Behind the Curtain: Guests Suicides in Hotels and Tourist Attractions

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Abstract

There is an unwillingness by managers and owners in the tourism industry to acknowledge that suicides take place on their premises. And this, along with the industry's reluctance to recognise that their guests' emotional baggage is not discarded at the entrance to tourism premises, has limited the exploration of suicides in hotels and attractions as a research topic.

The aim of this paper is to investigate suicides by tourists at hotels and tourist attractions, with the objectives of: (1) exploring the impact of suicides on housekeeping staff, (2) discussing the management's responses to suicides, and (3) investigating whether design changes to the physical and service environment could prevent suicides. Following a literature review of suicides in both hotels and tourism attractions, a postal survey of housekeeping staff, along with in-depth interviews with their managers in two capital cities was undertaken. The paper concludes that, while some changes could be incorporated in the design of facilities, from a human resources perspective there is a clear need to better understand the impact of suicides on staff both directly and indirectly involved, and that more pre and post suicide staff training and support could be provided. However, because of the anonymity provided by tourism facilities, they will always be attractive to those who are intent on committing suicide. The paper concludes by outlining some areas for possible further research, particularly in order to gain a better understanding of the motivation for such acts on tourism premises, and their psychological impact on staff.

Keywords: hotels, tourist attractions, suicides, HR management

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There are about one million suicides in the world each year (Shneidman, 1969). And suicide crosses all ages, demographics, ethnic groups and genders and is committed mainly by people suffering from some form of emotional or mental disorder or stress. Committing or attempting to commit suicide while on a tourism trip, although rare, does happen; for example, between 1997-2003, some 45, mostly younger**,** UK tourists committed suicide while on holiday in Australia (Flicking, 2004).

Suicide is defined as:

> the act of causing one's own death. Suicide may be positive or negative and it may be direct or indirect. Suicide is a positive act when one takes one's own life. Suicide is a negative act when one does not do what is necessary to escape death, such as leaving a burning building. Suicide is direct when one has the intention of causing one's own death, whether as an end to be attained, or as a means to another end, as when a man kills himself to escape condemnation, etc. (MedicineNet.com, 2009)

Although it is difficult to fully understand how suicide can be positive, the term is used in the context of a positive decision, rather than a positive act.

The reasons and signs of behaviour that lead to someone committing suicide are recognised by trained professionals, but these signs can easily escape notice by their family, friends and colleagues who might discount such warnings (Donnelly, 1998). Given this difficulty in detecting suicidal behaviour, even by people close to the person at risk, it is even more difficult for staff at tourist facilities – who barely know their guests – to be aware of such signs and to take preventive action.

Investigating the views of tourism staff and their attitudes to and understanding of suicides is a difficult proposition, because people are, understandably, reluctant to discuss the issue. Although the reasons for suicide have been well researched, there is a scarcity of studies relating to the tourism industry and this is reflected in the limited literature and research discussions on the topic. In one of the few studies that explores suicides by tourists, Gross et al (2007), in a study in New York, revealed that a significant number of suicides by tourists were committed in hotels. Wray et al (2008), in a statistical study of suicides by visitors to Las Vegas, estimated that just visiting the city doubled their risk of suicide compared to visiting other destinations, but could not provide an explanation for this difference.

Given this limited research and understanding, if any, of the relationship between tourism and suicides, the objectives of this paper are to explore suicides from the perspective of housekeeping staff in hotels, their managers' responses to suicides, and to explore if design changes to the physical and service environment could prevent suicides.

Literature Review

The annual international rate of suicides is 16 per 100,000 of the population, some 1.8 percent of all deaths globally (Suicide.org, 2009). However, the worldwide suicide rate over the past 45 years has increased by some 60 percent and no definitive explanation has been accepted for this increase. While there are no empirical explanations for the rise in suicide rates, the highest rates are in industrialized countries, including most of Europe and the former Soviet Union and in countries such as Japan, South Korea, Australia and New Zealand (Suicide.org, 2009). There also appears to be a superficial correlation between the popularity of tourism destinations and suicides, although this link is difficult to confirm (UNWTO, 2009).

The World Health Organisation (WHO) (2009) suggests that in Europe and North America, mental disorder and depression, as well as alcohol misuse, are the major factors in people committing suicide, while in Asian countries, Australia and New Zealand, people tend to commit suicide on impulse. They also suggest that the prevention of suicide has not received sufficient attention, either from those who build tourism facilities or from the medical community.

An Australian study expressed concern that reporting on suicides might actually lead to an increase in copycat suicides and so glorify the suicide location, especially when, for example, a famous person committed suicide at a hotel (Pirkis et al, 2006). The major difficulty in trying to understand suicides from a tourism industry perspective centres on the unreliability of data in the reporting of suicides, the unwillingness of managers to acknowledge that such acts take place, and the managers' reluctance to recognise that the emotional baggage of their guests is not discarded at the entrance to their premises.

In terms of where suicides take place, well-known tourist attractions (Table 1) are favoured locations, and in contrast to the lack of data on suicides in hotels, there are some data on suicides at tourism attractions. This may be due to the public nature of such places, which makes it is difficult for the owners to hide any negative publicity.

Table 1 The Ten Most Popular Tourist Attractions Suicide Destinations

Name	Location	Total Suicides	Suicides Per Year (approx.)	Comments
Aokigahara	Mount Fuji, Japan	Countless	70	The local railway station has a room where the bodies are kept.
Golden Gate Bridge	San Francisco, CA, USA.	1,500	30	Has been described as having a "fatal grandeur".
Niagara Falls	Ontario Canada / New York border	2,780	23	41 percent of jumpers are female – very high.
Beachy Head	East Sussex, UK.	500	20	See Tom Hunt's book 'Cliffs of Despair'.
Clifton Bridge	River Avon, Bristol, UK.	1,000+	4	The low number is a result of barriers to reduce access.
Prince Edward Viaduct	Toronto, Ontario, Canada	400+		Suicides have been prevented since the installation of an anti-suicide barrier in 2003.
Coronado Bridge	San Diego, California, USA.	200+		Reflects suicides from 1972-00.
Eiffel Tower	Paris, France	350– 400		
Aurora Bridge	Seattle, USA	230	10	
Jacques Cartier Bridge	Montreal, Canada	143	10	Suicide barrier added in 2004.

Source: RetardZone, 2009

Although the data does not distinguish between suicide by locals and tourists, nor clarify what attracts people to commit suicide at such places, some possible reasons may include: ease of access, previous press coverage (copycat) and the need to shock the public.

The Department of Health in the UK (2002) has suggested measures to prevent suicides, e.g. identifying hotspots such as railways, bridges and tourist landmarks. Although the study did not focus on particular locations, it did reveal the need for more specific locational data. In a study of suicides at the Clifton Suspension Bridge in Bristol, England, research identified (Nowers and Grunnell, 1996) some 127 suicide attempts made by jumping between 1974 and 1993, with April and August the most popular months, which also happen to coincide with Easter and summer holidays, the two main periods for tourism in the region (Table 2).

Table 2 Statistics of Suicides by month from the Clifton Suspension Bridge 1974-93

Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec
11	7	10	14	8	7	10	18	10	12	10	9

Source: Nowers and Grunnell, 1996.

Literature is as scarce for suicides in hotels as it is for landmarks/attractions. A study by Gross et al, (2007) examined the records of the Office of the Chief Medical Examiner in New York City and concluded that only five percent of suicides in that city between 1990 and 2004 were by non-residents (407), whereas 7,227 (95%) were committed by residents. Of the non-residents, 37 percent committed suicide by falling, 15 percent by hanging/suffocation/asphyxia, 14 percent used a firearm, 10 percent overdosed on illicit drugs, prescription-type drugs or alcohol, with nine percent as a result of throwing themselves in front of a moving train.

This study also found that 60 percent of non-resident suicides occurred in hotels and 26 percent in outside locations such as parks and bridges. This differs from residents of the city, where 75 percent of suicides were committed at home, 16 percent in another location and eight percent in an outside setting (Gross et al, 2007). This study raises the question of the duty of care for hotel guests. This concern is not new, as O'Gorman (2010) suggests that caring for guests can be traced back to the origins of hospitality, and the close relationship between hospitality and hospitals. He also highlights the fact that, throughout the history of hospitality, there is a strong tradition and even an obligation that guests who are ill should be cared by their hosts.

Hanzlick et al (1990) investigated jumpers from high-rise hotels and concluded that most of the jumpers were local residents who were not registered at the hotel and who jumped from the highest possible floor, while registered guests jumped from the floor of their room.

While the literature on suicides and tourism is not extensive, there are a number of issues from a Human Resource Management (HRM) perspective that may affect our understanding of staff reaction to suicides:

1. We are seeing much more flexibility in the workforce, with staff taking on a much wider range of functions, and this may lead to more uncertainty and stress, and confusion about action required when difficulties arise.
2. There is also a dark side to the hospitality sector as outlined by Baum (2006), long hours, low pay, high staff turnover, deskilling of staff. This raises the question, whether this results in uncaring staff? There are a number of factors that directly increases the stress by an employee — workload, physical environment, ability to control their workload, support arrangements (Heitmann & Roberts, 2009).
3. There is also a lack of training in helping low skilled staff, such as housekeeping staff, better understand guest behaviour, and spotting problems before they occur. This has been highlighted as a concern, and along with high staff turnover in low skilled functions, suggests that staff tend not to look for guest problems, as they just want to get on with their job (Cole, 2002).
4. The HRM literature also suggests that low skilled staff assume that it is the managers and front of office staff role to identify guests with problems (Armstrong, 2003). Robertson (2009) suggests that there is a major lack of understanding as to who is responsible for identifying guests with problems that may result in suicide.

The research problem that this paper attempts to address is not about the motivation for people committing suicides in hotels, but rather to gain a better understanding of the impact of suicides on those likely to first come across the body, namely the housekeeping staff and the managerial responses to dealing with suicides from both an operational and staff management/HRM perspective. In order to gain a better understanding of these issues, explorative research was undertaken with both housekeeping staff and the hotel managers. The reason for selecting hotels is that as suggested by Gross et al (2007), that hotel bedrooms because of the privacy they provide, present the most popular tourist setting for suicides.

Research Methodology

The limited availability of data on suicides in hotels is probably due to the unwillingness of owners and managers to acknowledge that such acts take place, which is a form of self-censorship (Fathers for Life, 2002). This makes it difficult to develop a robust statistical sampling frame. The unknown distribution of suicides in different types of tourism premises, the relationship between suicides at home and at tourism destinations, as well as the differing methods used to commit suicide, restricts the generalisation of conclusions from this research.

Given the sensitive nature of the topic, initial contact was through hotel managers known personally to the researcher and this restriction in the sampling is recognised as a limitation. Initially the managers of 15, three and four-star hotels in two capital city regions were approached informally, either by casual conversations or by telephone to assess whether they were amenable, in principle, to supporting this research; all agreed. The hotel managers were sent a letter outlining the aims of the study, providing an absolute assurance of confidentiality, and asking if they would permit their housekeeping staff to be interviewed. Initially, face-to-face interviews were planned with the housekeeping staff, but on the advice of the managers, it decided instead to distribute a short questionnaire to the relevant staff.

The 15 hotels (10 chain and five independent) employed 153 housekeeping staff in total. The managers spoke to their head of housekeeping to ascertain their willingness to distribute the short surveys to their staff and 14 agreed to ask volunteers to take part in the study. In all, 141 questionnaires were distributed by the heads of housekeeping, of which 63 were returned, in confidence, to the managers, who then returned them to the researcher **(**45% response rate). Before distributing the survey, two of the managers reviewed the questions and minor modifications were made to some of the questions. Given the lack of control in the distribution of the questionnaire and the unknown quality of information provided by the heads of housekeeping to their staff, it is acknowledged that there may be a concern over the information provided by the housekeeping staff.

Fourteen questions were asked in the survey, which used a five-point Likert Scale to gather the data. This method was selected because it provided the quickest means to obtain answers on a subject that the participants were likely to feel uncomfortable about. Nor did they want to be identified (simplypsychology, 2010). The questionnaires were designed so that there was no possibility that the participants/hotel could be identified.

The managers were interviewed using in-depth, face-to-face, semi-structured questions. They were interviewed after the housekeeping questionnaires were distributed. The results of the questionnaires completed by their staff were not discussed with the managers, although an analysis of the full survey of all the study respondents was made available to them at the end of the study. Cooper & Schlinder (2003) suggest that, when using explorative research, a point is reached when increasing sample size does not add to the quality of the data. The 15 interviews with hotel

managers reached such a saturation point after about 10 interviews, and this was arrived at when the findings from earlier interviews were repeated with little new added information. These interviews were analysed using an informal approach; each interview was broken into broad categories and then grouped by theme, which assisted in the identification of research issues. Perakyla (2005) suggests that this approach is suitable in a research design where qualitative text provides a complementary role to quantitative data.

Research Results

Table 3 Hotel Housekeeping Staff Questionnaire

	Chain Hotels (nine hotels, with 810 bedrooms)		Independent Hotels (five hotels with 260 bedrooms)	
	# of Responses /# returned	Mean Response Score (1=strongly disagree, 5= strongly agree)	# of Responses /# returned	Mean Response Score (1=strongly disagree, 5= strongly agree)
Q1 The type of hotel	45/45	n/a	18/18	n/a
Q2 Number of years worked at this hotel	45/45	3.3 years	18/18	4.1 years
Q3 Number of suicides at this hotel in past five years	41/45	3 suicides	16/18	1 suicide
Q4 The number of suicides at all the other hotels they had worked in, (excluding the above)	41/45	8 suicides	16/18	3 suicides
Q5 Involved in some capacity in handling any suicide	7/45	n/a	4/18	n/a
Q6 Hotel tries to avoid any publicity with suicides	43/45	4.3	17/18	4.4
Q7 Hotel has formal procedures for handling suicides	38/45	3.9	13/18	2.8
Q8 Staff instructed to contact HQ straight away	41/45	4.6	n/a	n/a
Q9 Duty manager is responsible for contacting the local police	41/45	4.1	17/18	4.5
Q10 Staff restricted from contacting the media	37/45	4.3	15/18	4.4
Q11 Staff restricted from speaking to either other staff or guests	37/45	1.7	16/18	1.6
Q12 Management does not speak to media	41/45	4.5	16/18	2.7
Q13 Design measures in place to prevent suicides.	38/45	1.6	9/18	1.4
Q14: Counselling available for staff	44/45	4.8	18/18	4.5

Most of the hotel staff had worked at the same hotel for between 3-4 years (Q2); a few had direct experience of suicides (Q3/4), but they had been aware of 15 suicides in total from working in hotels, with four at their current hotel over the previous five years.

Given the low incidence of suicides, it is surprising that 11 out of the 63 responses (Q5) indicated that they had been involved in some capacity in handling suicides; but this could be due to several members of staff being involved in the same incident, for example by supporting their colleagues, both emotional and physically. There was, however, strong agreement that both types of hotels tried to avoid any publicity (Q6).

Given that two very different types of hotels were surveyed (chain and independent hotels), it is not surprising that the housekeeping staff had different responses when asked about their awareness of formal procedures for handling suicides (Q7). The chain hotels' housekeeping staff were much more aware of their hotel's formal written policies, whilst the independent hotels' staff were less aware. They thought that such policies existed, but were less sure not only of their existence, but also their content. The chain hotels' staff were very much aware of the need to contact their headquarters as soon as possible (Q8).

There was strong agreement by all staff that the duty manager (and not themselves) had the responsibility to contact the police. This applied more to the staff in the independent hotels (Q9) and there was strong agreement that they were restricted in contacting the media (Q10).

Given the possible negative impact of suicide on the staff's wellbeing, it is surprising that those who completed the survey were not restricted from speaking to their colleagues and guests (Q11). On reflection, this question could have been better worded, separating speaking to other staff and speaking to guests. The staff welcomed this lack of restriction in talking to colleagues because it helped them to manage the stress. If asked by guests, they were able to say that they could not comment. It is difficult to know the degree to which this happened in practice and it may have been subject to self-censorship by the staff. In terms of the management speaking to media, the staff at the independent hotels thought it is more likely that their managers were freer to speak to the media, while this issue tended to handled by the headquarters of chain hotels (Q12). Staff knew and respected the limitations on management speaking to the media.

As far as design was concerned (Q13), the staff at both the chain and the independent hotels felt that design was not used to prevent such activities, but there must be a question about the ability of the staff to answer properly this question. Almost all the staff agreed that the management provided counselling support (Q14), although the extent to which this was taken up and its effectiveness are not known.

The results from the hotel managers' interviews suggested that they all had formal management procedures for dealing with suicides, but a number were unclear as to how such policies were communicated to their staff. Where staff had been informed, it was usually just 'call the duty manager, and don't touch anything'. All the hotel-chain managers had a formal policy of immediately informing their HQ, while the independent hotel managers felt that as suicides happen so infrequently 'somehow we will manage'. However, a number of them did say that they had/will use their network of professional colleagues for help/advice, as well as their trade associations. All the managers observed a strong, if unwritten, policy of trying to minimise any negative publicly, a form of self-censorship.

Although the chain hotels had formal written procedures for dealing with suicides in their staff manual, in some cases the section providing details of required action was included in a confidential appendix, available only to the head of housekeeping. In one case, it was referred to as 'the black book, which no one spoke about'! The independent hotels tended to cover this aspect in the first day of training for new staff, but it was seldom mentioned after that, while in chain hotels it was occasionally revisited in the regular staff meetings.

Although the focus of this study was suicides, other deaths occur in hotels and, when pressed as to how housekeeping staff could tell the difference, if any, from suicides, the most common response was 'they can tell'. Examples of differences included: finding the body in the bed, rather than lying on top, the body was usually in the bedroom, not in the hotel's public areas. Procedural differences between suicide and non-suicide deaths appeared to concentrate on the official handling of body and the emotional impact on staff.

From a HRM perspective, it is surprising that there was no formal training for either front-of-house or housekeeping staff to enable them to identify potential suicides among their guests. However, the managers acknowledged that the following indications were worrying signs: male travelling alone; the length of stay was very short (one night) and the lead-in time was also short (one to two days); the guests paid in cash or settled the bill the night before; they did not use room service; had no or very little luggage; did not make any telephone calls from the room; and asked staff to post letters in the morning. There was no consensus as to suicide notes; sometimes these were left and sometimes not, but the police took them away. In recent years, such notes tended to be left on the guest's laptop.

All the hotels indicated that their HRM departments provided support for all the staff affected by suicides, not just those who found the body. This included counselling and in many of the hotel chains, one week's paid special leave. A number of hotels HRM departments had also made contact with the local church to seek help, and some went so far as to organise a service for the deceased when no relatives could be traced, to which staff were invited. When the funeral was organised by relatives, none of the managers attended the funeral, but most sent flowers. None of the managers said they had lost any staff because of suicides, but their HRM staff did monitor staff behaviour. They also acknowledged that some staff did get informal support from other staff. For example, when first back at work, they asked other staff members to first open the bedroom door where a suicide had occurred, but this wariness normally did not last long.

Managers expressed concern about staff reading notes left in the room, as well as having access to messages on laptops. All said it was natural to read such messages, but all had a strict policy that staff should not communicate its contents to other staff or to the media. Contacting/speaking to the friends/relatives of the deceased was also discouraged, but this seemed to be dependent on the inner strength of the individual staff, and sometimes managers allowed them to speak to relatives when this was requested by the relatives, if they thought it would not be too stressful. Managers also felt that they should not talk to the deceased friends/relatives, unless they were approached directly. Sometimes the deceased friends/relatives asked to see the room where the suicide was committed, and this was always granted. Most of the managers indicated that they found it stressful when they spoke to friends/relatives of the deceased, because often they were seeking answers to questions that the manager could not possibly answer. What was surprising was that the HRM departments provided so little training/support to their managers on how to manage suicides.

The timing of suicides was also of interest to the managers. There was almost universal agreement that most occurred on a Saturday/Sunday/Monday as this coincided with the end of working week, which had provided a reason to be busy. Suicides were also most likely to take place in the late evening/early morning. Despite an inclination to suggest that winter months would see an increase in suicides in hotels, Easter and summer were the most common periods. The managers also suggested that those who committed suicide did not live in the local area, but in the wider city region, and they usually used public transport to travel to the hotel. This is at odds with a study of transjurisdictional suicides by Hanzlick and Ross (1987), but their study was based in the USA, where the transport system is predominantly car-based. However, a more recent study by Zarkowski and Avery (2006), again in the USA, suggest that there was an increased risk of suicides by local people who seemed to opt for nearby hotels.

As to why some people chose a hotel, a number of the hotel managers suggested that this is because the body will be found quickly, normally within 24 hours. Also choosing a hotel meant that the friends/relatives were not subjected to the shock of finding the body, although it could be argued that this is simply a displacement of the shock from friends/relatives to the hotel staff. However, if the recent trend of the unbundling of hotel services, such as optional daily cleaning continues (De

Lossis, 2010), the body may lie undiscovered for the length of the booking. Although, in reality it is likely they would only book one night's accommodation. In order to avoid undue stress to their staff, the managers did not use them to clean a room after a suicide, but employed a specialised external company to undertake a deep cleaning before letting the room. The managers also felt that a hotel was chosen as a place to commit suicide because it provided the relatives and friends with a definite date/time when the death occurred, which was important to them. The managers also thought that because hotels are used to dealing with strangers (police, doctors, undertakers, etc.) this avoided any intrusion into a person's private home space.

Although the great majority of suicides in this study were by domestic tourists, the managers said that dealing with suicides by overseas tourists is particularly difficult. In many cases, the family did not see the body, because their preference was for a local cremation. As one hotel manager said, 'it felt as if they were a family member' because the hotel had many legal issues to manage on the relatives behalf.

Some managers mentioned that their housekeeping staff may suffer from a kind of survivor's guilt, and two said that their staff had attended group meetings of relatives of people who had committed suicide, but they felt 'out of place', because other members of the group had a much more direct family link to the deceased. A number of managers expressed concern about the long-term impact on the mental health of their staff, although none of the hotels had any formal monitoring procedures, but relied on informal observation. None of the managers was willing to discuss if anti-depressants were made available to their staff. A small number of the managers suggested that foreign nationals on their staff appeared to cope better than locally employed staff, but they were unable to provide any reason for this difference.

As far as the methods of committing suicide were concerned, of the 21 identified by the managers, the consensus was that poisoning/drug overdoses (15) was by far the most common method; followed by drowning in a bath (two). Only one hotel had experienced someone who had jumped and none had had any deaths by shooting (the other three methods were not mentioned).

When asked about the incorporation of anti-suicide measures into the design of bedrooms, the chain-hotel managers stated that they had benefitted from advice from their head office, and a number of independent hotels' managers had discussed the issue with their architects when redeveloping their hotels. Actions included: lowering the shower head and ensuring that it could not hold any weight; removing light fittings from ceilings; making sure that ceiling fixtures such as smoke detectors and automatic water sprinklers could not take any weight; limiting the opening of windows; not providing razor blades with toiletries; and placing appropriate religious books in the room. Some hotels with large atriums accessible to the public had erected netting and limited window opening to discourage jumping. Others had provided useful telephone numbers in the bedrooms, including that of the Samaritans. To prevent drowning one even removed bath plugs. However, these design changes would have only a limited effect on the number of suicides, because most involved poisoning or drug overdose.

Conclusions

The commercial tourism sector appears to deal with suicides on an incident by incident basis, aiming for as little publicity as possible because of possible negative impact. The generally accepted perception by hotel staff of suicides is probably what one would expect in a modern and enlightened society, that of regret for failing to understand fully the reasons for such actions, and disappointment that they did not see any indication of suicidal behaviour in their guests and their failure to take preventive actions.

What is clear from this research is that from a HRM perspective the care that managers took to look after their staff following a suicide. There was a sense that while some managers, particularly in the independent hotels, did not always follow procedures, they were always concerned about the impact on their staff. They were also aware of the need to treat the deceased's friends/relatives with respect and to try to be as helpful as possible by providing information, although this was not always possible. The managers also tried to ensure that it was they and not their staff who dealt with the relatives and friends, and it was clear that the housekeeping staff and managers worked well together in dealing with the after effects of suicides.

In terms of further research it is suggested that tourists thinking about suicides tend not have back-up plans and so, when their initial avenue of suicide is blocked, they may decide to seek help or perhaps realise that things are not as bad as envisioned. There appeared to be no studies exploring failed suicides at hotels, and further research on this topic is merited. From a HRM perspective, research on the long-term impact of suicide on the mental health of all hotel staff, and not just those directly involved in the suicides is required. Although there appears to be a high level of post suicide counselling and support services available to housekeeping staff, the effectiveness of these services has not been fully investigated, and there is little HRM research on the impact of suicides on staff not directly involved. Clarity as to the operational procedures to be followed when a guest commits suicide would be welcomed by the hotel managers. As would the provision of clearer guidelines and the development of standard industry and best practice procedures, along with more advice from their professional trade associations.

Suicide is a serious social issue and reliable data are critical in monitoring trends, and so quantifying and identifying the locations of suicides and the methods used by tourists would help the tourism sector better understand the issue. The effectiveness of more training of staff in identifying potential suicides also needs further research. The lack of research in the commercial sector on suicides at attractions, amusement parks and hotels in part prompted this study, as did the clear need to have a better understanding of the issue. The impression that the commercial sector tries to avoid any publicity turned out to be validated by this limited study. While the evidence from this study is incomplete and may be biased because of the research methodology and limited sample size, it does provide some insights into suicides in hotels by looking behind the curtain.

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