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EDITORIAL

It is time to investigate all work-related suicides; it is an obligation and a public health issue

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In response to the suicide of a British headteacher, Ruth Perry on 8th January 2023, Waters and McKee, writing in the British Medical Journal [1], called for investigations of all work-related suicides [1]. They wrote that there had been at least eight other teacher suicides linked to the Office for Standards in Education, Children's Services and Skills (Ofsted) reports, but that the total number of suicides linked to Ofsted is unknown. While acknowledging a multitude of causations for mental health problems, the authors related concerns that Ofsted clearly plays a significant role with reports of denigration and abuse by inspectors and selective use of and miscited evidence [1]. Walter and McKee asked for mandatory investigations of work-related suicides to ensure they are subject to the same requirements for reporting and prevention as other occupational deaths [1], but is this enough?

There has been similar disquiet in the healthcare sector over the past decade, because of suicides of healthcare workers. On 24th November 2015, Dr Wendy Potts, a 46-year-old general practitioner (GP) hanged herself. The Derbyshire assistant coroner said, '*The investigation process lost sight that Dr Potts was a human being…, it seems that this is not an isolated case…, a sledgehammer to crack a nut*' [2]. The NHS Trust suspended and was investigating Dr Potts after a patient, who had read Dr Pott's blog about her (Dr Potts') bipolar disorder, complained. On 24th June 2015, Dr James Halcrow, a 34-year-old GP trainee hanged himself. The coroner concluded that it was '*reasonable to rely on (a potential GMC suspension) as a factor in James taking his own life*' [3]. Dr Halcrow had self-referred himself to the GMC (General Medical Council) for issues that he was having that led to restrictions being placed on him.

Twenty-eight doctors committed suicides while undergoing GMC investigations between 2005 and 2013, a quarter of all deaths of doctors undergoing GMC investigations during that period [4]. Twenty of the doctors had health issues with six reported to be a suicide risk, and four did not have a documented suicide status. 54% of these doctors were referred by their employers, and 11% were self-referrals. From 2007 to 2013, when data for the total number of GMC investigations were available [5], the incidence of suicides per 1,000 doctors investigated increased steadily from 0.72/1,000 in 2007 to 3.05/1,000 in 2013. In 2013, the incidence of suicide in the UK general population was 0.12/1,000 population [6], and the incidence of suicide in the prison population in England and Wales was 0.95/1,000 [7], meaning the suicide rate of doctors undergoing GMC investigation that year was 25 times that of the general population and three times that of the prison population. Casey and Choong have argued that suicides while undergoing GMC investigations were preventable, and that there is a demonstrable duty of care, established in law, owed by the GMC to its members [8].

These investigations are usually started by the employers [2, 9]. On 23rd January 2004, Dr Stephen Farley a 55-year-old GP died by hanging. He had suffered from depression from the pressure of a prolonged investigation that lasted 3 years by his local primary care trust (PCT). He was investigated because the PCT claimed that he was referring too many patients for specialist treatments. The coroner said at his inquest, '*This death clearly should not have happened*' [9]. Beyond investigations, there are other factors that contribute to these tragic outcomes including the pressure of work [10] and these pressures start early in medical school life [10, 11].

In her PhD thesis, Magdalena Najda [12] wrote about work in general, '*In the workplace, human beings build the knowledge of themselves as participants in social relations; they are able to answer questions about their attitudes towards other people. Since human relations are mostly reciprocal, workplace is also a source of these parts of self-narrative, which relate to the dignity expressed by attitudes of others toward an individual. People build their sense of dignity in workplace not only because of the respect they experience from others, but also because of the opportunity for self-actualization the work provides them. People spend the vast part of their time in the workplace, encountering others there and developing their own potentials. They also have the unique opportunity for justifying their existence as good and meaningful*' [12]. For many doctors, their work is their main source of self-esteem, making investigations threatening [13] and '*We enter medicine with our mental*

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health on par with or better than our peers. Suicide is an occupational hazard of our profession' [10].

Ofsted is a nonministerial department responsible for standards in educational institutes and regulation of early years childcare facilities and children's social care services. The GMC maintains the register of medical practitioners, and it is responsible for protecting and maintaining the health and safety of the public. Both bodies, like other regulatory bodies, have statutory responsibilities to the society at large; thus investigations are a necessary means of maintaining standards and protecting the public. This is very important in the healthcare sector where medical error rates are significant, and it is now the third leading cause of death, after heart disease and cancer, in the United States [14]. This notwithstanding, the protection of the public and the duty of care to the mental wellbeing and to the lives of practitioners are not mutually exclusive.

The importance of investigating all work-related suicides is seen in the GMC's annual Fitness to Practice Statistics [15, 16]. The figures from 2018 are the most recent that are complete with no outstanding outcomes from provisional enquiries that are published [15]. In that year, 2.9% (8,573) of all doctors on the medical register were referred to the GMC, 66% by the public and 10% by primary employers and the police [15]. Of those referred, only 18% were investigated, and 77% of cases were closed at the initial triage. Of the doctors investigated, 15.9% appeared before the Medical Practitioner Tribunal (MPT), 6.5% were suspended and 4.2% faced erasure. Overall, 1.2% of all doctors referred to the GMC in 2018 were suspended and 0.8% faced erasure [15].

In 2013, the last year with published numbers of doctor suicides [4], 3.8% (9,866) of doctors on the medical register were referred to the GMC, 66% by the public and 13% by primary employers and the police. Of these, 29.8% were investigated and 59.7% were closed at the initial triage. Of the cases investigated, 9.7% appeared before the MPT, 3.6% were suspended, 2.3% faced erasure [16] and 0.3% died by suicide [4, 5]. Even though two-thirds of all referrals to the GMC were by the public, and 10–13% by employers and the police [15, 16], 54% of suicides were in those referred to the GMC by employers and 14% by the police, and these two accounted for over two-thirds of all suicides compared to 7% of suicides in those referred by the public [4]. From the above, the yield of severe sanctions is low among all doctors reported to the GMC, but suicide rates outstrip that of the general population. The highest rate of suicides occurred in those reported by their employers.

A central argument by those opposed to investigating work-related suicides is that the causes of suicide are multifactorial and how can one decide what triggered the act. This question was addressed in the case of *Commonwealth v Carter* in Massachusetts, United States of America (USA) in 2017 [17]. Michelle Carter and Conrad Roy had a romantic relationship. Roy had mental health issues and had previously attempted suicide and shared his suicidal ideations with Carter. Carter initially dissuaded Roy from acting on those thoughts, but later regularly encouraged him to commit suicide. On the day of Roy's suicide, he drove a truck to an isolated lot, and he exposed himself to carbon monoxide. During this time, Ray and Carter shared two lengthy phone conversations. After some time, Ray left the truck because he was scared and he called Carter, who told him to get back in the truck. She listened over the phone as he died. Judge Moniz found Carter guilty of involuntary manslaughter and she was given a custodial sentence.

Judge Moniz explained that Carter's words, encouragement and support did not cause Roy's death because Roy had researched it, prepared for it and had expressed the desire to commit suicide. However, when Roy exited the truck and abandoned his suicide attempt, 'he broke that chain of self-causation'. Carter's instruction to get back into the truck created 'a life-threatening risk' to Roy by 'putting him into that toxic environment'. He said that Carter had 'a duty to take reasonable steps to alleviate that risk' and her failure to act caused the death of Mr Roy [17]. While there can be multiple reasons for workers with mental illness to commit suicide, the significant chain of causation may be because of work environments. In a review of 31,636 suicide victims in the United States, doctors who committed suicide were far less likely to have had a recent death of a friend, of family member or a recent crisis contribute to the suicide but are much more like to have a job problem contribute [18].

In 2008, the United Kingdom House of Lords (now Supreme Court) weighed into a case of an employee without pre-existing mental illness who committed suicide because of work-related injuries [19]. In 1996, Mr Corr was struck on the right side of his head by a machinery he was working with, and most of his right ear was severed. He had long and painful reconstructive surgery, but he remained disfigured. He had mild tinnitus, severe headaches, difficulty sleeping and post-traumatic stress disorder. He became depressed and he was admitted to hospital in February 2002 after taking an overdose. He was judged to be a significant suicide risk, and he was treated with electro-convulsive therapy in March 2002. On 23rd May 2002, Mr Corr committed suicide by jumping from the top of a multistorey car park, nearly 6 years after his accident [19].

In June 1999, Mr Corr had begun proceedings for damages for the physical and psychological injuries that he had suffered. After his death in 2002, the proceedings were amended making his widow the claimant, and she added a claim to recover the financial losses attributable to Mr Corr's suicide from the employer. In an appeal to

the House of Lords, five Law Lords agreed that financial loss attributable to the death of the late Mr Thomas Corr by suicide was recoverable by his dependent widow under section 1 of the Fatal Accidents Act 1976 from his former employer [19].

It was agreed that the employer owed a duty of care to take reasonable care to avoid causing Mr Corr personal injury, which included both physical and psychological injuries. Because of a breach by his employers, Mr Corr suffered severe physical and psychological injuries. It was agreed that the depression that led to Mr Corr's suicide was caused by the accident. The following reasons were given for their judgment:

1. The conduct of taking his life did not fall outside the scope of duty that his employer owed him.
2. That suicide is reasonably foreseeable as an outcome of acute depression, and that it is not incumbent on the claimant to show that suicide was foreseeable. They added that a reasonable employer would have recognised the possibility of acute depression, which may culminate in a small minority in suicide.
3. There was no break in the chain of causation because the suicide was not a voluntary act, but the effect of severe depression, which was the result of the employer's breach of its duty of care.

There was unanimous agreement by the Law Lords on all the three points above. However, there was a 3:2 split on the question of contributory negligence. How much did Mr Corr's actions contribute to his death? The minority opinion absolved the deceased of any causal responsibility for his own tragic death, while the majority felt Mr Corr contributed to his death by 20–50% [19]. Similarly, the persuasive arguments by Casey and Choong [8] about GMC's duty of care to its doctors will also apply to employers.

Beyond the individual [18] and the employer [19] duty of care, the State has a positive obligation to put in preventative measures to prevent suicides in certain circumstances under Article 2 of the European Convention on Human Rights (ECHR), the '*Right to Life*' [20]. This positive obligation has two aspects, the duty to provide a regulatory framework and the obligation to take preventative operational measures [20]. Most of the case-laws with this regard have been in vulnerable people in detention in custody or in prison, compulsory military service and voluntary/involuntary psychiatric care [20]. In this context, it is worrying and surprising, although welcome, that an NHS Trust in Cambridgeshire has just announced in July 2023 that it will be investigating 63 suicides among patients since 2017 in its Trust after concerns about a patient who took his own life and a former employee who raised concern about 'possible criminal activity' [21]. This investigation should be by an external independent statutory body.

Beyond institutions, the obligation of the State to take preventative measures to prevent suicides extends to individual members of the public as in the case where an applicant's wife set herself on fire in protest at a forced eviction [22]. '*If the State agents become aware of such a threat in a sufficient time in advance, a positive obligation arises under Article 2 requiring them to prevent this threat from materialising by any means which are reasonable and feasible in the circumstance*'.

Notwithstanding the above, the rule governing suicides by the Health and Safety Executive (HSE), a UK government agency responsible for regulation and enforcement of workplace health, safety and welfare, states '*All deaths to workers and non-workers, with the exception of suicides, must be reported if they arise from a work-related accident, including an act of physical violence to a worker*' [23] under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 2013. Rephrasing this rule, suicide from work-related accidents including acts of physical violence to a worker is not reportable under the UK government regulations. This means that they are not investigated. This is despite the UK common law that suicide does not fall outside the scope on an employer's duty of care [19] and the positive obligation to provide a regulatory framework to protect the Right to Life of vulnerable employees under Article 2 of the ECHR [20].

There has been a steep rise in workplace suicides across the world [24, 25]. More than 700,000 people die by suicide each year, and 58% of global suicides in 2019 occurred before the age of 50 years [25]. The World Health Organization (WHO) estimated that in a company of 1,000 employees, one worker will die by suicide every 10 years, and for every employee who dies by suicide, another 10–20 will make a suicide attempt [25]. The risk of suicide (Hazard Ratio (95% confidence interval)) for those exposed to sexual harassment is 2.82 (1.4–5.34), job strain is 1.28 (1.09–1.51) and for workplace bullying is 2.92 (1.74–4.91) [25]. In Japan, workplace suicide is treated as an urgent public health issue [24]. In France, workplace suicides are officially recognised and documented by authorities. When a suicide takes place in the workplace, it is immediately investigated as a work-related accident and the burden of proof is on the employer to prove that it is not work related [24]. In 2019, under Moral Harassment law of the French Labour Code, three directors of the France Telecom (now Orange) were found guilty of institutional psychological harassment of 19 workers who committed suicide and they all received custodial sentences [26].

There have been some independent investigations of suicides in the UK [4, 27]. Following the report into suicides of doctors undergoing GMC investigations in 2014 [4], the GMC implemented changes recommended by a

mental health expert [28]. Over 3 years, 2018–2020, 29 doctors died while under GMC investigation or monitoring, five (17.2%) died by suicide [28]. This was an improvement over 24.5% of suicides as a proportion of deaths of doctors between 2005 and 2013 while undergoing GMC investigations [4], but it fell far short of the global 1.3% of suicides as a proportion of all deaths in 2019 [29]. The GMC has now gone further than the HSE by committing to routinely collecting and publishing data on deaths and suicides with its fitness to practice annual statistics [28].

The GMC needs to go further by auditing the appropriateness of referrals from employers and the police to establish a more robust referral criteria. 10–13% of referrals to the GMC were by employers and the police, and 68% of all suicides came from this cohort [15, 16]. The urgency of this is highlighted by the case of an NHS Trust in the West Midlands found by an Employment Tribunal judge to have given inaccurate and misleading information to the GMC about a consultant the Trust had dismissed. The judge described the failings as serious [30]. Of the dismissal, Judge Broughton wrote, '*This further supports my view of an apparent bias and/or incompetence at senior management level*' and he continued, '*This, coupled with my more detailed findings in relation to the exclusion earlier in this judgement, potentially suggests a level of bias and collusion at a senior management level against the claimant*' [30]. The dismissed consultant won his case of unfair dismissal at the Employment Tribunal. After an investigation by the GMC, his fitness to practice was also found not to be impaired [30]. The Medical Director of the Trust was subsequently given a formal warning by the GMC for making misleading and inaccurate statement to the body about the consultant [31]. Over a 10-year period (2012 and 2022), the same Trust had referred 26 doctors to the GMC, and no further actions were taken by the GMC in all cases [32].

While none of the 26 doctors referred to the GMC by the Trust died during their investigations [32], there has been a cluster of publicly known doctors' suicides in the Trust over the same period [33–36]. Dr Vaishnavi Kumar, 35-year-old junior doctor, died 22nd June 2022 by drug overdose. In her suicide note, she wrote, '*I am sorry mum, I can blame the whole thing on the QEH*' [33]. Others were Lieutenant Colonel Andrew Haldane, 45-year-old consultant anaesthetist by drug overdose on 8th June 2022 [34], Dr Manish Kumar Sonsati, 45-year-old Associate Specialist by helium inhalation on 13th August 2018 [35], Dr Eduard Zigar, 25-year-old junior doctor on 27th August 2018 by hanging [35], and Dr Inigo Tolosa, 46-year-old consultant clinical psychologist on 10th March 2015 by self-inflicted wounds [36]. While no inference can be made by a cluster of five suicides over a 7-year period, which is five to eight times more than predicted by the WHO [29], the root causes of such a cluster will remain unknown if not independently investigated, and thus preventative measures are impossible to define and implement as is obligatory under Article 2 of ECHR [20]. This is important considering that the Trust where these doctors worked is currently undergoing three investigations because of growing concerns over bullying and poor workplace culture [37].

On 9th February 2016, Mr Amin Abdullah, a 41-year-old nurse at a London NHS Trust, doused himself in petrol in front of Kensington Palace, lit it and died of immolation. He had been investigated by his Trust for 3 months and was dismissed on 21st December 2015. He found the experience stressful and consequently suffered clinical depression. He had no history of prior mental illness. An independent investigation showed that evidence submitted to the hearing panel did not paint 'an honest and complete picture'. The investigating officer failed to disclose evidence that showed Mr Abdullah had been right, and that none of the other 18 signatories to a petition that he co-signed were disciplined [27]. This is what an independent investigation of suicides can achieve, and a chain of causation is arguable in this case [19]

Poignantly, on 11th April 1994, Professor Justine Sergent, a 44-year-old neuropsychologist at McGill University, Montreal, Canada, took her own life. Sitting alongside her was her husband, as they had passed a hose from the exhaust pipe from a running car to the passenger cabin [38]. Her suicide note read in part,

'*I had a rich and intense life, but there comes a point where you can no longer fight and you need a rest. It is this rest that my husband, who has supported me in all aspects of my activities and my life, and myself have decided to take*'.

She had been investigated for 2 years for possible scientific fraud. After her death, the investigation continued for another 3 years before it was shut down on March 20th, 1997 without any outcome [38].

Suicide was decriminalised in the United Kingdom with the Suicide Act of 1961, and in 2008, the UK House of Lord in *Corr v Ibc Vehicles Ltd [2008] UKHL 13* ruled that suicide was within the scope of duty of care an employer owed to an employee if the suicide was secondary to depression caused by the employer [19]. The antipathy of the HSE towards investigating suicides [23] can be gleamed from the argument the UK put before the European Court of Human Rights in 2001 in *Keenan v. The United Kingdom* [39], '*The Government have argued that special considerations arise where a person takes his own life, due to the principles of dignity and autonomy which should prohibit any oppressive removal of a person's freedom of choice and action*'. The House of Lords addressed this question in its judgment of 2008. The lead judge, Lord Bingham wrote, '…, *Mr Corr's suicide was not a voluntary, informed decision taken by him as an adult of sound mind making and giving effect to a personal decision*

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about his future. It was a response of a man suffering from a severely depressive illness which impaired his capacity to make a reasoned and informed judgements about his future, such illness being, as is accepted, a consequence of the employer's tort. It is in no way unfair to hold the employer responsible for this dire consequence of its breach of duty, although it could be well be thought unfair to the victim not to do so' [19].

Furthermore, the HSE only takes physical violence into account when investigating deaths [23], even though workplace violence is defined as behaviours or threats with the objective of physical, psychological, sexual, or economic harm [40]. The global 12-month prevalence of workplace violence is 62% among health care workers with a Hazard Ratio for suicide of 1.34 (1.15–1.56) [40]. The negative attitude towards suicide is more widespread in the society with the continued prosecution of people who have failed attempts at suicide almost 60-years after the Suicide Act of 1961 [41]. These prosecutions and criminalisation of vulnerable people must be outlawed with an amendment to the Suicide Act by the House of Parliament.

Conclusion

Majority of suicides occur in people who tragically succumb to their mental illnesses, but there are those without pre-existing mental illness who also take their own lives [1, 4, 8, 10, 13, 18, 19, 27, 38]. In a small number of those with pre-existing mental health conditions, adverse external factors contribute significantly to their tragic end [2, 4, 17], and this is more pronounced in those without preexisting mental health issues [4, 9, 10, 18, 19, 27]. In the workplace, such external factors include weaponised investigations, which contribute to poor working environments and in turn, negatively affect the mental wellbeing of employees with forceable tragic fatal consequences in a small number. Some examples of weaponisation of the investigatory process include selective use and misciting of evidence [1, 27], victimisation [27, 30], denigration and abuse [1], dehumanisation [2], prolonged and unending investigations [9, 38], collusion of senior management against individual employees [30], misleading regulatory bodies [30] and inappropriate investigations and referrals [2, 27, 32, 38]. Coroners [2, 3, 9] and an employment judge [30] have voiced concerns about these weaponised investigations. Ultimately, the purpose of weaponised investigation, which is synonymous with mobbing, sham-peer review and moral harassment, is to get rid of the employee through psychological terror [12, 26, 42–44].

'*Mobbing destroys social reality by isolating targets from the network of meaningful relationships, prevents victims from realizing their goals and shatters the beliefs about rationality of social world. It fractures the self-respect, reduces the subjective well-being, and constricts freedom*' [12].

'*Those who withstand the efforts of the bully risk being victims of mobbing, and over 90% cases of workplace bullying in the UK involves a serial bully'* [42].

'*Moral harassment (mobbing) is a combination of workplace bullying and psychological terror perpetrated by a group of people in a systematic way over a prolonged period to force a person out of the workplace. It is a process of abusive behaviours inflicted overtime*' [43].

'*In sham peer review, where the hospital controls the entire process and acts as judge, jury, and executioner, the truth or falsity of the charges makes no difference and truth and facts do not matter because the outcome is predetermined, and the process is rigged*' [44].

The lack of statutory enquiries into clusters of suicides is troubling. Five suicides among doctors in 7 years in a single hospital [33–36], nine suicides in those undergoing Ofsted investigations [1], 28 suicides between 2007 and 2013 and five suicides between 2018 and 2020 in those undergoing GMC investigations [4, 28] and 63 suicides in 6 years among patients in a single Health Trust [21]. For every successful suicide, there are more people who have made unsuccessful attempts and even many more with suicidal ideations [25, 40, 45]. The economic cost of suicides and nonfatal attempts in the workplace in Australia was estimated to be about $6.73 billion in 2014 [45]. It was estimated that for every dollar invested in prevention, the benefits would be more than $1.50 ($1.11 – $3.07).

In the United Kingdom, under common law, employers have a duty of care to take reasonable steps to avoid causing personal physical or psychological injury, and suicide is within this scope [19]. Employers can be held liable for the financial loss attributable to an employee's suicide that is secondary to a failure of duty of care [19]. In other jurisdictions, individuals [17] and employers [26] can be held criminally liable for the suicide of others. All vulnerable people, with or without mental illness, have a right to life under Article 2 of the ECHR, with a positive obligation to take measures to prevent self-harm [20, 22, 39].

For these reasons, it is not enough to investigate only work-related suicides; it is imperative that all suicides in all institutions are reported, registered and investigated. There should be a robust, prospective data collection by a national body, auditing suicide rates against published standards. It is time to introduce criminal liability, and if the chain of causation lead to individuals or employers, they should be prosecuted. Formulation of meaningful regulations and fit-for-purpose preventative measures can only be realised with robust data-driven investigations. The timely registration and regular monitoring of suicide form the backbone of effective national suicide prevention strategies, and prevention of suicide has been prioritised by the WHO and included as an indicator in the United Nations Sustainable Development Goals target 3.4, noncommunicable diseases and mental health [29].

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