Death Notification with Children after Sudden Parental Death: The Practice Experiences, Interventions, Support and Training Needs of Emergency Room Social Workers.

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MAJOR PAPER SUBMITTED
IN PARTIAL FULFILLMENT OF
THE REQUIREMENTS FOR THE DEGREE OF
MASTER OF SOCIAL WORK

In the School of Social Work and Human Services

UNIVERSITY OF THE FRASER VALLEY

Spring 2016

Approval

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Degree:	**Master of Social Work**
Title of Thesis:	**Death Notification with Children after Sudden Parental Death: The Practice Experiences, Interventions, Support and Training Needs of Emergency Room Social Workers.**

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Abstract

Sudden death occurs frequently in the emergency department. Parents of young children are not immune. Unexpected death often creates a crisis in the family system and the death notification, in and of itself, can be a trauma for survivors. Complicating this, young children are reliant on the care of their parents, and parental death fundamentally disrupts a child's sense of security and safety. Social workers in the emergency department are often involved in providing death notification, and the five participants of this study were often the sole professional responsible for death notification with children. Participants' narratives suggested that their preparedness was incongruent for this responsibility. Despite this, participants self-created their own practice, which intriguingly paralleled the guidelines found in the literature as well as one another's independent reports. Participants also described a situational and customized style of intervention with children and families that was evidence of their creativity and flexibility.

Acknowledgements

I would like to acknowledge Dr. Glen Paddock and Dr. Leah Douglas, both of whom were excellent instructors throughout my graduate education at the University of the Fraser Valley and were my mentors throughout the research and writing of this document. I would also like to thank my Clinical Practice Leader (Fraser Health Authority), Farimah Shakeri, who offered me many lifelines in the form of encouragement and accommodation.

On a personal level, I would like to thank my spouse, Alfred Hansen, for doing absolutely everything to help me succeed. Thank you for being my rock. I am also compelled to acknowledge my parents, Glenn and Pamela McKay. They have given me every imaginable form of support across my lifespan, and their unwavering belief in me has always been my greatest source of strength. Most of all, I would like to acknowledge the sacrifices that my children made while I pursued this passion project. Elijah and Maxwell, you have been so very generous. Thank you for your gifts of patience and grace.

In the end, it was the social workers who participated in this research who made my learning possible. I appreciate you sharing your experiences with me. It was my absolute honour to listen to your stories of heartbreak, humility, wonder, and hope.

Dedication

This research paper is dedicated to all young children who know grief,

especially to children who have had a parent die in an Emergency Department.

I aspire to do right by you.

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Personal Reflection

I have not forgotten the first death notification that I provided to a child. To children, in fact, a young sibling group who had witnessed their parent sustain a catastrophic head injury and, subsequently, a traumatic cardiac arrest. The eldest sibling ran to a neighboring house for help, while the youngest sat next to him, and the middle child attempted to cover his gaping wounds. The children witnessed a passerby attempt CPR, and when the emergency responders arrived, they witnessed the paramedics resuscitate and stabilize him for transport. They were then brought to the ER by the Police, as their other parent could not be immediately located. I greeted the children when they arrived and then they sat with me, covered in their father's blood and silent in their fear, as the medical team attempted to save his life. He died.

I had been a health care social worker for five years when I was notified that this man was en route to the ER and that his young and likely-to-be traumatized children were not far behind, without their mother. I had worked in four different emergency departments, had collaborated with physicians in previous death notifications, and had provided initial death notification independently. I had never been involved in death notification work with children.

I felt afraid, deeply aware of how significant the tragedy would be in their life, and acutely sensitive to their need for age appropriate care. I realized then that I had never been trained how to deliver death notification**;** certainly not to children and their surviving parent after sudden parental death. I did the best I could, at the time.

I have since been involved in or provided death notification to other children and their families, and I have to trust that my interventions have matured. I have still had no formal training on how to provide death notification (nor do I think this exists within my discipline), my practice is rarely witnessed, and I have never talked about it at length with my colleagues or

clinical superiors. Unfortunately, there is also limited published material to guide death notification practices with this population. Truthfully, until I began my graduate studies, much of my own growth had been self-led, informed by deductive reasoning, experience, and intuition.

My sensitivity to the significance of this work has never abated, and my curiosity about how others perform death notification, and with what information and support, has only grown. This research is a passion project, guided by a sense of duty for the scared and sad young children I have and will encounter and a strong respect for my colleagues who do this extremely demanding and challenging work. I want us to do good work, and I want us to be well.

Chapter 1: Introduction

Despite the skilled efforts of emergency and medical practitioners, patients frequently die "en route to the hospital or while being treated in the emergency room" (Kaul, 2001, p. 102). These deaths may have occurred secondary to motor vehicle or workplace accidents, acute cardiac or neurological health events, self-harming behaviour, or as a result of victimization and crime. Regardless, "they are often traumatic, sudden, unexpected, and occurring in a younger age group" (Parris, 2011, p. 139).

When a sudden death occurs, surviving family members are typically informed soon after their own arrival to the hospital, permitting little time for them to acclimatize, process, or integrate the tragic information they receive (Kaul, 2001; Von Bloch, 1996). Notification may then bring on a crisis for the surviving family (Galbraith, Harder, Macomber, Roe, & Roesthlisberger, 2014; Kaul, 2001; Leash, 1994; Roe, 2012). Given the possibility for peritraumatic distress, a subjective emotional and physiological response to trauma that may include "fear, helplessness and horror" (Hargrave, Leathem, & Long, 2012, p. 344), cognition can be overwhelmed and interrupted. For this reason, "sudden bereavement is a risk [factor] for posttraumatic stress disorder and complicated grief" (p. 344).

Young children are at increased risk of traumatic responses given developmental and social vulnerabilities related to their age (Briere & Scott, 2015). In addition, all parental death has been identified as a "fundamental" (Worden, Davies, & McCown, 1999, p. 1) and traumatic loss for children (McClatchey & Wimmer, 2012; McClatchy, Vonk, & Palardy, 2009), "regardless of whether the death is sudden, expected, violent, or peaceful" (McClatchey & Wimmer, 2012, p. 222).

Research has indicated that the "person-environment transactions" (Christ, 2010, p. 181) and the manner in which death notification is delivered can impact how grief is experienced by survivors (Harrington & Sprowl, 2014; Lord & Stewart, 2008; Parris, 2011; Roe, 2012), which can also influence how survivors cope (Kaul, 2001) and accommodate the death (Harrington & Sprowl, 2014). Death notification can either be experienced as sensitive and contribute to healing or, alternatively, interfere with the bereavement process (Harrington & Sprowl, 2011, 2014; Merlevede et al., 2004; Parris, 2011; Roe, 2012) and compound trauma (Harrington & Sprowl, 2014). Educated, informed, and thoughtful interventions are required to deliver notification that can have a healing impact (Miller, 2008) and "minimize the risk of adverse grief" (Speck, 2008, p. 190). Unfortunately, professionals performing death notification are often untrained (Iserson, 1999; Leash, 1994; Lord & Stewart, 2008; Roe, 2012) and underprepared, and delivering death notification can be difficult and anxiety provoking for them (Galbraith et al., 2014; Lord & Stewart, 2008; Von Bloch, 1996).

The purpose of this research was to explore the experiences of emergency room (ER) social workers who have provided death notification interventions with young children post sudden parental death and to determine their training and support needs. Participants were, therefore, asked a series of questions to ascertain: What experiences have ER social workers in the Fraser Health Authority (FHA) had in performing death notification interventions with children after sudden parental death and what information, education, training, or support do they believe would benefit their future death notification practices with this population?

The intent of this research was to start a conversation among the social work research and practice community about what is currently known, done, and required by ER social workers who perform this work. Highlighting the current academic and experiential knowledge base as

well as the perceived training and support needs of ER social workers may assist in planning to enhance the competence, confidence, and well-being of these practitioners and, ultimately, the quality of service delivery to the parentally bereaved and their families.

This research is specific to death notification interventions with children aged 3 to 12 years of age. In the case of a surviving infant or toddler, direct death notification practices would presumably not occur, and interventions would be delivered exclusively to surviving family. Although it can be presumed that the principles guiding best practices in death notification would be transferrable to an adolescent population, adolescents present with unique developmental considerations that will not be explored here.

For this research the term "death notification interventions" refers to pre-notification interventions, the actual task of delivering or collaborating for the delivery of death notification, and post-notification interventions. Pre-notification interventions might include identifying the patient; consulting with paramedics, nurses, and physicians about the patient's circumstance and condition; locating next of kin; calling the next of kin and requesting that family attend the hospital; greeting the family upon arrival; providing a space and essentials for the family such as chairs, tissue, water, and an orientation to the washroom location; performing a brief family, social, and risk assessment; sharing with family the context of the event and the patient's current status; continued and frequent dialogue with the treating medical team; providing timely updates to the family; facilitating discussion about code status, intervention wishes, and direction of care; negotiating family witnessed CPR if requested; offering anticipatory notification (if the patient's status is grave); and possibly creating access to view prior to death, which includes collaborating with the medical team about appropriateness and/or timing, preparing family for what they will see at that time, and remaining available to family for the duration of the visit in case of

questions, overwhelm, or a pressing need to exit. Death notification refers to telling surviving family members that a patient has, in fact, died. Post-notification interventions might include crisis containment, brief supportive counselling, facilitating visitation of the deceased, discussion about organ donation, psychoeducation about grief and trauma, post-mortem system navigation, resource counselling and referrals, and terminating involvement.

Family witnessed CPR and organ donation conversations were excluded from this research. It is also important to explain that environmental interventions, such as providing the bereaved with a quiet and private space, and viewing interventions, where family visit the deceased body, have not been a research focus. Though these interventions are considered to be fundamental in death notification (Harrington & Sprowl, 2011, 2014; Leash, 1994; Iserson, 1999; Kaul, 2001; Lord & Stewart, 2008; Parris, 2011; Wells, 1993), environmental options are within the operational scope and not always within the social worker's locus of control. Viewing of the deceased, a profound and significant transaction, is generally thought to be beneficial to those who request it (Harrington & Sprowl, 2011, 2014). It is a complex and sensitive intervention for many reasons, however, and the scope of this research did not allow for exploration of the considerations and implications of viewing by parentally bereaved children. Lastly, though some death notification work can be or has to be done on the phone, the focus for this research was on in-hospital and in-person interventions.

Chapter 2: Literature Review

There is a traditional expectation that physicians deliver death notification (Leash, 1996). Leash (1996) proposed that this was not necessary. Of the following four death notification variables: where, how, when, and by whom, respondents reported that by whom they received death notification was the least important variable, but that how they were notified was the most influential. To this, social work has been identified as an appropriate discipline to lead and coordinate death notification in acute care settings (Kaul, 2001). This is best understood in the context of Leash's definition of an "ideal notifier" (p. 29). He identified that the notifier should be:

> (1) someone with sufficient time to support the family at length; (2) a person who is well informed regarding both the medical details and other relevant circumstances of the injury or illness; (3) a person with the skills to aid in the accommodation and coping tasks of grief; (4) someone who can provide bereavement resource and referral information for family follow-up; and (5) a person, who through experience, is comfortable responding to the tremendous variety of emotional reactions survivors exhibit. (p. 29)

Leash noted that these notification tasks could be executed by various team members, depending on their availability, skill set or comfort level. Despite this, he also identified that having a key individual remain with the family for the duration of the death notification intervention will produce a more "holistic outcome" (p. 29).

In acute care, physicians and medical staffs are specialized in treating the emergency health care needs of patients. A shortage of time limits their capacity to offer continuity or extended care to suddenly bereaved families (Leash, 1996). Social workers, however, are trained specifically for assessment and crisis intervention (Kaul, 2001), have skills in managing

psychological trauma (Leash, 1994), and are employed for patient *and* family care. Social workers can focus exclusively on the family in crisis (Wells, 1993) prior to notification, during or while delivering notification, and following.

The physician continues to be involved in death notification. Certainly, it is only appropriate for a physician or primary care nurse to provide a "detailed medical explanation for the cause of a death" (Leash, 1994, p. 21). In addition, families "invariably want and need to hear firsthand about the treatment and resuscitation efforts" (Leash, 1996, p. 30). Contact with the treating team not only allows for family to comprehend better what transpired, but can also "be essential to the feelings of closure" (Leash, 1996, p. 30).

Most survivors do not object if a timely notification can be made by an alternate professional (Iserson, 1999), and it can actually be advantageous for the family if another professional delivers the initial death notification (Leash, 1994, 1996). When families receive timely notification and subsequent bereavement interventions, they can also begin to grieve in a timely way. They then have an opportunity to compose themselves some prior to meeting with the physician, allowing them to be at least somewhat better prepared to hear, integrate, and question the detailed information they will receive (Leash, 1994, 1996). Kaul (2001) elaborated to explain that:

> Social workers in the emergency department often inform the family that the patient has died before the formal notification delivered by a treating physician takes place. In this way, survivors are not anxiously waiting until medical staff can leave the resuscitation bay to talk with them. (p. 105)

She recommended that notification be deferred until medical staff is available, but noted that an initial notification may be required if a deferral would be harmful to the surviving family.

For clinicians who interact with children who are parentally bereaved, it is useful to understand the possible implications for adjustment post sudden parental death in effort to facilitate "constructive coping processes" (Corr, 2010a, p. 6). Parentally bereaved children are at a greater risk for adverse mental health outcomes than their non-bereaved peers (Melhem, Walker, Moritz, & Brent, 2008), and effectively "companioning a child who has had a parent die is the epitome of good preventive mental and spiritual health care" (Wolfelt, 2012, p. 56). A review of research pertaining to the development of children as it relates to parental death, grief and trauma in children, variables influencing the grief and adjustment experience of children, guidelines for death notification, and clinician preparedness for death work all added depth to understanding the focus of this research.

Children's Developmental Capacity to Comprehend Death

Young children are unique from adults in many ways, most notably in their dependence on others to fulfill their basic survival and security needs (King, Leschied, Whitehead, Chiodo, & Hurley, 2003)*.* This defining characteristic makes them particularly vulnerable, both physically and psychologically, if their primary caregiver is harmed or dies. Further complicating their adaptability and grief process is that their cognitive and psycho-emotional development has not yet been completed. They require support and guidance to interpret, comprehend, and reconcile life events.

Many age-related schemas have been proposed to comprehend children's developmental relationship to death comprehension. Despite there being evidenced value in these frameworks, Christ (2010) explained that they oversimplify the cognitive processes of children. Practitioners were instead encouraged to consider a child's capacity to process and understand death as being related to a complex exchange between their individual level of maturation and their lived

experience. Aspects of their lived experience can include their social location and context, such as racial, cultural, and religious membership; social and familial relationships; and previous experiences with death (Christ, 2010; Corr, 2010a, 2010b). Research supported that a child's grief experience is intertwined with their development (Auman, 2007), and process themes, such as "finality, universality / inevitability, and unpredictability" (Christ, 2010, p. 30) or "irreversibility, finality, inevitability, and causality" (Leash, 1994, p. 138), can only occur as children's cognitive capacity for reasoning allows. Among young children, their immature death conception ability can challenge the resolution process and "feelings of unreality [can be] prominent" (p. 137). Sudden and traumatic deaths can further interfere with comprehension, grief, and adjustment.

Grief and trauma in children. Grief is a normal psycho-emotional reaction to the experience of loss or death. If the loss is "non-normative", however, occurring outside of expected and traditional life transitions (Corr, 2010a, p. 5), there is no opportunity to anticipate or prepare, and normal grief reactions can be complicated by shock (Levine & Kline, 2007; 2008). Given this, in the event of a sudden and unanticipated death, survivors are likely to experience "severe shock" (Iserson, 1999, p. 5) and have a complex response reaction. This may include a traumatic bereavement, broadly understood as a complex grief reaction after a traumatic death, characterized by persistent, frequent, and distressing images and feelings related to the death (Briere & Scott, 2015).

Levine and Kline (2007) explained that when a person feels threatened, the brain releases energy to support defense mechanisms. These responses to disempowerment are physiological, instinctual, and intense, designed to support survival by activating a primal "fight or flight" mechanism (p. 4). If "flight or fight is impossible or perceived impossible" (p. 5), an additional

survival response, that of "freeze", is common (p. 5). The "likelihood of developing trauma symptoms is related to the level of shutdown and residual survival energy that was originally mobilized" (Levine & Kline, 2008, p. 11), but then not utilized while in a frozen state.

Unfortunately, as children "have less experience and internal resources to draw upon at times of crisis" (Auman, 2007, p. 34) and are also limited in their independence, agency, strength, and social power, they are rendered unable to flee from risk, fight off threats, or locate safety for themselves (Levine & Kline, 2007). This inexperience and powerlessness makes them especially "susceptible to freezing, and therefore trauma" (p. 7). Parental death is noted to be especially disturbing and disruptive to the world scope of young children, for whom "life is defined and ordered within the context of family . . . [and] family is most fully defined by one's parents" (Leash, 1994, p. 141).

Sudden versus anticipated loss. Research findings varied dramatically on whether a sudden or anticipated death of a parent produces differing or similar adjustment challenges for surviving children. Miller (2008) proposed that a sudden death "does not allow for anticipatory psychological inoculation to soften the traumatic impact" (p. 368). Parris (2011) endorsed this, explaining that a "lack of anticipatory grief" (p. 141) adversely affects the adjustment and grief journey for any person. Wolfelt (2012) held this same view, describing that an absent opportunity to prepare for death complicates the grief process for children. The circumstances around sudden death have also been listed as a risk factor for both adverse mental health outcomes (Christ, 2010; Harrington & Sprowl, 2014; Kaul, 2001; Melhem et al., 2008; Parris, 2011; Roe, 2012) and functional impairment in caregivers (Christ, 2010), resulting in worse health and functional outcomes for the surviving children who are reliant on the caregiver for support.

In contrast, Dunning (2006) reported that research "does not substantiate that sudden parental death is more difficult to reconcile" (p. 499). Instead, she posited that the death of a parent after two or more weeks of illness is associated with more distress and poorer "post-mortem outcomes" (p. 500) for the parentally bereaved. Hope and Hodge (2006) referred to the same research, finding that the longest anticipations were associated with the worst post-death adjustments in children (p. 108). McClatchey and Vonk (2005) also suggested that parental death after a prolonged illness can have serious consequences on mood, behaviour, and function of surviving children. Kaplow, Howell, and Layne (2014) further endorsed this perspective, reporting that "the circumstances surrounding anticipated deaths may be of equivalent or greater potency in inducing severe distress in bereaved youth" (p. 43). This may well be that parental loss begins "well before the moment of death when a parent is declining secondary to a chronic and terminal illness" (Werner-Lin & Biank, 2012, p. 13) and that the interpersonal, familial, and contextual stress surrounding this gradual decline is challenging for a young child to endure. Kaplow et al. also noted the increased likelihood of a child being exposed to disturbing images related to the progressive physical deterioration of their parent in this scenario.

Christ (2010) had a differing view. While endorsing that "children experience the highest levels of anxiety and depression during a parent's terminal illness" (p. 175) and agreeing that "changes in appearance and ability related to a parent's advanced stages of illness are particularly stressful for a child to witness" (p. 177), he reported that these worry and mood symptoms resolve following death, so long as the child receives adequate care. Dowdney (2000) concurred, describing high rates of depression and anxiety preceding a parental death, but highlighted that these rates were found to normalize following the loss.

Following an anticipated death, a protective factor for bereaved children may be that the surviving parent is provided with an opportunity to mourn gradually, and this may facilitate better adult adjustment (Dowdney 2000). This scenario could then enable surviving caregivers to better assume a supportive and facilitative role in the child's adjustment. Conversely, in a sudden death, the abrupt loss may disrupt the family's ability to support healing in the child (Yule, 2008). The research of Kaplow et al. (2014) was in line with this. They found that surviving caregivers experienced fewer disturbances in mood following the anticipated death of their spouse than those who had a spouse die suddenly.

A noted risk factor for children who have been expecting a death of a parent is related to professional responsiveness. Fearnley (2010) suggested that these children do not get timely, comprehensive, or a sufficient service response from professionals (p. 458), presumably because these deaths are not perceived as traumatic.

In any regard, McClatchey et al. (2009) found that the incidence of Post-Traumatic Stress Disorder was "comparable among children who lost a parent to an expected or unexpected death" (p. 308). For this reason, children who have lost a parent to any cause may benefit from trauma informed social work interventions.

Additional Considerations for Grief and Adjustment

A child's adjustment after parental death is complex and often in relationship with their age, the nature of the death, and whether the surviving adults are able to engage in an adaptive grief process (Dent, 2008; Hope & Hodge, 2006; Worden et al., 1999). Additional variables for adjustment include if a child witnessed the event causing parental death, if the parent dies as a result of a suicide or homicide, the gender and sex of the child, how the child's home is organized, and whether the child lost their sole or both guardians.

Child as witness. The death of a parent is a "fundamental loss for children" (Worden et al., 1999, p. 1) and threatens assumptions children hold about their own safety. It is important to consider if a child witnessed the accident or health event causing death of their parent, as observing the death of a primary caretaker would produce increased feelings of "fear, helplessness and horror" (Joseph & Murphy, 2014, p. 1098). If the death was sudden, violent, or gruesome, such as a disfiguring accident, a suicide, or a murder, the death can further "cause terror in surviving children" (McClatchey & Vonk, 2005, p. 286), heightening the sense of overwhelm and the risks for post-traumatic experiences, including "recurrent intrusive images that [can] interfere with positive reminiscing about the deceased" (Pynoos, as cited in Kaplow et al., 2014, p. 43).

Suicide and homicide. Parental death to either suicide or homicide is especially complicated. In either scenario, families may have greater difficulty reconciling the loss given how the death of their loved one occurred. As Wolfelt (2012) contends, there is a need to grieve both the death, and how the death occurred. Given this dual process, surviving adults may be consumed, distracting them from the emotional needs of the bereaved children. Suicide "can be a highly traumatic event, particularly for children or youth who are exposed to suicide of a parent" (Briere & Scott, 2015, p. 20). Offspring bereaved by suicide are at a higher risk for adverse mental health outcomes than other parentally bereaved children (Melhem et al., 2008).

With death secondary to murder, surviving family members may become "preoccupied with the nature of the injuries inflicted on the victim, the brutality of the killing, the types of weapons used, and the victim's suffering" (Miller, 2008, p. 368). Further, individuals and families may experience a grief deferral if there are operational and/or legal processes they must

participate in post-mortem (Harrington & Sprowl, 2011). This may distance themselves from their own grief or the grief of others.

For children who may have witnessed harm to their parent, witnessed their parent harm themselves, or discovered their parent's body harmed, it is crucial to be aware that the traumatic images associated with the death correlates with an increased likelihood of psychological disturbance (Dowdney, 2000). Relatedly, increased support needs for a child can be anticipated.

Gender roles and family organization. Gender differences in family adjustment have been noted, with mother loss causing more notable disturbances in both emotion and behaviour than the death of a father (Dent, 2008). Werner-Lin and Biank (2012) proposed that this is so, as women, given gender conditioning and related social organization, maintain household routines and can, therefore, provide continuity in both structure and emotional climate in the home after the death of a father. Werner-Lin and Biank posited that children who lose a father from a traditionally gendered home experience less environmental disruption. Further, women are found to be more likely to seek help and assistance for them or their children, which can service a child's bereavement needs and assist in their adaptation to loss (Werner-Lin & Biank, 2012).

This said, in homes where more traditional gender roles were maintained, with the father as primary breadwinner, the loss of a father could threaten financial security. This, no doubt, could be destabilizing and require "painful adjustments" in response (Auman, 2007, p. 35), particularly if a mother is pressured to relocate or work out of the home, both of which may be received by bereaved children as secondary losses.

Alternatively, surviving fathers may be required to occupy roles not previously mastered, and that may also be outside of their comfort zone (Leash, 1994; Werner-Lin & Biank, 2012). In addition to their acute grief, this could potentially contribute to parental overwhelm and create

difficulties with coping, which could influence a child's sense of security or interfere with the child having his or her own adjustment needs met. A compounding variable here is the age of the bereaved children, as the impact of a mother's death is higher on younger children who are more dependent on their caregiver for structure than older adolescents (Dowdney, 2000).

Sex differences in surviving children. Dowdney (2000) emphasized that male children consistently demonstrated greater rates of psychological challenge and behavioural disturbances than females, highlighting the likelihood of surviving male children externalizing their grief as compared to girls who were more prone to internalizing. In their research comparing parent loss versus sibling loss, Worden et al. (1999) also found differences in the reactions and adaptation between male and female children. They discovered that "boys who lost a parent [presented] at higher clinical risk" (p. 11), particularly if the loss was that of a father, presumably their primary confidant, which contrasted with the aforementioned research reflecting a mother's capacity to optimize adjustment post-spousal or post-parental loss.

In contrast, females were noted to form "same-sex friends earlier" (Worden et al., 1999, p. 11) and were, therefore, afforded greater social support post parental death. This said, a unique risk to surviving female children was that of being adultified, when children are expected to assume adult roles and responsibilities, in the context of parental regression (Werner-Lin & Biank, 2012).

Loss of sole guardian or both guardians. The research on the psycho-emotional adjustment of children post-parental death highlighted that a child feeling secure and remaining connected with what is familiar are both protective factors in the surviving child's resilience and adaptability (Hope & Hodge, 2006). The "importance of a bereaved child having an emotionally stable home environment" (p. 109) was identified as central to this, as constructive grief

mentorship and role modeling provided by a surviving parent can provide the child with permission to grieve (Hope & Hodge, 2006). Open, transparent, and sensitive dialogue with an adult connected to the deceased can also aid a young child process grief and support reconciliation of the loss (Hope & Hodge, 2006).

Given this knowledge, there are significant implications for a child who has either sole parent or both parents die, including additional strife related to secondary loss (Hope & Hodge, 2006; Wolfelt, 2012) and "place attachment disruptions" (Werner-Lin, Biank, & Rubenstein, 2010, p. 132) if relocated to an alternative care arrangement and separated from his/her familiar context (Appelberg, 1970). As posited by Werner-Lin et al. (2010),

> When the deceased parent was the sole caregiver, as in the case of earlier parental death, divorce, or separation, severed attachments are compounded by the need for children to transition into a new living environment. These children may lose access to their social and relational worlds, including important teachers, community leaders, friends and neighbors . . . These connections would have otherwise supported them after their parent's death. Grief is further complicated by the loss of familiar spaces. (p. 132)

This can be further exacerbated in the absence of formal guardianship alternatives. For instance, if a child is orphaned in British Columbia and is without alternative legal guardianship arrangements, the involvement of child protective services is required, and a child may be placed in a non-familial foster care placement. As detailed in the Child, Family and Community Service Act (1996), "if the child's parent is dead and adequate provision has not been made for the child's care" (§13(j)), this constitutes a protection concern.

This piece of law interacts with two other pieces of legislation: (a) the Infant's Act (1996) and (b) the Family Law Act (1996). The Infant Act articulates that if a child's appointed

guardian is deceased, then a director under the Child, Family and Community Service Act (1996) is appointed as the personal guardian of the child (§51). This has been further reinforced by Section 54 of the Family Law Act:

> If a child's guardian dies, a surviving parent of the child who is not a guardian of that child does not become that child's guardian unless appointed under section 51 *[orders respecting guardianship]* or 53 *[appointment of guardian in case of death].*

Ministry guidelines indicate that a placement plan could include relatives as well as foster care (Government of BC, Ministry of Children and Family Development [MCFD], n.d.), but a "removal" of a child for protection purposes with an MCFD social worker as guardian may be necessary if an appropriate alternative cannot be identified (Child, Family and Community Services Act, 1996, §30).

The protective decisions made under MCFD authority are currently influenced by the following two principles: (a) taking action felt most appropriate to a child's interest and (b) ensuring that plans are the least disruptive to the child (MCFD, n.d.). This said, a broad range of considerations are presented in §4(1) of the Child, Family and Community Services Act (1996), with the child's safety, physical and emotional developmental needs, and the importance of continuity in care all being listed as priorities.

Certainly decision making in a child's best interest is a complicated task. A sensitive evaluation of protection needs (i.e., adequate supervision and care) as well as a motivation to uphold the principles of family unity and continuity (Lauten & Lietz, 2008) would be required in an effort to determine an appropriate placement post parental death. The preferred option, of course, would be for extended family to be available, present as willing, and be assessed by a social worker as appropriate to allow for informal kinship care. This is attractive, in that it

"upholds the sanctity of the family" (Cradock, 2007, p. 23) and affords the child the opportunity

to experience a sense of control, which is also a protective factor with regard to their resilience

(Lauten & Lietz, 2008). Least intrusive and least disruptive principles allow for this to occur in

practice as per the parameters described in Section 8 of the Child, Family, and Community

Services Act (1996).

Fortunately, "in many instances a relative or friend is willing to take over some of the

functions of a parent" (Appelberg, 1970, p. 10), which can allow "the children to retain a sense

of normalcy under adverse circumstances" (Lauten & Lietz, 2008 p. 180). In this case, the

interest of the child protection system would be to develop an interim family placement while

awaiting an official permanency plan. There would still be MCFD involvement, but the children

would not come into care, per se (Burke & Schmidt, 2009).

This said, a placement with a family member may not always be possible to achieve

pending availability. If family is not immediately available for screening, the development of an

alternative care arrangement would then include a removal, which would bring the child into the

care of a foster home. Other children face limitations to the option of family placement as a

result of geography or nationality. Children who live out of region from family may experience

delays in family placement, for instance, and children of immigrants with no biological kin in the

country are unlikely to receive a familiar care placement.

There is also the question of which family arrangements are not perceived as suitable.

Children whose families are known to the system may be assessed as undeserving or as

incapable of the responsibility (Cradock, 2007), or family preservation may be seen as a risk to

the child (Strong-Boag, 2009). This is of particular relevance, as, statistically, the parents of

children already involved with child protection social workers are at a higher risk for death,

specifically parents of children who are overrepresented in the system (Csikai, Herrin, Tang, & Church, 2008).

Death Notification Interventions with Children

Lord and Stewart (2008) explained that a child witnessing the "emotional collapse of their caretaker" (p. 67) can be as disturbing as death itself. They recommended that death notification be delivered by at least two people in the case there were children present, so that children could be removed for the initial notification. They were also very clear that children should not be told prior to having a surviving parent or caregiver present, explaining that children would not only feel upset, but also helpless, without an adult carer for support.

Iserson (1999), Speck (2008), and Wolfelt (2012) all highlighted that children should receive death notification from someone who is known, close, and considered stabilizing. Lord and Stewart (2008) recognized that surviving adults may want the notifier to tell the children or, in other cases, may request that the notifier join them in informing the children. In his pioneer work on death notification, Leash (1994) did not state who specifically should notify children, though he did reference his experience as a clinical social worker in performing this work. He recommended that death notification should occur in a non-distracting environment and that the notifier customize an approach appropriate to the developmental level of the child. He also highlighted the importance of the notifier positioning him- or herself in close proximity to the child and looking at them directly before delivering death notification so that the child can focus and perceive the care being communicated.

Iserson (1999) concurred with Leash's (1994) advice to use age-appropriate language and also encouraged notifiers to use words that would aid children in understanding that death is permanent. He provided further direction for telling children after sudden and unexpected death,

which included advice to tell siblings simultaneously, so that they are in immediate receipt of mutual support and can have their notion of connectedness to family reinforced. In addition, Iserson also reviewed the importance of a child having familiar and stable routines, continuous supportive care, opportunities to dialogue about grief, and of feeing safe, secure, included, heard, and accepted, both with regard to their questions about death and expressions of grief.

Otherwise, the literature on death notification reported on practice with families of unspecified composition or referenced interventions with unnamed relatives of the deceased. Considerations for death notification with children was mostly undocumented, and death notification with children in an ER or immediately following sudden parental death was only mentioned in the works of Iserson (1999), Leash (1994) and Speck (2008). The impact of death notification interventions on the recovery of children was also largely undiscussed.

The impact of death-related interventions on the recovery of surviving adults was very clear in the literature, however, and the social work role in highlighting and advocating for the grief-related support needs of surviving children was also mentioned as central (Auman, 2007). Clinicians engaging in psycho-education about grief processes with survivors, a central tenant of death notification interventions (Kaul, 2001), can build parental knowledge and capacity, enabling them to be informed and empowered to care for their own bereaved children (Werner-Lin & Biank, 2012). The social worker, by "providing a holding environment for whole families, can help parents to facilitate children's grief reactions and, thus, mitigate long term adverse mental health outcomes" (p. 1). In these ways, quality death notification practices with an adult population can have an impact on the surviving children after parental death.

The research acknowledged that grief is a unique and personal experience for all persons (Walijarvi, Weiss, & Weinman, 2010). For this reason, it is likely that no prescriptive or fixed

rules for providing death notification interventions with individuals or families were located, though protocols have been proposed. Iserson (1999) and Leash (1994) provided non-discipline-specific protocols for delivering death notification. Kaul (2001) utilized these models to develop a death notification protocol for ER social workers. Though there were some constants and similarities across these three formalized protocols, there were also some conflictual directives. Alternatively, Lord and Stewart (2008) felt that having a rigid death notification protocol is both unhelpful to notifiers and is received as unsympathetic by survivor groups, and they proposed that a personalized approach may be more cathartic. Despite these differences in opinion about protocols, common principles and themes emerged across all of the literature. These themes, without being prescriptive, can guide best practice in talking to children about death, including notification with children and relatives of the deceased.

Talking to children about death. The most poignant message that emerged on the topic of conversing with children about death was the importance of this dialogue actually occurring. Even the very young can intuit that someone they love is missing (Fearnley, 2010; Iserson, 1999; Wolfelt, 2012), and children can become very anxious if they are not provided with information (Fearnley, 2010; Levine & Kline, 2008) or if they are denied sufficient opportunity to discuss and debrief the information received (Fearnley, 2010).

Dent (2008) explained that for children to accept the reality of loss, they first have to be told of the death. Speck (2008) reinforced this, asserting that "children need immediate and honest answers that allow them to share in the family grief. They need to know the truth" (p. 177). Wolfelt (2012) was confident that "kids can cope with what they know" (p. 86), but cannot be empowered to cope if denied the opportunity of being informed.

Iserson (1999) wrote that children adapt better and do not develop distorted concepts about death when adults are available to children and talk to them about death and their grief. This was reiterated by Lord and Stewart (2008), who also indicated that the "less children are told, the more they will have to fill in the gaps from what they overhear which can lead to significant misconceptions of the truth" (p. 68). Corr (2010b) also cautioned that without accurate information to guide their understanding of such events, children will instead "attempt to develop their own explanations about what is going on and their imagination may be far scarier than the truth" (p. 24). Because young children sometimes believe that their thoughts are causal, they "may feel a sense of culpability for the death" (Wolfelt, 2012, p. 39). Fearnley (2010) concurred, articulating that "without age appropriate support their assumptive world will be confused" (p. 453).

Inclusion in death-related conversations can be a protective factor, allowing for children to reconcile uncertainty by giving them a framework to process the disruption and emotion they perceive (Fearnley, 2010). Social workers who both facilitate honest information sharing with families and support families to process conversations with children can reduce "catastrophic worry" (Levine & Kline, 2008, p. 189) and foster adaptation (Webb, 2008) in surviving children.

Research demonstrated, however, that "younger children do not get the same quantity of information [about death] as older children and are often not included [in conversations] at all" (Fearnley, 2010, p. 453). Corr (2010b) implored adults to accept the responsibility of helping children cope, including the very young, by supporting them to "understand loss and death related events in keeping with what they want to know, what they need to know, and what they are able to understand" (p. 22), which spoke to the value of an age-appropriate approach. Age-appropriate language, descriptions, and answers were also referenced in Leash's work (1994).

Guidelines for death notification. The guidelines discussed in this section were sourced from multiple articles and books and provide a framework to deliver quality death notification. The guidelines do not direct specific tasks of care, but focus on themes such as preparation, timing, communication, supportive interventions, psycho education and parental capacity building, resource counselling and coordinated follow-up, and closure. It is important to mention that these recommendations are not discipline specific, though the social work role is highlighted here. They are also not exclusive to children. This said, considerations for the needs of bereaved children have been included.

Preparation. Gathering accurate data about who died as well as when, where, and how is the foundation for a competent death notification (Lord & Stewart, 2008). Further, in order to adequately manage a family crisis response, the notifier has to be well informed of the context of death (Leash, 1994). After receiving notification after sudden death, families often need to reconstruct the events preceding it (Leash, 1994) and "seek to establish a context through which they can accept their loss. A skilled notifier will be able to supply sufficient information to assist [them build] this loss context" (p. 42).

An additional component of preparation is the assessment (Kaul, 2001). This would include assessment of family make up; family dynamics; home context; distress level of survivors; the skills, internal resources, and psychological stability of survivors; and the availability of additional support persons (Kaul, 2001; Lawson, 2012; Lord & Stewart, 2008; Myer, Lewis, & James, 2013). This is important information for both support planning and crisis management (Leash, 1994). A need for ongoing assessment of grief and crisis responses is also indicated to ensure safety and aid in crisis stabilization (Kaul, 2001).

As a matter of preparation, professionals need to trust themselves (Levine & Kline, 2007). Levine and Kline (2007) reminded staff that death notification and death work interventions are not fixed tasks that can be done right or wrong, per se. Instead, the task is to provide the conditions for the healing transformations to occur. Specific to children, Speck (2005) reminded readers that any attempt to include or speak with children is better than the alternative.

It is important to be grounded prior to performing death notification interventions. Levine and Kline (2007) asserted that "the importance of calmness cannot be overemphasized" (p. 84). They directed practitioners to manage their own reactions and needs first, ensuring they afford enough time for their adrenaline to settle and employ their role skills in such a way that conveys confidence. Staff preparedness (Miller, 2008) and composure (Scott, 2013) are of value, so that the worker's own nervous energy does not intensify the feelings of fear or guilt the survivors may be experiencing (Lord & Stewart, 2008).

Timing. In the case that family arrive while resuscitation efforts are ongoing, the research repeatedly reflected the wishes of families to be provided with updates about the patient's status in timely and regular intervals (Iserson, 1999; Kaul, 2001; Leash, 1994; Merlevede et al., 2004; Von Bloch, 1996; Wells, 1993). Communication about prognosis can be an opportunity for foreshadowing (Iserson, 1999; Kaul, 2001; Leash, 1994; Miller, 2008), can support the family acclimatize to the severity of the situation, and "gradually prepare them for the pronouncement of death" (Wells, 1993, p. 339). When a death is expected or imminent, "anticipatory notification" (Leash, 1994, p. 61) provides the family an opportunity to begin grieving less abruptly. Preparatory grief is an important transition (Leash, 1994). Pre-notification can be facilitated if the medical team provides the social worker with explicit details about the patient's

condition that can be relayed to family (Iserson, 1999; Kaul, 2001; Leash, 1994). This information can also help family discern if it is appropriate to have young children in the room.

With regard to timeliness, it is important to "respond immediately to a child's feelings and questions, whatever they may be, with open, honest answers" (Speck, 2008, p. 184). This responsiveness and timely validation will support children process their stress reactions. Iserson (1999) explained that if answering the questions are too difficult, offer physical comfort, such as a hug. He suggested that this would reassure their primary though possibly unasked question, reassuring them that they will still have physical and emotional support.

Communication. Death notification should not be a monologue (Lord & Stewart, 2008). Instead, the notifier takes an initial leadership role, then follows the lead of the survivor group and responds to their needs (Iserson, 1999; Lord & Stewart, 2008). Statements should be delivered in coordination to the emotional responses of the surviving family (Leash, 1994). In this way, the bereaved family has opportunities to process and prepare, and notification can be delivered in a fashion sensitive to readiness (Leash, 1994).

Choosing language that is comprehensible, avoiding euphemisms, and providing accurate and concrete details about both the context of death and confirmation of death are pivotal in the comprehension and acceptance of a death notification (Harrington & Sprowl, 2011, 2014; Iserson, 1999; Kaul, 2001; Leash, 1994; Parris, 2011; Scott, 2013; Wells, 1993; Wolfelt, 2012). Clear and direct language is of benefit to both adults and children; however, simple and direct communication about death is of critical importance when notifying children or answering children's questions (Leash, 1994). In speaking with children about death, using simple and concrete language and avoiding euphemisms is regarded as necessary practice (Fearnley, 2010; Scott, 2013; Wolfelt, 2012).

Though children may not actually understand the meaning of the words, using language that reflects the truth, such as "dead" and "died" can assist them at least begin to differentiate between other goodbye words such as "gone bye-bye" and "all gone" (Scott, 2013; Wolfelt, 2012). Additionally, using concrete language such as death, died, or dead provides a model for reality-based dialogue, promoting that the family do the same, instead of adopting ambiguous words like gone, lost, and passed, or similar patterns of language avoidance (Fearnley, 2010), all of which can confuse young survivors (Lord & Stewart, 2008).

Children need not only to understand that the patient has died, but also how the patient died so to challenge magical thinking (Wolfelt, 2012), such as "wish fulfillment" (Leash, 1994, p. 139), where a child might assume they caused the death if they recently wished for the adult to go away, leave them alone forever, or die. Informing the child of how the adult died in an age-appropriate fashion may assure them that they in no way caused the death (Leash, 1994) and will likely reduce feelings of guilt or responsibility (Speck, 2008).

Talking to children about death is no easy task, and some professionals are uncomfortable using such direct and concrete language (Fearnley 2010). Regardless, Bremner (as cited in Speck, 2008) implored that "professionals have to have the most courage and the least amount of anxiety about getting it wrong" (p. 185). For social workers working with the parentally bereaved in an emergency department, an emotionally charged and potentially distressing practice context, this may be difficult to achieve.

The pace of conversation should be slowed (Leash, 1994; Scott, 2013). This is, of course, of particular importance when dialoguing with children so to not overload them (Speck, 2008). Answering questions generously is important (Iserson, 1999; Kaul, 2001, Leash, 1994).

Repeating the death notification may be required (Scott, 2013), particularly in sudden, unexpected, and shocking deaths.

To ensure clarity and comprehension, notification should be delivered in the surviving family's first language. For notification to be sensitive and compassionate, Lord and Stewart (2008) stated that "the notifier must speak the same language as the family" (p. 34). This may not always be possible. Formal medical translation services are available, however, and should be engaged (see Iserson, 1999). Iserson (1999) and Lord and Stewart cautioned against using a child as a translator for adults in their family. Iserson articulated that this "inverts family roles" (p. 26) and runs the risk of exposing children to information they do not understand or their adult relatives would prefer them not to hear. Lord and Stewart explained that children "will be traumatized by what he or she is hearing and then will have to face the burden of becoming the notifier for his own family" (p. 69).

Using personal as well as professional skills and emotional as well as intellectual knowledge (Wolfelt, 2012) to communicate compassionate, authentic, and sensitive concern for family members after the death of their loved one is of great importance (Harrington & Sprowl, 2011, 2014; Iserson, 1999; Kaul, 2001; Lord & Stewart, 2008; Miller, 2008; Parris, 2011; Roe, 2012; Scott, 2013). Para-verbal and non-verbal communication aids in this messaging (Iserson, 1999). An **e**mpathetic, kind and respectful approach was presumed to be even more impactful for those who suffered the death of a loved one to a violent cause such as murder (Miller, 2008).

Supportive interventions. Once family are notified, "it is imperative that the notifier provide both psychological and emotional support to survivors" (Leash, 1994, p. 69). Levine and Kline (2007) highlighted that being helpful is about being patient and respectfully following the lead of the bereaved. Sometimes, what the family needs after a death notification is silence (Lord

& Stewart, 2008), or they may require debriefing, "the staging and presentation of details" (Leash, 1994, p. 69), to assist them conceptualize the reality of death.

During or immediately following a notification, practical assistance, such as providing a chair, water, tissue, or telephone, has also been identified as useful (Harrington & Sprowl, 2011, 2014; Kaul, 2001; Wells, 1993). The value of remaining present or available to families for supportive accompaniment after a notification was also named as supportive (Lord & Stewart, 2008; Miller, 2008; Roe, 2012). Levine and Kline (2007) directed adults, whether it be a parent, relative, or professional, to stay with children at all times immediately following a death so to communicate that a helper is both physically and emotionally available, which can enhance feelings of safety. This may mitigate the development of trauma symptoms, for when children feel safe, they can surrender to involuntary sensations and move through them (Levine & Kline, 2007).

Both bereaved adults and children require psychological space to vent (Miller, 2008), and it is important for children to have a chance to express themselves (Iserson, 1999). This said, children need to be provided with permission to feel, as they often behave as they believe is expected of them or mask their grief to protect the adult (Speck, 2008). In order for permission to be fully accepted, families and children need to be reassured that their sensations and experiences are acceptable (Levine & Kline, 2007) and will not be pathologized. All responses to grief are "unique and therefore normal" (Shuurman & Decristofaro, 2010, p. 262), and normalizing or validating statements can be cathartic for this reason. Children, in particular, need to have their expression and behaviour accepted (Iserson, 1999).

Containing anger (Iserson, 1999), crisis management (Kaul, 2001; Leash, 1994), managing shock reactions (Iserson, 1999; Lord & Stewart, 2008), tension relieving and

stabilizing interventions (Kaul, 2001; Leash, 1994; Roe; 2012), and initial bereavement counselling would also occur in response to assessed level of need. All this said, determining what supportive interventions to offer should be family led.

Levine and Kline (2008) reminded readers that trauma is "the antithesis of empowerment" (p. 7). Van der Kolk (as cited in Shuurman & Decristofaro, 2010) elaborated on this, explaining that "people are traumatized more by the feeling of powerlessness than by the actual event" (p. 267). Being actively empowered by choice (Harrington & Sprowl, 2011, 2014), therefore, is a productive counter to mitigate the impact of trauma (Shuurman & Decristofaro, 2010). Assisting families to determine their own support needs and preferences (i.e., knowing more or less details, having an opportunity to meet the nurses and doctors involved in care, viewing of the deceased) is, therefore, indicated.

Psycho-education and enhancing parental capacity. To help prepare families for the emotional, cognitive, and physical pain of bereavement, Kaul (2001) recommended that the social worker discuss typical grief and traumatic stress reactions with remaining family after sudden death. For children, Wolfelt (2012) asserted that a "child's grief journey is particularly vulnerable to the help or lack of help provided by significant adults" (p. 122), and Auman (2007) identified that learning support for surviving parents via psycho-education is a very important tool to enrich the ability of parents to offer this help. Werner-Lin and Biank (2012) explained that many parents "have trouble recognizing symptoms of grief in their children" (p. 19). Teaching parents about the symptoms of grief in children enriches their sensitivity skills and is, therefore, a very tangible, empowering, and protective intervention in the interest of children.

Research consistently identified that a child's adjustment to parental death was related to the surviving parent's functional level (Dent, 2008; Hope & Hodge, 2006; Melhem et al., 2008,

Worden et al., 1999) and ability to actively cope after a death (Werner-Lin & Biank, 2012). As "children depend on surviving caregivers to clarify and validate the reality of death" (Shapiro, Howell, & Kaplow, as cited in Kaplow et al., 2014, p. 43), the surviving parent's ability to healthily engage with their own grief process renders them more adept to responding to their child(ren)'s grief and attending to their developmental needs (Werner-Lin & Biank, 2012).

A parent engaging productively in their own grief process also provides grief mentorship to bereaved children (Hope & Hodge, 2006; Yule, 2008), an example for them, which offers the children the permission to grieve themselves. This mentorship can help facilitate the grief reconciliation process (Kaplow et al., 2014; Yule, 2008). Werner-Lin and Biank (2012) conferred the importance of this parental role, asserting that "the biggest protective factor mediating [adverse outcomes related to] early parental loss is the presence of a involved, supportive, and nurturing parent who models healthy grief and supports the child's emotional expression" (p. 2). Relatedly, Leash (1994) suggested that children should be included in the entire grief process. It is pertinent, however, to ensure parents have an opportunity to grieve independent from their child (Hope & Hodge, 2006) so to ensure that children are not burdened by exposure to grief expressions that frighten them (Levine & Kline, 2007; Speck, 2008; Wolfelt, 2012).

Parents may have reduced capacity following the loss of a partner and "difficulty empathizing with their children early in the course of their own bereavement" (Christ, 2010, p. 185). If the surviving adults are consumed or paralyzed by their own grief, this can be isolating and alienating for children (Wolfelt, 2012). Further, in effort to protect their parents from further pain (Levine & Kline, 2007; Speck, 2008), children may minimize or silence their own grief, and as a result, their need for reassurance can be underestimated (Yule, 2008).

In their research with parentally bereaved children, McClatchey and Wimmer (2012) found that most children expressed worry that they would also lose their surviving caregiver. This theme was found across all ages and sex differences in respondents. Feeling safe and secure with a surviving parent (or other primary caregiver) is pivotal in reducing the post-death anxiety of a bereaved child (Iserson, 1999), and the social worker encouraging this via providing reassurance, mentoring responsiveness, and attentiveness to the child's needs as well as parental capacity building are key. For these reasons, it is also important to ensure surviving parents are adequately supported or resourced, so that they and their children can both have their grief and security needs met.

Resource counselling and follow-up services. Resource counselling for family members about community services is a standard post-notification intervention (for example, Harrington & Sprowl, 2011, 2014; Iserson, 1999). In the case of sudden parental death, the introduction of formal supports can provide adults with an appropriate outlet for their grief and offer children respite from their parents' grief: that is, a space for children to express themselves where they do not have to consider the feelings of others (Walijarvi et al., 2012). For instance, in their study of children and sibling death, Youngblut and Brooten (2013) found that children of every age could recognize their parent's grief and responded in effort to comfort them. In addition, adults who had been younger children (early school years) at the time of their sibling's death recalled feeling responsible for both the death and their parent(s) pain. Older children craved "relief from their parents' grief" (Avelin, as cited in Youngblut & Brooten, 2013, p. 479).

Harrington and Sprowl (2011, 2014) researched how families experienced the post-notification interventions they received following the sudden death of a family member. Bereaved families provided feedback that information about community resources was not

received as helpful "in the initial hours post notification" (Harrington & Sprowl, 2014, p. 60). It was also identified that families did not find the receipt of social work contact information or grief referrals helpful in the hours immediately following the death. With the suddenness of the event, their process priorities were elsewhere, and this information was not perceived as relevant at the time. The suggestion made by the families they interviewed was that "follow-up calls or visits would be potentially more supportive" (p. 60).

The research completed by Parris (2011) reinforced the need for bereavement follow-up services, particularly for those bereaved from sudden and traumatic loss, as they are thought to be more susceptible to complicated grief reactions (Kintzle & Bride, 2010). Merlevede et al. (2004) discovered that "some questions only arose a few days after a traumatic death" (p. 346), as time allowed them to further understand and integrate the event, making follow-up integral in the care of the bereaved relative. Kaul (2001) also spoke to the therapeutic impact of follow-up, both to offer condolences and perform an assessment of coping and additional support needs. Lord and Stewart (2008) directed readers to make a "second day call" (p. 85). Iserson (1999) and Leash (1994) also highlighted the importance of supportive follow-up a few days after a death notification. In addition, Iserson referenced two successful long-term hospital bereavement programs, one that included graduated telephone follow-up care for survivors extending over one year following death and another that included follow-up phone calls and a comprehensive support program available to survivors of sudden death for up to two years.

Similarly, in their research on helpful interventions following a sudden death, Kintzle and Bride (2010) proposed a social work-medical examiner model to offer continuity of care for bereaved families. Using this model, follow-up support after a sudden death is provided by social work at structured and strategic increments: immediately, at 10 days, after 4 to 6 weeks, and then

again at 3 months, post-mortem. The benefits of these extended approaches are not difficult to conjure: receiving attentive and staggered follow-up from a practitioner with whom rapport and intimacy have been established would certainly be validating, useful in considering developing needs, and, hopefully, cathartic. A unique challenge to the likelihood for successful follow-up under these models pertains to families who could not attend the hospital. Merlevede et al. (2004) highlighted that these bereaved relatives would be without any opportunities to contact or connect with those who provided care.

Recommendations for extended follow-up support bring up two practice points worthy of review. First, death notification and related interventions may be most effective if staggered. Immediate crisis management, information updates and preparation for notification, death notification, and related post-mortem interventions would be followed by in-house bereavement and/or trauma processing support and psycho-education. A brief social assessment regarding the availability of social resources prior to the family leaving the emergency department would be completed, and a risk assessment pending mental status and affective stability would be performed on first contact. Extended psycho-education, assessment of ongoing support needs, provision of resources, and referrals would all be deferred and would, instead, occur in the days and possibly weeks post mortem.

Second, in emergency department work, where contact is often "short and single" (Merlevede et al., 2004, p. 342), the quality of service may be limited by time restrictions and the sheer volume of priority referrals. Mayer, Rosenfeld, and Gilbert (2013) went so far as to say that "survivors of sudden death are often neglected by health care professionals who quickly move on to care for their next client" (p. 173). Ideally, this would not occur but, unfortunately, "the needs of current in-patients and families can overshadow those that are no longer in the

department" (Kaul, 2001, p. 113), and follow-up with the families of former patients, now deceased, is often neglected as a result (Kaul, 2001). Also, as staff members typically work shifts in the emergency department, the coordinated follow-up model for bereaved relatives recommended by Mayer et al. would be challenging to operationalize. In addition, follow-up may be of questionable therapeutic value if the practitioner had never met the family in the hours surrounding or following the death of their relative.

Closure. Regardless of whether resource counselling occurs in the immediate hours after a death or if there is an opportunity to deliver staggered follow-up, closing involvement with a bereaved family in a therapeutic manner is of importance. In the research completed by Harrington and Sprowl (2011, 2014), effectively terminating involvement was an area recognized as needing development.

The Clinician's Tool Box

Other best practices for providing death notification have been noted. These include being trauma informed for assessment and interventions, developing both professional and personal competencies for death work, obtaining debriefing and clinical supervision, and engaging in diligent self-care.

Trauma lens. Lord and Stewart (2008) reported that "some family members experience complicated and difficult grieving processes because they cannot dismiss the way their notification of death was handled" (p. 43). Relatedly, McClatchy et al. (2009) advocated that clinicians incorporate a trauma focus into traditional interventions informed by grief theory citing positive outcomes. Lord and Stewart elaborated to explain that "in high-stress situations the neurotransmitter norepinephrine is pumped into the brain, activating the fight, flight or freeze response" (p. 43). This was in line with Levine and Kline's (2008) description that "with trauma,

terror supersedes sadness, and it can be difficult to talk" (p. 161). A child, in fact, "is often left speechless" after a death as "feelings and images cannot be assimilated at once" (p. 160). In order for a child to access their grief, the horror, shock, and excess energy must be accessed and energetically discharged from the body prior to healing being possible (Levine & Kline, 2008).

It is pertinent for practitioners to identify and address trauma reactions promptly, as trauma can interfere with a normal or adaptive grief process (Auman, 2007; Christ, 2010) and can create "long-term problems in adjustment and pathological reactions" (Yule, 2008, p. 191), including disturbances in childhood development (Corr, 2010a). In order to support a child move through the natural grieving process, "the trauma symptoms must be treated before grief symptoms" (Cohen, as cited in Christ, 2010, p. 180). For these compelling reasons, professionals need "to be well versed in assessing and treating trauma symptoms" (McClatchey & Wimmer, 2012, p. 233).

Levine and Kline (2008) recommended that practitioners monitor children's presentations to assess for changes in appearance, posture, and behaviour, as well as aide and guide them to recognize, name, and track their experiences, including "sensations, images, and feelings" (p. 171). He also reminded practitioners that "children need consistent and patient support to release [their] highly charged [energy] and return to a healthy, flexible, and functioning state" (p. 11). While "companioning" (Wolfelt, 2012, p. 61) children in their shock, Wolfelt (2012) encouraged practitioners to engage and connect with them so to keep them in touch with a supportive and caring world. He reminded readers that it is a suitable and appropriate intervention to spend time just being present, with no mandate or fixed plan to talk about the death. He also encouraged that practitioners watch cues and help children contextualize their physiological responses as normal given their emotional pain.

Though trauma is a daunting repercussion of parental loss, the potential impact of trauma informed interventions with parentally bereaved children in the ER is encouraging. Levine and Kline (2007) asserted that "a large factor influencing symptom development is the quality of care the child receives immediately following a fright" (p. 73) and that helping a child discharge traumatic energy is the most efficient trauma prevention. Engaging children in this trauma work can reasonably be within the practice scope of social workers in an emergency department performing brief interventions following a parental death. Though this will not reduce the grief-related pain a child will experience secondary to the loss of a primary attachment figure, these post-mortem interventions may mitigate the development of a trauma reaction.

Development of skills and self-knowledge. The practitioner's ability to provide quality death notification interventions is of paramount importance when working with the bereaved (Fearnley, 2010). However, the quality of these interventions is not exclusive to possessing adequate communication skills, and these are particularly insufficient when intervening with children of families where a parent is dying or has deceased (Fearnley, 2010). Fearnley (2010) acknowledged the challenge of dealing with death and the emotional distress experienced by children, but cautioned that if practitioners perceive themselves to lack skills and are reluctant to engage with children as a result, then parentally bereaved children will be "rendered invisible by avoidance" (p. 457). A need for training programs to develop knowledge and clinical skills as well as "strengthen the professional confidence, disperse stressors, and enhance the [practitioner's] sense of efficacy" (Hamama, 2012, p. 123) was acknowledged as specifically relevant to those who serve children, though obtaining training for death notification and sharing this information with colleagues and peers was noted to be generally empowering (Lord & Stewart, 2008). The importance of personal preparation was also heavily referenced in the

literature as critical to reduce "death anxiety and therefore non-empathetic responses" (Chow, 2013, p. 373).

Considering social workers in emergency departments are frequently exposed to trauma and death, they are confronted with issues of mortality at close proximity, and their own "death anxiety can be easily activated" (Chow, 2013, p. 377). These "existential challenges" (Chan & Tin, 2012, p. 900) paired with the "emotional challenges" secondary to intense survivor emotions (Chow, 2013, p. 374) require a refined level of personal awareness, groundedness, and preparation in order to be proficient at death related social work interventions, on both personal and professional levels. In this regard, "recognizing one's limitations and being able to hand over to a colleague can be an important strength" (Speck, 2008, p. 184). Further, given the use of self in social work practice (Chan & Tin, 2012; Chow, 2013), "a program that enriches emotional competency addressing past unresolved losses, anticipated losses as well as projected self-mortality" (Chow, 2013, p. 376) is recommended to support emotional resilience and enhance social work capacity to serve the bereaved with confident and effective therapeutic interventions.

Debriefing and clinical support. Access to mentorship, supervision, and clinical debriefing was consistently identified in the literature as paramount to the stress reduction, health, well-being, burnout prevention, and growth of practitioners who provide support to the bereaved (Chow, 2013; Hamama, 2012; Scott, 2013). Considering the high emotionality and distress of the client population while performing death work, Christ (2010) identified that "issues of countertransference are high" (p. 185). Also sensitive to this, Speck (2008) implored that "staff support should be a regular part of life on units which deal with trauma since you can never predict which cases will draw you in more than others" (p. 184). It was also recognized that debriefing support from leadership and case consultation from experienced staff enhanced

the quality of therapeutic care delivered to bereaved families (Werner-Lin & Biank, 2012).

Iserson (1999) noted that debriefing is often omitted from after care, however.

Self-care. Lord and Stewart (2008) acknowledged that "death notification is inherently difficult. During the process, it involves emotionally laden multitasking as notifiers impart tragic information, manage reactions within themselves, and monitor the emotional reactions of the survivors" (p. 93). Furthermore, working with children was recognized as particularly trying, as it required the diligent application of sensitivity, creativity, compassion, and intellect (Hamama, 2012).

The value of performing regular self-care was emphasized as critical for the maintenance of practitioner mental health (Chan & Tin, 2012) and for quality assurance. For example, Lord and Stewart (2008) asserted a need for death notifiers to employ healthy coping mechanism, both for their own benefit and that of bereaved families.

Hamama (2012) highlighted that self-care in the workplace can be a challenge at times, identifying that in the complex daily life of social workers, "emotions run high and personal needs go unmet" (p. 113). This said, self-care to allow for stress release and energy recharge was identified as protective against burnout. Burnout, characterized by psychological arousal, emotional, physical, and mental exhaustion, pessimism, decreased performance, and decreased confidence in personal and professional competence (Hamama, 2012), is not then compatible with either workplace satisfaction or excellence. Affecting the worker's capacity to engage, intervene, perform, and support pro-social outcomes (Hamama, 2012), burnout is antithetical to best practice. In contrast, self-care, by virtue that it supports worker resilience, is a fundamental element of strong practice and will "ensure that survivors, in their worst moments, receive the best [that] the notifier can offer" (Lord & Stewart, 2008, p. 19).

Summary and Gap Analysis

The literature was rich with information about parental death as a source of trauma. The readings also detailed the complicating variables related to sudden death, particularly shock. Many general recommendations for quality death notification were available, and clinical suggestions for death work with children and capacity building with surviving caretakers were available to support interventions in a bereaved child's interest. Recommendations for practitioners performing death notification were also located, and clinicians were encouraged to engage in self-exploration, skill development, clinical debriefing, and self-care.

The literature inadequately represented population diversity. Articles were vague in their description of *family*; the idea of family was consistently not defined and composition was rarely specified. No information specific to the death of a parent in a same-sex partnership was sourced. With the exception of one article (Parris, 2011) and three books (Iserson, 1999; Leash, 1994; Lord & Stewart, 2008), culture and religion were also not mentioned in the literature. Iserson (1999) suggested that any standardized protocol would have to be modified for survivors of a non-dominant culture. Leash (1994) recommended that practitioners make efforts to accommodate diverse religious and cultural practices. Lord and Stewart (2008) implored the relevance of cultural and religious diversity in death notification. Despite this, the influence of culture and religion on death conceptualization, customs, and related practice responses after a sudden death were not thoroughly examined.

Outside of actually communicating the news of a death, the literature was brief in detail on other death notification interventions with children. Literature about children being involved in family witnessed CPR or organ donation conversations was not located, and limited literature was available on the topic of children viewing their deceased parent. Aside from the chapter

written by Speck (2008), articles that considered death notification with children who were injured in the same accident or incident that resulted in the parent's death, a circumstance which would certainly have practice implications, was not found.

Though Iverson (1999), Leash (1994), Lord and Stewart (2008), Speck (2005), and Wolfelt (2012) provided some direction on providing death notification to children, there was a shortage of literature to guide death notification practices with this population. Information on the bereavement experiences and adjustment outcomes of children as it related specifically to their experience with death notification interventions could also not be sourced. Given what is known about the risk for children to experience a complicated and traumatic bereavement post-parental loss, the relative dearth of academic information that could inform best practice for death notification with parentally bereaved children is unfortunate.

Chapter 3: Theoretical Framework

The conceptual framework from which this research was informed was an amalgam of ecological systems theory, trauma theory, and crisis theory. Ecological systems theory views individuals in the context of their environment, and as relational beings located in a social and familial system that influences attachment, development, and adaptation (Cox & Paley, 1997). Trauma theory respects that individuals and families may feel as though their sense of personal or collective safety is threatened when they are exposed to overwhelming events and they might experience the event(s) to be destabilizing and traumatic. Crisis theory asserts that they will need time to work through their responses prior to returning to a place of equilibrium. In this discussion, how these frameworks relate to the research on death notification intervention practices with children or with children and a surviving parent post sudden parental death will be explained.

Systems Theory

Bereavement theories have largely centred their analysis on the grief experienced by individuals (Walsh & McGoldrick, 2013, p. 20). A family systems orientation recognizes that "the individual is embedded in a larger matrix of relationships" (Hayslip & Page, 2013, p. 50) and that death has an impact on "the family as a relational system" (Walsh & McGoldrick, 2013, p. 20). This approach appreciates "the social context of bereavement" (Mayer et al., 2013, p. 168), noting that grief is interpersonal in nature (Hayslip & Page, 2013). A systems orientation considers the manner in which a family is organized prior to a loss, what member of the family system is lost, and what role the deceased occupied in the family. These are all relevant with regard to how a family system will receive news of loss, approach the loss, experience their individual and collective grief reactions, engage in adaptive changes pertaining to both

relationship and role functions, and, ultimately, reconcile the death of a loved one. From this

perspective, a bereaved child will benefit when the entire family system is supported (Wolfelt,

2012).

Regardless of the strength of a family system, individuals within families remain

vulnerable to traumatic events and residual trauma effects. Trauma theory recognizes that

individuals experience and reconcile life events in ways that are unique to them.

Trauma Theory

The traditional definition of trauma is informed by the *Diagnostic and Statistical Manual*

of Mental Disorders (American Psychiatric Association, 2013). By the criteria outlined by the

American Psychiatric Association (2013), directly experiencing an event where death occurred

or was threatened, witnessing the death of a close family member or friend and learning of a

family member or close friend dying as a result of a violent or accidental cause are all recognized

as potentially traumatic for children over the age of six adolescents, and adults. The definition of

trauma is similar for children under the age of six except to specify that witnessing the death of a

parent or primary caregiver is especially significant and that learning of a death (secondary to

violence or accident) is considered traumatic only if the death occurred to a parent or to a

primary caregiver.

An alternative definition of trauma highlights injury to the cognitive and assumptive

world, describing trauma as "an event or events that shatter the fundamental, and often

unconscious, beliefs we have about the world and who we are as a person" (Joseph & Murphy,

2014, p. 1099). Trauma theory supports this expanded definition, recognizing that "an event is

traumatic if it is extremely upsetting, at least temporarily overwhelms the individual's internal

resources, and produces lasting psychological symptoms" (Briere & Scott, 2015, p. 10). By this

definition, trauma is a personal and subjective response to any number of significant events.

By both definitions, death notification could certainly be considered a traumatic event.

This has practice implications for social workers who are often "at the interface of traumatic

circumstances" (Joseph & Murphy, 2014, p. 1094), encountering those who have been

traumatized or intervening as a first-line support immediately following traumatic events (Joseph

& Murphy, 2014). This is certainly true of emergency social work practice, where by definition

of the department, social workers regularly, if not exclusively, interact with those in crisis. Crisis

theory further assists in conceptualizing the presentation of the suddenly bereaved and in

informing interventions.

Crisis Theory

Crisis theory relates to systems theory and trauma theory, in that it refers to events that

disrupt and disturb a system's "homeostasis" or "steady state" (Sands, 1983, p. 253). A crisis is

often measured in terms of the impact of an event on a system and death is recognized as an

event that "can disrupt a family's functional equilibrium" (Walsh & McGoldrick, 2013, p. 20).

Sudden death is sufficiently disruptive that it can create a crisis in the family's systemic function,

cause disequilibrium and compromise the application of normal coping strategies (Kaul, 2001).

Notifiers, "having initiated this . . . bear some responsibility for the outcome" (Leash, 1994,

p. 42).

Crisis interventions are brief and time limited, with the goal to support the individual or

system re-establish equilibrium (Sands, 1983, p. 255). This is completed via establishing rapport,

completing assessment of individual and family functioning, managing the immediate situation

and reactions, providing support, ensuring psycho-emotional safety, exploring the meaning

related to the crisis, drawing on past coping strategies, supporting cognitive capacity to engage in

resolution finding, empowering ownership of solution finding, skill building, referring to

resources, and offering continued follow-up (Myer et al., 2013).

Chapter 4: Design and Methodology

The research was completed using an inductive and descriptive research design. It was a cross-sectional study using mixed methods to obtain both quantitative and qualitative data. The design and methodology were chosen to obtain detailed narratives from ER social workers about what they have done when intervening with children after sudden parental death, as well as discover how they perceive their comfort, confidence, and competence with regard to their interventions; learn what knowledge and training informed their practice; contextualize their narrative in their education and work history; and discern what training and support they need to best perform death notification work with children after sudden parental death in the ER.

Sampling and Recruitment

Data were collected from five participants using a non-probability sampling technique. The sample did not include all ER social workers in the Fraser Health Authority (Fraser Health), as criterion sampling was employed and participation was voluntary.

The criteria for participation was that the research participant was a current Fraser Health social worker who worked or had worked in a Fraser Health ER and had experience with death notification interventions with children and/or surviving parents after sudden parental death while working in the ER. Social workers who met the criteria were asked to self-identify if interested in participating in the research.

Recruitment began after the researcher secured approval from the Human Research Ethics Board at the University of the Fraser Valley (Appendix A) and the Fraser Health Research Ethics Board (Appendix B). As per the approved recruitment plan, the social work clinical practice leaders at the acute care hospitals within Fraser Health were provided with an invitation to participate in the research (Appendix C), the letter of informed consent (Appendix D), and the

two certificates of ethics approval to forward to their ER social work team for consideration. Four qualified participants subsequently contacted the researcher expressing an interest in participating.

An amendment approval from the Fraser Health REB allowed the researcher to expand the sample to include current Fraser Health social workers who *formerly* worked as ER social workers and who had experience as per the inclusion criteria. A revised letter of invitation (Appendix E) and a revised consent form (Appendix F) were distributed to all social workers in the region along with an updated approval log from the FH REB (Appendix G). This led to one additional participant being included in the study.

Three other social workers expressed an interest in the project but were excluded from the research after review of their eligibility. Two social workers were excluded as it was determined they did not have experience providing death notification to children in between the ages of 3-12 in the ER after sudden parental death. Another social worker who had extensive experience in performing death notification with children and surviving parents after sudden parental death was also excluded, as it was determined that these interventions did not occur while employed as an ER social worker, nor in the ER setting.

Data Collection and Analysis

Data were collected on five separate occasions. All meetings were held 1:1 to ensure confidentiality and safety. Four meetings occurred face to face and the last was held over the telephone. Two meetings occurred outside of work hours; three occurred while the participant was on shift. The location and time of the research meeting were determined by participants, to ensure their comfort and convenience. The telephone interview was not planned, but proved necessary when traffic issues prevented an in-person meeting.

After obtaining informed consent, a questionnaire (Appendix H) and interview (Appendix I) were used to collect information from each participant. The questionnaire was provided to obtain basic demographic information about research participants. This data was garnered through the use of a forced-response questionnaire. Quantitative and forced-response questions were also used to measure how the participants perceived their personal confidence and competence at delivering death notifications both in general and specifically with a parentally bereaved child population. The questions related to this area of data collection were posed using a Likert scale, with "response categories that proceed[ed] in order from one extreme to the opposite extreme" (Dudley, 2011, p. 98).

The entire questionnaire was completed by the participant in writing and submitted to the researcher prior to commencement of the interview, with the exception of the fifth research encounter. For this meeting, the participant was read the questionnaire over the phone, and the questions were documented on her behalf. Upon completion, each questionnaire was numbered for reference purposes and to protect participant confidentiality.

Qualitative data were obtained by semi-structured 1:1 interviews. Participants were asked open-ended questions about their knowledge base, experiences, and supports, and they were also invited to name what would enhance their clinical competence and confidence. The researcher also inquired into the self-care and wellness-preservation strategies of participants. Participants were provided with as much time as they required or desired to answer these questions.

Interviews were audio recorded with participant consent and transcribed verbatim by the researcher following each participant encounter. The transcribed documents were titled using the number that corresponded to the participant's labeled questionnaire form.

Data obtained with regard to participant demographics, education level, and years of experience were analyzed for central tendencies. These data highlighted personal, professional, and practice details of respondents and provided a context for the anecdotal qualitative reports. The participant self-reports on personal comfort, confidence, and competence of working in the ER with bereaved families and performing death notification were analysed for choice frequency and then summarized to capture how participants rate and perceive themselves.

Qualitative data were analyzed using a thematic analysis to "uncover common patterns in responses as well as the range of differences" (Dudley, 2011, p. 251). Practitioner definitions of the term "death notification" and the specific interventions participants have performed with children after sudden parental death were coded, categorized, and summarized to offer a succinct indication of baseline participant experience performing death notification. Feedback about the frameworks, skills, and attributes participants utilized; how they were trained; what self-care methods they employed; and if they received support at their workplace to aid in their direct practice in this circumstance were also analyzed for trends and discrepancies. What supports exist to assist ER social workers in the maintenance of their well-being and ideas about what training and support they require to enhance their confidence and competence in their death notification interventions were also coded, labeled, grouped, and assessed by theme.

Ethical Considerations

The ethics of this study were approved by the research ethics board at the University of the Fraser Valley on March 9, 2015 (Appendix C) and the Fraser Health Authority on October 6, 2015 (Appendix D). Informed consent was obtained from all participants. To protect confidentiality, completed questionnaires were numbered, not named, as were transcribed interviews. Consent forms were securely stored at the researcher's home office. Audio

recordings were destroyed after transcription. Transcripts were password protected on the

researcher's personal computer. The names of participants were not released to any person or

party.

The emotional safety of participants was considered. Participants were informed they

could take breaks as needed. Reports were not time limited, and each participant was allowed to

take as much time as they required to share their story. At the time of reviewing consent forms,

participants were advised that they had access to free debriefing, counselling, and support via the

Employee and Family Assistance Plan.

Chapter 5: Findings

Participant Demographics

Five participants participated in the study. The five participants were all female health care social workers. Together, they brought 45 years of combined medical social work experience and 37 years of experience specific to the ER. The mean score for participant work experience in the ER was 7.4 years, with a median of 8 years and a mode of 4. Two participants had 5 or less years of experience in the ER, one had in between 6 to 9 years of experience, and two had 10 or more years of experience. Two had left their ER social work position. One remained casual in the ER, and the other had not returned, nor did she feel interested or prepared to do so. Participants brought experience from both community and regional hospitals.

Participants were all university trained. They had an average of 6.9 years of university education, with a median of 7.5 and a mode of 6. All held a Bachelor of Social Work (BSW) degree, and three also had their Master of Social Work (MSW) Degree. Two participants were MSW-level social workers at the time of commencing their ER social work position, and one began and completed her MSW while employed in the ER. Of the master's qualified practitioners, one was also a registered clinical social worker with the BC College of Social Workers. Two BSW-level participants were in the process of obtaining their graduate degree. Three participants began their work in the ER with a BSW, and these three also began their health care career in the emergency department.

All participants had performed death notification interventions with children after sudden parental death in the ER. Three also described having done so across the hospital while working as an ER social worker, often as the sole SW in the facility. All five had performed these

interventions solo and in a team with a physician. Four of the five participants had performed this work on a number of occasions.

Self-Report on Personal Comfort, Confidence, and Perceived Clinical Competence

All participants reported a high level of comfort performing general social work interventions in the ER. They also reported a high degree of personal comfort when working with bereaved families. Four participants felt less comfortable working with parentally bereaved children, however, and only one respondent had the same level of comfort when working with bereaved adults and parentally bereaved children. Not one participant identified as being very comfortable working with children who have had a parent die in the ER, whereas three had previously identified as being very comfortable working with bereaved families in the same setting (Table 1). Those who reported a moderate level of comfort, being either comfortable or somewhat comfortable working with parentally bereaved children in the ER, did not elaborate on their perspective at the time of the questionnaire.

Table 1

Participants' Comfort Level with Death Notification

How comfortable?	Very	Comfortable	Somewhat	Not at all
When performing social work interventions in the ER?	4	1	0	0
When working with bereaved families in the ER?	3	2	0	0
When working with children who have had a parent suddenly die in the ER?	0	2	2	1

One respondent, who reported being both very comfortable in the ER and very comfortable working with bereaved families, identified that she was not at all comfortable

working with children who had had a parent suddenly die. She elaborated: "I'm not comfortable with it. I don't like it. I've never felt good [doing it]. I hate it" (Participant 5). She also reinforced this point throughout her interview stating, "It isn't about being inexperienced, I don't think it has to do with skill. . . . It's just that I don't want to do it. I just don't want to tell them. I would rather do anything else than tell them." Regardless of her limited comfort, this participant realized that her role would require her to do this work:

> I know that with our communication skills and sensitivity training that [social workers]
> are the right ones to do it. . . . I know that the person who does it has to follow through,
> and I know there isn't any other profession who can do that.

Despite this recognition, she reinforced that death notification with children had been very difficult for her and had never gotten easier. She had 10 or more years of experience as an ER social worker.

Most respondents identified being only somewhat confident in their clinical capacity to perform death notification with parentally bereaved children in the ER (Table 2). In contrast, four participants rated themselves as being confident or very confident about their death notification practice with adults. Compared to how they perceived their therapeutic usefulness when dealing with an adult population of bereaved family members, participants also perceived their efficacy to be reduced with parentally bereaved children. The data did not suggest a correlation between years of ER experience and personal comfort, confidence, or perceived competence, nor did it endorse a relationship between level of education and comfort, confidence, or perceived clinical skill.

Table 2

Confidence and Competence in Performing Death Notification Interventions

How confident?	Very	Confident	Somewhat	Not at all
In your ability to perform death notification interventions in the ER?	2	2	1	0
In your ability to perform death notification interventions with children, or with children and a surviving parent, who have had a parent suddenly die in the ER?	0	1	4	0
In your ability to deliver useful therapeutic interventions with bereaved families in the ER?	2	2	1	0
In your ability to deliver effective support to children, or to children and a surviving parent, who have had a parent suddenly die in the ER?	0	3	2	0

Thematic Analysis

Three themes became apparent in the participant reports about their death notification practice with children after sudden parental death in the ER. First, it was evident that the manner in which participants approached their general death notification practice (with adults) was context and circumstance dependent, meaning that their practice was responsive and creative. This theme has been named: A responsive and creative practice. Second, when performing death notification with children after sudden parental death, participants indicated that their practice was similar to their interventions with adults, but contingent on family systems function and was further customized and, therefore, different. This theme is titled: Same but different. Within this theme, three sub themes materialized, related to trends in participant reflection about what held influence on the delivery of death notification interventions with children. These included that

(a) ER social work practice is distinct from medical surgical social work; (b) participants felt inadequately prepared for death notification work upon commencement of their ER social work role and continue to feel ill prepared for death notification interventions with children; and that (c) feeling unprepared has threatened the ability of participants to trust the efficacy of their interventions and, for some, has been a striking and memorable source of moral distress. The third emergent theme was that death notification work in the ER, particularly with children, required that participants use personal as well as professional tools, and the quality of their interventions was related to the care and maintenance of self. This theme has been labelled: The use, grounding, and care of self.

A responsive and creative practice. Participants denied having been academically prepared for death notification work with either child or adult populations. They explained that the theoretical frameworks they utilized to frame their death notification practices were instead chosen because they were intuitive for them and thought to be in line with the ER context. The use of crisis theory, brief strengths-based, and solution-focused interventions predominated participant reports. Grief and loss theory, family systems theory, and trauma informed practice, including an awareness of vicarious trauma, were also guiding frameworks listed by respondents. Two participants also mentioned a need to be aware of child development and developmental psychology.

Despite some differences in theoretical frameworks, the application of theory was described by all practitioners to be circumstantial and non-scripted. This was elaborated on by Participant 4, who shared: "There is not one way, you cannot go step by step. You have to develop the tools and then pick what's going to work per case." This style was reinforced as necessary by two other participants, who explained that a flexible case conceptualization was

useful to ensure responsiveness to situational factors. They explained that unexpected and sudden deaths in the ER "usually involved some kind of trauma" (Participant 1), created crisis, and that this crisis determined and defined the work (Participant 5).

Social work interventions were described as being contingent on context, circumstance, and contributions from other team members. As an example, practitioners explained that notification with adult next of kin (NOK) typically occurred either one of two ways: (a) doctor informed or (b) social worker informed. The doctor informed adult NOK of a patient death with or without other family members or social work present. Social work would then offer reiteration, reinforcement, support, and subsequent notifications with the NOK and extended family after the physician left. Thinking it most appropriate for family to hear death notification from the medical perspective, one participant was committed to adhering to this method of death notification. Despite this, she recognized that "though I am not the first person to tell a family, I am often the first person the family actually hear it from" (Participant 2). This spoke to the impact of process support interventions such as the repetition and reinforcement of the death reality offered by social workers post notification. "Summarizing the information that the medical team has shared is a big part of it because people don't hear it all because they are in shock, the stress and trauma and shock [requires reiteration]" (Participant 2).

The other four participants emphasized that while doctors typically deliver death notification to adult NOK, with or without a social worker present, that they too have performed initial death notification, depending on circumstantial and contextual factors, with physicians joining later to confirm death and answer medical questions. This was named as the second form of death notification practice with adult NOK. Participants felt that social worker NOK notification was sometimes a consequence of competing physician priorities and limited

physician availability, occasionally a bi-product of physician practice style, often in response to family needs and wants, and periodically a result of social work practice values. "It's not my practice to withhold information. . . . When I am asked, my practice is one of honesty" (Participant 1).

Participants used different levels of detail to describe their death notification practice. While there was some variance, the interventions they described were largely consistent.

Four participants spoke to providing anticipatory death notification interventions. Their descriptions included details about gathering information about the health event/accident; determining the severity of suspected injuries; determining and locating family; calling family; receiving family; facilitating family access to private space; providing family with information about the injury or illness; reporting on interventions and patient; suggesting outcomes; providing frequent updates; providing repetition; "acting as a liaison and advocate, getting the Doctor to talk to the family" (Participant 5); negotiating family witnessed CPR or closure opportunities (i.e., bedside visits pre death/while dying) as requested or needed; and reinforcing the gravity of the situation.

The interventions reportedly performed by participants at death or post death were comparable, with the exception being that anticipatory notification was no longer feasible. Participant 2 noted that shock management was more imperative in these cases. She shared that she provided extended reinforcement and repetition when forewarning was not possible:

> I reinforce over and over again . . . particularly if a family hasn't been there. If a family
>
> has been waiting outside or something, they seem to process it a bit faster, but when they
>
> come in cold off the street, it takes some time, so you sit with them for that.

With bedside visitations pre death no longer being an option, practitioners reported negotiating opportunities for family to view the deceased instead.

It was highlighted by all participants that certain interventions were active in either an anticipatory death notification scenario or post-mortem death notification and were ongoing from the commencement of social work involvement until termination had occurred. These interventions included (a) consultation and collaboration with the medical team to obtain medical information, "as much information as possible" (Participant 3), such as details about injuries, concerns, plans, prognosis; (b) establishing a relationship with family; (c) assessment about context; severity; patient demographics; family composition, organization, emotional stability and resourcefulness; safety concerns; family need for information and comprehension level; (d) shock management interventions; (e) practical support, which includes access to family room, chairs, water, orientation to the bathroom, prompting family to tend to basic needs; (f) remaining an empathetic, compassionate, and available connection for family for the duration of their time in the department; (g) the actual confirmation of death (with or without team); (h) grief counselling; (i) systems navigation and resource counselling; and (j) termination.

Additional interventions were reported by some participants to also be available, but only delivered as needed, dependent on family presentation. These included containment of extreme emotional reactions (including boundary setting), crisis management, risk screening, and safety planning.

Despite there being a progressive nature to the notification practices described, four participants clarified that their intervention delivery was not a linear process. Conversely, death notification interventions were led by patient status, practitioner assessment, and family needs.

One participant indicated that her practice was fully responsive to the reactions of the family she was present for: "I walk beside them on the journey, wherever they go, and I let them lead the dance" (Participant 1). Another referred to her family led intervention plan as "insightfulness"—a deliberate act of "gauging" the needs of the family (Participant 4).

Same but different. Participants shared that they had significantly less experience in performing death notification with children after sudden parental death as compared to their death notification experience with adults. Where death notification interventions with an adult population were frequent and almost common in the ER, death notification work with children after sudden parental death was relatively rare. Death notification work with children after parental death was also distinguished from death notification interventions with adults as being more intense, more challenging, and more fraught, in part because of the emotionality surrounding parental death and, in part, as a result of limited experiences equating fewer chances to develop a sense of mastery.

Participants reported that their death notification practice was similar whether working with adults or children and that practice remained responsive to situational and circumstantial factors as well as family system considerations. The intervention differences with children were noted to ones of approach (i.e., age appropriate language); pace (i.e., slower communication, with more time dedicated to these referrals); and priority focus, with an expanded priority on comfort, safety, empowerment, and preparation. These priorities were addressed by (a) rapport building; (b) assisting the child(ren) to feel comfortable in the hospital environment (e.g., clean clothes if relevant, warm blankets, coloring books, comfort toys); (c) offering more choices (e.g., what they want to know and viewing); (d) monitoring the family system process; (e) ensuring the immediate emotional needs of the child(ren) are adequately met; (f) resourcing adults to caregive

for the child(ren); and (g) providing the child(ren) with preparation (i.e., sensory details) related to the milieu, bedside visits, or viewing.

Unique to death notification with children, all five participants highlighted that they were almost always the sole professional providing the death notification interventions with this population. Participants referenced a few cases where an entire family, including the child(ren), were notified at once by the physician and/or social work team, but most participants had experienced notification to occur in stages with adults being notified first, whether by physician, social worker, or both, and children receiving notification after the physician left, whether by parent, social worker, or both. This was a striking practice distinction. Participants perceived the notification work with the children to be their responsibility and a function of their role scope.

All participants reported that interventions with children were determined by the emotional state and support needs of surviving parents, with the social work role being more or less active depending on the coping capacity of the remaining parent. Two participants explained that their priority was to empower surviving adults to notify and support their child(ren). Their interventions were targeted to achieve parent stability and optimize parent function to facilitate family connection and promote family resilience. One stated her rationale for this approach:

> I think that in a devastating circumstance, the child is going to look at the parent to make the world come back together. All the shattered pieces . . . the child looks to their parent to fix it, not you; they aren't looking for you. As benevolent as your intentions are, you are not the best person to comfort that individual. They need the support of their family and their friends and their network. You help facilitate that, and you offer the support you can from your position, but you are never going to make it okay. You have to realize you are not that person. (Participant 3)

The other was clear that her role was time limited and that her job was to be a catalyst for family cohesion:

> We as professionals are only with the family for one small step of a journey. I would most often encourage the parent or a family member that is close to tell the child and coach the family in how to do that. It's my belief that the family and friends will be continuing this work, so I try to get the caring exchanges happening between them. . . . We need to develop that connection between them; that's where the connection needs to be for ongoing relationship. I want them to remember their loved ones as the most supportive people. (Participant 2)

In contrast, Participant 5 referenced cases where a surviving parent would say, "I need you to tell them, I just can't tell my child." She chose not to push back, given their evident desperation, and explained:

> I got better at it, over time, establishing what it was [the parent] wanted. Sometimes they wanted you there as a support to them while they told their child, or sometimes they wanted you for guidance, like giving them the words, but sometimes they wanted you—needed you—to lead.

Participant 4 was also sensitive to the surviving parent's need for respite and did not burden parents with the task of notifying the child(ren) if they demonstrated any overwhelm. With a "focus on the child and getting that child's needs met," she identified her role as open and "doing what's needed to pick up the pieces for the family." Depending on the situation and a family needs assessment, she too had assumed the responsibility of child notification with the surviving parent's consent and continued presence.

Participant 1 reinforced that interventions with children and their surviving parent were situational and had to be responsive to the coping processes of the surviving parent. "You try to find some resilience, something in the parent," she explained, but also acknowledged that sometimes a surviving parent might be temporarily unable to meet the needs of the child(ren). Thinking back to a recent case of maternal death in which the children were both witnesses, she shared:

> Dad was numb. He was in shock and so guilt ridden. . . . He couldn't, I had to. I needed to give the kids care. . . . They were screaming high-pitched screams, begging me to give them one more time, one more time to see their mom alive and talk to her. I held them. . . . I told them a story about the stars and that their mom was the brightest one, and I told them to remember the good times, and I told them to cry when they needed to, and I told them how much their mom loved them.

In light of the surviving father's shock and shut down, her interventions were both functional and compensatory to ensure the bereaved and traumatized children had their comfort and support needs met.

A distinct and isolated practice context. Participants named ER social work practice as being distinct from medical surgical social work and all but one participant offered that they perceived ER social work to be a specialization within acute care practice. The crisis nature of ER was identified to be the striking distinction between ER social work and medical surgical practice, with the nature of referrals, the pace, and the intensity and brevity of involvement noted to be features exclusive to ER. In addition, an investigative quality to assessment, thinking on their feet in the moment, and delivering spontaneous interventions were also noted as unique practice features. Having little to no time to prepare for their intervention responses (including

critical and complex cases such as the sudden death of a parent with young children) was specifically highlighted by all five participants as unparalleled. "In ER there is not time to research your interventions or look at effectiveness [of certain interventions] or what the newest study is on" (Participant 5).

Though all participants received onsite orientation when hired to acute care social work, not one participant felt that she had received specific training, either onsite or at regional training, to manage the pressures and demands of the ER setting. Some participants were hired prior to the development of the Fraser Health core training for social workers and did not attend when implemented. One was not supported to attend from her ER role given operational requirements (i.e., backfilling, staffing difficulties). The participant who did attend reported that there was no session to prepare her for ER social work nor the social work role on death notification. One participant, who had not attended, questioned the relevance of these workshops for ER social workers: "You don't get taught how to work on the fly. There is no core training about figuring it out in the heat of the moment" (Participant 4).

This participant also did not feel that the current administrative and clinical support structure within social work was informed or sensitive about her work reality nor practice considerations. She explained, "I feel like the CPLs [Clinical Practice Leaders] are for medical surgical practice. I don't case consult with them, it's different in ER" (Participant 4).

Participant 4 also felt disconnected from her non-ER social work colleagues. Her sentiment was echoed by three other participants, all of whom felt that medical and surgical social workers did not understand ER social work, which led to feelings of isolation and alienation: "The others try, but they have no idea what it's like to have [grief and pain] as your focus" (Participant 3).

In contrast, Participant 5 spoke to a close relationship with her social work peers that transcended departmental differences. Although she did not feel emotionally or clinically supported by the supervisory structure in her department, she identified that the collegial relationship she had with her peers provided a safety that allowed her to be vulnerable and provided a milieu for honest and invaluable learning exchanges. For her, this rapport with her social work peers contributed to her longevity in the role and was considered a protective factor with regard to her psycho-emotional well-being.

Upon further reflection, three participants speculated that shift work was the real source of isolation from their medical surgical peers, not the differing practice realities among them, and also the barrier to timely and meaningful engagement with clinical supervision. The rotating schedule common with ER social work resulted in ER social workers often being the sole social worker on site, whether it was on the weekend, evening, or overnight shift: "I think we are just so used to doing it alone, there is no one else here, that we don't even think we have any one to call" (Participant 3). This aloneness was identified as a practice challenge by every participant and elaborated on by Participant 5: "I noticed a real difference then. Those were hard days. Not only were you running, covering most of the hospital, but you were dealing with extraordinary cases all on your own." Those who had the opportunity to work in pairs reported increased feelings of camaraderie, security, and emotional safety.

Affirming relationships with like professionals with whom they did not have to explain themselves was specified by four participants as being the most normalizing, validating, and cathartic dynamic for them: "I don't necessarily need to talk about it; [I just need] the solidarity." (Participant 3). Though most participants worked in their ER role solo, four accentuated that the brief contact and overlap they had with their ER social work peers was both meaningful and

constructive for them as well as for their debriefing and reconciliation process. It was also noted by two participants that the connections they made with the ER nurses and doctors, particularly when collaborating on a traumatic and intense cases, were experienced as intimate and remedial.

Inadequately prepared. All participants felt underprepared to perform death notification in the ER, particularly with children. Participant 1 characterized her BSW-level training as "generalist" and denied attending any specific courses on grief or trauma. Though she was able to draw on her previous (non-social work) work experience to guide her in death work, she highlighted that her ER death notification training was purely experiential. Participant 5 felt that her BSW degree prepared her somewhat for death notification interventions, in that she was educated in social work theory, had some practice in assessment, and received some base-level counselling training. She denied having received any formal education on grief, traumatic loss, or related interventions, however, and did not actually realize that death notification would be part of her ER social work role until she was confronted with same.

Participant 2 had a similar experience, having begun her ER role without being cognizant about the possibility of performing death notification. Considering this, she certainly had not had an opportunity to develop any expertise in these interventions. She stated,

It was not part of orientation, not a part of training; there were no courses in that regard. Emerg was my first go at it, and I definitely stumbled though my first few not knowing how to share this information.

Another participant was only minimally aware of the social work role in death notification, having had a brief 4-hour orientation to the ER:

> There was a code [blue], and I followed the social worker into the trauma bay, and the
>
> patient was deceased, and we got in there, and she said, "Are you okay with dead bodies?"
>
> And I remember thinking, "Well, I'm going to have to be, aren't I?" (Participant 4)

Though her orientation exposed her to sudden death in the ER and to some aspects of the social work response, Participant 4 remained largely untrained and unfamiliar with death notification interventions, stating,

> It's not even really talked about, but [the medical team] are saving lives, and you are the
>
> one wrangling the rest together. You are the one making phone calls, you are the one
>
> giving intra-medical updates, you are the one who is the point of contact until the doctor
>
> is free. It's a lot to figure out quickly: who are these people, what do they know, what do
>
> they need to know and what can they handle? How am I going to do this? You just come
>
> up with stuff. . . . It's happening now, so you need to know what to do now.

This participant expressed disappointment about the limited training for ER social workers, especially considering the incredibly difficult nature of death notification work. "I think a lot of onus is placed on ER social workers, and there's not a lot of training or support for that level of responsibility. . . . It's just part of your job, and off you go. I find it appalling," she said.

Having completed her MSW practicum in a hospital, Participant 3 was familiar with facilitating end-of-life dialogue when she began her ER social work role. She recounted that this experience was in an ICU setting, however, and was primarily affiliated with withdrawal-of-care conversations. She distinguished these interventions from ER death notifications and remarked that she had not had practice having end-of-life conversations with children upon commencement of her ER social work position. Overall, Participant 3 felt unready for ER death

notification interventions: "I didn't do my first death notification until I started working on my own. . . . I was phenomenally unprepared. . . . I learnt what not to do."

Unfamiliarity with the demographic (i.e., children) was proposed by two participants to be a source of difficulty in performing death notification with this population, with the assessment of the child(ren) noted to be a specific challenge by one participant:

I'm not an expert on children, I'm not an expert on child development, and I'm certainly not an expert on children and grief, and I didn't ever know how to read their responses. I didn't know if I was saying too much or not enough because I couldn't read them. Because how they respond is different from adults. They don't react the same way . . . or at all sometimes. (Participant 5)

The other participant proposed that social workers do not feel confident working with parentally bereaved children because of inexperience and a lack of knowledge, training, and tools. This sentiment was repeated by Participant 5, who disclosed, "With children, I always felt like I was looking over my shoulder, thinking 'good God, I am not the person that should be doing this, am I'?"

It was further recognized that the death of a young child's parent brings "a sense of immediacy and pressure to the department . . . [and that] a lot of transference happens, with social workers taking that on" (Participant 2). Considering the child's dependence, vulnerability, and evident fear, other participants similarly defined death notification with children to be more loaded and more charged than when working with adult survivors.

Experience in death notification work with adults was suggested to be an informing support for death notification interventions with children. As an example, one participant

described a memorable case where she supported a 9-year-old girl say goodbye to her mother prior to withdrawal of life sustaining interventions:

> I facilitated an opportunity for the daughter to crawl into bed with her mom, to give hugs. It was a hard one, really hard, [but] the benefit of that one was that I had been doing that work for a couple of years by then, and I'd witnessed a wife crawl into bed with her husband while they withdrew care. I never would have thought to have done that, to facilitate contact. (Participant 2)

In addition to drawing on previous experience with adults, her experience base of death notification with children empowered her to trust that the child was old enough to be included and educate the family and assist them to understand the child's needs and process as normal and appropriate.

Relatedly, participants suggested that a lack of experience made the challenging work of death notification work even more daunting, certainly for new health care social workers. Two participants acknowledged that Fraser Health has had difficulties recruiting social workers for the ER, especially in recruiting experienced staff, and also has had difficulty retaining ER social workers. It was the belief of these participants that young or perpetually new staffs are, therefore, being exposed to death notification work without any experience to draw from.

One participant speculated that the feeling of being unprepared contributed to widespread disinterest or avoidance of the ER among the medical social work community and also generated feelings of distress for those who do work in ER, therefore, exhausting them prematurely from the position: "They are so desperate for ER social workers. . . . Retention might improve if people didn't feel like they were out on a limb" (Participant 5).

Am I doing it right? Will I ever know? For four participants, the feeling of being uninformed and unpracticed for death notification with children was identified as having a negative consequence on both the participants' professional sense of security and personal wellness, in part because they were cognizant of the magnitude of the event for the survivor. Participants were aware that they would be delivering life-altering news and would potentially become the face of a child's traumatic memory. This was humbling for them and amplified their desire to be skilled in their notification practice. It was in the not knowing, being unsure if they were delivering quality intervention, where they experienced feelings of insecurity:

> I never had the opportunity to witness someone doing it. Even after seven years of
> practice, I've never seen another social worker [notify] or support, so I have no idea if my
> practice is even correct or appropriate. I just do what I do. . . . It leaves you with
> uncertainty. (Participant 2)

They also identified that when their feelings of uncertainty were exaggerated because of the context of the parental death (i.e., suicide, murder-suicide, overdose in front of child, traumatic death witnessed by child, child making initial efforts to help or get help) they were at greater risk for a confidence crisis and experienced moral distress. As an example, one respondent shared that being uncertain of how to conduct her first death notification with a child caused her significant angst:

> It was a sudden death in the hospital, likely a suicide, and I wasn't seasoned. . . . I
> remember this little girl. I had to tell her that her dad died. Obviously, I didn't tell her
> how, but I had to tell her that he was dead, and he was a relatively young guy, and she
> was really young, like kindergarten or grade one, and I remember feeling like: I have no
> idea what to say to this little girl, and this child is going to remember this moment for the

rest of their life. I didn't want to screw it up. Right? And then how would I know if I had

screwed it up? How would I know if I got it right? I remember walking away from that

experience thinking that this was such a horrific experience for me, I mean of course for

her too, but I wasn't prepared. I didn't have any idea of what I should have done there,

and all the decisions . . . viewing . . . how do we decide? Because they look to us, parents

look to us, but you can never know, you never know for sure. All you can do is try, but

not having any idea of whether I had it right . . . for me, it was one of my first

experiences of extraordinary moral distress. (Participant 5)

It was evident that reflecting on death notification experiences with children remained

emotional and, at times, a source or moral distress for most participants. Memories of the

children and their reactions had clearly been impactful and remained so. One participant spoke to

how death notification with children "leaves a lasting impression" (Participant 1). Another

described her experience of notifying children of parental death as having been "transformative"

(Participant 5). Many commented that they continued to wonder about the children and their

outcomes; if they were getting the help they needed; and, mostly, if they as practitioners had

been appropriate, useful, and/or effective.

All respondents wished to improve their proficiency in death notification with children,

and areas requiring further development were identified. Learning about pediatric cognition and

the capacity of children to comprehend death at various developmental stages was felt necessary.

Having a better understanding of how children grieve and the grief reconciliation process of

children was also desired. One participant determined a need for training in termination with

both adults and children: how to terminate involvement and provide cathartic closure. Another

reasoned that it would be useful to learn from parents who had received notification of their

spouse's death either alongside or separate from their child:

> Was it helpful when we separated you to tell you so you could have space to feel what
>
> you needed to feel . . .? Or, when we told you together, because that's just the situation
>
> we were in, [how was that for you?]. I've always wondered. . . . I don't want one person
>
> to internalize everything and not ask what they might want to ask to protect another . . .
>
> with other family it's different because you want to be surrounded by each other but with
>
> a parent child relationship where you are not equals and one is responsible for the other I
>
> would imagine it's different. Is it kinder to separate? I just don't know enough about that,
>
> what it might be like and what people would want for themselves. (Participant 3)

There was widespread recognition that skill-building opportunities would enhance

confidence and reduce feelings of personal and professional strife, and the value of instituting a

formalized mentorship program was suggested by two participants, "so that it's not a favour, and

[it becomes] a part of practice" (Participant 2). It was suspected that having the opportunity to

dialogue with experienced social workers about death notification interventions with children

would be validating and encouraging: "It would be normalizing to hear from senior social

workers that there is going to be discomfort, maybe always, and to practice from a place of

accepting that as opposed to doubting your skills because you feel that way" (Participant 5).

The use, grounding, and care of "self". All participants considered their personality as

an asset to their professional death notification practice. Whether it was by how they accessed

their personality (i.e., release of self) or how they managed their personality (i.e., restraint of

self), the relationship between self and practice was recognized as having an influence on their

chosen interventions. For some, their personal self was described as being enmeshed with their professional practice:

> I have a hard time even separating the two anymore . . . . What I do for a living is an extension of who I am as a person. Yes, there are parts of myself that I do not share at the workplace, but it's few and far between. For the most part, I am there as my authentic self. (Participant 5)

This sentiment was echoed by others who associated a number of their professional death notification skills with a manifestation of their authentic self and experience base. For instance, personal factors were seen as directly contributing to their suitability for the ER social work role; ability to accept the inevitability of death; capacity to maintain calm in crisis; potential to empathize, relate, develop rapport, and connect with survivors; and their competency to provide for assessed emotional needs.

To this, all respondents named the practice of grounding self and performing self-care as instrumental aspects of their pre- and post-notification practice. Not one participant reported having accessed or received formal clinical debriefing about death notification with either adults or children. The shortage of structural support, paired with the little time available to attend to their own needs throughout the notification journey, resulted in a strong commitment to maintain their own wellness and was highlighted as being essential to their practice.

Grounding acts were described as taking preparatory action for the intense and extended interventions they anticipated: the purposeful act of settling and containing self for the benefit of practice. "Grinding my feet into the ground, taking deep breaths, clearing the mind" (Participant 1), "doing a self-check" (Participant 2), "hollowing myself out . . . so I can go in empty . . . [and] getting a firm hold on myself" (Participant 3), and "being quiet with myself" (Participant 5) were

examples of purposeful efforts made to get ready for survivor emotion and enabled them to offer

care consistent with survivor needs (Participant 4). Increased grounding and self-preparation acts

were endorsed as required by four participants pre death notification work with children after

sudden parental death.

Self-care was defined in relation to the ER, with participants highlighting that the self-

care acts they referenced were more self-preservation acts, such as ensuring hydration and

nutrition in-between referrals, sometimes removing themselves from the overstimulating

environment, offloading stress by stretching, going for a walk, doing something frivolous,

finding humor, and trying to make time to take allocated breaks. A focus on self-care, regardless

of whether it was possible in reality, was referenced as a tenant of responsible death notification

practice. Some participants described having extended self-care needs after deaths that were

"more horrific" (Participant 5), which included the deaths of young parents.

Limitations of the Study

The study was developed with narrow eligibility criteria and, therefore, produced a

limited sample size. Despite being a descriptive study, the data were drawn from a non-

probability sample and, therefore, cannot be considered representative, nor can the findings be

generalized. Other limitations include that all participants were female and Caucasian. Finally, it

is possible that the researcher being internal to the organization of study; the personal qualities of

the researcher (Dudley, 2011), including proximity to the subject material and likeness to

participants; and the chosen research methods may have influenced participation, testimony, and

researcher objectivity.

Researcher internal to the organization where data is situated. Participants were

asked to discuss their education, training, and experience as related to death notification with

children after sudden parental death as well as their educational, mentorship, and support needs. This occurred in dialogue with the researcher, who was also a Fraser Health staff person, ER social worker, and a current or potential colleague. For some, the researcher being internal to the organization may have hindered participation or contribution, as the researcher's relationship to their department or to leadership in their department may have been perceived as a threat to confidentiality.

Researcher proximity to participants and practice context. In reviewing the questions with participants, it became clear that there was an assumption of knowledge, language, or otherwise that the researcher applied while writing the questions. Questions were expanded upon by request to assist participants understand what was being asked of them. Further, while transcribing interviews, the researcher realized that clarity or specificity had not been requested for some replies. It was apparent that the content of responses was familiar to the researcher, based on experience and familiarity with the literature. This practice and research framework may have allowed some statements to go unexplored or assumptions about participant responses to go unchecked. Four research participants noted that they too made assumptions about what the researcher knew. They used terms, expressions, or references without explanation and chose not to elaborate where they might have otherwise, trusting that the researcher was able to reconcile their message based on likeness, shared professional experiences, and familiarity with the topic.

The researcher was cognizant of this dynamic and attempted to approach the research from a place of not knowing, which is critical for a qualitative approach. As Dudley (2011) explained, "The purpose of using qualitative methods is to discover something that is unknown or not well understood by most people" (p. 212). He further implored that "qualitative data collectors are supposed to suspend their own beliefs, perspectives, and predispositions as if

everything were happening for the first time and nothing is taken for granted" (p. 212). Though

the researcher had a genuine intent to learn about the experience of others without comparison or

agenda and was diligent not to interpret stories, her immersion in both the practice context and

research seemingly influenced her ability to "hear" the data without absorbing the narrative in to

her own construct.

Influence of methods on objectivity. The researcher's familiarity with the topic was

informed by both direct practice experience and a thorough review of the academic material.

Given these factors, the researcher was situated quite closely to both the research material and

the research participants. In addition, using qualitative methods required the researcher to build

rapport and relationship, use empathy, and be spontaneous (Dudley, 2011). Interviews were very

collegial and conversational. Presumably, this was as much related to shared researcher-

participant characteristics and the influence of same on relationship (Dudley, 2011) as it was to

the researcher's approach. After all, familiarity with research participants and similarity to them

based on sex, education, and shared roles within the health authority were very real, and it was

not difficult for the researcher to see things from the perspective of participants.

Dudley (2011) clearly warned that "over identification is a state to avoid because of its

threat to the validity of the data" (p. 212). The researcher's method of being subject focused,

paired with proximity to the research topic and those interviewed, may have caused some over

identification. This said, the collegiality may have also fostered an intimacy that allowed for

participants to pursue a deeper connection to the material as well as reflection on the topic. The

researcher trusts that the process was not contaminated.

Reliability certainly would have been increased if a non-health care social worker had

been involved in developing the questions and reviewing the data. It may have even been

preferable to have another party administer the interview, to reduce the likelihood that

interpersonal/interprofessional dynamics held influence on the decision to participate, or not.

This approach may have also helped ensure that collegial aspects to the research and participant

relationships did not interfere with the provision and collection of data or the interpretation of

results.

Chapter 6: Discussion

The purpose of this research was to explore the experiences, interventions, training, and support needs of ER social workers who have provided death notification interventions with children post sudden parental death. Five participant narratives were gathered. The narratives were rich in detail and provided clear evidence of the strength and flexibility of respondents, all of whom had performed death notification interventions with children after sudden parental death without relevant academic or professional training.

Three striking themes emerged in participant reports. First, the death notification interventions of participants were varied and delivered responsively and creatively. Secondly, their death notification practice with children after sudden parental death was both similar and different from their typical interventions with adults. Three important subthemes manifested in dialogue about death notification with children after sudden parental death in the ER. These included that (a) participants typically worked in isolation from other social workers including the social work support structure, as actualized by the clinical supervisor role; (b) participants felt inadequately prepared for their role as death notifiers; and (c) participants experienced angst, self-doubt, and distress not knowing how to best intervene appropriately or effectively with children after such a critical loss. The third theme evidenced was that participants relied on aspects of their personal selves while performing death notification and that grounding and caring for themselves was instrumental to the quality of care they could offer others.

Ultimately, the research findings demonstrated that the death notification interventions of participants paralleled the practices outlined in the academic literature. It was of interest that death notification interventions were conceptualized similarly by all participants, and the interventions they reported performing were largely in line with the guidelines sourced from the literature,

even though not one participant reported having been educated or trained in death notification

practice prior to or since beginning their work in this domain. Interventions with children after

sudden parental death were similar to death notification work with adults, though family system

function became the primary assessment tool to gauge a need for social work involvement and to

determine what interventions were delivered to children. Differences also manifested as stylistic

in nature or as a priority distinction. A composite of base-level training and professional

experience drawn from on-site exposure informed the choices made by participants in death

notification practice with either adult or child populations.

  All participants were aware that the coping capacity of the surviving parent would

influence the child(ren)'s care and adjustment support received. This was certainly supported by

the literature on children's grief reconciliation and mental health post parental death. Two

participants placed emphasis on empowering the family to meet the need of the child(ren)

themselves, and others offset family responsibility in the short interim to allow time for the

adults to regroup. Both approaches are consistent with a crisis intervention model to provide

brief, stabilizing interventions.

  A unique feature of practice verbalized by participants that was not discussed at length in

the literature was the description of responsive, spontaneous, ever-changing, and creative

interventions to support and stabilize the family. The literature on this topic, aside from one

article that presented a protocol for social work death notification interventions in the ER (Kaul,

2001), did not provide a linear or prescriptive guide for social workers providing death

notification. Considering this, the reactive practice solutions of participants supporting families

in crisis does not seem to be out of line. Instead, their practice style reflects compassionate and

sensitive family centred care, which was clearly supported by the academic material on this topic and was also congruent with family systems theory and crisis theory.

The subtheme that arose with regard to the ER as a distinct practice context was not anticipated. No interview questions on this topic were asked; however, this theme was spontaneously raised by participants across four out of the five interviews. This was a passionate issue for most participants, and it was undeniable that they understood their practice to be milieu sensitive. Limited connections to the social work team or clinical support structure was thought to be a result of both their unique context and compatibility issues, which meant that they often worked independently and in isolation from others. It is possible that this isolation and disconnect further contributed to the sense of insecurity regarding practice efficacy.

It was evident that participants were unsure of whether their interventions with parentally bereaved children were sound. This was of concern to them, as they all wanted to be proficient for the benefit of the children receiving their interventions. The lingering doubt was also troubling for them, as they recognized it influenced their well-being and potentially also impaired the quality of their work. The literature endorsed that death notifiers were often untrained (Iserson, 1999; Leash, 1994; Lord & Stewart, 2008; Roe, 2012) and experienced anxiety secondary to this reality (Galbraith et al., 2014; Lord & Stewart, 2008; Von Bloch, 1996). Ironically, the literature also implored that practitioners trust in themselves and their skills when engaged in post-mortem grief and trauma work with children (Levine & Kline, 2007).

Participants employed a personal approach to their death notification interventions. Considering that participants had limited training for this practice, their use of intuition and their purposeful application of personal characteristics to support their interventions were both adaptive and useful. Personhood was not only present, but "the medium through which knowledge, attitudes

and skill [were] conveyed" (Reupert, 2007, p. 107). The successful use of self is dependent largely on self-awareness, however, and requires evaluation and exploration (Reupert, 2007). The limited access or relationship with clinical supervisors who could provide debriefing is, therefore, concerning. The participants, all experienced practitioners, continued to experience self-doubt in their death notification skills and practice choices at the time of the research interviews, and all spoke to a need for education, training, and support to both enhance their sense of efficacy and reduce their moral distress. Certainly, feeling unprepared for this paramount practice is unacceptable, and it is not difficult to appreciate how this could be destabilizing.

In recognizing the active use of personality and other aspects of self while performing death notification work with children, participants also spoke to the importance of being grounded and prepared pre commencement and, in the absence of debriefing opportunities, that is was critical to care for themselves post. The literature clearly articulated a need for practitioners to settle any anxious energy and manage their own reactivity so to be calm (Levine & Kline, 2007), prepared (Miller, 2008), and composed (Scott, 2013) are of value, so that the social worker's own nervous energy does not interfere with his or her interventions or intensify confused survivor feelings (Lord & Stewart, 2008). Self-care has been recognized in the literature as a best practice for social workers performing death work and is critical for both practitioner mental health (Chan & Tin, 2012) and quality assurance (Lord & Stewart, 2008).

Chapter 7: Implications for Practice, Policy, and Future Research

The research was completed with contributions from only five participants, and therefore, the findings cannot be generalized. Despite this, policy, practice, and research issues were raised in participant narratives, and future consideration of these issues would be interesting.

Further attention to the consequences of the exchange between self and practice appears to be required as does the absence of clinical debriefing opportunities. Most participants revealed that their death notification work with children after sudden parental death in the ER remained emotionally and psychologically impactful, and on interview, three participants became tearful, describing cases in which they had previously been involved. It was also proposed by four participants that the sadness they had experienced, witnessed, or absorbed had not been fully released, and in talking about it, they became conscious of the empathetic grief that remained within them. This raises questions about whether there is a relationship between the loaded context of death work with children, the intimate use of self as an instrument of practice, the limited access to timely or meaningful debriefing, and the risk for vicarious trauma. Exploring this theme in clinical supervision, a resource reportedly under accessed by participants, may be pertinent.

The use of supervision could accent, but not replace, ER-relevant and death notification skill building, for which a significant need was also advised. To this, it would appear that education and training opportunities in both theory and skills for death notification work in the ER would be both useful and appreciated. Many participants operated with family systems theory and crisis theory as their theoretical framework, two applied a brief solutions focus to their intervention planning, and two included trauma informed practice as a guiding framework for their case conceptualization. The literature strongly recommended a trauma informed practice

model when working with children exposed to sudden death, particularly the sudden death of a parent. The immediate aftercare children receive after a frightening event is incredibly impactful, and Levine and Kline (2007) asserted that supporting children discharge traumatic energy is both efficient and effective for trauma prevention. Advancing the theory base of ER social workers to ensure that potential death notifiers are trauma informed could be progressive.

Further, despite reporting comprehensive interventions in their death notification practice, participants felt insecure in their skills and had a strong desire for skill-building and practice opportunities. Considering the reported efficacy of trauma informed interventions with children, skill building in this area would likely be empowering for ER social workers performing death notification with children after sudden parental death. This said, any education session where ER social workers could reflect on, discuss, and grow their death notification practice with children might offer an opportunity for ER social workers to feel validated in their practice and would likely increase the confidence of practitioners.

It is worth questioning if the training required to decrease anxiety and enhance confidence and perceived competence is skill based though, as participants' practice reports highlighted skilled interventions. Education may need to be expanded to focus on the exploration of self and on the development of emotional self-competence (Chan & Tin, 2010; Chow, 2013) for the potentially triggering work of death notification with children after sudden parental death.

Developing a policy or guideline for death notification with children may be of interest. During interviews, the five participants spoke to their typical death notification process (with any demographic), and there were no significant contradictions in their feedback. These interventions are represented in Figure 1, which also provides a tentative model for death notification. It would be compelling to test this model and research if this depiction of death notification is

representative of practice for other ER social workers. Certainly, an expanded pool of

participants to test out this model would be necessary.
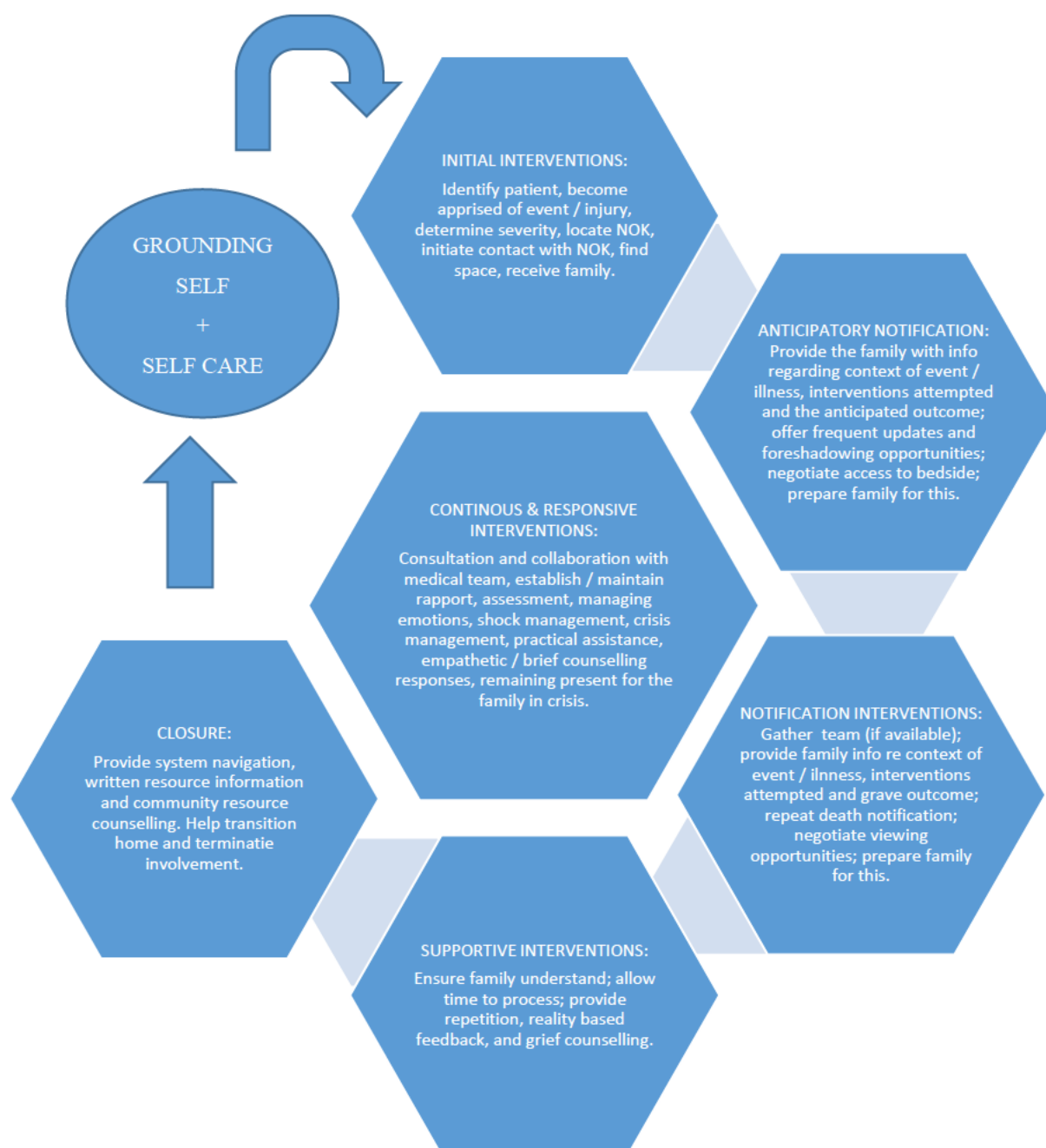
Figure 1. The death notification process as per participants

Considering the limited academic material on death notification work with children and the dearth of literature on death notification with children after sudden parental death in the ER, it would be beneficial to continue and expand research in this area. It would be especially pertinent to examine the relationship between the incidences of traumatic bereavement or PTSD with children as it relates to death notification, as no material on this phenomenon was located, though the possibility of adverse adjustment post sudden parental death and death notification was cautioned. To mitigate risk for future children who might receive death notification, a better understanding within the practice community of children's propensity for trauma after sudden parental death is imperative.

Chapter 8: Conclusion

Sudden death occurs frequently in the emergency department. Parents of young children are not immune. Unexpected death often creates a crisis in the family system, and the death notification, in and of itself, can be a trauma for survivors. Complicating this, young children are developmentally and socially reliant on the care of their parents, and parental death fundamentally disrupts a child's sense of security and safety. Providing informed, sensitive, compassionate, and age-appropriate notification and after care to support comprehension, reconciliation, and adjustment for parentally bereaved children is required.

Social workers in the emergency department are often involved in providing death notification, and the five participants of this research study reported they were often the sole professional responsible for death notification interventions with children. Participant narratives also suggested that their preparedness was incongruent for this responsibility. Despite this, participants self-created their own practice, which, at its core, intriguingly paralleled the guidelines found in the literature as well as one another's independent reports. Participants also described a situational and customized style of intervention with children and families that was evidence of their creativity and flexibility.

Intervening with children after sudden parental death in the ER is a challenging area of social work practice. Increased training, education, and support were requested by participants to enhance their personal confidence and sense of professional efficacy. Participants did not feel particularly connected to the supervisory structure in their department. Considering debriefing is considered a best practice, this is of concern. Collegiality with other social work peers and other disciplines in the ER were identified by respondents to be protective factors. Diligent self-care to maintain personal wellness was recognized by participants as being required.

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Appendix A: Approval from the Human Research Ethics Board at the University of the

Fraser Valley

Certificate of Human Research Ethics Board Approval

Contact Person	Department	Protocol #
Heather Hansen	Social Work	753S-15

Co-investigator(s)		
Leah Douglas; Glen Paddock		

Title of Project
Death Notification with Children After Sudden Parental Loss: The Practice Exeriences, Interventions, Support and Training Needs of Emergency Room Social Workers.

Sponsoring/Funding Agency
N/A

Institution(s) where research will be carried out
University of the Fraser Valley; Fraser Health Authority

Review Date:	Approval Date:	Approval Term:
26-Feb-15	09-Mar-15	09-Mar-15 - 08-Mar-16

Certification:
The protocol describing the above-named project has been reviewed by the UFV Human Research Ethics Board, and the procedures were found to be in compliance with accepted guidelines for ethical research.
Andrea Hughes, Chair, Human Research Ethics Board
NOTE: This Certificate of Approval is valid for the above noted term provided there is no change in the procedures or criteria given.
If the project will go beyond the approval term noted above, an extension of approval must be requested.

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Appendix B: Fraser Health Research Ethics Board Ethics Approval Certificate

Fraser Health Research Ethics Board
FHA, Evaluation and Research Services
#400, 13450 102nd Avenue, Surrey, BC V3T 0H1
Phone: 604.587.4436 Fax: 604.930.5425

CERTIFICATE OF FHREB APPROVALS

Official Notification - FHREB Number *(to be used on all future correspondence)*: **2015-067**

Principal Investigator: HANSEN, Heather

Hospital/Facility & Department: RCH/Allied Health

Institution(s) or Geographical Areas where research will be carried out: ARHCC, BH, LMH, RCH, SMH

Co-Investigator(s): Glen Paddock, Leah Douglas

Funding Agencies and/or Corporate Sponsor: Unfunded

Title: Death Notification With Children After Sudden Parental Death: The Practice Experiences, Interventions, Support And Training Needs Of Emergency Room Social Workers.

Documents Included in this Approval	Date of Approval	Date of Expiry	Type of Approval	Approval of the FHREB
• Application for Initial Ethical Review • Researcher Response, 2015 August 27 • Researcher Response, 2015 September 18 • Protocol, 2015 June *(*The FHREB has determined that the collection of the data elements as described in the protocol/data collection form are justified and required in order to conduct the research)* • Consent Form Version 3.0, 2015 September • Letter of Initial Contact, 2015 June • Questionnaire, 2015 June • Interview Questions, 2015 June	2015 October 06	2016 October 06	Initial Approval; Delegated Review	Digitally signed by sara.oshaughnessy@fraserhealth.ca DN: cn=sara.oshaughnessy@fraserhealth.ca Date: 2015.10.06 09:32:32 -07'00'

CERTIFICATION:

With respect to clinical trials:

1. The membership of the Fraser Health Research Ethics Board complies with the membership requirements for research ethics boards as defined in Part C Division 5 of the Food and Drug Regulations and the Tri-Council Policy Statement.
2. The Fraser Health Research Ethics Board carries out its functions in a manner consistent with Good Clinical Practices.
3. The Fraser Health Research Ethics Board has reviewed and approved the clinical trial protocol and the informed consent form for the trial which is to be conducted by a qualified investigator named at the specified clinical trial site. This approval of the documentation listed above and the views of the Fraser Health Research Ethics Board have been documented in writing.

With respect to delegated review:

A co-chair or delegated member of the FHREB has reviewed and approved the documentation listed above for the forenamed research study in accordance with the FHREB Policy on "Ethical Conduct of Research and Other Studies Involving Human Subjects", the Tri-council Policy Statement: Ethical Conduct for Research Involving Humans", and the "International Conference on Harmonisation Guidance E6: Good Clinical Practice E6: Consolidated Guidelines".

With respect to full board review:

Full FHREB review and approval of the documentation listed above was completed for non-expedited review in accordance with the FHREB Policy on "Ethical Conduct of Research and Other Studies Involving Human Subjects", the Tri-council Policy Statement: Ethical Conduct for Research Involving Humans" and the "International Conference on Harmonisation Guidance E6: Good Clinical Practice E6: Consolidated Guidelines".

The FHREB approval for this study expires ONE year from the approval date of this certificate. Researchers must submit a Request for Annual Renewal for ongoing research studies prior to the expiry date in order to receive annual re-approval.

Appendix C: Invitation to Participate in the Research

Death notification with Children after Sudden Parental Death: The Practice Experiences,

Interventions, Support, and Training Needs of Emergency Room Social Workers.

Principal Investigator: Heather Hansen, RSW BSW BA
                             Emergency Room Social Worker, Royal Columbian Hospital
                             MSW Student, University of the Fraser Valley (UFV)

Co-Investigators: Dr. Glen Paddock, PhD MSW BSW LMFT
                              Dr. Leah Douglas, PhD MSW BSW
                              School of Social Work and Human Services, UFV

Dear colleagues,

My name is Heather and I am conducting research on the knowledge base, practice experiences, training and support needs of current FHA ER social workers who have provided death notification interventions with children who have had a parent suddenly die. This includes death notification practices with children and their surviving parent.

The research is being completed as part of the Master of Social Work program at the University of the Fraser Valley and the data will inform my Master's thesis. My paper will be will be presented to the UFV School of Social Work and Human Services and will be published in the UFV Library. The paper may also be used for publication in professional journals or presented at meetings and conferences for the purposes of social work education and professional development. The research study, including the purpose and methodology, has been reviewed and approved by the Human Research Ethics Board at both the University of the Fraser Valley and the Fraser Health Authority.

You have been invited to participate because you are an Emergency Department Social Worker. If you self-identify as having had experience providing death notification interventions with children who have had a parent suddenly die and/or their family members, you meet the inclusion criteria. ER social workers who have not have experiences with performing death notification with children, are on medical and/or stress leave, are receiving active therapeutic treatment for trauma related distress, or who have not passed their probationary period and therefore do not have access to extended benefits such as the Employee and Family Assistance Plan will be excluded from this study.

Participation is voluntary. Should you choose to participate, you will be asked to complete a questionnaire and engage in an individual interview lasting approximately one hour. With your consent, the interview will be audio recorded. ***The confidentiality of participants will be protected in full.*** If you have any questions or desire further information, please contact me to discuss further.

Sincerely,

Heather Hansen, RSW BSW BA
[email address]
[phone #]

Appendix D: Letter of Informed Consent

LETTER OF INFORMED CONSENT

Death Notification with Children after Sudden Parental Death: The Practice Experiences,

Interventions, Support and Training Needs of Emergency Room Social Workers

Principal Investigator:	Heather Hansen, RSW BSW BA
	Emergency Room Social Worker, Royal Columbian Hospital
	MSW Student, University of the Fraser Valley (UFV)
	▮▮▮▮▮▮▮▮▮▮▮▮▮
Co-Investigators:	Dr. Glen Paddock PhD MSW BSW LMFT
	Dr. Leah Douglas, PhD MSW BSW
	School of Social Work and Human Services
	University of the Fraser Valley
	33844 King Road
	Abbotsford, BC V2S 7M8

Purpose/objectives of the study

Heather Hansen is an ER social worker within the Fraser Health Authority (FHA) and a UFV

MSW student who is researching the knowledge base, practice experiences, and perceived

training and support needs of current FHA ER social workers who have performed death

notification interventions with children who have had a parent suddenly die, or to children and a

surviving parent. This will satisfy Heather's education requirements and will formulate the basis

of Heather's MSW thesis. Once completed, the paper will be available in the UFV library. The

hope is that information from this study will also be used to improve training and support for ER

social workers, and enhance both practitioner well-being and the quality of care delivered to

surviving family members of deceased parents.

Ethics

The ethics of this research project have been reviewed and approved by both the Fraser Health Research Ethics Board and the University of the Fraser Valley Human Research Ethics Boards.

Participant selection

You are being invited to participate in this research because you are an ER social worker and have been identified as a professional who has practice experience with death notification with parentally bereaved children or with children and a surviving parent.

Exclusion criteria

ER social workers who have not had experiences performing death notification with children, are on medical and/or stress leave, are receiving active therapeutic treatment for trauma related distress, or who have not passed their probationary period and therefore do not have access to extended benefits such as the Employee and Family Assistance Plan will be excluded from this study.

Procedures involved in the research

Your demographic information such as age, sex, years of university education, level of social work education training, level of social work education upon commencement of your ER social work role, years of social work experience, years of health care social work experience, and years of ER social work experience, will be acquired by use of a questionnaire. Quantitative methods will also be used to measure how you perceive your personal confidence and competence at delivering death notification to children or to children and a surviving parent. The

remaining research will completed by 1:1 face to face interviews. You will be asked open ended questions about your experiences, knowledge base, training and support needs. The questionnaires and interviews will be administered at a location of your choice. Data will audio recorded and transcribed verbatim, by Heather Hansen, the Principal Investigator.

Potential harms, risks or discomforts to participants

Reflecting on and discussing death work, specifically cases of parental death, may be distressing. Breaks and supportive debriefing will be available as required. The interview can be stopped at any time or rescheduled for a later time. You are also welcome to withdraw from the research process altogether. Please be reminded that you have access to free professional counselling via extended health benefits if you perceive this to be useful or required.

Potential benefits

The information gathered in this research study will highlight the perceived knowledge, skill, and training needs of a sample of ER social workers in the FHA. This information will be presented to the academic institution (UFV) and possibly to the organization (FHA) i.e. the SW Clinical Practice Leaders (CPLs). This may benefit the participants, and possibly future ER social work staff, as your expressed training, development and supervision needs will be available for consideration. The research community will benefit as death notification interventions with children are understudied, and the experiences and self-identified knowledge, skill, and support needs of clinicians will begin a conversation about how to strengthen the practice context and the confidence and competence of those engaged in this area of emergency room social work practice.

<u>Confidentiality</u>

Specific interview reports will not be discussed with any party aside from the primary and co-investigators. Raw data will be coded so that all identifying information will be absent from the report. Original audio recordings will be erased after transcription and no later than December 20th, 2015. Audio and written transcripts of coded data will be stored in my private home office in a locked file cabinet and/or on my private password protected computer. All data will be destroyed using the UFV School of Social Work & Human Services confidential shredder in May of 2021, five years following the completion of my MSW.

Your confidentiality will be respected. However, research records and health or other source records identifying you may be inspected in the presence of the Investigator or his or her designate by representatives of the UFV Human Research Ethics Board and the Fraser Health Research Ethics Board for the purpose of monitoring the research. No information or records that disclose your identity will be published without your consent, nor will any information or records that disclose your identity be removed or released without your consent unless required by law.

You will be assigned a unique study number as a subject in this study. Only this number will be used on any research-related information collected about you during the course of this study, so that your identity [i.e. your name or any other information that could identify you] as a participant in this study will be kept confidential. Information that contains your identity will remain only with the Principal Investigator and/or designate. The list that matches your name to the unique study number that is used on your research-related information will not be removed or released without

your consent unless required by law.

Participation

Your participation is entirely voluntary. Should you choose to participate, your participation will include completion of a questionnaire and interview. The entire process will take approximately two hours of your time. You are free to withdraw at any time without consequences. You are also welcome to abstain from answering some questions and remain a study participant. If you choose to withdraw, any data you have provided will be destroyed unless you indicate otherwise. Your interview will be erased from the audio recorder and the paper transcript will be destroyed in the School of Social Work and Human Services confidential shredder.

Compensation

Please note that there will not be any compensation for participating in this research project.

Study results

The research findings will form the body of Heather's MSW thesis. The paper will be shared with the academic institution (UFV) via submission, in person presentation and/or publishing in the library, with yourself and the other participants as requested, and possibly to the FHA (organization) via presentation to the Clinical Practice Leaders. The research may also be presented at professional conferences, other academic institutions, and/or submitted for publication in professional journals.

Contacts

If you have any questions or desire further information about before or during

participation, you can contact Heather Hansen at ██████████ or

██████████████████████ If you have any concerns about your rights as a research subject

and/or your experiences while participating in this study, contact the Fraser Health Research

Ethics Board co-Chairs by calling 604-587-4681. You may discuss these rights with the co-

chairmen of the Fraser Health REB. You are also welcome to contact Adrienne Chan, Associate

Vice President of Research, Engagement, and Graduate Studies at UFV, (604) 557-4074 or

adrienne.chan@ufv.ca .

CONSENT TO PARTICIPATE

Death Notification with Children after Sudden Parental Death: The Practice Experiences, Interventions, Support and Training Needs of Emergency Room Social Workers.

- I have read the participant information and cannot identify any reasons why I should be excluded from this study.

- I have read the participant information and am consenting to participate in research conducted by Heather Hansen about my knowledge base, experiences, and training and support needs as it relates to death notification with parentally bereaved children and their families in a FHA ER.

- I understand that my participation in this research is voluntary and that I am completely free to refuse to participate or to withdraw from this study at any time without consequence.

- I understand that Heather will maintain strict confidentiality standards and will not discuss my report with my colleagues, supervisor or anyone outside of her research committee.

- I understand that Heather will protect my identity by not using my name or any other identifying information in her documentation, final report or subsequent presentations or publications.

- I understand that the final report will be Heather's graduate paper and will be published in the UFV library, presented on, and may be used in future academic and/or professional events and publications.

- I consent to participating in Heather's research as a voluntary research participant.

Printed Name of Participant   Signature   Date _____

Printed Name of Witness   Signature   Date _____

Printed Name of Principal Investigator   Signature   Date _____

Consent letter, version 3.0, September 2015
FHREB Approved 2015 October 06

Appendix E: Revised Letter of Invitation

Death notification with Children after Sudden Parental Death: The Practice Experiences, Interventions, Support, and Training Needs of Emergency Room Social Workers.

Principal Investigator: Heather Hansen, RSW BSW BA
                                   Emergency Room Social Worker, Royal Columbian Hospital
                                   MSW Student, University of the Fraser Valley (UFV)

Co-Investigators: Dr. Glen Paddock, PhD MSW BSW LMFT
                                   Dr. Leah Douglas, PhD MSW BSW
                                   School of Social Work and Human Services, UFV

Dear colleagues,

My name is Heather and I am conducting research on the knowledge base, practice experiences, training and support needs of FHA social workers who have worked or currently work in ER and who have provided death notification interventions with children who have had a parent suddenly die. This includes death notification practices with children and their surviving parent.

The research is being completed as part of the Master of Social Work program at the University of the Fraser Valley and the data will inform my Master's thesis. My paper will be will be presented to the UFV School of Social Work and Human Services and will be published in the UFV Library. The paper may also be used for publication in professional journals or presented at meetings and conferences for the purposes of social work education and professional development. The research study, including the purpose and methodology, has been reviewed and approved by the Human Research Ethics Board at both the University of the Fraser Valley and the Fraser Health Authority.

You have been invited to participate because you are a social worker within Fraser Health. If you self-identify as having had experience providing death notification interventions

Invitation to Participate, v.2.0, December 2015

with children who have had a parent suddenly die and/or their family members in the ER, you meet the inclusion criteria. Social workers who have not have experiences with performing death notification with children in the ER, are on medical and/or stress leave, are receiving active therapeutic treatment for trauma related distress, or who have not passed their probationary period and therefore do not have access to extended benefits such as the Employee and Family Assistance Plan will be excluded from this study.

Participation is voluntary. Should you choose to participate, you will be asked to complete a questionnaire and engage in an individual interview lasting approximately one hour. With your consent, the interview will be audio recorded. ***The confidentiality of participants will be protected in full.*** If you have any questions or desire further information, please contact me to discuss further.

Sincerely,

Heather Hansen, RSW BSW BA
[email address]
[phone #]

Appendix F: Revised Consent Form

LETTER OF INFORMED CONSENT

Death Notification with Children after Sudden Parental Death: The Practice Experiences,

Interventions, Support and Training Needs of Emergency Room Social Workers

Principal Investigator: Heather Hansen, RSW BSW BA
Emergency Room Social Worker, Royal Columbian Hospital
MSW Student, University of the Fraser Valley (UFV)
████████████████████████

Co-Investigators: Dr. Glen Paddock PhD MSW BSW LMFT
Dr. Leah Douglas, PhD MSW BSW
School of Social Work and Human Services
University of the Fraser Valley
33844 King Road
Abbotsford, BC V2S 7M8

Purpose/objectives of the study

Heather Hansen is an ER social worker within the Fraser Health Authority (FHA) and a UFV

MSW student who is researching the knowledge base, practice experiences, and perceived

training and support needs of FHA social workers who have worked or who currently work in

the ER and have performed death notification interventions with children who have had a parent

suddenly die. This includes death notification interventions with children and a surviving parent.

This will satisfy Heather's education requirements and will formulate the basis of Heather's

MSW thesis. Once completed, the paper will be available in the UFV library. The hope is that

information from this study will also be used to improve training and support for social workers,

and enhance both practitioner well-being and the quality of care delivered to surviving family

members of deceased parents.

Ethics

The ethics of this research project have been reviewed and approved by both the Fraser Health Research Ethics Board and the University of the Fraser Valley Human Research Ethics Boards.

Participant selection

You are being invited to participate in this research because you are a FHA social worker and have been identified as a professional who may have had practice experience with death notification with parentally bereaved children or with children and a surviving parent.

Exclusion criteria

Social workers who have not had experiences performing death notification with children, are on medical and/or stress leave, are receiving active therapeutic treatment for trauma related distress, or who have not passed their probationary period and therefore do not have access to extended benefits such as the Employee and Family Assistance Plan will be excluded from this study.

Procedures involved in the research

Your demographic information such as age, sex, years of university education, level of social work education training, level of social work education upon commencement of your ER social work role, years of social work experience, years of health care social work experience, and years of ER social work experience, will be acquired by use of a questionnaire. Quantitative methods will also be used to measure how you perceive your personal confidence and

competence at delivering death notification to children or to children and a surviving parent. The remaining research will completed by 1:1 face to face interviews. You will be asked open ended questions about your experiences, knowledge base, training and support needs. The questionnaires and interviews will be administered at a location of your choice. Data will audio recorded and transcribed verbatim, by Heather Hansen, the Principal Investigator.

Potential harms, risks or discomforts to participants

Reflecting on and discussing death work, specifically cases of parental death, may be distressing. Breaks and supportive debriefing will be available as required. The interview can be stopped at any time or rescheduled for a later time. You are also welcome to withdraw from the research process altogether. Please be reminded that you have access to free professional counselling via extended health benefits if you perceive this to be useful or required.

Potential benefits

The information gathered in this research study will highlight the perceived knowledge, skill, and training needs of a sample of social workers in the FHA. This information will be presented to the academic institution (UFV) and possibly to the organization (FHA) i.e. the SW Clinical Practice Leaders (CPLs). This may benefit the participants, and possibly future ER social work staff, as your expressed training, development and supervision needs will be available for consideration. The research community will benefit as death notification interventions with children are understudied, and the experiences and self-identified knowledge, skill, and support needs of clinicians will begin a conversation about how to strengthen the practice context and the confidence and competence of those engaged in this area of emergency room social work

practice.

Confidentiality

Specific interview reports will not be discussed with any party aside from the primary and co-investigators. Raw data will be coded so that all identifying information will be absent from the report. Original audio recordings will be erased after transcription and no later than December 20th, 2015. Audio and written transcripts of coded data will be stored in my private home office in a locked file cabinet and/or on my private password protected computer. All data will be destroyed using the UFV School of Social Work & Human Services confidential shredder in May of 2021, five years following the completion of my MSW.

Your confidentiality will be respected. However, research records and health or other source records identifying you may be inspected in the presence of the Investigator or his or her designate by representatives of the UFV Human Research Ethics Board and the Fraser Health Research Ethics Board for the purpose of monitoring the research. No information or records that disclose your identity will be published without your consent, nor will any information or records that disclose your identity be removed or released without your consent unless required by law.

You will be assigned a unique study number as a subject in this study. Only this number will be used on any research-related information collected about you during the course of this study, so that your identity [i.e. your name or any other information that could identify you] as a participant in this study will be kept confidential. Information that contains your identity will remain only with the Principal Investigator and/or designate. The list that matches your name to the unique study

number that is used on your research-related information will not be removed or released without your consent unless required by law.

Participation

Your participation is entirely voluntary. Should you choose to participate, your participation will include completion of a questionnaire and interview. The entire process will take approximately two hours of your time. You are free to withdraw at any time without consequences. You are also welcome to abstain from answering some questions and remain a study participant. If you choose to withdraw, any data you have provided will be destroyed unless you indicate otherwise. Your interview will be erased from the audio recorder and the paper transcript will be destroyed in the School of Social Work and Human Services confidential shredder.

Compensation

Please note that there will not be any compensation for participating in this research project.

Study results

The research findings will form the body of Heather's MSW thesis. The paper will be shared with the academic institution (UFV) via submission, in person presentation and/or publishing in the library, with yourself and the other participants as requested, and possibly to the FHA (organization) via presentation to the Clinical Practice Leaders. The research may also be presented at professional conferences, other academic institutions, and/or submitted for publication in professional journals.

Contacts

If you have any questions or desire further information about before or during

participation, you can contact Heather Hansen at ██████████ or

██████████████████. If you have any concerns about your rights as a research subject

and/or your experiences while participating in this study, contact the Fraser Health Research

Ethics Board co-Chairs by calling 604-587-4681. You may discuss these rights with the co-

chairmen of the Fraser Health REB. You are also welcome to contact Adrienne Chan, Associate

Vice President of Research, Engagement, and Graduate Studies at UFV, (604) 557-4074 or

adrienne.chan@ufv.ca .

Appendix G: Updated Approval Log from the FH REB

CERTIFICATE OF FHREB APPROVALS

Official Notification - FHREB Number *(to be used on all future correspondence)*: **2015-067**				
Principal Investigator: HANSEN, Heather			**Hospital/Facility & Department:** RCH/Allied Health	
Institution(s) or Geographical Areas where research will be carried out: ARHCC, BH, LMH, RCH, SMH				
Co-Investigator(s): Glen Paddock, Leah Douglas				
Funding Agencies and/or Corporate Sponsor: Unfunded				
Title: Death Notification With Children After Sudden Parental Death: The Practice Experiences, Interventions, Support And Training Needs Of Emergency Room Social Workers.				
Documents Included in this Approval	**Date of Approval**	**Date of Expiry**	**Type of Approval**	**Approval of the FHREB**
• Application for Initial Ethical Review • Researcher Response, 2015 August 27 • Researcher Response, 2015 September 18 • Protocol, 2015 June *(*The FHREB has determined that the collection of the data elements as described in the protocol/data collection form are justified and required in order to conduct the research)* • Consent Form Version 3.0, 2015 September • Letter of Initial Contact, 2015 June • Questionnaire, 2015 June • Interview Questions, 2015 June	2015 October 06	2016 October 06	Initial Approval; Delegated Review	Digitally signed by sara.oshaughnessy@fraserhealth.ca DN: cn=sara.oshaughnessy@fraserhealth.ca Date: 2015.10.06 09:32:32 -07'00'
• Amendment Application, 2015 November 30 • Consent Form Version 4.0, 2015 December • Letter of Initial Contact Version 2.0, 2015 December	2015 December 09	2016 October 06	Amendment Approval; Delegated Review	Digitally signed by sara.oshaughnessy @fraserhealth.ca DN: cn=sara.oshaughnessy@fraserhealth.ca Date: 2015.12.09 14:58:03 -08'00'

CERTIFICATION:

With respect to clinical trials:

1. The membership of the Fraser Health Research Ethics Board complies with the membership requirements for research ethics boards as defined in Part C Division 5 of the Food and Drug Regulations and the Tri-Council Policy Statement.
2. The Fraser Health Research Ethics Board carries out its functions in a manner consistent with Good Clinical Practices.
3. The Fraser Health Research Ethics Board has reviewed and approved the clinical trial protocol and the informed consent form for the trial which is to be conducted by a qualified investigator named at the specified clinical trial site. This approval of the documentation listed above and the views of the Fraser Health Research Ethics Board have been documented in writing.

With respect to delegated review:

A co-chair or delegated member of the FHREB has reviewed and approved the documentation listed above for the forenamed research study in accordance with the FHREB Policy on "Ethical Conduct of Research and Other Studies Involving Human Subjects", the Tri-council Policy Statement: Ethical Conduct for Research Involving Humans", and the "International Conference on Harmonisation Guidance E6: Good Clinical Practice E6: Consolidated Guidelines".

With respect to full board review:

Full FHREB review and approval of the documentation listed above was completed for non-expedited review in accordance with the FHREB Policy on "Ethical Conduct of Research and Other Studies Involving Human Subjects", the Tri-council Policy Statement: Ethical Conduct for Research Involving Humans" and the "International Conference on Harmonisation Guidance E6: Good Clinical Practice E6: Consolidated Guidelines".

The FHREB approval for this study expires ONE year from the approval date of this certificate. Researchers must submit a Request for Annual Renewal for ongoing research studies prior to the expiry date in order to receive annual re-approval.

Appendix H: Questionnaire

Death Notification with Children after Sudden Parental Death: The Practice Experiences, Interventions, Support and Training Needs of Emergency Room Social Workers.

Qualifying question

Please circle one answer.

1. Have you been involved in or performed a death notification to parentally bereaved

    children or to children and a surviving parent in the ER?   ☐ YES   ☐ NO

Participant demographics

    Please provide your answers in number form.

2. Age: _____.

3. Sex: _____.

4. Total years of university education: _____.

5. Years of social work experience: _____.

6. Years of health care social work experience: _____.

7. Years of ER social work experience: _____.

8. Level of social work education upon commencement of ER social work role: _____.

9. Current level of social work education: _____.

Self-report on personal comfort and perceived clinical competence

Please circle the answer that best represents your thoughts.

10. How comfortable do you feel when performing social work interventions in the ER?

        NOT AT ALL COMFORTABLE   SOMEWHAT COMFORTABLE

        COMFORTABLE   VERY COMFORTABLE

11. How comfortable do you feel when working with bereaved families in the ER?

      NOT AT ALL COMFORTABLE   SOMEWHAT COMFORTABLE

      COMFORTABLE   VERY COMFORTABLE

12. How comfortable do you feel when working with children who have had a parent suddenly die in the ER?

      NOT AT ALL COMFORTABLE   SOMEWHAT COMFORTABLE

      COMFORTABLE   VERY COMFORTABLE

13. How confident are you in your ability to perform death notification interventions in the ER?

      NOT AT ALL CONFIDENT   SOMEWHAT CONFIDENT

      CONFIDENT   VERY CONFIDENT

14. How confident are you in your ability to perform death notification interventions with children, or with children and a surviving parent, who have had a parent suddenly die in the ER?

      NOT AT ALL CONFIDENT   SOMEWHAT CONFIDENT

      CONFIDENT   VERY CONFIDENT

15. How confident are you in ability to deliver useful therapeutic interventions with bereaved families in the ER?

      NOT AT ALL CONFIDENT   SOMEWHAT CONFIDENT

      CONFIDENT   VERY CONFIDENT

16. How confident are you in your ability to deliver effective support to children, or to children and a surviving parent, who have had a parent suddenly die in the ER?

NOT AT ALL CONFIDENT   SOMEWHAT CONFIDENT

CONFIDENT   VERY CONFIDENT

Thank you for your time and participation. We will now begin our interview.

Sincerely,

Heather Hansen, RSW BSW BA

Appendix I: Interview Questions

Death Notification with Children after Sudden Parental Death: The Practice Experiences,

Interventions, Support and Training Needs of Emergency Room Social Workers.

1. In your experience, what interventions are encompassed by the term "death notification"?

2. What death notification interventions have you performed with children, or to children

    and a surviving parent, who have had a parent suddenly die?

3. What theoretical frameworks guide your interventions?

4. How were you trained to perform these interventions?

5. What professional skills do you draw upon when delivering these interventions?

6. Do you see your personal attributes such as your personality and style as a being a "tool"

    when delivering these interventions?

7. If so, how? What aspects of yourself do you incorporate in to your professional practice?

8. On a personal level, how do you prepare yourself to deliver these interventions?

9. Does this differ from how you prepare yourself on a professional level? If so, in which

    ways does your preparation differ?

10. How do you debrief after performing death notification interventions?

11. What supports do you have within your workplace (environmental, organizational,

    departmental, professional & personal) to assist you perform death notification?

12. What supports do you have within your workplace (environmental, organizational,

    departmental, professional & personal) to assist you maintain personal wellness?

13. How do you care for yourself at work?

14. How do you care for yourself out of work?

15. Please tell me about one (or more) experiences with death notification involving a child and/or a surviving parent that was / were particularly meaningful for you.

16. What information, education, training, mentorship or support would help you develop your personal comfort in performing death notification with children or with children and surviving parents?

17. What information, education, training, mentorship or support would help you develop your professional competence in performing death notification with children or with children and surviving parents?