

**Work-related suicide: a qualitative analysis of recent cases with
recommendations for reform**

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Ethical approval for this project was provided by the University of Leeds. All interview participants were provided with a project information sheet and invited to complete a written consent form.

1. Introduction

Suicide rates are rising in the UK and the highest rates are amongst working age men aged 40-54 (Iacobucci 2020, NCISH 2021). Certain occupations for male and female employees have higher suicide rates than others with low-skilled occupations and in particular, construction workers having the highest rates for men and care workers having the highest rates for women (ONS 2019, Windsor-Shellard & Gunnell 2019). Meanwhile suicide charities, trade unions and professional associations point to a mental health crisis in the workplace.¹ According to the government commissioned *Thriving at Work* report, there are more people at work with mental health conditions than ever before and at a far greater rate than physical health conditions (Stevenson & Farmer, 2017).

Despite growing evidence of the causal connections between work and suicide (Milner et al. 2013, Milner, Morrell & LaMontagne 2014, Clot 2015, Waters, Karanikolos & McKee 2016, Waters 2020), employee suicides are still largely treated as an individual mental health problem that has no direct relevance for work or for the workplace. In the UK, no data is collected on suicides that occur in the workplace or that are identified as work-related.² There is currently no regulation or oversight of work-related suicides. Suicide is excluded from the health and safety framework that applies to all other work-related deaths. There is no HSE (Health & Safety Executive) inspection of a workplace following a suicide by an employee or multiple suicides by employees. Suicide is excluded from the joint protocol on work-related deaths. Employers are not obliged to undertake an investigation following a suicide, implement any changes to workplace policies or practices or put suicide prevention measures in place.

The failure to recognise, monitor and regulate work-related suicides poses serious and ongoing risks to the health and safety of UK employees. In some of the cases studied in this report, suicides were repeat incidents or formed part of a 'suicide cluster' according to the Public Health England definition of this term (PHE 2019). Suicides could be prevented if they were treated with the same rigour, oversight and regulation as other work-related deaths. While an employer is legally obliged to report the fracture of an arm or leg at work to the HSE for investigation, a suicide that takes place in the workplace or is related to work, does not need to be reported to any public agency.

There is an urgent need to modernise health and safety regulations in order to prevent avoidable deaths and bring the UK in line with other industrialised countries where work-related suicides are systematically monitored, regulated and treated as a serious public health concern. According to the WHO, suicide remains one of the leading causes of death worldwide, accounting for one in every 100 deaths and countries need to commit more resources to suicide prevention.³

2. Aims of the study

The purpose of the study is to examine some of the causal links between work and suicide through an in-depth qualitative analysis of a small selection of suicide cases across different occupations and economic sectors. We selected cases where work-related causes had previously been identified by an official source (police, coroner and/or employer's investigation) and we aim to provide an in-depth analysis of the causal factors linked to these cases. The study aims to address an important gap in UK research on suicide by examining evidence of the role of complex and diverse factors of work-related causality.⁴ This is not a clinical study of suicide but focuses specifically on workplace structures and practices with the aim of making these safer for employees in terms of suicide prevention.

The study addresses both the causes and aftermath of suicide cases across different workplace contexts. For each of the cases studied, we examined how the relevant authorities (police, employer, HSE, coroner, union) investigated, reported and followed up the suicide. Our aim is to shed light on current regulatory and organisational responses to work-related suicide.

We also examined the situation of bereaved family members and colleagues in the aftermath of a suicide, looking closely at the support available to them (counselling, legal/financial advice, communication with the employer).

The project aimed to address the following questions:

- What are the diverse causal factors that underpin suspected cases of work-related suicide? How do these causal factors relate to workplace policies, practices or behaviour? How can workplace suicide risks be mitigated and prevented?
- How do the relevant authorities and organisations respond to work-related suicides (HSE, employer, coroner)? Is there a consistent organisational response to suicide across the cases?
- How are bereaved families and colleagues supported in the aftermath of a suicide in the form of counselling, debriefing, therapeutic services, financial and legal advice?

3. **How we carried out the study**

We studied 12 suicide cases where evidence of work-related factors had previously been identified either during an inquest, police enquiry and/or an employer's investigation. We selected these cases from a wider database of 25 cases gathered from a multiplicity of sources (outlined below). The selection criteria aimed to represent a diverse range of occupations / sectors and a range of potential work-related causal factors. Our approach is based on a qualitative case study methodology designed to enable in-depth exploration of intricate phenomena within a specific context (Stake 1995, Creswell 2013, Baskarada 2014, Yin 2017).

The suicide cases cover the period from 2015 to 2020 and include a range of occupations and sectors: police services (2), fire fighters (2), teachers (2), doctors (2), ambulance service (1), university lecturer (1), mechanic (1), nurse (1) and consist of 9 males and 3 females. In 2 cases, there was a previous history of mental ill health and in the other 10 cases, there was no evidence of long-term mental ill health. 2 of the suicides took place in the workplace and 10 outside the workplace.

For the suicide cases, we analysed multiple sources of documentation: employer investigation reports, police reports, coroner verdicts, inquest transcripts (where available), Preventing Future Death reports, internal communication, staff wellbeing surveys, media reports, suicide notes. This material was obtained through Freedom of Information requests and through our liaison with employers, family members and colleagues in each of the cases studied. Some of this material was publicly available (PFD reports, employer reports). In addition, we drew on expert opinion on individual cases from solicitors, coroners and trade union representatives.

We undertook interviews with bereaved family members and / or colleagues, trade union representatives, professional association representatives (18 participants were interviewed online for 60-90 minutes each). Additional family members who did not wish to be interviewed responded to our questions by email. Managers and employers were invited to participate in the project to discuss the cases. Our approach is shaped by an interpretive paradigm that

emphasises social context and human complexity with regard to how people understand the phenomena under study. Our study recognises the importance of participants' subjectivity as part of this process (Kaplan & Maxwell 2004, Scotland 2012).

4. Main points

- (i) Suicides in the cases studied are linked to a diverse range of work-related causes (unmanageable workloads, exposure to violence and trauma, workplace bullying, long or irregular working hours, inspections, sickness absence). In 11 out of the 12 cases selected, workplace factors, either organisational or managerial were identified as the dominant causal factor in the suicide. In 1 of the cases, work circumstances exacerbated a pre-existing mental health issue linked to personal factors outside of work.
- (ii) In 9 of the cases, the employer was aware of work-related problems affecting the employee prior to the suicide, as these had been reported to managers or colleagues and/or documented in staff appraisals.
- (iii) While studies have identified known suicide risks in certain occupations (long/irregular working hours for healthcare professionals, exposure to violence and trauma for the emergency services, unmanageable workloads for educational professionals), this knowledge has not led to organisational/managerial processes to mitigate suicide risks in the workplaces we studied.
- (iv) The type of workplace behaviour (bullying) that can lead to some suicides is not unlawful under UK legislation, unless it is defined as discrimination against a person with protected characteristics (2010 Equality Act). We studied 2 cases of workplace bullying and in one of those cases, suicide was linked to a cycle of vicious bullying that was well documented and reported to managers, yet no action was taken against the employer in the aftermath of the suicide. Workplace bullying is unlawful in most other European systems.
- (v) In the UK, suicide is excluded from the list of work-related deaths that need to be reported to the HSE (RIDDOR) for investigation and no data is collected on work-related suicides. Without reliable and transparent data, it is impossible to monitor, regulate and prevent work-related suicides. Moreover, there is no health and safety investigation of a workplace by the HSE or Local Authority in the aftermath of a suicide.
- (vi) Employer-led investigations were only carried out in 4 of the 12 suicide cases studied (33.3%). The organisational / managerial factors that have caused or exacerbated a suicide are therefore not consistently investigated, reported or regulated and may continue to pose a health and safety risk to other employees.
- (vii) We found that the organisational response to work-related suicide in our selected cases is inconsistent and arbitrary and often depends on the individual discretion of an employer. Public Health England's toolkits for employers are a positive development but rely on good will rather than enforcement.
- (viii) Preventing Future Death reports were issued by coroners in 3 cases, despite documented evidence of diverse work-related factors in all 12 cases. Of these 3 PFD reports, only 2 included recommendations addressed to the employer. A key recommendation of this report is for consistent use of PFD reports where evidence of work-related factors is presented at the inquest.

- (ix) Support for bereaved families in the aftermath of a suicide is inconsistent and often depends on the good will of police officers and / or an employer. The family members we interviewed often felt abandoned and left to themselves to find out which steps to take, with little official advice, support or counselling. In 3 cases, family members took initial steps to pursue litigation but were dissuaded from taking it further because of the unlikelihood of success under current legislation. Even where there is extensive documented evidence of work-related factors in a suicide, there is limited legal recourse available for bereaved family members because of the lack of a robust health and safety regulatory framework.

5. Limitations of the study

The study draws on a small selection of suicides covering different occupations and geographical areas where evidence of work-related factors has previously been identified (by coroner, police or employer) and it is not necessarily representative of broader suicide trends nationally. Our study does not aim to analyse all the possible causes of employee suicide but focuses on the nature and extent of potential work-related factors in selected cases. Our findings confirm recent national and international studies that have identified causal links between work and suicide and have established suicide risks and trends pertaining to specific occupations.

The study draws on the narrative accounts of bereaved family members and colleagues. While these accounts provide valuable and detailed insights into the circumstances surrounding a suicide, they may have placed particular emphasis on identifying work as a causal factor, given the focus of the study and the nature of the questions asked. However, we have endeavoured to include multiple accounts and sources of evidence, as detailed in section 3 above. Taken together, these multiple sources provide strong evidence of work-related causality in the suicide cases we studied.

6. Work-related causal factors

The section below describes the causal factors identified in the 12 suicide cases studied.

(i) Unmanageable workloads

In 6 of the cases studied (50%), an unmanageable workload was identified as a contributory factor in the suicide and was identified as the main causal factor in 3 (25%) of the cases. In these cases, employees seemed to be burdened with so many different tasks and roles that their working lives became increasingly unmanageable with devastating consequences for their mental health.

A first case involved a 31-year-old secondary school chemistry teacher who took her own life in February 2016. She had been working at her school for 9 years and was a popular teacher who had helped some of her pupils to achieve outstanding GCSE results. In an interview, her mother reported that her daughter had been happy and was performing well at the school before taking on a new management role as assistant head in the science department in October 2015. Her mother stated that she did not initially want to apply for this role because of workload concerns but had been persuaded to do so by school managers. The new role generated immense pressure in what was already an extremely busy workload with a full teaching timetable and additional mentoring responsibilities. Her mother commented that following the promotion there were not enough hours in the day for all the jobs she had to do and her mind was constantly in overdrive. She was only sleeping 2 to 3 hours a night and

experienced hair loss and face rashes. Within 3 weeks of the promotion, her daughter had resigned from the role, was diagnosed with severe anxiety and work-related stress and took a sickness absence of 2 months.

A second case involved a 48-year-old university lecturer who took his own life shortly after arriving at work early in February 2018. He left two suicide notes on his computer, one of which referred directly to work pressures: “So, workload finally got me. Stress, worry, long hours, depression and I lost it, cracked.” He worked in a department which had recently experienced an exponential rise in student numbers and he was responsible for running modules with large cohorts of hundreds of students. When the deputy head of school resigned, he was asked to take on this role, even though he was reluctant to do so because he knew that he would struggle alongside his other commitments. 6 months after taking on the new role, he took his own life. We interviewed 4 of his colleagues who described him as a sociable, talkative and dedicated person, someone who gave 100% to all his tasks, but always found time to chat to colleagues and to respond to student emails. His wife reported at the inquest that he was working evenings, weekends, and holidays to keep on top of marking, preparing lectures, setting exam papers and answering emails. On the morning he died, he was in the middle of marking 418 exam papers.

In a third case, a 47-year-old consultant cardiologist who was working extremely long hours and doing the equivalent of two jobs because one of his team members was off on sick leave, took his own life in November 2018. In the inquest, his wife described him as honest, kind, hardworking and dedicated and remarked that he hadn’t taken a single day of sick leave in the 21 years that they were married. When a colleague went on sick leave and wasn’t replaced with a locum, she remarked: “In my opinion, this was the straw that broke the camel’s back. He was already doing more than humanly possible and he had more work added to his schedule.” She added “The Trust (...) turned a blind eye to the situation and let my husband work himself to death, they don’t care as long as their targets were met.” According to his brother, he had experienced a severe burn-out due to an unrelenting workload, lack of resources and poor support: “being a doctor played a significant part in his death”. The coroner noted in the inquest: “yes undoubtedly he was very, very seriously overworked.” The hospital where he worked commissioned an independent investigation into the suicide and the factors it raised included an excessive workload, a lack of resources and poor management oversight of workload.

In each of the above cases, the employer seemed to fail in its duty to protect the health and safety of an employee by burdening them with so much work, that they experienced a rapid mental health decline. In each case, the symptoms of overwork were evident – in the second case through individual staff appraisals and staff surveys, and in the other two, by physical symptoms of extreme distress. In the aftermath of the suicide, the employer was not formally required to make any changes to workplace policies or practices. Preventing Future Deaths reports were not issued in the above 3 cases and no legal action was pursued against the employer. The relevant health and safety regulators were not involved in these 3 cases.

(ii) Long /irregular working hours

Long or irregular working hours were identified as a contributory factor in 5 cases (41.6%) and as the main causal factor in 2 of those cases (a GP and a nurse). For these employees, hours of work were long, irregular and unpredictable to the extent that they disrupted home /family life and seemed to have damaging effects on mental health. In some cases, working hours

triggered a deterioration in mental health to such an extent that they were unable to cope with other adverse life experiences which might, in other circumstances, have been manageable (relationship breakdown, financial concerns).⁵

A 35-year-old mental health nurse who was working 12-hour hospital shifts and who was struggling with long hours and unpredictable working patterns took her own life in October 2018, leaving a two-page suicide note that described how she felt trapped in her job and unsupported. Her irregular work patterns prevented her from having stability, maintaining a relationship or having a social life outside of work. Friends reported at the inquest that she was struggling with shift patterns and was keen to buy a house and start a family, but didn't have enough spare time around work. She saw her GP a few weeks before her death and was offered anti-depressants but refused as she believed her problems were linked to her work situation. She broke up with her boyfriend a week before her death which was a source of considerable distress.

In another case, a 43-year-old GP was working long hours in two separate medical practices, a NHS practice and a private practice. In an interview with his wife, she reported that he was working constantly, day and night and at weekends. He had begun to stop sleeping and had lost 8 kilos in weight. Although, he had no previous history of mental health problems, long working hours were starting to take a significant toll on his mental health. He had spoken to a colleague in his medical practice who had prescribed him medication 6 weeks before his death. When he received a letter from a medical insurance company which mistakenly stated that he owed them thousands of pounds, his mental health was in such a poor state that he was unable to cope with the shock of this news. He took his own life in May 2019, leaving a wife and 2 children, aged 3 and 5.

(iii) Workplace bullying

Recent studies have confirmed the causal links between workplace bullying and suicide ideation (Leach, Poyser & Butterworth, 2017). Yet, under current UK legislation, bullying is not unlawful unless it is defined as harassment against someone with 'protected characteristics'.⁶ Workplace bullying was a causal factor in 2 of the cases we studied (16.6%) involving young trainees and was identified as a contributory problem in a third case. A first case involved an 18-year-old apprentice mechanic who was viciously bullied in the garage where he worked in the months prior to his suicide in April 2015. The inquest heard evidence that he had been locked in a cage, had his clothes set alight, been beaten up, placed in the boot of a car and driven half a mile away from work and left to walk back. Colleagues had witnessed some of these incidents and they had been reported to his line manager by the employee himself and by his parents who visited the garage. This did not lead to a change in the pattern of bullying, but instead the deceased was mocked for telling his parents about his problems at work. In his verdict, the coroner concluded that the employer was not to blame and there were no recommendations made for changes to workplace practices or behaviour. The coroner made a Preventing Future Deaths report for the medical practice which the deceased had attended in the period before his death. As part of this study, we liaised with the father of the deceased by email, but he preferred not to be interviewed. A Freedom of Information request submitted to the regional HSE confirmed that no health and safety inspection of the garage had taken place after the suicide.

Another case involved a 21-year-old trainee fire fighter who was the youngest member of a team of 22 fire fighters in the station where he was completing his probation and who took his

own life at home in August 2020. He had no previous history of mental health problems apart from a diagnosis of dyslexia. We interviewed 2 of his fellow trainees with whom he had become good friends. They described him as cheerful, shy, funny and keen to do well and succeed. Despite the challenges of an intense training period, with weekly exams, long hours, and constant pressure, he thoroughly enjoyed his training, formed close friendships and passed his exams without difficulty. His problems started when he was posted to a fire station to complete his 18-month probation where he was allegedly mistreated by his line manager and isolated by other members of his team. He complained to family and friends that he was very unhappy at the fire station and that he was being singled out to do tasks, was assigned roles that were unreasonable for someone at his level and was being taunted about his cultural background (he was teased for eating Caribbean food). He had made 16 transfer requests to move to a different station in the 6 months prior to his death. One of his fellow trainees pointed to poor management of young recruits at the fire station: he was not assigned a mentor; his transfer requests were not taken seriously; he was obliged to speak to his apprenticeship coach while he was at work with the fire officer present (who was allegedly the person who was bullying him): “He was really happy when he was doing his training. He always had a smile on his face. None of us were aware of any mental health issues. His problems started when he was posted to (...) Fire Station. It had a really bad reputation amongst trainees”. Following the suicide, the fire brigade commissioner undertook an internal review and made 24 recommendations which we obtained under a Freedom of Information request. In March 2021, the commissioner also launched an independent external review focusing on how the fire service treats young recruits and also considering issues surrounding mental health, as well as race and gender.

In a further case in an ambulance service Trust where 3 suicides took place in a ten-day period in November 2019, there were ongoing systemic problems of bullying and sexual harassment within the organisation. In 2018, the trust had issued 28 non-disclosure agreements in response to hundreds of bullying complaints. 10 days prior to the first suicide, a whistle-blower had published an open letter warning of potential suicides because of a toxic workplace culture. In the letter, he alleged that staff were subject to “psychological abuse” and he referred to a “use of fear to silence people”. We studied the first of the 3 suicides in this ambulance service (a 24-year-old ambulance dispatcher) and interviewed the brother of the deceased (who still works as a call-handler in the same ambulance service) and a regional trade union representative. According to his brother, the deceased’s mental health problems stemmed from relationship problems with his partner, but he believed that his brother was poorly supported by managers during his sickness absence. An inspection report (Care Quality Commission) of the ambulance service published on 30 September 2020 stated that there were still “continued high levels of bullying, harassment and discrimination and the organisation had failed to take adequate action to reduce this”. We obtained the report stemming from an independent investigation into the 3 suicides under a Freedom of Information request and this report recorded a 4th employee suicide at the Trust in 2019 and noted common characteristics with 2 of the other suicides.

(iv) Exposure to violence / trauma

In 2 of the cases studied (16.6%), both in the emergency services, the suicides were directly linked to exposure to violence at work, as both employees had been exposed to the death(s) of their colleagues. In a first case, a 41-year-old firefighter who took his own life in October 2015, had been involved in the team that responded to a massive blaze at a shop 2 years

previously, during the course of which his colleague and friend tragically lost his life. In an interview with the wife of the firefighter who died by suicide, she reported that her husband had experienced a dramatic change in character and behaviour in the aftermath of the blaze, experiencing extreme mood swings, angry outbursts, chronic anxiety and obsessive behaviour: “he couldn’t function afterwards. It was like as if he had experienced a brain injury. His personality changed completely”. His wife believes the therapeutic support offered in the workplace was inadequate and that managers did not fully recognise or understand the symptoms of PTSD. In response to the death, her husband was included in debriefing sessions and offered 6 counselling sessions that provided general support rather than specialist support for severe trauma. Because her husband had not been directly involved in fighting the blaze (he was operating the control board and remained outside the building) and not in direct physical proximity to the incident, he was not considered a priority for occupational health support and there was little consideration of his close friendship and affective ties with the firefighter who had died. In his PFD report, the coroner pointed to a “less than effective support” for the deceased and more broadly, a “failure to support staff in stressful situations”. The deceased was given a diagnosis of PTSD posthumously by a panel of doctors (at the instigation of his wife’s solicitor) and this allowed the bereaved family to secure additional payment through the employer’s compensation and pension scheme.

In a second case, a 46-year-old police officer was severely traumatised when he arrived first on the scene following the murder of 2 of his female colleagues (and close friends) in September 2012 and he took his own life 4 years later in August 2016. He and the 2 murdered police officers were part of a close-knit team of 7 officers in the same police station and they used to meet socially outside of work. He returned to work a few days after the incident but was soon diagnosed with PTSD by his GP and he took 12 months leave. We interviewed his former partner with whom he lived for 7 years and she described his intense state of trauma following the incident: “he stopped sleeping and eating and I’d wake to find him pacing the room. He would have tremors and looked shell-shocked”. He complained to her that he could see the face of one of his deceased colleagues every time he closed his eyes. He separated from his long-term partner 8 months after the incident. In response to the event, the police force arranged sessions with a police psychiatrist and he was offered counselling and other treatments (EMDR and CBT). He also stayed for a short period at a police recuperation centre which helped him. He decided to resign in December 2015 because he felt that leaving the police force was the only way to leave the tragic events behind him. He began working for a delivery company and he seemed to be improving and benefitting from his new work routine. Before taking his own life, he had completed his own police fatality report and attached a police identification tag to his body. According to his partner, he had left correspondence criticising the police on his laptop and his mobile phone, but this material was not recovered for the inquest.

(v) Work inspections

Suicides have been connected to the extraordinary pressures linked to a workplace inspection where a manager or leader may feel individually responsible for the outcome of an inspection, with the results of the inspection determining his or her reputation and career.

In 2 of the cases studied, the pressures of a workplace inspection were a contributory factor in the suicide and in one of the cases it was the main causal factor. A 58-year-old female headteacher of a primary school took her own life in July 2015 shortly after Ofsted downgraded the school to inadequate. The teacher had won a regional primary school Head Teacher of

the Year award and the school had previously achieved results that were in the top 5% in England. At the time of the Ofsted inspection, the school was undergoing a 2.5 million building expansion in order to add capacity for a further 200 pupils. The chaotic environment this caused, combined with the pressures of the school year and the timing of Ofsted's inspection, created an immense amount of pressure on the headteacher. According to the police report, she experienced a swift mental decline following the inspection. She contacted her GP 3 times prior to her suicide and told him that the school had failed its inspection and she had let everyone down. The coroner concluded a verdict of suicide and confirmed: "she just felt she was under so much pressure".

Another case involved a firefighter who was acting as watchman at his station and was extremely anxious about an impending inspection and was worried his station would fail. He had been in poor mental health with post-traumatic stress disorder since experiencing the death of his colleague and friend at a fire a few years previously. He was described by his wife and colleagues as someone with high professional standards who was conscientious and concerned that tasks were completed properly. On the night of his suicide, he was involved in leading a training drill for the firefighters in the station but was very distressed about their lack of preparedness and spoke to his wife on the phone about this: "He was in a state and said the fire fighters didn't know any of their drills". He took his own life at the fire station several hours later.

(vi) Lack of management mental health training

In 7 of the suicide cases studied (58.3%), bereaved family members and colleagues identified poor mental health training amongst managers as a contributory factor in the suicide. In the police and fire services more specifically, they pointed to a 'macho' management culture that was dismissive of mental health issues, failed to recognise when employees were struggling, showed little understanding of work-related stress and expressed insensitivity to the effects of exposure to trauma.

We interviewed a colleague and close friend of a firefighter who took his own life in October 2015 who was very critical of some senior managers in the fire service where they were both employed. He believed the lack of mental health training and absence of human empathy amongst senior managers was a contributory factor in his colleague's suicide: "Most of the senior managers had no understanding of mental health and had been promoted without any basic training or characteristics of human empathy". In the case of his colleague, he reported concerns about his mental health to managers twice and told them that he was not coping, yet no changes were made to the latter's work schedule. Another colleague had offered to take over the deceased's watch duties when he was struggling, but managers allegedly refused this request. He emphasised that managers should normalise mental health issues and try to remove the stigma attached to them.

In the case of a police officer who took his own life in August 2016, his colleague pointed to a lack of understanding and sensitivity to mental health issues amongst senior management. He described how when they both attended the funeral of the two murdered police officers in 2012, a senior manager had told them that the experience was just like falling off a bike, remarking "you just need to get back in the saddle". Managers prioritised getting them both back to work as soon as possible to the detriment of their mental health and wellbeing. The colleague we interviewed who was also severely traumatised by the murder of the 2 colleagues, took medical ill health retirement in 2017 and left the police force.

In the case of the 3 suicides at an ambulance service Trust in November 2019, the investigation into the suicides was highly critical of management and their lack of training in supporting mental health. One of the 12 recommendations from the report was that the Trust should “develop training for managers in supporting staff with mental health problems – in partnership with specialist mental health professionals” and advised that the Trust should “incorporate suicide prevention into its strategic goals”.

(vii) Sickness absence

In 8 of the cases studied (66.6%), the employees had previously taken a period of sick leave and in 6 cases (50%), the suicide took place during or at the end of a period of sickness absence when the person was due to return to work. Recent studies have identified sickness absence as a risk factor in suicide and suggest that employees should receive additional support during this time, particularly if the absence is prolonged or is related to mental health difficulties (Tang et al. 2019, Mars et al. 2020). In the cases studied here, we found that some employees were not adequately supported during sick leave, others were assigned tasks or responsibilities during sickness absence or their return to work was not properly managed.

In one case, a 31-year-old teacher who was on sickness leave following a diagnosis of severe anxiety and work-related stress, was allegedly required to complete work during her leave, including completing a spreadsheet of grade predictions for her pupils and providing lesson plans. Her mother told us that her husband went into the school once to hand over a large carrier bag of work that her daughter had completed during sick leave. She was contacted with work requests by the school manager by email and phone. In preparing for the return to work, she had 2 occupational health assessments with a union representative but was refused permission to bring a family member (her father) into the meeting for emotional support. In the inquest, the coroner criticised the school for requiring her to work during sick leave but did not issue a Preventing Future Deaths report.

In another case, a 37-year-old police dog handler who was on leave for 18 months following a physical injury, took his own life the day before he was due to return to work in October 2018. Having worked for the police service for 17 years, he had suffered arthritis in one of his knees, as a result of an accident at work and his other knee was also affected. Following an unsuccessful operation, his dogs had been re-allocated to a different officer and he was upset about this. He had seen his GP a few days before his death and told him that he dreaded the thought of returning to an office-based job.

In another case, a 24-year-old ambulance dispatcher who suffered from anxiety and depression linked to problems in his personal life, took his own life in November 2019. He had taken a number of sickness absences and was prescribed anti-depressants by his GP. During his final sickness absence, he had requested flexible working arrangements, but this had been refused in favour of a phased return to work. In an interview, his brother stated that he was not properly supported during his sickness absence and would be obliged to speak to a different manager each time. While some of the managers were familiar with him and his case history, others knew nothing about him and were therefore unable to detect signs of a mental deterioration in the period before his death. One of the recommendations that came from the investigation into the suicides called for “guidance for the welfare and management support of staff on sick leave”. When we asked the brother what he considered the most important change that needed to take place to prevent an employee suicide from happening again, his

response was “consistent support from trained and empathetic managers for those on sickness absence”.

In a further case, a 35-year-old mental health nurse was signed off work a few weeks before her death and reported to her manager when she was due to return to work that she was feeling low and couldn't get out of bed. When the period of sickness absence ended, she reported to her manager that she was not ready to return to work. She took her own life a few days later.

In 2 suicide cases concerning doctors, sickness absence was identified by bereaved family members as a contributory factor in the suicide. In these cases, sickness absence was experienced in terms of a sudden transition from a very intense and all-consuming work schedule to having no work at all. This had a very destabilising effect on their mental health. In the case of a 47-year-old consultant, he felt a sense of shame at having to take a month's sick leave and believed that he was abandoning his patients. As a doctor accustomed to helping others, he perceived sick leave as a mark of failure and was concerned that others would think negatively of him if he returned to work. He took his own life 6 days after commencing his sickness absence. His wife reported in the inquest: “he kept on saying how he had let his colleagues down, the hospital down by taking sick leave and that he would never return to that job and they would make sure that he would never be able to get another job.” His brother recommended a phased introduction to sickness absence for doctors where work is gradually reduced instead of a disruptive transition to having no work to do. Similarly, the wife of a GP remarked that sick leave ultimately made things worse for her husband because he lost his working routine and sense of normality: “suddenly, he had nothing”.

(viii) Change in work status

In 4 of the cases (33.3%), the suicide followed a recent change in work status (promotion) which significantly increased the employee's workload and made working life impossible to manage. In 2 of the cases, the employees felt pressurised to take on additional management roles that they allegedly did not want. In these cases, the change in status disrupted their control over working patterns with a loss of “control over their pace of work” as defined in the HSE's Stress Management Standards.⁷

In the case of a university lecturer, he felt pressurised to take on the role of deputy head of section when the previous incumbent had stepped down due to workload pressures. He believed that he did not have the option to turn down the role and according to his wife: “he didn't want to apply for that job because he knew he was really going to struggle to do it, but he felt he had to and then ultimately, it was just too much”. In our interviews with his colleagues, they confirmed that the deceased knew he wouldn't be able to cope, as his workload was already completely out of control. According to one colleague, “this role was wrong for [.....]. He was sociable and caring and liked helping people out, not telling them what to do and checking up on them”.

In the case of a firefighter who was suffering from severe PTSD, he agreed to take on role of watch manager when the previous manager had resigned on the condition that it was a temporary situation until a replacement could be found. He had reported to his manager that he was struggling and finding it difficult to cope but was told he would have to stay in the role until a replacement was found.

A mental health nurse took her own life 6 months after being promoted to senior staff nurse. She struggled in her new role with increased responsibilities, workload and a lack of training.

She took the promotion because she believed there was light at the end of the tunnel and there was an opportunity to change direction and move on to a less demanding job.

In the case of a secondary school teacher, she had told her mother that she was not going to apply for promotion to assistant head of science because of the workload implications but was allegedly persuaded to do so by her managers. The increase in workload meant that she resigned within 3 weeks and was signed off on sickness absence.

7. Organisational response to suicide(s)

For each of the suicide cases, we investigated the organisational response that followed the suicide. This analysis was underpinned by the following questions: How did the various authorities (employer, HSE, coroner) respond to these suicide cases? What protocols or guidelines were followed in responding to the suicide? How did employers communicate with other employees about the suicide? Did coroners make recommendations to the employer? What support was offered to bereaved family members and colleagues? Were suicide prevention measures put in place in the workplace after the suicide?

We found across the 12 cases that the organisational response to suicide was often inconsistent, arbitrary and dependent on the individual discretion of the employer, rather than on a specific protocol or set of guidelines. Unlike in cases of other work-related deaths, an employer is not obliged to report the suicide, undertake an investigation of its circumstances or make changes to workplace policy or conditions.

(i) Employer response

Communication

Bereaved colleagues we interviewed emphasised the importance of open, honest and direct communication from the employer in the aftermath of a suicide. We found one exemplary response where a fire brigade commissioner addressed all employees directly and committed to undertaking a thorough and independent investigation into the suicide. In a social media post, he spoke openly about the suicide, addressed underlying workplace issues and committed to a full external investigation: “We lost one of our own...[...]'s death posed tough questions for us. This independent review is the start of the process to find those answers.” Similarly, an independent investigation into 4 suicides at an ambulance Trust in 2019 found that employees were well supported following the deaths, and one manager was praised for communicating with staff in an open and transparent manner.

In many of the other cases studied, the employer chose not to communicate openly or even endeavoured to silence discussion about the suicide. In the case of a university lecturer, his colleagues were allegedly instructed not to speak about the suicide amongst themselves or with anyone outside the organisation. One colleague who spoke of the suicide in a meeting was told to stop talking about it and they organised a break in the discussion immediately after she mentioned it. Another colleague in the same university commented: “they tried to brush it under the carpet, they did not want to talk about it, they denied it had anything to do with workload. Their priority was to protect the university’s reputation”. In the above case, the employer explained a reluctance to speak about the suicide in terms of a mark of respect for the bereaved family. In response to a UCU (university union) open letter about the suicide, the Vice-Chancellor replied: “out of respect for [.....]'s family and his colleagues during a very difficult time, I do not think that it is appropriate to comment on an individual case in this letter.”

Yet, bereaved family members and colleagues urgently wanted the employer to address the circumstances of the suicide in this case and in the other cases we studied.

Framing as an individual mental health problem

In the absence of HSE guidelines on work-related suicide, employers do not have a common framework for understanding the significance of a suicide in health and safety terms. In many of the cases we studied, management tended to frame the suicide as an individual or personal event linked to mental ill health that had no connections with work. In the case of a university lecturer, the employer framed the suicide in terms of complex individual problems and presented him to the media in terms of someone who was “suffering in silence” with his workload and who had not asked for help. This narrative was strongly refuted by his colleagues and family who emphasised that the deceased was very vocal about his workload issues and had told colleagues and managers about them repeatedly: “the idea that he was suffering in silence is nonsense. He spoke to us all the time about how his workload was impossible. He did not keep this to himself”.

An employer’s independent investigation into the suicide of a cardiac consultant pointed to workload issues but also linked the suicide to personality type and to the “emotional nuances of his personality”, including an “immense capacity for work”, perfectionism and an introverted nature which meant he didn’t communicate his problems to colleagues. While the report points to excessive workload and the absence of a general manager in post at the time of his death, the suicide is attributed partly to the deceased’s hardworking disposition: “The question of where responsibility lies for his unsustainable workload is difficult. In many ways, Drwas responsible for his own workload”. The report concludes that his hardworking nature was “the path that led to his self-destruction.”

Employer responsibility

During inquests, coroners showed that problems and complaints had often been reported to managers on multiple occasions, with verbal and written evidence presented at the inquest. Inquest reports also show that employers were often unaware of their duties under the 1974 Health and Safety Act and did not see themselves as responsible for protecting employees’ mental health. An 18-year old trainee mechanic complained to his manager that he was being bullied and his parents also spoke to the line manager about their son’s treatment. However, this behaviour was dismissed at the time as banter and horseplay and the bullying continued.

In the case of an overworked lecturer, he had stated in his previous 3 years of staff appraisals that his workload was unmanageable and that he was unable to take annual leave or spend time with his family. In the 2 years preceding the suicide, university management had been alerted to problems of excessive workloads through staff surveys, reports from focus groups, professional associations and communication from the union. In our interviews, we asked colleagues of the deceased what they would change at work to prevent a suicide from happening again and all 4 of them pointed to workload, stating that workloads were still unmanageable despite their colleague’s suicide (and other employee suicides at the university).

In a further case, an ambulance Trust had received hundreds of complaints of bullying and harassment in the year preceding a cluster of 4 suicides, but used non-disclosure agreements to prevent discussion of the bullying from escalating. A whistle-blower’s open letter described a toxic culture that tended to deny or suppress complaints. He concluded his letter by stating that it was impossible to report to senior management as they were the ones involved in the

bullying: “Going to the Trust to seek assurances by the very people who are accused of carrying out the behaviour appears to me to be non-sensical. I have a genuine concern that if this situation continues then the risk of suicide and increase risk to patients will result in reputational damage to the NHS and potential loss of life”. These problems were not resolved in the period preceding the suicide cluster.

In the case of a cardiac consultant, the investigation into his death referred to complaints he made about his workload in January 2018, May 2018 and in the weeks immediately preceding his death in November 2018. In May 2018, he suggested that someone else take on the role of cardiology lead, but he was persuaded to continue in this role because he was doing such a good job. Nursing staff in his department were increasingly concerned about him and the nursing matron had reported her concerns about his wellbeing to senior management a week before he died.

In these cases, organisational and managerial problems affecting an employee were not addressed or resolved in the period preceding a suicide as a result of either poor management or a tendency to prioritise targets over the health and safety of employees. We found no evidence that the HSE’s Stress Management Standards had been followed in the above cases.

Employer investigation

In 4 of the suicide cases (33.3%), the employer launched an independent investigation into the suicide(s) in order to identify and address underlying causes. The reports stemming from the investigation are subject to confidentiality clauses and are not available for public scrutiny, but we were able to obtain the recommendations through Freedom of Information requests and through family members.

An ambulance service Trust launched an in-depth investigation into 4 suicides led by an external consultant that included a 77-page report into the suicide case we studied. The recommendations from the investigation, published in May 2020, included important changes to workplace policy to improve the management of incidents involving the death of a member of staff, training for managers in supporting staff with mental health problems, guidance for the welfare and management of staff on sick leave, incorporation of suicide prevention measures, measures to prevent sexual harassment.

The internal investigation into the suicide of a 21-year-old recruit at the fire service made 23 recommendations, including more careful consideration of transfer requests, better support for new recruits including allocation of mentors, improved access to counselling and trauma services, more considered process for allocating recruits to stations, improved liaison with bereaved family members.

The independent investigation into the suicide of a cardiac consultant included 5 recommendations: better monitoring of employees with high workloads, introduce personal and/or team coaching, promote formal leadership development, improved mental health care for staff and urgent intervention by a psychologist/psychiatrist in cases of work-related stress.

In a further case at a university, the employer limited the investigation to a health and safety check and this was followed by the installation of window locks as a suicide prevention measure and the introduction of therapeutic services (counselling, yoga, mindfulness walks).

It is clear that while workplace investigations can be a powerful tool for improving health and safety in a workplace and for preventing further suicides, they are only carried out in a minority of cases of work-related suicide.

(ii) HSE

We have no evidence of a health and safety investigation taking place following the suicides studied in this report. In our interviews, participants stated that as far as they were aware, the suicide was not reported to the HSE and they were not contacted by the HSE. We spoke to union safety representatives who reported that they were not aware that they could directly contact the HSE with a concern and request that the latter investigate a case. We made a Freedom of Information request to a regional HSE office and they confirmed that despite a corpus of documented evidence of bullying at a local business, no investigation of the workplace took place and no guidelines or recommendations were made to the employer. In the case of a suicide by a firefighter who was deeply traumatised by death of his colleague in a blaze two years earlier, the latter case was reported to the HSE as a work-related death, but the suicide was not.

(iii) Coroners

While a Preventing Future Deaths (Section 28) report⁸ can act as an important window on risks to public safety and a powerful lever for change, these were only produced in 3 of 12 cases (25%) and were only addressed to the employer in 2 of those cases. In 8 of the cases (66.6%) the coroner identified work or the workplace as a causal factor in the suicide at the inquest, yet a PFD report was only sent to the employer in 1 of those cases. In 4 of the 12 cases, mental ill health or personal problems were identified as the main cause of the suicide. In 2 of these 4 cases, there was clear and documented evidence of work-related causes, yet the coroner still concluded that mental health problems were the main cause. This confirms the findings of an earlier study which showed that the majority of PFD reports (57.2%) are issued to the NHS and concern issues of medical / clinical neglect (Minh 2017).

In one case, where there were reports of systematic workplace bullying, the coroner stated in the PFD report that the employee “took his own life whilst suffering from a depressive disorder brought on by life events”. His medical practice was criticised for the amount of medication he was prescribed, but no criticism or recommendations were made to the employer.

In another case where there was no history of mental health problems apart from dyslexia, the coroner attributed the suicide in the PFD report to “undiagnosed mental health problems”. She suggested that the employer had not recognised a deterioration of mental health and that his symptoms were not recognised: “Unbeknown to those with whom he worked at [...], [...]’s mental well being was deteriorating significantly in the last weeks of his life, and it deteriorated to the point where he killed himself”. In our interviews, one of his fellow trainees responded to the PFD report in the following terms: “If he had mental health problems, these were created by the toxic working environment in which he was placed. Before being posted to this station, he was happy, cheerful and full of enthusiasm.”

In a third case, the wife of a GP who took his own life reported to us that she was surprised about the emphasis on mental health causes in the coroner’s verdict, as her husband had no history of mental health problems, apart from severe work-related stress in the period before his suicide.

(iv) Support for bereaved families

Support for bereaved families was inconsistent and fragmented and seems to depend on the good will of police officers and the employer. In one case, a GP's wife reported that the police came to see her to tell her about the death of her husband and quickly left leaving her with a slip of paper with a phone number to ring if she needed support. In another case, the police officers were very supportive, providing advice on legal steps in the face of the employer who allegedly didn't want to confront the issues.

There was often no communication from the employer in the aftermath of a suicide. Bereaved family members often felt abandoned and were left with no counselling, legal or financial support. It was close friends who advised on next steps and how they should communicate with the employer. Unlike in cases of crime where bereaved family members are treated as victims and given support, in cases of suicide, such support is not systematically offered.

8. Recommendations

(i) HSE

A first recommendation of this report is to include suicide in the list of work-related deaths that must be reported to the HSE under RIDDOR reporting requirements. This should include employee suicides that occur in the workplace or where evidence of work-relatedness exists (use of workplace vehicle or means, work uniform or suicide note blaming work, documented workplace problems).

Including suicides in RIDDOR reporting requirements will ensure that suicides are treated with the same rigour, oversight and regulation as other work-related deaths. It will extend a health and safety framework to work-related suicides and ensure that they are investigated. It will also allow essential data to be collected that will enable work-related suicide patterns to be monitored and evidence-based prevention measures to be put in place.⁹ We believe that including suicide in RIDDOR will also create a profound change in the mindset towards suicide, pushing employers to take mental health seriously and to take responsibility for putting suicide prevention measures in place.

Suicides should be included in the Joint Protocol on Work-related deaths which provides a framework for collectively managing and investigating work-related deaths. While the protocol includes suspected homicide and unlawful killing, it excludes suicide as this is assumed to be a non-work-related death that does not require a joint investigative process. No public interest recommendations or regulatory and enforcement measures therefore arise from cases of work-related suicide.

The HSE should consider providing **guidelines to employers on general workplace suicides risks and suicide risks that are specific to certain occupations.** Existing research should be used to shape tailored suicide prevention strategies and mental health training within these occupations.

HSE suicide prevention guidelines should also advise employers on how to respond to the suicide of an employee. These would include (i) effective communication with colleagues; (ii) debriefing and counselling for employees (in particular for those present at the scene of death); (iii) liaison with bereaved family members; (iv) suicide prevention measures. In the absence

of an effective organisational response, the workplace may be left without adequate measures for preventing future suicides.

(ii) Employers

While employers are not responsible for their workers' mental health, they are responsible for preventing known risks to mental health in the same way as their responsibility in relation to physical health. Studies have established that certain work conditions create a heightened suicide risk (unmanageable workloads, excessive hours, bullying, PTSD) and employers should be expected to safeguard their employees from these suicide risks. This should be treated as an obligation on the part of employers rather than an act of individual discretion or benevolence.

Our specific recommendations to employers are:

- Full compliance with the HSE's Stress Management Standards.
- Ensure management oversight of workload and working hours for all employees, making adjustments where an employee has an excessive workload or where an employee reports that they are struggling with workload.
- Ensure that employees on sickness absence are provided with consistent and ongoing support from a single manager and that the return to work is properly supported. Consider phased introduction of sickness absence where appropriate, with a gradual reduction of working hours rather than a sudden transition to full leave.
- Draw up a suicide prevention plan that includes general suicide risks and risks affecting a particular occupation or sector and put prevention measures in place.
- In all cases of employee suicide, the employer should consider and assess work-related factors and report cases to the HSE where work-related factors are identified.
- In the event of a work-related suicide, the employer should undertake an independent investigation to evaluate the circumstances of the death, identify any organisational or managerial shortcomings and make recommendations for changes to workplace policies and practices. Involve trade union health and safety representatives and review risk assessments using the HSE's Stress Management Standards.
- In the event of an employee suicide, communicate openly and honestly with colleagues, addressing workload concerns and plans for preventative action.
- Provide debriefing and counselling for employees, particularly those present at the scene of death or close to the deceased.
- Provide a single point of contact for liaising with family members.
- In emergency services (ambulance, fire, police), all managers should have mental health training, particularly on the effects of exposure to trauma.¹⁰ According to Public Health England "Mental health training for line managers is essential (...), and the training should include learning the signs of poor mental health and suicide risk, as well as the likely impact of suicide on colleagues and the business."¹¹

(iii) Public Health England

The highest suicide rates are amongst working age men, yet the workplace is not identified by Public Health England as a potential site for a suicide cluster.¹² While suicide clusters are linked with certain institutional settings (communities, mental health services, schools /colleges, universities), workplaces are not included. Public Health England defines a suicide cluster in terms of 3 incidents and in some of the cases studied here, suicides were repeat

events (one workplace had 4 employee suicides in 2019). **A key recommendation is to define the workplace as a potential site for suicide clusters and to include the workplace in the preventative health measures in place for other organisations.**

Public Health England's toolkits for employers are a very positive development, but rely on the good will of the employer. There is no specific requirement for an employer to assess suicide risks or put prevention measures in place. **A key finding of this study is the need for explicit and enforceable legal requirements which oblige employers to put suicide prevention measures in place and undertake a full and transparent investigation in the aftermath of a suicide that takes place in the workplace or is work-related.**

(iv) **Coroners**

We found that Preventing Future Death Reports are rarely and inconsistently used in cases of work-related suicide and as a result, opportunities for suicide prevention in the workplace are lost. Where a PFD report is issued to an employer, this acts as a lever for change that prompts concrete and reportable changes in workplace conditions and practices. A PFD report also provides a documented record of health and safety concerns that can be used more widely by health and safety regulators. **A key recommendation of this report is that coroners should consistently issue a PFD report to an employer where evidence of work-related causality is presented at the inquest.**

(v) **National Suicide Prevention Strategy Advisory Group (NSPSAG)**

The existing UK approach to workplace suicide prevention is led by a range of different groups (Public Health England, HSE, National Suicide Alliance, trade unions, suicide charities and bereaved support groups). A key recommendation of this report is launch **a coordinated strategy on workplace suicide prevention to bring together different organisations** in order to create a comprehensive and sustained strategy, possibly under the auspices of the National Suicide Alliance. This could follow a similar model to the **National Guidelines on Workplace Suicide Prevention** introduced in the United States in 2019 which involves effective collaboration across a wide range of relevant authorities.¹³

Effective long-term change requires a coordinated campaign to push for **legislative reform** in order to make protection of mental health and suicide prevention in the workplace a legal requirement. Health and safety legislation was conceived in relation to the adverse effects of work on physical health and still provides inadequate protection against the adverse effects of work on mental health. While existing guidelines on workplace mental health (HSE Management Standards, BITC/PHE Suicide Prevention toolkits) are extremely valuable, they rely mainly on the goodwill of employers, rather than enforceable standards. In the PHE's postvention crisis management tool kit, legal expert David Young acknowledges that "There is no explicit duty to 'prevent' at-work suicide and certainly no duty to provide a postvention strategy."¹⁴ We would like to work with the NSPSAG to lobby for legislative reform to improve suicide prevention in the workplace. This campaign could draw on the vast body of evidence about rising suicide rates amongst working age men and on studies of occupational/work-related suicide. Recent research from Australia confirms that stronger regulation and monitoring of workplace mental health can considerably reduce suicide risks.¹⁵

The key aims of legislative reform include: (i) specific reference to mental health in the 1974 Health and Safety Act to bring the UK in line with other European systems where employers are explicitly obliged to protect physical and mental health. Without a stated requirement to protect mental health, employers do not always see themselves as responsible for protecting

the mental health of their employees; (ii) Make prevention of known workplace suicide risks a legal and enforceable requirement. UK employers are currently not held responsible for preventing suicides and bereaved families have limited legal recourse in the aftermath of a suicide; (iii) Reform the 2010 Equality Act in order to define workplace bullying alongside harassment as unlawful. All employees should be protected from bullying and not just employees with protected characteristics.¹⁶

(vi) Support for bereaved families

Bereaved family members, colleagues and friends interviewed in this report experienced a profound sense of injustice that the causes surrounding a suicide have not been properly investigated or treated with due rigour and diligence. None of the cases studied here resulted in legal action against an employer despite a corpus of evidence of work-related causality and in 3 of the cases, family members told us that they were dissuaded from pursuing litigation because of the weakness of existing legislation. A bereaved family member has no automatic right to compensation following a work-related suicide. Those interviewed as part of this study are keen for lessons to be drawn from the suicide in order to prevent other families finding themselves in a similar situation. **A key recommendation is for bereaved family members to benefit from a comprehensive system of victim support, including counselling and legal /financial advice.**

9. APPENDIX: Specific occupations / sectors

Certain occupations are characterised by particular types of suicide risk that are well-documented in research publications and specialist reports. Yet this research evidence has not led to systematic changes in the working policies and practices that exacerbate this suicide risk and there is a lack of correlation between research evidence and occupational practices. A key aim should be to tailor suicide prevention strategies to known suicide risks within particular occupations in order to support evidence-based changes in the workplace.

Doctors

We studied 2 cases of doctor suicides, both men in their forties, that occurred in the space of 5 and a half months and which shared similar causal factors: (i) chronic work overload and excessive working hours; (ii) lack of management oversight of workload; (iii) stigma linked to mental health amongst doctors; (iv) sudden transition to sickness leave. In both cases, they were working extremely long hours: in the first case, the GP was working in 2 separate practices, one an NHS practice and the other a private clinic. His wife confirmed that in the months preceding his death, he was working continuously, day and night and at weekends. When he was not seeing patients, he was dealing with prescriptions and a mountain of other paperwork. In the second case, the consultant was also working extremely long hours and was working the equivalent of two jobs as one of his team members was on sick leave. In both cases, bereaved family members remarked that no one seemed to be aware of the hours the deceased was working in the period before the suicide. In the second case, the brother of the deceased remarked that there was no system in place for monitoring workload and doctors are just expected to get on with it: "The NHS does not have a process to measure how much someone is working."

In the first case, our interviewee remarked that her husband feared talking about mental health issues because he felt it would jeopardise his reputation and career. She commented that her

husband would listen to his patients talk about their suffering and trauma every day over long hours, yet there was no debriefing or counselling support available to him. In the second case, the interviewee remarked that his brother saw his own mental ill health as a mark of failure: “had my brother been able to reach out and get the right level of help he needed without fear of retribution or judgment, he would be alive today.” He also pointed to the stigma surrounding mental health amongst doctors and the lack of therapeutic spaces where they can talk openly.

GPs have higher rates of suicide compared with the general population and other professional groups despite sharing protective factors such as a well-paid, secure job and social status. 430 health professionals died by suicide between 2011-2015 according to the ONS. Professional medical associations (RCGP, BMA, GMC) have called for urgent action to address a soaring workload in general practice which has increased as the number of practising GPs is in decline. A BMA survey in 2019 revealed that 9 out of 10 GPs faced a high risk of burnout. BMA representatives backed a cap on the number of GP appointments per day at its 2018 annual conference, this had not yet been implemented.¹⁷ In her study of doctors and mental health, Clare Gerada confirms that “the most important risk factor is **the job**” which carries an “emotional labour” that places them at risk of mental illness (Gerada 2021, 23). This report confirms the recommendations made by other professional associations to reduce doctor suicides: (i) a cap on the number of patient appointments; (ii) procedures for overseeing and monitoring workload; (iii) therapeutic spaces where doctors can debrief and reflect on their professional experiences and mental health;¹⁸ (iv) postvention support in the aftermath of a suicide.

Teachers

We studied 2 cases of suicides by teachers whose deaths were linked to well-known stressors in the teaching profession (excessive workload and pressures linked to an inspection). Both cases involved dedicated and high-performing teachers who were achieving excellent results. In a first case, the workload pressures linked to taking on a management role (assistant head of section) alongside a full teaching timetable caused acute physiological symptoms including insomnia, hair loss and skin rashes. When the teacher went on sick leave, she was allocated work by the school. In a second case, the pressures linked to an Ofsted inspection that took place during a major building expansion and that resulted in a downgrading of the school placed the head teacher under immense pressure. She reported to her GP shortly before her death that she felt she had let everyone down.

Teachers have higher suicide rates compared with the general population and other professional groups. 507 teaching and educational professionals took their own life between 2011 and 2018 according to ONS figures.¹⁹ There were 170 suicides amongst primary or nursery teachers during this period. 90% of primary school and nursery staff are women.

Suicides have been linked to unmanageable workloads, national assessment procedures including inspections and league tables and long working hours. Recent studies suggest that work-related stressors such as Ofsted inspections and the pressure to perform under the threat of poor Ofsted ratings have been connected to recent suicides. Since 1998, coroners’ inquests into the suicides of at least 10 teachers have heard that they took their own life before or after an Ofsted inspection.²⁰

In response to pressures from teaching unions, Ofsted released a clarification document for schools of 2015 that aims to “dispel myths about inspection” that can generate unnecessary workloads in schools. The HSE Talking Toolkit, *Preventing work-related stress in schools* (19

December 2018) reiterates some of the points from the Ofsted clarification document and sets out how Stress Management Standards might be applied to schools in order to reduce stress. Alongside general initiatives to reduce teacher stress, Ofsted should incorporate specific suicide prevention measures to help better prepare teachers for inspections, improve mental health awareness, reduce pressure on individual teachers and provide counselling following an inspection. A key recommendation of this report is also for every school to have a workload management system that monitors individual workloads and ensures that they are manageable for the employee.

Emergency services

We studied 4 suicide cases in the emergency services (police, fire service, ambulance service) and one of these suicides was part of a cluster of 4 suicides in the same Trust during the same year. The main causes of the suicides were linked to exposure to violence (2), bullying (1) and poorly-managed sickness absence (1).

We interviewed 3 colleagues of a policeman who took his own life and they were highly critical of senior management's response to the trauma experienced by the deceased when he turned up at an incident where his two colleagues had been murdered. At the time, there was a culture that emphasised the need to "man up" and supervisors were keen to get officers back to work as quickly as possible. He described feeling harassed at the funeral when an inspector tried to persuade them to return to work as soon as possible. He remarked that if you work as part of a team in frontline policing, you are expected to be resilient and you depend on one another, so that if one person is faltering, it can be seen as a chink in the armour which protects the whole team. When asked what changes needed to be made, all 3 interviewees stressed that managers and supervisors should do mental health training as a requirement of their job.

In the case of a fire fighter, his colleague was also highly critical of some managers who he described as insensitive and "tone deaf" on issues of mental health. He believes the lack of effective management intervention and support was a contributing factor in his colleague's suicide. This colleague had decided himself to undertake a programme of mental health training after the suicide in order to better understand the issues. When we asked him what change was needed to prevent a suicide ever happening again, he said incorporating mental health training for all fire brigade managers.

The above 2 cases confirm recent studies that point to a heightened suicide risk within the emergency services where employees are routinely exposed to traumatic events and violence (Mars et al. 2020). According to one study, police officers and fire fighters are more likely to die by suicide than in the line of duty (Heyman, Dill & Douglas 2018). More generally, studies have established that PTSD contributes to a heightened suicide risk within the general population (Fox et al. 2021). In both cases, symptoms of severe PTSD were not adequately supported by management, were not taken account in their workload and were treated by some managers with a lack of sensitivity and understanding to the extent that their lives were endangered by their working situations.

A key recommendation of this report is for mental health training to be mandatory for all managers in the emergency services.

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Notes

¹<https://www.centreformentalhealth.org.uk/news/mental-health-problems-work-cost-uk-economy-ps349bn-last-year-says-centre-mental-health>. See also the campaign led by Hazards: [SUICIDE NOTE | Global experts back call for protection from work suicide risk - Hazards magazine](#)

² According to the HSE's instructions on types of reportable incidents: "All deaths to workers and non-workers, **with the exception of suicides**, must be reported if they arise from a work-related accident, including an act of physical violence to a worker." <https://www.hse.gov.uk/riddor/reportable-incidents.htm>.

³ <https://www.who.int/news/item/17-06-2021-one-in-100-deaths-is-by-suicide>

⁴ While the causal connections between suicide and work have been established in international studies, there is still a gap in research on causality in the UK context. Hence, a recent study identified differing rates of suicide by occupation but pointed to a lack of evidence on causality: “Although our study indicates the relative risk of suicide for different occupational groups, the analysis does not provide any direct evidence concerning causation.” (Windsor-Shellard & Gunnell, 2019, 598)

⁵ Recent studies have found that long working hours are associated with stress, depression and suicidal ideation (Yoon et al. 2015, Choi 2018, Sato, Kuroda & Owan 2020, Park et al. 2020). In Japan which has some of the longest working hours in the world, this phenomenon is defined as ‘Karoshi’ or death by overwork (Xiao et al. 2019)

⁶ Protected characteristics are defined in terms of age, gender, disability, pregnancy, or maternity, race, religious belief or sexual orientation. <https://www.gov.uk/workplace-bullying-and-harassment>.

⁷ <https://www.hse.gov.uk/stress/standards/control.htm>

⁸ The 2009 Coroners and Justice Act conferred a duty to raise all matters discovered during investigation that could prevent a future risk to life, whether or not they had contributed to the death in question. Such reports are known as Preventing Future Death reports. On receipt of a PFD report, recipients must provide the coroner with a written response, (a time limit of 56 days is given), and the coroner must send a copy of the PFD report and any responses to the Chief Coroner, who may publish them.

⁹ In countries such as the United States, such data is systematically collected and the US Bureau of Labor Statistics has collected data on workplace suicides since 1992. This data is included in the Census of Fatal Occupational Injuries. <https://www.bls.gov/opub/ted/2020/workplace-suicides-reach-historic-high-in-2018.htm>

In the UK, the ONS now records rates of suicide by occupation. However, for approximately a third of suicides, occupation is unavailable as it is not recorded at the time of death and these are historical rather than real-time statistics.

¹⁰ https://www.shponline.co.uk/wellbeing-2/you-need-the-right-people-doing-it-for-the-right-reasons-phil-spencer-on-wellbeing-in-the-police-force/?elq_mid=5421&elq_cid=207532

¹¹ <https://www.bitc.org.uk/wp-content/uploads/2019/10/bitc-wellbeing-toolkit-suicidepostventioncrisismanagement-mar2017.pdf>, p.12

¹² https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/839621/PHE_Suicide_Cluster_Guide.pdf

¹³ <https://workplacesuicideprevention.com/>

¹⁴ <https://www.bitc.org.uk/wp-content/uploads/2019/10/bitc-wellbeing-toolkit-suicidepostventioncrisismanagement-mar2017.pdf>, p.19.

¹⁵ https://d3n8a8pro7vhmx.cloudfront.net/theausinstitute/pages/3491/attachments/original/1620849022/Workplace_Mental_Health_May2021.pdf?1620849022

¹⁶ This might follow the example of the 2011 Brodie’s Law Victoria in Australia where a case of suicide led to the implementation of new legislation which makes serious bullying a criminal offence. <https://www.justice.vic.gov.au/safer-communities/crime-prevention/bullying-brodies-law>

¹⁷ <https://www.bma.org.uk/media/1145/workload-control-general-practice-mar2018-1.pdf>

¹⁸ Clare Gerada Preventing suicide in medical staff *BMJ* 2019;366:I5231 doi: 10.1136/bmj.I5231 (Published 27 August 2019) Page 1

¹⁹ <https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/adhocs/10498/numbersofsuicidesamongteachingprofessionalsenglandandwalesdeathsregistered2011to2018>

²⁰ <https://www.channel4.com/news/teachers-suicide-rates-double-in-a-year>