65) of cases the person lived alone at the time of death.

Hanging/strangulation was the most common method of suicide and occurred in 68% (129) of cases. In a further 22% (42) of cases the method was self-poisoning. In 67% (128) of cases the location was home.

Toxicology reports indicate that 32% (61) of cases had alcohol in the blood at the time of death. Of these cases, 64% (39) were over the legal driving limit of 80 milligrams of alcohol per 100 millilitres of blood.

51% (97) of cases were known to the police prior to their death; 25% (24) had been in contact with the police in the 3 months preceding their death.

5% of all cases (9) were prisoners at the time of death. A further five cases died in less than a year of being released from prison. Four of the cases were referred for review with the following findings:

Case 001

- Suicide risk factors noted throughout (low mood, observed noose around neck, disturbed sleep).
- Professional practice issues (did not receive antidepressant medication).
- Process and training issues.
- Possible bullying.
- Risk of suicide code not implemented immediately.

Case 002

- Suicide risk factors noted.
- Data communication issues (no GP records on admission; no record of family phoning expressing concerns; no documentation of monitoring low mood; personal officer scheme—no documents).
- Low mood.
- Process/pathway issues (mental health referral not actioned).
- Process and training issues (teacher assesses physical state and returns him to his cell).
- Risk of suicide code not implemented immediately.

Case 003 (declared as not preventable)

- Suicide risk factors (history of self-harm; first time alone in cell).
- Alcohol use linked to assault—no intervention.
- Court appearance due.
- Process/training issue: risk of suicide code not implemented immediately.

Case 004

- Suicide risk factors (single cell; reliance on personal presentation—no GP record; self-harmed 2 days before; suicidal thoughts recorded in police custody; depression; alcohol misuse; evidence of self-harm and cuts to wrist).
- Training issue: healthcare did not open at-risk note; did not think at risk—no detox.
- Risk of suicide code not implemented immediately.

A date of last contact with a GP was known for 125 cases, of which 65% (80) had been seen by a GP within three months of their death.

50% (95) of cases were recorded as being known to mental health services at some point prior to their death. Of these cases, 4% (7) had been referred to mental health services but were never seen. 57% (54 cases) had been seen by mental health services in the three months prior to death.

Themes were identified for 158 of the 190 cases. The most common single theme was relationship problems/breakdown which featured solely in 22 cases. This also featured in a further 16 cases where there were multiple themes. Overall, 24% of all cases (38) featured relationship problems/breakdown. Financial/debt featured in 13% (20) of cases and bereavement in 12% (19).

Table 1 shows the number and percentage of deaths by age band, with 67% (298) of all cases being people under the age of 50.

Table 1: Percentage of deaths by age band 2005-2015

Age Cohort	Number of deaths (n445)	Percentage
19 and under	19	4
20-29	88	20
30-39	82	18
40-49	109	24
50-59	75	17
60-69	45	10
70-79	20	4
80 and over	7	2

Table 2 shows the employment status at the time of death. More cases were employed than unemployed, and there were also significant numbers of cases classified as retired or long-term sick/disabled.

A third of cases were employed at the time of death (33%, 148 cases), a further 30% (132 cases) were unemployed, 13% (58 cases) were retired and 6% (26 cases) were long-term sick or disabled. Students made up 5% (21) of deaths and those in prison at the time of death 3% (15). (Students and those in prison are included where they died in this area.)

In 35% (156) of cases the person lived alone at the time of death. 23% (102) lived with only a spouse or partner and a further 8% (36) lived with children under the age of 18 years.

Table 2: Employment status at time of death 2005-2015 by percentage

Employment status	Cases %
Employed (33% fulltime/ 0.5% part-time) & (2% self-employed)	36
Unemployed	30
Retired	13
Long-term sick or disabled (1 x medically retired)	6
Unknown	5
Other (Prisoners)	3
Student (full-time)	5
Caring for home / family	2

Figure 1 shows the percentage deaths by method used for those with a conclusion of suicide of undetermined injury from 2005-2015. Most common methods were hanging or strangulation (64%) followed by self-poisoning (18%).

Figure 1: Deaths by suicide and undetermined injury by method 2005-2015 and percentage

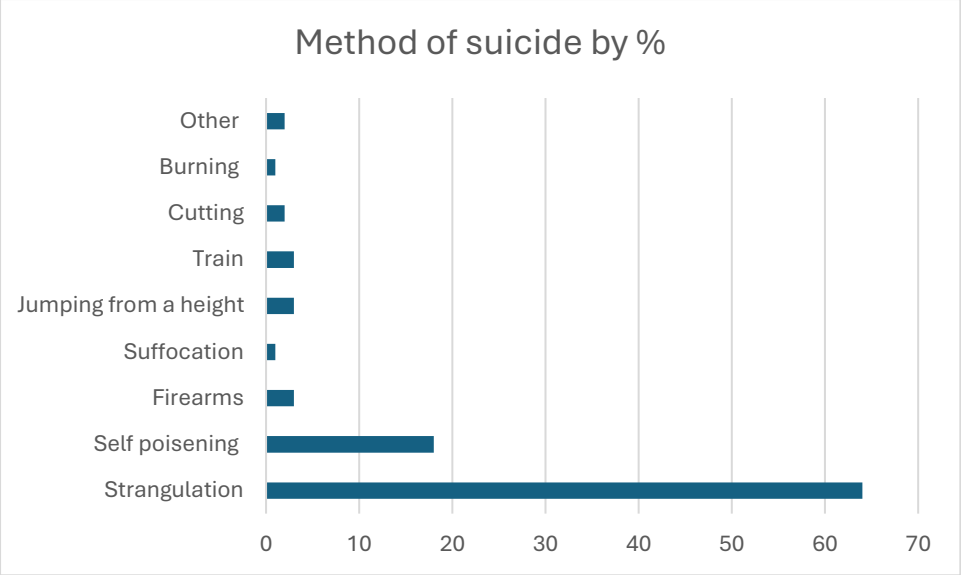


Table 3 shows the location of the suicide. The most common location was the deceased home address with 65% (291) taking their lives at home. A wooded area was the second most common location with 11% (48) people. The location of the death and who witnessed the death or discovered the body has an impact on who and how many people could potentially need support after suicide.

In 40% (177 cases) toxicology indicates alcohol in the blood at time of death, of which 26% (118 cases) were over the legal drink driving limit of 80 milligrams of alcohol per 100 millilitres of blood. This means toxicology results indicate just over a quarter of all cases had more than the drink driving limit of alcohol in their blood.

Table 3: Location of suicide 2005-2015 by percentage

Location	Cases %
Home	65
Wooded area / Field	11
Hospital	5
Family, Friends, work other address	5
Railway	4
Prison	3
Viaduct/bridge	3
River	1
Beach / Cliff	1
Jumped in front of vehicle	1
Other	2

7.2 Contact with NHS prior to suicide

A date of last contact with General Practice was known for 71% (319 cases), of which 43% (193 cases) had been seen in General Practice within three months of their death, with 20% (90 cases) seen within 15 days of death. A further 17% (75 cases) were seen between 3–12 months prior to death. 37% (164 cases) identified as attending for predominantly physical health issues while 23% (104 cases) attended for their mental health, and 8% (36 cases) attended for both. 29% (127 cases) were diagnosed with a mental health condition in the 12 months prior to death. Of those who attended, 2% (10 cases) were assessed using an evidence-based assessment tool, while a further 29% (130 cases) had some level of mental health assessment documented.

11% (47 cases) accessing General Practice expressed thoughts and ideas about suicide but no intent or plan. Patients with clear suicide intent or suicide plans documented in 5% of cases (n=24). 31% (139 cases) had expressed no thoughts, plans or intent of suicide.

Treatment offered through General Practice consisted mainly of referral to talking therapies and/or prescription medication in 36% (159 cases); 8% (37 cases) were not offered any treatment.

Contact with acute hospitals was identified in 31% (136 cases), with 3% (14 cases) seen either on the day of death or within five days of death; a further 2% (8 cases) were seen within 15 days and 11% (49 cases) within three months of death. The main recorded reason for attending acute hospital related to self-harm for 14% (63 cases). A psychosocial assessment was carried out in 6% (n=28) of these cases.

50% (224 cases) were recorded as being known to mental health services at some point prior to their death; of these cases, 4% (n=20) had been referred to mental health services but were never seen prior to death. 22% (99 cases) were on caseload at time of death, 12% (54 cases) were assessed but not taken on caseload, and 10% (43 cases) were discharged from service.

Of the 29% (127 cases) that had been seen by mental health services in the three months prior to death, 4% (16 cases) were seen on the day of death, 10% (46 cases) were seen within five days of death and a further 5% (24 cases) within 15 days of death. The main sole mental health diagnosis was depressive illness in 7% (31 cases); however, when combined as part of multiple diagnoses it was a common illness.

History of self-harm is a significant risk factor for suicide. 21% (95 cases) had a record of self-harm; with 13% self-poisoning (60 individuals on 104 occasions) followed by 4% cutting/stabbing (19 individuals on 37 occasions), hanging in 2% (8 individuals on 11 occasions) and gas poisoning in 0.5% (2 individuals on four occasions).

Cases with a recorded history of domestic abuse include 1% (4 cases) as a perpetrator of abuse and 1% (4 cases) as victim of abuse.

7.3 Themes

Table 4 provides a summary of themes as described from the suicide audit. Themes were identified for 400 of the 445 cases. The most common single theme was relationship

problems/breakdown, which featured solely in 50 of the cases. This also featured in a further 16 cases where there were multiple themes.

Table 4: Summary of key themes of suicide 2005-2015

Themes	**Cases %**
Multiple Themes identified	27
Relationship problems / breakdown	16
Ill health (3% cancer or worries about cancer, 2 x pain and mobility)	8
Bereavement (including by suicide)	7
Mental Health Diagnosis – known to Secondary MHS	8
Financial / debt problems	3
Depression anxiety	1
Drug misuse	1
Under Police investigation	3
Court Hearing Pending	2
Prisoners	4
Alcohol misuse	1
Emotional distress (following argument with partner or family member)	6
Other	4

7.4 Suicide note analysis

Suicide notes are transcribed verbatim including grammatical phrasing.

Suicide notes were left or sent prior to death through a range of media. 63% (281 cases) left no note; 31% (n=139) notes left were handwritten; 5% (n=24) text messages were sent prior to death; and 0.5% left a voicemail.

The notes and messages can show a complex interplay of circumstances which have led to the person taking their life and leave a lasting impact on the recipient. The notes are aligned to the witness statements and police Notification of Death form data from the scene to bring together initial aspects of the circumstances. Notes fall into three broad groups and are written verbatim.

- General and practical instructions
- Instructions set to influence
- Apologies and forgiveness

General and practical aspects and instructions

Numerous notes contained funeral wishes, financial details and solicitors' details along with the names of people to leave belongings to. For some people, they want to make it clear that they were not assisted in taking their lives. This may be related to the need to ensure protection of loved ones after they have gone.

Apologies

Many of the notes apologise to their families and loved ones for taking their lives and for hurting them when they were alive. These notes were written by men to their partners and include that they will not be able to hurt them anymore.

> *Sorry for this, this will be the last time I hurt you I promise...This will by my last text ever, I won't see your reply... PS thers something i've left in my pocket i'd like you to keep forever xxxxx*

One note suggests their ex-partner will continue to watch them after they are deceased and seems to suggest this as a threat, with no "xxxx" of love expressed.

> *by the time you read this it will be too late, U have a good life, I will always be watching over you now good bye*.

The mother of the person who wrote the note below is included in the interview data; Joan lost her son Michael. Michael's note is directed at his estranged wife.

I'm sorry for what I have done, you were my life, it was not your fault, it was me, I'm sorry I love you & thank you for everything, be happy, love Michael

Details from the Notification of Death notes that Michael's marriage had broken down due to arguments, some of which were violent. On separating, his wife informed him the relationship was finished. He took this badly and initially talked of suicide and then expressed a wish to move to Canada because he had nothing in his life to remain. His behaviour became erratic and irrational. He had threatened to kill himself 10 years ago after she found out he was seeing someone else and said he would kill himself if she left.

Instructions which aim to influence A note from the deceased to his son included instructions which aimed to influence the son's life beyond his dad's death and the relationship with his mother and her new partner.

Sorry for all the embarrassment, never speak to him who is going with your mother, because of what he said about her in the club, love you Mark, Christopher & Kev

Carers

Many of the notes apologise for the embarrassment of the suicide and the trouble the suicide causes the family.

"Can't bear the anxiety attacks, I'm sorry for any trouble I have caused you"

The deceased's' cousin reported that the deceased was a full-time carer for his mother who died May 2011, cousin stated he lived for her, also cared for father who died 1992, constant break ins at his farm which impacted on his depression and anxiety attacks

The loss of a loved one due to death through ill health was noted in a number of cases. For some the person had recently lost their partner who they also cared for.

Couldn't live without her no more & want to be with her, sorry to family I just can't live without her, I love you all

This man's wife died 3 months prior to his own death, after a long period of ill health and he was the main carer for his wife for approx. 14 yrs prior to her death, he had struggled to come to terms with the loss and shows the impact of bereavement on carers.

Relationship

Tension between ex partners and access to their children is included in notes along with the loss of contact. One male noted that his behaviour resulted in his partner's children being placed under a care order. Taking his life would mean she could have the children returned, note was found under his girlfriend's pillow

> *loves her and family, sorry, hopes she can get her kids back now he has gone*

The deceased has recently been withdrawing from drugs (Heroin), whilst living with girlfriend. They needed to be apart until 25th June until a child in need order expired with social services, regarding the risks having him with her, both upset but ok when he left the home, girlfriend later found suicide note. Since being with this girlfriend (Dec 2008) had previously threatened to take own life a few times, but she never took the threats seriously. He was on Methadone, but stopped taking it, trying to be substance free on his own. Over the last 3-6 months 5 of his close friends have killed themselves.

Depression

In the case of a female who took her life the family note she had been suffering with depression since the birth of her twins and was taking anti-depressants. A few days prior to her death her ex-partner informed her he'd found someone else. Her note to her family describes how she can't go on

> *To mam, dad and Ashley I'm so selfish I no if you had every…… of life I can't go on I've lived my life it's been so hard Since I've had the babeys Please forgive me Never let my babies forget me and Toney Sorry But I've had enough Love you all see you All I hope in next life Lesley XXX Tell that Bastard he's fucked Me up he's stuck a Knife through my Heart*

Where deceased has been prescribed medication for mental illness including depression, some struggled with the medication and believed it changed them into someone else who they didn't want to be

> *The last 4 months after taking anti-depressant has been a living hell. they have altered my brain cemistry, I want some piece and put myself in the hands of god. I don't want a funeral but would like to be scattered in a beatiful place*

Complexity and loss

Many notes were complex and numerous to different people and described complex lives and losses. This detail combined with the family detail describes challenging life circumstances and the deceased want to 'give up'

> *I'm so sorry Joanne (sister) I love you & mam, I give up, Colin*

Colin suffered from depression for the last 10 yrs since the death of his girlfriend and father, eventually dismissed from work due to the length of time taken off following bereavements, Father 1999, Step Grandson 2000 (aged 3/4 months) and girlfriend 2001 after battling breast cancer, turned to alcohol in 2001. Also saw mother suffer with Mental Health issues and the family think he became more paranoid and deluded thinking the house was bugged. Mother admitted into care permanently by social services and it is believed she was suffering with mental health issues & incapable of caring for herself, Colin took this news very badly.

Veterans

A number of males who took their lives were veterans and were also cared for by their spouses or partners with difficult personality changes and struggling to adjust to life.

> *I can't fight my physical pain at the same time as I fighting my heart break over loosing Mandy, I think it's better this way*

The deceased was medically discharged from Army, had a number of unsuccessful operations and his wife became his carer, she found this difficult as he got worse, she left him & took their two children to stay with her parents, she said she loved him but as a friend & not a wife.

Another male who took his life is described by his family as a quiet man who was reluctant to express his feelings, he worked for the Army as a spray painter, made redundant and had since struggled to find permanent work going from one temporary job to another and felt he could not provide for his partner and her daughter, as he thought a man should. Recently had to get a crisis loan from the job centre and his partner felt that he had lost all pride and that this was the final straw, thought this would solve things as RAF would release money to help partner and daughter and become solvent again (pension & gratuity). His note describes his distress of not being able to talk to his partner

I have never felt so low in my life before, I wanted to talk to you about it. I got the feeling you would not be understanding, which left me no option but to do what I have done as I had no one else to talk to. I feel such a failure in life with little or no hope of finding permanent work, facing financial meltdown & increasing debts.

Young people and bereaved by suicide

A smaller number of young people were recorded in the suicide audit and who also left notes on their death. For some they were lengthy rationales for taking their lives. Two of the young people were in the looked after children system and were living in children's home at the time of their death. There notes describe the sense of hopelessness of what life has for them. The young female recently lost her friend to suicide.

I just wanted to say sorry for all the problems I've caused. All my mum tried to do was help me. I'm sorry to my dad, Tina and granddad and grandma. I've really ruined it for myself, I'm a laughingstock. I know this is really selfish of me, but it's the only option I have left. Seeing Sarah do this has helped me do it. I've felt this way for months and I just want to leave. Even if I do "turn a new leaf" and do well, what's the best that will actually happen? Spend my life behind a shitty desk?

Another 15-year-old female describes the want to die and that she had been considering this for a long period of time. She left number of notes to friends, mother and father, also to a boyfriend who had gone to live in Dubai.

Note to mum: - *If you get this then I just want you to know I love you and wanted to die. I wasn't scared of dying but scared it would fail and everyone knew I was suicidal. I have wanted to do it for a while now, but Goodbye xxxxxxxxxxxx.*

Note to dad: - *I know I don't see you anymore but I killed myself because I missed you and Maggie. I love you forever and always*

Criminal justice system contact

Recent contact with the criminal justice system is noted in the suicide audit data as a potential risk factor, especially related to sexual crimes and indecent images of children. One of the notes in the records is written by a young male (<18 years old) to his mum following a visit by police regarding sexting a young female aged <16 years of age. The concerns of being on sex offenders register was noted as a significant contributory factor in the coroner audit data

as the deceased thought he had been charged with an offence. His note is intended for his mum and said she could go to wherever she wanted now on holiday.

A veteran who took his life and whose father was interviewed as part of the interviews with people bereaved by suicide, left a note. His father Brian was interviewed and did not share that his son had left a note nor the circumstances of his relationship with the police charges. His son's note was left for his wife apologising; however, his wife was not sure for what. Coroner records show that police contacted him as a suspect in a sensitive allegation following a report received that a young girl had been in touch with the deceased and they were exchanging indecent images of each other, the girl is only 14 at the time. He died 5 weeks after the police contact.

Finance

Financial concerns and debt were described in some notes with husbands leaving financial details of debt in the notes for their wives.

> *Bev - sorry for the shit I have got us into & the mess I have made, forget me soon Alex*

On the back of an envelope was a telephone number for the national debt advice line, and 2 other numbers which were loan agreements. Since his death she has realised there was a lot more debt than he had told her about.

Physical pain

Several notes were left by the deceased and described the physical pain they were experiencing and how they wanted this to end. Some people were having treatment for cancer and others had physical health pain from back problems which restricted their ability to live a full life and work. One male had been undergoing cancer treatment, and the family reported the police had been trying to revoke his shotgun licence. He left 3 notes

> *To all my family I am very sorry for what I am about to do but I cannot stand all this pane anyemore can not eat drink. Look forward to life when the police take my cons. Love you all xxx PS don't want to choke slowly.*
>
> *Love you all XXX PS exsus the spelling HaHa joan get wont you whant.*
>
> 3rd envelope with £227.74 cash in. *To Joan thank you for everything you have dohn for me love you is for you xxxxx*

7.5 Northeast and North Cumbria 2024–2025 suspected suicide audit

The purpose of the Near Real Time Suicide Surveillance System in the Northeast and North Cumbria is to collate and provide data to local authorities (n=14), NHS directors and clinical leads to enable local preventative action. The data highlights any emerging trends, clusters or risks. The data is anonymised and is provided by police or coroners. The definition of cluster as described in Key Terms is used; if a cluster is not initially evident yet there is an increasing trend, the factors of a cluster may not be known.

The data is shown as a population rate and notes that these deaths are suspected suicides as shown below in Figures 2–6.

Figure 2: Northeast and North Cumbria suspected suicides population profile from October 2024 to September 2025

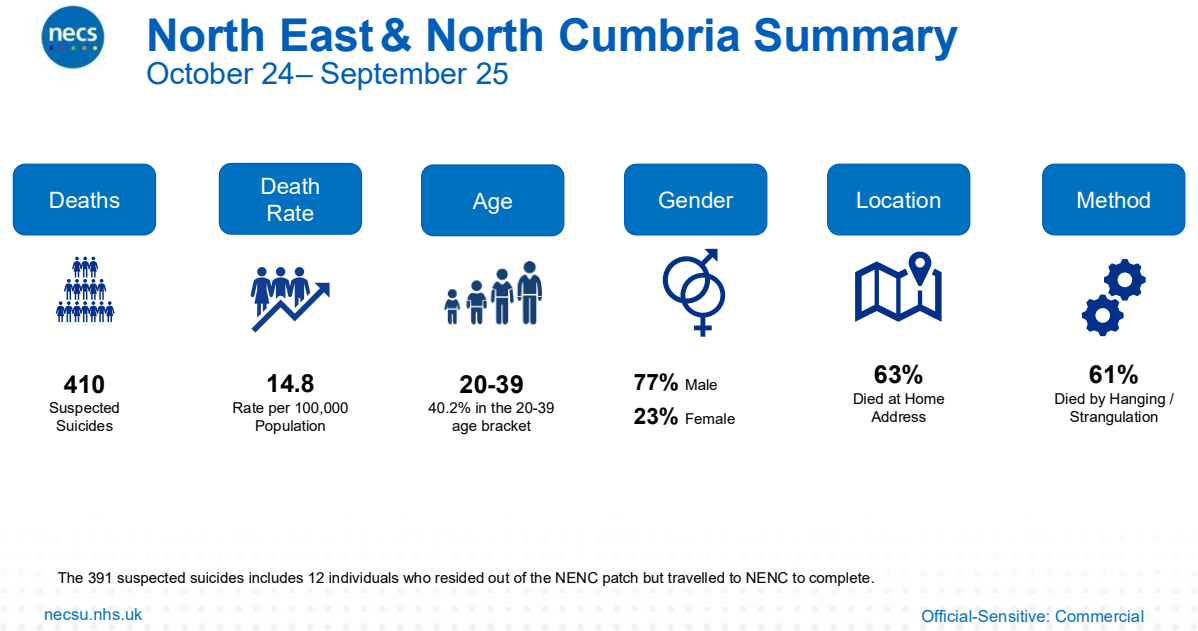


Figure 3: Northeast and North Cumbria suspected suicides for those in contact with mental health services, history of self-harm, and use of alcohol and substances in the 12 months prior to death (October 2024 to September 2025)

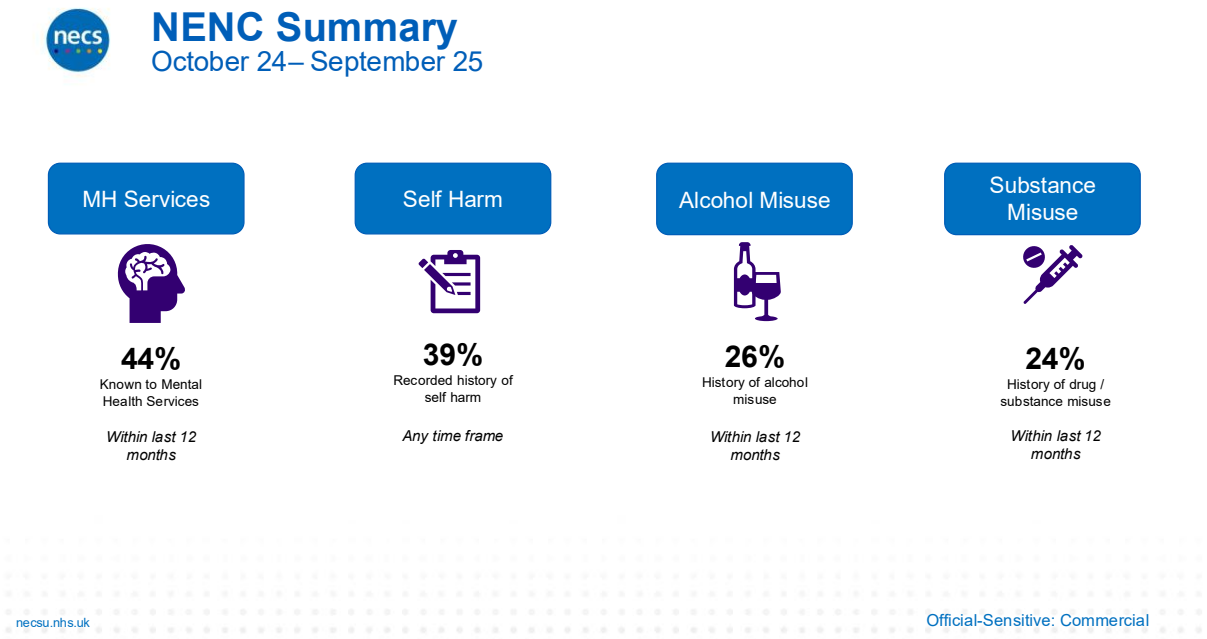


Figure 4: Northeast and North Cumbria suspected suicides marital status, living situation and ethnicity for deaths between October 2024 to September 2025

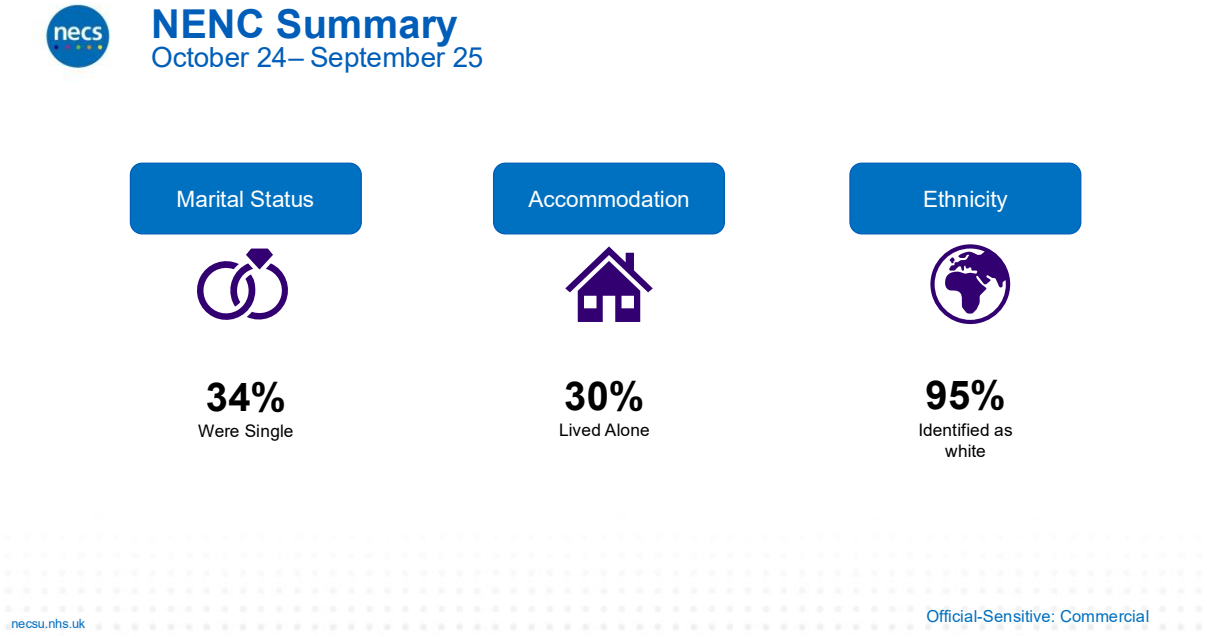


Figure 5: Northeast and North Cumbria suspected suicides for those who came into contact with the criminal justice system (October 2024 to September 2025)

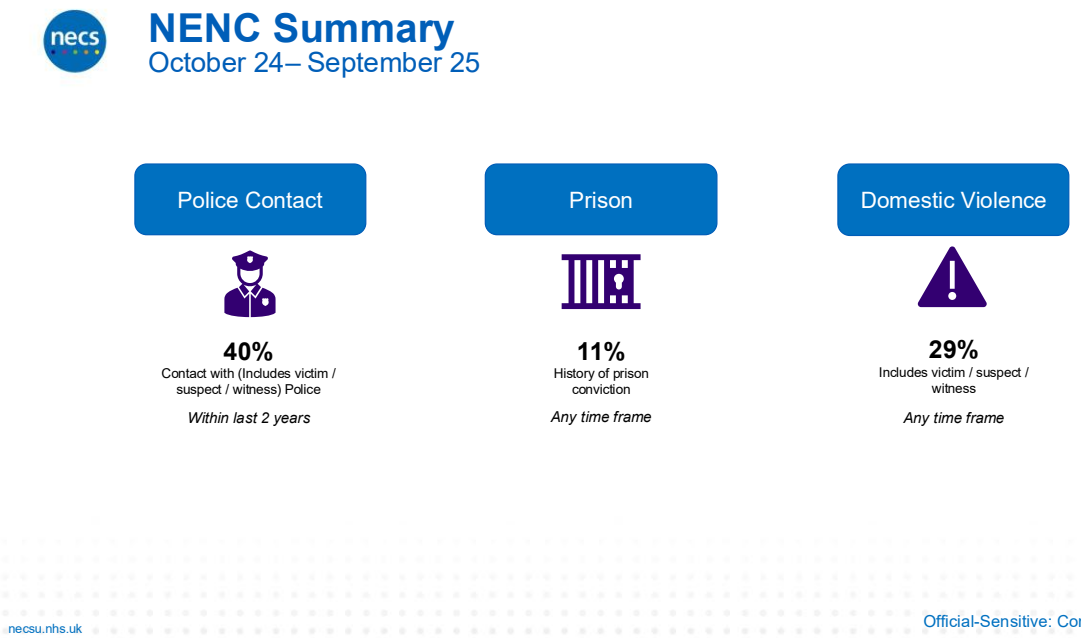


Figure 6: Northeast and North Cumbria suspected suicides rate per 100,000 (October 2024 to September 2025) by local authority of residence and location found

Collated themes from suicide and suspected suicide data from 2005 to 2015 and 2024 to 2025 show some areas which could be improved to reduce the risk of suicide for those who come into contact with NHS, local authority, voluntary and community sector and criminal justice services. Using the qualitative intelligence sought through records and from multi-agency consultation on cases, areas of improvement and recommendations have been identified.

These findings and recommendations are detailed in Table 5.

Table 5: Summary of findings and opportunities from suspected suicide audits

Themes from cases	Opportunities
Substance Misuse • Alcohol/Drug related injury • Co-occurring substance misuse and mental health issues	Evidence of significant alcohol and or drug use over many years impacting on physical health but limited evidence of referral or engagement with substance misuse services. Limited evidence of support from mental health services and issues with integrated

	services for those with co-occurring mental health and substance use
Mental health diagnosis • Mood disorder • Schizophrenia • Post Traumatic Stress Disorder • Bi-polar	Serious mental ill-health diagnosis was noted but the opportunity of annual physical health checks was not maximised or taken up and therefore opportunity missed for contact.
Undiagnosed neurodivergence	Evidence notes cases of those deceased were waiting for diagnosis but no evidence of screening of those who were vulnerable to prioritise assessment given the extensive wait time for assessment.
Waiting for diagnosis/assessment including gender identity and transition	Waiting well reviews and support for people's mental health while waiting for physical health diagnosis was not routinely offered.
Prescribed medication contra-indication of medication was noted in case notes including prescribing of medication which may increase suicidal ideation. These included Doxy, Promethazine, Propranolol, Gabapentin, Zopiclone, Finasteride Changes in medication including antidepressants were noted as high risk. Purchasing prescription medication as a method, including insulin	Collection of unused medication being used as method to take own life, this includes deceased relatives' medication that wasn't collected or returned.
Self-harm and previous suicide attempts heightened risk of taking own life	High proportion of people who took their lives had previously self-harmed or attempted suicide in 12 months prior to

	death and had been in contact with NHS services
Physical Health noted in cases • Chronic pain • Life limiting and age-related morbidity. • Head injury and impact of alcohol use. • Neurological conditions • Cancer • Tinnitus • Unspecified pain • Neurodiversity • Sensory loss	Opportunities for treatment of the person as a whole with consideration of impact of poor physical health on mental health and wellbeing. With services having the knowledge and confidence to refer people to support. Highlight risk with NHS services including pain management services.
Prison and prison release Criminal justice contact Sexual related offences Domestic abuse Deaths after custody and those on bail Prison early release Financial crimes and the impact on position of trust and stigma; shame of arrest	Preventative opportunities within the Criminal justice system with joint working with NHS and local authority services to reduce risk of suicide.
Trauma and significant life altering events Experiencing loss was a key theme • Relationship breakdown and long-term relationship loss • Child removal from parent • Looked after child and care leaver • Generational trauma history • Retired, job loss • Abuse child, adult, domestic	Build resilient populations to manage change and be supported through trauma Trauma informed services for those with behaviours which create barriers to accessing NHS and social care services noting health inequalities for this group of excluded people; those who experienced homelessness and inclusion health groups.

• Bereavement including: - loss of a parent or carer - loss and bereavement linked to dementia and other loss of those still living - suicide loss	
Carers Carers for people with chronic pain, physical illness, living with substance misuse, mental ill-health	Awareness of carers stepping away from care responsibilities for self-care • Bereavement • Abuse • Victim or Perpetrator of domestic abuse
Cyber related suicide Cyber enabled suicide Media influences both method and reporting Searching for method creation Services vilified. Access to www. in terms of ordering equipment to use as a method Live streamed death or threat to death	Share learning with Samaritans online media team to escalate action
Financial issues Issues with benefits and ill health Employment issues and job loss Gambling and debt Self-employment and business problems	Improved training and policy support for employers and raise issues of finance and impact within NHS and local authority services

Socio-political concepts were analysed in the 2024–2025 data to establish wider aspects and influences on people's decision to take their lives. Through this data set the multi-agency

process discovered specific social factors and political directives which impacted on death by suicide. These factors have been grouped into the points below.

Health and social care

- Pressures on social care thresholds and carers' support; pressure on carers to continue to care and the long-term impact on their mental health
- Opioid prescribing benchmarked as higher in the Northeast and North Cumbria and linked to pain management and the costs of prescriptions

Criminal justice system

- Impact of the 2024 prison early release scheme and the preparedness of prisoners to re-enter the community without secure accommodation or support
- Right Care Right Person ("last service standing"): risk of non-statutory services disengaging and VCSE provision seeing more people who are higher risk without the support of statutory services, including information sharing on high-risk individuals
- Crime strategy and local police approaches in Northeast and North Cumbria, including concerns about access to emergency services; increases in knife and gang crime; and police using social media to share "wanted" messaging

Policy

- Financial issues including the impact of the cost-of-living crisis, annual prescription cost rises, heating costs and increased poverty; increases in minimum wage and national insurance; access to the rental market; and winter fuel payments ceasing
- National policy impacts on farming and rural communities (e.g., farmers' inheritance tax, changes to subsidies and rural poverty) resulting in changes to gender roles, including household income shifts and workforce changes
- Government policy on animal health (e.g., TB, avian flu, foot and mouth, bluetongue) and the impact on farming and rural communities
- Immigration policy and media coverage affecting residents and migrant populations (e.g., employment, accommodation and community tensions, including unrest in 2024) and the impact on vulnerable people relocating to the UK

Unemployment

- Changes to disability allowances and related approaches, including mental health policy

- Impacts on small business owners and the hospitality and alcohol sales industries, including the legacy of COVID-19

Education

- Literacy in the Northeast and North Cumbria is lower than the rest of England, with an average reading age of 7 years

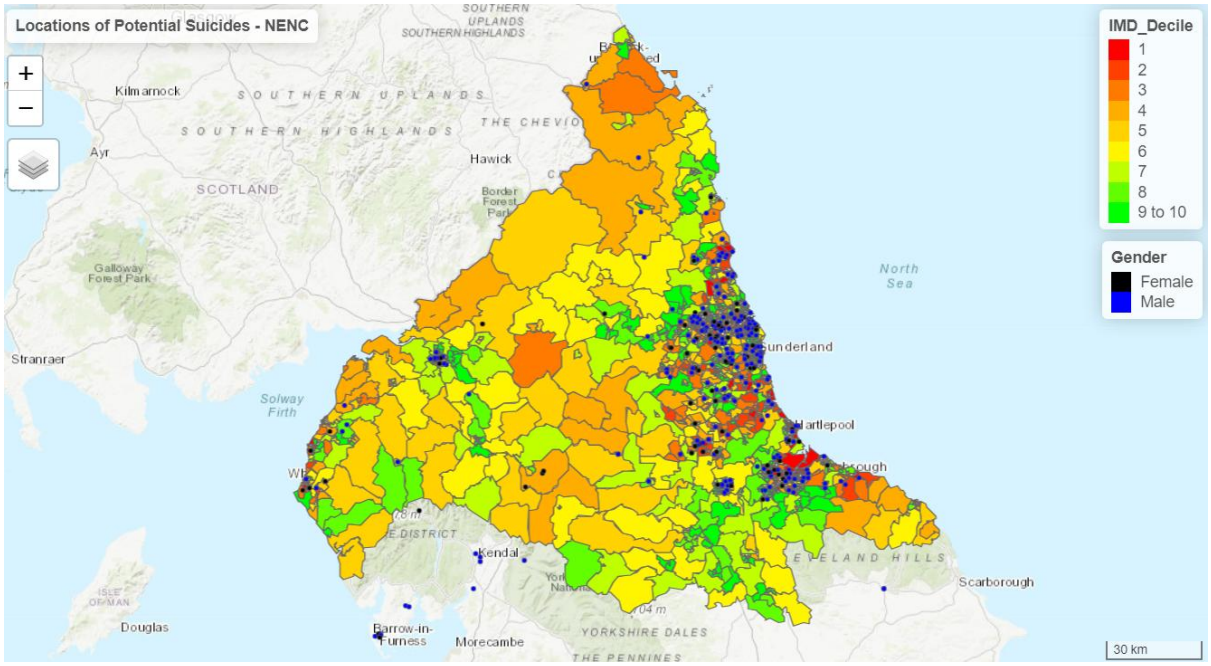
Deprivation and poverty

- Spend per capita north–south divide and differences within the Northeast and North Cumbria, noting Teesside received less NHS and local authority spend compared to the rest of the region
- Gambling and advertising approaches, showcasing the opportunity for a better life and increased wealth, particularly affecting more deprived communities

Deprivation and poverty in the Northeast and North Cumbria reflect health inequalities experienced by the population and are noted as a key factor contributing to suicide in this area. The map below shows suspected suicides by the Index of Multiple Deprivation for the 2024–2025 data. The Index places the deprivation scores of individual areas into one of ten groups of equal frequency, ranging from the 10% most deprived areas to the 10% least deprived areas. Red shows the most deprived areas and green shows the least deprived areas.

Map 1 shows the Northeast and North Cumbria as a whole and there is a clear picture of the resident postcodes of suspected suicides from 2024–2025 with higher numbers of cases in the lower IMD decile (the most deprived areas).

Map 1: Suspected suicides resident postcode by IMD (1 October 2024 to 30 September 2025) Northeast and North Cumbria



7.6 Conclusion

The suicide audit data from 2005 to 2015 shows a naïve approach to analysis in trying to establish a singular theme of causation. The sourcing of this data included mental health services, primary care and coroner data and records. Suicide is complex and rarely due to a singular cause and more about the relationship the person had to the circumstances they found themselves in, and the response they took to these. The response will vary to each individual and what one person will see as a reasonable reaction to circumstances, for example suicide, someone else wouldn't consider this. For some the weakening of social relationships or familial concerns may lead to suicide; for others not. For people with trauma and attachment issues, loss of key social relationships may lead to a decision to take their life.

Where a person is in their life course may also affect the decision to consider suicide. We note from suicide audit data that those in midlife are more likely to take their lives; this may be due to the impact a change in circumstances may have on their sense of self, their lifestyle and their values and beliefs.

In terms of the data analysis for the 2024–2025 suicide audit, coroner data was not included, and the focus was on a multi-agency analysis of data from mental health services, police and prison, health and care records and postvention services. This data was reviewed through group analysis of specialists including professionals from safeguarding, GPs, mental health professionals, public health, police, health and justice and clinical quality. This individual-

level data was used to show social circumstances and construction of the life before death. The findings from this data show a broader range of concepts and include the socio-political influences and deprivation in addition to individual aspects.

Key limitations of the suicide audit data include the lack of recording in NHS services, coroner and criminal justice systems relating to key characteristics of the deceased. No data was recorded on social class, and limited data was available regarding the employment status of the deceased, their sexuality and ethnicity. Marital status wasn't routinely recorded although some details became evident through coroner records.

Chapter 8: Findings

This chapter reports the findings from the qualitative data collected through interviews with suicide survivors. The data were analysed as described, using Quirkos (2023). The tool generates a canvas view of the data as the researcher develops themes; these are called Quirks. The Quirks can contain subthemes of data and can be shown in multiple formats, as shown in Appendix C. The main canvas developed by the researcher identifies key themes and subthemes. The quotes included are transcribed verbatim and therefore retain any grammatical errors.

When coding the data, a specific focus on change over time guided the analysis and the development of the final themes. How time affected and the survivor's journey to this point was discussed with them individually and their reflections on how their view of the world has changed since suicide loss. All the participants have been bereaved by suicide with one exception, Dot who was a medium who supported many suicide survivors.

The data analysis identified seven themes which follow a timeline from the reconstruction of the suicide to prevention of future deaths. These themes are used as a guide to the sections of the findings within this chapter as detailed below

The seven themes are outlined below and are discussed in turn in the sections that follow.

8.1 Context of suicide and reconstruction

8.2 Suicide in communities and generational suicide

8.3 Community response

8.4 Deal – Dealing with suicide and survivorship

8.5 Feel – How suicide survivors came to adapt over time

8.6 Heal – Growth and healing following suicide

8.7 Hope after suicide and prevention

Table 6 details the sample characteristics of the participants within the study and includes a pseudonym, gender and age band. The relationship of the participants to the deceased is shown alongside the age of the deceased when they died and how long ago the death took place. The suicide survivor stories are detailed in case studies in Appendix D and provide the context and circumstances of the suicide and the story following for those left behind.

At the beginning of each theme the quirks and sub themes from the coding of the interviews are detailed which provides overview of the analysis as detailed in Appendix C.

Table 6: Sample characteristics of participants

Participant number or family number	Age range of participants	Relationship to the deceased	Age of the deceased	How long ago was the death from interview date
Case study 1 Sue Chris Charlotte	 55-65 55-65 22	 Mother Father Sister	22 years	5 years
Case study 2 Joan	 60-70	 Mother	32	2 years
Case study 3 Lynn	 35-45	 Mother	19	1 year
Case study 4 Sharon	 45-55	 Mother	32	11 months
Case study 5 Joanne	30-40	Long term partner	35	2 years
Case study 6 Adele	 40-50	 Wife	32	2 years
Case study 7 Natalie	 50-60	 Mother	35	1 year 10 months
Case study 8 Jane	45-55	Mother	20-25 20-25	2 years 3 years
Case study 9 Phil	 20-30	 Cousin	19	3 years
Case study 10 Barbara	 55-65	 Mother	33	5 years
Case study 11 Brian	55-65	Father	27	3 years 6 months
Case study 12 Colin Angela	 55-65 55-65	 Father Mother	25-35	1 year 2 months
Case study 13 Kevin Helen Joseph	 40-50 40-50 22	 Father Mother Brother	25	1 year 2 months
Case study 14 Dot	 40-50	Medium spiritualist		
Case study 15 David Carol	 20-30 40-50	 Cousin Aunt	23	11 months
Case study 16 Stuart	 40-50	 Partner	40-50	1year 2 months
Case study 17 Paul	40-50	 Partner	30-40	1year 6 months

8.1 Context of suicide and reconstruction

8.1.0 Overview of the theme

This section describes suicide survivors' beliefs that led to the suicide of a loved one and the experience immediately following the death. The analysis of interview data and overview of each death in the form of case studies contextualise these circumstances.

8.1.1 Reconstruction

This section describes the experience of suicide survivors and analyses of the data from interviews which describes the circumstances of the suicide and reconstructs the experience. Data from interviews were analysed and concepts emerged. These were developed into quirks as detailed below in Table 6 and in Appendix C.

Table 6: Details quirks included in concept Reconstruction

Concept – Reconstruction Experience of suicide itself and immediately after death - 368 quotes
Coroner
Deceit
Method of death
Circumstance of the death
Who died
Circumstanced before the death
Activity straight after death
Social media
Police/Crime
Funeral
Inquest
Visit grave/body
Police notifying death

8.1.2 Circumstances of the death and activity straight after the death

Those bereaved by suicide described how they found their wife, husband or partner deceased and attempted to revive them at home before emergency services arrived – one lady couldn't cut her husband down on instructions of ambulance service.

> *'My husband came in from nightshift, got the kids ready for school and then he was going to bed, and I went to the doctors and did a bit of whatever I needed to do, shopping and what not um came back and found him hanging'* Adele

> *'I came out of the house screaming, literally…it took me 15 minutes to remember how to ring 999 and I was calm then. I was just like 'well what do I do'. It was weird you know. You'd think I would be completely off it by then wouldn't you but straight away. I don't make sense of it really, but um I made the call and that's when I started to get upset cause the women on the other end of the phone said 'can you get him down' I said 'look' I says 'If I thought there was one breath left in his body I would have tried to get him down but no' and that got me upset then and then I came running'* Adele

One lady was traumatised following the death of her partner and regretted that emergency services wouldn't let her touch him before they removed the body.

> *'I had to give him mouth to mouth. He'd bit the end of his tongue and his tongue was black, his eye was sunk in, you just don't. I cannot give you a picture. They wouldn't let me come back in here and kiss him before he came out of the house, you know, and I just want…all I wanted to do was touch him…you just cannot…you cannot comprehend it'* Joanne lost her partner to suicide

Through the interviews parents and family members recall the circumstance around how their children found their parent or brother deceased

> *'Yeah they were both there, and being the dummy he was watching Netflix and that and he just said 'I'll see you later' and that was it….his mates in fact, his friend, his brother..he got his brother off the washing line, both of them got his brother off the washing line'* Kevin lost his son to suicide

> *'The bairn normally gets up really early, and he's sat downstairs on the couch and all I heard was someone running up the stairs shouting 'mam, he's hung himself'. When I came down, he'd hung himself over the treadmill in the corner. He must have come*

down and seen the lights were off and his dad wasn't on the couch, so he must have come down and sat down there, not realising his dad was behind him' Joanne lost her partner to suicide

'He'd been babysitting, er, he was staying in the house…they found him (his children)…don't think he's ever..' Phil lost his male cousin to suicide

'I came out of the room, it was about quarter to 3 in the morning, um, didn't have me glasses on and there was someone near the curtains and I saw C in front of the motorbike. I says to Lisa (child) 'get up back upstairs now, go to bed!' I thought she went back to bed. Anyway, I get up at ten to seven in the morning. Claire is still here, skipping ropes around her neck. Lisa wasn't there so I shouted to get upstairs and phone an ambulance. I went and grabbed her, put her down and give her mouth to mouth on the floor um but I later found out that Lisa had sat on the stairs from quarter to three and just sat there watching her mum' Paul lost his long-term female partner to suicide

Where a parent was searching for the missing son and found them deceased was recounted in detail the circumstances with one parent feeling they live through the details daily since the death.

'Cos when it happened it was a nasty nasty night, it was snow and chucking it down, helicopter was there about 2oclock, and I was out there as well, you know, all the police and all that like. They says they would start in the morning. I didn't sleep. I went down there about 6 o'clock in the morning. There was one copper sitting with a cop in his car. I just parked up and walked, start again, hunting are you with me?' Police came to me and asked 'what are you doing' I says 'am looking for my boy' they told me they were going to have a search party out tomorrow morning, so there's nobody here….what happened if something went fucking wrong, are you with me. She (police) says it takes time to get a search together….I went fucking ballistic, I was going fucking ballistic. Searched all day. I knew, I knew he were dead. In the back of your mind, I knew…..so at about 4 o'clock we found it, the body and I had to go and identify it about 8 o'clock at night. That's one of the worst things I've ever done man' Brian lost his son to suicide

'The officer took the phone from me and he was going…he threw it on the floor and that's when he told me everything. He said 'I've got some bad news for you' and I just

looked at him and I said 'don't be fucking stupid, you just told me he's going to be alright, you're going to get him to hospital' and then I remember kicking the shit out of this tree, writhing at the grass and punching the copper and kicking and…he just held onto us. And then he said, 'let's go and have a cuppa coffee' and I said 'no I want me baby…nobody would take me to the hospital…I hugged him, yeah but I even begged, I begged him, I said 'I can make him better. He needs his mam and that' they wouldn't let me' Jane lost her 2 sons to suicide

'It's coming up to a year next Wednesday…. its feels like the last hours just sort of haunts you, seeing her going through, laughing and joking one minute to her dad trying to bring her back to life in the space of not even an hour' Lynn lost her daughter to suicide

Some families didn't find their son or weren't aware of their death immediately, with one mum and dad being on holiday abroad when they were told their son had died.

'He died on the Friday and we didn't get…the trouble is we didn't know until the Saturday evening. Because we'd gone on a trip for the day…they couldn't contact us…our son had contacted the hotel…when we got back there was just this sheet of paper in the room 'please contact the desk'…you'd never in your wildest dreams. Has somebody had an accident, but not this. This never goes through you mind' Helen lost her son to suicide

'He'd bought some…got a rope in his glove compartment and everything. We didn't know anything about that; we had no idea. Until we got a phone call on Sunday night saying he'd gone out and he was going to do something…I mean we went looking for his car, Sue had an inkling it was down by this pub in the middle of the woods, and sure enough it was there. And that was it, we looked for him for about an hour, but he'd parked at one end of the woods, and he'd walked all the way to the other end, so we never found him until the Tuesday, found him on the Tuesday' Chris lost his son to suicide

8.1.3 Social media

Social media was used positively for support while families were searching for those who were missing, communicating with people through Facebook helped before and after their sons were found.

Positive aspect of social media and impact on community support

> *'I had a lot of support on Facebook when Darren went missing. A lot, a lot of support'* Jane lost her 2 sons to suicide

> *'I don't like Facebook, but it was great for that. Because she* (Charlotte who lost her brother to suicide) *just went on Facebook and says can everybody stop searching because you are getting in the police's way and destroying evidence – that's how everybody communicated, it was like the whole village because the majority of the village that was helping search..in groups all over'* Chris lost his son to suicide

> *Social media actually got that organised and got them to stop texting…. normally you would have to phone individual people. You got across to so many people in seconds. And they all stopped searching because if they had kept it up ringing him, they would never have found him, trying and getting a phone signal… we had hundreds of people searching…somebody would have found him. I wouldn't have liked to have been that person because I didn't want to find him. Social media was a really big help in that case.'* Sue lost her son to suicide

8.1.4 Social reactions, rumours and stigma in the community

Accounts also described how information spread quickly through local networks, with rumours and speculation shaping how families experienced the aftermath and how safe they felt within the community.

One parent described impact of stories of her husband's death on Facebook and the effect on her children finding out about their dad's death through social media.

> *'I didn't tell the girls initially straight away, but they went to school with the kids on the street, the parents opened their mouths and you know they don't care, there were just that many rumours. I mean the first one was that I murdered him…..I mean it was*

on Facebook within 20 minutes…..I had to tell them because the kids were being cruel. Facebook. I hate Facebook!' Adele lost her husband to suicide

8.1.5 Responses from statutory services and systems (police, coroner and inquest)

This section describes survivors' interactions with statutory processes following a suspected suicide, including initial police response, coroner processes and the experience of the inquest.

One dad recounts the repeated request to identify his son, the trauma of that experience which he felt was callous of the police.

'You knew what you were going to go and do anyway, but the thing is, I got there early before the police, at the morgue, and I went in and sat with him a but and I come out and the police come 'Oh Mr 'Jones' could you do that again please' and thinking what the fuck do you want me to do that again for. 'just so we know who it is like' do you not believe me like, I've just told you its my boy in there. 'oh but could you do it while we're there like' Oh fucks sake you want me to go in and identify my boy twice like….now I found that callous like…'I thought fuck its traumatic enough without having to do it twice – just so they can witness your sadness or whatever it is like' Brian lost his son to suicide

Suicide survivor's experience of the police when trying to locate their missing family member was difficult and for many uncaring in their response.

Policeman said to the parents about their son who was missing*, 'I'm just saying now, normally when we hear things like this they don't come back'* Chris lost his son to suicide

'They (the police) didn't ring us for a week before so when the phone rang I knew it was them and I says 'oh, you've remembered me now' and he just blurted it out 'oh, there's a body been found. Um we're sure its Darren jane' and I'm sitting here going oh yeah uh-huh alright. There was nobody here. He goes 'are you on your own, are you with somebody and he went 'we most almost sure its Darren from the type…but I'll ring you back' and I was like oh okay then, right bye. Put the phone down walked

into the other room and collapsed because it wasn't going through my head what he was telling me' Jane lost her 2 sons to suicide

'I got an apology from the police when Darren went missing (10 weeks to find him) he said (police) 'its all an experience for us as well' Yeah, cost my son his life'. Jane lost her 2 sons to suicide

Suicide survivors experience of the police when they were being notified of the death, one parent acknowledges the impact on the police of their role in notifying families of a death and how difficult it is.

'I remember the 2 policewomen come in, it was a shock to the system, funnily enough I took it all of it in and remember exactly what they said and what their mannerisms were. They weren't very good, not good at all' Stuart lost his long-term female partner to suicide

'I don't think they (the police) should be the first ones your put in touch with…the police I mean come to me door, I thought they were coming for me cos I had to give a statement 2 or 3 hours after he died, and I didn't know what was going on' Joanne lost her partner to suicide

'One of the female officers, I mean they rushed in and I was screaming at her even though I knew she'd gone. I could just seeing her, I knew she'd gone this one oh she was lovely, I screamed at her, shouted and swore at her and then when she'd come in and says let sit down, I said don't you dare come in here and tell me she's dead, I says get out…I often think about the police, you know because it has a massive effect on them…she was crying as well, you know she was in tears you know' …. You just think the police are made of steel, not having feelings but they're human at the end of the day. Bless her I feel bad for her when I look back at me reaction to her. It wasn't personally aimed at her you know. I just didn't want her coming in and telling me she were dead, even though I knew. I knew but soon as she saying them words confirmed it and then they came to take her away' Lynn lost her daughter to suicide

8.1.6 Inquests

Experience of Inquest for families was extremely difficult. Families recall being offered to look at the evidence including photos of the deceased. The media presence for others felt intrusive and further impacted on the stigma they felt from the suicide of their loved one.

> *'I'm not kidding you it was a big book of photographs of what they took and she went (police officer) do you want to have a look? And we just went I don't think so – that will be the last thing we see. And then she just said alright, do you want the rope? I'd got out and when he said you can go (coroner) I just broke down, I said I cannot handle this'* Kevin lost his son to suicide

> *'When Michael died, the day of the inquest, I did take an overdose. It was just too much for me'* Adele lost her husband to suicide

> *'I cried down the phone to the coroner…because obviously there was going to be an inquest and I didn't want the kids…I thought if the papers were there, I don't want the kids knowing he was a smackhead, that's all I could think of'* Joanne lost her partner to suicide

8.1.7 Practical arrangements and community support immediately after the death

The practical tasks that followed the death—such as identification, funerary arrangements and immediate support—were described as both necessary and emotionally overwhelming.

Identifying the body of the deceased or visiting deceased in the chapel of rest

Participant wanted to see the body of deceased while still in the place they died when they were not the person who found them. Police discouraged this and advised the family to visit them at chapel of rest. For many this was very distressing and terrifying, but families found they wanted to be next to their child for as long as possible, talking to them and touching them.

'And then I went to see him. Oh god. No. That nearly killed me, I was terrified, terrified…I'll never forget it! I can still see him now in that coffin. When I picture (him) now its always in that coffin and I wish I could get that out of me head' Joan

'I said eee son, why have you done this too me, eee honest, he was too cold, but when I did touch him I couldn't leave him alone. I was rubbing his face and his hair and I was just talking to him, asking why he could do this. All of a sudden I got a lot of fear in me and thought he was going to sit up and go BOO!'…'ow it was awful! I went to say my goodbyes to him that night and I just said 'save a place for us in heaven, if there is one and they had to drag us out. Awful – I didn't want to leave him' Joan lost her son to suicide

'we went and identified the body and stuff, when we went to the chapel of rest, we put him some clothes on that we knew he liked, his trackies and that and then we done his hair didn't we, gelled his hair and that. Because he just looked the exact same I mean I've been, we were like…we were…it was like we lived there. He went the first time, he says I cannot go back. I don't want to go back. But you just couldn't stop yourself…we spent hours in there sitting and talking to him. We spent hours because it it felt right' Sue lost her son to suicide

The parent of children who found a parent deceased, the remaining parent wanted them to remember their dad differently and encouraged them to visit the deceased in the chapel of rest.

'Knowing he had hepatitis we had to close the coffin..I had to get the Dr to ask the funeral director to open the coffin for us because the last thing, I know its awful like, but I had to ask them (children) if they wanted to see him because the last thing they saw was him over there with a rope round his neck, you know and he just looked asleep' Joanne lost her partner to suicide

Arranging the funeral or send off (one parent talked about sending their child off to somewhere better than here) was a blur for many with just the practicalities being challenging. Survivors received a lot of help and support from people including vicars who supported families daily and, in some cases, didn't charge for their time or the church as part of the funeral.

'I can't remember actually doing the funeral…it was just an emotional blur. The vicar didn't charge for the church…I didn't realise how much that was, it was about £600, aye, for the vicars time. And I thought oh, then we got the bill and he says you don't have to pay for that and I thought that's a nice gesture' Sue lost her son to suicide

'I remember the crem. I cannot remember going in, what the vicar said but I can remember them shutting the curtains. That's it. Because that's it. Final. That's it and that's, I think when you really. That's when you know like….you come and you think he's not going to be coming in from work and he's not going to be doing this and he's not going to be blasting music and you start to think along them lines' Sue lost her son to suicide

'I changed his sheets. I said I must change his sheets….we um had him cremated. I put woody in. You know Woody from Toy Story, we couldn't find his hat, we were looking everywhere. We said he must have lost the hat. So I pulled the bed out and took them all, the hat drops on the floor and that was it. I was..' Helen lost her son to suicide

'your heart feels like…oh it feels like a bag of sand. It's that heavy. And it it literally does scar your heart. There's a proper scar there where.. I, I have 2 now (sons) but my head won't accept D had gone. It just wouldn't accept. Like when he lay there in his coffin and I played all his songs. I tried to … it is Darren, I kept…it is Darren. don't be daft it's not Darren. It is, it's my bairn in here and cannot even touch him' Jane lost her 2 sons to suicide

8.1.8 Life after the funeral: ongoing grief and survival

In the immediate days after the funeral survivors felt that they couldn't see a way forward to continue and the hurt they have for losing their loved one continues. Their journey doesn't end with the funeral.

'I mean you can't see a way. The first thing is I found is you can't see a way forward. You can't see a future. But it hurts so bad at the start, you can't see…you have to go hour by hour. I used to say to her 'we'll have to get up tomorrow because time doesn't stop. We've got to go on. We can't stop time; we've got to go to bed and

we've got to get up tomorrow. Even though you don't want to. But you've …. But you can't see. I couldn't see a future' Chris lost his son to suicide

8.1.9 Unseen circumstances and safeguarding concerns including domestic abuse

Suicide survivors share that their family member was a victim of domestic abuse before their death, this was physical in some cases and emotional and coercive for some. They saw physical signs of the abuse and messages from the abusers to their loved ones.

'She was a big part of it, a very very big part of it. He was a victim of domestic abuse, but he wouldn't tell anyone, and I could see him more, uh wasting away and that. She would never let me sit and talk to him, she always had to be there and when shed had a drink…a few months before that I had to pull her teeth out of his face' Jane lost her 2 sons to suicide

'The night before he went, she was drunk and all..all the people said she was lacing into him in the street, and they'd gone to visit their son on the morning …it was a red-hot day, and Darren had a thick jumper on. The supervisor asked if he wasn't warm and he went no am alright …so am gathering he had bite marks and things like that' Jane lost her 2 sons to suicide

Joanne describes how her partner's behaviour changed following alcohol use and how she felt she had to manage risk and safety at home, '*when he had a drink he would change…he could be lovely and then he'd just flip… and I'd be trying to keep the kids out of the way. I didn't tell people what it was really like because I didn't want anyone thinking badly of him or me'* Joanne lost her partner to suicide

8.1.10 Peer groups and loss of everyday support

Survivors felt their sons had lost their friends and therefore their support before they died. Their life had changed and so had their friends as they grew up, had families or left the army and lost their support network. This wasn't mirrored for daughters who were lost to suicide.

'I think his peer group meant a lot to Dermot; he'd link in with them when he didn't link in with us at times. They're all doing their own thing as well and he's say 'oh I haven't seen so and so for ages…yeah but they all got married and they had partners but that's what's growing ups about, you might meet each other every now and then but not every day because that, it doesn't work like that' Angela lost her son to suicide

8.1.11 Working after suicide

This section focuses on survivors' experiences of returning to work, including decisions about whether to disclose the cause of death, the adjustments offered (or not offered), and how workplace cultures shaped feelings of support, stigma and safety.

8.1.12 Adjustments, disclosure and return-to-work experiences

Some suicide survivors felt they weren't in a position to work following the death, for those who were self-employed and were financially able they stopped work many months.

> *'for the first few months (after her suicide) I didn't (work) I couldn't face it. I eventually after a few weeks I had to send a blanket email saying a family bereavement, I didn't tell anyone because it's personal I just said family bereavement and I would be back soon as I can…it was about 4 or 5 months before I picked up a pen and started little bits of work but I found it really hard to start with'* Stuart lost his long term female partner to suicide

8.1.13 Employer responses to those bereaved by suicide

Jobs survivors enjoyed before the death felt difficult to manage post suicide, jobs where the survivor worked on their own for a significant time they felt unable to carry out. One employer moved the bereaved to an office on their own to work on computer as they felt this was the space they needed on their return to work to avoid other work colleagues, they felt

this was the worst thing the employer could have done. Survivors note there was little understanding from line managers on managing people who are bereaved by suicide.

> *'I got sent off to do certain jobs by meself, I was a green keeper at a golf course. So sometimes I was like by meself for two and a half hours doing trees or cutting leaves or that, so it's frustrating really but because I enjoy, like now if I went back I'd probably love it but at the time I wasn't in the right place to do it..the guy who owns it he said I should have just told him and I could have had time off but the manager was just, he just..you could tell he hadn't really had the loss in his life'* David lost his male cousin to suicide

For survivors who couldn't return to work this related to either their own mental health or that of their children. There was difficulty accessing trauma informed therapy which ran up to 3 years after the death which impacted on their return to work. For one survivor the impact on the family related to finding their partner and children's father deceased in the house and the difficulties the children felt staying in the house alone after the death.

8.1.14 Workplace environment triggering trauma

One parent who lost her daughter to suicide returned to her role in a school. She is reminded of her daughter at a younger age and some of the children have the same name which she finds triggers flashbacks to losing her own child.

> *'I had 6 weeks off, a lot of people said I shouldn't have gone back after 6 weeks..in the June I said I need to go back for the last week before simmer holidays otherwise I won't go back. So in a way, oh god, I don't think I were ready mentally because I work with children, there's blonde haired little kids called Tina you know….they're playing in the playground, screaming like kids do and I'm like oh it brings it back to me, him screaming upstairs when he found her you know, you get flashbacks and its horrendous I wouldn't wish it on my worst enemy'* Lynn lost her daughter to suicide.

8.1.15 Working with organisations on suicide prevention or postvention support

One suicide survivor shared the experience of taking a job at a charity local to them who supported people bereaved by suicide, he took the post after his experience of being bereaved and being supported by the charity. The charity employs people who have had experience as a suicide survivor to provide lived experience support. This can be sometimes upsetting for the survivors who are reminded of their own grief.

> *'I'm employed full time, so I've been here about a year now…it is hard um I have hard days there's photos of my cousin everywhere in the office and there's like details of my family on the database and all that, it's just hard'* Phil lost his male cousin to suicide

8.1.16 Immediate support for survivors after suicide

Suicide survivors felt there was no immediate support available to them after the death. They described not knowing what to do or where to turn and emphasised that support should be proactively offered to suicide survivors straightaway.

> *'No help came from the government as far as I know nobody…nobody's come to your door offering bereavement'* Chris lost his son to suicide

> *'I find that atrocious (when support service isn't available) somebody sat there is absolute despair thinking 'I haven't got a clue who to turn to, I mean if you're a churchgoer you might turn to the vicar or the minister but even that sometimes is not enough, might not be the answer'* Angela lost her son to suicide

8.1.17 Charitable support

There was a local charity who offer postvention support mentioned but suicide survivors sometimes didn't know they were available, and they don't support children bereaved. It was

felt there was nothing other than mental health services for children and young people bereaved by suicide.

> *'We need to know they exist cause not everybody knows about it yet and the other thing is there needs to be a service for young kids in this situation and there's absolutely nothing for the kids. There's just CAMHS (Child and adolescent mental health services) which is just like a general thing… they make sure I am ok and I am able to cope at home with the kids but the kids need something in these scenarios and there is absolutely nothing, we've been all over the internet at there's nothing for them'* Adele lost her husband to suicide

8.1.18 NHS support

When survivors were referred to support this was initially Talking Therapies, the waiting time for first contact was 6 weeks which was felt to be too long for people who needed immediate support. For those who did attend Talking Therapies the interventions were not appropriate for them after experiencing a suicide.

> *'well, they just to turn and say I need somebody now, not is 6 weeks' time I need somebody now'* Colin lost his son to suicide

8.1.19 Money and financial advice

Financial advice, wills and assumptions by survivors around their financial position now they were no longer in a relationship wasn't an immediate concern however it was another area to contend with which survivors found challenging and lonely.

> *'If you pick up a law book or on the internet it tells you that you are ok if you are not married but it's a load of rubbish, so I went to see a solicitor …and he said urrhh..talking about money it's not really a big deal at the time but then you think you're by yourself now and you have just moved into a house there is nobody else here to mop up after you'* Stuart lost his long term female partner to suicide

8.1.20 Social context surrounding the suicide

This section describes the suicide survivor's perception of the social context and factors that may have led to their loved one taking their lives. They describe the personality of the deceased, their relationships and challenges along with how the family supported them.

Suicide survivors described the deceased as always happy and smiling, the life and soul of the party who loved life with many noting the deceased had plans, something to look forward to. There were repeat comments that survivors believed the deceased didn't mean to take their lives given the plans they had for the future.

Parents did reflect on some difficulties the deceased had shared or that they were aware of in the time leading up to the death which included depression, relationship issues, romantic, family and/or work. Survivors spoke of the deceased's experience of domestic abuse and coercive behaviours within their domestic relationships. However, there were also many survivors who had no awareness of any difficulties that they had felt were major issues.

There was some mention of previous suicide attempts by a small number of the participants and some acknowledgement of emotional struggles, work stresses and support being sought prior to death. There was some awareness that the deceased was bereaved or affected by suicide loss. Survivors were aware of the deceased family and friends' who had taken their own lives and the negative impact this had on the deceased because of their suicide loss.

Partners reflected on disappointment that their partner hadn't shared their feelings with them and/or the intent to take their lives, the hurt they felt at not being trusted enough for these feelings to be shared but also that they are now the only remaining parent to children and the impact of losing a parent and partner to suicide.

8.1.21 Suicide survivor regrets and blame for the death

Parents experienced some regrets from their last conversation with the deceased before they died or they worried that their deceased child had felt they were abandoned and had nowhere to turn. Some survivors attributed blame for the suicide to a relationship breakdown between the deceased and an ex-partner of the deceased.

'I bumped into her (ex-girlfriend) on the Christmas…I was out in the car and we went past her, I wasn't going to kick off, it isn't in my nature. I ate at the pub next door she comes in and gave us a cuddle, and I thought if you were a bloke I would smash your head in' Helen lost her son to suicide

There were some suicide notes left by the deceased which described how the deceased blamed themselves for the relationship breaking down.

'he blamed himself on the letter, you know. He said he was a bully and a coward and he..I found it…I'm sorry mum, failed me…its horrible..oh look at all the kisses' Joan lost her son to suicide

8.1.22 Children and young people bereaved by suicide

Children especially teenage children attributed blame for losing a parent to the remaining parent. Similarly, parents blamed their child's ex partners for their loss. Siblings of those deceased felt the pressure of being the remaining child, with increased surveillance from parents and more attention to feelings. Surviving siblings reported wanting to make their sibling proud, for example by going to university. Parents felt that if they didn't have other children, they wouldn't be here and may well take their lives. Parents were acutely aware of the increased attention and pressure on remaining children with closer monitoring from them, but also an increased closeness in the family unit and awareness of one another's moods and emotions.

8.1.23 Parents losing a child to suicide

Photos and visual reminders of the deceased were mentioned, especially not having enough photos of the family together, and regret of not having more photos in general. Mothers had left their child's bedroom as was and spent time in there, looking through their sons or daughters' belongings.

Not being able to control the situation and not being able to make the situation any better for themselves or others was noted by male family members as having a significant impact on them personally.

'I couldn't do anything about it, I couldn't control it, I couldn't help anybody because I couldn't make it better and I think that was one of the hardest things that ever hit me, not being able to make it any better or reverse it' David lost his male cousin to suicide

The experience of losing a child to suicide and the trauma experienced was described explicitly. Some parents found their deceased child and tried to resuscitate them while awaiting emergency services and describe screaming at police to not say their child had died, not wanting to hear the words.

Some parents were admitted to mental health acute care following being told their child had died. Parents noted their regret for screaming and shouting at emergency services and health care staff and their wish to meet staff again to apologise for their actions. Survivors understood that the job of emergency services and health care staff to help during a suicide and the aftermath was distressing for the staff.

'I must have been out of memory for about 6 weeks and then I was in the shower, I thought I decided to go in the shower because I had neglected myself, I hadn't ate or drink…I knew I didn't have a reason to live but I didn't know why and I keep getting these names…and whose that over there, I said have I got a son who has died, I don't know who he is or what he is called…I hadn't slept god this women was screaming all the time…I said what was that noise she said it was you screaming' Natalie lost her son to suicide

8.1.24 Parents need for answers to why they took their life

The time that passed from the death to the time of interview ranged from 10 months to 5 years. However, there was a general lack of understanding of why the deceased had felt they had to die, expressed as confusion and frustration from all the survivors. Families continue to look for answers, going back through personal belongings of the deceased looking for anything which might give them insight into why.

'I've been sat in Tina's bedroom and I've gone through every single piece of paper I could find, college work, old school things, just to see if there' anything at all to give me answers, there's nothing' Lynn lost her daughter to suicide

8.1.25 Suicide note

Where there was a suicide note families kept these, going back through the notes for anything they could find to get answers and in some cases attribute blame for the death. However, few left notes or any indication as to why they took their lives, and there is some acknowledgement from survivors that families will never know, and they will never get a 'proper answer'. This acceptance that there isn't an answer takes years for some and acceptance is needed in order to find some peace from the suicide.

> *'I devoured books, trail the internet for all these sites, these dodgy sites to see what was going on because I never even thought about it before. You struggle to get answers that are the thing. I mean I know now after months of trying I know that I am not going to get any answers. I am ok with that now. But at first, you think everyone needs some sort of peace'* Stuart lost his long-term female partner to suicide

8.1.26 Death by suicide is different

Suicide is described by the survivors interviewed as completely different from other deaths, shocking, brutal and inconclusive

> *'We all have these feelings when somebody dies, just suicide is a brutal shock..normal deaths are normal deaths, we all got to go, full stop…we got on with it but suicide you can't cos it's an inconclusive story'* Brian lost his son to suicide

Partners of the deceased couldn't understand why the deceased didn't stop the suicide act when they could, why they didn't put their feet on the floor or just stand up. This was interpreted by some as the deceased not fighting for the relationship and the family and being abandoned.

> *'I couldn't understand why he didn't stand up..like, I just kept thinking 'why didn't you stand up', he was on his knees on the floor, like I kept thinking, surely you would fight for us..and I searched and searched and searched until I found out why, like how, it was like a meaning into it, you know like why didn't he get up, why I don't understand why he didn't get up'* Joanne lost her partner to suicide

8.1.27 Responding to bereaved children and young people

Where a suicide of one parent left the surviving parent with young children, they struggled to give their children answers to the reasons the child's parent died, some describing the cause as heart attack and expressing they don't know why they died. This depended on the age of the child, with some noting they may share the suicide as the child got older.

> *'I didn't have a note, I didn't have anything so I'll never know ..my girls were older when he died so I told them at the time and it's like I was lying to them 'cause I wouldn't tell them why, I says I don't know why I wish I could tell you why' and my son still doesn't know to this day because he was only six and I don't know how to tell him'* Adele lost her husband to suicide.

8.1.28 Perception of suicide

The strength and courage of the deceased in taking their own lives was felt by some families, and that gave the survivors courage to face the death and anything in the future noting nothing can be worse than suicide.

> '*I feel what he did was the ultimate and that if he could face that then I can…I can face anything'* Chris lost his son to suicide

There was also acknowledgement that the situation can't be changed, life can't be changed

> *'But like I says, it doesn't really bother me, he isn't here now, that's it, I've got to live with it'* Brian lost his son to suicide

For some parent survivors, their child and their act of suicide was selfish and resulted in them being immortal to their families.

> *'It's a selfish act…alright, it's you're always, maybe I shouldn't be saying this, but these ISIS fellas, the suicide bombers, why do they do it? I'll tell you why because they're guaranteed martyrdom. Go to paradise and all this crap like. That's all they've done it for, but why do we do it…because in a way you become immortal…because you're constantly thought about. I mean, I don't go to a grave and all that, I mean, it might be funny way of putting it, but this is how I think. I sit here*

and I think, quite a lot cos by meself, you know what I mean..and they're being made immortal. You'll never forget them' Brian lost his son to suicide

8.1.29 Gender responses to loss

There are differences in those who take their lives linked to gender. Parent survivors who lost sons to suicide felt their sons were frightened of something and weren't able to share or tell anybody about their fears. Some felt they feared the situation they were in, leaving the armed forces, serving a prison sentence, however some felt that now their son was deceased they are not bound or haunted anymore

'you've got away with it..you're not haunted any more..you're not bound by whatever made you do it…yeah, you're not frightened of anything anymore'. Brian lost his son to suicide

The deceased had escaped the pain left behind for the family,

'they've got away with it', 'they are out of there, but their pain's gone to the family – you see someone kill themselves and you think poor buggar but they're out of it, they'll be happy, but the family cannot take it, the family's not out of it'. Chris lost his son to suicide

Parent survivors who lost their daughters to suicide also noted their daughter's fear which was different to sons' who took their lives as daughter's fear was attributed to their relationships with boyfriend's and the controlling coercive behaviours they experienced.

8.1.30 Loss of identity

Parent survivors felt robbed of their futures and the experience of having someone who they feel is important in their lives disappear. It deprives them of having a child and watching them grow, taking their next steps through life and being proud of them. Some of the interviewees reported that the deceased was their only child, with one parent describing the loss of both sons to suicide. There was an acknowledgement that 'they couldn't make another one' for some it's too late and the future the parents envisaged for their family is gone.

> *'I mean he was 22, I was waiting for him, his next steps was to get married and I feel not in a nasty way, I've been robbed…that's robbed our future, you can't make another one…that's the kid we brought up…he was a good kid and we were proud of him and then you feel where has all that gone, that should be the natural progression but we haven't got that'* Chris lost his son to suicide

8.2 Suicide in communities and generational suicide

Overview of the theme

This theme examines how suicide was experienced within communities, including patterns of multiple deaths, multigenerational exposure, and the ways local norms and shared histories shaped survivors' understanding and support-seeking.

8.2.1 Suicide contagion

Some survivors believed that a suicide in a community can have a 'knock-on effect'. When someone known or known about dies by suicide, this can result in others taking their own lives – where suicide becomes an option or a possibility.

> *'But you then think would you do it, cos they do, they do, there was a lot of them did it round here and that's what they say, it's a knock-on effect and it's for the biggest rate, it's a knock-on effect isn't it because some kills themself and they hear and one person who's been depressed hears about someone killing themselves and they think, 'they've done it, I'll do it'* Joanne lost her partner to suicide

There is a general increased awareness by the bereaved of other suicide deaths in the community or local areas, on the news and when people were reported missing, they are perceived as suspected suicide.

8.2.2 Multigenerational suicide

Some suicide survivors referred to deaths by suicide being a generational occurrence, noting the impact of bereavement and loss on other family members could result in further deaths.

> *'It's strange because we've had three suicides within the family through marriage so there's like me cousin who died and then me uncle, like me mums sisters husband, his sister committed suicide last year and then his dad committed suicide a month ago, he couldn't cope with the emotion of losing his daughter'* Phil lost his male cousin to suicide

Those suicide survivors who were parents or grandparents discussed their concerns and worries that other members of the family or friends may take their lives when they had experienced other suicides in the family.

> *'But Dave's mam also committed suicide, when he was 20, she took tablets. He never got any counselling for it or nothing like that…I didn't know his mam cos she'd killed herself before then….but when your 13 year old tells you he doesn't want to wake up in the morning and his dad's killed himself and his nana's killed herself, do you know what I mean'* Joanne lost her partner to suicide

There was some acknowledgment from survivors that suicide runs in families with some experiencing multiple suicide loss over many years.

> *'Suicide runs in my family..I think there was five of them..I'm going back in history. My mother's still alive, and she says like 'this one did it'. I mean, the ones I can think about, this is before my mother butted in, I had an uncle who committed suicide, he jumped in front of a train. I had a cousin; she took an overdose'* Brian lost his son to suicide

8.3 Community response and support

This theme focuses on how communities responded after a suicide, including practical support, social reactions, stigma and silence, and the roles of community connectors such as neighbours, schools, workplaces, faith groups and peer networks.

8.3.1 Supportive community connectors and practical help

This section explores the practical support survivors received and the ways changes in everyday relationships shaped their experience in the weeks and months following the death.

8.3.2 Positive experience of support

Community response and support is described by survivors as valuing relationships, appreciating social support and the importance of peer support from those with lived experience of suicide bereavement.

Survivor families spoke of huge amounts of support from their family, friends and the community they live in. Some families report that when the death initially occurred, they were never alone with close family being there constantly. Many family members were close to the deceased and were very distressed by the death. Being close to one another and supporting each other was important in the early days.

> *'There was so much going on, trying to help herself because when you're in that state and there were sisters who we couldn't get rid of, she wouldn't go home one of the sisters to look after her own kids, she was that upset because they were very close. We were trying to sort ourselves out and people just kept coming'* Chris lost his son to suicide

Family disputes were forgotten, and the small disagreements paled into insignificance as they came together in support of one another.

> *'Some family members didn't speak there was some people that didn't get on and all that and all that got washed under the carpet, like it was all forgotten..it just didn't matter no more, like life's too short, like there's more important things than just falling out over something stupid'* Sue lost her son to suicide

8.3.3 Unexpected support from their community

Support for survivors varied from person to person and in some cases, it came from people the bereaved hardly knew. The kindness of some people to those in distress was recounted as valuable in their time of need.

> *'I have seen and met people who I hardly know, have been like something out the bible, just so generous and kind and then I have had the complete opposite, who have been nigh on evil and don't realise what they are saying'* Stuart lost his long-term female partner to suicide

Families recalled support from their neighbours and friends of the deceased calling at their homes with condolences, flowers and gifts of food. Emotions and tears were shared through sharing their loss and memories of the deceased.

> *'Unbelievable like how people rallies around and the lad lad next door made pie. I mean, he's a he's a car man and he builds things and he was the one that got John into cars …and he come in with a corned beef mince pie…it was horrible, but I mean the thought was there'* Chris lost his son to suicide

8.3.4 Northern communities

Some reflected that northern people and communities tend to rally around one another in times of need. The church as a community was important for some survivors with the vicar playing a key role as a source of support in most cases.

> *'It was nice the way people made a point of linking in but I think it's the kind of community we're in you know people do rally round don't they, they do northern people the church rallied round like a family you know that's because they knew my mum…but they weren't claustrophobic they're just sort of there if you want them'* Angela lost her son to suicide

It was important to survivors to make a connection with others who had experienced suicide loss as some felt that when it happened to them, they were the only person to experience a suicide.

8.3.5 Suicide survivor community

When survivors accessed support services it felt reassuring to know there were other people who had gone through losing someone to suicide with whom they could relate to, someone to offer a level of understanding of what they were experiencing.

For some survivors support came from sport communities they were part of, from the initial death and continued ongoing support, memorial fundraising.

> *'I got a lot of support off my football team which that was real massive for me…we did a minute's silence before the game, and we've done fundraisers and stuff'* Phil lost his male cousin to suicide

Those bereaved by suicide showed a sense of compassion and a willingness to help others bereaved by suicide. The experience of loss had made the bereaved more sensitive and empathic to others. People wanted to do activities to raise awareness that would support people bereaved by suicide who may not know what to do when it happens to others. Some have completed the Great North Run for charities who support bereaved by suicide.

> *'I've actually thought about things meself. What can I do you know, would I need qualifications just, can I do it from me house just for people who've lost children or family members to come and have a cup of tea with me…because nobody understands … I can talk till am blue in the face to family and friends, but they don't truly understand you know, you can't unless you've been through it'* Lynn lost her daughter to suicide

The importance of talking to other people who have been through the same suicide loss was reiterated throughout all the suicide survivors.

> *'Just somebody who's not really affected by it like you know, my son committed suicide type thing, they sympathise but they don't understand….I would need support from somebody who would have been through the same situation…I thought I could fight it meself like, but you can't. You do need that support. If it had been somebody who hadn't been affected by it, wouldn't have done nothing for me, I'm sorry'* Brian lost his son to suicide

Some survivors were interested in supporting others actively through initiating local support groups.

'I did want to set a support group…so others could talk because I just think that unless you've been through it, you don't know what it's like' Paul lost his long-term female partner to suicide

8.3.6 Volunteering

For those who were already volunteering and supporting those bereaved by suicide this was felt valuable as giving something back for the support they had received.

One individual had taken a role in a support charity and found this challenging and emotionally hard when seeing photos and details of their deceased family member at work.

'I'm employed full time, so I've been here about a year now…it is hard um I have hard days there's photos of my cousin everywhere and there's like details of my family on the database and all that, it's just hard' Phil lost his male cousin to suicide

8.3.7 The importance of signposting

Families were often referred to support, some found support on the internet, and some were sent a package of information which detailed everything that would happen next including coroner information and where to get emotional support. People found this package very helpful when they didn't know what was going to happen.

'This package came and it was brilliant what it had in it. It was so informative…I was likening it if you broke your leg you would go straight to A&E, and I feel this …there should be something that you can just turn to immediately...anybody in this situation, because you, you don't know whether you're on your head or your elbow to be quite frank with you..you have this terrible thing happen and you think well, you're not quite certain which way to turn' Angela lost her son to suicide

8.3.8 Support for children and young people

Support for children and young people was limited to school counselling and some limited services from children's charities. Parents felt lucky if their child or grandchild received some support given the limited availability. There was some support available from national services but only to those children who were aware their parent had taken their lives. Some parents felt their child was too young to understand suicide and they were told the deceased parent had died from another cause.

> *'I don't think there's a lot, he was just lucky that he got in that appointment at all because there was very limited spaces for a young person'* Sharon lost her daughter to suicide

8.3.9 Negative community response and support experience

For some survivors they experienced a negative response from their community following a suicide. This was described by some as very difficult and distressing incidents that added to the distress they were already experiencing from the death.

8.3.10 Adverse life events after loss

One family had moved into their new home only a few weeks prior to the suicide of a partner. The bereaved found their partner at home and the community response was described by them disgusting. The family moved away from the community shortly after the death.

> *'I just completely lost it and went running out of the house and then all of a sudden there was every man and his dog there was people hanging out of bedroom windows, there was more and more people coming and then I remember thinking to myself, is that in now, is the local news gonna come… but I couldn't understand why so many had turned up, it was all just a days entertainment.. And there were people would stare at me, stop and stare and talk and I had somebody thought it were funny just to creep me out a bit more when I was on my own on a nighttime...somebody banging my bins, messing about in the garden ... I woke up one morning for an effigy to be hung on my washing line'* Adele lost her husband to suicide

Adverse life events following suicide is detailed in-depth in the From Grief to Hope Report (2020) which surveyed over 7000 adults bereaved by suicide in the UK. The report notes that

the most common adverse life events were family problems, relationship breakdown and financial difficulties which mirrors the risk factors identified in the suicide audit for Northeast and North Cumbria.

8.3.11 Isolated and ostracised from their community

Some survivors experienced being excluded by long term friends following the suicide with little understanding as to why this should happen and no explanation.

> *'I had a friend who I used to see quite regularly, she came round asked us what had happened and since then I never get asked on a night out, ever, and I find that strange and I go and do their hair so they're going on a night out and they've never once said to me, and I don't know what the reason is'* Carol lost her nephew to suicide

Survivors felt let down by some family and friends and were surprised that they didn't make contact or made contact belatedly. Those who did contact survivors belatedly, reported that this was due to people not knowing what to say following the death.

Communities were not understanding of the children who lost a parent to suicide and who subsequently experienced some difficulties attending school. Some children were self-harming through this time and with a single parent who was also grieving the loss of a partner.

8.3.12 Support from schools for children and young people bereaved by suicide

Counselling was offered by some schools to the bereaved and this was taken up by the child. Some schools did send attendance letters to parents of children not in school.

> *'the kids just couldn't go to school, they didn't want to be in school..then I was getting threating letters off the school to say 'why aren't the kids in school and I was like 'where is your support here, you know what's gone on…they offered counselling but that was it but they knew that some days the girls were struggling and they didn't want to go in but I was getting the threatening letters saying 'you're going to court..we're going to fine you'* Adele lost her husband to suicide

8.3.13 Inappropriate support one to one

Those bereaved in many cases reached out to NHS services for mental health support as some felt stranded and suicidal. Counselling and Talking Therapies were those most commonly accessed initially, but with poor outcomes for the bereaved.

Some professionals showed limited appreciation of the suicide survivor trauma, treating suicide bereavement as they would other bereavement experiences.

> *'I went to the counsellor which didn't help…he was like 'well why aren't you over your bereavement' that was his words,' it's been 2 years you should be over it by now' and obviously I was just like, this is, I was probably at my lowest at this point, it was just after I left work and I kind of just looked as if like 'I don't know what to say'* David lost his male cousin to suicide

8.3.14 Inappropriate support via group therapy

Where group therapy was accessed via Talking Therapies, the experience caused more distress for the bereaved, whereby some other members of the group accessing therapy were sharing suicidal thoughts.

> *'No no no the group, that was why I ended up getting separate counselling cause they put me in a ..they put me in a frigging support group that had 3 people that had wanted to kill themselves'* Joanne lost her partner to suicide

8.3.15 Support from social services

Families with children and grandchildren expected support from a social worker as they perceived the child to be vulnerable as a result of the suicide and the impact of this on the family. Two families contacted with social care requesting help and support, but both were declined as suicide bereavement and subsequent behaviour were deemed outside of the service criteria.

'He's a vulnerable kid because his mum is dead and his dad was in prison you know but they decided that he was fine here (with grandparent), okay, so he doesn't really have a social worker' Sharon lost her daughter to suicide

Trying to access support from primary care or a GP was difficult, with families describing that the GP didn't know how to handle things and families found it difficult to get referred to anywhere that would help them.

8.4 Deal - Dealing with suicide and survivorship

This section describes how suicide survivors deal with survivorship and analyses the data from interviews which describes the key concepts and constructs from their experience. These were developed into quirks as detailed below in Table 7 and in Appendix C.

Table 7: Details quirks included in concept Deal

Concept – Deal Dealing with suicide and suicide survivorship - 390 quotes
Relationship to the deceased
Toxicology (results from the deceased)
Mental health issues (of the deceased)
Circumstance of the death
Why did they take their lives
Deceased personality
Spirituality/ Medium
Letter or note
Looking for information

8.4.1 Coping Strategies

Coping strategies include adaptive and maladaptive strategies. Adaptive strategies include cognitive and behavioural efforts to manage stressful situations that cause emotional distress.

Maladaptive coping strategies are often actions that may worsen the stress or emotional distress and could include increased use of substances, drug and alcohol, negative rumination, self-harm, procrastination and intrusive thoughts.

Suicide survivors discussed personal growth or development going forward and some gained greater strength, changed priorities, responsibility, and maturity in the aftermath of suicide. Survivors gained insight into negative influences and relationships and the impact of these on their lives, gathering strength to remove them from their lives. Some survivors described a lack of feelings including no longer feeling angry at some of the small things in life that used to make them cause trouble prior to their loss.

One parent described their son taking his own life as the ultimate and that if he could face doing that then he (dad) can face anything.

> *'I feel strong enough to face anything that's has to come my way and that's, that's a way it changes me, I feel nothing now'* Chris lost his son to suicide

> *'I've felt a lot better over the last few weeks, removing people from my life what do nothing for me and just put me down'* Adele lost her husband to suicide.

Positive lifestyle changes and self-care were reported by suicide survivors including drinking less alcohol, looking after physical health through sport, accessing holistic therapies to help with managing stress and looking after their dogs.

Suicide survivors who have a dog describe having a structure to their day, caring for the dog assisted in motivating the bereaved to leave the house, get out of bed to feed the dog and improved their mental and physical health through caring for another being.

8.4.2 Substance use by deceased

Some survivors reported their loved one had taken substances, illegal drugs, prior to death but made it clear they were not taking any drugs themselves, with many noting they needed to ensure they cared for children and grandchildren to the best of their ability.

> *'I'll be honest I drank for a solid year, every day, too much it was my way of dealing with things…I don't drink at all now'* Chris lost his son to suicide

Survivors experienced improved family bonds following the suicide. Members rallied round in some families and previous tensions were forgotten as they pulled together to deal with their grief and support one another. Some suicide survivors described the best way to cope is to think of others and helping them. There was an awareness for those who may have previously dealt with their own issues that in the case of suicide they were unable to do that and needed family support.

8.4.3 Keeping belongings of the deceased

Keeping the belongings of their deceased child was a repetitive motif with parents going into the rooms to spend time with their child's possessions. Some survivors felt there was external pressure to remove the belongings but that they weren't ready to do that at this stage.

> *'I cannot touch his clothes..our Kieron's are still in his room, he's got freakin onesies up there and his superman onesie…his toothbrush is still in the bathroom..I might do it one day'* Helen lost her son to suicide

Memories brought on from the belongings of the deceased reinforce that the deceased is not forgotten by their parents.

> *'I mean her bedroom is untouched, we have never touched her bedroom. She'd still got the same bedding on that bed but I'm not ready to do that and I'll know when am ready…we're both not ready to do that uh, and in her bag, her college bag is still on her bed and there's wipes in it..there's toothbrush still in the bathroom because I think once you start putting things away, that's it, even though people say to me but you've got her with you in your heart, you know, she's still going to be, you've got memories but it's like I just need to keep her here..I don't know if you understand that'* Lynn lost her daughter to suicide

8.4.4 Photographs of the deceased

Photographs were important to families and seen as continuing the bond with the deceased as still part of the family. There was a feeling that there was a difference between how those who took their own lives and others who had died were remembered.

> *'I mean, un, straight away we thought, well we're not going to take the photographs down you know, why should we..we'll keep the photographs up, he's part of our family and its happened, both my parents have died and I wouldn't take their photographs down..I think that's the thing with this, when old people die, you get the 'oh, well they had a good innings' and you think at least that person had a life…you feel cheated in a way on his behalf..where as he hasn't'* Angela lost her son to suicide

8.4.5 Memorials – tattoos

A few suicide survivors described getting a tattoo as a commemorative symbol of their loved one or of the loss they have endured.

> *'People use tattoos to tell the story of to, to symbolise the hurt that they've gone through and its always there with them and in the same way that the person's always there with them. It walks with them..it's not that we need reminders buts it's the reminder of,of that love isn't it… it's the story's not over, it's to be continued, semi-colon is to be continued…it's about life continuing despite the big, uh you know struggles…I had one on my left shoulder, same side as my heart and had the initials of the lads done'* Jane lost her 2 sons to suicide

8.4.6 Continuing to communicate with the deceased

Memorialisation of the deceased was talked about with many survivors talking to them regularly, telling them what's happening. One mum sits in the garden area her son made for her and talks to him, she remarks she can feel him next to her when she is there.

'I talk to him all the time out loud, when I'm out walking, I'm in the bathroom, I do. I've done it ever since the day he done it and I kind of, uh, peace with that like. Whether he can hear me or not, I don't know, but I can talk to him all the way around. I tell him what's happening and thank him for things and different things' Sue lost her son to suicide

8.4.7 Spiritualty and mediums

The concept of spirituality, spiritual faith, the afterlife was described as a helpful coping mechanism with varying degrees of reliance but was referred to as bringing some comfort. One parent describes sending their daughter off to somewhere better than here and specifically said not to talk about their child as deceased.

'we involved him in the send a send off, that's what I like to call it because I think – I would like to think that I've sent her off to somewhere better than here' Lynn lost her daughter to suicide

Visiting a medium both one to one or through a spiritualist church was a common discussion in all the interviews, both men and women. One father spent a significant amount of time and money buying and reading books on the subject to try and understand the concept and whether it could be relied on prior to visiting a medium. This was compared to his wife and daughter who contacted a medium much earlier on in their bereavement.

On going to see a medium 'we've been down that road and I'm not saying we'll not go down that road again because they'll probably…they said years on like it-it takes a few year for him to actually come to you…went out to buy books about it and that and read about it..the other day I was sitting on the morning and I looked at his, uh, picture and I says, I says you can come to us now, I'm ready, I says, you can come to us and anyhow later on, I mean, it..just coincidence, but I've still kept it anyhow…it's in me bag..later on we're all sitting and in blows a white feather. I mean the nets up and that and it blows in and like I says I says to these, cause they say it's like the sign that an angel's close…but you clutch at straw like that, because it's still comfort and nice..if you see it that way, that it's a comfort aye' Chris lost his son to suicide

8.4.8 Coping strategies

Providing comfort to the families was an important function of the medium. People said that simple messaging that report their loved ones didn't mean to hurt anyone or they didn't mean to do it helps survivors cope with their loss. Survivors report going to the medium at different stages of their grief or when they think they need to, to help them through the journey or when they are ready for contact.

> *'I've seen a medium, um yeah it was very very accurate…it was really good she was very..she knew a lot of things…she knew how he died, she was doing like that, he hung himself..she told me ..Just he was sorry, he didn't mean to do it…my mum and my auntie went to one very early on. I've just been to this one recently in the last few months. My mum and auntie went to one very early on and that was er, a lot more, the messages were a lot more clear and everything was just spot on, um, about then he was saying he was sorry, he didn't want to hurt anyone, it was just a spur of the moment rash decision…think it helped them'* Phil lost his male cousin to suicide

For some who use a medium or spiritualist church regularly there is an acknowledgment that it can become addictive as they want to hear more from their loved ones and maintain the bond and contact. A mum who lost her 2 sons to suicide described her experience of spiritualist church.

> *'I went to a spiritualist church once..I've got our Kevin's tattoo on the back of my neck and I wanted Tony's underneath and it's a total mess..I was sitting in this spiritualist church and he suddenly went, um he said to the audience ' please excuse me for what I'm about to say' he said 'but I have to give this now' and he come to me and he went Kevin's saying your tattoos fucking shite' and I just thought then I went 'oh my god'* Jane lost her 2 sons to suicide

Jane is very aware that continuous use of mediums or trying to contact her sons can be addictive and conscious this may lead he to wanting increased contact.

> *'you've got to be careful with this because it can become very addictive, you just want, want, want, want all the time, um and a lot of people are going through it and it just becomes very addictive..and if you don't get what you want, they're very upset*

and it's getting quite expensive..but the church is alright because they don't charge' Jane lost her 2 sons to suicide

For some families just the thought that their loved one is there somewhere and is fine provides enough comfort. For those who haven't visited a medium, the belief in the spiritual world holds some power when they reflect on where they imagine their spirit is now

'I believe in it, I think I've got to believe in it, I often dream of see him on an American bus he always has his earphones in..and he sees me and he's waving, waving and smiling' Barbara lost her son to suicide

8.4.9 Creating a diary

The use of a diary was discussed as a way of coping with feelings and memories. Some survivors use the diary as a way of writing down what they want to say to the deceased while others recorded events prior to the suicide and since, reviewing and revising the details, self-analysing the story as a way of coping which they found helpful.

'I kept a diary afterwards..if I had dreams I would write them down..I would self-analyse it and it was my way of coping and in this little diary I wrote all the information leading up to that terrible night and I thought just for my private use, just to document things..and the book's just put away' Angela lost her son to suicide

8.4.10 Sleep issues for those bereaved by suicide

Issues with poor sleep and distressing dreams were described, some survivors mentioned seeking support, but nothing was available to help. One parent continued to have poor sleep for 5 years since the death of her son, she sought help through NHS, but nothing has improved her sleep. The need for sleep is discussed as important for their wellbeing and to clear their thoughts.

'It sometimes gets full,(brain) full though..perhaps it's just full (brain) and it's full of all different emotions and everything else …it's worse when you don't sleep and I

don't sleep much and you've got to sleep to clear you, your brain out haven't you' Jane lost her 2 sons to suicide

Medication to help with sleep and depression following suicide was sometimes used by survivors with some nervousness in both taking the medication and, in some cases, being too frightened to cease use.

'The doctor put me on, on medication because my head just…I overthink, think, think, think , think…I am frightened to come off them' Jane lost her 2 sons to suicide

8.5 Feel – How suicide survivors came to adapt over time

This section describes how suicide survivors Feel with survivorship and analyses the data from interviews which describes the key concepts and constructs from their experience. These were developed into quirks as detailed below in Table 8 and in Appendix C.

Table 8: Details quirks included in concept Feel

Concept – Feel How suicide survivors came to adapt over time - 413 quotes
Emotions in response to suicide
Keeping the truth about suicide from children
Blame
Who else was affected by suicide
Regrets and memories
How it changed me

8.5.1 Suicide changes assumptions about life

Suicide shatters the assumptive world of survivors. The shock of an unexpected death changed the view suicide survivors had about life. The impermanence of life being short and that there were no longer guarantees was discussed throughout the interviews.

Suicide shatters the assumptive world of survivors. The shock of an unexpected death changed the view suicide survivors had about life. The impermanence of life being short and that there were no longer guarantees was discussed throughout the interviews. Memory-building encompasses dealing with the legacy of suicide by preserving reputation and presenting a public storyline intended for people outside the family circle (Castelli Dransart, 2013).

Survivors note how other family members feel and their increased unease that other loved ones may consider suicide also. The impact on children who lost a parent was seen as significant and concerning for the remaining parent.

> *'when your 13-year-old tells you he doesn't want to wake up in the morning, and his dads killed himself and his nanas killed himself do you know what I mean; its crap, it is honestly..I have a weird outlook on life now'* Joanne lost her partner to suicide

Some felt they lost the innocence and trust in the goodness of the world and people; this included their loss of faith in a god who could let the suicide happen and allow for the pain it left.

8.5.2 Emotions post suicide

Emotions were altered post suicide and some core concepts described families' thoughts.

Survivors have the feeling of being burdened by additional responsibilities following the death of an adult child who had children. In these cases, the survivor took the responsibility for the care of their grandchildren.

One parent described the responsibility as a noose while another experienced challenges with older children and worries of them withdrawing following the death of their parent.

'I'm burdened, this is what Keiron has done to me, he has burdened me, same as his mother he has burdened her..I don't mind honestly, its..I would never ever stop the little'un (grandchild) coming or this that or the other..he has burdened us, he's put a noose, not a noose he's just, well he has..he's put a noose round our necks really, we daren't do things' Brian lost his son to suicide

Guilt for the death and the feeling the families let the deceased down or weren't there for them when they needed them was a recurring emotion. There was an acknowledgement that the feeling was unreasonable and that they should not feel guilty, that they couldn't change the outcome.

Caring responsibilities significantly changed the trajectory of grandparent survivors' lives and their expectations of their later years. In some cases, they took this role and shared among other family members, one family describing they were doing this out of guilt to the deceased.

'Like I said to the other boys, at my stage in life, I'm 60, I should be enjoying life, two three holidays a year you know what I mean, going out partying every weekend and stuff..that's all stopped because I feel guilty and I look after the little one and my wife does it, my ex-wife sorry, does it through the week – same reason she feels guilty' Brian lost his son to suicide

8.5.3 Anger and hate

Anger and hate were discussed in relation to the deceased, angry that they took their lives and with the situation survivors now found themselves in. For some this translated into higher level emotions and being angry in social situations. One participant avoided sport he played as he was becoming too angry during the activity.

'Yeah it's like the anger thing as well…you get a lot of anger with your child, for leaving ya, for the situation of, you know, there's a lot of anger and you don't want to show this anger to your family and friends, I know they'd understand but I don't know' Lynn lost her daughter to suicide

For some survivors the anger they felt wasn't directed at a person, but they were generally angry about why their child had to die and not someone else's.

> *'There's a bumper anger inside and you have to get rid of it some way….I will tell you one thing, the week after he dies I went to a posh auction and I was standing, I was just standing on a step on side of the room..it was a week after…aaaah…a week after his burial are you with me and I was looking around the room and I thought why couldn't it have been you, why couldn't it have been you, why couldn't it have been you..'* Brian lost his son to suicide

8.5.4 Pain felt post suicide

A parent who lost her two sons to suicide describes the pain she experienced and the emotions she felt when she lost her first son. She described that she felt broken and in physical pain after the initial suicide and when her second son took his own life, she was already broken emotionally, and it felt different.

> *'I remember saying 'how can you ..how can you break what's already broken' I cannot explain about (second sons death)..I could tell you all the emotions I went through with (first son) like the loss in my womb and I felt like I'd lost a baby, I felt it here, the pain oh its horrible, it's a horrible horrible pain'* Jane lost her 2 sons to suicide

8.5.5 Isolation and loneliness

Survivors described the isolation and loneliness that their loved one has left them, having their partner, child or close family member leave them alone, someone who they were used to living their lives with was difficult, getting used to being on their own and in their grief.

Families dealt with the grief and coped differently when in public or their community compared to their own family and while at home. They describe putting a mask on when they go out of their door and not being able to share their feelings with others.

> *'You put a mask on nearly all the time, every time I go out that door there is another mask on…it's just so difficult to go through all the emotions all the time…I should tell*

them how I feel and I do from time to time, on the whole I just bottle it up' Stuart lost his long term female partner to suicide

8.5.6 Moving forward after suicide

Moving on or not in a family's bereavement journey is difficult. Families described comments and pressure from family and friends to move on from the death and put it behind them. For some survivors this felt too soon and within a few months of the death. One partner continued to visit the grave a few times a day. Another parent notes how they felt pressured to move on as though the loss of their child had been dismissed by others.

> *'He says you have to move on..I says, its well, it's easy for you. He says it's not easy for me, but you have to move on and I was like what! Do you know what I mean? Move on!..and I was sorta like looking at him, what do you mean move on! It was like as if they'd just dismissed it, you know what I mean'* Sharon lost her daughter to suicide

A mother survivor described how she lost her son a year and 10 months previously and that she felt that only in the last few weeks had she started to live again and move on from the struggle through every day. While a father survivor acknowledged he doesn't know where to start, to move forward while fighting the feeling of guilt that he is still alive.

> *'It's like starting all over again, you think where on earth do I start now…(moving forward) and I'm still possibly fighting that'* Brian lost his son to suicide

8.5.7 Significant dates

Memories of the deceased are helpful in reminding the bereaved they aren't forgotten and continuing to talk about them and to them, in keeping the memory alive was described as a release and parents love to talk about their child. It is the first thing they think of when waking and the last thing when they go to sleep, they don't want to forget and worry they or others will forget. Anniversaries are important and emotional however, and described as a struggle with birthdays, Christmas and the date of the death being most difficult.

'So I started to cool down a bit and took my foot off the pedal and then the anniversary of her death came and hit just like a…its funny, you know it's coming and it's like dread…I can just remember I was ok up until the day before and I just went to jelly again and totally hit me like a brick…I went through a stage where I had like tunnel vision and I was like that for 2 or 3 weeks…it could be like her birthday, a nightmare and Christmas was obviously a nightmare' Stuart lost his long term female partner to suicide

There was no difference in the emotional impact on families however long since the deceased had died.

One family noted that their son died on the exact day 5 years previous and what the impact emotionally was.

'This year was the first year…the date landed on the exact day so we were sitting and like and then this time, the exact time like five years ago we knew what happened…I had a bad week, I was trying to make appointments with my doctor cause I couldn't control my temper..I couldn't control anything, I was in a bad way' Sue lost her son to suicide

Another survivor family shared their worries of the first anniversary of their daughter's death describing that they were having flashbacks of the day and how they consider continuing for another year.

'It's coming up for a year next week, next Wednesday…it just feels like, like the last hour and just uh sort of haunts you, seeing her going through, laughing and joking one minute and her dad trying to bring her back to life, in the space of an hour…flashbacks. They, I think they are getting worse because it's coming up to the anniversary…and then I just, you know, I sit here and I think it's coming up to a year and I just think how do you go, go on another year' Lynn lost her daughter to suicide

8.5.8 Suicide death changes everything

Families reported that they can't get away from the suicide, it changed everything about their lives and that losing someone to suicide is different to a normal death or even an accidental death. They felt there is a reason for most deaths, old age or car accident but for suicide there

is no reason apparent to the survivors. The death is described as an inconclusive story and that the deceased took everything with them. The impact of suicide is described as devastating to those survivors left behind.

> *'Excuse the expression but it fucks you up it does, mentally it fucks you up, you just do not know what to do….your constantly thinking about that, there's no getting away from it, I'm sorry it doesn't matter..even if you, you put a hosepipe in my ear and flush out my brain out, it still wouldn't do nothing, you'll block the hosepipe up honest. It wouldn't clean nothing..there's no getting away'* Brian lost his son to suicide

Survivor families described being *'knackered'* and '*ready to shut the door'* on their lives (Kevin & Helen). The early days and weeks of loss following suicide were noted as the time families consider taking their own lives. Survivors felt they were not able to see a future or a way forward, taking each day hour by hour even when they don't want to. Where there is another child and grandchild remaining, they become the reason survivors carry on day to day.

> *'We've often discussed we might have done the same, I couldn't have seen the point (in carrying on)…if it wasn't for Charlotte if we didn't have Charlotte, we wouldn't have been here'* Chris lost his son to suicide, and Charlotte lost her brother to suicide

8.6 Heal – healing after a suicide and hope for prevention

This section describes how suicide survivors Heal after a suicide and what survivors consider would prevent suicide. The analyses of the data from interviews describes the key concepts which were developed into quirks as detailed below in Table 9 and in Appendix C.

Table 9: Details quirks included in concept Heal and Hope

Concept – Heal Healing after suicide and hopes for prevention - 402 quotes	**Concept - Hope**
Time	Prevention
Stigma	Sport
Talking about it	Support at school
Future	GP
Supporting others bereaved by suicide	God and spirituality
Charitable work	Support from suicide survivors
Awareness of suicide	
Dogs as protective	
Health issues post suicide	
What's changed in life now	
Bereavement issues	
Isolating	
Children suicide survivors supporting one another	
Retelling the story	
Confidence	

8.6.1 Making sense of the death

How have survivor's sense of self changed as an impact/outcome of the suicide. The experience of losing a loved one to suicide gave survivors a better perspective on suicide deaths, their occurrence and also an individual's awareness of their own resilience on dealing with these extremely difficult situations.

> *'If I had to go through any of this again, no it wouldn't shock me..serious, I just get on with it if one of the other ones did it, I'd think fuck it, serious I wouldn't be shocked*

because I've been through it, I know exactly what it's like, I'd think fuck it and get on with it' Brian lost his son to suicide

8.6.2 The club of suicide survivors

How individuals and families were perceived post suicide felt different to before. This includes how the bereaved felt others within their community saw them after the death. Some families moved house to another village following the suicide which they attributed to being seen as 'the family who lost their son to suicide'. How others treat them changed from that point onwards.

'As long as I live here, and I have lived here all my life, I will always be that bloke that this happened to and it's going to be difficult for me to move on' Stuart lost his long-term female partner to suicide

Suicide survivor identity as a bereaved individual and family was described as being 'in a club' with other people bereaved by suicide, a club that no-one wants to be in but one that can relate to others bereaved.

'it's a small club that nobody wants to be a part of but uh unfortunately you know, there is one or two of us that have..that are going through with this and will do for the rest of our lives because I can't see a light at the end of the tunnel…I cry every day for her' Lynn lost her daughter to suicide

Once a person becomes a suicide survivor, others who had had a similar experience of suicide loss were drawn to them due to their shared experience.

Some mention that they may have known people for years, but they had never mentioned they had lost a loved one to suicide until it happened to them too, with people openly talking about their experiences.

'Well I said to him, it's like a little club but you don't want to be in it, but you're in if you know what I mean..you shouldn't be in but you're in it..it's like a little club because they come up to you, you're like a magnet and people go oh Kevin's son has done it and it is like a little club and I am thinking yeah we don't want to be in this' Kevin lost his son to suicide

8.6.3 Change of identity

The understanding of suicide loss by survivors in 'the club' is a shared experience that other people who haven't been through it do not understand especially the impact on the bereaved. Some survivors were offered sympathy which was unwelcome. The change to the identity of the bereaved is seen as a permanent change and one they will never get away from.

> *'Just somebody who's not really affected by it, like you know my son committed suicide type thing..they sympathise but they don't understand… I wouldn't say it was a mental illness, but it changes your way of thinking completely…completely, you're on a different wavelength to everybody else. It's like, when I was younger I used to take drugs, speed and all that…its basically the same but without the drugs..it's like speed, your head is going like this constantly are you with me and it always comes back to the same place, there is just no getting away with it…they will never ever understand it unless they have been there'* Brian lost his son to suicide

8.6.4 Change of role

Participants in the study identified themselves as 'bereaved' and a 'suicide survivor' but for some in addition to this a new bereavement related identity resulted.

Where a partner was lost to suicide, two females and one male in this study, found themselves as single parents to their children. Where an adult child had died, three parents made the transition from a traditional grandparent role to fulltime carer position as they took on the grandchild responsibilities full time. Grandparents felt their parenting days had been completed but there was an expectation that they would take on the grandchild responsibilities as they are part of the family.

> *'It's funny that, I don't think I could..even if I had no legs, I would still keep them somehow, you know what I mean. Mightn't be ideal but it's just well, it's what family does doesn't it, you have to, you take them on, aye…I didn't like think it might..at my age I thought oh I'll be finished, I'll be able to just sit back and relax, wrong!'* Sharon lost her daughter to suicide

There was some concern expressed by grandparents that at their age they wouldn't be able to see the progression their grandchild makes, especially where no parent is part of the child's life. Some sorrow was expressed that the deceased should be alive to see the child's development and experiences.

> *'I'm 60, my life's running out…but you'd like to see all their achievements (grandkids), and you know, from growing from a teenager, puberty and you know what I mean..the universities, going through school, different events and that's what he should be doing. I shouldn't be doing it..I should be proud of him for doing it..but he should be watching all this progress…I'm not going to be there to watch it all'* Brian lost his son to suicide

The loss of the previous identity and role of the bereaved is described as losing a sense of themselves, but in addition to this the change in their confidence in self and the world around them is damaged

Everyday tasks become difficult with a lack of confidence and the need to pretend they are happy to the outside world. For those who were in employment or worked for themselves, this had a significant impact on their return to work.

One employer is described as having experience from other employees who lost family to suicide so had put support in place so that the bereaved felt comfortable returning to a supportive and understanding environment. This contrasts with someone self-employed who struggled to return to work.

> *'I am just glad that I am at that stage of life where we are financially sound and didn't have to go out to work, I think as well if I had been working for a company or had to go to work I think I would have just thrown it'* Stuart lost his long term female partner to suicide

8.6.5 No positive to take from a suicide

Survivors described the time since the suicide and how long they would expect the grief experience to continue. The impact and trauma for those bereaved is long lasting and for all continues many years following the incident. Suicide changes lives forever and people don't want to forget their loved ones.

Suicide survivors in the study felt they had made no sense from the deaths within 5 years following the suicide and felt there wasn't any benefit or positive to take from the death.

> *'People say it's going to take time. It's never going to leave'* Sue lost her son to suicide

Acceptance of the death was discussed in terms of what the individuals and families' survivors believed happened to their loved one that contributed to them taking their lives. For many they believe that a brain malfunction occurred which made them harm themselves in that moment.

> *'He just wanted to die for that moment and not for the rest of his life…so there just must be have been a little window out of god knows why and then you know, they act on it and 15 minutes down the line he could have ..Oh I'll go make myself a cup of coffee..and it struck me I thought yeah…how can you prevent that?...if he'd had a heart attack we would have been devastated but would have accepted it more…look at it as though he has had a heart attack of the brain, that's the only way I can accept it because I just think something that 'bumph' it was a second of something which sadly he acted on'* Colin lost his son to suicide

8.6.6 Whole life changes post suicide

Reflection on how life changes post suicide was consistently described throughout by the survivors. The sudden and unexpected suicide of a family member changes the normal expectations of how life should progress and leaves the bereaved in a new world order. Nothing will ever be the same and suicide changes everything. There is a belief among survivors that no amount of time after the suicide will change the impact or outcome for the bereaved.

> *'Oh god on heaven, your whole life changes. It's like being kicked in the teeth'* Brian lost his son to suicide

8.6.7 Prevention of suicide

Participants talked about how they felt deaths could be prevented and what could work for others built on their experience.

8.6.8 Moment in time

They felt that the decision to take one's life was a moment in time when their loved one may have thought they wanted to die but that they believed this was just a moment and would've passed if they hadn't acted on it at that time. They described the need to break that thought with other activity which would have prevented them from acting in the moment.

> *'Whether you give them strategies to cope if you get to this point, something they could do to break the cycle and even recognising it as I don't think in all honesty he would recognise it as in himself really'* Colin lost his son to suicide

8.6.9 Increasing support

People felt that more support should be available and more help which would have prevented the suicide by pointing people in the right direction for support. Awareness of signs and symptoms of depression was seen as important for people to be able to support their family and reduce risk of suicide.

> *'I just think more people should maybe know the signs of like severe depression…I'm depressed myself but if I'd known that him not being able to look at me in the face was severe and sitting in here with his hood up and being the way he was, you know, like crying and that when it, I'd never seen him cry and I'd seen him once and over the last 3 weeks he maybe cried 3 times and was erratic like shouting and screaming and then he was alright…I don't know, he probably would have never gone'* Joanne lost her partner to suicide

8.6.10 More support for veterans

A family who lost their child who had recently been demobbed following many years in the armed forces felt more support should be provided to armed forces on the change to a civilian life. The change was described as significant and led to the suicide.

> *'Hold on, we're not talking about integrating them into society, you have to change their way of thinking, they're brainwashed all their army life, they have to think like the army, so how can they all of a sudden have to think like a civilian'* Brian lost his son to suicide

8.6.11 Talking about feelings

Parents bereaved by suicide feel that talking about their feelings is embarrassing and young people should be encouraged to share their problems and how they feel as a way to prevent suicide.

> *'Everybody has got their own story to tell, everybody will feel different, I just know that we need to bring something to help families and just tell the kids, you know like a local charity, there's always a way, you know talk to people, don't be embarrassed. I think that some of the problems they're too embarrassed, it's not cool thing to open up to people and tell them your problems…it's all gone wrong'* Lynn lost her daughter to suicide

8.6.12 Prevention of suicide is impossible

Some survivor families felt it was impossible to prevent suicide. The people who had died were described as getting away with it while the bereaved are left with the pain and loss.

> *'But I still think it's impossible to stop, it's impossible. I go across the Tyne bridge I see flowers on it…you've got away with it like you know what I mean …I'll argue the point that to prevent it, impossible'* Brian lost his son to suicide

Chapter 9: Summary of the study findings and discussion

9.1 Introduction

This discussion chapter summarises the principal findings of this study, compares the findings from the primary data collection with the secondary data from the suicide audits, and considers them in relation to what is already known from the literature. It also evaluates the relative strengths and weaknesses of the study design.

The final section of the thesis discusses the study's implications for further research and makes a series of recommendations relating to suicide prevention for survivors of suicide.

9.2 Summary of study findings

This thesis presents an exploratory study of the experience of suicide, a complex and challenging research topic. It aims to develop new knowledge by taking the sociological autopsy approach beyond the traditional model to consider suicide survivors' experiences, not only of reconstructing individual and collective suicides, but also of understanding and making meaning of the social context of suicide. There are few studies that use detailed suicide audit data to complement primary qualitative data from suicide survivors.

As noted in the literature, suicide survivors are themselves considered a high-suicide-risk population, with people bereaved by the sudden death of a friend or family member 65% more likely to attempt suicide if the deceased died by suicide than if they died by natural causes (Pitman et al., 2014). The impact of suicide on survivors is long-lasting and multifaceted, with survivors reiterating that the death of a loved one by suicide changes everything in their lives significantly and permanently. There is no escape from its impact: identities and roles change, the way survivors are viewed by others changes, and their perception of suicide risk in themselves and others is heightened.

The data generated from suicide survivors describe their journey after suicide, including the reconstruction of the death, concerns about suicide contagion, how survivors coped with

suicide, growth and healing over time, what the loss means to them today, and the opportunities and challenges for suicide prevention.

9.3 The policy context and implications

Past and current UK national suicide prevention strategies rely on quantitative data to inform their approach and objectives. The data used are predominantly drawn from suicide audits, coroner data for deaths concluded as suicide, and intelligence produced by the National Confidential Inquiry led by the University of Manchester (National Confidential Inquiry into Suicide and Safety in Mental Health, 2018). Coroner data are produced to establish the cause of death; their purpose is therefore not to establish the wider circumstances that led to the suicide, although these may be included in some reports. The National Confidential Inquiry relies on data collected from NHS services for deaths involving contact with NHS provision prior to death. The focus is on demographic information, service contact, and medical history. The consequence of this methodological approach is that suicide prevention strategies and national models of suicide prevention are based largely on psychological and medical perspectives and do not adequately consider the complexity of social concepts or the socio-political influences that contribute to why people take their own lives; consequently, suicide is perceived as a health issue to be solved.

For example, although the national suicide prevention strategy for England highlights high-risk groups, such as men, who account for over 70% of deaths by suicide, there is little understanding or acknowledgement of why this may be the case. The social world of men, their masculinity, roles in life, employment, and relationship status may all be significant in decision-making about suicide, as noted in the findings of this research.

In the Northeast and North Cumbria there is an agreed system target to reduce the suicide rate year on year compared with the England rate, yet, in light of the findings in this research, this could be seen as a crude measure. The differences identified between population groups indicate that a targeted approach for high-risk groups or populations would be more effective. To achieve this, the data collected should be broadened to incorporate collective system intelligence, and central to this should be suicide survivors' knowledge of the circumstances surrounding the death of their loved one.

9.4 Sociological autopsy

Extending a sociological autopsy approach to include in-depth qualitative data from suicide survivors produces key findings in relation to process, intelligence, and opportunities for learning and prevention.

9.4.1 Differences in the secondary data collection processes

The 2005–2015 suicide audit data included in this study were collected from police, mental health trust, primary care, and coroner records, producing a lengthy record of individual suicides and deaths of undetermined intent. The data relied on a coroner's conclusion, and there was a significant delay in producing the audit because coroners can take considerable time to establish the cause of death; this could be one to two years after the suicide. As a result, the audit findings are less timely than those in the 2024–2025 audit.

The 2024–2025 audit relies on police identifying, at the time of death, whether there is a suspected suicide. At that stage the audit process begins, with data collected from police, health and social care records, postvention support services, safeguarding services, mental health trusts, and health and justice agencies. Cases are then discussed by a multi-agency group that includes representatives from these organisations. The conclusion for the death is recorded when available. This model is based on real-time suicide surveillance data and enables learning to be identified far earlier in the process than the 2005–2015 approach. Any learning and preventative action are taken forward through NHS governance, quality forums, and services. The 2024–2025 audit model, through multi-agency discussion, can identify social influences contributing to the death, but this is only possible with open dialogue and trusted relationships between partners.

A recent development arising from *The Hewitt Review: An Independent Review of Integrated Care Systems* (published 4 April 2023) instigated changes to the roles of Integrated Care Boards by removing commissioner-led patient safety and quality framework oversight from NHS commissioners and aligning these functions with service providers. Providers now review their own patient care and quality when a death or serious incident occurs and are under no obligation to share findings with commissioners. There is no longer a requirement for after-action learning plans to be shared beyond the service itself, for example with partners or commissioners. This change in reporting and sharing is evident in the 2024–2025

audit multi-agency discussions, where there is limited reported learning from deaths involving recent contact with NHS services. Coroners will still request information from NHS providers, and there have been Regulation 28 reports during this time period. These reports relate to the prevention of future deaths (Courts and Tribunals, 2026) and highlight issues that could lead to further deaths if not addressed. During multi-agency meetings there is substantial verbal sharing of incidents and involvement; however, there is a reluctance to share learning reports and a tendency to deflect responsibility. Professionals who were in contact with the deceased often seek to demonstrate that the suicide was beyond their remit and that they were not to blame, whereas families often look for a service or person to blame. The focus of suicide survivors on seeking learning and accountability can lead to significant changes in service delivery, as seen in the case of Barbara, who has since worked with a mental health trust to learn from her son's death. Barbara's story is an example of good practice in families and trusts working together to learn from significant events.

9.4.2 2024–2025 audit learning and insights

The 2024–2025 audit has produced learning and insights into high-risk groups and has demonstrated where there is potential for suicide prevention. The groups identified below are also reflected in the qualitative data.

- Those experiencing domestic abuse, and perpetrators of domestic abuse. Quantitative data show that both are high-risk groups; however, perpetrators are more likely to take their own lives, and they were predominantly male. Suicide survivors' experiences reflect that domestic abuse and violence were present in the deceased's relationships. In Joanne's case, she experienced abuse from her partner, who later took his own life; this was also noted in Joan's story, in which she lost her son, who had been abusive to his wife. Jane's story describes her son Steven, who experienced domestic violence from his female partner and who took his own life.
- Those who had recently been arrested and released on police bail for alleged child sexual exploitation offences were at higher risk of taking their own lives prior to any court proceedings. These males were in a younger age range than that seen in the 2005–2015 audit. This is reflected in Brian's story about the loss of his son, Kieron.

- Those recently released from prison, or currently in prison, were a high-risk group. This was reflected in Natalie's story, in which she lost her son to suicide while he was in prison.
- Those who had experienced childhood trauma, including child sexual abuse, domestic violence, and the traumatic loss of a parent or carer, including suicide. Joanne's story about her partner describes the loss of his mother to suicide at a young age and the impact this had on his life.
- Older people's suicide is evident in the quantitative data and is associated with poor physical health or bereavement. Sensory loss, life-limiting illness, and loneliness are all noted as contributory factors. Some suicide survivors who had lost an older child to suicide and were widowed described loneliness and the loss of loved ones. Joan describes this and notes that getting a young dog for companionship has improved her wellbeing.
- Substance use, including drugs and alcohol, is a significant factor identified in both the audit data and the suicide survivors' stories. The use of substances, addiction, or crime associated with substances is noted in many cases, yet only Joanne's story mentions her partner accessing or receiving any treatment.
- The prescribing of antidepressants is common; however, their effectiveness in reducing suicide risk appears limited, given that these data concern deaths by suicide. The findings suggest that antidepressant prescribing may be seen as a response to social challenges experienced by patients presenting to their GP. There is limited recording of alternative support in health and care records, including social prescribing referrals. Evidence shows that any treatment of depression should form part of an overall assessment of an individual's social circumstances (National Institute for Health and Care Excellence, 2022).

Socio-political concepts were analysed in the 2024–2025 data to establish wider influences on people's decisions to take their own lives. Through this data set, the multi-agency process identified specific social factors and political directives that contributed to deaths by suicide.

The extension of sociological autopsy to include suicide survivors' experiences provides the social context of suicide and builds on the audit intelligence through the stories told by survivors. These reflections provided the social context of the death in ways not available from any other source. The in-depth qualitative exploration of suicide survivors' journeys, their recollections of loved ones, and their experiences following suicide has produced

powerful new insights that inform our understanding far beyond traditional autopsy models and reshape suicide prevention strategy. The co-production of suicide prevention plans and interventions should be built with suicide survivors and communities and complemented by data and intelligence. These plans should reflect what we now understand: that mental ill health and social factors both contribute to individual decisions to take one's own life, and that broader understanding can help reduce suicide risk in identified populations. By investigating individual suicides through a sociological autopsy approach, we can generate macro-level insights into the social factors that influence individual suicide acts.

9.5 The social context of suicide and reconstruction

Information on the social context of suicide is complex and requires the pooling of intelligence from multiple agencies, going beyond the cause of death presented in the coroner audit detail for 2005–2015. The involvement of suicide survivors and others affected by suicide provides a richer picture of the social circumstances surrounding the deceased than quantitative data alone can provide.

Research on suicide emphasises the importance of social and cultural contexts in understanding and preventing suicidal behaviour (Colucci and Lester, 2013; Mueller et al., 2021). This research supports existing evidence that survivors of suicide face challenges in reconstructing their lives, including dealing with the impact, searching for meaning, and finding coping mechanisms (Castelli Dransart, 2017). Social support and stigmatisation play crucial roles in the post-suicide bereavement process (Feigelman, Gorman and Jordan, 2009), as discussed in detail in this chapter and as identified through this research. Sociological perspectives highlight the influence of religious integration, ethnic minority status, and power dynamics on suicide rates (Pescosolido, 1990; McKenzie, Serfaty and Crawford, 2003; White and Kral, 2014).

Durkheim's foundational work on suicide continues to influence sociological theories of suicide, with recent research expanding and refining his key insights about social integration and regulation (Mueller et al., 2021). Critics argue that an overemphasis on biological approaches, at the expense of social and cultural understanding, hinders suicide prevention efforts (Colucci and Lester, 2013). Taking a multifaceted approach to sociological suicide research, including autopsy, provides insights into the broader social context of suicide and

moves away from describing suicide as an individual act towards an understanding of possibilities for population-level suicide prevention.

9.6 Suicide survivors in the workplace

Research indicates that suicide bereavement in the workplace presents unique challenges, impacting both individuals and organisations. Bereaved employees may experience difficulties in work performance, cognitive and emotional functioning, and social confidence (Pitman et al., 2018). Workplaces often lack formal bereavement protocols and support systems, highlighting the need for proactive organisational approaches (Gibson, Gallagher and Tracey, 2011; Austin and Mc Guinness, 2012). Grief demonstrably affects work outcomes, and the organisational response shapes those effects (Bergeron, 2025), with bereavement leave being associated with positive organisational support; however, leave alone was insufficient in supporting staff. What did matter were opportunities to discuss workplace accommodations and similar practices that created a sense of being cared for.

We note from this study that suicide survivors often found returning to work after a suicide difficult and felt pressured to return in line with workplace bereavement policies. Grief and bereavement policies can, in effect, dictate which losses people are permitted to grieve and for how long. Participants in this study reported feeling uncomfortable showing grief at work or seeing others grieve there, with one survivor being shown to a separate room to work in isolation because management believed this would be better. The way bereavement policies are framed has a clear link to language and to the stigma embedded within workplaces following a death by suicide, both for employees and for those affected by suicide.

Causer et al. (2022) analysed 17 studies on the impact of a colleague's suicide on surviving co-workers. The findings are particularly relevant to leadership and how stigma is managed in the workplace. Causer et al. (2022) found that stigma in this context can silence grief, with employees feeling they should not speak openly about a suicide death, fearing judgment or making others uncomfortable. Simultaneously, stigma can create pressure on managers, who must balance operational demands, their own distress, and the emotional needs of their teams, often without adequate guidance or training. The review found that existing postvention guidance is frequently disconnected from what affected workers need, and that a pattern of 'professional abandonment and silencing' was a recurring theme.

Effective interventions for suicide-bereaved individuals may include supportive, therapeutic, and educational approaches involving the social environment and led by trained facilitators (Andriessen et al., 2019). Workplace postvention strategies should address communication challenges, emotional impact, and increased tension associated with suicide bereavement (Clements et al., 2022). Leadership plays a crucial role in supporting bereaved employees and addressing potential stigma. Flux, Hassett and Callanan (2020) found that bereaved employees describe two things as most meaningful from managers: acknowledgement (simply naming the loss, not avoiding it) and a tailored response (not a one-size-fits-all policy, but attention to individual circumstances).

Implementing tailored postvention training for staff can improve confidence in managing suicide bereavement and increase willingness to share information about support services (Clements et al., 2022; Causer et al., 2022).

9.7 Suicide in communities and generational suicide

Suicide survivors shared their families' experiences of suicide and identified other family members who had taken their own lives. Some families described numerous deaths by suicide over generations and shared concerns about contagion. Some research on familial suicide focuses predominantly on mental illness and genetics (Gillespie, 2025). This may be linked to the data and methodological approaches commonly used in suicide research, as previously discussed. However, there are studies that attempt to identify sociological factors in familial suicide, although none were identified that used in-depth qualitative interviews with suicide survivors; the studies noted below utilise population-based registers or existing quantitative data (Tidemalm, 2011; Qin, 2003). From this research we have established that suicide survivors can describe the relatives who have taken their own lives and, for some families, these deaths are numerous and span generations, as noted in the case studies (Appendix D). These stories are often recounted matter-of-factly, with little awareness that this may be unusual. Suicide becomes part of the family story, although concerns were raised for younger generations and the potential suicide risk they may face. Danish longitudinal research (Qin, 2002) supports this concept and found that a family history of completed suicide and psychiatric illness significantly and independently increased suicide risk (odds ratio 2.58). These effects were not explained by socioeconomic status or the psychiatric history of cases. A history of family psychiatric illness significantly raised suicide risk only in people without a personal psychiatric history (odds ratio 1.55), whereas a family history of suicide increased suicide risk irrespective of psychiatric illness.

Recent research demonstrates that suicidal behaviour has a strong familial component, influenced by both genetic and environmental factors. Family studies show that relatives of those who died by suicide have significantly higher rates of suicide attempts and completed suicides compared with controls, even after adjusting for psychiatric disorders (Tidemalm, 2011; Bakian, 2023). This familial transmission includes suicide attempts and completed suicides, but not suicidal ideation (Brent, 2010). Family structure, socioeconomic status, and mental health history also play important roles (Maloku, 2020; Qin, 2003). The risk of suicide in children and young people increases when a parent dies by suicide or when they experience mental illness, unemployment, low income, poor education, and divorce (Samata, 2022; Ranning et al., 2022). Factors contributing to familial suicide repetition include exposure to stress, grief, guilt, suicidal role models, including parental suicide, and suicidogenic interpersonal styles (O'Reilly et al., 2020; Stallman, 2021). Higher levels of impulsive-aggressive traits are more strongly associated with suicide in younger individuals; however, research also notes that not all suicides are associated with impulsive-aggressive behaviours (Moore, Allott and O'Connor, 2023). Depression, hopelessness, and school-related issues have also been identified as risk factors for youth suicide (Richardson et al., 2024). In addition, several vulnerable groups of young people experience higher rates of self-harm and suicidal ideation, including lesbian, gay, bisexual, transgender and questioning groups, as well as young people with mental health disorders and behavioural problems (Richardson et al., 2024).

There is also research suggesting that social context, beyond individual characteristics, influences suicide risk. Environmental factors, such as abuse and adverse family environments, contribute to familial transmission (Moog et al., 2023). Sociological factors that may influence generational suicide rates include gender, marriage, family dynamics, unemployment, age, and education (Maloku, 2020). Socioeconomic status, migration, abuse, substance use, and sexual orientation may also contribute to suicide risk, particularly among adolescents. There is, however, considerable divergence in the literature regarding the relationship between income inequality and suicide rates across specific cohorts and countries. Tran and Morrison (2020), for example, found no significant association between income inequality and suicide rates after adjusting for confounders in standard regression models. By contrast, a worldwide ecological analysis using WHO and World Bank data found a negative overall association between Gini coefficients and national suicide rates, with

countries that had higher inequality showing lower overall rates, although this relationship reversed in lower-income countries (Abuabara et al., 2017).

It is important to note that, while these sociological factors contribute to familial or generational suicide risk, the strongest risk factor identified in the existing research is a history of mental illness in the individual. Agerbo (2002) suggests that the effects of socioeconomic factors may be confounded and overestimated if not adjusted for mental illness and suicide in the family. Understanding these complex sociological factors is crucial for developing effective suicide prevention strategies and mental health interventions.

How an individual experiences suicide bereavement may affect their later risk of taking their own life if circumstances arise that are similar to those experienced by the deceased. It may be that exposure to suicide creates a structure of risk through the repetition of common factors; this may apply to familial or generational suicide.

9.8 Suicide clusters

Within the Northeast and North Cumbria geography, the identification of suicide clusters, based on the definition noted previously, is initially undertaken through quantitative data based on police or coroner notifications. The approach is crude and relies on data categories or relationships within existing data, including family name, address, or links highlighted through police or coroner intelligence. Once a potential cluster is identified, further work to collate local information is initiated and relies on discussion and information-sharing between services involved with those who died. The process does not involve family, friends, or the local community in providing their local knowledge and experience. The findings from this research suggest that involving suicide survivors in the community response to a suicide cluster would improve survivors' experiences and tailor prevention activity to local need. Harnessing the experience of suicide survivors to support preventive interventions is a missed opportunity; their knowledge and commitment to preventing contagion could help drive a community suicide prevention model. There is evidence that familial clustering of suicide suggests both genetic and shared environmental influences (Bakian, 2023).

The evidence from the sociological autopsy shows links between deaths by suicide and peer groups, including suicide contagion, and moves beyond familial clustering to peer-group

clusters. This is seen in both young people and adults, but not older adults. Suicide survivors are clear in their wish to use their experience to help prevent other suicides. This knowledge may provide the motivation for a co-produced suicide prevention model, led by suicide survivors, aimed at preventing clusters and contagion. This approach may also provide survivors with the opportunity they seek to use their experiences to help others at risk and to support their own grief journeys.

9.8.1 Suicide clusters in high-risk groups

Suicide clusters among high-risk groups, for example looked-after children or care leavers, are clear from the research findings, and the level of contagion is higher in these groups. Analysis of suicide notes suggests that suicide becomes a feasible option when others have responded to similar circumstances in the same way. For some deaths within a cluster, the same method is used, and suicide may take place on a significant date, anniversary, or around the time of the funeral. Existing research suggests that dates and locations are significant indicators of risk for suicides within a cluster (Owen, 2010).

Moving beyond the traditional definition of a suicide cluster outlined in Chapter 1, and building further on a sociological view of suicide, a cluster of social circumstances may lead to an individual response of suicide or to a group of suicides. The 2024–2025 audit data began to gather this information by identifying socio-political influences on suicide. The cost-of-living crisis is one example, and the literature supports this point: if rising living costs create circumstances that individuals find difficult to manage, suicide may become the response for a number of individuals (Lemmi et al., 2016). The audit data also indicate a high-risk group among those leaving prison. The impact of the 2024 prison early release scheme, and the lack of preparedness among prisoners re-entering the community without secure accommodation or support, has heightened suicide risk in this group through a political programme and policy decision.

We note that the suicide rate in the Northeast and North Cumbria is one of the highest in England (Office for National Statistics, 2023). The map shown in Chapter 6, detailing the residence of the deceased against the Index of Multiple Deprivation, clearly identify that areas of higher deprivation experience more deaths by suicide than less deprived areas. Literacy in the Northeast and North Cumbria is also lower than in the rest of England, with an average reading age below 9 years of age (National Literacy Trust, 2024).

When reflecting on the Department of Health and Social Care's *Suicide prevention in England: 5-year cross-sector strategy* (2023) and considering the evidence shown through this sociological autopsy, some obvious areas for prevention are missing, which reiterates the psychological lens through which the strategy has been developed. A key concept raised by suicide survivors when reconstructing the suicide was difficulty in close relationships. This may involve the breakdown of intimate relationships, relationships with children, the loss of peers, or relationships at work. Analysis of suicide notes demonstrates the importance of relationships to the deceased and the need to ensure their loved ones knew they were sorry and loved them. This evidence is a key theme in the literature, yet the Department of Health and Social Care's *Suicide prevention in England: 5-year cross-sector strategy* (2023) does not consider interventions at either the micro or macro level to address relationships.

9.9 Suicide survivors and stigma

Historically, suicide has been viewed as a failure of both the individual and the family, contributing to societal blame and stigma (Cvinar, 2005). Suicide survivors do experience stigma, and this research consistently shows that stigma is a significant issue for people who have lost someone to suicide. Corrigan et al. (2017) mapped the structure of public stigma through factor analysis, identifying two core stereotypes directed at bereaved families: that they are 'dysfunctional' and 'blameworthy'. The discrimination that follows takes the form of exclusion, enforced secrecy, and avoidance. Sheehan et al. (2016) found that bereaved families were viewed by the public as having contributed to the death through abuse, neglect, or failure to seek adequate help.

Suicide survivors experience stigma in several ways, as shown through this research and supported in the literature, through three key concepts: perceived stigma, internalised stigma, and enacted stigma.

Perceived stigma**:** Survivors sense others' discomfort and fear negative reactions. They feel discredited and dishonoured because of the association between suicide and mental illness. We note that, for some survivors, the stigma of suicide or a drug-related death coroner's conclusion adds to the perceived stigma they feel. Suicide is underreported where families may know that the death was suicide but do not disclose it because of stigma or shame (Sheehan *et al.*, 2017).

Internalised stigma: Many survivors report intense feelings of shame and embarrassment. Some feel tainted or degraded, having internalised negative societal attitudes. This is

reflected in the literature (Oexle, 2018); however, it did not arise as a major theme in this research, with many survivors instead describing how brave they felt the deceased had been and how openly they talked about their loved ones to keep their memory alive.

Enacted stigma: Survivors experience avoidance, rejection, and ostracism from others (Peters, 2016). Some face blame, gossip, and strong negative reactions from people in their social networks. We can hear this in survivors' experience of being distanced from others, with people not knowing how to address them.

The consequences of stigma are associated with several negative outcomes for suicide survivors (Hanschmidt et al., 2016; McDonnell et al., 2022).

- Greater overall grief difficulties
- Increased depression and suicidal ideation
- Higher levels of guilt, anger, and problematic thoughts about the death
- More somatic and psychological symptoms
- Social isolation and withdrawal
- Concealment of the cause of death

While some studies found suicide survivors experience more stigma than those bereaved by natural deaths, the difference is less clear when compared to other traumatic deaths. This suggests stigma may be a common experience in traumatic bereavement generally, not just suicide.

In conclusion, the data generated from this research clearly shows that stigma is a prevalent and impactful experience for many people bereaved by suicide, with potentially serious consequences for their grief process and wellbeing. Healthcare providers face the challenge of addressing these complex issues and finding mechanisms to support survivors through the bereavement process (Bartley, 2025). A 2025 systematic review of international bereavement models of care (Bartley, 2025) covering 64 studies found that the most common components are bereavement packs, condolence cards, memory-making activities, and follow-up contact but only 14 of those models included formal assessment for complicated grief. Key barriers to implementation were staff discomfort, lack of dedicated staffing and institutional support, and inadequate follow-up infrastructure. Facilitators included formal protocols, dedicated trained staff, and adequate funding. For suicide bereavement specifically, where survivors

face compounded guilt, stigma and elevated risk for complicated grief, the evidence quality is low (Linde, 2017).

To combat suicide stigma, increased efforts are needed to change societal perceptions and provide support for those affected (Evans and Abrahamson, 2020). Support After Suicide Partnership's *From Grief to Hope* report calls for proactive outreach and multidisciplinary postvention and sits against a backdrop where most bereaved people are still not accessing any support at all, and the support available does not have a strong evidence base (Support After Suicide Partnership, 2022).

9.10 Mental health stigma

Stigma surrounding suicide and mental illness remains a significant barrier to suicide prevention efforts (Habeb, 2025). Research indicates that public stigma towards men's depression and suicide is highest among young adults, particularly young men (Mackenzie et al., 2019). This stigma can lead to social distancing and negative perceptions of suicidal individuals (Carpiniello, 2017; Oexle, 2018). Further research is needed to understand the relationship between stigma and national differences in suicide rates. Schomerus (2014) found that higher levels of stigma were associated with higher suicide rates; however, a replication study in 2025 by Oblak suggests that some stigma-related beliefs (such as fear that disclosing a mental health condition would harm one's career) predicted lower suicide rates, not higher ones. Oblak (2025) explicitly highlights inconsistencies in stigma measurement and temporal mismatches as sources of confusion and concludes that the field lacks sufficiently systematic, theory-driven measurement tools to draw clear inferences.

There is evidence that stigma also affects help-seeking behaviours, as individuals experiencing suicidal thoughts or attempts often feel ashamed and may avoid seeking help (Rudd et al., 2013). Furthermore, stigma extends to suicide survivors and family members (Support After Suicide Partnership, 2022). To combat this, experts recommend increased efforts to reduce public stigma, improve media portrayal of mental health issues, and provide specialised care for those affected by stigma (Support After Suicide Partnership, 2022).

The evidence strongly suggests that stigma increases suicide risk. Efforts to reduce public stigma, support those experiencing stigma, and improve help-seeking behaviours are crucial

for suicide prevention. However, there must be a careful balance when destigmatising suicide. In recent years, programmes in educational settings have raised awareness of the risk and impact of suicide on the lives of family and friends; these interventions are mainly delivered by the charitable sector. Although such programmes aim to warn young people, they may unintentionally increase awareness of suicide as a viable option and as an act through which a young person becomes immortalised. Programmes should instead focus on increasing mental health and wellbeing, building resilience, and encouraging help-seeking behaviour. This approach is supported in England through the expansion of the Thrive Model whole-school approach and the delivery of mental health support teams (Department for Education, 2021). Stigma around suicide still exists and needs to change, but not in ways that give a green light to suicide; there must be a careful balance to reduce the risk of romanticising the idea of 'being at peace'.

9.11 Stigma for those in contact with the criminal justice system

We have seen from this research that there are specific examples in which the stigma of being under suspicion of child sexual exploitation significantly increases suicide risk (Steel, 2022). Those placed on police bail for such offences are at increased risk of taking their own lives before any criminal proceedings are concluded (Steel, 2022). There is significant stigma associated with child sexual exploitation, and the potential disclosure to families and loved ones may increase suicide risk for both the accused and their family. Evans et al. (2020) found that families of convicted sex offenders face negative treatment from social networks and criminal justice officials, self-blame, and amplified harm from media coverage. One legal source notes bluntly that being labelled a child abuser *is one of the most loathsome labels in society* and that even false accusations leave social stigma, damaged relationships, and emotional turmoil that *devastates the entire family* (Evans et al., 2020).

As we saw in the case of Brian and his son Kieron, Brian, a suicide survivor, was interviewed but did not share the fact that his son had left a note or the circumstances surrounding the police allegations. Coroner records show that police contacted Kieron as a suspect in a sensitive allegation following a report that a young girl had been in touch with him and that they had been exchanging indecent images. Kieron died five weeks after police contact. The stigma associated with child sexual exploitation accusations may feel worse for families than

the stigma associated with suicide itself (Key, 2021). In these cases, the coroner's inquest may give suicide survivors more information than they previously had, and the deceased may take on a new identity in the eyes of loved ones or leave survivors with further unanswered questions. This new knowledge may subsequently increase suicide risk among those bereaved by suicide.

The sociological autopsy data for those under suspicion of child sexual exploitation and on bail changed between the 2005–2015 audit and the 2024–2025 audit, with the age profile becoming much younger and moving away from the traditional profile of middle-aged men. We note cases of young people under 18 years of age who took their own lives after sharing indecent images and following police contact. Analysis of suicide notes suggests that they did not want the impact of their behaviour to fall on their family. Support for perpetrators of child sexual exploitation is limited and is not routinely offered following initial police contact.

The lifelong trauma associated with being a victim of child sexual exploitation was evident in the audit data, with enduring trauma noted across the victim's life and low engagement with treatment or support. Both perpetrators and victims of child sexual exploitation appear to be at high risk of suicide and are therefore an obvious group for targeted suicide prevention interventions.

9.12 Community response

For some suicide survivors in this study, the response from their community following a death suspected as suicide was extremely positive. Immediate support surrounded family members from neighbours, friends, and relatives, and where this occurred, survivors felt loved and supported. The support offered continued beyond the funeral in small communities or villages, with others, previously unknown to survivors as being bereaved by suicide, sharing their experiences and common ground. This type of support was described by Edwin Shneidman (1972), cited in Leenaars (1993), who wrote of a benign community that ought routinely to provide postvention support.

The literature suggests that community support and acts of kindness can contribute to building resilience in suicide survivors (Finlayson-Short et al., 2019). Support that connects peers with similar experiences over several months is associated with better outcomes.

Support for people affected by suicide may be effective in improving suicide-related behaviour, psychological adjustment, quality of life, and caregiving (Finlayson-Short et al., 2019).

The most dominant and consistent finding throughout the literature is stigma, avoidance, and social awkwardness, rather than a positive reception. A systematic review by Evans and Abrahamson (2020), covering 11 qualitative and quantitative studies, found that suicide survivors reported feeling shamed, blamed, and judged, and perceived general discomfort and awkwardness surrounding the suicide that led to avoidance and secrecy. Peters et al. (2016), in a qualitative interview study, identified four core themes: feeling blamed, shamed, or judged; feeling isolated or rejected by friends and the community; feeling silenced; and feeling burdened by others' discomfort. Sajan et al. (2021) identified social withdrawal, cultural stigma, and disrupted family communication as dominant patterns.

Suicide survivors in the study, especially those who had recently moved into a community, often experienced a very difficult response following the suicide of a loved one. The support offered in their communities was negligible: the deceased was not mentioned, and the family were ignored and excluded. In one case, the local community victimised the family following the suicide both through direct acts and via social media. This family left the area as soon as they were able to move house.

9.12.1 Suicide deaths are different to other deaths

Suicide survivors often experience limited social support, which is linked to worse mental health outcomes, whereas increased perceived support is associated with improved mental health and personal growth (Oexle et al., 2018; Sheehan et al., 2016). Suicide survivors in this study felt that being bereaved by suicide was unique to them and that people who had not experienced this type of loss would be unable to support them. They reported that some friends tried to equate other deaths with death by suicide, which only upset the bereaved further as they tried to explain the differences. The literature consistently reports that survivors perceive their grief as distinctly different and feel that non-bereaved individuals cannot truly support them (Ross, Kõlves and de Leo, 2019).

Suicide survivors build understandings of how communities experience increases in deaths by suicide and suggest, for example, that there are more suicides of young women in some areas, as well as more coercive or abusive relationships contributing to these deaths (Gutierrez, Thakkar and Kuczen, 2000). Bereaved parents describe young women as having fewer life options and aspirations in deprived areas, with limited opportunities leading to unhealthy relationships at a young age. Similarly, suicide survivors report seeing more suicides, or becoming more aware of them, in their communities after being affected themselves. They are often concerned when they hear of people going missing through the media, including social media, because it reminds them of their own experience of searching for a missing person before a body was located. This finding is supported by Zimmerman (2023), who found that suicide survivors increasingly seek information about suicide prevention in their communities over time following their loss; this suggests that survivors become especially sensitive to suicide-related information in the media and community.

9.12.2 Community interventions for adolescents

There is some evidence that community interventions for adolescent survivors show initial positive effects on self-efficacy and social acceptance, but continued support may be necessary to maintain these gains (Sandor et al., 1994). Some online communities that support suicide survivors have demonstrated the power of supportive networks in facilitating post-traumatic growth among survivors (Walker, 2017). While the quality of evidence for community-based support for suicide survivors is generally poor, interventions that connect peers with similar experiences, are extended over several months, and involve experienced facilitators tend to yield better outcomes (Finlayson-Short et al., 2019). Further research is needed to evaluate models of community support for suicide survivors.

9.12.3 Support for suicide survivors

As noted, suicide survivors face unique challenges in coping with their loss and may require specialised support. Research has explored the potential of technology-based interventions to address these needs. LaRue et al. (2009) proposed COMPANION, a location-based mobile system designed to connect members of survivors of suicide social support networks, with the aim of improving support and positively influencing the bereavement process. Hollander (2001) examined the communicative practices of suicide survivors, highlighting their intense

communicative relations, exclusion from general society, and the process of reconstructing identity to include the loss. Online communities may provide high levels of support where personal relationships offer little support, emphasising the complementary role of online support groups in community building among survivors (Turner, Grube and Meyers, 2001). These findings suggest that tailored technological interventions and online communities may play a crucial role in supporting the unique needs of suicide survivors and improving their health-related quality of life and may reduce subsequent suicides.

Kawashima and Kawano (2017) identified three meaning groups that structured reactions to suicide: making sense of death and life, relationships with other people, and reconstruction of a bond with the deceased. A continued bond with the deceased is a concept identified by suicide survivors; a belief that death is not an eternal separation, and that there remains a connection between the living and the deceased, reduced the pain felt by survivors (Goodall, Krysinska and Andriessen, 2022).

The concepts of spirituality, spiritual faith, and the afterlife were described as helpful coping mechanisms, with varying degrees of reliance, but were generally referred to as bringing some comfort to suicide survivors (Castelli Dransart, 2017; Čepulienė et al., 2021). Visiting a medium, either one-to-one or through a spiritualist church, was a common theme in this study among both men and women. Men who considered using a medium to hear from the deceased often spent time and resources researching their effectiveness beforehand.

Maintaining a bond or relationship with the deceased was also highlighted, with survivors describing a need to keep contact and to receive reassurance that their loved one was well in the spirit world. Making sense of suicide is important to the bereaved; searching for answers through spirituality and trying to keep contact with the deceased can become all-consuming and may present certain risks. Čepulienė et al. (2021) found that spirituality can vary from being a source of support to a source of suffering. Castelli Dransart (2017) similarly noted that spirituality may either support recovery or make it more difficult, or both.

In terms of the grief journey, it may be that survivors who continue trying to maintain a bond through spirituality do not fully adjust to daily life without their loved one. It is not yet understood whether there is potential for heightened suicidality through experiences of hearing from a loved one’s spirit, seeing other relatives, or wishing to join them again in the spirit world. Some research by Gall (2015) suggests that those bereaved by suicide found

beliefs in an afterlife to ‘hold promise’ for meaning-making, but the literature in this area remains limited.

The interview with a medium whom some families in the study contacted for support presented interesting insights into the rationale for wishing to contact the deceased and how the medium put in some safeguarding measures for the survivor and herself. Some people the medium saw were angry when she was unable to give them the responses they wanted. The medium appreciated the responsibility she held over influencing someone’s life with what was relayed to them from the spirit and specialises in supporting people who have lost a child, irrespective of the age, and she doesn’t charge the survivor for her time. Survivors have described hearing from the deceased as a ‘calming pill’ that reassures them that they are well and the spirit continues to live on even when the physical presence isn’t with them.

Suicide survivors want to know why their loved ones took their own lives and acknowledge that they may never know, only that the deceased alone knew. The medium noted that, in some cases, she does not share the stories in detail with the survivor because she does not want to cause additional distress; however, she reported that spirits told her they were in a mental state in which some form of abuse triggered the suicide act. In this account, the role of the medium in enabling suicide survivors’ understanding of why the deceased took their own life may reduce the need to find someone or something to blame.

There is limited existing research available that studies the stories shared through the spirit world for those who have taken their lives via mediums and the impact on suicide survivors. There is some research however which suggests that spiritualism and mediumship can play a role in the grieving process, particularly for those bereaved by suicide. Lester (1982) explores spiritualist beliefs about communicating with deceased spirits through mediums but provides no empirical data on their role in suicide grief. Many individuals who have lost loved ones to suicide report experiencing after-death spiritual encounters, often in the form of dreams or sensing the presence of the deceased. These experiences are generally viewed positively and may represent continuing bonds with the departed (Jahn, 2014). Despite religious and medical model discouragements, mourners sometimes seek out mediums and find the experience helpful in coping with their loss (Walter, 2007). While the validity of mediumship remains debated, sociological perspectives focus on understanding the meaning and impact of these experiences for the bereaved, rather than assessing their truth (Walter, 2007). A 2025 systematic review analysing 11 studies found that spirituality generally

functioned as a ‘source of support, a sanctuary, and a catalyst for personal and spiritual growth’ though it also ‘posed challenges’ in some cases (Alexandre, 2025). These findings suggest that spiritual experiences and mediumship may offer comfort and support to some individuals grieving a loss by suicide.

Some parents in this study continued to maintain a bond with their child through other mechanisms, such as talking to the deceased daily, telling them what is happening in their lives, or writing them a diary of family and friends’ events as a way of communicating. Survivors found this helpful, even when the communication was one-way. Memorialisation of a loved one through tattoos as a constant reminder of the loss, the death, and the person is common; however, this may also act as a constant reminder and affect the survivor’s recovery journey. Memorial tattoos serve as a meaningful way for bereaved individuals to remember and maintain a connection with those lost to suicide, functioning as embodied expressions of grief and continuing bonds (Byard, 2014).

9.13 Cognitive emotion regulation strategies and sleep

Issues with poor sleep, distressing dreams, and rumination were described by suicide survivors, with some experiencing five years of disturbed sleep since the suicide. These problems are well documented in suicide survivors and attempters, with substantial empirical support (Holdaway, 2018; Richards, 2025). Support from NHS services had been sought, but there were no improvements in survivors’ sleep, even for those using prescribed medication. Recent research by Sullivan (2023) suggests that high-quality sleep and adaptive cognitive emotion regulation strategies can help promote resilience to depression and anxiety when people are faced with negative or stressful experiences. These strategies, when used by the individual, can help regulate emotional responses to stress or trauma that might otherwise result in repetitive negative thoughts.

For suicide survivors, sleep difficulties were described by some, but not all, participants in the study. This variation may relate to individuals’ ability to manage their emotions and to their cognitive emotion regulation strategies. These strategies fall into two broad types: adaptive, in which individuals reinterpret a situation in a more positive light or focus on problem-solving; and maladaptive, in which individuals focus repetitively on negative aspects, ruminate, or assume a negative outcome. Sullivan (2023) suggests that there may be benefits in targeting both positive emotion regulation strategies and sleep quality during

chronic periods of stress across a range of mental health diagnoses in order to improve sleep. This evidence may be relevant to suicide survivors who experience persistent sleep problems and may help improve their overall mental health and resilience.

9.14 How suicide survivors came to adapt over time

Research on children bereaved by parental suicide reveals complex grief experiences and long-term impacts (Sandler et al., 2021). These children are at higher risk of depression, anxiety, and substance misuse, particularly in the first two years after the loss (Melhem, 2011; Pham et al., 2018). They may experience more intense emotions, such as anger and shame, than those bereaved by other causes (Ratnarajah and Schofield, 2007). Factors influencing adjustment include the child's age, family support, and meaning-making processes (Ratnarajah and Schofield, 2007). Children who lose a parent to suicide show higher rates of behavioural problems and anxiety symptoms (Kaplow et al., 2010). Pfeffer et al. (2000) found that children bereaved by suicide reported significantly more depressive symptoms but also noted that parental reports of children's competence and behaviour were similar to those of a normative sample. This suggests discrepancies between child self-report and parental observation.

Children and young people who lose a parent to suicide may blame the surviving parent for the loss, as noted in this study. Hagström et al. (2024) analysed narratives from young people bereaved by parental suicide and found that they often interpret the suicide 'in line with stigmatising discourses regarding who is to blame', which negatively affects their identities. The findings also suggest that limited support is readily available to children and young people who lose a parent, with school counselling provision often being the main intervention offered. The suicide survivor experience described incidents in which the child of the deceased discovered the parent's body. The significant trauma for the child was often left untreated, with little or no support provided. The research evidence supports the conclusion that children experiencing parental suicide face significant trauma but receive inadequate support services, despite the recognition that effective postvention is, in reality, prevention.

The study highlights that where the surviving parent of a child is unable to continue caring for that child, whether because of legal intervention preventing them from being the main carer or because they no longer wish to be the main carer, the child experiences an additional loss. Bereaved parents in this study often expected to step into the parenting role and take

custody of their grandchild. In these circumstances, grandparents believed it was their duty to do this for their family and to assume this responsibility. Their new identity as full-time carers, and the change in what they expected from later life while grieving the loss of their own child, created a particularly difficult experience for these suicide survivors. The loss of both their child and their envisaged future changed the lives of both grandparent and child irreversibly.

Where the child remains with their parent, this parent describes the challenges of supporting their children through the loss while they are also experiencing trauma and bereavement following the suicide (Rossetto, 2015). Where social support or mental health intervention is requested by the parent, there is no bespoke service available to them, and they bounce from statutory services to charitable organisations looking for help (Weissinger et al., 2023). These experiences can spiral into challenging family circumstances with those bereaved trying to support children and young people who are also grieving, with little support from services or the community around them (Mitchell et al., 2007).

As research indicates, children who experience parental suicide are at increased risk of developing depressive, post-traumatic stress, and traumatic grief reactions (Cohen and Mannarino, 2018; Romanowicz, McKean and Vande Voort, 2018). Trauma-Focused Cognitive Behavioural Therapy (TF-CBT) shows promise in improving outcomes for these children by helping them develop coping skills, process the loss, and enhance attachment to current caregivers (Cohen and Mannarino, 2018). Group interventions focusing on reactions to death, suicide, and strengthening coping skills have been found to lessen distress in bereaved children (Pfeffer et al., 2000; Mitchell et al., 2007). A systems perspective approach, addressing the effects of trauma and loss on the child, family, and societal support system, is recommended for comprehensive treatment (López-Zerón and Blow, 2015). Complicated grief in children and adolescents has been identified as a clinically significant syndrome associated with functional impairment, psychopathology, and suicidal ideation (Melhem et al., 2007). Early identification and intervention are crucial, as bereavement can lead to functional impairment and increased vulnerability to depression, especially for children under 12 (Pham et al., 2018).

This study reinforces the evidence that trauma at a young age has a significant effect on lifelong suicide risk, yet the available research on effective support remains limited, and access to evidence-based interventions to treat grief following parental suicide in the

Northeast and North Cumbria is negligible. This may be an important area for future research.

9.15 Resilience as a protective factor to suicide

Much of the research has focused on resilience as a protective factor against suicide risk (Ki et al., 2024). Resilience, defined as the capacity to adaptively overcome stress, has been shown to buffer individuals from suicidality in the face of stressors (Shahram et al., 2021; Sher, 2019). Studies have found that resilience mitigates the suicide risk associated with childhood trauma (Shahram et al., 2021), and that positive self-appraisals may confer resilience to suicide (Johnson et al., 2010). While suicide bereavement can lead to trauma-related outcomes, it may also promote post-traumatic growth, albeit at lower levels compared with other types of bereavement (Moore, Cerel and Jobes, 2015). Quantitative studies have often failed to support the common perception that suicide causes particularly burdensome grief compared with other types of loss (Ellenbogen and Gratton, 2001); however, qualitative research has shown that families who lose someone to suicide are at higher risk of complicated grief than those bereaved by other types of loss (Sajan et al., 2021). This sociological autopsy, which includes qualitative data from suicide survivors describing the experience of bereavement after suicide, reiterates the need to move away from relying on quantitative suicide data alone to explain the impact of suicide. It argues that complementary data sets should be used to test findings based on quantitative data alone and to integrate suicide survivors' experiences. These findings highlight the importance of incorporating resilience-building strategies into suicide prevention and intervention efforts.

9.16 Hope

Hope is the one thing missing at the time of death and, for some suicide survivors, in the years that follow. Hope is what is felt by the suicide survivor, and any postvention intervention and support should provide the instillation of hope. Hope plays a crucial role for suicide survivors in coping with their loss and finding a path forward (Campbell et al., 2004). For those bereaved by suicide, hope serves as an essential counterbalance to the crushing hopelessness that often accompanies suicide bereavement (Grafiadeli, 2021). Research shows that hopelessness correlates more strongly with suicidal intent than depression for those contemplating suicide (Goldblatt, 2017). Prof. Rory O'Connor has recently developed the

integrated motivational-volitional model of suicidal behaviour, an extensive but intuitive model to understand suicidal behaviour as the result of the interaction of different psychological risk factors (de Beurs, 2021). For survivors, cultivating hope can help combat the intense feelings of despair that may arise after losing a loved one to suicide.

Hope can support a positive resolution to the psychic pain experienced by suicide survivors (Goldblatt, 2017). It allows survivors to direct their thoughts toward a more optimistic future outcome, even in the midst of grief (Goldblatt, 2017). This future-oriented perspective provided by hope can be vital in the healing process. For those bereaved by suicide, hope functions to support a sense of connection over abandonment and rescue over the wish to die (Goldblatt, 2017). A 2016 study by Berglund noted that suicidal patient's experiences centre on their struggle to maintain hope when life became difficult and their need to regain hope. This highlights how hope can help survivors maintain bonds with others and find reasons to keep living, despite their profound loss. This may be the additional responsibility of caring for grandchild or in some cases a new pet as seen in this study.

Importantly, hope plays a role in suicide prevention for survivors by delaying self-destructive actions (Huen, 2015). Given that suicide survivors are at higher risk of suicidal behaviours themselves, nurturing hope may be critical in reducing this risk and developing a pathway to healing for suicide survivors (Ropaj, 2022). It should be a core activity for support services to cultivate hope in suicide survivors.

While the grief process after suicide can be extremely challenging, hope remains an important factor in recovery. By fostering hope, suicide survivors may be better equipped to cope with their loss, maintain connections with others, and find meaning in life after such a profound tragedy (Chang, 2021). Therapeutic interventions that specifically target building hope could be beneficial for this vulnerable population.

9.17 Postvention

As noted, suicide survivors experience profound psychological distress, including depression, guilt, anxiety, and trauma (McDonnell et al., 2022). The loss is often complicated by feelings of rejection, shame, and stigma (Hofmann and Wagner, 2024). Survivors are at higher risk of developing major depression, PTSD, and suicidal behaviours (Hofmann and Wagner, 2024). Complicated grief is common among survivors and is characterised by intrusive thoughts and avoidance behaviours (Bellini et al., 2018). Hope plays a crucial role in suicide prevention

and in supporting survivors (Campbell et al., 2004). Survivors benefit from both professional help and informal support, particularly one-to-one contact with other survivors (Griffin et al., 2022; O'Connell et al., 2023), as noted in relation to peer support groups. However, depression and a lack of information about available resources can act as barriers to help-seeking (Scocco et al., 2019).

Research indicates that people bereaved by suicide have unique support needs and face challenges such as stigma, isolation, and increased suicide risk (Ross, Kõlves and de Leo, 2019; Pitman et al., 2018). While many bereaved individuals express a need for help, there is often a gap between support needs and service provision (Wilson and Marshall, 2010). A key finding from suicide survivors is the lack of postvention support offered to them and they struggle to find any service in the immediate and medium-term aftermath of suicide; survivors felt that if they knew where to get support from they would have no hesitation in accessing it but spent significant time searching for support and advice. The need for help and guidance was significant post suicide and the feeling of being lost in the system they did not understand added to their distress. While there is a significant need for help among the suicide-bereaved, many do not receive adequate support; McDonnell et al. (2022) found in a UK survey that participants felt that the provision of suicide bereavement support in local areas was inadequate. The Support After Suicide Partnership was founded in 2013 to transform the support people impacted by suicide receive in the UK. The partnership has a vision to ensure everyone is offered timely and appropriate support and provides significant information and signposting to local services through its website.

The type of support suicide survivors wanted varies throughout the journey from being informed of the death, managing the coronial process, saying goodbye to their loved one, and the aftermath of managing without a family member (McDonnell et al., 2022). For many, practical and emotional support is needed in the early days following a suicide (McDonnell et al., 2022). Survivors may not have experienced identification of a body or how the coroner process is carried out; arranging or funding an unexpected funeral can also be challenging, and practical advice is needed at this time.

Knowing and being in contact with other suicide survivors and being supported by people with experience of suicide bereavement, was noted as key (Inostroza et al., 2023). The affinity to others who understand suicide loss was described as being in 'a club', even when survivors do not want to be part of the club. It is a shared experience that other people who

have not been through it do not understand, especially the impact on the bereaved. Survivors often feel that only others who have experienced similar losses can truly understand them (Feigelman, 2008). Suicide survivors are less likely to receive informal support and may face delays in accessing any support compared with those bereaved by other sudden deaths (Pitman et al., 2017).

Suicide survivor peer support groups play a crucial role in helping those bereaved by suicide cope with their loss. Peer support groups have shown positive outcomes for both supporters and clients, reducing grief symptoms and increasing well-being (Barlow et al., 2010; Bartone et al., 2019). These programs are particularly valuable for suicide survivors, who may face stigma and lack of support from family and friends (Bartone et al., 2019). The groups may provide social support, facilitate healing, and enable survivors to make sense of their experiences (Feigelman, 2008; Supiano, 2012; Inostroza et al., 2023). These groups provide a safe space, sense of belonging, and hope for survivors (Griffin et al., 2022).

While evidence of effectiveness is limited, components such as tailoring support to grief levels, involving trained peers, and focusing on grief seem beneficial (Andriessen et al., 2019). Griffin et al. (2022) suggest that peer support groups have shown improvements in wellbeing and reductions in grief reactions among suicide survivors. This type of support may be particularly valuable for military families affected by suicide, addressing unique issues associated with military suicide loss (Harrington-LaMorie et al., 2018). Internet-based peer support programs are emerging as beneficial due to their accessibility (Bartone et al., 2019).

Despite their widespread use, more research is needed to determine the effectiveness of these support groups and to develop evidence-based interventions (Cerel et al., 2009; Inostroza et al., 2023). However, methodological limitations in existing research highlight the need for more rigorous evaluations, including clear definitions of ‘peer’ and detailed intervention descriptions (Higgins et al., 2022).

9.18 Postvention services

Effective postvention support can be understood as contributing to suicide prevention among the bereaved (Andriessen, 2009), yet Peters et al. (2016) found that responses by agencies were often insensitive and poorly aligned with the needs of those bereaved by suicide. This reflects the experiences of survivors in this study, with specific mention of mental health and

talking therapy services lacking awareness of how to engage effectively with people bereaved by suicide. Geekie et al. (2017) examined 51 NHS mental health providers, averaging 20.5 suicides each, yet only one provider could report whether NICE-recommended psychological therapy had been offered. Training for service providers, alongside policy changes, is recommended to improve support, sensitivity, and accessibility, which is also reflected in the *From Grief to Hope* report (Support After Suicide Partnership, 2022).

Bespoke suicide postvention services aim to support those bereaved by suicide and potentially prevent further suicides (Gehrmann et al., 2020). The StandBy service, for example, has been suggested as effective in reducing suicidality and social isolation when provided as part of a coordinated response for people bereaved by suicide, compared with those who did not access the service (Gehrmann et al., 2020). Peer support at the time of suicide can create hope for the bereaved and shows how survivors continue through their journey; however, further evaluation of community-based postvention services within the UK is needed to establish effectiveness (Abbate et al., 2022).

Although there is limited evidence on the effectiveness of postvention services (Abbate et al., 2022), some studies suggest that they may be cost-effective and even cost-saving (Comans et al., 2013). There is also evidence to support specific services, such as the StandBy service, which has been associated with reduced suicidality and social isolation (Gehrmann et al., 2020), potentially contributing to the economic benefits identified by Comans et al. (2013). However, more research is needed to evaluate community-based postvention services, particularly in the UK (Abbate et al., 2022). Cultural sensitivity is crucial in understanding and addressing the needs of the bereaved across different societies (Dyregrov, 2011; Andriessen et al., 2019).

9.19 Strengths of the study

9.19.1 Validity

There are no clear issues with the validity of participants' responses, particularly as the researcher carried out face-to-face interviews and built a level of trust and openness with participants. The researcher was able to monitor body language, tone of voice, and signs of distress, and, in all but two cases, the interviews were carried out in participants' own homes. The researcher was also able to observe memories shared by participants, including

photographs, rooms, memory boxes, and, in one interview, music and songs recorded by the deceased. Because of the face-to-face nature of the interview, the researcher was able to retain some control over the interaction and note any behaviour or distress displayed by the participant and how this was responded to.

The strength of the sociological autopsy model, extended to include suicide survivors' accounts and experiences of the death of a loved one, is a key strength of this research. Suicide audits alone are unable to capture the depth of the deceased's social circumstances and the context of the suicide from the perspective of family members and the subsequent impact on those affected. Suicide audits, as discussed in Chapter 7, rely on coroner or police records which, by their very nature, view the death through the lens of identifying a cause of death. This extended sociological autopsy model provides an in-depth understanding of the extent of the trauma families experience, the life-changing roles and responsibilities that arise because of suicide, and the types of support that survivors feel are helpful on their journey towards hope. This is not a triangulation of data, but an extension of an existing data source that adds context, the reality of life and death, and an in-depth understanding of experience that brings the suicide story to life.

9.19.2 Reflexivity

Reflexivity is increasingly recognised as a crucial element in grounded theory research, enhancing rigor and transparency (Hall, 2001; McGhee, 2007). It involves researchers critically examining their influence on the research process, from data collection to analysis and theory development (Engward, 2015; Hughes, 2024). While some argue that reflexivity is inherent in grounded theory's constant comparative method (Glaser, 2001, as cited in Neill, 2006), others advocate for its explicit incorporation to address researcher-participant interactions and power dynamics (Hall, 2001).

The Alvesson and Sköldberg model of reflexivity is a multi-paradigmatic approach to qualitative research that emphasises critical reflection and interpretation throughout the research process (Engward, 2015). This model helped guide me, as a researcher, to consider critically my interaction with, and influence on, the study from the initial literature review through to the data and findings. By being aware of my own experiences and beliefs, as discussed in Chapter 1, and of my existing knowledge in the field of suicide and suicide

prevention, I was able to consider critically how my perceptions might influence or shape the data presented in this research.

In considering the complex relationships between myself as interviewer and the participants in the research, I used continuous peer debriefing (Frels, 2012) throughout the research programme, although this was more intensive during the data collection stage of the study. Being able to reflect on interview discussions with my support team was important in considering any influence I may have had on the data collection process and throughout the constant comparative method, which is critical in grounded theory (Charmaz, 2014). I believe this approach limited the effect I may have had on the data by helping me remain aware of the potential influence of my existing knowledge and experience of suicide on the research and findings.

How the data were interpreted, and what was regarded as important, could be seen as both a strength and a limitation of the study. The use of constant comparison and immersion in the data, focusing on what the data are saying rather than on what the researcher 'sees', is an important aspect of grounded theory (Charmaz, 2014).

9.20 The limitations of the study

Limitations of the data in both the 2005–2015 and 2024–2025 suicide audits are similar and relate to the recording of demographic and protected characteristics of the deceased. A relatively small proportion of records detail marital and employment status, whether the deceased had children, ethnicity, disability, or sexuality. In both audits, the data tend to focus on medical and psychological perspectives. There is some detail on the person who found the deceased, for example drivers of trains or cars/vans, walkers, in addition to emergency services.

Separation from children is recorded in suicide note analysis but little is known of the children of the deceased through the audit data in this study. Whether an individual is a parent is not recorded in primary care or through NHS health and care records. Coroner data may make note of children in their records, but this is not required or clear in the notes. This omission results in an underrepresentation of the children who are suicide survivors and underestimates the number of children and young people who experience trauma through the loss of a parent to suicide. The familial suicide evidence can therefore be difficult to establish through quantitative suicide audit data alone.

The sample of participants who took part in the interviews was identified via a gatekeeper. This may have resulted in those who participated in the research being drawn from a particular demographic group, with all participants identifying as White British. As noted in the suicide audit data, the ethnicity of those who take their own lives is not routinely collected; therefore, it is difficult to ascertain whether the sample reflects those who die by suicide as predominantly White British. This may be a limitation of the study.

9.21 Implications of the study and recommendations for prevention

Based on the findings from this study there are key implications for policy, postvention support, NHS services, data and suicide prevention. Each of these will be discussed and recommendations made.

9.21.1 Policy

Any proposed policy directives should be accompanied by impact assessments that consider their potential effects on mental health, wellbeing, and suicide. The social context of suicide, and the impact of policy changes that may appear unrelated to suicide on the surface, may inadvertently increase suicide risk in specific population groups. A targeted approach for high-risk groups or populations should be implemented, informed by intelligence and embedded within policy.

9.21.2 Postvention services

We have in this study focussed on suicide survivors who were family members of the deceased. What we do know is the increased risk of suicide for those affected by a death who may know the deceased as a patient, for example GPs, emergency responders (McDonnell et al., 2020) and others who may find the deceased, for example hotel staff or those out walking. Anyone who engages empathetically with survivors of traumatic incidents and material relating to their trauma is potentially affected, including postvention services and health professionals (Tsirimokou et al., 2022). This impact of suicide can be far-reaching, and further research is required to understand the support needs and what we can learn from the experience of witnesses to a suicide. This may include the effect of suicide on those who find a body; some evidence suggests disenfranchised grievers believe they do not have or deserve to grieve and may find it challenging to justify why they need postvention support (Cesur-

Soysal and Arı, 2022). Effective postvention support can be viewed as contributing to suicide prevention among the bereaved (Jordan, 2017).

Suicide survivors in this study have shared their wishes to maintain some contact with the spirit of loved ones in various ways. Preconceived ideas and a lack of research in this area should not undermine the value of a positive connection with a loved one's spirit as a function in supporting suicide survivors' journey to hope (Grafiadeli, 2021).

9.21.3 NHS services and training

Training for NHS, primary care and public service providers should sit alongside policy changes to improve support, sensitivity and accessibility for suicide survivors and those at high risk of suicide (McDonnell et al., 2020).

Awareness of suicide survivors' specific needs to facilitate access to appropriate, evidence-based interventions and making reasonable adjustments to service models should be implemented (Wainwright et al., 2020; Andriessen et al., 2020).

Trauma intervention and treatment services should be made available for suicide survivors, adults and children and young people (Young, 2012). This study reiterates the evidence that trauma at a young age has a significant effect of lifelong suicide risk yet the available research on effective support is still quite limited (Young, 2012) and access to evidence-based interventions to treat grief following the suicide of a parent in the Northeast and North Cumbria being negligible.

NHS systems should:

- establish formal processes for highlighting conclusions from coroners that have implications for suicide prevention. This may result in strengthening the integration between safeguarding intelligence and quality and safety of NHS services.
- embed long-term physical health conditions into suicide prevention reporting to support the development of health-psychology and chronic pain responses; highlighting the suicide risk to NHS teams working in areas of pain management and safer prescribing programmes.
- improve pre and post diagnostic support for those individuals with a diagnosis or suspected diagnosis of autism and or ADHD (attention deficit hyperactivity disorder), including for existing inpatients and outpatients. Ensure services across health, social

care, education, police, probation and forensic pathways are neurodivergence-aware, aligned with the Autism Act.

- develop primary care systems that can document and refer gambling-related harm appropriately. Services which provide services related to substance misuse and gambling should include suicide prevention workforce guidance and training.
- Strengthen links and commissioning of mental health and suicide prevention services with higher education and universities.
-

9.21.4 Improvements in data collection

Consideration should be given to broadening the collection of suicide related data to incorporate collective system intelligence and central to this should be suicide survivors' knowledge of the circumstances of losing their loved one.

A data improvement programme should be implemented to ensure the routine collection, as a minimum, of data on ethnicity, sexuality, and whether there are children in the family, including how many. This would enable a better understanding of the population and help ensure that postvention support reaches wider family members.

Those who attempt suicide or present with serious self-harm from a range of touchpoints, should be collated to enable a review of service pathways to improve effectiveness.

9.21.5 Suicide prevention

Taking a multifaceted approach to sociological suicide research including autopsy provides insights into the broader social context of suicide and moves away from the description of suicide as an individual act and towards an understanding of possibilities for population suicide prevention.

Understanding the impact of sociopolitical factors is crucial for effective suicide prevention strategies.

Suicide survivors share a passion to prevent future deaths by suicide and feel they could use their experience to help and support others. This potential knowledgeable population should be built on further to co-produce suicide prevention plans, interventions and programmes.

The data produced through this study shows clear opportunities for prevention by a range of professionals who were the last contact prior to death. Opportunities to raise awareness of the interventions and support which could be offered by police, primary care services, social care, prison services and workplaces present a real opportunity to prevent deaths by suicide.

9.22 Further research

More research is needed to evaluate community-based postvention services and peer support groups. Support for children and young people bereaved by suicide is an under researched area yet the long-term benefit of early intervention is significant.

Cultural sensitivity is crucial in understanding and addressing the needs of the bereaved across different societies (Dyregrov, 2011; Andriessen et al., 2019). Further research targeting ethnic groups to gain an understanding of their experience of suicide in the UK (Rivart, 2021) is needed, which will support the development of effective postvention support.

There is little known about suicide in groups who identify as LGBTQ+ which may be due to poor data recording. Further research on the impact of suicide in this population would be beneficial for prevention and early intervention programmes.

This study found that those bereaved by suicide sought support and connection to the deceased spirit through mediums and spirituality. This is an area of research with limited evidence.

This research has focussed on those who have experienced a death by suicide however we know that a high proportion of people attempt suicide and have a wish to die. The impact of these attempts on family and friends is not understood and there are no apparent support mechanisms in place to help families live with the knowledge that a loved one wishes to take their lives.

9.23 Conclusion

This study set out to develop an understanding of the experiences of those bereaved or affected by suicide and of the role communities play in providing support. It has shown that the experience of losing a loved one to suicide is devastating for families and changes the lives of survivors permanently.

Support available to survivors is limited, ad hoc, and predominantly peer-support based, although there have been some improvements as a result of UK suicide prevention policy. There are few evidence-based services available, and those that do exist often do not meet the needs of survivors and others bereaved by suicide. The impact on children and young people is vastly underestimated, and this population is provided with less support than adults bereaved by suicide. Familial suicide was an unexpected finding, one that was normalised by suicide survivors and presents a significant opportunity for targeted prevention activity.

Where suicide survivors are part of a community the support post suicide was positive and consistent. This was not the case for new members of a community who lost a loved one to suicide, who were presented with stigma and discrimination and acts of bullying in response to their loss.

This study sought to test a sociological autopsy model extended to include qualitative data from interviews with suicide survivors. Empirical data were gathered to complement quantitative suicide audit data, producing comprehensive findings grounded in the social world. The study recognises that suicide is complex and that each suicide is unique; therefore, any intervention must also be sensitive to this uniqueness. At the same time, the social context of suicide is clearly identifiable and presents opportunities for system-wide approaches to suicide prevention. This study is the first of its kind and provides a framework for expanding this approach within the field of suicide prevention.

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Appendices

Appendix A: Ethical Approval Documentation

A1 University of Sunderland research ethics decision statement

University of Sunderland

RESEARCH ETHICS COMMITTEE DECISION STATEMENT

Application Number: 286

Project Title: The role of communities in a suicide cluster, a suicide survivor perspective.

Chief Investigator: Professor Ann Crosland

Co workers: Catherine Richardson (PhD Student), Emily Henderson, Stephanie Wilkie

Date: 02-03-2016

YOUR RESEARCH PROJECT DECISION IS LISTED BELOW

APPROVED WITH NO CONDITIONS: This means you may start the project immediately.	

PRE-CONDITIONS: This means you must complete the conditions listed below before you start the project. However, you DO NOT have to send any information back to the Committee. The Committee will assume completion of these conditions.
 	
Recruitment Procedures:
The Committee felt that the recruitment procedures should include dissemination of an invitation letter with participant information sheet attached. Interest to take part in the study should be expressed by completing a return slip with preferred contact details or by phoning the research team. The slip may be returned to the organization involved in recruitment or by post to the research team.
 	
Participant Information Sheet
The leaflet is easy to read but it needs to address the following issues:
• Include that participants must be older than 18 years.
• Right to withdraw from the study without giving a reason. Statement about what happens to data collected up to the point of withdrawal.
• "Will I be identified?"
  ○ The first sentence needs rewording because it is difficult to understand.
  ○ Delete "Only the researcher will see the transcripts." Note that the supervision team will also have access to the data as well as individuals authorized by the UoS may access the data for audit and quality assurance purposes. Include appropriate statement.
• Include where and for how long data will be kept (audio recordings, transcripts, consent forms).
	✓

1

• Include that study has been approved by UoS Research Ethics Committee and provide contact details for the Chairperson. • Include full contact details for Student and DoS **Consent Form** Replace recorded by audio recorded in "I agree to have the session recorded	
COMMITTEE-CONDITIONAL: This means you complete the conditions listed below and that you MUST send the information requested back to the Committee's officer Mrs. Michelle Marshall at ethics.review@sunderland.ac.uk. Once the committee has received this information, it will contact you again about its decision. You must await the Committee's final decision, before you start the project.	
REJECTION: This means the committee does not wish this research to commence. You should not start this research. The Research Ethics Committee will explain why it has reached this view. Please contact the Committee Chair if you have any questions.	
RECOMMENDATIONS: These are simply points of advice from the committee. They are OPTIONAL. You do not have to undertake them or contact the committee about them.	

Signed by the Committee Chair:

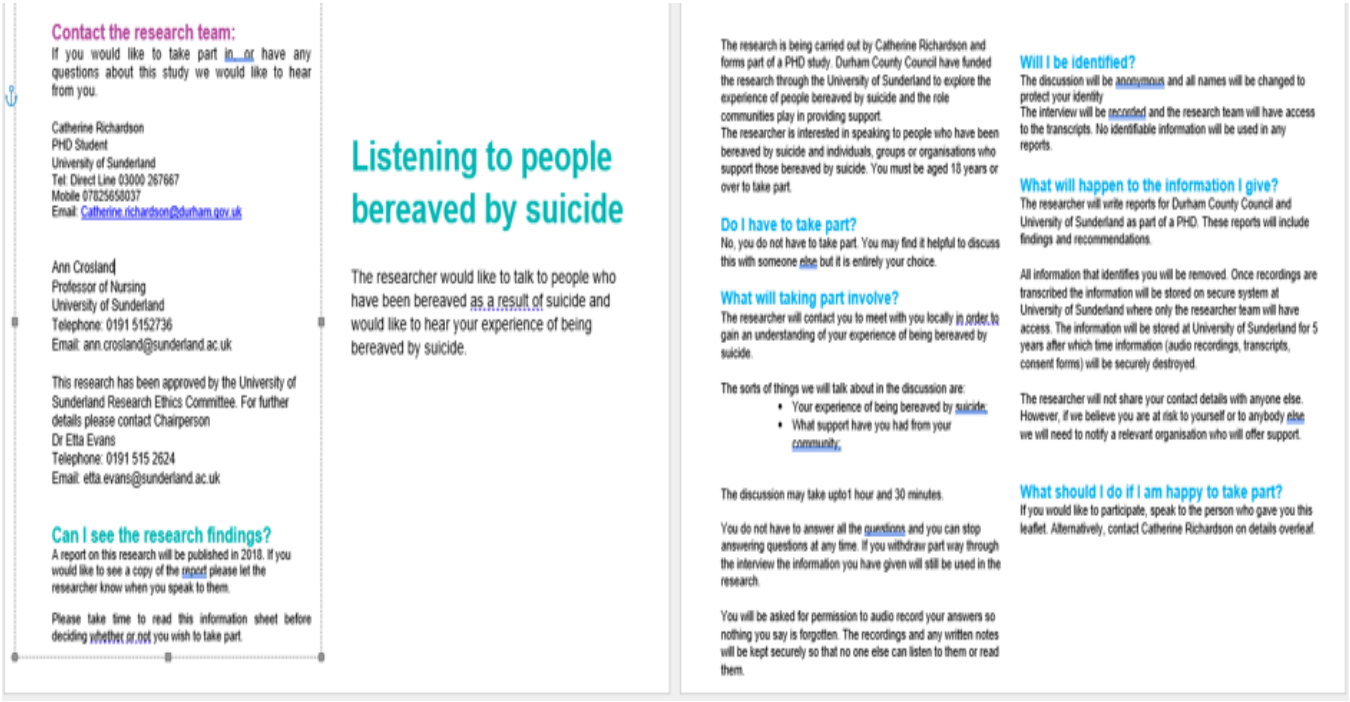
E. Evans

Dr Etta Evans

NOTE:
- The Research Ethics Committee must be informed about any changes to the approved study protocol.
- The University of Sunderland 'Research Ethics Completion Statement' proforma must be completed and submitted to the Committee within three months following the project end date.

2

A2 Participant information sheet



Contact the research team:

If you would like to take part in or have any questions about this study we would like to hear from you.

Catherine Richardson
PHD Student
University of Sunderland
Tel: Direct Line 03000 267667
Mobile 07825658037
Email: Catherine.richardson@durham.gov.uk

Ann Crosland
Professor of Nursing
University of Sunderland
Telephone: 0191 5152736
Email: ann.crosland@sunderland.ac.uk

This research has been approved by the University of Sunderland Research Ethics Committee. For further details please contact Chairperson
Dr Etta Evans
Telephone: 0191 515 2624
Email: etta.evans@sunderland.ac.uk

Can I see the research findings?

A report on this research will be published in 2018. If you would like to see a copy of the report please let the researcher know when you speak to them.

Please take time to read this information sheet before deciding whether or not you wish to take part.

Listening to people bereaved by suicide

The researcher would like to talk to people who have been bereaved as a result of suicide and would like to hear your experience of being bereaved by suicide.

The research is being carried out by Catherine Richardson and forms part of a PHD study. Durham County Council have funded the research through the University of Sunderland to explore the experience of people bereaved by suicide and the role communities play in providing support.
The researcher is interested in speaking to people who have been bereaved by suicide and individuals, groups or organisations who support those bereaved by suicide. You must be aged 18 years or over to take part.

Do I have to take part?

No, you do not have to take part. You may find it helpful to discuss this with someone else but it is entirely your choice.

What will taking part involve?

The researcher will contact you to meet with you locally in order to gain an understanding of your experience of being bereaved by suicide.

The sorts of things we will talk about in the discussion are:

- Your experience of being bereaved by suicide;
- What support have you had from your community;

The discussion may take upto1 hour and 30 minutes.

You do not have to answer all the questions and you can stop answering questions at any time. If you withdraw part way through the interview the information you have given will still be used in the research.

You will be asked for permission to audio record your answers so nothing you say is forgotten. The recordings and any written notes will be kept securely so that no one else can listen to them or read them.

Will I be identified?

The discussion will be anonymous and all names will be changed to protect your identity
The interview will be recorded and the research team will have access to the transcripts. No identifiable information will be used in any reports.

What will happen to the information I give?

The researcher will write reports for Durham County Council and University of Sunderland as part of a PHD. These reports will include findings and recommendations.

All information that identifies you will be removed. Once recordings are transcribed the information will be stored on secure system at University of Sunderland where only the researcher team will have access. The information will be stored at University of Sunderland for 5 years after which time information (audio recordings, transcripts, consent forms) will be securely destroyed.

The researcher will not share your contact details with anyone else. However, if we believe you are at risk to yourself or to anybody else we will need to notify a relevant organisation who will offer support.

What should I do if I am happy to take part?

If you would like to participate, speak to the person who gave you this leaflet. Alternatively, contact Catherine Richardson on details overleaf.

A3 Consent form

Research project exploring the experience of people bereaved by suicide and the role communities play in providing support

Discussion

CONSENT FORM

Full name .....

1. **I confirm that I have read and understood the information sheet for the above study and have had the opportunity to ask questions** ☐
2. **I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my rights being affected.** ☐
3. **I agree to have the session recorded** ☐
4. **I agree to take part in the above study** ☐

Date	**Participant Signature**
Date	**Researcher Signature**

Appendix B: Interview schedules

Suicide Clusters: The role of communities in a suicide cluster, a suicide survivor perspective.

Bereaved Families - Interview Topic Guide draft

Notes for researchers
This research is supported by University of Sunderland and Durham County Council to conduct a qualitative research project to explore the lived experience of those bereaved or affected by suicide and the role communities play following a suicide cluster.

There are three topic guides for the three groups involved in the research (individuals and families bereaved or affected by suicide, service providers and stakeholders). This topic guide is for individuals and families who have been bereaved or affected by suicide.

A suicide survivor is defined as someone who has been bereaved or affected by suicide.

Bereaved by suicide - People who have experienced the suicide of someone they cared deeply about.

Affected by suicide – People who have been affected by the suicide of someone through either knowing them, but not deeply maybe as a member of a group or a service user, or being affected by suicide e.g. discovering the body, observing suicide or attempting to stop a suicide

A community is defined as a group of people with similar characteristics this may include people who reside in the same geographical area or be part of the same group e.g. club, school, workplace

The aim of the interviews with individuals and families is to explore the lived experience of those bereaved or affected by suicide.

The key issues to be explored are:

- What is the lived experience of being bereaved or affected by suicide
- How does the community interact following suicide/s and are there key community members or roles who support
- Are there individuals, services, groups, organisations, agencies that individuals and families bereaved or affected by suicide interact
- What information, support or signposting could be provided to help individuals and families bereaved or affected by suicide
- Are there key factors which need to be considered in order to help ensure those bereaved or affected by suicide are able to access support.

Section 1: Introducing the study and gaining verbal consent

- Introduce self
- Introduce the study:
    - Taking part in the research is completely voluntary.
    - If they choose to take part, they will be asked about:
        - Their lived experience of being bereaved or affected by suicide
        - Their views on how the community interacts and reacts following suicide/s and who are the key community members or roles who support
        - What organisations/individuals have been key in supporting them, their families and the community
        - Their views on whether more could be done to assist those bereaved or affected by suicide
    - They do not have to talk about anything they do not want to discuss and interviews can be paused or stopped at any time.
    - There are no right or wrong answers. The discussion is an exploration of people's views. We are not looking for anything in particular
    - They can withdraw from the project at any time and for any reason
    - It may take up to 90 minutes.
    - Check if they are happy for their answers to be audio recorded so that nothing they say is forgotten. Explain they can ask for written notes to be made instead. The recording or notes will be kept securely so that no one else can listen to it or read them.
    - A written report about the issues that they and others have spoken about will be produced and be shared with each participant.
    - When the research and the report is talked about or written no-one will be named.
    - No one individual will be identified in the report.
    - **Talk through Disclosure Policy** - We may need to tell someone we believe any participant is at risk to themselves or anybody else. If this is the case, we will mention to this to the individual at the end of the discussion.
    - Check whether they are happy to take part.
    - Gain audio recorded consent.

Section 2: Background and warm up

The purpose of this section is to help the participants to feel at ease

- Brief introduction
- Where they live
- What they do day-to-day

- Outline personal experience that they may want to share – for example when they were bereaved, relationship to the person, community perception and support, anything else they would like to add.

If appropriate use the time line to chronologically chart their experiences. Refer back to this for Section 4 re access to support

Section 3: Their experience of being bereaved or affected by suicide

The purpose of this section is to engage participants to share their experience of suicide bereavement and impact of this on their lives, their families' lives and their community.

- Considering the impact of the death of someone you cared about/a loved one to suicide. What was the initial impact on your life?
- Discuss any specific social, work, economic pressures, access to services and impacts on relationships
- What was the initial impact on your family?
    - How have others in your family been affected?
- Do you think there was an impact on the community?
    - What was the impact
- What is the longer term impact, self?
- What is the longer term impact on your family
- What is longer term impact within the community?
    - Anything further they would like to add

Section 4: How the community interacts and reacts following suicide/s and are there key community members or roles who support

- Over last few years there has been an increase in men/women/young people taking their own life

    - Is this something they are aware of? other deaths by suicide within the local community?
    - Do they have any views on why this might be
    - Discuss any specific social, work, economic pressures, access to services that may inform their personal views
    - Explain if you think there are any connections between those who have died
    - Do you think the community is aware of deaths by suicide?
        - How? And what is the impact?

- What does the community think about suicide?
    - Do people support one another?
    - Talk openly when someone has died by suicide
        - Explain why that is

- Who are the key community members?
    - Did these members offer support?
    - What was the support?
        - What was their role?
    - If no support, do they have any views on why that might be?
    - Who would you expect or want support from?

    - Are there any social issues or stigma associated that may have influenced support?

    - Why do think that is?

Section 5: Are there individuals, services, groups, organisations, agencies that individuals and families bereaved or affected by suicide interact

The purpose of this section is to understand which agencies, professionals organisations, groups (including GPs, social services, banks, debt advice line, schools, employers, church, funeral director, community centre etc) interact with individuals and families bereaved or affected by suicide. The

intention is to identify who these agencies/individuals are and what support they do or possibly could provide.

> Explain that for the purpose of this research the term 'support' can mean anything whether this be individual support, emotional support, therapeutic support, medical support, advice, comfort, the provision of information and can come from anyone whether an individual, a professional, a GP, an employer, a charity, mental health services etc. The idea is for you to think what 'support' means to you and who provides this and if relevant, who could or should provide this.

- Which agencies provided support to them and their families following the suicide
    - Talk through what type of support this was
    - How was this support accessed/were they referred or did they refer themselves
    - Talk through any personal experiences they may know about regarding any of these organisations
    - Based on their experience, do they think this type of support worked well
    - If so why or why not

- Outline the range of different organisations/agencies and see if all the different types of agencies have been covered.

- Focus on the role of 'other' in support including community, individual and group support
    - Which local individuals or groups provided support following suicide
    - What role/level of interaction did or still have
    - How did they support?
    - Do or can any of these groups support others bereaved by suicide
    - Are there any additional organisations/individuals within the that have not been mentioned who supported if so, what role do they have

Based on their experience, is there anything that any of the organisations/or professional discussed could have done which they think may have helped them

- Explore any personal experience. Include discussions regarding why they think that.
- Explore any suggestions for improvements that could be made
- How do they think this may prevent suicide

Section 6: Their views on whether more could be done to assist those bereaved or affected by suicide

The purpose of this section is to explore whether anything else could be done (whether through service provision, support, awareness, individual behaviour, social attitudes) which might help assist those bereaved or affected by suicide

What information, support or signposting could be provided to help individuals and families bereaved or affected by suicide

- Do they think there are ways to help increase the number of people bereaved by suicide accessing some form of support
    - Explore how and why
    - Explore nature of change required e.g. service provision, societal change, cultural change, organisational flexibility
- What are the key factors which should be considered in order to ensure those bereaved or affected by suicide are able to access support
    - Explore how and why
    - Who should be involved in this and why
    - How do they think this would help

Section 7: Close

- What are the key things they want us to take away from the interview
- Check whether anything else they would like to talk about or discuss

Switch off recorder

Reassure regarding confidentiality and anonymity

Check if they are ok with what was discussed and whether they would like to retract anything.

Explain what they should do if the change their mind at a later date.

Provide list of relevant support services. Explain this is being given to everyone.

Check in regarding disclosure issues with individuals as appropriate.

Thank them for their time and contribution, and offer to share the end report.

Appendix C: Quirkos report and coding

Quirkos

Quirkos Report

This report was generated by Catherine on Sun Feb 02 2025 21:48:31 GMT+0000 (GMT Standard Time) for the following file: C:/Users/Catherine/OneDrive/PHD/Quirkos/v1.4 300918.QRK.

Source Summary

Title	Author	Date and Time	Length	Quotes #
Paul	Catherine Richardson	Invalid Date		83
Joan	Catherine Richardson	Invalid Date		226
Phil	Catherine Richardson	Invalid Date		59
Stuart	Catherine Richardson	Invalid Date		116
David and Carol	Catherine Richardson	Invalid Date		108
Sue, Chris and Charlotte	Catherine Richardson	Invalid Date		241
Dot	Catherine Richardson	Invalid Date		72
Kevin, Helen & Joseph	Catherine Richardson	Invalid Date		91
Colin & Angela	Catherine Richardson	Invalid Date		121
Brian	Catherine Richardson	Invalid Date		168
Barbara	Catherine Richardson	Invalid Date		98
Jane	Catherine Richardson	Invalid Date		150
Natalie	Catherine Richardson	Invalid Date		58
Adele	Catherine Richardson	Invalid Date		222
Joanne	Catherine Richardson	Invalid Date		219
Sharon	Catherine Richardson	Invalid Date		394
Lynn	Catherine Richardson	Invalid Date		159

Quirks Summary

Quirk Title	Parent	Grandparent	Description	Author	Date	Total Codes
Drugs	Social context and community response		use of drugs by deceased	Catherine Richardson	Invalid Date	
Relationship	Deal		Relationship to deceased	Catherine Richardson	Invalid Date	
Time	Heal		How long known the deceased	Catherine Richardson	Invalid Date	
Argument	Social context and community response		argument with the deceased	Catherine Richardson	Invalid Date	

Coroners	Reconstruction		coroners inquest	Catherine Richardson	Invalid Date	
Toxicology	Deal		Tox results of the deceased	Catherine Richardson	Invalid Date	
Deciept	Reconstruction		Deceased lied or withheld info e.g.use of drugs	Catherine Richardson	Invalid Date	
Alcohol	Social context and community response		Use of alcohol at time of death	Catherine Richardson	Invalid Date	
Mental health issues - deceased	Deal		deceased had MH issues	Catherine Richardson	Invalid Date	
Stigma/gossip	Heal		Stigma	Catherine Richardson	Invalid Date	
Method of death	Reconstruction			Catherine Richardson	Invalid Date	
Emotions in response to suicide	Feel		emotions and reactions	Catherine Richardson	Invalid Date	
circumstance of death	Reconstruction		where and who found body	Catherine Richardson	Invalid Date	
Support after suicide	Hope		what support received or wanted and didnt receive	Catherine Richardson	Invalid Date	
Talk about it	Heal			Catherine Richardson	Invalid Date	
who died	Reconstruction			Catherine Richardson	Invalid Date	
other deaths	Suicide in communities			Catherine Richardson	Invalid Date	
Job	Social context and community response			Catherine Richardson	Invalid Date	
children	Social context and community response			Catherine Richardson	Invalid Date	
Future	Heal			Catherine Richardson	Invalid Date	
Community	Community	Social context and community response		Catherine Richardson	Invalid Date	
why they do it	Deal			Catherine Richardson	Invalid Date	
supporting other people bereaved	Heal			Catherine Richardson	Invalid Date	

circumstances before death	Reconstruction			Catherine Richardson	Invalid Date	
charity	Heal			Catherine Richardson	Invalid Date	
other suicide deaths	Suicide in communities			Catherine Richardson	Invalid Date	
awareness of suicide	Heal			Catherine Richardson	Invalid Date	
dogs	Heal			Catherine Richardson	Invalid Date	
SAS other support	Hope			Catherine Richardson	Invalid Date	
Health issues after suicide	Heal			Catherine Richardson	Invalid Date	
Past - what changed				Catherine Richardson	Invalid Date	
Activity straight after death	Reconstruction			Catherine Richardson	Invalid Date	
Family circumstances	Social context and community response			Catherine Richardson	Invalid Date	
MH Issues bereaved	Hope			Catherine Richardson	Invalid Date	
Bereavement issues?	Heal			Catherine Richardson	Invalid Date	
Family support	Social context and community response			Catherine Richardson	Invalid Date	
Deceased personality	Deal			Catherine Richardson	Invalid Date	
Working after suicide	Social context and community response			Catherine Richardson	Invalid Date	
lying to kids	Feel			Catherine Richardson	Invalid Date	
Blame	Feel			Catherine Richardson	Invalid Date	
Community	Social context and community response			Catherine Richardson	Invalid Date	
social media	Reconstruction			Catherine Richardson	Invalid Date	
School	Social context and community response			Catherine Richardson	Invalid Date	
Police/Crime	Reconstruction			Catherine Richardson	Invalid Date	

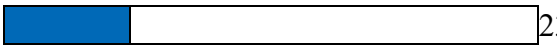
Employer	Social context and community response			Catherine Richardson	Invalid Date	
Funeral	Reconstruction			Catherine Richardson	Invalid Date	
Social Services	Hope			Catherine Richardson	Invalid Date	
Money	Social context and community response			Catherine Richardson	Invalid Date	
Service gaps	Social context and community response			Catherine Richardson	Invalid Date	
Inquest	Reconstruction			Catherine Richardson	Invalid Date	
Violence DV	Social context and community response			Catherine Richardson	Invalid Date	
Isolating	Heal			Catherine Richardson	Invalid Date	
Looking sfter kids	Social context and community response			Catherine Richardson	Invalid Date	
Friends	Social context and community response			Catherine Richardson	Invalid Date	
who was affected	Feel			Catherine Richardson	Invalid Date	
support at school	Hope			Catherine Richardson	Invalid Date	
kids supporting kids	Heal			Catherine Richardson	Invalid Date	
Bereavement	Heal			Catherine Richardson	Invalid Date	
Regrets/memories	Feel			Catherine Richardson	Invalid Date	
prevention	Social context and community response			Catherine Richardson	Invalid Date	
GP	Hope			Catherine Richardson	Invalid Date	
Visit grave/body	Reconstruction			Catherine Richardson	Invalid Date	
God	Hope			Catherine Richardson	Invalid Date	
Spirit/medium	Deal			Catherine Richardson	Invalid Date	
Letter/note	Deal			Catherine Richardson	Invalid Date	

Dog/pets	Heal			Catherine	Invalid Date	
Looking for info	Deal			Catherine	Invalid Date	
retelling the story	Heal			Catherine	Invalid Date	
Confidence	Heal			Catherine	Invalid Date	
Police notifying death	Reconstruction			Catherine	Invalid Date	
Anniversary	Heal			Catherine	Invalid Date	
Sport	Hope			Catherine	Invalid Date	
Cant talk about it	Heal			Catherine	Invalid Date	
Tattoo	Heal			Catherine Richardson	Invalid Date	
how it changed me	Feel			Catherine	Invalid Date	
family impact	Social context and community response			Catherine	Invalid Date	
bereaved suicide risk	Heal			Catherine	Invalid Date	
Tatoos	Heal			Catherine Richardson	Invalid Date	
Reconstruction			experience of suicide itself, immedialtly after death	Catherine	Invalid Date	
Deal			Dealing with suicide and survivorship	Catherine	Invalid Date	
Feel			How suicide survivors came to adapt over time	Catherine	Invalid Date	
Hope			Coping mechanisms; Trauma, stress, self support, medical	Catherine	Invalid Date	
Heal			Growth and healing following suicide	Catherine	Invalid Date	

Social context and community response				Catherine	Invalid Date	
Suicide in communities			generaltional and community clusters	Catherine	Invalid Date	
TOTAL NUMBER OF CODES						
TOTAL NUMBER OF QUIRKS	85					

Properties Summary

Age of deceased



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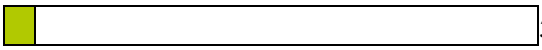

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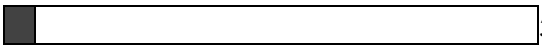

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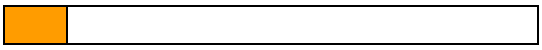

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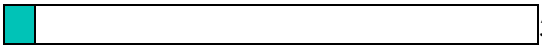

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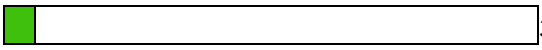
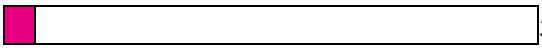
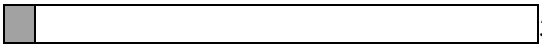


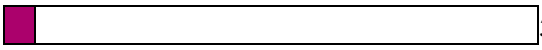
5.88% 25



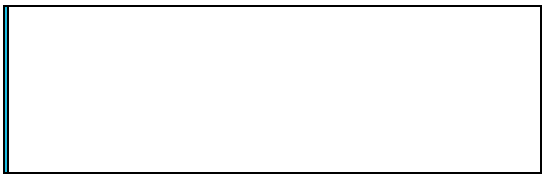
5.88% 25-35



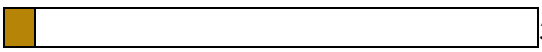
5.88% 27



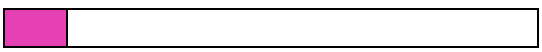
5.88% 33



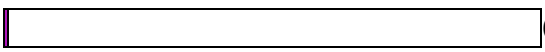
- The role of communities, how communities interact and react following suicide/s.



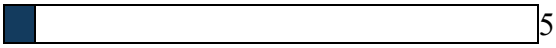
5.88% 20-25 years



11.76% 35

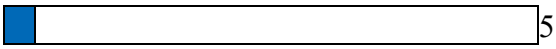


0% 35-40 years

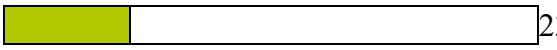


5.88% Not Defined

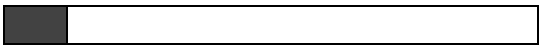
Age of suicide survivor



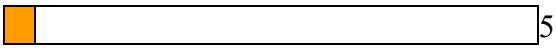
5.88% 30-40



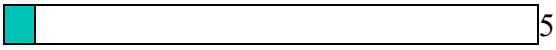
23.53% 40-50 years



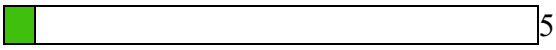
11.76% 21 and 40-50 years



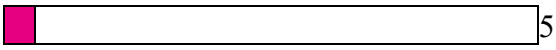
5.88% 60-70 years



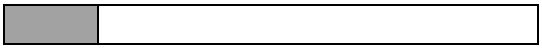
5.88% 20-30 years



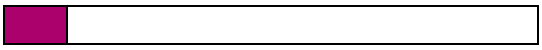
5.88% 22 and 45-55 years



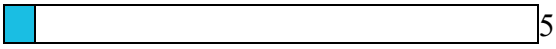
5.88% 50-60 years



17.65% 55-65 years



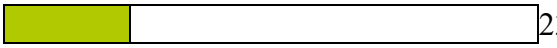
11.76% 35-40 years



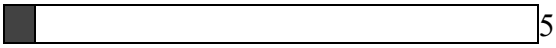
5.88% Not Defined

Gender of deceased

70.59% Male

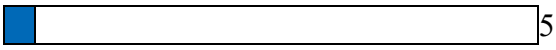


23.53% Female

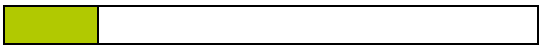


5.88% Not Defined

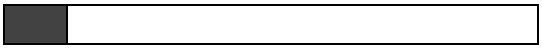
How long ago did they die



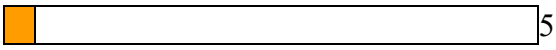
5.88% 18 months



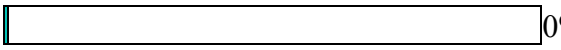
17.65% 14 months



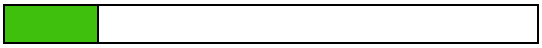
11.76% 11 months



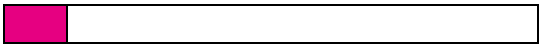
5.88% 28 months



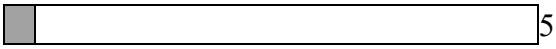
0% 36 months



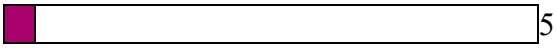
17.65% 24 months



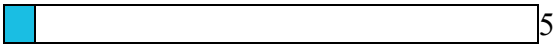
11.76% 60 months



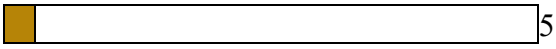
5.88% 42 months



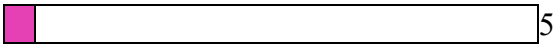
5.88% 24 and 33 months



5.88% 22 months

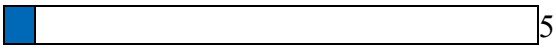


5.88% 12 months

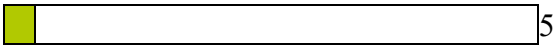


5.88% Not Defined

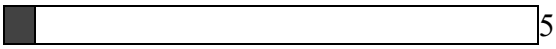
Name



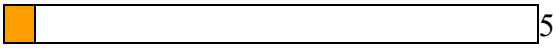
5.88% Paul



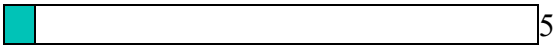
5.88% Stuart



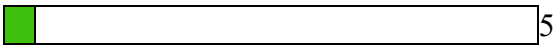
5.88% David and Carol



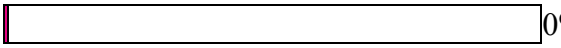
5.88% Joan



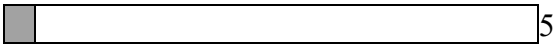
5.88% Phil



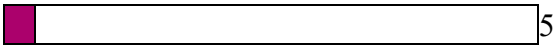
5.88% Sue, Chris and Charlotte



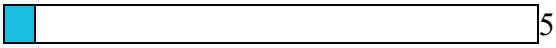
0% Dot



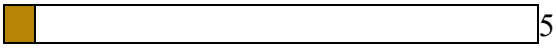
5.88% Dot - Medium



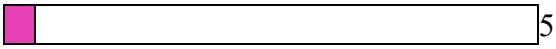
5.88% Kevin, Helen & Joseph



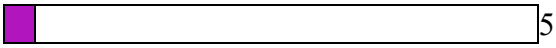
5.88% Colin & Angela



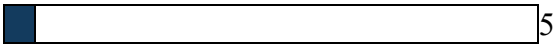
5.88% Billy



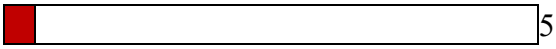
5.88% Barbara



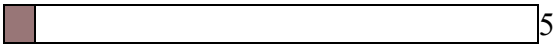
5.88% Jane



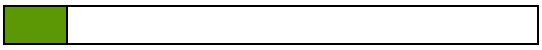
5.88% Natalie



5.88% Sharon

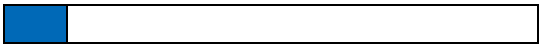


5.88% Lynn

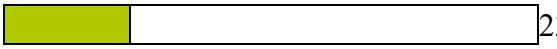


11.76% Not Defined

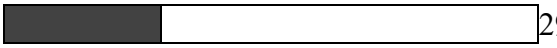
Number of children alive



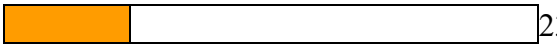
11.76% 3



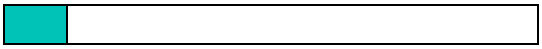
23.53% 0



29.41% 1



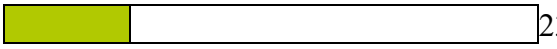
23.53% 2



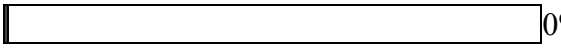
11.76% Not Defined

Number of children deceased

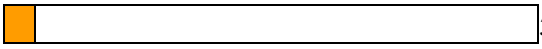
58.82% 1



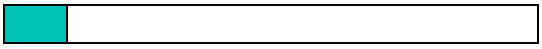
23.53% 0



0% 2



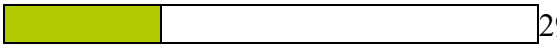
5.88% 3



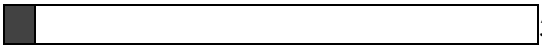
11.76% Not Defined

Where did they die

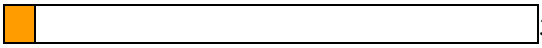
52.94% At home



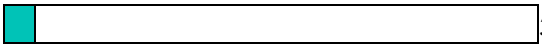
29.41% Wooded area



5.88% empty property and wooded area

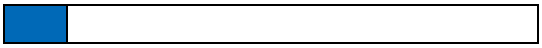


5.88% Prison

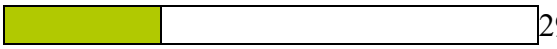


5.88% Not Defined

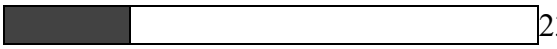
Who found the deceased



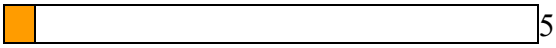
11.76% Child of deceased



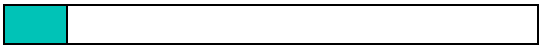
29.41% Police



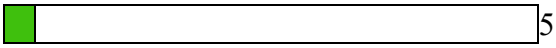
23.53% Freind of the deceased



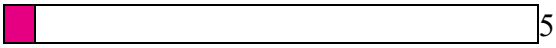
5.88% young cousins of deceased



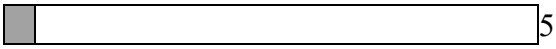
11.76% Wife of deceased



5.88% Prison staff

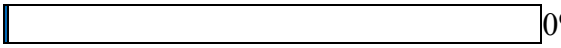


5.88% Parents

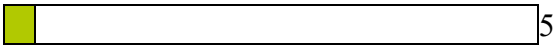


5.88% Not Defined

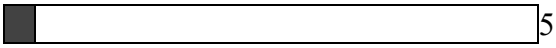
Who was lost to suicide



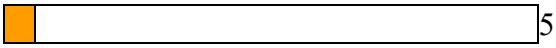
0% Partners



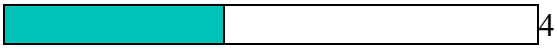
5.88% Partner Clare



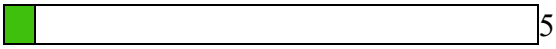
5.88% Partner Nicola



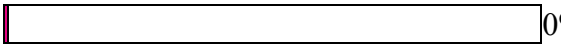
5.88% Cousin and nephew



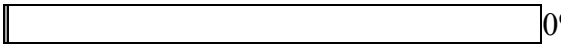
41.18% Son



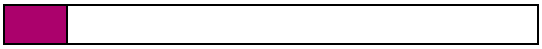
5.88% cousin



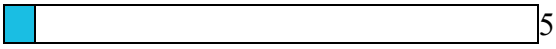
0% Brother



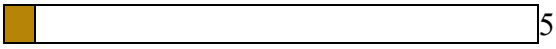
0% 2 sons



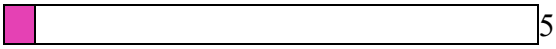
11.76% Daughter



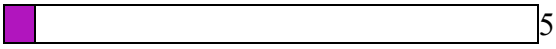
5.88% Husband



5.88% Partner John



5.88% 3 sons



5.88% Not Defined

Quirks Canvas - Primary

Appendix D Participant Case Studies

D1 Case study 1 - Sue, Chris and Charlotte's story

Sue and Chris are Ben's parents and Charlotte is Ben's younger sister. Sue described losing her son, Ben on the 10th of July 5 years ago, the anniversary of Ben's death was last Sunday. There were no warnings and no change in her son. Ben had just moved back home, and everything seemed to be going well. He had had a job from the age of 16 and had always worked hard. Ben had a few problems with his girlfriend, he found out his best friend was sleeping with his girlfriend, that's why Sue believes he took his life. The family went out on the Sunday to the local park; he then watched TV with his sister and a game of rugby with Sue. He said he was popping out to take a CD back to his friend and didn't return. Sue found out after the death that he'd been threatening to take his life, telling his friends and planning it but the family knew nothing about that until the Sunday night. Ben had a rope in his car glove compartment, but the family didn't know. The family searched for his car and found it near the woods, they searched for days and the police found him on the following Tuesday. He was 22 years old when he died.

The family describe suicide as a common thing because a couple of Ben's friends died by suicide, but their son always said he would never do that to them. The GP had seen Ben and prescribed him antidepressants, Sue saw his GP record and Ben's response to question 'are you considering suicide' as 'no' and that he couldn't do it as he knew how much it would hurt his family.

Sue and her husband are both taking anti-depressants. The family have gone over the circumstances since the suicide searching for answers, thinking there is something that must have been a sign that they missed. The only thing is that his ex-girlfriend did tell him to go and kill himself on the day he died, but the family know he had been planning it beforehand.

The family fall out over the circumstances and the cause, but they all think that something in his head just clicked, and he went into a zone and took his life, without regret or fear but just did it. He did it on that day and never said goodbye his mam, dad or sister. Sue is still receiving psychological treatment and can't sleep due to images of her son. A local charity has been the only service that has really helped the

family, and they stumbled upon the service. When it happened Sue was suicidal and contact with the crisis team who intended to admit her to hospital. The family feel the crisis team left them in a worse place after their intervention through need to retell their story to different people and the service didn't know what to do. The family don't want the grief to go as they don't want to forget Ben. It changed their lives the day it happened; the five members of the family know from that day their lives went to another level of living.

Support from suicide survivors has made the biggest difference to the family especially in the initial couple of years. Last year the family engaged in the Walk to the Light at the Angel of the North for world suicide prevention day – they couldn't believe there were hundreds of suicide survivors there including some people the family knew whose sons had also died by suicide.

Sue has a tattoo for her son, when people ask her about it other people share that they have a tattoo also for their family members who have died by suicide. Sue and Chris are now overprotective of their daughter and remaining child since the loss of their son. The family moved from their home after the death as they couldn't stay in the village with familiar faces, their son's friends as people mentioned the suicide all the time and his friends remind them of what he would have been at their age. Chris drank alcohol solidly for a year following the death to try and block it out.

When their son went missing the local community searched the area and called Ben on his phone, this was co-ordinated through Facebook. When he was in the chapel of rest the family couldn't stay away, they just wanted to be with him sitting and talking. The local community were constantly in touch after the death, donating money, food and rallied around the family. In the year that followed the family lost interest in anything, they ate unhealthily and put lots of weight on from comfort eating. Bens' sister was 16 years old when she lost her brother. She wasn't going to go to college, but Ben's friends supported and encouraged her, and she attended college which the family is very proud of.

Chris talks to his deceased son all the time, telling him things that are happening, and he talks to God which he never did before the death. Sue and her daughter have both seen a clairvoyant a few times. The family also attended the spiritualist church on Sundays but that stopped when Bens ex-girlfriend started to go to the same church. The family feel they might well see another clairvoyant as they understand it sometimes takes a year after death before they come through. Chris has bought

numerous books to read about spiritualism and acknowledges that they clutch at straws to understand if their son's spirit is close. They describe it as a comfort and nice, but Chris is sceptical and refers to inquiring through the books, he would love it if Ben did present but needs something concrete to happen to believe he is near.
The family have supported a local charity through selling wrist bands for the charity in their local community to raise funds to support other suicide survivors.

D2 Case study 2 - Joan's story

Joan lost her son Michael 2 years and 4 months ago and describes it as feeling like it happened yesterday. Michael was 32 years of age. Michael lived next door to his mum with his wife, they had been married for 5 years. Joan has lost her husband, brothers, sisters, many had cancer and Michael her son to suicide. Joan didn't think would ever take his life and she will never get over the loss.

Michael didn't want children, but his wife did but they decided they would have a small family, one of two children. Michael's widow got remarried and moved away, the house she shared with Michael is now for sale and she doesn't visit Joan regularly anymore.

Before Michael's death his wife left him for a month and came to tell his mum on the Saturday night before he took his life on the Monday that his marriage was over and his wife wasn't coming home. Michael suffered for the month, not eating while going to work and laying on the couch when he got home. He replaced his wedding photos on the wall with other family photos. The Sunday before his death he told his mum that he had taken her tablets next door, Joan asked him to bring them back. She asked him why he took them and he said he was going to do away with himself but he changed his mind. He said he had tossed the tablets down the sink but on the police report he had taken Joans tablets and that had killed him in addition to carbon monoxide poisoning from his car engine.

Joan didn't realise he was depressed but Michael's friend called Joan to say he was worried about him and would be over to see him after he went to the GP. When he arrived, he found Michael dead in his car. The medics and police arrived and went into the garage, came out and told Joan they were sorry, but he had gone.

Joan's next door neighbour, Julie supported her, but 9 months later Julie's brother took his life leaving 2 daughters. Michael's brother and Julies brothers were friends.

Joan describes Michael as short tempered, fussy and angry. As a young teenager when he was frustrated, he would punch wall or smash something. Joan always wished she had seen a doctor about it, but as he got older the behaviours were still there and if his wife wound him up he would put his fist through a door. He was very talented and could do anything, he renovated his house, mend washers and ovens.

Joan doesn’t know if she believes in spiritualism as she finds it frightening but she has experienced her mum coming back to her with her friend Pauline. Joan doesn’t tell many people as they don’t believe her. She sleeps with the light on now as she is frightened, and she thinks that if she puts the light out Michael won’t come back to her because he knew she was frightened of spirits.

Joan has a dog which is her motivator to keep moving forwards and to get up in the morning, the dog is good company.

Michael left a letter when he died and blamed himself, said he was a bully and a coward. He says he is sorry to his mum and that he failed her. The impact of the letter on Joan is distressing.

D3 Case study 3 - Lynn’s story

Lynn lost Tina her daughter aged 19 and she is married to Jades dad who was a veteran, they have a son who was age 10 years at the time of Jades death. Interview took place 1 year after Tina died. Jades’ dad also had another daughter from previous relationship.

Lynn’s initial support was offered through local bereavement charity, the lady who arrived at the house had no experience of suicide bereavement and loss and had not had children herself. Lynn felt the lady was critical of the photos of Tinashe had on display and hasn’t bothered to ask for support from the charity again.

Lynn forgets lots of information and uses a diary to try and record things and feelings. The main support has been from family but the impact on the local community and Tina’s friends has been significant.

Within their local community there have been several young ladies take their lives, one was a few days before the interview and was aged 22 years. Lynn described Tina as beautiful inside and out. Tina’s brother has had support from a local charity, he has also seen Child and Adolescent Mental Health Services but Lynn thinks that was a waste of time as they aren’t bereavement counsellors, but they did see him for anger issues.

Lynn thought she could manage her grief by herself and help her son, but she recognised she needed help first before she could help anyone else. She had received a pack of information from the police and found a local charity information and got in touch with them, a worker came to visit the family.

Jades’ death haunts Lynn, seeing her laughing and joking one minute and her dad trying to bring her back to life all in the space of an hour. Tina took her life in her bedroom in the family home. She had an argument with her boyfriend and texted him to say she was going to kill herself. He had fallen asleep and didn’t see the text. When he did, he ran to Tina’s home which was close by and her dad found Tina hanging. He started CPR and the emergency service came but they couldn’t revive Jade. Tina’s mum was still very distressed and crying through the interview, she feels guilty and that she let Tina down because her parents couldn’t save her. Lynn loves talking about Tina and keeping her memory alive.

Lynn has her rooms with many pictures of Tina on the walls, Tina's room continues to be untouched, and Lynn spends time in the room looking at Jades possessions and college work. The family access counselling via the GP except for Tina's dad. Lynn reports he has really struggled with loosing Tina and feels responsible as he couldn't keep her alive.

Lynn knows of several young females around Tina's age and who Tina was friends with or knew of them through social media. Lynn's uncle took his life 25 years ago and since moving back to the northeast 7 years ago another family member took his life, Tina knew him also. Lynn knows of 2 other girls Tina knows who took their lives, they are in the cemetery together. Lynn blames social media and the lack of face-to-face communication; she felt words spoken in text can't be taken back and it is different than talking face to face.

Lynn has thought about what she can do to support people who have lost a child to suicide, offering a place to have a chat with someone who has been through the same thing. Lynn has a dog and since Tina died the dog goes everywhere with Lynn, she doesn't ever leave her side.

D4 Case study 4 - Sharon's story

Sharon lost her daughter Amy to suicide. Amy met a guy at college when she was 16 years old, and he was 17 years old. When Amy was 18 Paul and her had a baby boy together, but the relationship didn't last, and Amy moved back home with her mum. After several years and failed relationships Amy reconnected with her Paul, and they started seeing one another until he moved into Amy's house with her and their son. Sharon was aware that there were some domestic violence issues, but Amy would try and say it was accidental. Amy and Paul moved house 3 times in the following 4 years, Sharon was concerned about the family and her grandson and suspected there was more going on with them than she understood.

One day Sharon's grandson arrived at her door after school and told Sharon he needed to come for tea as the police wouldn't let him in his house. Sharon asked where his mum was and she was at work, her son had called her, and she told him to go to Sharons house. Paul had been caught dealing drugs and the cellar of the house was used as drug storage with over £100,000 worth of drugs and semi-automatic guns.

Paul went to prison and on release contacted Amy, Sharon thinks Amy was frightened of Paul in the end. Amy and her son were extremely close, it had always been the two of them through different relationships. Amy lost her house due to Paul and the drugs; this was a massive shock to Amy. Sharon wondered why she just didn't get her another house at the time but she didn't think it was that important. Amy wanted to leave the relationship but told Sharon if she did there would be repercussions. Amy sought help from her GP who prescribed her some antidepressants. Amy took her life at her home address while her son was staying out for the night.

Sharon was awarded custody of her grandson until he is 18 years old. Her grandson won't talk about his mum and turns the pictures of her face down in the house. Sharon has kept a memory box for him of Amy's things for when he is ready. He has accessed counselling through the school which has helped him, and he has told Sharon that another boy at school has lost his mum to suicide also and that he has talked to him

about it. Sharon knows of several young women Amy's age who have taken their lives and who have also been involved in the drug culture in the area.

Sharon had three daughters and Amy was the youngest, she thought she was finished with parenting a teenager when her children left home and didn't think she would have to start doing it again at her age with her grandchild, she thought she would be able to just sit back and relax at this time of life, but Amy's death has changed everything.

The community around Sharon has changed in recent years and although Sharon has lived on the same street most of her life there is only one friend who was able to offer her support when she lost Amy. She found out about a local charity through the police officer, they helped her understand the coroners and mental health systems for support and she found their support an outlet for her emotions.

D5 Case study 5 - Joanne's story

Joanne and John were together on and off since they were 17 years old, at 22 John was a heroin addict. Joanne describes the drug when they were younger as like any other drug like cannabis, it was just normal. John stopped using heroin and Joanne gave birth to their 1st child, but John started using again and continued off and on until his death. Their second child was born, and Joanne fell out of love with John and described the relationship as snapping, her focus was on the children. John left and returned frequently, and Joanne let him back for the children, he would join the family for meals and then go and sleep elsewhere. When John died the children were 12 and 8 years old.

Johns' mam took her life when he was 20 years old, mother died of an overdose, he didn't receive any support, subsequently his dad left the 3 children to go and start another family. John went to jail not long after his mum's death and his 2 younger brothers were also addicted to heroin.

In the weeks leading up to John's death, Joanne recalls how it was the 1st time she had seen him cry in 10 years, but she misread the signs of him being depressed and thought he was trying to get back into the relationship. John had been volatile when Joanne had been going out in the weeks before his death and had threatened to kill himself, she told him he needed help. He swore he would never leave the kids as there was just John and Joanne to look after them.

The night John died Joanne was going out with friends and John was looking after the children. John had said to Joanne before she left that it would probably be better if he wasn't here, but she thought he meant just not in the house. Joanne came home and John was in the kitchen; she let the dog out and went to bed. John was staying downstairs on the couch. Early morning her son would normally get up to watch some television and had gone downstairs and sat on the couch. Joanne heard him shouting for her, John had hung himself from the treadmill behind the couch and her son hadn't noticed when he sat down initially. Her daughter and Joanne were all in the lounge with the children screaming while Joanne called the ambulance. Joanne's son has needed significant support and is angry, her daughter needed less support. Her son now knows that his nana and dad took their lives and says to his mum he doesn't want to wake up anymore.

Joanne has struggled to go back to work since the death and has experienced mental health issues. She has accessed Talking Therapies but with negative experience of group sessions where she was in group of people some of which had suicidal thoughts which she found deeply upsetting. Joanne can't understand that in 20 years of being with John that he couldn't just walk up the stairs and tell her he needed help or stand up to save himself.

Joanne was referred to a local charity by the coroner and has relied on them to support her throughout including reminders to get her to mental health appointments and help her complete paperwork, bills and accompany her to the coroners.

John was seeing another woman when Joanne was pregnant and she hung herself, then one of John's best friends hung himself in prison. Joanne has her dog that she adores, and that John bought for her.

D6 Case study 6 - Adele's story

Adele lost her husband Jim to suicide in 2014. They had recently moved house and have 3 children. Jim worked nightshift and had returned from work to get the children ready for school before going to sleep. Adele took the children to school and did some shopping before returning home to find her husband had took his life and hung himself. There were no signs of depression and Adele describes Jim as always a joker and never took life too seriously.

Adele told her 2 daughters about Jim taking his life but hasn't been able to tell them why he did it, there was no note and she has no idea why. Her son was younger, and he still doesn't know and now she doesn't know how to tell him, he was only 6 years old at the time Jim died and thinks his dad just died in his sleep.

Adele tried to access support for her son but this wasn't available if he didn't know the cause of death, so she has struggled to get support for him. Adele's tried to get support for her daughters and contacted lots of organisations including CAMHS and social workers, but they haven't been able to find any help and the family didn't have anybody close by as they were new to the community.

At the time of death police and emergency services arrived at the house and the community in the area came to watch the activity in the street. Adele remembers people standing on her lawn to try and see in the house and her husband. In the nights after his death there were some people in the community who would try and frighten the family by banging bin lids at their house and tying an effigy hanging from their washing line. Adele moved away from the area within 4 weeks of the death. The reporting on social media was extensive and Adele's daughters found out about the suicide through Facebook.

In the days before Jim's death the family dog escaped, and their neighbour accused the dog of attacking their dog. The neighbours knocked on Adele's door asking for money as compensation, Adele wanted to call the police, but Jim just paid it – they came daily and when Jim wouldn't pay them the man hit him on the head with a metal bar. Jim had to go to hospital but still wouldn't call the police and told the hospital it was an accident.

A police officer visited the family after Jim's death and Adele had asked him for help but he didn't know anywhere. That night he went home and mentioned it to his mum

who knew of a local charity. The next day he called Adele and gave her the number. If it hadn't been for that call, she wouldn't have found the help for herself. They only deal with adults but with the help Adele was able to support her children better. Adele's daughters have recently lost their friend to suicide, they are 14 and 15 years old now, and one of her daughter's friends mums took her life in the last week. Adele feels let down by NHS and social services and when asking for support continues to be given Samaritans phone number. Adele feels a lot more positive and can see a future, she is in a new relationship and has taken steps to remove people from her life who make her feel unworthy of happiness.

D7 Case study 7 - Natalie ’s story

Natalie lost her son Kevin to suicide, he took his life in prison 1 year and 10 months ago, but she thinks it is only the last 4 or 5 weeks that she has started to live again after the death. Natalie has another son who is estranged and a granddaughter whom she doesn’t see now.

Kevin had walked into a police station and admitted to growing cannabis and that he was going to take his life. The police arrested him, and he was sentenced to 8 years in prison. Kevin’s dad was a police officer. Kevin was terrified about going to prison in case anyone found out his dad was in the police. He though the police would save his life. He attempted suicide two times in Durham prison and was transferred to Northumberland where he took his life on the third attempt. Natalie spoke to him by phone every Saturday and he was crying to her. Kevin had mental health problems but wouldn’t seek help and told his mum the week before he died that he was struggling and that he couldn’t continue.

Natalie didn’t get to speak to him the final two Saturdays he rang, and she didn’t get to send him his birthday card, she worried that he thought she had abandoned him and that is why he took his life.

Natalie has been admitted to mental health hospital in 2013 at which time her other son wouldn’t contact her and stopped her granddaughter seeing her also. She feels like she has no family left and is alone. Following Kevin’s deaths Natalie was readmitted to mental health services for just over 5 months, she feels she lost her memory and blocked out that Kevin had died, she wouldn’t accept it.

When Natalie returned home from hospital, she recognised her home and the garden and tree that Kevin had planted for her, when she sits in the garden, she can feel him next to her and talks to him there.

There is little community support or neighbours who know Natalie in the area, and she doesn’t mix well with others. Kevin had lived with his girlfriend for 20 years before his death and she helped Natalie gather some of Kevin’s things together with pictures to hand to his dad. Kevin’s girlfriend had two daughters aged 13 and 2 years old.

Natalie had forgiven Kevin for taking his life and that has helped her move forward with hers. She is doing a course on volunteering in bereavement services as she wants to give something back even though she could never give back what she has been given.

Natalie has started attending a spiritualist church, although she isn't religious this is helping her. She was a very spiritual person before Kevin died and she thinks she is getting that back.

D8 Case study 8 - Jane's story

Jane is married and had 2 sons and 3 grandchildren and in addition she fosters a 14-year-old girl. Jane has lost both sons to suicide, Darren and Steven within 11 months of one another and now has custody of her grandson who was aged one year. Jane also has her niece staying with her who subsequently went on to take her life post interview date.

Darren was desperate for help before he died, he had been in contact with the mental health crisis team and had been to A&E but got turned away. Crisis services asked the police to check on Darren and he told Jane he was trying to get help but kept getting turned away. He went to the GP and while the GP was on the phone Darren heard someone giggle and he thought it was over him, he was upset and walked away. Darren had taken an overdose 6 weeks prior to his death and had been admitted to hospital. Jane still thinks services weren't there to help him and she could see and feel him going in on himself and saying help me. Darren had phoned Jane to tell her he had spoken to an angel called Michael and he felt loads better, he went missing the following day. That was the day before his brother Stevens birthday and Jane never saw him again.

Darren was missing for 6 weeks before the police found his body, his family and friends searched everywhere during that time and eventually found him in an empty property 600 yards away from his home. The coroner wouldn't give Jane a suicide verdict due to the lack of evidence that Darren intended to take his life. Darren had taken an overdose of prescribed medication. Darrens partner wouldn't let him grieve for his brother, she has lost 2 children taken from her through neglect, prior to meeting Darren. He was unaware of this, and they had a child between them who was then removed by the courts. Darren was trying to get his son back and had planned to move back in with Jane. Darren was experiencing domestic violence from his partner but wouldn't tell anyone, his partner was controlling. The night before Darren died his partner was punching him in the street, he had marks on him and although the next day was warm he wouldn't remove his jumper when they visited social workers and their son.

Jane describes Steven as the life and soul of the party and was the younger brother of Darren. Steven is described as deep and didn't show his emotions, but the 2 brothers

were extremely close. There was 11 months between the deaths of Darren and Steven. Steven had recently left his girlfriend and had moved into a relative's empty house. Jane visited him daily taking him shopping, he was also out of work at this time. Jane picked him up from the house on the day he died and noticed that he didn't seem right, he was asking Jane to leave him alone. Jane refused and took him back to her home. She made him a meal, and he was eating this and rambling, Jane knew something wasn't right with his behaviour. He took a drink, stood up and told Jane he loved her and that she had done everything for him. He asked Jane to open the door and left the house, as he was walking down the street Jane was following him. She wanted to try and stop him, so she fell on the ground and shouted she had hurt her leg. He continued to walk, and she shouted she was phoning the police. The police arrived within minutes, and Jane showed the officer where Steven had gone, they saw him at the bottom of a field and the police officer and dog ran across the field towards Steven. The officer returned to Jane who was calling her husband at the time as he was coming to help. The officer asked her to cut the call and told her he had some bad news for her. Jane recalls hitting out and the policeman just holding onto her as she fell to the floor. Steven had hung himself in the woods.

Jane is not sure how she has continued following the death of her second son but she knows she has the additional responsibility of custody of her grandchild now.

Jane was referred to support at a local charity a couple of weeks after Steven died and they helped Jane through the coroner process and the media who were there at the coroners. Jane was upset about the media reporting. Jane was referred for counselling at her GP but walked out and didn't return after the initial session, she didn't find it helpful. Her main source of support has been through her local priest and a local charity. Jane had a lot of support on Facebook when Darren went missing but there were tensions and arguments within the family when members recall thinking they saw him in the street or people told them they had seen him alive during the time he was missing. Jane had a lot of mediums contact her describing different locations for Darren – she did have a medium contact her from London who told Jane Darren was 600 yards in a particular direction, she wasn't sure if he went to work that direction but that is where he was found, in a derelict building. Jane initially thought it was another hoax, but she was correct, Jane never went back to this medium.

Jane didn't really grieve for Steven as she was still going through the emotions from Darren, and she felt like her mind just wouldn't accept they were gone. Jane has

tattoos in memory of her sons, she has their names with a semicolon after which signifies that the story isn't over or to be continued, it's about life continuing despite the struggles. The tattoos are on the same side as Jane's heart. Tattoos tell a person's story to symbolise the hurt they've gone through, it's always there with them in the same way a person is always there with them- it's not that Jane needs the reminder, but it is a reminder of the love. Jane visited the spiritualist church and the message from Steven relating to her tattoo was shared. Jane recognises that she must be careful both financially and emotionally seeing a medium as she has the tendency to want more contact all the time and can feel upset when this doesn't happen. That's why she attends the church as they don't charge.

D9 Case study 9 - Phil's story

Phil lost his cousin Joe to suicide in 2013. He and his cousin were very close, and Phil felt that his cousin was his older brother as he was an only child. Police initially referred Phils' aunty to support from a local charity and his aunt shared the details with Phil's mum and that's how Phil accessed support also. Phil's other cousins also accessed support. Phil was 23 years old when he lost his Joe and he was 30 years old when he died, Joe's siblings were 19, 16 and 15 years old. Joe took his life 2 years ago.

Phil was studying for a master's degree when Joe took his life, he struggled to complete this but achieved a pass in ancient history which is his passion. Since losing Joe his life has changed significantly, and he now works for a local charity fundraising. He has organised football fundraisers and both Joe and Phil were big football fans. He accessed support for 12 months before starting to work with the charity. He envisages that long term he will go back to ancient history and possibly teaching.

Phil finds it hard working in the charity some days as there are pictures of his cousin and his details on their systems which he finds difficult. It results in Phil being constantly reminded of his loss and he can't just forget or get space from suicide. His family have become increasingly close since Joe's death and go on holiday once a year all together, they are always seeing one another and that is a great source of support.

Phil thought Joe would be the last person to do anything like this, he was the life and soul of the party. He was a similar personality to the other guy Phil worked with who also took his life. There were some issues that emerged after Joe died, he had been experiencing some problems at work and with his girlfriend and his van was broken into and tools stolen. He was babysitting his younger cousins the night he took his life, and Phil thinks it was an immediate decision and not planned. Phil's younger cousins found Joe and have experienced mental and physical health issues since, including excessive alcohol use.

Phil has had a lot of support from his football teammates and Joe's friends. He is not ashamed of what Joe did and doesn't hide it from anyone. He did ask the GP for help,

but they just offered antidepressants which he still takes. A local charity managed to get Phil support through Barnardo's which was helpful.

Phil's cousin who lived away from core family found Joe's death difficult and said hurtful comments to Phil. His cousin had lost his dad a few years ago to illness and said it was disgusting that Joe had taken his life when his dad would have done anything to live. Some of Phil's friends also find it difficult to speak about suicide and Phil think there is still stigma or a taboo towards people who take their lives.

Phil has seen a medium who he thought was good and very accurate and told Phil how Joe died. She told Phil that Joe said he was sorry, and he didn't mean to do it. Phil's mum and aunty have also been to see a medium soon after the death, their experience was good and had clear messages from Joe saying he was sorry, he didn't mean to hurt anyone and that it was a rash decision. Seeing feathers and butterflies signal that a loved one has visited, Phil doesn't know whether to believe these things but does find it a comfort. Phil has felt Joe with him at times and on important days.

D10 Case study 10 - Barbara ’s story

Barbara lost her son to suicide and has since worked with the local mental health trust to develop videos and training on suicide prevention and the impact of suicide on families. William took his life 5 years ago when he was 33 years old, he had a diagnosis of bi-polar. Barbara didn’t know until the mental health trust reported through the serious untoward incident process that William has tried to take his life beforehand. William was a mental health inpatient when he attempted suicide the first time, the trust discharged him from hospital on the Monday, and he took his own life on the Thursday of the same week. The trust didn’t ask William’s family if he could be discharged to her home because they said William didn’t want to discuss anything with his family.

William’s friends knew about his bi-polar and how when he was on top form, he was brilliant, but when he wasn’t he just wanted to sleep. William had lots of girlfriends, but none were long term and he had lifelong friends from school that he was in a band with until he died. Barbara took his medication to the GP after the suicide as she couldn’t understand why he was on so many different types of medication and the GP said people who were taking these many prescriptions were in a bad way. Barbara didn’t know what he was taking even though William had been living intermittently at his mum’s house.

William had moved into his own place with his girlfriend and Barbara had been trying to contact him for almost 1 week, he eventually picked up his phone and told her he was in a mental health hospital as he had tried to kill himself. He didn’t want Barbara to go into hospital to see him but William’s older brother visited him and told Barbara William was worried his mum would be disappointed in him and he couldn’t face Barbara.

The hospital had told Barbara that William wouldn’t be discharged until he was stable and had a place to live. The day Barbara and William’s dad were due to go on holiday, Barbara called the hospital to be told that William was due to be discharged the following day – William had been found with street Valium on him in hospital. Barbara asked to where and William said he didn’t know he was waiting to find out and would let Barbara know. Barbara contacted the hospital who told her that William would be housed in homeless accommodation as he was homeless.

On Barbara and Brian's return home there was a car outside their home, and they couldn't park, Brian went over and Barbara was getting out of the car, Brian said it's about William and he didn't make it. Barbara fell into the car and asked what he meant; he didn't make it. William had taken an overdose in his accommodation and one of the residents raised the alarm as he couldn't get a response from Simon. Barbara had a professional background in care and felt that the care William had received was lacking. She started to document everything and met with the trust and social worker. Barbara documented everything and contacted legal advice. At the coroner's hearing the coroner requested more information about William's discharge – the coroner ruled that there was no multi-agency discharge plan for William and recommendations for the mental health trust, police and council were made by the coroner. Barbara has worked with the trust to develop improvements taking on the learning from William's death.

Barbara engaged with a solicitor due to the failings she saw in William's care and fought for justice for Simon. She didn't sue the mental health trust but did thoroughly highlight their failings alongside the coroner process for others who might find themselves in a similar situation to Simon.

D11 Case study 11 - Brian's story

Brian lost his son Kieron three and a half years ago. Brian describes Kieron not as the prodigal son, but he was always the child that needed special attention. He wasn't a bad boy, but he was gullible and yet very clever but always needed that little bit of mollycoddling. Brian has two sons and one daughter including Kieron. Brian describes Kieron as the life and soul of the party all the time, he was a sergeant in the army for 10 years and Brian was very proud of him. When he left the army Brian thinks he lost his way in life, he got married to a girl and Brian believes this was just for the sex and not love. Kieron and his wife had a daughter who was only three years old when her dad died. The grandchild hasn't forgotten her dad and when Brian asks her about him, she describes him as a big man with blonde hair, yet Brian says he didn't have blonde hair. Three weeks after his death his wife had a new partner. Brian and his ex-wife look after their grandchild most of the time and Brian has her every weekend as he still works.

Brian describes getting lots of tattoos since he lost his son to suicide, he calls it a comfort but also sees it as self-harming. He describes a bumper anger inside that getting tattoo helps. Brian believes his personality has completely changed since the death of his son who took his life and says all the good things in life aren't good anymore.

It was two years before his children pushed Brian to get some support as they saw something was wrong after Kieron's death. His ex-wife was already involved with a local charity and Brian's son got in touch with them and gave them Brian's number, at that time Brian was just sat at home drinking every night, he didn't go to see his GP as he didn't think he was sick. Brian's son and daughter both live in other parts of the UK.

Brian feels that Kieron taking his life was a selfish act, because Kieron has become immortal; he is constantly thought about. Brian sits quite a lot as he lives on his own and thinks about Kieron. Brian is 60 years old and feels that at his stage of life he should be enjoying life, going on a few holidays a year and out partying on a weekend but that's all stopped because he feels guilty, so he looks after his grandchild as does his ex-wife because they both feel guilty for Kieron's death. Brian feels his time is running out and that he shouldn't be the one to watch his granddaughter grow up, all her achievements and support her, that should be Kieron and he should be proud of Kieron doing it, it's not Brian's job to do it.

Brian physically neglected himself after Kieron's death, he has lost all his teeth even pulling some out himself, drank and smoked excessively. He feels he was guilty and looking for sympathy but now when people show him sympathy, he finds it irritating. Brian thinks people who lose loved ones to suicide are not looking for sympathy but understanding and not enough people know about suicide and how it impacts on suicide survivors.

Brian thinks that the Army should have prepared his son more before he was discharged. Kieron was seventeen years old when he joined the army and although they helped him get a job they didn't prepare him enough for civilian life and Brian feels he was institutionalised. Kieron took his life two months after leaving the army, he got a job at Nissan, and it was very different environment and over £10,000 reduction in salary. In the army the people you are with are mates, there is a camaraderie but civilian life they are work mates which is different. Kieron was demobbed in December and was dead by February, Brian didn't see his death coming. Suicide runs in Brian's family; there are four or five family members who had taken their lives including a cousin and uncle. Brian's mother thinks suicide is hereditary because Brian's uncle had schizophrenia. Brian has been to see a medium but didn't rate the experience and thought they were talking rubbish; he doesn't believe in signs that Kieron might be close.

When Kieron went missing, Brian knew something was wrong as he was texting him and there was no response. The police were planning a search party on the next morning near some local woods as they had found Kieron's car, but Brian went out all night searching on his own. Brian felt that Kieron was dead and the next day the search party found Kieron's body at 4pm. Brian describes having to identify his body at 8pm as one of the worst things he has ever had to do. Brian feels he has to live with Kieron not being here now and he has to live with that.

D12 Case study 12 - Angela and Colin's story

Angelas eldest son, Andrew was searching on the internet for support for his family following the suicide of his younger brother Dermot and found a local charity and requested an information pack. They felt the information was informative and really, they needed this along with someone to talk too who had experienced losing someone to suicide. They felt this should be standard for family and friends as soon as possible after a suicide.

Angela and Colin were away on holiday when their son took his life, so Andrew took on the initial responsibility and looked after everything including his younger sister. Dermot was married and lived in the next village to Colin and Angela. Dermot died just over 12 months prior to the interview. Colin and Angela contacted their GP and were referred for counselling which they received a few weeks after the death. Their daughter in law, Dermot's wife and his mother-in-law waited months for any support from counsellors and Colin and Angela felt they needed support quicker as they had found Dermot's body.

A local charity linked Colin and Angela with other families who had experienced suicide, and they felt this helped them to be able to share similar experiences and emotions. Some people they met they already knew to speak to however they hadn't shared that they also had lost a loved one to suicide until it had happened to Colin and Angela. They have found themselves in a community of suicide survivors they didn't know existed who rallied around them. The local community and church members were a great support to the family.

Dermot had only been married 9 months before he took his life, and his parents still have no idea why he ended his life. The only thing they were aware of was his work and how he was becoming stressed about his recent change in job which he was in for only 4 weeks before he died, and he had a flood at their new home. He was always very eager to please others, and they felt he was burnt out. When the house flooded, he went to work as he didn't want to let them down and was worried as the job was only temporary. When his parents rang on an evening, he was often in bed for 9pm. Dermot had always wanted to join the Navy and was all set until the GP report indicated he had once been prescribed an inhaler and he was subsequently refused. He was devastated about this as although he had been prescribed this, he hadn't ever used

an inhaler. He subsequently joined the Army and stayed in the forces for initial training before leaving, he didn't like the shouting. Dermot's wife and friends didn't know he was contemplating suicide.

The day Dermot died he had spoken with his wife and mother-in-law; he had been to work and had a haircut. He was watching television on the night alone and his wife was out with friends. He put the television on pause as you would to go a make a cuppa and took his life. His parents like to think that he had a heart attack of the brain at that point. They believe that Dermot wanted to die at that point but not for the rest of his life.

Colin and Angela were teachers and had worked with young men, they recognise that men are more at risk of suicide and how difficult they had found it working with them to get them to open about their troubles. They have thought a lot about prevention and how suicide could be stopped if the analogy was a heart attack of the brain, Dermot could have easily made that cup of tea and returned to watch TV but he didn't.

Dermot's sister announced she was pregnant shortly after Dermot died so the family have experienced a very emotional year with a death and a birth. Andrew has been raising funds for a local charity cycling the coast to coast and the family have participated in charitable events to support suicide survivors. Andrew and his dad have found having an allotment have helped them to manage through their journey and give them space to think and focus on gardening.

Angela wrote a diary about her dreams, and she would analyse these and the events leading up to the night she lost her son. They also created memory box of her son's possessions. Dermot's wife left the house after the death and wouldn't return to it, it was recently sold which was a relief to the family.

D13 Case study 13 - Kevin, Helen and Joseph's story

Kevin and Helen are Ed's (deceased) parents and Joseph is Ed's younger brother (aged 22). Ed took his own life just over 1 year ago. Kevin and Helen were on holiday when Ed took his life, Ed was 25 years old.

When they returned from holiday there were information leaflets on their table left by police. They contacted a local charity as they raised funds for the charity from the funeral in lieu of flowers, Kevin drove to their office to hand the money over, Grace asked him to stay and talk and that was their first access to support. They had no idea nor heard about the charity before they lost Ed.

Joseph was the last person to see Ed alive; he is still full of guilt for the loss of his brother. Ed had recently moved back home due to a relationship breakdown. His ex-girlfriend would self-harm and she took all his wages from Ed, she was very manipulative of Ed. He had recently discovered that she was having an affair with someone she worked with, he took the breakup badly and would tell his parents it wasn't his fault. Ed had planned to propose to his girlfriend on a holiday to Venice. His parents have never disclosed that to his ex-girlfriend.

Kevin and Helen feel they are lost, knackered and ready to shut the door on their lives. Their sons were good mates not just brothers, they were always in contact, facetiming when they were apart. Joseph was on his way home from shopping and passed a field near home and he could see something but thought a horse had been run over because there was a shirt over something. Ed's uncle had found Ed in the field dead and Joseph had arrived soon after, they removed Ed hanging from a washing line.

His parents don't recall Ed being sick or depressed, just that he had broken up with his girlfriend. They never thought he would take his life. There was only 4 days between the brothers' birthdays and the family have found that quite difficult, as was Christmas which they struggled with. The family took the day off work on the anniversary of Ed's death and went out in the car for the day after they visited the cemetery.

After Ed's death Helen felt she needed something to keep her occupied so the got a dog, it has been the only thing that helped them smile since the death. The local community was very responsive and supportive to the family and Ed's friends have

stayed in contact. The family were invited to one of Ed's friend's wedding, but they couldn't face seeing all his friends, they felt it was too soon for them. Helen and Kevin are more protective of Joseph now and Joseph keeps in contact with them all the time so they don't worry. Helen was offered counselling from the GP but she didn't want it, she felt she could talk to her family and a local charity was enough. Ed's parents felt they returned to work too soon after Ed's death, being off 6 weeks, they struggled with work colleagues not knowing what to say or how best to mention suicide, some colleagues didn't speak to them. In Kevin's workplace his employer gave him a different role where he was in a room on his own working for 8 hours a day, he found this very difficult to manage as it would give him time and space to think about Ed and his death. Ed's parents felt their employers could have done things differently to support them and other suicide survivors. They hear comments from people and they are identified as the parents of the one who killed himself, they feel that's what they are now.

Ed's clothes and bedroom are still the same, untouched, and his toothbrush is still in the bathroom. Kevin and Helen would sell the house and move abroad if it was only the two of them but they wouldn't leave Joseph, when they go on holiday Joseph stays with his aunty and he takes the dogs.

Being a suicide survivor is being in a club Kevin and Helen don't want to be in, but they are. They describe being like a magnet to other suicide survivors and people coming up to them to share their stories of their losses. Kevin visits his GP regularly for a chat and finds it helpful, one of the GP's in the practice lost a son to suicide following Ed's death and the practice is more aware of the impact because of this.

D14 Case study 14 - Dot's story

Dot trained and a nurse and worked in foundation trusts until 2011 when she left the NHS to follow her beliefs into working as a medium. Dot recalls she has been able to have a connection with spirit world since she was little but understands why some people are sceptical, if they haven't had a connection themselves why would they believe. In her teenage years the connections increased and when she was a nurse she could see spirits come for people at work. Dot worked in oncology but never said anything about what she saw at work in fear she would be dismissed.

Dot feels she has a gift and that should be shared but she also felt she shouldn't charge people, but when people lose someone, people don't care about money, money is irrelevant. Dot knows there are many fakes delivering readings to people and taking their money and hopes which she finds difficult.

When Dot started doing sittings she was still working in the NHS, she didn't advertise her services and people found her through word of mouth. Dot struggled to manage the additional work plus her NHS job and studying for a masters, she found it difficult to say no to people when they rang requesting a sitting and they were distressed and crying which added more pressure to her life. She was exhausted and eventually left the NHS to focus on her mediumship work.

Dot specialises in people who have lost children regardless of age in the most extreme circumstances including murder and suicide and has worked with the police on missing person cases. The work she does in mainly outside of the public eye, but she does do public demonstrations which is where her income comes from. She doesn't charge for sittings, many people would pay anything, but she doesn't charge as she believes she is employed by the spirit world to do this work. Dot acknowledges the number of fake mediums who charge significant amounts of money to the bereaved and people pay it as they are desperate. That is also why she doesn't charge and believes there is no money in spirit it is just a tool, yet people have become obsessed with it.

The people that Dot sees tell her that nothing else helps them, people are grieving the physical even if people know the deceased carry on and are still with them, some people Dot sees describe the experience as being given a calming pill. Dot believes there is a certain amount of scepticism in our society of the spirit world in comparison

to other cultures in the world. Being open minded to it, it is arrogant to think that there is nothing else out there. When Dot meets people she is careful what she says as she doesn't want their situation to worsen so she doesn't describe the persons last moments, but she also knows she is just the interpreter and passing on messages, mind to mind.

People Dot sees tend to want genuine evidence first, things no-one else would know which could be what the person put in a letter or what went into the casket with the deceased. If Dot is working with someone who was high profile with news coverage, she doesn't recap that information as many fakes research details on social media before they see someone. Dot will ask people to have a mind-to-mind conversation with the deceased, maybe on the way to see her and discuss something that is just between them, she encourages people to open their mind to the person being with them. When a connection is made Dot can relay that information to the person and that is the evidence they need that they are indeed travelling with them still.

Men are especially sceptic of spirit world, and some come to see Dot as their last hope when they have tried everything else. Men are generally less complex and Dot finds them easier to work with than women. Dot sees suicide survivors from all cultures and classes and has worked with families who have lost more than one child to suicide which reflects the breadth of people who take their lives. She explained spirits have shared their reasons as to why they took their lives with triggers being physical or sexual abuse in their younger years which put them on the wrong life path. Some have shared they were mixed up in drugs and alcohol, or they haven't meant to do it and they were just sick in that moment. Dot is clear that every person who has come through her is incredibly sorry for the devastation that's been caused.

Dot is very aware of the responsibility she holds and how delicate the interaction with the bereaved is, it's immense and people hang on every word she says, if she says the wrong thing or they take her meaning the wrong way they may go home and brood and this may make their situation worse. She doesn't want to traumatise them further by sharing historical abuse that the person may not be aware of, so she takes the conversation gently.

Lots of parents who have lost children request sittings on Christmas eve, birthdays or anniversaries. Dot will see people more than once if it is helpful but makes it clear it cant become a crutch to the bereaved and has to be healing. She doesn't use the word suicide as people don't like the word so she tends to say people took themselves over

to the spirit world. Dot spends time detailing who the spirits are with, maybe a grandmother and also works through any religious misconceptions about people being stuck or not moved on which some people think will happen due to the cause of death. They discuss what they are doing in the spirit world and one young man told Dot that he had a motorbike now and that he always wanted one but his mum would never let him have one. This helps the suicide survivors move on knowing that their loved ones are alright. They also discuss things that have happened since their passing, babies being born or people getting married.

Dot works on two levels, psychic level whereby she can sense things about the person like having a terrible marriage, there is no contact with the spirit world for psychic work. Mediumistic level is where there is a connection with a spirit and she is interpreting their messages to the person. All mediums are psychic but not all psychics are mediums. People don't need to know the mechanics of the spirit world and in most cases, people will never need it or bothered by it as life may be fine. It is not until there is a tragedy in life that they start to question it and start to search for meaning, people have a choice whether to believe. People Dot sees explain to her that what makes them feel happy is to know that their loved ones are fine and that they are still living on, it helps take away the guilt they feel after suicide. Dot has had some people who have told her they intend to take their lives following their suicide loss, this was frightening but her nursing background has helped her to navigate these conversations and to get them help from their GP.

A common message Dot heard from bereaved was that there was not enough support for them. Dot set up a support group in her area for bereaved, they were not all from suicide but many were. Dot is starting a charity to support people who have lost children, when people want to pay Dot she asks them to input into the charity instead and then the people who have lost can decide to do something for their loved ones, it helps to give people something worthwhile and to help others.

Although Dot had a natural ability to feel spirits she also trained at The Arthur Findley College, Essex. People come from around the world to train in how to deepen the evidence and train to be a medium. Dot feels it is a lonely job after working in the NHS in a team to predominantly working on her own, but it is rewarding bringing hope to others.

D15 Case study 15 - David and Carol's story

David is Carol's son and they are cousin and aunty to Matt. David is 21 years of age has a younger sister aged 9 and cousin aged 10 years. He lost his cousin Matt nearly 12 months ago at the time of the interview, he was aged 23 years of age, there was five days between their birthdays and Matt took his life just before David's 21st birthday. There have been four suicides in David's family, Matt his cousin, his uncle took his life last year following the suicide of his uncle's sister and then his uncle's father died by suicide last month, he was 77 years old and David thinks he couldn't cope with losing his children. David knew all the deceased well apart from his uncle's sister who he met some years before. The last year has had a big impact on David, since Matt's funeral everything has been raw and traumatic. Matt had two children who David is godparent to, on the morning Matt took his life he messaged David asking him to look after Joshua, Matt didn't react to the text as he didn't understand, then he realised and something was wrong. Matt was Davids's hero and he would never have thought he would take his life.

Matt's dad had been attacked by Matt's bulldogs and had his arm ripped off, Matt had struggled with what had happed to his dad and having to get his dogs put to sleep. His nana then fell down the stairs and had a head injury so over the year before Matt died there seemed to be nothing good happening.

David's mum went to the GP for support, and they gave her some information leaflets with a local charity's details, his mum contacted them as David was getting worse following the suicide, he was just working coming home and going to bed. His workplace didn't know how to support him, and he eventually broke down at work as he couldn't continue emotionally and subsequently left the job.

David has accessed support from a local charity which has helped him through his journey after suicide and feels that the relationship he has with the team is like an extended family and friends and it's based on friendly conversations with people who are also suicide survivors.

David is currently studying a degree in sport and exercise and also volunteers at the charity a local charity on developing the school's education programme and sports clubs, he regularly goes into schools to work with young people on the charity's

suicide prevention programme. Before suicide David had planned to work towards becoming a teacher, but suicide changed him and he is now considering psychology as a career and is learning lots delivering sessions in schools and sports clubs. David has run the Great North Run twice in support of a local charity and David's mum is also going to run it this year. David sometimes misses his university course to go to a local charity office and help out which helps with meeting the course requirement of 50 volunteering hours per year.

David has always enjoyed team sport but after the suicide he had a long period of time where he avoided it, he felt too angry to play sport. He did some weight training and was working on a golf course but found that lonely and would spend lots of time thinking about his loss. David finds he does sport or trains to excess and then crashes, he doesn't eat often and has had anorexia some years ago. When this happens, he manages it by staying at home and zoning out for a number of days, listening to music that Matt had or playing football helps because he can focus on the ball and just everything else goes.

David struggles with his confidence especially when going into schools to deliver the suicide prevention sessions, he feels he has to push himself to do it and does become nervous sharing his experience of suicide with young people in the sessions. He will say that you don't need any experience to support people, the experience is being a suicide survivor there is no other way to learn about it.

a local charity accompanied David to meet a counsellor shortly after he left his job as he was really struggling at that time. The counsellor asked him why he wasn't over his bereavement and that he should be over it by now. David looked to Grace for support and Grace told the counsellor about the experience of being a suicide survivor which David found helpful as he didn't know what to say to the counsellor. He then was referred to Talking Changes, and it took 100 days for them to get in contact with him and when they called David, he told them he didn't want to see them and that it was a poor service. Davids's mum did see Talking Changes, and they really helped her and she had a good relationship with the counsellor.

David's mum worries about him when he is struggling and needs some time on his own, but he finds it difficult to show any emotion now when things happen to others or they lose someone it doesn't seem to bother him, he has no emotion left as Matt was his everything.

Matt's mum goes to see spiritualists, David has been to the church twice and the second time was chosen to hear the messages which were all correct. He has also been a few times with his uncle to see a medium who offers sittings for people who have lost a child. David talks to Matt when he wins at sport, or something happens which keeps Matt close to him. When it first happened, David felt he needed to go to church or visit the tree where the suicide took place and couldn't go a week without visiting but now it doesn't matter if he goes or not. He believes that Matt isn't at the grave but is around them as a family, that gives him comfort that he's not completely gone. David does hate Matt for what he has done not only to him but for his kids and his dad, and he has a lot of anger towards him.

Carol is David's mum and visits people's homes to do her job; she had a close set of friends who she regularly did work for but also socialised with. Since the suicide Carol has continued to be asked to do their work but she is no longer asked to join them when they are socialising. She notices that people don't mention the suicide maybe because they don't know what to say or they don't want to hear about it as it's distressing. The local community were not a source of support; there isn't much of a community spirit where the family live. When she goes to the shops, she has seen people she knows actively dodge having a conversation with her.

Carol has struggled to support her wider family following the suicides of other members as she doesn't know how to help, if she talks about it she then also gets upset and she doesn't want to put herself in that position as needs to protect herself. Carol worries being out of control, she looked after her brother for months following the dog attack and then would listen to him when his son Matt took his life, they would talk for hours, and she was overwhelmed with emotion and worry for her family. She liked to think she could look after her family but the hardest thing when Matt went was not being able to control it, make things better or reverse it.

D16 Case study 16 - Stuart's story

Stuarts partner Nicola took her life in April; it has been a year and 2 months since her death at the time of the interview. Stuart didn't have a problem going to the GP for help when he needed to or offloading his problems to family or friends, but when he lost Nicola it turned his world upside down. After 2 weeks he still hadn't talked to anyone who could offer him support and a close friend gave him local charities contact details. Initially he didn't contact them, but he was struggling and rang them to make an appointment, he felt so comfortable when he met Grace he shared his life story with her. He is grateful he stumbled on a local charity as he doesn't know what sort of a situation, he would have been in without them. They helped him emotionally and with the practical things including through the coroner process.

Stuart and Nicola bought a new house the previous year and Stuart spent 6 months renovating it. The couple had only been in the house for 2 months when Nicola died. Stuart still can't understand why Nicola took her life, with the new house it should have been their best years together. When the 2 police officers knocked on Stuarts door, he knew it was going to be bad news because there was 2 of them, but he never thought it was suicide. Whenever he talks about it he was in floods of tears and although he has a nice house, a business and can look after himself nothing means anything anymore. Stuart and Nicola didn't have children, and he wonders if that would have helped, he does have close family though.

Stuart can go 2 or 3 days without speaking to anyone as he is self-employed and works from home, he feels he would have been lost without his dog. He spent many months searching for answers on the internet and books trying to understand why, he has now accepted he will never know why Nicola took her life. He tried to blame someone for what happened but now asks himself whether Nicola was happy with their lives together. Stuart experienced indescribable pain that just doesn't go away, when he meets people, they tell him he looks better but he doesn't feel anything. Taking the dog for a walk helps him not but initially he hated it, he kept meeting people who didn't know what had happened and having to retell the story of Nicola's death repeatedly. Stuart bought the dog for Nicola as a valentine's gift and Nicolas death has also impacted on the dog, he doesn't leave Stuarts side now.

There were times early on after Nicola had died when Stuart didn't want to be alive either but the support he received was critical to him in the early stages. After 6 months people started to fade away, and Stuart spent more time alone. He contacted his work clients and told them there had been a family bereavement, he didn't go back to work for 5 months.

Nicola was a positive person compared to Stuart and would see the upside of everything, which is another reason that Stuart struggled with her taking her life, he just couldn't believe it and asked the police if they had the right person. Stuart doesn't have any memories in their home as they had recently moved in, so there is no attachment to it. He has considered selling and moving away from the area. He has lived in the area all his life but now feels that he will always just be the guy whose partner took her life. Although he isn't thinking about relationships at the moment, he would find it virtually impossible to start a new relationship where he lives now.

Stuart's confidence to try new things has diminished, but he even struggled with normal things, making a phone call for an appointment was difficult. Meeting other suicide survivors made a huge difference to Stuart and he could talk to people who knew how he was feeling.

Stuart's sister in law's brother's son took his life a few years before Nicola.

D17 Case study 17 - Paul's story

Paul and his partner Clare had been together for 13 years before she took her own life. She was using drugs for several years before she died and tried to hide it from Paul. She mainly used amphetamine which Paul and Clare fought over when he found it hidden in the house. When the toxicology came back after her death, she had a large amount of cocaine in her system which shocked Paul, he wasn't aware she was using cocaine. She had drunk 22 cans of larger and a bottle of wine before she died. Clare suffered from depression and was taking medication while also self-medicating with alcohol and drugs. Clare hung herself from the stairs at their home during the night, they had 2 children, and she used the children's skipping rope. She died 18 months ago and 10 days after her death, her mother, the children's grandmother died from a heart attack. Paul has lost his best friend, his father and his son and considers his life are difficult.

Paul got up when he heard a noise at 2.45am the night Clare died. He saw Clare downstairs and their daughter sat on the stairs, he told his daughter to go back to bed and he also went to bed. He thought Clare was downstairs drunk and left her there. He got up at 7am and realised Clare had hung herself, he shouted his children to call an ambulance, he later realised his youngest daughter had sat on the stairs from 2.45am until her dad woke up, looking at her mum.

The family have found losing Clare very difficult and they have had lots of support from Grace, a local charity and support through the school for the children. They have a social worker who visits weekly, and Paul feels he has had lots of help, too much sometimes. Paul has taken the children on a few holidays abroad which they have enjoyed since they lost Clare and will be going away for Christmas this year.

Paul felt the local community were uncomfortable around the family after Clare's death with many people not speaking and just staring. Paul and his sister are joining the Walk for Life again this year, suicide survivors gather at 4am World Suicide Prevention Day to walk to the Angel of the North. In the area the family live there have been 5 people die by suicide in the last 2 years but thinks once you have lost someone to suicide that you become aware of others more easily. Paul finds that speaking about his experience of losing Clare to other suicide survivors makes him feel better, he also offers to talk to people through a local charity. He believes that survivors should receive counselling, people must share their story, he finds it easier now to talk but initially he wouldn't talk to anyone. Paul has had 4 children and only

3 are alive, the 2 daughters (aged 8 and 7 years old) he had with Clare are in his sole custody and his son is shared with his ex-partner.

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Acronyms

ADHD	Attention-Deficit/Hyperactivity Disorder
CAMHS	Child and Adolescent Mental Health Services
DBS	Disclosure and Barring Service
GP	General Practitioner
HPA	Hypothalamic–Pituitary–Adrenal
ICB	Integrated Care Board
IMD	Index of Multiple Deprivation
MHS	Mental health services
NICE	National Institute for Clinical Excellence
NHS	National Health Service
PTSD	Post-Traumatic Stress Disorder
RAF	Royal Air Force
TB	Tuberculosis
VCSE	Voluntary, Community and Social Enterprise