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Dying at work. Work-related suicide – how does the UK regulatory context measure up?

Abstract

Purpose: The purpose of this paper is to examine how work-related suicides are monitored, investigated and regulated in the UK examining a small selection of cases and drawing on international comparison with other countries. Effective data collection and regulation are the cornerstone of suicide prevention and this paper aims to consider whether the UK's current regulatory framework provides an effective basis for preventing work-related suicides.

Methodology: The study draws on qualitative sociological methods and is based on an in-depth analysis of 12 suicide cases occurring between 2015 and 2020. In each case, work-related causal factors had been previously identified by at least one official source (police enquiry, coroner or employer's investigation). We analysed multiple sources of documentation and undertook interviews with individuals close to each suicide case. Our aim was to consider the organisational response of three stakeholder organisations in each case: the Health and Safety Executive (HSE), the coroner and the employer.

Findings: The study points to serious shortcomings in the UK's regulatory response to work-related suicides. Suicides are currently not recorded, investigated or regulated. Whereas the fracture of an arm or leg in the workplace needs to be reported to the HSE for further investigation, a suicide occurring in the workplace or that is work-related does not need to be reported to any public agency. Employers are not required to investigate an employee suicide or make any changes to workplace policies and practices in the aftermath of a suicide. The work-related factors that may have caused one suicide may therefore continue to pose health and safety risks to other employees.

Originality: Whereas some recent studies have examined work-related suicides within specific occupations in the UK, this is the first study to analyse the UK's regulatory framework for work-related suicides. The study on which the paper is based produced a set of recommendations that were targeted at key stakeholder organisations.

Keywords: work-related suicide, health and safety, regulation, data collection, prevention

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Introduction

The World Health Organization has called on countries to improve the comprehensiveness, quality and timeliness of their suicide-related data, indicating that rigorous data collection is the cornerstone of effective suicide prevention (WHO, 2021). An accurate recording of suicide data is essential to understand changing suicide patterns, which population groups are affected, and what the emerging socio-economic or cultural determinants are. For Sheila Jasanoff, data collection is a means to transform a social problem into a classifiable phenomenon and it is therefore a critical instrument of social justice: "Numbers and justice have long kept company, as the paired words counting and accounting attest. If you can *count* something, you can also *account* for it" (Jasanoff, 2017, 1).

This paper examines the phenomenon of work-related suicide considering how such suicides are recorded, regulated and prevented in the UK context.[1] The paper draws on the findings of an in-depth qualitative study of 12 suicide cases occurring between 2015 and 2020 that culminated in a report submitted to the Health & Safety Executive (HSE) and a number of other public agencies (Waters and Palmer, 2021). For each suicide case, we examined how key stakeholder organisations responded to the suicide and the extent to which the suicide was recorded or investigated. Our aim was to assess whether existing regulatory systems in the UK are adequate as a framework for preventing further work-related suicides.

Recent studies across different countries point to a rise in work-related suicides, often against a background of deteriorating working conditions across the global economy. While employment can be a protective factor against suicide (Blakely et al., 2003), the vast majority of suicides occur among working age adults, with many employed at the time of death (Ko et al., 2019). In the United States, the suicide rate within the working-age population has increased by 40% in less than two decades. While other types of work-related death are in decline, rates of workplace suicide are rising and increased sharply after 2007 (Tiesman et al., 2015; Peterson et al., 2020). In Australia, most suicides occur amongst those of working age and the risk of suicide is more prevalent in occupations where there is a high job demand, low autonomy or control, shift work, physical danger and access to lethal means (Case et al. 2020). In Japan, *karojisatsu* or suicide by overwork is treated as an urgent public health issue and the number of people taking their own lives because of their working situation reached a peak in 2011 at 2,689 and decreased to 1,918 in 2020 (Engelmann, 2021). In the European Union, there were 39,265 (estimated) suicides amongst working age adults in 2015 (Łyszczarz, 2021). In countries such as France, where work-related suicide rates are recorded, a new government report has found that 10% of all suicides are work-related (Gigonzac et al., 2021).

In the UK, there is no official data collected on work-related suicides and the phenomenon is not recognised formally in legislation. However, recent studies show that suicide rates are highest 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 and Gunnell, 2019). One recent report suggests that the likely correlates in occupations with high suicide risk are precarious employment with episodic unemployment, a predominantly male workforce, a relatively high incidence of workplace accidents, lack of consistent social support and high rates of alcohol and drug misuse (WHEC, 2021). The Hazards trade union group has estimated that there are 650 work-related suicides every year or over 54 suicides per month in the UK.[2] Suicides are recognised as the tip of the iceberg in a wider mental health crisis in the workplace. 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 and Farmer, 2017).

Recent studies have identified some of the causal connections between work, working conditions and suicide (Milner et al., 2013; Milner et al., 2014; Waters et al., 2016; Waters, 2017; Milner et al., 2018; Choi 2018, Waters 2020). In a review of 22 independent studies of work-related suicide, Milner et al. conclude: "results of this review suggest that exposure to various psychosocial job stressors was associated with elevated risk of suicide ideation, attempts and death." (2018, p.247). Other studies have identified an elevated suicide risk within specific occupations (for example, Mars et al., 2020 or Riley et al. 2021). Potential work-related causes or stressors include work overload, irregular and long working hours, bullying, exposure to violence or trauma, work inspections, sickness absence or poor mental health awareness amongst managers (Waters, 2017; Case et al., 2020).

This study draws on a sample of suicide cases occurring between 2015 and 2020 where work-related factors were previously identified by at least one official source. The sample includes a range of occupations, consisting of police services (2), fire fighters (2), teachers (2), doctors (2), ambulance service (1), university lecturer (1), mechanic (1), nurse (1) and includes 9 males and 3 females.

The study was underpinned by the following research questions: (i) To what extent are work-related suicides registered for purposes of data collection?; (ii) Are work-related suicides investigated in order to identify potential work-related stressors?; (iii) Are recommendations made in the aftermath of a work-related suicide for purposes of suicide prevention? Our aim is to evaluate the current regulatory response to work-related suicide, considering whether it

provides an effective foundation for safeguarding workplace health and safety and preventing further suicides.

Comparative context

While data collection and surveillance are recognised as critical tools in suicide prevention (Owens et al., 2014; Public Health England, 2020), governments vary significantly in their willingness or capacity to acknowledge, monitor and regulate suicides occurring in the workplace or related to work. Whereas in some countries, work-related suicide is treated as an urgent public health phenomenon, with organised data collection and regulatory oversight, in other countries, it remains an invisible social problem that is unrecorded, unrecognised and overlooked (Waters et al., 2016). Work-related suicide is arguably subject to processes of 'social visibility' or 'regimes of visibility' which imply that only certain social phenomena are considered relevant, important and worthy of government intervention (Neumayer et al., 2021).

In comparative terms, Japan is the country where work-related suicide is the most socially visible, where rates are monitored and preventative legislation has been put in place. *Karojisatsu* or suicide by overwork has been connected to a Japanese corporate culture of long working hours and overwork. Statistics on work-related suicides are collected by the police services which register all suicides and include 'work' as an identifiable cause of suicide (Jobin and Tseng, 2014). Japan was the only country to introduce a law (June 2014) that specifically requires the government to take measures to prevent deaths resulting from overwork, including suicides.

In the United States, work-related suicides have been officially recorded by the Bureau of Labor statistics since 1992 through its Census of Fatal Occupational Injuries. Suicides are included in the census if they occur in the workplace or if they occur outside the workplace but can be definitively linked to work. A suicide note that mentions work as a factor in the suicide is cited as an example of a definitive link to work. The public health authorities explicitly recognise the role of work or working conditions as a causal factor in suicide and according to the National Institute for Occupational Health and Safety, low job security, low pay and job stress can increase the risk of suicide for some occupations (NIOHS, 2021).

In the European context, France is distinguished by the quality of its statistics and the number of suicides recognised and compensated as work-related deaths (Eurogip 2013, Waters 2020). The Ministry of Health has recently put in place systems for improving the surveillance of work-related suicide by centralising and collating the methods of collecting suicide data (Bossard et al., 2016). A recent report by the French National Public Health

Agency that analysed 1,135 suicide cases, found that 10% were potentially work-related and amongst those who were employed at the time of their death, work-related causal factors were identified in 42% of the cases (Gigonzac et al., 2021).

The UK stands apart from other countries by the absence of an official system of data collection. Indeed, suicides are explicitly excluded from the list of work-related deaths that need to be reported to the HSE for further investigation: "All deaths to workers and non-workers, *with the exception of suicides*, must be reported if they arise from a work-related accident."[3] (emphasis added). Whereas an employer is legally obliged to report a fracture of an arm or leg, asthma or a skin rash caused by unsafe working conditions, a suicide occurring in the workplace or that has definitive links to work does not need to be reported to any public agency apart from the coroner. Suicide is excluded from the health and safety framework that applies to all other work-related deaths. Employers are not obliged to undertake an investigation following a suicide or put suicide prevention measures in place. Suicide is also excluded from the joint protocol on work-related deaths.

Methods

The study draws on qualitative, sociological approaches to suicide that emphasise the value of in-depth case-study analysis as a means of uncovering complex, nuanced and experiential factors that may be overlooked in broader quantitative studies (Hjelmeland and Knizek, 2010; Fincham et al., 2011; White et al., 2016; Chandler, 2020; Button and Marsh, 2020; Mueller et al., 2021). This perspective is shaped by Jack Douglas's post-Durkheimian interpretive approach that emphasises the value of analysing "real world" cases of suicide and attending to the written and verbal documentation surrounding them (Douglas, 1976, 82). The study draws on a "sociological autopsy" methodology that is characterised by a post-mortem qualitative analysis of individual cases through the study of multiple sources of documentation (Fincham et al. 2011). Unlike the more established, but much criticised psychological autopsy approach, sociological autopsy broadens the scope of the analysis beyond individual mental health to consider the social context and circumstances of the person who died by suicide (Mallon et al. 2016).

Following Douglas's investigative social research approach (Douglas 1976) and a sociological autopsy method, our study undertook an in-depth analysis of 12 suicide cases, examining multiple and diverse sources of documentation linked to each case (inquest reports, Preventing Future Death reports, suicide notes, staff surveys, internal organisational documents, workplace inspections, employers' investigation reports). We also undertook semi-structured interviews with individuals close to each suicide case (family members, colleagues, trade union representatives, professional association representatives) who

recounted their experiences of the suicide and their encounter with stakeholder organisations. Bereaved individuals can provide valuable and countervailing narratives of suicide that are not always aligned with the accounts of official organisations (Peters et al. 2016). The aim was to deepen insights into the organisational response to suicide by examining how interviewees witnessed and interpreted this response, and in particular, whether they viewed the response as effective in identifying causal factors and in helping prevent further suicides. 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 by email to participate in the study to discuss individual suicide cases.

The limitations of the study include the small size of the sample and that it draws on the narrative accounts of individuals close to the suicide cases. While such accounts provide valuable and detailed insights into the circumstances surrounding a suicide and its aftermath, they may place particular emphasis on identifying work as a causal factor given the focus of the study and the nature or the questions asked. We endeavoured to address this bias by including multiple and diverse accounts and sources of evidence from both within and outside the workplace.

Data sample

Our sample was drawn from a database of 25 cases accessed through the archives of the bereavement advocacy group FACK (Families Against Corporate Killing) based in the Hazards Greater Manchester Centre. We limited the selection of suicide cases to those where work-related causal factors or stressors had previously been identified by at least one official source (police enquiry, coroner's inquest, employer's investigation). As there is no official data collected on work-related suicides, we had to evaluate potential work-related causes in the database by analysing all sources of documentation pertaining to each case.

The selection criteria for the sample of 12 suicides was designed to represent both a diversity of occupations and a range of potential work-related factors. While criteria based on age, gender, ethnicity, geographical location and previous mental health history was recorded, these indicators were not used to determine the selection. We chose cases in order to include a representative sample of jobs and sectors and a range of potential work-related causes, identified using criteria established in earlier studies on the psychosocial stressors of workplace suicide (Milner et al., 2013; Waters, 2017; Milner et al., 2018; Choi 2018). Our aim was to examine how stakeholder organisations responded to suicides across different occupational groups and sectors and where different causal factors had been identified by an official source. The causal factors or stressors identified in the 12 suicide

cases were: unmanageable workloads, long/irregular working hours, workplace bullying, exposure to violence/trauma, impact of work inspections, lack of management mental health training, sickness absence and change in work status (Waters and Palmer 2021).

Findings

This section discusses the organisational response of three stakeholder organisations to the suicide cases and aims to evaluate the current regulatory framework and its effectiveness in safeguarding workplace health and safety and preventing suicides.

Health and Safety Executive (HSE)

The HSE is the UK's regulator for workplace health and safety, responsible for ensuring that workplaces are safe and that employees physical and mental health is protected: "HSE's primary function is to secure the health, safety and welfare of people at work and protect others from risks to health and safety from work activity." (DBEIS and HSE, 2017, p.1). The HSE is also responsible for carrying out research into new and emerging workplace health issues through its independent Workplace Health Expert Committee (WHEC) which published a report on work-related suicide in January 2021 (in response to a request made by the authors).

The HSE was not involved in investigating, reporting or regulating any of the 12 suicide cases. This was checked through an in-depth analysis of the multiple sources of documentation linked to each case and through targeted interviews questions. In one case involving an 18-year-old apprentice mechanic, where there was extensive documented evidence of severe workplace bullying in the period prior to his suicide (April 2015), we sent a Freedom of Information request to the regional HSE to enquire as to whether they had been involved in the case. They responded by confirming by email (16 March 2021) that the only actions that HSE took were two years after the suicide when a complaint was raised. At that point, the HSE made enquiries, but took no action. They confirmed that the HSE did not inspect the premises after the suicide and that no inspection report was produced.

In our interviews, all participants stated that they were unaware of the HSE being involved or consulted at any stage. Only 2 of the 18 interviewees (both trade union health and safety representatives) were aware of the HSE's Stress Management Standards and one confirmed that these had been integrated into company health and safety policy. Another interviewee observed "managers are not always aware of the Stress Management Standards or their duties with regard to preventing stress."

We sent a copy of the report stemming from this study to the HSE with a recommendation that the HSE include suicide in the list of work-related deaths that must be reported to them for investigation. Their response reiterated the HSE's long-standing stance that work-related suicide is too complex, multifactorial and subjective to regulate (see Hazards Magazine, 2019). The HSE's chief executive confirmed by email (9 August 2021) that "There will be significant complexities, for employers, in identifying the reasons why an employee may have taken their own life."

Coroner

A coroner plays a critical role in investigating the circumstances surrounding a suicide and has a duty to act in the public interest by raising concerns that might prevent future deaths. Hence, coroners have a legal duty to issue a Preventing Future Deaths (PFD) report where they have a concern that "circumstances creating a risk of further deaths will occur, or will continue to exist, in the future. It is concern of a risk to life caused by present or future circumstances" (Chief Coroner, 2016, p.2). A PFD report can act as an important window onto risks to public safety and a powerful lever for change. As the employer is legally obliged to respond to such a report, it can bring about important changes in workplace policy and practice in the aftermath of a suicide.

While work-related factors were documented as a causal factor in all 12 of the cases studied and were identified in a coroner's report in 8 cases, a PFD report was only issued in 3 of the cases (25%) and was only addressed to the employer in 2 cases. Previous studies have shown that coroners tend to prioritise medical diagnoses as an explanation for suicide and may overlook pertinent social factors (Mallon et al. 2016). One study showed that the majority of PFD reports (57.2%) are issued to the NHS and concern issues of medical / clinical neglect (Minh 2017).

In our study, we found that the use of PFD reports in cases of work-related suicide was inconsistent and depended on the individual judgement of a coroner, rather than on the scale of evidence on work-relatedness. In suicide cases that seemed to present strong documented evidence of work-related factors at an inquest, there was often no PFD report issued. For instance, in the case of a 31-year-old secondary school teacher who took her own life (February 2016), following a period of sickness absence for severe work-related stress, the coroner criticised the school for allocating her work to complete during her sickness absence, but no PFD report was issued. In an interview, the deceased mother stated: "the causes of the suicide weren't investigated fully and the role of the school in pushing [……] to her death was not taken seriously enough". In the case of a 48-year-old

university lecturer who had stated in his previous three years of staff appraisals that his workload was unmanageable, who complained of mounting pressure in the weeks before his death (February 2018), and who left a suicide note specifically blaming work, no PFD report was issued. In an interview, one of his colleagues remarked: “his suicide wasn’t properly investigated as a work-related death. As a result, the employer was able to brush the suicide under the carpet”.

A PFD report was issued to an employer in the case of the suicide of a 41-year-old firefighter (October 2015) who had experienced PTSD following his involvement in a blaze during which his colleague and friend had died. The report raised concerns that although his employer knew he was suffering in the aftermath of the death of his colleague, they burdened him with management responsibilities and failed to provide adequate occupational support. In its response to the PFD report, the fire service committed to changing the procedures for occupational health support in order to allow employees to self-refer and established a working group with trade union participation to review the support available to employees working in stressful situations. A colleague and friend of the firefighter who died by suicide confirmed in an interview with us that mental health training for managers had improved significantly in the aftermath of the suicide.

In the vast majority of cases, coroners attributed the causes of suicide to individual mental ill health rather than workplace conditions or practices. For instance, in one case involving a 21-year-old trainee fire fighter who was completing his probation at a fire station when he took his own life (August 2020), 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 wellbeing 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 challenged this assessment of a mental health condition: “If he had mental health problems, these were created by the toxic working environment in which he was placed. Before being posted to [……] fire station, he was happy, cheerful and full of enthusiasm.”

In another case, the wife of a 43-year-old GP who took his own life (May 2019) reported to us in an interview that she was surprised about the emphasis on mental health causes in the coroner’s verdict, as her husband had no history of mental ill health, apart from severe work-related stress in the period before his suicide.

We sent a copy of the report stemming from this study to the Chief Coroner's office with a recommendation that coroners should consistently issue a PFD report to an employer where evidence of work-related causal factors are presented at the inquest. In their response (23 July 2021), they stated that as coroners are independent, "the Chief Coroner has no power to review, investigate, comment on, or otherwise intervene in the individual judicial decisions of coroners including on whether the coroner considers it their duty to issue a Prevention of Future Death report." When we stated in our reply that inconsistent use of PFD reports meant that opportunities to prevent avoidable deaths were being missed, they confirmed (4 August 2021) that they would consider our report in their ongoing review of PFD use.

Employer

Employers have a duty to assess and manage risks to their employees' health and safety, including psychosocial risks. The HSE's Management Standards set out categories of psychosocial hazard to be considered (demands, control, support, relationships, role and change). In the aftermath of an employee suicide, an employer may decide to undertake an investigation in order to examine any work-related circumstances surrounding the suicide and implement suicide prevention measures. However, there is no legal obligation to investigate an employee suicide or implement any changes to organisational or managerial practices in the aftermath of a suicide.

In our sample, employer-led investigations were carried out in 4 of the 12 cases (33.3%) and these all involved large public and semi-public organisations (an NHS ambulance trust, an NHS hospital trust, a fire service and a university). In three cases, the investigation consisted of an extensive and independent enquiry that led to a detailed report with a set of recommendations. In a fourth case (a university), the investigation consisted of an internal health and safety review to assess physical hazards (jumping risks). We obtained two reports through Freedom of Information requests, one through a family member of the deceased and there was no response to a fourth request to the employer (a university).

An ambulance service Trust launched an in-depth investigation into 4 employee suicides occurring in 2019 that included a 77-page report into the suicide case we studied. The report refers to problems of bullying and sexism within the organisation and poor management of employees on sick leave.The recommendations from the investigation, published on the Trust's website 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, new suicide prevention measures, measures to prevent sexual harassment.

In another case, an employer undertook an internal and external investigation following the suicide of a 21-year-old firefighter recruit who was undergoing probation at the time of his death. Evidence was provided at the inquest that he had complained of racism and bullying. The internal investigation led to 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.

In a further case at a university, the employer limited the investigation to a health and safety check and this was followed (according to interviews with 4 of the deceased's colleagues), by the installation of window locks as a suicide prevention measure and the introduction of therapeutic services (counselling, yoga, mindfulness walks). The deceased colleagues were very critical of the university's response, with one describing it as "patronising" and "insensitive" and a way of deflecting attention from underlying workload problems.

It is clear that while employer investigations can be a powerful tool for identifying psychosocial risks in a workplace and for preventing further suicides, they are only carried out in a minority of cases and as reports are not publicly available, no public interest lessons can be learnt from them. In workplaces where no investigation takes place, the organisational or managerial factors that might have led to a suicide can continue to pose a health and safety risk to other employees within the same organisation.

Discussion

Our study points to serious shortcomings in the UK regulatory oversight of work-related suicides. Unlike many other industrialised countries, there is no data collected on work-related suicides, and suicides are explicitly excluded from the list of work-related deaths that need to be reported to the authorities for further investigation. Suicide is still treated largely as an individual mental health problem that has no proven connections to work or the workplace. Suicides are not officially investigated and where an investigation does take place, it depends on the individual discretion and good will of an employer. While coroners can use a PFD report to indicate concerns about safety and to help prevent further suicides, these are rarely and inconsistently used and depend on the individual judgement of a coroner rather than on the scale of material evidence on work-relatedness. The key finding of this small-scale study is that the UK lacks adequate systems and protocols for monitoring

and regulating work-related suicides and that opportunities to prevent future avoidable suicide deaths are therefore being missed.

A key recommendation of our study is to include suicide in the list of work-related deaths that an employer is legally required to report to the HSE for further investigation**.** 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). Such reporting systems are already used in countries including France and the United States. Including suicides in the HSE's reporting requirements will ensure that suicides are treated with the same rigour, oversight and regulation as other work-related deaths and will extend a health and safety framework to work-related suicides. 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. These critical steps will also help change the existing cultural mindset in relation to suicide by pushing employers to take mental health seriously and to take responsibility for putting suicide prevention measures in place. The UK's regulatory response to work-related suicide corresponds to what public health researchers define as 'denialism', a position that seeks "to convince that there are sufficient grounds to reject the case for taking action to tackle threats to health" (Diethelm & McKee, 2009, 2). Yet denying that a social problem exists or claiming that it is too complicated, doesn't make that social problem go away. Rather, as we found in our study, it creates a deep sense of social injustice for bereaved individuals who believe that the causes of a suicide are being overlooked and that measures are not being put in place to prevent further suicides. Furthermore, health risks that may have triggered one suicide are not investigated and may continue to pose serious risks to the health and lives of other employees.

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[1] Work-related suicide has no formal definition in the UK and in this paper, we draw on the definition used by the French National Public Health Agency (Santé publique France) which sets out a comprehensive set of criteria for identifying a potential work-related suicide. A work-related suicide is identified for purposes of further investigation using any one of the following five criteria: a suicide occurring in the workplace, a suicide note blaming work, a victim in work uniform, testimonies of bereaved pointing to work-related factors, and known difficulties in work prior to the suicide (Gigonzac et al. 2021). Any suicide having one of more of these criteria is subject to an investigation to determine the causes and to prevent further suicides. Work-related suicide is also defined in the United States as a suicide that occurs in the workplace premises or that occurs outside the workplace, but has a definitive link to work (e.g. a suicide note pointing to work problems). https://www.bls.gov/iif/cfoiscope.htm#Suicides

[2] See the campaign led by Hazards: SUICIDE NOTE | Global experts back call for protection from work suicide risk - Hazards magazine

[3] https://www.hse.gov.uk/riddor/reportable-incidents.htm