The safety branch should also investigate staff harm

27 FEBRUARY, 2017 BY NARINDER KAPUR

HEALTH SERVICE JOURNAL

Narinder Kapur suggests that the Healthcare Safety Investigation Branch also examine 10 cases a year of death or serious harm to staff arising from workplace issues

The government acknowledged the case for the recently established Healthcare Safety Investigation Branch to examine incidents where patient safety has been seriously compromised, so that lessons can be learned. It is widely accepted that working in healthcare can sometimes harm the physical and mental wellbeing of staff, even to the point of staff suffering serious ill health or committing suicide.

I propose that the HSIB also includes within its remit 10 cases a year of death or serious harm to staff that related directly or indirectly to workplace issues.

Karl* was a dedicated junior doctor. He was in many ways a perfectionist, and he fretted over making mistakes. He found himself pondering again and again over cases that he had recently seen, going through textbooks to check on his decisions.

This got to the point where it became an obsession and he lost confidence in his ability to work as a doctor. He could not cope.

He took time off from medicine, telling others that he “was studying”. One day, as a cry for help, he complained that he had gone totally blind as a result of looking at the sun.

Over the coming months and years, he developed new psychosomatic symptoms. Eventually, he was diagnosed with schizophrenia. Karl never practised medicine again. When he was in his early 50s, he hanged himself.

In August 2011, Dr Lauren Connelly was seven weeks into her first job after graduating in medicine. She had just finished her 12-hour night shift when she was involved in a fatal crash. Her father, Brian Connelly, believed she was suffering from fatigue which had built up over the previous seven weeks.

Her father discovered that she worked excessively long hours, and that she was starting a run of seven nights back-to-back when she was killed driving home after her night shift. It was only after a campaign by her father that a change in the rota system for doctors such as Lauren was introduced in Scotland.

Avoidance of such cases

Could these deaths have been avoided? It is possible that Karl's death could have been avoided if he had been given proper support and advice early in his clinical career, not only about his perfectionist and obsessional tendencies but also about alternative careers outside clinical medicine.

In Lauren's case, it is possible that if less punishing shift rotas were in place or if there was a provision, even a requirement, that after a night shift a doctor could use a taxi, paid by his/her employer, to travel home, she might have availed herself of that option. Only proper investigations would have discovered the truth and lessons to be learned.

In the case of another doctor, Dr Carl McQueen, who committed suicide in February 2016 after making an error that was followed by a patient's death, there was a full, independent investigation into earlier mistakes in the medical management of the patient, but there was no corresponding investigation into Dr McQueen's death (other than a coroner's inquest, which has restricted terms of reference).

Burnout and the risk of depression have been well documented in the medical profession,[1-5] together with possible remedial measures.[6-8] In his report into the Mid-Staffordshire Foundation Trust, Sir Robert Francis documented the case of Eva Clark, who committed suicide in the context of being bullied, but no proper investigation of her death appears to have been carried out.

In his 2015 report into whistleblowing in the NHS, Francis referred to the existence of "kangaroo courts" that were used by managers to victimise and dismiss staff. These or similar settings can result in extreme distress that can lead to suicide, as in the case of the award winning nurse, Amin Abdullah.

We now have a Healthcare Safety Investigation Branch that examines patient safety incidents, including some "Never Events". What we need are comprehensive and professional investigations of the circumstances surrounding cases where staff wellbeing has been seriously compromised, cases which might be termed "Staff Never Events".

Study after study has shown the close relationship between patient safety and staff morale and wellbeing. Where healthcare staff suffer major distress or harm during their working career, there is also often an effect on the public purse, with costs of sick leave, hiring locums, legal expenses, etc.

So it is a win-win situation if such cases are properly investigated and lessons learned. This is not to decry the importance of other factors, such as the need to destigmatise mental health issues among healthcare staff, and the need to examine workloads and related issues pertaining to resources.

It may be too costly and burdensome to set about establishing a new investigative body to look at such events. I, therefore, propose that, in addition to its planned investigation of 30 patient safety events a year, the HSIB also examines 10 cases a year of death or serious harm to staff that arose directly or indirectly from workplace issues.

Narinder Kapur is a consultant neuropsychologist and visiting professor of neuropsychology at University College London