Suicide by clinicians involved in serious incidents in the NHS: a situational analysis

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EXECUTIVE SUMMARY

The first victim of any patient safety incident is by definition the patient. However, often there is a 'second victim', i.e. the professional who is variously adversely affected by the incident. We studied the tip of the iceberg of this problem, namely suicides of clinicians involved in incidents and investigations, by ascertaining the burden of such suicides and the support systems available. We also explored the potential for a new Never Event in order to improve the necessary support for clinicians.

We employed a number of methods including surveys of professional regulators in England, as well as NHS employers and NHS England Area Teams in one region, supplemented by literature reviews and a workshop to discuss the findings and next steps.

Although suicides by healthcare professionals involved in incident and investigations do happen, the extent of the problem remains hidden, and we found no peer-reviewed literature on this subject. Only about half of the responding organisations were confident that they would know about such suicides.

Systematic review of the published literature on supporting second victims describes existing strategies at individual and organisational level, but little effectiveness evidence. Existing policy and guidance in the UK contains limited information on how staff should be supported after incidents, and there is little evaluation of existing support systems.

We identified a wide variety of organisations external to the NHS which provide support to clinicians in difficulty; it is unclear whether practitioners find it sufficiently easy to navigate this plethora of offerings in their hour of need.

There was some support for a new Never Event to help raise the profile of this neglected issue, but many of our respondents cautioned against it.

A pressurised NHS cannot afford to take its eyes off staff wellbeing. Despite relevant initiatives and services in place, there are considerable gaps in both knowledge and practice. Whereas we limit our recommendations to those arising from this report, we anticipate that some of them will link to work on related initiatives, e.g. on whistle-blowing and complaints handling, and look forward to working with others to support healthcare workers and promote patient safety.

Recommendations and Next Steps

1. One way to learn about prevention is to investigate the circumstances of suicides by clinicians involved in patient safety incidents or whilst under investigation. We recognise the problems of introducing a specific Never Event but recommend that a National Confidential Enquiry type approach should be considered. Given

the rarity of such reported events, it should not be too difficult; such deaths should be carefully and confidentially reviewed, and learning should be identified and shared systematically. In this regard, we request the GMC to publish its report of their enquiry into suicides by doctors as soon as possible so that its lessons can inform future work.

2. All organisations need to have policies on how to support clinicians under investigation (regardless of the reason), ensure their provision, and, importantly, monitor the effectiveness of such support. A wider evaluation of support available from the perspective of those needing it is required.

3. Support systems for independent practitioners in particular need to be re-examined and strengthened.

4. A user-friendly 'directory' of support available is required which practitioners should find easily accessible when they need support – this could be a national and/or a regional initiative.

5. There should be mechanisms for hosting a mentoring scheme, and a platform for organisations to be challenged, as well as supported to develop their culture and effective approaches to supporting staff. This may be better organised regionally.

In the light of the comment by the delegates about what the CLN could do especially how the CLN could organise and host a cross-organisational mentorship scheme, bring regulators and professional bodies together for joint work, and provide a network to support organisations in developing standardised, best practice approaches to investigation, and organisational culture, we will be discussing the report with the relevant stakeholders and develop a systematic programme of work including further research.

Introduction and Aims

In recent years, much national and international work within healthcare has focussed on improving patient safety, often drawing on lessons from other safety-critical industries.[1-6] Where patients are harmed by healthcare, staff invariably suffer too, and it is not surprising that clinicians can become affected in different ways by those events.[7] In some cases, healthcare professionals can endure psychological trauma that has been likened to post-traumatic stress disorder.[8, 9]

For some time, there has been an interest in looking at the extreme manifestation of this phenomenon, which is suicide by a clinician. The issue came to the forefront in this country in 2012 following the suicide by nurse Jacintha Saldanha – a nurse who suffered unbearably in the aftermath of an information governance error, and a less well-known suicide by a dentist.[10] There are of course other high-profile cases elsewhere, e.g. the suicide of Kimberly Hiatt in 2011, a nurse whose medication error had contributed to the death of a child in Seattle Children's Hospital,[11] Overall, however, the extent of the problem of clinician suicides is unclear, although recently, the General Medical Council revealed that 92 doctors have died in the past eight years whilst being investigated (although the causes of death could not be shared), [12] and has launched an investigation.

We decided to study further the issue of suicides of clinicians involved in incidents and investigations by ascertaining the burden of such suicides and the support systems available. We also wanted to explore the potential for a new Never Event ("No healthcare worker will commit suicide whilst being investigated for a patient safety incident") in order to improve the necessary support for clinicians.

Our work aimed to:

1. estimate the magnitude of suicides by clinicians involved in serious incidents (SIs) and under investigation in England and Wales;
2. describe the existing knowledge base which may help prevent such suicides of clinicians;
3. describe existing policy and practice aimed at preventing such suicides of clinicians;
4. refine the definition of an appropriate Never Event with clinical leaders;
5. develop a plan for testing and implementing the Never Event, including measures for success.

Methods

We undertook a mixed methods study. Table 1 summarises the methods used to address each of our aims. A description of each method follows after the table.

Table 1: Overview of aims and methods

Aims	Method				
	Survey of regulators	Survey of hospital trusts and NHS Commissioning Board organisations in one region	Literature review	Document review	Scoping review
Estimate the magnitude of suicides by clinicians under investigation in England and Wales	x	X	X		
Describe the existing knowledge base which may help prevent such suicides of clinicians			X		
Describe existing policy and practice aimed at preventing suicides of clinicians	x	X		X	X
Refine the definition of an appropriate Never Event with clinical leaders	x	x			
Develop a plan for testing and implementing the Never Event, including measures for success	x	x			

In addition to the methods listed in the table, we held a workshop on 7 April 2014 at which the draft report of this work was shared and discussed, and suggestions for next steps were developed by the delegates. The discussions at this workshop also contributed to the final version of this report.

a. Literature reviews

We conducted a research scan of the literature in MEDLINE, EMBASE, CINAHL, and Google scholar. Search terms included 'second victim' or 'healthcare professional' or 'clinician' or 'doctor' or 'nurse' paired with the term 'suicide.' Only studies or abstracts available in English were eligible for inclusion due to time constraints preventing translations. We scanned more than 6,000 pieces of potentially relevant research. Our inclusion criteria were:

- any study that reported on suicides of healthcare professionals who were being investigated for a patient safety incident;
- any study that reported on harm to healthcare professionals who were being investigated for a patient safety incident;
- studies that reported on any intervention for suicide prevention specifically for health professionals, and their support following serious incidents;
- all study designs were permissible.

The exclusion criteria were:

- studies about second victims in general, as there already exists a body of literature on the subject;
- studies in languages other than English.

We selected the most relevant empirical material to summarise here. No formal quality weighting was undertaken within the scan. As this was a rapid synthesis, no formal flow chart was created and where possible evidence was drawn from the highest forms of evidence e.g. systematic reviews. Two reviewers (SSP and AC-S) selected studies for inclusion. A third person (RM) was available to arbitrate over any uncertainties in inclusion of papers.

b. Survey of regulators

There are nine healthcare professional regulators in the UK and we included them in the survey.[i] The survey covered questions relating to three main areas: (1) support offered to clinicians by these organisations, where else they referred clinicians for support, and any evaluation of such support; (2) suicides and deaths of clinicians during and after (up to one year) investigations, and how and whether the organisation recorded and investigated those; (3) comments on definition and implementation of a never event.

c. Survey of provider trusts, and NHS Commissioning Board Local Area Teams in one region

To obtain comprehensive information for one region, a similar survey was sent to all 36 provider NHS trusts and four NHS Commissioning Board Local Area Teams (LATs) of the North West of England (a region chosen opportunistically because of the lead

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[i] http://www.professionalstandards.org.uk/regulators/statutory-regulators-directory

authors' base and networks). The questions were adapted slightly to take account of clinicians' suicides following patient safety incidents (not only clinicians under formal investigation). The survey covered all acute, mental health, ambulance, specialist, and community care provider NHS organisations. LATs commission independent contractors providing primary care services (general practitioners, dentists, community pharmacists, optometrists).

d. Document reviews

Relevant national policy documents were reviewed to describe the current policy background. These were identified through contacts with organisations, as well as snow-balling.

e. Scoping review of available sources of support (besides employers)

Search terms such as 'support', 'whistleblowing', 'investigation', 'counselling', 'help', were systematically entered into Google in combination with healthcare professional roles (e.g. nurse, doctor, physiotherapist etc.).

We then undertook searches of websites of identified support organisations: professional regulators, professional bodies, defence unions, trade unions, and social networking websites for healthcare professionals (see Appendices 1 and 2 for a full list of organisations searched). Any signposting or links from any websites to other available services were also pursued. We developed a coding framework and used this to extract information on: the types of intervention from each organisation, which professional groups the support was aimed at, the nature of the support offered (who, what, when and how), and the availability of support services. Most of this information was available from the websites of the organisations. When this was unclear or incomplete, we enquired further by e-mail or telephone. .

Results

Of 36 provider NHS trusts, 19 responded (response rate 53%). Of the nine regulators we surveyed, four returned completed forms; one non-responding regulator was not relevant to England and Wales (response rate 50%). A further regulator responded with a letter. All four LATs included in the survey responded (100%).

a. How common are suicides of clinicians under investigation?

i. Synthesis of the literature

We found no published estimates in the peer-reviewed literature of the number of suicides of clinicians following patient safety incidents, or being investigated. However, a Freedom of Information request made by Doctors4Justice to the General Medical Council revealed that since 2004, 92 doctors have died while facing fitness-to-practice proceedings (up until 19 April 2012); the GMC also reported three ongoing investigations of doctor suicides whilst undergoing fitness-to-practice proceedings.[12] We are not aware of any similar information being published by other regulators, although individual cases of suicides by clinician under investigation are occasionally reported in the media.[10] At such an occasion, the Chair of the British Dental Association's general dental practice committee said that "The sad death of Dr Kamath is not the first suicide by a dentist under pressure in this way..."[13]

A study of 7905 American surgeons found a prevalence of suicide ideation of 6.3% in the past 12 months (response rate 31.7%), with few of them having sought psychiatric or psychological support (26.0%), and 60.1% being reluctant to do so due to concerns about how this might affect their medical license.

In the absence of any estimates of the size of the problem of suicides by health professionals following incidents and/or under investigation, we briefly considered the related literature on the prevalence of (non-suicide) harm to such individuals, the 'second victims'[9], i.e. the health care professional involved in an adverse event, and adversely affected by it. Second victims are at risk of psychological distress similar to post-traumatic stress disorder,[7] which is expressed as an inability to successfully process the feelings of fear, sadness, guilt, and shame. Often, personal lives are affected, as are professional interactions.[9] The literature also describes other effects on second victims, including fear of consequences (loss of job, income, professional respect,[14, 15] fear of returning to work, loss of confidence, self-doubt, remorse, depression, a wish to make amends, and hyper-vigilance,[16] as well as the characteristic of post-traumatic stress disorder, including sleep disturbances, flashbacks, suicidal thoughts, and damaged self-perception.[16] Some healthcare workers leave their profession and a few invariably commit suicide following the experience.[17]

The prevalence of second victims has been addressed by a recent systematic review.[18] The review found the prevalence of second victims in health care to be from as low as one in 10.4%[17], to as high as 30%[15] to 43.3%.[19] The study reporting a second victim prevalence of 43.3% surveyed a random sample of 402 clinicians about a serious medication error.[19] The study reporting a 10.4% prevalence was an anonymous survey of 2,500 otolaryngologists in the United States about medical errors in their practice (to which only a fifth replied); 210 respondents (45%) reported a total of 212 analysable error reports and 230 corrective actions. Emotional reactions to errors and adverse events were reported by 22 (10%) otolaryngologists, including regret,

embarrassment, guilt, anxiety, loss of temper, and irritation; legal action was mentioned by five physicians (2%).[17]

ii. Survey findings

The results of the literature review on the burden of suicides were to some extent expected, which is why we also attempted to collect comprehensive information for one region, by surveying national regulators, as well as NHS provider organisations and NHS Commissioning Board Local Area Teams in North West England. Table 2 provides an overview of the relevant results, with details provided below.

Table 2: Overview of survey findings in relation to suicides and their investigation:

Question	Provider trusts	LATs	Regulators
Routinely know about deaths/suicides of staff involved in investigations?	53% yes (n=19) (some other think they would know if it happened)	50% yes (n=4)	50% yes (n=4)
Number of such deaths by cause in past 10 years?	1 suicide reported	No deaths reported	6 suicides reported* *(information does not cover 10 years)*
Are such deaths investigated?	68% yes (n=19)	Seemingly not by the LATs	50% yes (n=4)

*more recently, GMC Audit and Risk Committee minutes from June 2013 record that the organisation is aware of 16 suicides of registrants under GMC restriction or investigation since 2004.

Of the 19 provider trusts which had responded, ten (53%) reported that they routinely know about deaths of staff involved in investigations, eight (42%) reported that they do not routinely know, and one did not respond.

Some comments by trust survey respondents imply that they think they would be aware of such deaths, others seemed less certain. It would appear that information is held in different parts of the organisation (e.g. human resources, and risk management).

Trusts were asked for the number of deaths by cause (suicide, open verdict, other cause of death, cause unknown) during the past ten years, of staff involved in a patient safety incident (up to a year after any relevant investigation), and whether any of these staff have been under investigation themselves. Ten trusts (53%) reported no deaths, although one said they would not necessarily know, except if this was reported as an incident. Four said they did not have the data recorded, and a further three did not answer the question. One trust recorded several deaths in service, but none of the deceased staff members were under investigation. One trust reported a suicide of a staff member under investigation.

Of the four regulators who responded, two reported that they routinely know about deaths during and after investigations. One of them mentioned that this information was necessary for case closure, and also that after investigation, a reason for erasure from the register is recorded (although that depends on the regulator being notified). Two regulators reported that they do not routinely know about deaths during and after investigations.

As with NHS provider and LAT organisations, we asked regulators for information on deaths by cause during a 10-year period (2003-12). Three of the organisations reported being aware of a total of six suicides either during or after investigations. The fourth organisation is only able to record the numbers of deaths without a cause. There are several caveats around the data of the three organisations, e.g. they cover different time periods (one from 2004, another did not give the time period; the third does not have routine processes for recording such information at all, but reports being aware of two suicides, so there is a possibility that the information is incomplete). More recently we have become aware that GMC Audit and Risk Committee minutes from June 2013 record that the organisation is aware of 16 suicides of registrants under GMC restriction or investigation since 2004.

Of the four Local Area Teams, two reported no deaths, and two do not record such data.

Asked whether they plan to collect such data in the future, the two LATs without data have no plans to collect such data in future. Five trusts indicated that they would collect such data in future, six said they would not. The two regulators without routine figures are not planning to collect information on deaths of registrants during or after investigation in the future either (but one mentions a new case management system being introduced, and it is unclear whether this means that such data will be available to the organisation in future).

We asked all three types of organisations whether in the case of a death of a clinician under investigation, they would undertake a review of the circumstances leading up to the death. Of the four responding regulators, two indicated that they would do so in the case of suicides. A third said that they would review any cases where there was reason to believe that the organisation's actions were part of the cause of death, and they would undertake reviews in future. Thirteen out of 19 trusts said they would investigate such a death (68%), three said they would not currently investigate, but two of them plan to do so in future, and three trusts did not respond to the relevant question. Although the four LATs did not indicate clearly that they would investigate such deaths (2 did not respond; 1 no; 1 yes, referring to reviews by Coroner and police, rather than LAT), their explanatory comments imply that they would want to understand the circumstances of the death, particularly if related to an incident.

b. Support available to clinicians under investigation

i.   Evidence base on preventing suicides of clinicians under investigation

In terms of preventing suicides of doctors specifically, Hawton *et al* (2004) suggested that a range of strategies could be effective; they include improved recognition and management of psychiatric disorders, measures to reduce occupational stress and minimising means and attempts at suicide.[20]

Arguably, in the context of serious incidents, the acute stress reactions of healthcare workers need to also be managed. A recent systematic review by Seys and colleagues summarises existing individual and organisational strategies to prevent harm to clinicians as second victims.[21] The review had judged the included studies to be of moderate to high quality.

Support strategies at individual level are multi-modal and involve the various actors such as managers, counsellors and peers concerned with the incident and the clinician. The literature also suggested that for support to be effective, a culture of open disclosure should exist and clinicians should be willing to accept criticism from supportive colleagues.[22] However, one study suggests that 30% of physicians were uncomfortable discussing their errors[23] even though open disclosure of the mistake could have a positive impact on the psychophysiology discussed above and reduce the likelihood of future incidents. An overview of individual strategies is shown in Table 3.

Table 3: Overview of identified considerations and intervention strategies to support second victims[21] (with permission from Elsevier):

Considerations
• Time between adverse event and support is crucial with 24/7 availability (Schelbred and Nord, 2007 and Scott et al., 2010)
• Structured sessions need to be provided (Engel et al., 2006)
• Highly respected physicians or physicians in a senior position should be encouraged to discuss their errors and feelings (Levinson and Dunn, 1989)
• Programs which focus to prevent, identify and treat burnout (West et al., 2006)
• Promote empathy within the team (West et al., 2006)

Strategies
• Talk and listen to second victims (Arndt, 1994)
Organize and facilitate open discussion of the error (Engel et al., 2006, Fischer et al., 2006 and Meurier et al., 1998)
• Share experiences with peers (Engel et al., 2006)
• Organize special conferences on the issue of second victims to increase awareness (Levinson and Dunn, 1989)
• Provide a professional and confidential forum to discuss their errors (Levinson and Dunn, 1989)
• Inquire about colleague coping (Wu, 2000)
• Expressive writing (Wu et al., 2008)

At organisational level, the strategies are dependent on the organisational culture. Some notable models mentioned in the review by Seys and colleagues are:

- 'Scott three–tiered emotional support system': this is a three-layered system which offers varying degrees of support from emotional first aid to professional counselling;
- Medically Induced Trauma Support Services (MITTS): offers a team-based approach (mental health professionals and peers) providing counsel to groups of affected individuals;[24]
- The Institute for Healthcare Improvement (IHI) Clinical Crisis Management Plan: a strategy of avoiding harm after the occurrence of an adverse event and providing support for the organisation, the patient and the second victim.[25]

The interventions and prevention strategies reflect the organisational and health system and accordingly there is no one single 'best' method which can be applied for all clinicians everywhere.

ii. Policy background

In this section we describe what currently 'should happen' by listing key national policy and guidance documents applicable to providing support to staff following incidents, and under investigation.

All employers are legally responsible for minimizing the risk of stress-related illness or injury to employees.[26] For the NHS, the NHS Litigation Authority Risk Management Standards require participating organisations to have policies to support staff involved in patient safety incidents.[27] At the basic 'Level 1', organisations need to have relevant policies in place. At the highest 'Level 3', organisations are required to monitor their relevant processes *'in relation to action for managers or individuals to take if the staff member is experiencing difficulties associated with the event.'* (p.92) (At the last round of assessments, about half of the acute trusts nationally were assessed as 'Level 1', and less than a quarter at 'Level 3'.)

The framework for investigating serious incidents by the NHS Commissioning Board[28] builds on the work of the former National Patient Safety Agency (NPSA).[29] The framework suggests that both commissioners and providers should '*ensure that their senior leadership teams receive summary information, […] to help gain assurance that appropriate action has been, or is being, taken to safeguard patients and staff and to understand the impact on individual patients and on staff.*' (p.12). The framework seems to assume that providers have policies on supporting staff involved in incidents.

In 2009, the NPSA released the *Being Open* policy.[30] The document stresses that open and honest communication with patients is at the heart of health care. The onus is on organisations to provide a safe and just culture for staff being investigated. One important lever for this is to promote a culture of open disclosure. Research has shown that being open when things go wrong can help patients and staff to cope better with the after effects of a patient safety incident.[30] For the first time, a new role of senior clinical counsellors was advocated; these individuals would help clinicians being investigated to navigate the terrain and offer support to them during the difficult period. No formal evaluation has been undertaken of the *Being Open* policy.

The National Suicide Prevention Strategy for England, published in 2012,[31] includes a section on doctors and nurses as an occupational group at high risk of suicide. The document references some of the support examples included later in this report, as well as a number of relevant guidance documents, notably the Department of Health 2008 report on doctors' mental health and ill health, which recommends that key organisations make information about support more readily available.[32]

In 2011, the Department of Health published a comprehensive 'NHS Health and Well-being Improvement Framework' which brings together a wealth of relevant policy and guidance for boards.[33] However, it does not mention the second victim phenomenon or staff affected by patient safety incidents.

There is guidance from a number of organisations on managing stress, for example by the Health and Safety Executive, or for nurses by the Royal College of Nursing.[34]

The National Institute for Health and Care Excellence has produced guidelines on PTSD in 2005,[35] as well as a relevant care pathway, which describes the professional support which those affected should receive.

In summary, there is no shortage of well-informed policies, including an intention to monitor organisations' success in supporting their staff. However, there is very little specific guidance on the nature of any support for staff affected by incidents. In the following sections we report on the existing support systems organisations have told us about in their survey responses.

The next three subsections report the findings of our surveys of regulators, employing trusts, and Local Area Teams. The findings are summarised in Table 4**Table 4** here and detailed in the text below.

Table 4: Summary of survey findings on support available

	Regulators	**Employers**	**Area Teams**
Sources of support	• No support provided directly by regulators; GMC commissions Doctor Support Service externally. • Support mainly seen as providing information about processes and support elsewhere.	• Range of internal and external support options mentioned by all trusts, including line manager, occupational health services, HR, unions, counselling, 24/7 employee assistance programmes, formal debriefing sessions, chaplaincy services etc.	• Range of external sources of support reported, including occupational health, local representative committees, appraisers, professional advisors, educational institutions, NCAS (National Clinical Assessment Service), indemnity organisations, sick practitioner schemes.
Policy to support	• 1 regulator has policy for supporting registrants (n=4).	• 89% (17) report to have a policy for supporting staff (n=19).	• No policy to support contractors or performers (n=4).
Evaluation of support	• GMC commissioned evaluation of Doctor Support Service.	• 63% (12) report to have undertaken an evaluation, but the detail does not bear this out; very few organisations seem likely to have undertaken evaluation of support offered.	• No evaluation of support (n=4).

iii. *Support provided by employers*

Sources of support

All 19 trusts were aware of a number of sources of available support for staff and gave detailed explanations. Trusts mentioned a whole range of support services, starting with the line manager, occupational health services, HR, union support, counselling, to employee assistance programmes available 24 hours, seven days a week, and formal debriefing sessions. One trust mentioned bespoke confidence building and retraining programmes for staff involved in clinical error (offered by the clinical education department), and in another organisation, the patient safety team offers support to staff.

Fourteen of 19 trusts (74%) reported that they routinely refer staff for support. Some of the five others noted that the decision to refer is made by the line manager of affected staff. Referral destinations are mostly occupational health services, and staff support / wellbeing services, but also include line managers, as well as chaplaincy services.

Some interesting examples, in addition to the above include:
- Trauma Support Meeting – facilitating meeting of those involved, 5-10 days post-incident, lasting 1-3 hours. Staff can request these. Aim is to provide safe environment to discuss experiences, give and receive support, and consider strategies to deal with unresolved issues and how to move on.
- Individual psychological interventions.
- One-to-one support and debriefing by experienced counsellors.
- 24-hour support by phone, with referral within 24 hours to incident support service provided by senior clinicians within the staff support service.

Policies

Seventeen of the 19 trusts (89%) have policies for supporting staff, two say that they do not. Only six responded 'yes' to the question of whether this is shared with staff on induction, nine said 'no' (at least one mentioned that this is referred to but not physically shared on induction); four did not respond to this question.

Evaluation

Twelve trusts (63%) said they have undertaken an evaluation of the support they provide to staff; the remaining seven responded with 'no'. Only six trusts provide details. Crucially, these often do not seem to amount to formal evaluations, and quite possibly do not include staff experiences or views. Trusts mentioned the following:
- A review of each serious incident by a panel which includes consideration of staff support issues;
- 'Reflections' on pre-inquest support available and planned subsequent training;
- 'Audits';
- Evaluation planned 'as per monitoring requirements outlined in the policy';
- Review of arrangements by the governance director;

- Passing of NHSLA Level 3 (*Note: NHSLA Level 3 requires monitoring of success of relevant policies).*

iv. *Support available by regulators and Local Area Teams*

Regulators:

Sources of Support

In response to the question about their role in supporting registrants under investigation, two of the four responding organisations pointed out that their primary purpose was the protection of patients and the public, and emphasised the importance of being clear with registrants about the investigative processes. None of the organisations seem to provide support directly to registrants, but all make reference to external sources of support including defence organisations, professional associations, Samaritans and the healthcare providers.

Regulators see their support mainly in terms of providing clear information about the process of investigations, and about sources of support from elsewhere. The GMC notably commissions an external organisation (the *Doctor Support Service* provided by the British Medical Association) to support doctors undergoing fitness-to-practice proceedings, and does not refer directly to it in order to preserve independence and confidentiality. The service offers confidential emotional support throughout proceedings.

One organisation said it tries to identify vulnerable people as early as possible, and e.g. does not post letters on a Friday as there will be no support available until Monday. Another mentioned a process for registrants with health problems, involving referrals for medical examination, and correspondence with a registrant's GP.

Policies

Only one of four responding regulators reported to have a policy in place for supporting registrants.

Evaluation

Only for the GMC-commissioned support service mentioned above is an evaluation planned.

Local Area Teams:

Sources of Support

In response to the question of which support for independent contractors they were aware of, LATs mentioned a mixture of external organisations, including occupational health, local representative committees, appraisers, professional advisors, educational institutions (e.g. Health Education England, GP tutors), NCAS, and indemnity organisations, as well as sick practitioner schemes.

Three of the four organisations reported that they routinely referred for support.

Whereas patient safety is seen as the priority, most LAT respondents described their approach as supportive to practitioners and appreciative of the stress which investigations can cause. The support offered by LATs directly is both in form of referral to other sources of support, but also through appraisal schemes, GP tutors, and professional advisors.   One respondent mentioned that occasionally mentors are assigned to practitioners. Another respondent reported that '*the vast majority of our work is supportive, developmental, and remedial*'.

Policies

None of the LATs have a written policy or a description of the process for supporting independent contractors under investigation.

Evaluation

None of the LATs have evaluated the support they offer to independent contractors.

v.   Support from other organisations

We identified over 20 local and national organisations and professional bodies that offered relevant support to a variety of healthcare professionals (results are presented in Appendix 1).

In terms of what support these organisations could provide for their members or professionals referred to them, specifically, the most common forms were general emotional support and advice and signposting to other sources.   Over half of the organisations also provided some form of education on the legal processes or complaints procedures, usually in the form of published guidance.   The most common method of accessing any of the services was by telephone.   Only 10 organisations provided any face-to-face support.

The Doctor Support Service commissioned by the GMC (mentioned above) appears to be the most comprehensive support mechanism available at this time.

We suspect that there are more local sources of support than we were able to identify through our methods, specifically also through local representative committees, but possibly also through deaneries and other organisations, We have also only included some and not all unions which represent healthcare workers, and most of these will offer support and advice to their members.

c. Views about a Never Event

All three survey respondent groups were asked to comment on the definition and the implementation of a proposed Never Event ("*No healthcare worker will commit suicide whilst being investigated for a patient safety incident")*. The responses were in free text and covered a wide range of views.

Some respondents agreed with the proposal, but there were repeatedly expressed concerns about a Never Event: firstly, around attribution (i.e. the inability to determine to which extent, if any, a suicide was due to an investigation or incident), and secondly, the concern that complete avoidance was not possible or within the control of organisations.

Changes suggested to the definition included:

- Broaden scope beyond suicides (any death under investigation is of concern)
- Broaden scope beyond patient safety incident (investigation for fraud can be equally stressful)
- Clear definitions are needed, e.g. clarify 'investigation' – i.e. serious incident, or disciplinary
- Focus on support available: 'no healthcare worker shall not be appropriately supported by the organisation whilst being investigated for a patient safety event'
- Only coroner defines suicide post event – suggest 'suspected suicide' as terminology
- Should include 'attempt suicide as well as will commit'
- 'No healthcare worker will commit suicide as a result of poor handling of an investigation for a patient safety incident'

Comments on implementation of the Never Event:

- Report and monitor through National Reporting and Learning System to enable appropriate investigation
- Employers do not have full control of investigation process, only the employment element. If this is a Never Event, organisations may not engage as robustly with partner organisations
- The introduction of a Never Event would make it yet another NHS target rather than a value-based purpose

- Identifying and measuring would be difficult
- How can we factor out other stressors?
- Amend to 'always' event – staff are always supported…. This could be monitored through Quality Accounts
- Organisations would need to look at mandatory referrals for support…
- Staff support policy is possible to audit, but human response to incident is not possible to control
- Access to support services for independent contractors would be required
- Funding would be required to determine individual's state of mind

d. Support needed by organisations themselves

None of the regulators identified any support they need with preventing harm to second victims.

Provider organisations suggested they may benefit from information sharing with other trusts, guidance and support material, and experience from others.

LATs expressed the comparatively greatest need for support with this agenda. They face a lack of resources for swift case investigation, remediation, as well as support. Other needs they expressed related to information on 'what good support looks and feels like', training on offering support, and on recognising a vulnerable practitioner, agreed services provided by other organisations (such as local representative committees and indemnity insurers), capacity, and continued access to occupational health services.

Workshop 7 April 2014

We invited all respondents and others, including known support organisations, to a workshop to discuss the draft of this report and develop next steps. The workshop was attended by some 30 delegates. We encouraged discussion of five areas arising from our work thus far:

1. Knowledge, and intelligence: the extent of suicides (and the second victim phenomenon) in the UK remains unclear;
2. Effective support: There is limited knowledge on what support is effective (and even less on how effective the existing support is), but the literature points towards immediate support, peer support, within the working environment, and exploring and learning from error;
3. System response: There is a need for an accessible, coherent, comprehensive support system for all professional groups;
4. Priority groups: independent practitioners may be particularly vulnerable;
5. Never event: our findings suggest that this should not be pursued further.

The notes of the discussion appear in Appendix 3. Delegates suggested that (provider) organisations had to go much further in developing a culture of openness and learning, and better investigative processes, including a consistent approach (across organisations), and a less blame-focussed style of investigation, and automatic and competent support for all persons under investigation, as well as mentorship schemes. Delegates related these culture issues to the fate of practitioners who have been bullied or who have blown the whistle in the interest of patient safety.

In terms of support available, delegates suggested that this should be better published, and uptake should be monitored, and staff involved in investigations should be surveyed. The need for consistent occupational health service coverage and improved referral processes has been highlighted, particularly for independent practitioners.

Delegates also suggested that regulators needed to work together on consistent approaches, and should only deal with serious cases, and referrers needed to let them know if a person was considered to be at risk.

We asked delegates to consider what the CLN could do. It was suggested that the CLN could provide space for sharing good practice and regular discussion of patient safety issues, as well as take a more campaigning approach for justice. More specifically, the CLN could organise and host a cross-organisational mentorship scheme, bring regulators and professional bodies together for joint work, and provide a network to support organisations in developing standardised, best practice approaches to investigation, and organisational culture.

Discussion

a. Clinician suicides following incidents and investigations

It is not possible to estimate comprehensively the size of the problem of suicides associated with patient safety incidents or investigations of clinicians, either from published reports, or existing data within organisations. Many organisations appear unable to report relevant data confidently.

The trust responses were completed by different types of staff (human resource staff, and governance staff); it is likely that they only know part of the whole picture within their organisation. Thus staff records (and information about staff deaths) are not routinely linked to incident management systems to be able to identify staff who died and were also involved in a serious incident (particularly if they were not the subject of an investigation themselves).

Many organisations without data indicate no intention to collect such information in future. It is unclear whether this indicates either a technical inability, or an unwillingness

to collect the information. One possibility is that the lack of a relevant performance indicator means that such information, and possibly the issue itself, is not seen as a priority.

Data on staff suicides are not collected systematically or reported, although some organisations hold relevant information. Any surveillance of staff suicides related to investigations or incidents would face considerable definitional issues, and our work has not sought to resolve those (for example, should suicide attempts or open verdicts be included? should fraud cases be dealt with differently from genuine human error events?),

Organisations need to understand the circumstances of any staff/registrants' suicides in such circumstances to learn potentially important lessons, regardless of the cause and nature of an investigation or incident, or the potential association with the suicide. To suggest that investigations of such deaths are only required where (organisational) culpability is a possibility, suggests a blame- rather than learning-focussed approach to investigations.

Most provider organisations say that they would investigate a death of a staff member under investigation (notwithstanding the fact that they may not always know about it at the moment). However, only two of four regulators said they would review suicides of registrants under investigation, and a third said it would do so, if there was reason to believe that the organisation's actions may have contributed to the death. These responses indicate that there is a lack of system thinking in dealing with deaths of clinicians under investigation, which may stifle the opportunity to learn from such sad events.

The impact of staff wellbeing on service quality are well documented,[36] and suicides associated with serious incidents or investigations are merely the tip of the iceberg of (a lack of) staff wellbeing. The estimated 10.4-43.3% prevalence of second victims after an adverse event[18] signals that the effects these events have on clinicians (and indeed their ability to practice) are serious, are severely affecting their work and lives, and warrant urgent attention. There are some initiatives to raise awareness of the second victim issue, and to develop relevant support - several in the US[15, 24], and some hopeful beginnings in the UK, notably work by the Royal College of Physicians[ii], and the College of Emergency Medicine.[37]

The fate of practitioners who have blown the whistle in the interest of patient safety and have paid with their livelihood, health, and/or family life is very closely linked to the issues discussed in this report.

[ii] http://www.rcplondon.ac.uk/what-we-do/patient-safety/second-victims

b. Support and prevention

There is clear legal impetus on employers to provide support to their employees after incidents and reduce their exposure to and effects on stress. A comprehensive incident response by provider organisations tends to include mechanisms for supporting involved practitioners. However, there is little express guidance on how to support and protect second victims, and it is not clear how effective the existing system is in preventing 'second victim' consequences, or suicides in particular. In a recent interview study in two London hospitals of 27 surgeons' perception of support in the aftermath of complications, respondents found institutional support to be generally inadequate; formal mentoring was the most frequently quoted suggestion for better support; peers were almost universally seen as the 'most commonly available and most sought after source of support".[38]

The regulators responding to our survey were primarily focussed on conducting investigations of practitioners, and whereas these organisations strive towards ensuring that their processes minimise stress, they do not see direct support of practitioners as their role. LATs hold a particularly complex position as they may be required to investigate a practitioner, at the same time as providing remedial as well as financial support, to individuals who are not employees of the organisation.

It is not clear how the different types of organisations work together; certainly the workshop discussions indicated the need to work more closely together, including improving referral mechanisms (e.g. to regulators), standardising approaches, and making the various sources of support more widely known.

In terms of the wider support available, our searches of external support organisations revealed a wide range of organisations involved in supporting professionals, but we are unable to say whether the support landscape is comprehensive, sufficient, efficient, or effective. We detected a potentially stronger emphasis on medical professionals. Similarly, it is unclear whether the local support through LATs is equally distributed between professional groups. In any case, there is scope for a more coordinated and systematic approach to offering support, and easier access to information about the support offers available. We have made a start by collating information on a sample of organisations in the appendices of this report.

Whereas literature on support services for second victims exists,[18] there is no consensus in the literature on how to effectively support them or on what support systems should look like. The national *Being Open* policy has never been formally evaluated, and apart from the planned evaluation of the Doctor Support Service commissioned by the GMC, we are not aware of any formal evaluation of support services, particularly evaluations involving staff responses. However, it is likely that at least some provider trusts have basic systems for reviewing the effectiveness of their support, and it would be helpful to bring this learning together, or commission a larger scale formal evaluation across several organisations.

A 2011 PhD thesis on the topic identified three supportive interventions for second victims: exploring and learning from the error as a process for providing support, using peers as supporters, and developing mechanisms for support within the immediate working environment, along with a management structure that supports this.[39] The author rightly poses the question whether these approaches could work within or alongside the usual investigative approaches.

Hawton and colleagues have suggested that preventing doctor suicides requires reduction in work stress, improved management of psychiatric disorders, and reduction of access to means for suicide.[20] It could be argued that some of these measures are easier for larger organisations to implement, such as hospital trusts, and that independent contractors may be inherently more vulnerable.

Interestingly, the major source of support identified by employers was occupational health services; the provision of which is very variable across the NHS. There are also issues of confidentiality and such clinicians may require out of area referrals; again it is unclear whether there are relevant arrangements in place across the country to allow this.

In summary, whereas there are some pointers in the literature on how support could be structured at least at the individual and organisational level, there is little evidence on how effective this is in practice. Organisations may have support services in place or refer to others, but for individuals it may remain difficult to navigate the different sources of support. Moreover, there are indications that the culture in some organisations remains punitive and blame-focussed and unable to accept failure, which is counterproductive to any support. And there also appear to be considerable gaps (e.g. structured support for independent practitioners).

c. Never event

"Never Events" are defined as *'serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers'*.(40)[(p.3)] Never Events invariably receive an organisation's attention, as their occurrence now attracts financial penalties, as well as negative reputational consequences for organisations. We assumed that a Never Event could place the issue of staff suicides firmly onto relevant organisations' agendas and wanted to explore this potential.

There are five criteria applied by the NPSA to Never Events: (1) The incident has clear potential for or has caused severe harm/death, (2) there is evidence of occurrence in the past (i.e. it is a known source of risk), (3) there is existing national guidance and/or national safety recommendations on how the event can be prevented and support for implementation, (4) the event is largely preventable if the guidance is implemented, and (5) occurrence can be easily defined, identified and continually measured. The proposed Never Event only falls short of criterion (3). Whereas there is plenty of

guidance to reduce the likelihood of the event, the event can obviously not be completely prevented by available interventions.

Our respondents were not convinced that a Never Event is necessarily the way forward as there seem to be a number of concerns about attribution and definition. The association of Never Events with penalties and loss of organisational reputation may be at least partly responsible for that view. Also nationally, it is not clear whether the introduction of Never Events has resulted in their reduction. The commitment of organisational leaders to an issue of such grave importance as staff health and wellness is key to success.[41] But it is not clear whether a Never Event would achieve the required level of commitment. Nevertheless, an agreement to monitor suicides following incidents or investigations could provide a helpful focus on the quality of staff support systems, and a detailed investigation of such suicides and the events leading up to them could provide invaluable learning.

Conclusion

Suicides associated with incidents and investigations do happen, but the extent of the problem essentially remains hidden, as not all organisations are able to identify them with confidence. We have not been able to identify any reviews of such deaths or resulting learning (except that the GMC committed to a study the publication of which is awaited). The Second Victim phenomenon is a known issue with considerable impact on patient and staff safety, but very little is known about the extent of the problem in the UK, although organisations such as the Royal College of Physicians, and the College of Emergency Medicine have begun work in this area.

We identified a varied picture of support provided by a number of organisations, including employers, and it may be difficult for individuals to navigate this complex picture at a time of need. Regulators do not provide direct support to individuals. Whereas the literature gives some pointers towards what may constitute effective support for individual practitioners as second victims, we know little about the effectiveness of such systems in practice. Many organisations seem to need further support to be able in turn to support their staff.

Recommendations and Next Steps

1. One way to learn about prevention is to investigate the circumstances of suicides by clinicians involved in patient safety incidents or whilst under investigation. We recognise the problems of introducing a specific Never Event but recommend that a National Confidential Enquiry type approach should be considered. Given the rarity of such reported events, it should not be too difficult; such deaths should be carefully and confidentially reviewed, and learning should be identified and shared systematically. In this regard, we request the GMC to publish its

report of their enquiry into suicides by doctors as soon as possible so that its lessons can inform future work.

2. All organisations need to have policies on how to support clinicians under investigation (regardless of the reason), ensure their provision, and, importantly, monitor the effectiveness of such support. A wider evaluation of support available from the perspective of those needing it is required.

3. Support systems for independent practitioners in particular need to be re-examined and strengthened.

4. A user-friendly 'directory' of support available is required which practitioners should find easily accessible when they need support – this could be a national and/or a regional initiative.

5. There should be mechanisms for hosting a mentoring scheme, and a platform for organisations to be challenged, as well as supported to develop their culture and effective approaches to supporting staff. This may be better organised regionally.

In the light of the comment by the delegates about what the CLN could do especially how the CLN could organise and host a cross-organisational mentorship scheme, bring regulators and professional bodies together for joint work, and provide a network to support organisations in developing standardised, best practice approaches to investigation, and organisational culture, we will be discussing the report with the relevant stakeholders and develop a systematic programme of work including further research.

Acknowledgements

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Appendix 1: Support organisations and their support offers

Name	How				What									Who		For Whom					
	Telephone advice	Face-to-face	Online discussion board	Published guidance	Psychotherapy (group or individual)	Counselling (individual)	Counselling (group)	Education (document, course etc.)	Medico-legal advice	Financial advice/support	General Emotional Support	Signposting	Attendance at legal proceedings	Peer	Non-Peer	All doctors	Junior Doctors	Specialty Doctors	Dentists	Nurses	Other
Sick Doctors Trust	√			√		√		√			√	√	√	√		√					
Dentists Health Support Programme	√			√		√		√			√	√		√	√				√		
Practitioner's Health Programme (London)	√	√			√	√					√	√			√	√			√		
House Concern (Northern Deanery)	√	√			√	√	√	√				√			√	√			√	√	√
Take Time (NE Yorkshire, W Yorkshire and E Lincolnshire)		√			√	√					√				√		√		√		
Staffordshire Support Scheme (S Staffordshire)	√	√			√	√						√		√	√				√	√	
Avon COPE	√	√				√					√			√	√			√			

Name	How				What									Who		For Whom				
Scheme																				
Clinical Psychology Associates for West Midlands Deanery	√	√				√									√		√		√	
British Medical Association - Doctors for Doctors Service	√	√									√	√	√	√		√				
British Medical Association - Counselling Service and Doctor Adviser Services	√			√		√					√	√		√	√	√				
Chartered Society of Physiotherapy				√			√													√
Confidential Support and Advice for Surgeons	√										√	√		√				√		
Doctors' Support Group		√						√	√		√	√		√	√	√			√	
Dental Protection	√	√				√			√	√	√	√		√	√				√	
Doctors' Support Network	√		√					√	√		√	√		√		√				
Dental Defence Union	√			√					√	√	√			√	√				√	
General Medical Council				√					√			√				√				
Medical Protection Society	√			√					√	√	√				√	√				

Name	How				What									Who		For Whom					
Royal College of Nursing	√	√	√	√		√		√	√	√				√	√					√	√
Medical Defence Union	√			√				√	√		√				√	√					
Medical and Dental Defence Union of Scotland	√								√		√			√		√					
Psychiatrist Support Service	√			√				√			√	√		√				√			
Support 4 Doctors				√				√			√	√				√					
Royal Medical Benevolent Society	√									√	√	√				√					
Pharmacist Support	√			√		√	√	√	√	√	√		√	√							√
British Dietetic Association				√							√										√
Royal Pharmaceutical Society	√			√						√					√						√
Association of Optometrists	√			√				√	√		√				√						√

Appendix 2: Contact Details of Support Services

British Medical Association
(http://bma.org.uk)
- → Doctor Support Service
    - o Phone: 02073836707
    - o E-mail: doctorsupportservice@bma.gov.uk
    - o Information on service available at: http://www.gmc-uk.org/The_Doctor_Support_Service_0512.pdf_48983557.pdf.
- → BMA Counselling Service
    - o Phone; 08459200169

General Medical Council
(http://www.gmc-uk.org)
Written guidance available at:
http://www.gmc-uk.org/concerns/doctors_under_investigation/a_guide_for_referred_doctors.asp)

Medical Protection Society
(http://www.medicalprotection.org/uk/)
Medico-legal advice available on:
   Phone: 0845 605 4000
   E-mail: querydoc@mps.org.uk

Published guidance available at: http://www.medicalprotection.org/uk/booklets/common-problems-hospital/if-things-go-wrong)

Medical Defence Union
(http://www.themdu.com)
Medico-Legal advice available on: 0800 716 646
E-mail: advisory@themdu.com
Published guidance available to members at: http://www.themdu.com

Medical Defence Shield*
(www.mdsuk.org)
E-mail: info@mdsuk.org
Tel: 01234 330243

The Medical and Dental Defence Union of Scotland (MDDUS)
(http://www.mddus.com/mddus/home.aspx)
Support is available for members via the Medical and Dental Advisory Teams, contactable on:
Tel: 08452702034
E-mail: advice@mddus.com

Chartered Society of Physiotherapists
(http://www.csp.org.uk)
Support is available to members only. The general enquiries number is 02073066666 – accessible 8:30-17:00 Monday-Friday.

Confidential Support and Advice for Surgeons
(http://www.rcseng.ac.uk/surgeons/supporting-surgeons/professional/csas)
Support can be accessed at 020 7869 6212 where you will put in contact with an appropriate colleague to discuss concerns with.

Doctor's Support Group
Access to this service is via a form on their website (http://doctorssupportgroup.com)

Dental Protection
(http://www.dentalprotection.org/uk)
Support is available to members only on tel: 0845 608 4000 between 8:30 am and 5:30 pm Monday-Friday.

An emergency advice helpline is available for urgent enquiries on 0845 608 4000 to speak with a dento-legal advisor.

Doctor's Support Network
(http://www.dsn.org.uk)
A telephone helpline is available on 0844 395 3010 on weekday evenings and Sunday afternoons:
Mon and Tues : 8pm-11pm
Weds-Fri – 8pm-10pm
Sunday 4pm-10pm

Dental Defence Union
(http://www.theddu.com)
A telephone helpline is available 9-5 Monday-Friday on 0800 374 626 for members.
There is also an on-call service available for emergencies or urgent enquiries 24 hours a day.

Dentists Health Support Programme
http://sick-doctors-trust.co.uk/page/dentists-health-support-programme-helpline
Telephone: 020 7224 4671
24/7 helpline for dentists with alcohol or drug addiction

Royal College of Nursing
(https://www.rcn.org.uk)
Members can access support by calling 0345 408 4391. Accessible between 9:30-4:30 on weekdays. Counseling services are accessible via this number between 8:30am and 8:30pm, 7 days a week.

Psychiatrist Support Service
(http://www.rcpsych.ac.uk/workinpsychiatry/psychiatristssupportservice.aspx)
Telephone: 020 7245 0412
E-mail: pss@rcpsych.ac.uk
Available during office hours Monday-Friday.
Signposting to other services can be found on their website at: http://www.rcpsych.ac.uk/workinpsychiatry/psychiatristssupportservice/resources.aspx

Sick Doctors Trust
(http://sick-doctors-trust.co.uk/)
Telephone: 0370 444 5163
24/7 helpline support for doctors with alcohol or drug addiction problems.

Support 4 Doctors
(http://www.support4doctors.org)

Royal Medical Benevolent Society
(http://www.rmbf.org)
Tel: 0208 540 9194
Address and E-mail contact can be found at http://www.rmbf.org/pages/contact-us.html

Pharmacist Support
(http://www.pharmacistsupport.org)
Telephone advice available to members, more details can be found on website but some specific telephone support lines include:
Specialist Advice: 0808 168 2233
Listening Friends: 0808 168 5133
Health Support Programme: 0808 168 5132

Dietetic Association
(http://www.bda.uk.com/index.html)
Telephone Address: 0121 200 8080
Open Monday-Thursday 9-5 and Friday until 430pm.

Royal Pharmaceutical Society
(http://www.rpharms.com/support/enquiry-service.asp)
Tel: 0845 257 2570 (9-5 Monday-Friday)
Online Enquiry Form or E-mail access also through their website. For members only.

Association of Optometrists
(http://www.aop.org.uk)
Legal advice provided by an in-house group of solicitors at AOP. 24 hour legal helpline accessible on 0845 200 3510.
Legal team e-mail: legal@aop.org.uk
Published guidance available at:
 http://www.aop.org.uk/uploads/legal_services/legal_flyer_final_1

*Declaration: Rajan Madhok is the Chairman of BAPIO, the parent body of MDS, and he is also the chief executive of MDS.

Appendix 3: Notes from 7 April Workshop Discussion

1. **What can we do in our organisation?**
   - Leadership/Open Culture +++
   - Less bureaucracy (lip service)
   - Learning culture/organisation
   - Improve professional development
   - Resources for supporting staff e.g. leaflet on suspension
   - Effective handover e.g. to regulators (e.g. let them know a person is at risk)
   - Clear bullying policies
   - Occupational Health +++
   - Better data capture
   - Consistent (across organisations) investigations
   - Learning- (not blame-)focused investigations
   - Allocate mentor to <u>all</u> persons under investigation

2. **What do we want others to do?**
   - Larger national study
   - Make available and publish support
   - Monitor uptake of support services
   - Apology when things go wrong in investigations
   - Standardize Occupational Health referral processes (improve access for primary care)
   - Create mentor network
   - CQC and others: monitor staff wellbeing / support
   - Survey staff involved in investigation
   - A mentor who has been through regulatory process themselves (RCN have a programme)
   - Regulator/legal survival guide (whistleblowing and regulatory processes) (RCN SW Regional Office has relevant programme)
   - Staff support
   - NCAS produce guideline for Boards
   - Regulators only to take serious cases
   - Regulators – joint work
   - Training in patient safety (how to avoid mistake)
   - Feedback to leaders at Board level - CQC can support this

3. **What can the CLN do?**
   - Campaign for justice
   - Space for acknowledging injustice
   - Sharing good practice
   - Mentor scheme
   - Patient safety forum for regular discussion of issues
   - Standardise approach to suspension (e.g. incident decision tree)
   - How can we help organisations to learn? (e.g. from Haringey)
   - Joint work between regulators and professional bodies

Appendix 4: Participants in the 7 April 2014 Workshop
(Workshop led by Judith Strobl and Rajan Madhok)

Antony Samy	Network Director	Lancashire Care NHS Foundation Trust
Adriana Roscoe	HR Manager	
Alistair Hutchinson	Clinical Head of Division	Manchester Royal Infirmary
Amanda Smith	Staff Support Services Manager	Mersey Care NHS Trust
Audrey Wood		Cheshire & Wirral Partnership Foundation Trust
Brian Westbury	Senior Dentolegal Adviser	MPS
Burt Burton	Risk Manager	Manchester Mental Health and Social Care Trust
Clare Baguley	Psychological Professions Network Lead	Health Education North West
Diane Leicester-Hallam	Charity Manager	Pharmasist Support
Eileen Platt	Strategic HR Business Partner	East Chesire Trust
Eleanor Poole	Case Review Manager	General Dental Council
Gita Bhutani	Professional Lead - Psychological Services	Lancashire Care NHS Foundation Trust
Harish Babu		
Ian Boit	Central Investigations Officer	Cumbria Partnership NHS Foundation Trust
Jacqueline Chang	Area Visitor	RMBF
Jo Galvin	Medicolegal Adviser	MPS
Jonathan Green		General Dental Council
JS Bamrah	Interim Medical Director	Manchester Mental Health and Social Care Trust
Julie Seed	Head of Governance	Lancashire Teaching Hospitals NHS Foundation Trust
Manju Meda	Consultant Microbiologist	Cumbria
Narinder Kapur	Professor of Neuropsychology	University College London
Paulette Storey	Head of Opperations	Pharmasist Support
Ray Cochrane	Employee Health & Wellbeing	University Hospitals South Manchester
Sarita Khaira	Head of FTP Service Improvement	The Health and Care Professions Council
Sarndrah Horsfall	Consultant	GMC
Suresh Rao	Consultant Orthopaedic Surgeon	Cumbria
Tim Walker	Chief Executive and Registrar	General Osteopathic Council
Tista Chakravarty-Gannon	Regional Liaison Adviser	GMC
Umesh Prabhu	Medical Director	Wrightington, Wigan and Leigh FT
Vino Apok	Neurosurgical trainee	Salford Royal FT
Wendy Makin	Deputy Medical Director	The Christie NHS Foundation Trust
Yvonne Guilfoyle		