NHS
Health Education England

Supporting trainees involved in Serious Incidents and attendance at the Coroner's court

Introduction

There is good evidence that many local education providers across Yorkshire & Humber already have robust processes in place to provide support to trainees who are involved in serious events. This guidance summarises much of that good practice and is targeted at both trainees, who may require extra advice, as well as senior educators to ensure consistency across the region.

The Director of Medical Education (DME) is responsible for the oversight and management of trainees involved in serious incidents and/or attendance at the Coroner's court. Within each Trust it is important that systems are in place whereby the DME is notified of any serious incident (SI) investigation when a trainee is involved. Commonly the practice of the trainee is not at fault but declaration and reflection in the ePortfolio is still expected. Additional support and pastoral care may be required during what is often a distressing time for doctors in training. It's important that involved trainees receive a copy of the trust SI report once finalised even if they have left the trust.

Most trainees will not have been involved with the Coroner previously and should be provided with support in preparing statements. They may access their own defence organisation for independent advice but can benefit from generic support from the trust and locality. A single comprehensive statement suitable for all possible investigations is recommended.

If trainees are required to attend the Coroner's court as a witness they will need advice and guidance. In many cases defence organisations do not attend but trainees should be offered trust support. A briefing by the Trust legal department, including a run through of proceedings, is very beneficial.

Local processes

In the first instance, SIs and inquests are usually managed by the trust's risk management team who will report trainee involvement to the postgraduate education team, including DME and medical education manager. The DME may choose to meet all referred trainees. The trainee's educational supervisor and college tutor should be informed at this stage in order to provide pastoral support and to check if there are other performance issues or outstanding training needs. Support following a particularly distressing event, such as a patient death, may include counselling and advice from the trainee's GP or trust occupational health. Any identified clinical performance concerns need to be highlighted to the DME and a remediation plan considered – if significant the Medical Director is informed. The trainee should make an ePortfolio entry including reflection. An exception report is completed and forwarded to the deanery. The trust will undertake an investigation. Exit reports should provide an update on the trust investigation to the deanery. The trainee should include the incident on Form R as part of the ARCP process.

A Coroner's inquest may follow. If the trainee has left the trust and is required to produce a statement, access to the medical notes must be arranged, ensuring compliance with information governance rules. The risk management team in association with the medical director's office will usually coordinate the trust's approach to an inquest. Risk management usually provide hands-on support and coaching throughout the process. Ahead of the day, the trust solicitor will brief the trainee on the processes to be followed and what to expect. The risk management lead will accompany the trainee and other trust staff to the inquest, arranging transport, lunch and a debrief.

Responsibilities

Clinical Supervisor: Ensures trainee remains supported in their day to day clinical work, and provides extra supervision as necessary.

Educational Supervisor: Ensures and coordinates extra trainee support during the process. Ensures trainee has reflected on the incident. Advises on other sources of help e.g. medical defence organisation, occupational health, Take Time, etc.

College Tutor: Responsible for ensuring that a trainee involved in a SI has appropriate clinical supervision and an Educational Supervisor with the knowledge and skills to provide good support.

Director of Medical Education: Supports trainers. Ensures lessons are rolled out more widely in the organisation and liaises with Medical Director, Clinical Director, Head of School, Dean and other external agencies as required. Reports outcome to Dean / School. Ensures final report reaches trainee.

Medical Education Manager: Key role in facilitating communication between all parties and maintaining records.

Training Programme Director: Supports trainee particularly if issues impact performance and training progression. Ensures ongoing support and suitable placements.

Medical Director's Office: Ensures DME is informed of all incidents involving trainees and final trust report is sent to DME.

Postgraduate Dean's Office: Ensures DMEs report trainees involved in SIs to the LETB and that mechanisms are in place to support trainees. Considers impact on revalidation. Shares learning across schools.

Acknowledgements

NACT UK. Faculty Guide. The Workplace Learning Environment in Postgraduate Medical Training. October 2013.

Other documents

Coroner's Inquest Trainee Guide v2
Writing a Statement

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February 2015