

## Implementation of a comprehensive program for the bereaved in the Accident and Emergency (A&E) department

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This article describes the establishment of a program for the bereaved of sudden death in the Accident and Emergency (A&E) department using a multi-disciplinary approach. Based on the traumatic grief model in tackling the psychosocial need of the bereaved, the detail from the first contact to their leaving of the hospital is covered. Practical protocols and guidelines are designed for guiding the assessment and intervention. Special issues are highlighted and controversy is discussed in this paper. These include breaking bad news, handling extreme grief reaction, the presence of relatives during resuscitation, volunteer involvement in the acute grief handling, and the outcome measures of the program. (*Hong Kong j.emerg.med.* 2001;8:16-26)

**Keywords:** Sudden death, traumatic grief, volunteer

### Introduction

Deaths and the process of dying occur every day in hospitals. The hospice movement has made an important contribution to the management of the terminally ill. It is estimated that over one third of people die in hospital within a few hours of arrival.<sup>1</sup> The statistic of a local district hospital, Tuen Mun Hospital (TMH) shows that around 15% of the total number of death incident occurred in A&E department. This figure does not include those who die suddenly in the intensive care unit. There is evidence that sudden and unanticipated loss can be particularly disabling.<sup>2-6</sup> The on-the-spot reaction of the staff plays a part in the subsequent adjustment. Studies had shown that the overall management and feeling conveyed by the staff to the bereaved can intensify the reactions and memories experienced later in the grief process.<sup>7-8</sup> Appropriate intervention during the crisis experienced by the suddenly bereaved has a significant effect on the grief response and subsequent resolution of the loss.<sup>9</sup> However, the services provided to the suddenly bereaved are

varied.<sup>10</sup> Medical and nursing staff may not be adequately equipped to manage the suddenly bereaved. Local study indicates that general consensus over the inadequacy of bereavement services in A&E department, limited preparation and training of the staff, emotional stress on staff, and lack of coordination among different helping personnel.<sup>11</sup> Responding to such inadequacy, a pilot project using multi-disciplinary approach under the coordination of the clinical psychologist was tried in TMH. This article aims at giving an outline of the design, the review of the preliminary results and the difficulties encountered in this program.

### Description of the program

#### ***Background and the evolution of the services***

Approximately 230 cases of death are certified annually in the emergency department of Tuen Mun Hospital. A program named 'Care for the Bereaved in A&E department' has been launched since 1997. The clinical psychologist, who is the coordinator of the program, is involved in the planning, monitoring and overseeing the progress. Besides, she also provides professional support through training and direct consultation on the spot and after-care in some difficult cases. The collaboration includes the medical and nursing staffs in the A&E

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department, the medical social worker, the volunteers and the volunteer service coordinators. The volunteer is a group of housewives and working adults who have committed themselves in helping the needy in A&E department. They are on regular duty during daytime and on weekend evenings. The social worker interviews the bereaved in the A&E department right after the death incident or calls in the next working day if the sudden death occurs beyond their duty hour. The routine services from the social worker are offered to those cases of sudden death aged 65 or below. The age criteria is due to limited manpower. In fact, any needy bereaved, regardless of the age of the patient, can also be referred to the social worker on an individual basis.

### ***Framework and protocol of the program***

The traditional grief model talks about stages and anticipatory grief reactions. In the case of sudden death, the unexpected and often violent manner of the death adds an element of trauma in the grief process. The program adopts the traumatic grief model by Sprang & Mcneil.<sup>12</sup> This model addresses the symptomatology depicted in grief models and in the post-traumatic stress disorder. Crisis intervention and stabilisation are the two main foci. Sprang and Mcneil suggest the validation of the reactions of the bereaved, the screening for critical indicators and meeting the basic deficiency needs. Based on such theoretical idea, the program sets the targets on (1) facilitation of the grief reactions; (2) offering timely services for the immediate tangible needs; (3) provision of assessment on the emotional conditions and making referral for appropriate services offered in the community.

The literature on sudden death in emergency was reviewed.<sup>7,13-19</sup> The clinical psychologist conducts training workshop separately for three groups of team members i.e. staff of the A&E department, the medical social workers and the volunteers. The training emphasises sensitivity to the needs of the bereaved, the complementary roles of the team members, and some practical skills. The team members' feedback and suggestions collected during the training are incorporated into the program. A protocol with six phrases for the on-the-spot management is designed (Appendix A). The cooperation among different parties was facilitated and their roles have also been delineated

(Appendix B). A protocol for the bereaved children is incorporated (Appendix C).

### ***Discussion on the use of protocol***

#### ***Phase I: Contact the bereaved***

The team members are concerned with how to tell the truth when the relative asks about the current condition of the patient when in fact death has already been confirmed. Since the breaking the news concerning death is shocking, the avoidance of notification over the phone is widely accepted in the literature reviewed.<sup>18,20-21</sup> If the relative presses for a definite answer over the phone, it is suggested that the staff announces the death, but at the same time leave room for the relative to confirm the identity of the patient. In so doing, it may avoid the suspicion later over the information offered. In fact, this arrangement may shield the shock created by their thinking of 'it may not be her/him' while on the way to hospital.

#### ***Phase II and III: Arrival of the bereaved and notification of death***

There are controversies concerning if relatives should be allowed to view the process of resuscitation. It is a usual practice in some countries and is found to be the desire of the majority of the bereaved in North America.<sup>15</sup> However, a local survey indicates that over 90% of doctors and over 55% of nurses disagree with this practice.<sup>11</sup> Some of our staff in A&E department are worried that the relatives who usually do not possess the essential medical knowledge may misunderstand the situation. They are probably afraid of the chaos as a result of strong emotional reactions of the relatives. There will be pressure on the medical team which may not be favourable to the resuscitation process. In fact, as supported by a study report, there is a significant decrease of desire of the bereaved to view the resuscitation if greater support and more information are provided.<sup>13</sup> The bereaved will be emotionally settled if they realise that not being present during the resuscitation process is the best way to help the team concentrate on the resuscitation. Arrangement should be flexible to suit individual cases. For example, an old man has promised his wife to hold her hand in her last minutes of life and his presence during resuscitation realises his will and avoids the unfinished task that may hamper his grief process.

#### ***Phase IV: Grief reactions***

The three most common difficulties mentioned by the team members are (1) how to approach the family, (2) what appropriate words to say in order to console, and (3) where to set the limit on the extreme behaviours of the bereaved. A literature review was done on the aspect of initial assessment and the types of helpful and unhelpful comments.<sup>15,18,22</sup> Notes are provided as references to the team members (Appendix D & E). Regarding the suggested responses, the team members are reminded to apply them in a sensitive manner. An example is the statement that 'the patient no longer suffers pain'. It is a comfortable comment for the bereaved of patients who have been chronically ill and suffered pain for a long period, but irrelevant for sudden death with good health.

Similar to the acute stress disorder, a wide range of responses of the suddenly bereaved is accepted as 'normal' reactions under 'unusual human experience'. The presented emotions are usually intense but varied among individuals. Staff is encouraged to facilitate grieving of the bereaved instead of restricting the release of emotion. In order to facilitate the assessment of the intensity of the acute reactions, staff members are provided with a checklist on acute symptoms (Appendix F).

With reference to the basic principle of ensuring the safety of the bereaved and those in the vicinity, the self-destructive behaviours and aggression to others are discouraged and should be controlled. The emotional outburst may also endanger the health of the bereaved. With good timing, relaxation exercise with the bereaved is helpful in calming their emotions. Indeed the bereaved can never cry and shout non-stop. Usually after a hysteric outburst, a short episode of silence appears. During that episode, speaking any empathetic statement in a slow pace may lengthen the rest period.

#### ***Phase V and VI: Viewing the body and concluding process***

Viewing the body is the most crucial part to confront the bereaved with the reality of the death. Physical presence of the corpse reviews the reality which is sometimes less horrible than imagined, and gives a chance to say goodbye. According to the

protocol, the bereaved is invited to view the corpse. A study indicates that the number of bereaved who regretted not having seen the body were much higher than those who did.<sup>23</sup> In our program, majority of the next-of-kin had the last view of the dead. For those who did not, it was either because they were afraid or were discouraged from doing so by their relatives.

These obstacles can be eliminated by better preparation. In Chinese culture, the harmony among family members and the respect of the senior are highly regarded.<sup>24</sup> Therefore, the staff may identify the respected member of the family, and explain to him/her the importance of viewing the body in the grieving process. The respected family member and other less disturbed relatives are arranged to see the body first, and then to be followed by those emotional ones. The fear of the bereaved can be minimised by tidying the body and giving factual description of the body damage.

The risk of suicide is high right after the sudden death of a loved one, particularly by homicide and suicide.<sup>21</sup> As a precautionary measure, the bereaved is strongly encouraged to be accompanied upon leaving the hospital. The social worker is asked to make a preliminary assessment of critical indicators, such as previous psychiatric and suicidal history, and violent behaviours on the spot. High risk cases are referred to the clinical psychologist for urgent consultation.

### **Program results and difficulties encountered**

In the past three and a half years, the bereaved of 364 cases of death presenting to A&E department of Tuen Mun hospital have been served in our program. Seventy volunteers were involved in 29 of these cases. It is estimated that the bereaved of suicide and violence victim made up about 20% of cases. In the latest follow-up contact, the social worker obtained the bereaved's opinion regarding this service. Literature on the client satisfaction survey was reviewed<sup>13,25</sup> and six items were selected as relevant to the program (Appendix G). However, the social worker encountered great difficulties tracing the bereaved after the incident. Moreover,

many bereaved have failed to remember the details at that time and could only give a general impression. Some were too disturbed to comment on our services. To collect more feedback, an evaluation questionnaire was sent out to the bereaved one month after the incident.

There were a total of 115 bereaved who either gave feedback through the interview with the social worker or returned the feedback questionnaire. Twenty one percent rated the service as being 'very satisfactory', 78% rated as 'satisfactory'. Only one respondent rated 'dissatisfactory' due to doubt on the possible delay in transferring the patient. No negative comment was received concerning the psychosocial care provided but it may be because those bereaved who were dissatisfied did not bother to comment or have not been located. Comments from the respondents regarding the most useful components of the service included prompt action taken, receiving information on the progress of the resuscitation, providing a quiet room for them to express their grief freely, and the caring attitude of the team. Moreover, the A&E department staff reported that they are now more competent and confident in dealing with the bereaved. With the help of other team members, the A&E department staff are better able to handle their emotion and resume their other duties quicker than before.

Practical difficulties, such as limited manpower in the odd hours are identified. For those sudden death case that occur during non-office hours, no social worker is available to offer on the spot service while at the same time A&E department staff faces heavy workload. As a result, emotional support and the comprehensive assessment of the bereaved may be compromised.

In the recent ten years, there are now literature on the training and maintenance of the volunteers' services, particularly on the hospice volunteer program.<sup>26-29</sup> The issues on screening of suitable volunteers, the demands of training, and the stress and burnout of the volunteers are cautiously addressed. An example from Canada is that a volunteer program for the acute bereavement service has been disbanded due to the problem of maintenance.<sup>13,30</sup>

The coordinators of the volunteers, who are the social workers, are responsible for screening, orientation, basic training and arranging their duties. Training workshops are provided periodically by the clinical psychologist. The volunteer is suggested to approach the bereaved in pair and should include an experience worker. The newcomer is arranged to be an observer or assigned to play a minimal role so as to test one's each individual's readiness. The volunteers are also encouraged to be rotated in the program if the bereaved poses great demands on them. To monitor the impact on the volunteers, the volunteers are requested to complete the Impact Event Scale.<sup>31</sup> With reference to the results of the scales, the coordinators offer supportive counselling. In our project, about one-third of the involved volunteers showed transient symptoms of intrusion and avoidance after the case management. None of the volunteer reports persistence in symptoms nor requires continuation of counselling services.

## Conclusion

Many factors contribute to the success of a comprehensive program for the sudden bereaved in A&E department, such as the initiatives and enthusiasm of the personnel, good communication between different parties, adequate back-up services and the concern for the mental health of the team members. Other factors of importance include periodical practical training, and genuine caring attitude to the suddenly bereaved. In our program, the medical and nursing personnel who are the only team members working during the non-office hours need to be further equipped to perform the initial screening on the risk of the suddenly bereaved. Research on the critical indicators of the acute grief reactions and the role of the acute bereavement program in the subsequent adjustment of the bereaved is required.

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**Appendix A.** Checklist for the management of the acute grief of the sudden death in A&E department**Task 1.** Inform the family on phone

<input type="radio"/>	Introduce yourself with surname
<input type="radio"/>	Identify who is on phone. Try to talk to an adult
<input type="radio"/>	Speak slowly & precisely
<input type="radio"/>	Give a warning shot
<input type="radio"/>	Briefly tell the situation
<input type="radio"/>	When further asked: On resuscitation - Avoid to tell something final, only highlight the severity Confirmed death - Announce the death, but ask them to come to confirm the identity
<input type="radio"/>	Assured that the staffs is doing / has been done the best to rescue
<input type="radio"/>	Find out if someone is present to provide support. Encourage companion to come together
<input type="radio"/>	Warn not to leave young kid alone at home
<input type="radio"/>	Ensure that they know the location of the hospital
<input type="radio"/>	Inform them where and whom to find while they arrive
<input type="radio"/>	Alert them about their safety while rushing to hospital
<input type="radio"/>	Leave contact telephone number if needed

**Task 2.** Family on arrival & while waiting

<input type="radio"/>	Inform the receptionist about waiting for the family
<input type="radio"/>	Assigned staff to stand by to receive the family
<input type="radio"/>	Settle the family in suitable area (with privacy/near the resuscitation room)
<input type="radio"/>	Brief the family about the current information
<input type="radio"/>	Confirm the identity of the patient (physical description, identify the belongings, etc.)
<input type="radio"/>	Give initial support, but no over-reassurance
<input type="radio"/>	Arrange the tangible services (provide temporary child-care/tea/inform other relatives)
<input type="radio"/>	Arrange doctor or other staff to update the information
<input type="radio"/>	Inform MSW if service is available and is needed
<input type="radio"/>	Inform volunteer to accompany and to assist (if available)

**Task 3.** Break bad news

<input type="radio"/>	Identify relatives who can help preserve equanimity in the face of the devastating news
<input type="radio"/>	Doctor sits down to talk with the family
<input type="radio"/>	Be sure to talk to the nearest next of kin. Should not use a child as translator.
<input type="radio"/>	Give family a sequential narration of what has happened and what have been done. Do not use jargon or vague descriptions
<input type="radio"/>	Highlight everything that could be done was done
<input type="radio"/>	Avoid blaming the victim in any way for what happened, even though he/she may have been fully or partially at fault
<input type="radio"/>	Be warm and compassionate. Show your concern and condolence
<input type="radio"/>	Accept whatever first reaction of the family
<input type="radio"/>	Allow some time to be with the family (even in silence)
<input type="radio"/>	Prepare to answer the questions honestly
<input type="radio"/>	Avoid words imply 'fault' to the angry family (I'm sorry/We failed to rescue)
<input type="radio"/>	Ensure companion after doctor leaves

**Appendix A.** (Con't)**Task 4.** Handle the emotions

<input type="radio"/>	Prepare to face with intense acute grief reactions
<input type="radio"/>	Refrain from false reassurance and pseudowisdom
<input type="radio"/>	Give the family permission to cry
<input type="radio"/>	Use non-verbal gestures to convey the concern (touch, give them tissue, sit aside silently, etc.)
<input type="radio"/>	Legitimize and validate the family's feelings (verbalize the unsaid feelings/summarize their concerns)
<input type="radio"/>	Answer the family's questions honestly. Prepare to say 'I don't know'
<input type="radio"/>	Avoid being defensive in face of anger and blaming. Listen patiently. Highlight the shared wish of preventing the death
<input type="radio"/>	In case of extreme guilt, listen patiently and highlight what the survivors have already done or/and the circumstances leading to not doing something

**Task 5.** Viewing the body

<input type="radio"/>	Give the family option of viewing the body. But general rule is to gently encourage to view the body by pointing out the advantage, particularly when the key bereaved figure is advised by relatives not to do so
<input type="radio"/>	Prepare the body in the best form (cover the mutilated part, clean the blood, remove the tubes and drains, etc.)
<input type="radio"/>	Prepare the family for what they will see before they actually see by giving a physical description of the room or morgue, and the outlook of the victim. Injuries and signs of medical intervention should be described.
<input type="radio"/>	When fear is expressed, let someone see the body first before others come along
<input type="radio"/>	Refer the body by name
<input type="radio"/>	Should not blame the bereaved for not viewing the body though they are facilitated to do so
<input type="radio"/>	Ask or observe the bereaved whether he/she would like to stay with the deceased alone or in company. Staff should stay nearby and attend to the need of the bereaved.
<input type="radio"/>	Give time for family to grieve with the body. Reassure that it is all right to take time to say goodbye to their relatives in their own way
<input type="radio"/>	Treat the deceased person with dignity and respect especially in the family's presence
<input type="radio"/>	Invite the family to a less stimulating place to rest for sometimes before returning to the deceased if he/she cannot cope with this stressful situation.
<input type="radio"/>	Allow the family to view the body repeatedly or highlight the chance to see again in funeral if request cannot be entertained

**Task 6.** Prepare the leave

<input type="radio"/>	Explain what will happen to the body, including autopsy if this is required
<input type="radio"/>	Return the belonging of the deceased to the family. Explain what it contains and the condition of the items so they will know what to expect when they decide to open it
<input type="radio"/>	Educate on the symptoms of grief responses
<input type="radio"/>	Get the supportive relatives to complete the procedures if the next-of-kin is too disturbed
<input type="radio"/>	When the bereaved is alone, summon someone to accompany if possible
<input type="radio"/>	Assess the emotional state of the bereaved
<input type="radio"/>	Receive the unstable and risky ones to ward
<input type="radio"/>	Give all the relevant materials (e.g. pamphlet, sympathy card, information sheet on community resources, etc.) to the family
<input type="radio"/>	Give the contact phone number for any question and assistance required

**Appendix B. Roles of different parties*****Medical and nursing staffs***

Gear to a new culture:

- \* Extend the role from medical to psychosocial aspects
  - \* From patient to his/her family
  - \* Rely on team work instead of fragmentary services
1. Gradual and sensitive ways of breaking bad news
  2. Steps to increase the sense of reality of the death and facilitate the initial acknowledgment/acceptance
  3. Provide adequate support and make considerate arrangement for the bereaved to express the intense emotions

***Medical social worker***

- \* From reactive to proactive services
  - \* Increased awareness on the assessment role
1. Provide tangible helps promptly to settle the immediate practical difficulties arisen from the crisis
  2. Assess risk and make appropriate referral
  3. Provide support and crisis intervention

***Volunteer***

- \* Express the community concern
  - \* Plenty of time and effort focusing on the bereaved
1. Provide support
  2. Take care of the children to reduce the burden of the bereaved
  3. Run errands and give tangible helps
  4. Observe the needs and emotions of the bereaved and seek appropriate helps

***Volunteers' coordinator***

1. Coordinate the services
2. Support the volunteers
3. Assessment and counselling to the needy volunteers

***Clinical psychologist***

1. Monitor and oversee the program
2. Provide training
3. Provide consultation for needy case

**Appendix C.** Checklist for the management of the acute grief of the bereaved child

1. Check own emotion and readiness before approaching the child	
2. Observe the child's developmental level and emotional state	
3. Tune in the language of the child	
4. Introduce yourself e.g. name and who you are	
5. Promptly settle the child e.g. in children corner, wait with relatives in quiet room	
6. Orientation to child e.g. explain where the child is, the nature of the setting, and the reason why the child staying here	
7. Connect child to parents, relatives or other adults if possible	
8. Reassure the availability of companion/help	
9. Attend child's practical needs e.g. toileting, drinks and food, warmth, etc.	
10. Express support or comfort either verbally and/or non-verbally	
11. Provide child with information regularly regarding their family members if child wants	
12. Orientation to adults involved e.g. how they perceived the incident, and how they want the child to be involved	
13. Encourage adult to allow child to be involved as far as the child wants	
14. Support adult to explain the incident. If they are unable to do so, ask for permission to explain the incident of death.	
15. Advise adult on the possible reactions manifested by child and things to do to support child	
16. Ask the child if he/she is ready to view the body. Brief the appearance of the body, particularly on the changes	
17. Accompany child to view the body if needed. Let child decide how near he wants to be	
18. Prepare child for grief reaction	
19. Allow for expression and questions	
20. Prime the adult on possible grief reactions manifested by child and things to do to support the child	
21. Find out someone the child can rely on or/and give one for the child to turn to in case of need arisen	

**Appendix D.** Initial assessment in the approach of the survivors

1. Gather information about the circumstances of the event leading to the death
2. Discuss with the staffs who are dealing with the survivors to obtain their observation on survivor's reactions
3. Obtain basic information about the family and familial relationships
4. Determine whom the family members should be addressed first
5. Introduce yourselves and observe the readiness and responsiveness to be approached and helped
6. Assess the group of family members: what are their relationships, who is connected to whom, who are the leaders, who are most disturbing and composing, how cohesive and supportive of the group.
7. Select the main target clients to work for
8. Observe the bereaved and assess their mental and emotional states
9. Draw conclusion on the immediate concerns of the family, the priorities of the needs, the severity of their emotional conditions
10. Make decision whether more team members should be called for to help

**Appendix E.** Suggested list of helpful and least helpful statements for the acute grief of the survivors

**Helpful comments**

- \* It must be hard to accept
- \* It is so sudden
- \* If there is anything I can do, please let me know
- \* I'm here with you/I'll just sit here with you
- \* I know you are feeling totally overwhelmed right now
- \* You must feel very confused and don't know what to do next
- \* If you want to cry, just let it come out
- \* It is too much for you, let us take care of the arrangement
- \* I feel for your pain
- \* I can't imagine how difficult this is for you
- \* I would give anything to be able to make it better for you, but I know I can't

**Least Helpful comments**

- \* I know just how you feel
- \* You shouldn't feel/act that way
- \* Be grateful you still have your other children/spouse, etc.
- \* You must be strong for your children/spouse, etc.
- \* You must go on with your life
- \* Everything is going to be okay
- \* He/She wouldn't want you to be upset
- \* I don't know what to say
- \* Doesn't life seem so unfair
- \* Things will get better
- \* I know it hurts now but time can heal
- \* He/She will always be alive in your memories

**Appendix F.** Checklist for the acute symptoms

<b>Affective dimension</b>	
1. Affective Flooding e.g. panicked, enraged	
2. Affective Numbness e.g. absence of emotional responsiveness, reduction in awareness of the surrounding	
<b>Cognitive dimension</b>	
1. Memory Impairment e.g. inability to recall personal information	
2. Concentration Difficulties e.g. train of thought is often interrupted	
3. Denial e.g. demand the dead relative gets up and returns home	
4. Ruminations & Intrusions e.g. obsess with the details, repeat the same answered questions	
5. Guilt and Hopelessness e.g. self-blame and expressed suicidal thoughts	
<b>Physiological dimension</b>	
1. High Arousal Level e.g. flushed, sweating	
2. Somatic Discomfort e.g. dizziness, palpitation, tachycardiac	
<b>Behavioural dimension</b>	
1. Withdrawal & Avoidance e.g. turn away from people	
2. Regression e.g. speak and act like a child	
3. Aggression to self or others	

**Appendix G.** Client satisfaction survey

	Item	Rating			
		Very satisfied	Satisfied	Dissatisfied	Very dissatisfied
1.	Clear instructions on procedure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	Convenient & comfortable physical setting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	Friendly and supportive staffs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	Prompt service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	Adequate service to meet the needs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	Overall sense on service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Other comments</b>					
What is most helpful:					
What is most unhelpful (need improvement):					