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Review

Suicide whilst under GMC's fitness to practise investigation: Were those deaths preventable?

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ABSTRACT

The suicide of doctors under regulatory investigation in the United Kingdom has recently been under scrutiny. Despite a commissioned report into the issues surrounding these deaths, we discuss a variety of procedural and legal lacunae not yet openly considered for reform. We identified that the UK coronial system has in place several legal instruments requiring coroners to report the physician suicides as preventable to the regulatory body, the General Medical Council (GMC). We were unable to identify that these suicides were reported in line with established legislation. We also explored the relationship between the GMC and its registered doctors, concluding that the GMC does indeed have a duty of care towards its members on this important matter and that there should be procedural reform to tackle the inherent risk of suicide whilst under investigation.

1. Introduction

28 doctors committed suicide between 2005 and 2013 whilst under fitness-to-practise (FTP) investigations. These were the alarming and distressing figures revealed following a Freedom of Information (FOI) request made independently to the General Medical Council (GMC) in 2012 by a psychiatrist, Dr Helen Bright.[1] The reasons for the suicide are multitudinous. However, a common theme is the stress and threat of investigation by the GMC and the painfully named 'death by 1000 arrows'[2] associated with an almost simultaneous investigation by various other authorities. This may include the police, an employer, the Clinical Commissioning Group, NHS England, and the Local Medical Committee. These deaths were not contemporaneously highlighted as preventable and only recently made public.

In this article, we seek to explore whether these deaths could indeed have been averted, and if so, by whom and how. Part 2 below will discuss how far FTP investigations should be recognised as a distinct suicide risk factor. By analysing firstly the high rate of suicide among doctors in general, the discussion will then assess the extent to which ongoing FTP investigation either exacerbates existing suicide tendencies or poses as an abnormally insurmountable challenge, so much so that it warrants consideration as an independent risk factor for physician suicide. In Part 3, we will argue that the failure thus far to isolate and recognise FTP investigation as a risk factor has meant that insufficient effort has been made to prevent the death of the affected doctors. The 2 main parties on whose shoulders lie the bulk of the responsibility are the coroners and the GMC itself. We aim to highlight specifically, that none of the deaths were reported by the coroner under Rule 43 of the Coroners Rules 1984 or as Prevention of Future Deaths (PFD) Reports under the Coroners and Justice Act 2009.[3] The reporting of these deaths to the GMC may have promoted brisk, efficacious changes in the manner in which doctors are investigated and may have prevented the loss of lives. Further, even in the absence of a PFD report, it will be argued that the GMC has actual or constructive notice of the cause of death. This, coupled with the gravity of the issue, gives rise to a duty to take appropriate actions to ensure that further suicides are averted. Part 4 reflects on the lessons that need to be urgently learnt from the array of failings to date.

2. FTP investigation: a suicide risk factor?

Following on the heels of the FOI request, the GMC commissioned an independent report in 2013. The aim was to review the deaths of those who committed suicide while under FTP procedures during the time framework examined.[4] It was prepared by Sarndrah Horsfall, who was the Chief Executive for the National

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Patient Safety Agency (NPSA). The report revealed that of the 28 suicides recorded between 2005 and 2013, 20 of these cases were male, two-thirds were under 50 years old, and 2 were trainees.[5] There was an equal preponderance for hospital or general practice doctors. 20 of the doctors were highlighted as having a health concern – thus identifying them as potentially more vulnerable. These 20 doctors were further subdivided - 6 of them were reported to be a suicide risk; 4 did not have evidence of a documented suicide status; and the current health provision status for 2 of the doctors was unknown.[6] In this part of the discussion, we will investigate the extent to which ongoing FTP procedures could have played a significant role in these suicides.

2.1. Physician suicide in general

Doctors have been identified as hard-working, professional members of society.[7] They are perfectionistic, high-achieving and talented with studies confirming that their work and productivity is intimately associated with their perception of self-esteem.[8,9] Most doctors are able to channel this method of working effectively and find ways in which to thrive from their delivery of care to patients. In some circumstances, actual or perceived criticism leads to a collapse of this self-esteem and resultant physical and/or mental health issues associated with low self-esteem including anxiety and depression arise.[10] Doctors may have developed maladaptive methods of coping with the stress associated with the delivery of 'perfect' care and these include alcohol, drugs and reckless behaviour.[11,12] The balance between mental health, physical health and the misuse of alcohol or drugs is unclear.[13] However, this balance may be lost when further stress is added in the form of professional, regulatory investigation.

Several studies have highlighted that medical professionals are a high suicide risk.[14] This risk is greater than in other professions and much greater than the general population.[15] The same studies have also demonstrated that female doctors are high-risk.[16] Overall, there is a higher-rate of mental health problems amongst doctors and studies have demonstrated that even in the absence of regulatory investigation, some 10–20% of doctors are depressed at some point in their careers.[17] Indeed this concern is further highlighted by a recent survey that demonstrated that those doctors subject to complaints were at a markedly increased risk of suicidal thoughts, anxiety and depression.[18]

Recently, the stresses placed upon doctors, even in the absence of regulatory investigation by the GMC, have increased. A report issued by the Royal College of Physicians in 2012[19] demonstrated that currently there are one-third fewer acute trust beds than 25 years ago yet there has been a 37% increase in hospital admissions over 10 years.[20] Two-thirds of patients admitted to hospital are greater than 65 years old and most have complex multimorbidity requiring greater skill, higher levels of care and cautious management.[21] The report also highlighted that buildings, staff and services are not of a calibre designed to cope with this degree of multimorbidity. Amongst all of this, 75% of medical consultants reported being under more pressure than 3 years ago and 25% of medical registrars reported their workload as unmanageable.[22]

In the same survey, half of consultants reported spending less time with these trainees than 3 years ago, exposing a worrying preponderance for lack of supervision due to service commitments, unmanageable workloads in junior staff and a high background risk of anxiety, depression and suicide.[23] Currently, not only are hospital staff suffering from the increased burden from healthcare delivery. It has been reported that general practitioners (GPs) are suffering from the highest levels of stress since 1998 with approximately half of all GPs over 50 planning to retire in the next 5 years.[24] The results of the GP national worklife study revealed that '[GPs have] the lowest levels of job satisfaction … [and] the highest levels of stress'.[25] The subsequent addition of a regulatory investigation can surely be seen to be an additional stress that for some may increase the risk of mental and physical illness and suicide.

There is an extensive body of research behind physician suicides, reflecting the concern and desire to prevent such deaths at intense personal, social and financial cost to society.[26] Most methods of suicide within a medical body reflect what is known about gender differences in suicide.[16] The majority of cases are of self-poisoning or self-harming; with males more likely to undertake physical methods of suicide. Anaesthetists are more likely to use chemical methods of suicide whereas hanging, cutting, shooting and even burning are options taken by some doctors.[27]

Perhaps most worryingly of all is why doctors do not seek help when experiencing difficulties with stress, depression or substance misuse. A 2011 literature review[28] of these reasons revealed that doctors may perceive the need for assistance as a sign of weakness, they may fear regulatory involvement particularly if substance misuse is a method of maladaptive coping or they may attempt to frustrate the natural process of healthcare delivery by the use of 'corridor conversations.'[29] This final point has been demonstrated clearly in the case of Dr Daksha Emson, a consultant psychiatrist who committed suicide. A report into her death and that of her young daughter revealed in 2000 that:

'Daksha was afraid of being stigmatised if others knew of her illness … Her fear would seem well justified, as the NHS was considered by a senior expert in health employment, with experience of both the private sector and the NHS, to be far worse than the private sector for stigmatising mental illness in its employees.'[30]

The report also highlighted that those doctors who are struggling may not receive the true benefit of being treated as a patient, rather than a colleague. It states that 'a large number of doctor-to-doctor consultations are carried out on an informal basis, the "patient" seeking advice from a colleague often without reference to the General Practitioner. Self-medication, particularly of psychotropic medication, is commonplace'.[31] The recommendations made in the array of professional literature discussed, demonstrate how doctors are at high-risk for mental illness and suicide; yet not as able to access conventional methods of healthcare due to perceived stigma or inadequate service provision.

Thus even in the absence of FTP investigations, heavy threats are posed to doctors' health when considering the skill, perfectionistic approach and burdens associated with the delivery of complex healthcare in the UK today. As will next be seen, the addition of pressures associated with regulatory investigation can have a truly harmful effect particularly on those already at high-risk of suicide.

2.2. Suicide whilst under investigation

Although the presumption of innocence operates in FTP investigation just as it does in court, doctors undergoing FTP proceedings often feel that they are judged 'guilty until proven innocent'.[32] This was the agonising experience of those confronted with GMC disciplinary procedures, according to the Horsfall report. Contributing to this perception are multiple causes of stress stemming from various aspects of the procedures, some of which are described below:

- some doctors received multiple letters from the GMC investigation team, with one doctor receiving up to 5 letters over a 4-day period[33];
- many doctors felt that the tone was 'accusatory' with emphasis on legal terminology and a subsequent failure to reflect compassion or recognition of underlying health complaints[34];

- some doctors received minimal communication and felt that they did not receive support over this delayed period of communication; and
- unacceptable delays in investigating some concerns, in some instances leading to an increased risk of suicide. Thus, as highlighted in the report, '*if the GMC had responded in a more timely fashion the death may have been prevented.*'[35]

A referral to the GMC, as viewed by external stakeholders, was in effect found to be depersonalising and dehumanising.[36] It revealed that there is an expectation that doctors who are referred to the GMC health procedures need to disclose all aspects of their medical reports including sexuality, previous psychiatric history, abuse as a child and covers all documented aspects of the doctors' and their families' lives. It is thus not difficult to identify the GMC investigation as a stressful process, more so when the allegations are made against a doctor who identifies with mental health or substance misuse issues. The independent review also raised a concern that the process is not open to being paused or delayed once in motion.[32] This exacerbates the doctors' distress as they may feel like they have no control over the process or even their lives, throughout the usually protracted course of the proceedings.

Against this background, it comes as no surprise that some doctors are now lobbying for a GMC investigation to be classed as an independent risk factor for suicide.[37,38] This, undoubtedly, is a rational step since the evidence is clear that involvement with the GMC after a referral may worsen mental health concerns. Indeed, it was the failure to recognise it as a risk factor, which has resulted in not enough having being done to prevent the regrettable loss of an unacceptably high number of lives. But who were accountable for this inaction?

3. The failure to care for doctors under investigation

If the suicide of the doctors subjected to FTP investigation was, as argued, preventable, there seems to be 2 parties that were in a pre-eminent position to prevent them. These, as to be discussed in turn, are the coroners and the GMC itself.

3.1. The role of the coroner

As the FOI request revealed, over an 8-year period, there were 28 completed suicides of doctors under investigation by the GMC. 24 of these cases received a verdict of suicide, a verdict that requires the criminal burden of proof – beyond all reasonable doubt.[39] These 24 doctors made it clear they intended to kill themselves, the remaining two cases were reported as 'suspected suicide.'[40] Those deaths falling under Her Majesty's coroner in England and Wales are governed by the Coroners and Justice Act 2009 – which came into force in 2013. The chief coroner, under the same legislation, has stated that

> 'Coroners have a *duty* … where appropriate, to report about that death with a view to preventing future deaths. A bereaved family want to be able to say: "his death was tragic and terrible, but at least it shouldn't happen to somebody else."'[41]

This statement is enacted in current legislation. However, the concept is not a new one. Previously Rule 43 reports existed under the Coroners Rules 1984 and were replaced on implementation of the Coroners and Justice Act 2009 with Reports on Action to Prevent Future Deaths. These are commonly abbreviated to PFDs or PFD reports and embody the desire to prevent further deaths where possible. The importance of PFD reports is clearly demonstrated by Schedule 5 s7 (1) of the Coroners and Criminal Justice Act 2009 which specifies that the coroner '***must*** report' in certain circumstances, rather than just a duty to ***consider*** reporting. The chief coroner has stated that the coroner's duty to report arises in the following situation[42]:

a. The coroner has been conducting an investigation into a person's death.
b. Something revealed by the investigation gives rise to a concern.[43]
c. The concern is that circumstances creating a risk of further deaths will occur, or will continue to exist, in the future. It is a concern of a risk to life caused by present or future circumstances.
d. In the coroner's opinion, action should be taken to prevent those circumstances from occurring or to reduce the risk of death.
e. If sections a–d apply, then the coroner has a duty to report (i.e. 'must report') the matter to a person who the coroner believes has the power to take action to prevent further deaths.

Although the chief coroner's guidance on issuing a PFD report only came into force in 2013, the guidance to issue a Rule 43 report to prevent future deaths has been in force since 2008 when the Coroners (Amendment) Rules 2008 came into operation. The latter modified the Coroners Rules 1984. It suggested reporting when '*the evidence gives rise to a concern that circumstances creating a risk of other deaths will occur, or will continue to exist, in the future …* '[44]

It is therefore clear to see that since 1984, with the original Coroner Rules and then through the Coroners (Amendment) Rules 2008 up until the Coroners and Justice Act 2009, there has been a continuous and consistent requirement for coroners to initially *consider* a report to prevent future deaths and that this is now encapsulated in law as a *duty* to report.[45]

Despite the plethora of information revealed by the recent failings on behalf of the GMC,[46] at no point has it been raised that there was a failure of the coronial system to report on these deaths under the appropriate legislation. 28 doctors committed suicide and at no point did the coronial system consider that circumstances might be prevailing that contribute to the future deaths of doctors. This is despite the coroner, in one case, asking the GMC to comment on a suicide note, which clearly implicated the GMC in the doctor's death.[47] It is unclear why a Rule 43 or PFD report, under the relevant legislation, was not issued to the GMC. Reviewing the chief coroner's recommendations on *when* to issue, we can clearly see that there were future risks of death. Should there have been a cluster of mental health deaths – the coroner would have issued a report. Should there have been a series of preventable hospital inpatient deaths – the coroner would have issued a report.[48] 28 doctors committed suicide, beyond all reasonable doubt, whilst under GMC investigation – there is no evidence that the coroner issued a report.

There could be a variety of reasons why there was a failure to recognise these deaths as a whole. There may be a failure of cross-talk between coroners including opportunities to discuss local demographic findings. There may also have been subconscious reluctance to issue a report to the medical regulator by a medically-qualified coroner. The deaths may have been so temporally and spatially discrete that this pattern of deaths went un-noticed. Unfortunately, it appears that the Cumulative Act effect[49] allowed the GMC to place doctors in particularly stressful situations contributing to suicide without the coronial system sounding the alarm and reporting that the GMC's processes were not only contributing to deaths but also risking future deaths.

3.2. The role of the GMC

Even without any formal notice received from the coroners, it is arguable that the GMC knows or ought to know of the problem. To start with, it is already GMC practice for all known or suspected suicide cases to be reviewed by a senior manager, through a significant enquiry report (SER). In addition, when an inordinately high number of doctors did not attend their FTP hearings or complete the proceedings on account of having died, this should have alerted the Council that something was amiss.

The Horsfall review nevertheless reported that 29% (eight) of the deaths had no SER recorded – demonstrating a potential internal failure or delay in assessing the needs of other doctors at risk of suicide under current investigation.[50] The potential delay or severity in failure to act becomes clearer when the individual deaths per year is reviewed. As highlighted, the FOI request that generated the initial review was made in 2012. The GMC report into the deaths whilst under investigation was commissioned in 2013 but released at the end of 2014. The breakdown of deaths revealed that in 2012, 4 doctors committed suicide and in 2013, 9 further suicides took place.[51] It is submitted that the interval between concerns about suicide being raised and the release of the report were unacceptable. An immediate cessation in the active investigation of doctors by the GMC could have taken place with an emergency reform of the processes and assessment of the risk posed to these doctors could have been made. The extrapolated effect of an immediate failure to act leaves no doubt that these further cases of suicide – 13 deaths – could have been managed differently. Thus although the GMC did commission an independent review in 2013, the report was ultimately reactive, not proactive.

This failure to take timely preventative measures is aggravated by the lack of any psychological or other practical support whilst waiting for conclusion of the FTP hearing, despite GMC claims to the contrary.[52] This sense of abandonment and neglect at a highly vulnerable and stressful time was vividly captured in the suicide note penned by one of the 28 doctors: “I am extremely stressed and cannot carry on like this. I hold the GMC responsible for making my condition worse with no offer of help.”[33]

The absence of timely measures to review and improve the process that has led many doctors to take their own lives, and/or any suitable support over the length of the investigation, arguably amount to a dereliction of the GMC's duty of care towards those doctors. As will be argued below, the unique circumstances before us strongly suggest that the GMC did owe a positive operational duty to those 28 doctors who committed suicide. This is not withstanding the fact that the GMC's declared role is to “protect patients” and ensure that they “receive a high standard of care”,[53] rather than to protect the doctors they regulate. It is also not withstanding the fact that a duty of care is not usually owed for omissions[54] since the situation falls within one of the recognised exceptions to the rule.

Although the responsibility of regulators towards those they regulate remains unclear, the case of *Watson v. British Boxing Board of Control (BBBC) Ltd*[55] demonstrates that a regulatory body does owe an affirmative duty to exercise care towards those it licensed as professional boxers. Therefore, the relationship between a regulator and those it licensed falls within an established category of liability for which a duty of care arises. Some may, however, argue that the BBBC is distinguishable from the GMC not least since the former is a sporting body and a non-statutory regulator, whereas the latter is a statutory regulatory body.[56] Even if the current situation is, on this consideration, deemed to be outside any existing category of duty of care, it would still meet the 3-stage requirements outlined in *Caparo Industries Plc v. Dickman*.[57] According to the House of Lords in that case, in situations where the courts have not previously recognised a duty of care, its presence can be established if injury is reasonably foreseeable; the parties are in a relationship of proximity; and it is fair, just and reasonable for a duty of care to be imposed.

In relation to the first stage, the 28 doctors fall within a class of individuals (namely those under FTP investigation) to whom it is reasonably foreseeable that the GMC's failure to exercise care would cause them harm.[58] The GMC as highlighted in Part 2 of this work, knew or ought to have known of a real and immediate risk to the lives of those identifiable individuals.

As regards proximity, the following wider principle from medical treatment cases which Lord Phillips referred to in *Watson* would be highly pertinent and demands a closer look:

> “where A (*in our case, the GMC*) places [itself] in a relationship to B (*in our case, doctors undergoing FTP investigation*) in which B's physical safety becomes dependent upon the acts and omissions of A, A's conduct can suffice to impose on A, a duty to exercise reasonable care for B's safety. In such circumstances A's conduct can accurately be described as the assumption of responsibility for B, whether “responsibility” is given its lay or legal meaning”.[59]

Here, it is relevant to note that every doctor who wants to practise in the UK would *need* to be licensed by the GMC. They would also *need* to comply with the guidelines issued by the GMC and can be disciplined by the same when these are deviated from. *The GMC therefore exercises a high degree of control over such doctors' professional lives.* When a complaint is received and FTP investigation commenced, doctors who are subjected to this process would have to succumb and cooperate with the ensuing investigation, every aspect of which is controlled by procedures laid down by the GMC.[60] In other words, the GMC determines the rules and what to do when the rules are violated or compromised. Consequently, the doctors do not voluntarily submit themselves to the risks of injury associated with this process. Neither could they have been reasonably expected to adequately protect themselves against this harm, not least because of the many uncertainties linked with the process as emphasised earlier. For that reason, it would be reasonable for such doctors to rely upon the GMC for their safety and welfare.[61]

This assumption of responsibility on the GMC's part, brings it into close proximity with the doctors under investigation. As they knew or had constructive notice that such investigations pose a danger to the relevant doctors, they could have used the power they wield to remove or prevent the danger or source of injury.[62] As noted by Hobhouse LJ in *Perrett v. Collins*, in situations where a defendant controls a situation which may be harmful to another, “he comes under a duty to act reasonably in all respects relevant to the risk.”[63] This is a fairly contained responsibility as those who are under FTP investigations form a determinate class. In short, the fact that the GMC has complete control over a situation that can result in harm, combined with the fact that reference is here made to an ascertainable group of individuals (i.e. only to doctors under FTP investigation, rather than to a large and indeterminate class of people) whose vulnerability places them in a position where they are not fully able to protect themselves against those harm, can give rise to a sufficiently proximate relationship between the GMC and those doctors. This is not withstanding the fact that the injury in question (i.e. suicide) is self-inflicted.[64] This is because, the GMC had reason to know that those doctors were a suicide risk[65] and were thereby in that category of vulnerable group who are closely and directly affected by its actions and omissions.

As for the third stage, it is highly likely that a court of law would find that it serves the interest of justice to impose a duty of care in these circumstances. Doctors undergoing FTP investigation rely upon the GMC to see to it that the proceedings which they are subjected to are conducted in a manner which is reasonably attentive to their welfare, and do not end up making them feel so suffocated and overwhelmed that suicide seemed the only way out.

In satisfying the 3-stage test adumbrated in *Caparo*, the GMC therefore has a duty to take reasonable care to ensure that FTP investigation is conducted in a way that is not injurious to the physical or mental health of the doctors affected. They should have given proper consideration to the risk/harm of those investigations and revised the procedures and/or provide adequate support from the start. The failure to do so when they are deemed to have assumed responsibility for this, led to an exceptional circumstance where a duty to take reasonable care can be recognised. The GMC thereby joins the coroners in failing to act in time, when they were both under a duty and have the ability to prevent those deaths.

4. Conclusion

The high prevalence of suicide among physicians in general should not obscure the fact that suicide whilst under the GMC's FTP investigations is sufficiently unique and deserves special attention. It is thereby a matter of profound regret that it had to take a random FOI request by an independent party to eventually highlight just how serious and extensive the problem is. That FTP investigation has never, prior to that, been isolated and identified as a distinct risk factor for physician suicide meant that practically nothing has been done to avert such deaths.

As argued above, culpability for the omissions lies mainly with two parties: the coroners and the GMC itself. The coroners, being the first to have notice of the situation, did not detect the pattern that has developed. This was therefore a missed opportunity to ensure that the GMC, at least, is made aware of the extent of the problem so that appropriate steps are taken to avert further deaths. Irrespective of this, the GMC itself has, as argued, actual or constructive notice of the situation. This gave rise to a legal duty to take positive action to ensure that FTP proceedings are conducted in a way that is not detrimental to the physical or mental health of doctors. Further or in the alternative, adequate support should have been provided to the doctors whilst investigation is on-going. Yet it seemed to have failed to do both.

This paper has sought to understand what the failings were that have led to the high number of suicides. In so doing, it argued that those deaths were indeed preventable. It has identified that the coronial system needs robust methods of identifying patterns of suicide within discrete demographic groups, such as physicians. Also, that coroners must utilise the low threshold set by the chief coroner to report deaths as preventable and if this is not able to take place, the barriers to reporting are highlighted. The paper has also identified that as necessary as FTP investigations are in ensuring that appropriate actions can be taken against doctors who fall short of the high standards expected of them, it is important that lessons are learned so that the process no longer contributes to physician suicide. This paper has also demonstrated that there is a demonstrable duty of care established in tort between the GMC and its member-doctors on this important matter.

Conflict of interest

None declared.

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36. Horsfall S. *Doctors who commit suicide while under GMC fitness to practice investigation*. The General Medical Council; December 2014. p. 35.
37. See http://www.bmj.com/content/350/bmj.h813/rapid-responses [accessed online 3/5/2015].
38. 'Of the 5,728 doctors subjected to an investigation by the GMC in 2012 AND 2013 (GMC, 2013 & 2014), 13 tragically committed suicide, a suicide rate of 227/100,000 (GMC, 2014). In the general population at that time, the suicide rate was 11.6/100,000 (ONS, 2014); amongst prisoners, the suicide rate was 65.5/100,000 (DH, 2014; MoJ 2013). The relative risk of dying from suicide whilst under GMC investigation in 2012 was therefore twenty times that of the UK general public…' Powys-based GP Dr Alan Woodall, accessed via resilientgp.org 2/8/2015.
39. *Statistical update on suicide*. Health Improvement Analytical Team. Department of Health; January 2014. p. 4.
40. Suspected suicide may mean narrative verdict, open verdict or reputable source of information reporting strong possibility of death by suicide but not meeting the criminal burden of proof.
41. *Guidance number 5. Reports to prevent future deaths*. The Chief Coroners Office. HH Judge Peter Thornton QC; September 2013. Page 1 (emphasis added).
42. Ibid. ref 41 page 2.
43. This diffuse statement is representative of the fact that to give rise to a concern requires only a relatively low threshold – see Coroners Inquests into the London Bombings of 7 July 2005, per Lady Justice Hallett, ruling 6 May 2011 p15.
44. Rule 43(1)(b).
45. Coroners Rules 1984 rule 43 'a coroner who believes that action ***should*** be taken…may announce…that he is reporting the matter…' versus 'the coroner ***must*** report the matter' under paragraph 7, Schedule 5 of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
46. See the discussion in part 2.2 above and part 3.2 below.
47. Horsfall S. *Doctors who commit suicide while under GMC fitness to practice investigation*. The General Medical Council; December 2014. page 29 'In one case the coroner asked the GMC to comment on a note in which the doctor said: "I am extremely stressed and cannot carry on like this. I hold the G.M.C. responsible for making my condition worse with no offer of help".'.
48. It is possible to see a list of Prevention of Future Death reports at https://www.judiciary.gov.uk/subject/prevention-of-future-deaths/ [accessed online 3/5/2015].
49. Reason J. The contribution of latent human failures to the breakdown of complex systems. *Philosophical Trans R Soc Lond Ser B Biol Sci* 1990;**327**(1241):475–84. also known as the Swiss Cheese model of errors.
50. Horsfall S. *Doctors who commit suicide while under GMC fitness to practice investigation*. The General Medical Council; December 2014. p. 24.
51. Horsfall S. *Doctors who commit suicide while under GMC fitness to practice investigation*. The General Medical Council; December 2014. p. 22.
52. Horsfall S. *Doctors who commit suicide while under GMC fitness to practice investigation*. The General Medical Council; December 2014. p. 33–4.
53. GMC, 'The role of the GMC', available at: http://www.gmc-uk.org/about/role.asp (visited 12/08/2015).
54. Stovin v. Wise [1996] AC 923, per Lord Hoffman at 943; Smith v. Littlewoods Organisation Ltd. [1987] 1 All ER 710 per Lord Goff at 729.
55. [2001] 2 WLR 1256.
56. Set up by the Medical Act 1858.
57. [1990] UKHL 2.
58. Haley v. London Electricity Board; Mitchell v. Glasgow City Council [2009] UKHL 11.
59. At 1270A-B, as cited in J. George Watson v British Boxing Board of Control: Negligent rule-making in the court of appeal. *Mod Law Rev* 2002;**65**. 105 at 110.
60. Note that although it is the Medical Practitioners' Tribunal Service (MPTS) which now adjudicates on all FTP cases, it still needs to adhere to guidance issued by the GMC. For discussion, see K.A. Choong & M. Barrett, 'The Medical Practitioners' Tribunal Service: One year on' (2014) Lex Medicinae – Revista Portuguesa de Direito da Saúde (Portuguese Journal on Health Law) 83 at 88.
61. Barrett v. Ministry of Defence [1995] 1 WLR 1217; Bhamra v. Dubb [2010] EQCA Civ. 13.
62. Sutradhar v. Natural Environment Research Council [2006] UKHL 33.
63. [1998] 2 Lloyds Rep 255 at 262, as cited in J. George, op. cit., p. 118.
64. Savage v. South Essex Partnership NHS Foundation Trust [2008] UKHL 74; Reeves v. Commission of Police for the Metropolis [2000] 1 AC 360.
65. Peel E, Goudkamp J, editors. *Winfield and Jolowicz on Tort*. London: Sweet & Maxwell; 2014. p. 102–8.