Root Cause Analysis Investigation Report into the Death of Dr Julien Warshafsky

Incident Investigation Title:	Root Cause Analysis Investigation Report into the Death of Dr Julien Warshafsky
Incident Date:	Final incident and date of death was 28.06.16
Incident Level:	Level 3 Independent
Author and Job Title	Dr Andrew Foulkes FRCGP Clinical Adviser NHS England (Southeast) Qualified at Bristol University in 1980. He trained in several surgical specialties before becoming a General Practitioner in 1987.Since that time he has held a number of Medical Director posts in provider and commissioning organisations in the Southeast of England and now is a clinical adviser for NHS England undertaking performance reviews and significant incident investigations across the South of England. He has been the Responsible Officer for several NHS and Independent organisations between 2012 and 2019.
Investigation Report Date:	Final draft 22.05.19 (taking into account family comments). Individuals redacted for organisational comment Recommendations added January 2021

Foreword

Although the report will follow the familiar format when investigating such incidents, the approach, content and style is somewhat different to many significant incidents that are investigated. This is about the untimely death of a trainee anaesthetist, Dr Julien Warshafsky who passed away on the 28 June 2016. The report has been produced with close co-operation from Julien's family, who have themselves made a significant contribution to obtaining the evidence that supports this investigation.

The report has considered the statements and the oral testimonies that were provided for the coroner's inquests that took place in March, May and June 2018. An article also appeared in the BMJ in June 2018 titled "Julien Warshafsky: how this doctor died and what it tells us about the system that failed him[1]".

Julien's family did not wish this report to be anonymous. It is about Julien and his family and their struggle with his addiction whilst he was trying to take forward a career in anaesthesiology. The report highlights the difficulty NHS Trusts will encounter if one of their trainees misuse controlled drugs in a work setting. But it also raises many issues about how addiction in doctors is managed both by the regulatory and the caring system.

There were missed opportunities to detect Julien's continued drug use and failures of the regulatory system that allowed a sick doctor to continue working whilst misusing drugs for more than two and a half years after the first incident was detected[2]. It is perhaps fortuitous that no patients were harmed. Sadly, Julien died following a drug related incident, an overdose of acetyl fentanyl that he had purchased from the dark web. In the year that he died, he was resuscitated four times by his family and the ambulance service, and on each occasion attended an Accident and Emergency Department, three of which were in the Southeast of England. On the fifth occasion Julien could not be resuscitated.

This is a complex case involving many individuals and organisations over a three-year period. The coroner concluded that Julien died accidentally. It was, she said, a drug related death. But could Julien's death have been prevented? What else could have been done to keep Julien and those he looked after safe? And what still needs to change? This review will provide some, but not all of those answers. The intention is to provoke discussion and debate within and across organisations and enable actions in both the regulatory and care system that will keep doctors and patient safe.

[1] [1] BMJ 2018;361:k2564 doi: 10.1136/bmj.k2564 (Published 14 June 2018)

[2] Julien did not work from May to September 2013, was suspended for a brief period in 2014 and stopped work altogether in December 2015

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Executive Summary

Brief incident description: Respiratory arrest
Incident date: Final incident 28.06.16
Incident type: Unexpected death
Healthcare Specialty: Anaesthesia Trainee
Actual effect on patient and/or service: Death of NHS employee
Actual severity of incident: Severe

Level of investigation conducted
Level 3 Independent

Involvement and support of the relatives
Dr Robin Warshafsky, Wendy Warshafsky, Mariana Warshafsky and Gabriel Warshafsky

Detection of the incident
First incident May 2013 (misappropriation of fentanyl at Maidstone and Tunbridge Wells Hospital NHS Trust)

Care and service delivery problems

These are considered under two headings:

- Monitoring and supervision in the workplace
- Management and treatment of Julien's health problems

There were significant failings in the way Julien was supervised and monitored by the GMC. Opportunities to have detected continued substance misuse were missed by both the GMC and the Trusts where he worked. The true extent of Julien's addiction remained unknown to the healthcare professionals looking after him.

Contributory factors
There are several different factors that contributed to the care and service delivery problems identified. Detection of continued use of fentanyl was made more difficult by Julien who concealed his addiction. There were opportunities to have detected this much earlier that were not taken. Julien's wish for confidentiality may have contributed to this, but too many healthcare professionals and organisations involved in his care failed to communicate and risk assess effectively. Few appreciated that they were dealing with a doctor with a serious underlying addiction issue.

Root causes
The root cause of Julien's death was a disorder known as addiction. The coroner concluded that this was an accidental death after Julien self-administered acetyl fentanyl intravenously. Both his addiction and his underlying depressive illness contributed to his death.

Lessons Learned
See relevant section

Recommendations
See relevant section

Arrangements for sharing learning
This case has already been discussed at one of the regional Responsible Officer training events and has been reported in the British Medical Journal. It is recommended that the local health system (Kent, Surrey and Sussex) review their approach to the management of trainees with an addiction illness and use this as a case study in that process.
Learning to be shared regionally and nationally through the Quality Surveillance governance mechanisms.

MAIN REPORT:

Incident description and consequences

Incident description:

Julien Warshafsky was a 31-year-old Specialist Trainee in Anaesthesia on sick leave from the Trust 3 at the time of his death on the 28 June 2016.

His death was the culmination of a long struggle with mental health issues and addiction. Julien began to use fentanyl in at least May 2013 and probably a little time before that. Those involved in Julien's monitoring and treatment made the false assumption that this problem was in remission. However, the evidence suggests otherwise before a worsening of his addiction problem and mental health issues which resurfaced in December of 2015.

Between March and May 2016, Julien experienced four respiratory arrests which if they had occurred whilst he was alone would have resulted in his death. Unfortunately, on the 28 June 2016, the fifth respiratory arrest occurred whilst he was alone, and he could not be resuscitated.

Incident date: Final incident 28.06.16

Incident type: Unexpected death

Specialty: Anaesthesia Trainee

Actual effect on patient: Death of NHS employee

Actual severity of the incident: Severe

Pre-investigation risk assessment

A Potential Severity (1-5)	B Likelihood of recurrence at that severity (1-5)	C Risk Rating (C = A x B)
5	3	15

Background and context

Julien was the eldest son of Robin and Wendy Warshafsky. The family moved from Canada to the UK when Julien was 14 years old. Julien excelled at secondary school and won a place at Exeter College, Oxford to read medicine and then transferred to University College London to finish his medical degree. He obtained the Foundation Year posts he wanted and then a place in an anaesthesia training programme in Health Education England (HEE) Kent, Surrey, Sussex. He was developing into a highly skilled and trusted anaesthetic trainee and was recognised by his colleagues to excel at this work.

Julien was in good health but had suffered with periodic depression between 2003 and 2013 that had been treated with antidepressant medication. He had experimented in occasional recreational drugs whilst at college but gave no indication of regular substance misuse.

In May 2013 it was in his second year as an anaesthetic trainee that he was observed removing an ampoule of fentanyl from the operating theatre. He subsequently confessed to injecting himself on several occasions with the drug to relieve anxiety. He also admitted taking ketamine and morphine.

Julien self-reported to the GMC and was given conditions to adhere to. Julien returned to the anaesthesia training programme after a three-month absence in September 2013. In February of 2014 he was again accused of misappropriating fentanyl but was exonerated after an investigation and again returned to training.

In June of 2015, after moving on to another trust, he collapsed in theatre at 02:00, five minutes into administering anaesthesia, probably suffering a respiratory arrest requiring resuscitation. At least to the Trust and to the GMC, there was no evidence of fentanyl misuse, but a hair test organised by Julien in July 2015 was positive for fentanyl[3]. It wasn't until December 2015 that his parents became aware that he had taken further fentanyl when he again collapsed at work at the Trust 3 and had a further respiratory arrest. Following that episode, he went on sick leave and never returned to anaesthetic practice.

Julien was under the care of a GP and at various times had seen several treating psychiatrists, occupational health specialists, and the Practitioner Health Programme. He attended three Accident and Emergency departments in the Southeast of England.

Unbeknown to his work colleagues and those treating him Julien had a far more extensive history of substance misuse than he was prepared to reveal. This only became apparent after his death when texts and email correspondence confirmed that he had been using various psychoactive drugs, some misappropriated from hospital sources and others obtained from the internet.

[3] This incident was not reported to the GMC until after Julien's death

Julien's death was investigated by the Assistant Coroner for Surrey. There were three hearings between March and June 2018. The coroner returned a verdict of an accidental drug related death. Although she had identified some missed opportunities to detect continued drug misuse during 2015, she did not believe that this contributed directly to his death.

The main purpose of this report is to identify and explore those "missed" opportunities and to record the learning that has arisen from this case. Some of the changes that organisations have made because of this have also been captured. Another purpose is to raise everyone's awareness to the needs of sick doctors, and, the behaviour of doctors addicted to drugs who fear the consequences of their illness and the effect it may have upon their career.

Terms of reference

Purpose

This investigation is to establish whether the death of Julien Warshafsky could have been prevented and how treatment and monitoring could have supported Julien to continue safely in his chosen career as an anaesthetist.

The focus of this case review is not to apportion blame to individuals or organisations but to explore opportunities for collective learning and identify actions that could be either considered or taken to avoid a similar case in the future

Objectives

- To ensure that the family of Julien are fully updated as per the Duty of Candour (Department of Health and Social Care 2014).
- To ensure that there is a clear governance process, timelines, reporting mechanisms and robust case managing of the investigation.

The investigation will aim to:

- Establish the full facts of the case
- Examine the provision of clinical care and treatment, including both risk assessment and risk management as appropriate
- Ascertain if a duty of care towards Julien was maintained by his employers
- Identify any learning for involved organisations (including regulatory bodies) in the management and support of doctors with a history of substance abuse
- To set out findings in this case with regard to risk, safeguarding and best practice.
- To establish whether failings occurred in care or treatment.
- To look for improvements rather than to apportion blame

- To establish how recurrence may be reduced or eliminated
- To formulate recommendations

The expectation is that any learning will subsequently be shared throughout the organisations involved and where appropriate, the wider health community in order to minimise the likelihood of a similar recurrence.

Key Deliverables

- To provide a report and recording of the investigation process and outcome
- To ensure that any deficiencies and/or failings are recognised
- To ensure that areas of good practice are noted and recognised.

Scope and Methodology

This case is unusual in so far as the father of Julien is an experienced General Practitioner with an interest in safe practice in healthcare settings and currently an Assistant Medical Director for Trust 5. Dr Robin Warshafsky has already met with many of the organisations involved in Julien's employment, care and supervision. He has in his possession case notes, reports, test results, correspondence and other material from the organisations involved with Julien. At the time of this review there was an ongoing coroner's inquest into the death of Julien. It is proposed that an independent reviewer works closely with Julien's family and examines the evidence that has so far been collected, seeking further evidence if required.

The investigation will be undertaken by Dr Andrew Foulkes, Independent Reviewer, with the administrative and co-ordination support of the Nursing and Quality Directorate NHS England South East (Kent Surrey and Sussex). This is a Level 2 investigation.

It is expected that the staff from all 13 organisations will fully cooperate with the case review. The case management will be coordinated through the Nursing and Quality Directorate who will contact each provider in advance of this investigation. It is not expected that they will be required to provide any information initially, but as the investigation proceeds, the case investigator may seek further information or request an interview with relevant parties.

The draft report will be shared with all interested parties for comment prior to finalisation.

Investigation type, process and methods used

This is a multi-incident investigation. Written Information has been gathered from Julien's family, from the providers and from selective interviews.

Investigation Commissioner

NHS England South East, Kent, Surrey and Sussex

Investigation team

Dr Andrew Foulkes, Independent Reviewer on behalf of NHS England - Case investigator
Dr Alison Taylor, Interim Medical Director , NHS England (South East, KSS)
Natalie Warman Deputy Director of Nursing -Patient Safety NHS England (South East)
Dr Claire Cochrane-Dyet Associate Medical Director, NHS England (South East)

Resources

Case management support provided by the nursing directorate.

Involvement of other organisations
There are 13 organisations that have been involved at some point with this case.
Principal Stakeholders/audience
The family of Julien – Dr Robin Warshafsky, father, GP & Deputy Medical Director. ○ Mariana Carmo, wife (widow), ITU Nurse, St Thomas Hospital, London ○ Wendy Warshafsky, mother, Manager Gabriel Warshafsky, brother, Architect • Trust 1 • Trust 2 • HEE • GMC • Trust 3 • Trust 4 • Trust 5 • Trust 6 • Trust 7 • Practice 1 • Practitioner Health Programme • Dr A, treating psychiatrist
Timescale
It was envisaged that the review will be completed by 31 August 2018 and consider the findings of HM Coroner. Health Education England requested more time to produce their submission which led to a further delay.

Level of investigation

This is a multi-agency independent investigation.

Involvement and support of relatives

This list is not exhaustive. Both Robin and Wendy Warshafsky have met with a number of other individuals from different organisations and continue to do so. They have made available significant amount evidence upon which this report is based.

28.07.16 Meeting with Practitioner B, Practitioner Health Programme Present:
Practitioner B, Robin, Wendy and Gabriel Warshafsky

29.07.16 Meeting with Dr C, Medical Director, Trust 3 and Professor O - Present, above plus Robin and Wendy Warshafsky

29.07.16 Meeting with Dr D, Practitioner Health Programme with Robin and Wendy Warshafsky

23.08.16 Meeting with Dr A, Hospital 2

21.02.2018 Meeting with NHS England (Robin W)

08.08.2018 Meeting with NHS England (Robin W, Wendy W and Mariana W)

30.08.2018 Telephone discussion with NHS England (Gabriel W)

Information and evidence gathered

Information and evidence have been gathered from several sources. Much has been provided by Julien's family who has shared emails, letters, clinical notes and other correspondence. The author attended the coroner's inquest in May and June 2018. Further details of the evidence gathered is provided in the appendix.

Common abbreviations used in this report

GMC	The General Medical Council
HEE	Health Education England
MDU	Medical Defence Union, Julien's professional indemnity provider
PHP	Practitioner Health Programme

FINDINGS:

Chronology of events

Chronology (timeline) of events	
Date & Time	**Event**
August 2012 to August 2014	CT2 ACCS Anaesthetics, Trust 1
25.08.12	Text messages found on Julien's phone after his death suggest that he had by this date already started to abuse fentanyl.
30.05.13	Use of fentanyl from hospital theatre discovered at Trust 1. Text message from Julien's phone on this date suggests that he had previously stolen fentanyl from work: "I finally got caught stealing fentanyl. It's not looking good for my career".
31.05.13	Date of statement for internal Trust investigation by Practitioner E (Senior Operating Department Practitioner) and an anaesthetist.
	Self-referred to the GMC.
	Julien's suspension from the Trust on health grounds. Trust notifies HEE.
13.06.13	Seen by Dr D, Practitioner Health Programme. Julien self-referred to the Practitioner Health Programme (PHP). Under an agreement with HEE he was eligible for an initial assessment, then 8 sessions of CBT.
17.06.13	letter from Interim Orders Panel of the Medical Practitioners Tribunal Service outlining conditions and restrictions.
17.06.13	Self-referral to Trust 1, Occupational Health Service.
19.06.13	Seen by Dr F, Occupational Health, Trust 1
09.07.13 Hair sample	Cansford Labs covers 10.04.13 – 03.07.13 **Fentanyl 0.8ng/mg**
16.07.13	Interim Orders Panel hearing at the Medical Practitioners Tribunal Service. GMC Interim Orders Panel: 13 conditions imposed.
8.08.13	Sick note from GP covering 30.07.13 to 30.08.13.
16.08.13	GMC Medical Assessment (Dr G). Diagnosis of recurrent depressive disorder and Mental and behavioural disorders due to the use of opioids, harmful use.

21.08.13	GMC Medical Assessment (Dr H) Depressive episode noted. History given by Julien to Dr H was that he had injected himself with fentanyl taken from the theatre about eight times; that he had taken and used ketamine on one occasion; and that he had used diamorphine tablets (4 ½ mg) on one occasion, but it had had no positive effect on him. Conclusion – not fit to practise except under medical supervision; should have a supervising psychiatrist with an interest in the management of substance problems. Dr H arranged hair for testing for Ketamine, Amphetamine, Cocaine, Methamphetamine, Opiates and Cannabis. This did not include fentanyl.
23.09.13	Julien returns to work.
04.10.13	Seen by NHS psychiatrist. Letter dated 7 November 2013 from Dr I, Consultant Psychiatrist, stating that he wished to discharge Julien back to the care of his GP.
10.12.13 Hair sample	Alere labs covers 07.09.13 – 10.12.13 Fentanyl not tested Julien requests a PHP appointment, and requested that PHP take a hair sample for analysis to enable him to prove his abstinence between tests for his next hearing. Sample tested and negative for all substances including fentanyl.
19.12.13	Letter to GMC from GP Dr J, who confirmed that he completely agrees on clinical grounds with Dr I's opinion that Julien does not need ongoing psychiatric care and is happy to continue to monitor Julien in primary care.'
31.12.13	Letter from Mr B of PHP stating that Julien's depression had been successfully treated and recommending removal of the conditions requiring him to engage with the PHP and a Consultant Psychiatrist. These two conditions were subsequently removed.
06.02.14	Allegation of misappropriation of controlled drugs (fentanyl), serious Incident Investigation undertaken by Trust 1
06.02.14	Letter informing of exclusion from practice for four weeks from Dr Y Consultant Anaesthetist, Clinical Director.
10.02.14	Julien self-reported to the GMC. The letter to the GMC from the Trust outlined the suspension (from 6 February 2014 to 5 March 2014) of Dr Warshafsky as a neutral act in relation to an allegation that he had misappropriated a Controlled Drugs.
15.02.14 Hair sample	Cansford Labs covers 26.12.13 – 09.02.14 Fentanyl Negative (ordered by JW).
23.05.14	GMC case examiners conclude that Julien's fitness to practice was impaired to a degree justifying action on his registration, and that undertakings would be a suitable outcome.
27.09.14 Hair sample	Cansford Labs covers 23.06.14 - 21.09.14 Fentanyl Negative (ordered by JW)
August 2014 to August 2015	CT2+ ACCS Anaesthetics, Trust 2

09.14	Discharge by PHP "as he was receiving care privately, was back at work, and was through the difficult first few months of GMC supervision for which we were initially supporting him". Source: Practitioner B Statement to Coroner.
06.10.14	Julien's first appointment with new GMC medical supervisor (Dr G) takes place by telephone, due to Dr G's health circumstances. Hair test arranged by Dr G covering this period by The Doctor's Laboratory is negative for all drugs of misuse including opioids, but fentanyl was not specified in the request (03.07.14 – 03.10.14).
11.12.14	Anonymous concern to the GMC "I would like some advice, I am aware of a Doctor who is still stealing drugs from work for his own use who currently has undertakings due to previously doing the same". No action taken by the GMC.
01.15	Primary FRCA passed first attempt.
11.02.15	Julien's second appointment with new GMC medical supervisor (Dr G) takes place by telephone, again due to Dr G's health circumstances. Subsequently he advises that Julien is fit to have a restriction on his prescribing habits lifted.
20.02.15 Hair sample	The Doctors Laboratory covers 08.11.14 – 06.02.15 Fentanyl not tested.
06.15	GMC Case Examiners vary Julien's undertakings based on the positive information received from a number of sources, not noting the absence of fentanyl testing. Julien re-gains his prescribing abilities following lifting of those restrictions.
19.06.15	Julien experiences a collapse at work at the Trust 2, attributed to dehydration and exhaustion after a viral illness. Fentanyl levels not checked Probable Respiratory arrest. HEE and GMC not informed of the incident.
July 2015	Dr P replaces Dr K as Trainee Programme Director (TPD) for Trainee Support for the anaesthetic and intensive care trainees within HEE.
09.07.15	Julien's third appointment with GMC medical supervisor (Dr G) takes place face to face. Dr G does not carry out any hair analysis or blood tests today "but if necessary, Dr Warshafsky is willing to have these investigations carried out". GMC arranges hair testing to be carried out by a new laboratory.
27.07.15 Hair sample	Cansford Labs covers 07.05.15 – 21.07.15 **Fentanyl 0.06ng/mg** (ordered by JW).
06.08.15	Offer and Acceptance of a Training Post, Trust 3Post ST3 Anaesthetics. Dr K (Trainee Support Lead) of Health Education England hands information about Julien to Dr L, College Tutor at Trust 3 , and asks him to inform the Medical and Clinical Directors (July 15).
August 2015 to June 2016	ST3 Anaesthetics, Trust 3 (on sick leave Dec 2015 - Jun 2016)

November and December 2015	Julien's "strange behaviour" was noted by a colleague. It was observed that "he has mood swings, blood stained tissues are found in the bins where he has been working, he is wearing long sleeve gowns and has some blood on his scrub sleeves and going out for toilet breaks immediately after performing procedures. He often has plasters on his wrists and arms. The ODP comments that he always makes an obvious show of disposing his waste opiates in front of her (Trust 3 Investigation / report).
13.12.15	Collapsed at work at Trust 3. Julien collapses in the coffee room, cyanosed and had a seizure. He was noted to be difficult to cannulate, with track marks on his arms. Resuscitated and seen reviewed by Dr M (Consultant Physician). He denied opiate use at the time.
13.12.15	Sick leave period commences; Julien is suspended from work.
15.12.15	Change of Medical Supervisor by GMC; no explanation given.
18.12.15	Julien expressed a wish to self-refer to the GMC on the grounds of alcohol misuse and depression. Toxicology tests were performed, which came back with a positive result for fentanyl and breakdown products of fentanyl. His liver function tests were deranged, in keeping with alcohol excess.
13.01.16	Seen by Consultant Psychiatrist - Dr N (Hospital 1).
27.03.16	GMC 'We agree it is necessary to amend his undertakings to ensure he does not work in any post that requires a GMC licence to practise until such time as he has recovered, and consideration can be given to further amendment to allow his return to practise.' Varied undertakings were signed on 27 March 2016 and it was agreed that any contact with Dr Warshafsky would be made via his representative until his health had improved.
30.03.16	1st respiratory arrest in flat in XXX; resuscitated by Mariana/paramedics; taken to **Trust 4**. Admitted having taken fentanyl
31.03.16	Letter from Dr Z, Deputy Medical Director Trust 3 informing him of exclusion from practice and investigation of the incident in December.
31.03.16 03:42	Paramedics called as was very "hyper", tachycardia, febrile. Julien refused to go to the hospital but accepted to see his GP in the morning.
31.03.16 approx 2pm	2nd respiratory arrest at parents' home in East Sussex. Found collapsed in the bathroom by mother. Resuscitated by father and **Trust 7**
06.04.16	Consultation with Dr A, private psychiatrist, Hospital 2. Julien said he had obtained some Acetyl Fentanyl through the Internet. He took some at his home in XXX and ended up going to Trust 4 on 30 March 2016. He told me that he deliberately led the medical team there to believe that his symptoms of collapse were due to serotonin syndrome.
April 16	Julien re-referred himself to the PHP for using drugs at work.

08.04.16	Letter from Professor O, Director of Professional Standards, Trust 3 Hospital, to Julien, to advised that he will be chairing an investigation into his collapse whilst on duty.
12.04.16	Consultation with Dr A, private psychiatrist, Hospital 2
15.04.16	Appointment with Dr J, GP.
30.04.16 11.11	3rd respiratory arrest, collapsed in shower, resuscitated by Mariana. Consciousness regained after manual ventilation with oxygen by paramedics, taken **to Trust 4**. Able to ascertain that Julien was obtaining acetyl fentanyl over the internet using bit coin to purchase it.
04.05.16	Robin (father) sees Dr J for minor problem, tells him about the third respiratory arrest.
20.05.16	4th respiratory arrest in France **Beziers.**
18.06.16	Julien and Mariana are married. They were in France from 10.06.16 to 25.06.16.
25.06.16	Wendy and Robin attend Sick Doctors Trust meeting. Mariana and Julien arrive back in UK late evening.
27.06.16	Julien returned to their flat in XXX at the end of the afternoon.
28.06.16 0700	Julien woke up around 07.00. Mariana left house around 07.55 to get the train from XXX station to go to work (St Thomas Hospital, London).
28.06.16	5th respiratory arrest. Julien made telephone calls and exchanged texts with family. At 16.41 no further emails were opened. 17.55 Mariana returned home and found Julien collapsed. Commenced resuscitation procedures. Paramedics attended. Life confirmed extinct at 18.45 when resuscitation attempts ceased.

Detection of incident

Julien's death followed a long struggle with mental health issues and addiction. Julien began to use fentanyl in at least May of 2013. Those involved in Julien's monitoring and treatment made the false assumption that this problem was in remission. However, the evidence suggests otherwise with a worsening of the addiction problem and mental health issues which led to a respiratory arrest and seizure in December 2015.

During 2016 Julien experienced four respiratory arrests which if they had occurred whilst he was alone would have resulted in death. There were also several other "collapses", two whilst at work whilst an anaesthetist were probably respiratory arrests. Julien's use of fentanyl went largely undetected. Unfortunately, the fifth respiratory arrest during 2016 occurred whilst he was alone on the 28th of June 2016. Julien was not able to be resuscitated.

Notable practice

Whilst there were care and service delivery failures (see below) there were organisations and individuals within organisations who did their very best to help and support Julien during his training programme.

Care and service delivery problems

Julien's care and any service delivery problems will be discussed under two headings:

- Monitoring and supervision in the workplace
- Management and treatment of Julien's health problems

Monitoring and supervision in the workplace

1 The GMC

Julien had been under GMC supervision arrangements at the time of his death but had not been working since collapsing at work in December 2015 from the effects of misusing fentanyl. This was confirmed following investigations of his collapse. The GMC were notified of this episode, but by agreement, the GMC had not engaged directly with Julien after January 2016 as he was unwell and on sick leave.

Julien self-referred to the GMC in May 2013 after he took fentanyl from open ampoules whilst employed as a CT2 in Anaesthetics at Trust 1. He agreed to undergo a GMC Health Assessment which took place in August 2013. Both examiners concluded that Julien was only fit to practise on a limited basis under GMC supervision. Chemical testing for drugs of abuse was directed by the case examiners but did not specify testing for Fentanyl although this was intended.

The testing carried out on behalf of the GMC[4] did not therefore include Fentanyl which was a significant error. This was not identified by the Medical Supervisor, or by the GMC on receipt of the testing results from the testing company.

In January 2015 the GMC received an allegation from a work colleague that Julien had been taking drugs from work and had been accessing the medical records of unnamed celebrities. These allegations were never substantiated. The complainant refused consent for this allegation to be put to Julien. At the time there was a requirement for the GMC to pursue these matters formally. In the absence of any further evidence and without the consent of the individual to disclose, this allegation was closed with no further formal action. This information was not

[4] At the time, this testing was arranged by a consultant psychiatrist using a laboratory of their choice and it was their responsibility to request appropriate tests.

shared with the Medical Supervisor, the Responsible Officer (HEE) or the Hospital Trust (Trust 2) where Julien was working at that time.

In June 2015 based on recommendations from Julien's occupational health physician and Medical Supervisor, the case examiners agreed to vary undertakings so that Julien could prescribe controlled drugs. It would have been difficult to pursue his training in anaesthetics without this adjustment in his undertakings.

In December 2015 Julien suffered a hypoxic grand mal seizure whilst at work Trust 3 following suspected opiate misuse. He initially denied opiate misuse, but subsequent testing was positive for fentanyl. He was placed on sick leave. The GMC were made aware of this incident.

The MDU advised the GMC on 19 January 2016 that Julien remained unwell and was not able to engage with them. On 20 January 2016 the MDU forwarded an undertaking to refrain from all forms of clinical practice until his Medical Supervisor advised that he was fit to return to work. Subsequently, the MDU proposed and the GMC accepted a variation to the undertakings to the effect that he would not work in any post requiring a licence to practise. This was with effect from 27 March 2016.

1.1 Fentanyl testing

In making their decision, the case examiners relied on the medical reports of Dr G and Dr H. The case examiners failed to note that fentanyl testing had not taken place and incorrectly assumed that the 'opiates' tested for would include fentanyl.
The same error was repeated during medical supervision. All parties assumed incorrectly that the synthetic opioid fentanyl was included under the opiate category in hair testing whereas a specific request for fentanyl testing should have been made.

It was intended that Julien should be tested for fentanyl. However, the fact that no fentanyl testing was conducted under the GMC's direction was not identified by anyone involved with the GMC case was concerning. Julien was aware of this and mentioned this with his fiancée at that time (source: interview with Mariana W).

Julien had started to test himself for fentanyl. In July 2015 a sample submitted to Cansford Laboratories was positive for fentanyl. The GMC were not aware of this at the time as Julien had arranged the test himself. The results were only known to Julien and were not communicated to the GMC. The test result in July 2015 was significant because it was only shortly after Julien had been allowed to possess and prescribe drugs again. The month before Julien had collapsed in theatre at the Trust 2 and a trainee colleague had noticed an irregularity in the use of fentanyl in the operating theatre (source: statement to Coroner, Dr P).

The GMC agree that monitoring of toxicology ought to have been increased at this point to reflect his increased exposure to drugs and therefore to the risk of relapse. The GMC state that they have tended to support the gradual relaxation of restrictions as a doctor's fitness to practise

improves and have not usually accounted for the fact that relaxing restrictions on prescribing for doctors with a history of opiate abuse might reasonably be accompanied by a temporary increase in the testing regime to reflect the possible increased risk of relapse that might come with greater exposure to available drugs.

However, the GMC noted that Julien was not deterred from resuming opiate abuse by the fact that other testing had identified fentanyl. However, Julien's motive for self-testing was to find ways of avoiding detection. He already knew that the GMC were not testing for fentanyl. The GMC point out that no amount of regulatory action can fully prevent a determined individual from obtaining access to drugs of addiction and regulatory responsibility is to manage the patient safety consequences of a doctor's ill-health rather than directly to manage the course of the doctor's treatment programme. Evidence now made available from texts and emails confirm that Julien was monitoring his fentanyl levels by commissioning his own tests.

The GMC agree that no individual in the GMC process had an identified responsibility for actively checking what testing had been carried out and for then deciding what and when further testing may be required. There was insufficient consideration of how to manage the potential risks of the lifting of prescribing restrictions and no co-ordination of 'soft' information such as the allegations from the work colleague to give an overview of any developing problems. In this way, the GMC agree that the risk to patients was not fully assessed or managed.

At the time case examiners set out testing guidance at the commencement of restrictions on a doctor's practice[5]. They do so based on the Health Assessment reports. The GMC are unlikely to be asked to review their recommendations unless there is a change in circumstances. Test results are usually sent to Medical Supervisors via the GMC's officers who are not medically qualified and so not well placed to fully quality control this aspect of the process. There was therefore a shortfall in clear ownership of quality control of this part of the process.

The testing advice template in use at the time did not specify the doctor's previous history of fentanyl use. The case examiner advised that 'hair test for drugs of misuse' should be taken 'minimum 4 monthly'. It was incorrectly assumed by the case examiner that fentanyl testing would be included in each request for testing made by the Medical Supervisor. The template form used by the case examiners did not specify the drug(s) known to have been used previously. The case examiner should have specified that testing for fentanyl (and other drugs) was required. Neither Medical Supervisor noticed this error.

On the single occasion that the GMC arranged testing directly (when this had not been done by the Medical Supervisor), the sample was collected and processed by DNA legal. A Panel B screen should normally have been requested which included screening for a wide range of drugs including fentanyl. This did not occur.

[5] At the time of events, the Medical Supervisor had control over frequency and specific content of testing. This is now directly managed by the GMC.

Hair analysis for drugs was carried out at the health assessment and during supervision. Both examiners incorrectly interpreted the 'opiates negative' result as indicating that the synthetic opioid fentanyl had been tested for. During the period of supervision, the case examiners and Medical Supervisor also misinterpreted the 'opiates negative' result as indicating that fentanyl had been tested for. The tests were incorrectly taken as evidence that there was no ongoing use of fentanyl, but this interpretation was not correct.

Testing during supervision was being carried out by the Medical Supervisor and a case examiner had requested a minimum of 4 monthly hair testing. Hair samples of 3cm length are usually obtained and can show evidence of drug use over the preceding three months. In Julien's case the GMC was provided with three hair test results during supervision (i.e. after undertakings were agreed) covering the approximate periods:

- July 2014 to October 2014
- November 2014 to February 2015
- April 2015 to July 2015

Dr G was due to be replaced as Medical Supervisor, but the proposed new Medical Supervisor did not get the opportunity to meet with Julien. A further test would have been expected in October 2015 but there was no further testing carried out by, or on behalf of, the GMC after July 2015. The GMC was unaware of additional testing being carried out by Julien. Information provided to the GMC by Robin W (father) suggests that additional hair testing, specifically for fentanyl, was being carried out regularly by Julien during his supervision.

Julien's family provided the GMC with several additional test results of which they were previously unaware. The GMC approached the testing company (Cansford) who had arranged these tests and, after taking legal advice, has confirmed that the requests were made by Julien. From the results provided, it is apparent that there was some fentanyl use during the period of supervision between May and July 2015 which was not detected by the GMC's own screening as fentanyl was not included in testing.

1.2 Sharing health information with the Responsible Officer

The GMC do not routinely share the details of a doctor's health with employers out of sensitivity to the question of patient confidentiality. However, the GMC can share information subject to the consent of the doctor. This includes the Responsible Officer. Julien's Responsible Officer was the Deanery (HEE) and not the Medical Director at the employing Trusts. This provides a barrier to communicating important information and from the employing Trusts perspective makes it more difficult for them to undertake purposeful risk assessments.

1.3 Allegations of further misappropriation of drugs in January 2015

The GMC took no further action on these allegations because the maker of the allegations withheld consent and wished to remain anonymous. The GMC felt they lacked evidence on which to proceed.

The GMC regard the withholding of consent as a major obstacle to formal action. They believe taking decisions under their processes without following clear legal principles such as on admissibility of evidence will lead inevitably to inconsistency, unfairness and legal challenge.

However, they do accept that those supervising a doctor already in their process could tailor their monitoring according to an 'index of suspicion' based on soft intelligence suggesting a more nuanced approach on this occasion might have led to the GMC reviewing the case and adjusting their 'index of suspicion'.

1.4 Visibility of GMC process

The GMC acknowledge that various people and agencies were engaged with Julien during these events and at points had only partial knowledge of his situation and his conditions. These include his employers and work colleagues, his Responsible Officer, his defence organisation, his occupational health physician, the Practitioner Health Programme, his GMC Medical Supervisor, his GMC Case Officer and his family and friends.

The GMC also acknowledge that there would not have been a consistent view across this group about the appropriate point of contact in the GMC process to discuss concerns about Julien.

Julien expressed an understandable wish to maintain confidentiality about his health condition, but this may well have contributed to no one individual or agency having a clear overview at any one time of his current state of health or the risk of relapse. Such a situation might protect confidentiality, but it also increases the risk of a doctor's relapse to go undetected. In some cases, it could also present an opportunity for a doctor to circumvent regulatory action.

Whilst the GMC are aware that sharing of information too widely is highly likely to add to the stress of a GMC investigation, they acknowledge that a protected confidential route of communication from the various parties to one individual with oversight might have enabled a clearer picture to be gained of the risk profile at any one time.

The GMC also recognise that the Medical Supervisor is better placed to act as a conduit for any information relevant to a doctor's current fitness to practise when the doctor is already in the GMC process. At that time, there was no clear or signposted pathway for that information to be passed in confidence to a named individual.

1.5 Medical Supervision

"Medical supervision is the framework the GMC uses to monitor a doctor's health and progress during a period of restricted practise. Doctors whose fitness to practise is impaired because of adverse physical or mental health must have a Medical Supervisor.
The Medical Supervisor is appointed from an approved list held by the GMC. The Medical Supervisor is not responsible for or involved in the doctor's treatment or care. The supervisor should meet with the doctor regularly to discuss their progress, and liaise with any treating doctors, as well as the workplace, clinical or educational supervisors. The Medical Supervisor will obtain information from a variety of sources but will not disclose confidential information to an employer without the doctor's consent. The Medical Supervisor reports to the GMC on a regular basis, setting out their opinion about the doctor's progress under treatment, whether the doctor is complying with conditions or undertakings and the doctor's fitness to practise in general."[6]

The GMC appointed Dr G as Medical Supervisor although he was not a specialist in the treatment of addictions. It is not clear why this decision was made. The GMC acknowledge that a specialist in addiction should have been appointed as supervisor. Guidance available to GMC staff at the time of these events indicated that a substance misuse specialist should be appointed in cases where substance misuse had been identified. This did not happen in this case. No records are available to assist in understanding how this decision was reached.

Dr G did not meet Julien face to face at the first or the second supervision meetings as he was suffering from health problems and was unable to travel to his consulting room. The consultation took place by telephone which provided no information about the physical appearance of Julien and no information of non-verbal cues. The third appointment was face to face. Dr G did not inform the GMC in advance that he had been unable to meet Julien in person. The GMC was therefore unable to decide in whether using Dr G as a supervisor was appropriate in these circumstances. No action was taken by the GMC on receipt of the progress report in which these circumstances of the interview was mentioned by Dr G.

As part of the GMC's ongoing review of the role of the Medical Supervisor they plan to significantly revise the 'Standards for medical supervisors' and the 'Handbook for medical supervisors'. The previous standards anticipated that face to face appointments would be the usual means of review, but this was not clearly stated. The new documentation and revised job description will make it clear that, where face to face appointments are not possible, the GMC should be informed at the earliest opportunity so that alternative supervision arrangements can be considered and put in place where necessary.

1.6 The management of the undertakings

At the point that the GMC varied Julien's undertakings (June 2015) there was support from his supervising doctors for the removal of restrictions related to his access to anaesthetic drugs. In

[6] GMC Glossary for undertakings and conditions

hindsight the confidence of the Occupational Health Physician and Medical Supervisor in their views appears to have been based on incorrect assumptions about the drug testing being undertaken. The recommendations made by the Occupational Health Physician and Medical Supervisor were accepted by the GMC case examiners who also based their decision on incorrect assumptions about the testing being undertaken.

1.7 The GMC offer the following conclusion

"By the time of Dr Warshafsky' s tragic death, the GMC had entirely appropriately disengaged with him to allow him space to receive treatment. There is no evidence that GMC engagement played any role in the events immediately preceding his death, since GMC engagement had been suspended by agreement with his representatives.

It cannot be said either that any different management of Dr Warshafsky' s GMC case could have prevented his opiate abuse and collapse at work in December 2015. However, the events preceding this collapse highlight weaknesses in the GMC's processes for monitoring health cases and in the factors that drive those processes. Three weaknesses stand out:

- *The absence of fentanyl testing was not identified*
- *The 'soft' intelligence of possible opiate abuse was not shared*
- *When prescribing restrictions were lifted, insufficient consideration was given to the possible need for increased monitoring for drug abuse*

In addition, insufficient prominence of the Medical Supervisor's role may have inhibited the sharing of information which might have helped inform the management of Dr Warshafsky' s chemical testing and practice restrictions.

All of the above factors will be fully addressed by our plans to significantly enhance the role of the Medical Supervisor in our processes. This programme is likely to require re-advertising and recruitment of the role followed by comprehensive training and is therefore expected to be concluded in the first half of 2018. Meanwhile guidance should be improved in anticipation of this programme to address immediate issues highlighted by these events."

2. The Training Programme

"As Postgraduate Dean, I am satisfied that effective and efficient support mechanisms were put in place to manage Dr Warshafsky's complicated requirements, both when he was in training and when he had been suspended from training. However, we are currently undertaking Lessons Learned Review following the death of Dr Warshafsky, so we can take some positive steps to improve the management of trainee who require additional support. Once this review is complete, HEE will ensure that any improvements to our processes are embedded in our governance structures and such trainees can receive as best support and advice as possible."

Professor Q

Postgraduate Dean

HEE

The letter to the coroner included a detailed log of activity and actions recorded by HEE. The Postgraduate Dean at the time was Julien's Responsible Officer (RO). This arrangement is potentially more difficult for case management and supervision. The RO regulations place a statutory duty on the designated body to provide this support, but in practice, it is the employing organisation who are involved in the day to day practicalities of this.

Professor Q reported that the College Tutors in the Trusts he worked at provided regular updates to the HEE School of Anaesthesia, so Julien could be managed effectively. There is a formal process of Transfer of Information concerning trainees who have had past complex training issues that could potentially endanger themselves or patient safety (source: statement to the coroner). However, at the inquest it was apparent that on occasions valuable information about Julien was not shared with HEE by the employing authorities.

Both Dr K and Dr P acting as the Trainee Support Leads were involved in supporting Julien together with the College Tutors and Educational Supervisors at the Trusts. This was a new role and some of the contacts were through email or telephone calls. Much of the information that was received by the Trainee Support Leads was through contacts with Julien rather than through the GMC or other interested parties (source: Dr K, coroners' inquest).

After Julien had died, Dr P (Consultant Anaesthetist, Trainee Programme Director for Trainee Support HEE) asked for colleagues to be informed of his death. HEE were unaware that Julien had collapsed in theatre at Trust 2 in June 2015. Julien had explained that his antidepressant medication (venlafaxine) had been increased and he thought that it made him feel dizzy. He also said that he had not had anything to eat and drink on his shift and had been running around busily. HEE did not have a record of this episode at the time of the occurrence. Following Julien's death, a colleague who knew about his substance misuse mentioned that she had worked with him the day before his collapse and had reported an anomaly with fentanyl ampoules in theatre. HEE were not made aware of this. Julien tested positive for fentanyl in July 2015 (self-test).

Julien started to show some strange behaviour at Trust 3
in November and December 2015. This was noted locally by one of the ODPs (Operating Department Practitioners) but this information was not reported to HEE at this point.

Reports from College Tutors and Educational Supervisors were positive, and Julien was successful in passing his examination.

3. The Acute Trusts

Julien worked at the following hospitals

- August 2012 to August 2014 CT2 ACCS Anaesthetics, Trust 1
- August 2014 to August 2015 CT2+ ACCS Anaesthetics, Trust 2
- August 2015 to June 2016 ST3 Anaesthetics, Trust 3 (on sick leave Dec 2015 - Jun 2016)

There were five incidents at the following hospitals. Only two of the five were investigated.

- Trust 1 30.05.13. Diversion of fentanyl from theatre for own use. This was investigated and led to a referral to the GMC
- Trust 1 06.02.14. Allegation of misappropriation of controlled drugs (fentanyl). This was investigated but the allegation was not upheld.
- Trust 2 11.12.14. Anonymous concern to the GMC "I would like some advice, I am aware of a Doctor who is still stealing drugs from work for his own use who currently has undertakings due to previously doing the same". Neither the Hospital nor the Responsible Officer was made aware and this was not investigated by the GMC
- Trust 2 19.06.15 Collapse at work? Respiratory arrest. This was not investigated further and the Responsible Officer (HEE) was not made aware of this
- Trust 3 13.12.15 Collapse at work – Grand mal seizure. This was investigated by the Hospital and the GMC / HEE were informed.

3.1 Trust 1

Julien worked at Trust 1 from August 2012 to August 2014. He had previously worked in that Hospital as a Foundation 2 doctor.

On 30.05.2013 Julien was found acting suspiciously around the anaesthetic rooms. He had been allocated to work in the intensive care unit. His excuse was he was doing an audit although theatre staff were not aware of an audit taking place. Theatre staff were also concerned as there was unusual movement of control drugs from theatre to theatre which could not be explained as all ampoules were accounted for. Theatre staff had also noticed unusual clinical practice in relation to Julien working a night duty and then staying behind to support the staff on day shifts. Julien was then seen taking an object from the drug tray which was situated on the anaesthetic machine in the emergency operating theatre. After he had left the room, it was noted that the only object missing from the drug tray was an opened 10ml ampoule of fentanyl {only 2ml had been used). This was reported to the on-call consultant and then it was escalated to the Medical Director. During an interview with the Medical Director on the same day, Julien admitted that he had a history of depression but initially denied taking the fentanyl. Later that evening, he admitted taking the fentanyl and was allowed to take a period of sick leave rather than be excluded from the Trust (source: serious incident review).

When the use of fentanyl from hospital theatre was discovered at Trust 1 a text message from Julien's phone on this date suggests that he had previously stolen fentanyl from work: "I finally got caught stealing fentanyl. It's not looking good for my career".

When Julien self-referred to the Practitioner Health Programme (PHP) he was interviewed by Practitioner B who reported “Julien injected himself with fentanyl. He reported that he did this approximately eight times. There was also one occasion where he also took ketamine, again to help him sleep. There was also one occasion where he took diamorphine (this was an intravenous solution which he drank).

Julien returned to the Trust on 23rd September 2013 on a phased return to work and resumed on call duties from 5th November 2013. There were no further concerns raised until 5th February 2014. Julien’s observed behaviour during the theatre list on 5th February 2014, In the context of his previous history, may have indicated that he was misappropriating controlled drugs again (and in particular fentanyl). This was investigated by the Trust. They concluded:

“There is no doubt that some of JW's behaviour was unusual - in particular the way he insisted on drawing up the drugs despite being told by the consultant to go and scrub and by placing an unopened syringe and needle in the pocket of his theatre scrubs……..There is no evidence that Julien took any fentanyl (or any other controlled drugs). During his interview on 24/02/2014 he produced a hair test result which was negative for several substances including fentanyl. This test was dated 10/12/2013. He agreed to undergo another hair test on 10/03/2014 which again proved negative. His GP verified by email that he had collected this sample. If Julien had taken fentanyl (or any other controlled drugs) within the last 6 months, it would have been detected in these hair samples.”

However, texts from Julien discovered after his death indicate that he was using fentanyl at that time (text 20.02.14 “my hair treatment worked”). Julien had researched different methods of interfering with the hair testing regimes.

3.2 Trust 2

Julien worked at the Trust between August 2014 and July 2015. At first, he was apprehensive about working there, largely because of the commute and the inevitable change, but also because of the need to disclose information about his substance misuse (source: Mariana W, wife). He did enjoy working in Trust 2 and, on all accounts, appeared to be well liked and was successful in passing his anaesthetic primary examinations.

Whilst he was working at the Hospital the GMC received an anonymous call to say that Julien had misappropriated fentanyl from the Trust and had accessed (inappropriately) the notes of celebrities. This was never investigated further by the GMC and the Trust was never made aware of this (source: coroner’s inquest; letter from Trust 1 07.08.2018). There were no reports of missing fentanyl at that time through the Trust’s normal checking procedure, but this may not have detected misappropriation as Julien had already found ways around this.

The clinical notes from the emergency department state in an entry made at 02.20 on the 19/06/2015 that Julien collapsed in theatre whilst giving an anaesthetic. He lost consciousness.

He told the staff that he had been unwell for about a week with a viral illness and was taking venlafaxine for depression. He denied using recreational drugs. The observations at the time of that assessment (02.30) showed a normal respiratory rate and blood pressure, a tachycardia, an oxygen saturation of 95% and a GCS score of 15/15. The cardiac arrest / medical emergency form records the event occurring at 02.00 as a respiratory arrest.

Following Julien's death, a colleague of Julien's who knew about his substance misuse mentioned to Dr P (Consultant Anaesthetist, Trainee Programme Director for Trainee Support HEE) that she had worked with him the day before his collapse and had reported an anomaly with fentanyl ampoules in theatre. The trainee said she had discussed the issue with the College Tutor and Educational Supervisor at Trust 1. However, the Trust says that the College Tutor and Educational Supervisor have no recollection of a report from a trainee that an ampoule of fentanyl had been misused nor were they informed of this following Julien's death (source: letter from Trust 2, 07.08.2018)

In correspondence between the Hospital and the family (08.12.2017), the Hospital has questioned whether this was a true respiratory arrest, although in retrospect and with the evidence that is now available, they agree that fentanyl use was the most likely cause. They say this incident was not reported on their Datix system at that time as no concerns were raised at the subsequent review of the report of the arrest call as Julien made such a rapid recovery. It was felt it was not necessary to raise it as a serious incident and no further investigation was undertaken at the time. The Trust confirm that they checked their theatre records and found no anomalies in the records regarding fentanyl. Julien was not tested for opiates at that time since no one present at the time of the incident and no one in the ED department would have known about Julien's health problems. The circumstances of this incident were not reported to the Responsible Officer (HEE).

The Anaesthetic department consultants were made aware of the incident of the collapse but only the College Tutor, the Educational Supervisor and the Clinical Director were aware of Julien's GMC undertakings and his ongoing testing by the GMC.

Julien was well liked and well regarded at the Trust. In January he had passed his primary examination in anaesthetics and in April gained a placed as a ST3 trainee in Trust 3. He reassured his educational supervisor that he was engaging with Occupational Health and the GMC and drug taking was a thing of the past (source: Educational Supervisor, Trust 1).

Subsequent hair testing (undertaken by Julien in July 2015) was positive for fentanyl. The events of the night of the 19.06.2016 were similar to further collapses witnessed by the family and subsequently at the Trust 3 in December 2015. It seems more likely than not that this episode at Trust 2 was caused by fentanyl rather than the explanation Julien put forward at that time. He later explained to Mariana, his fiancée, that he had taken fentanyl as a "one off" following a period of anxiety.

3.3 Trust 3

Julien worked at the Hospital from August 2015 to 13.12.2015. Julien found this post more stressful, partly because of the responsibilities of a ST3 doctor but also because he felt less supported. Julien reported to his wife, Mariana that when he had his induction at Trust 3, the College Tutor told him that if he misappropriated medication again from theatre this would result in the police being informed. At the inquest the College Tutor explained that he had sought advice from colleagues who had managed previous trainees with similar difficulties and that the advice that both he and the Educational Supervisor had received was to make it clear to Julien that the Trust would follow a" zero tolerance" approach to any irregularities with regard to misappropriation of drugs.

The Trust 3 Medical Director, the Clinical Director for Anaesthetics, Perioperative Medicine and Chronic Pain and the Director of Medical Education were made aware of the Julien's GMC undertakings and his medical history relating to controlled drug misuse in the workplace. The Trainee Support Lead HEE Deanery indicated to the Anaesthetic College Tutor that Julien would appreciate as much confidentiality as was reasonably possible and considered that not all supervisors needed to be aware. The information was shared with his designated Educational Supervisor but only a subgroup of Consultant Anaesthetists and intensivists and Lead Operating Department Practitioner (ODP) were to benefit from the knowledge of his previous difficulties (source: Trust 3 serious incident review). Julien was allocated an experienced Educational Supervisor who met with him every fortnight.

When Julien was on call for anaesthetics the Trust ensured there was a third doctor on the rota in case extra support was required. Feedback from consultants during August and September was positive. This then seemed to change, and his Educational Supervisor noted that there was a change in his attitude and demeanour during the autumn.

In November 2015, one of the Educational Supervisor's anaesthetic consultant colleagues noted that she was concerned that Julien had appeared sweaty and behaving suspiciously, disappearing into the male changing room inexplicably. At their subsequent meeting, the Educational Supervisor thought Julien seemed low in mood and they talked at length about work life balance, exam revision, stress and morale. During their conversation, the Educational Supervisor asked Julien directly whether he had on any occasion taken, or felt tempted to misuse drugs available to him, but he denied any form of drug or alcohol misuse.

On the 13/12/15 Julien in the presence of two other Anaesthetic Trainee colleagues, collapsed mid conversation, slumped in his seat, lost consciousness, obstructed his airway and become profoundly cyanosed and had a seizure. Julien was resuscitated, and this was investigated further.

The ICU Consultant examined Julien's forearms and hands and noted multiple bruise and needle track marks of varying age. On questioning him about these bruise and marks, he explained to her that he had been undergoing serial blood monitoring from his GP for a problem

associated with his liver. He informed the ICU Consultant that he had been prescribed antidepressant medication (venlafaxine) for approximately two years and when she asked him directly, he stated that he had not taken any substances that day. When she enquired about his previous medical history, Julien described a similar episode of "collapse and seizures", which occurred in June 2015, at Trust 2 whilst he was anaesthetising a patient. This information had not previously been disclosed to any of the Anaesthetic Consultant staff.

Although Julien initially denied taking drugs, a drug screen proves positive for fentanyl. After the incident Julien then took sick leave from the Trust. He never returned to work.

One of the Operating Department Practitioners (ODPs), who attended the priority call that day expressed concern to the on-call Consultant Anaesthetist regarding Julien having recently noticed several concerning behaviours that had led her to become suspicious. These included leaving the obstetric operating theatre for the toilet immediately after administering a patient fentanyl spinal anaesthetic and on returning, emphasising disposal of the remaining amount of the controlled drug. On another occasion, the ODP noticed that the Julien had fresh blood spots on the side of his theatre 'scrub' tunic (October 2015) but when she remarked, he could not provide an adequate explanation. This was not reported. The ODP was not aware of Julien's previous substance misuse history.

4 Communication between the organisations

Communications between organisations responsible for Julien's training and supervision were at times ineffective or absent.

A concern arose at Julien workplace in February 2014 when he was suspended by his employer (Trust 1). Julien self-reported the incident and the GMC was made aware. However, despite still being at the same employer as the index concern, and despite previous correspondence between the Trust and the GMC, the letter of suspension was not initially copied to the GMC. The details of the local investigation and the conclusion (including negative testing for fentanyl) were obtained after a request made by the GMC investigation officer.

When Julien started to show some strange behaviour at Trust 3 between October and December 2015 this information was not reported to the GMC. Nor was it shared with the Responsible Officer (HEE).

The Responsible Officer (HEE) and the GMC was unaware of the events that took place at Trust 2 in June 2015 (collapse in theatre).

Sharing of information between the workplace, the other professionals involved, and the GMC was at times poor. Each of the health professionals involved with Julien fulfilled a discreet role but there was limited sharing or active calibration of information between the medical professionals involved with no single person acting as an obvious coordinator.

The GMC believe the proposed change to the role of the Medical Supervisor will make the Medical Supervisor a 'hub' for all information relating to a supervised doctor. The GMC propose that the Medical Supervisor will actively obtain clinical and other information directly from others involved in the care of a supervised doctor rather than relying on this information to be obtained by administrative staff at the GMC. By actively contacting those involved in treatment the GMC hope this will develop more open and positive relationships so that information is shared at an early stage.

The GMC was unsighted on the level of discussion about the historic incidents between Julien's Responsible Officer and the workplaces, line managers and trainers involved with him. Although the GMC has an obligation to protect the confidential information it holds about a doctor's health, they acknowledge that this can represent a barrier to communication in certain types of cases, particularly when doctors are moving between posts.

5 Communication within provider organisations

Julien did not wish his health problems to be disclosed widely and provider organisations respected his wishes, only making key individuals aware of his substance misuse history. This had the unintentional effect of making any drug seeking behaviour more difficult to identify by his work colleagues, some of whom were unaware of his drug misuse.

When Julien collapsed in theatre at the Trust 2 in June 2015, drug misuse was not suspected nor was it investigated further. However, a trainee colleague at that time was aware of his substance misuse history and reported a missing fentanyl ampoule from theatre (Statement to Coroner, Dr P Consultant Anaesthetist, Trainee Programme Director for Trainee Support HEE). It would appear this was never investigated, nor was a link made between Julien's collapse and his previous drug misuse. We now know for certain that Julien tested positive for fentanyl in July 2015. It is more likely than not that Julien was misappropriating fentanyl from hospital sources such as ICU or theatre during his attachment to Trust 1. The extent of this remains unknown.

Julien's wish to privacy was respected at Trust 3 where only a small number of colleagues knew about his drug history. However, an ODP (Operating Department Practitioner) in theatre noticed some abnormal behaviour in November and December 2015, but this was not widely shared, and the ODP had no knowledge of Julien's past.

Management and treatment of Julien's health problems

All parties involved in treating Julien concentrated on his depressive illness and underestimated the significance of his previous (and current) use of drugs.

1. The Providers of Care

1.1 The Acute Trusts

Julien attended the following acute hospitals for treatment:

- Trust 2 (Collapse in operating theatre – probable respiratory arrest June 2015). See previous section.
- Trust 3 (Collapse in operating theatre – respiratory arrest December 2015) See previous section.
- Trust 4 (Respiratory arrest twice 2016)
- Trust 5 (Respiratory arrest 2016)
- Hospital 3, France (Respiratory arrest 2016)

1.2 Trust 4

(Source: clinical notes, statement Dr P)

On the 30.03.2016 Julien collapsed at home, was given naloxone by the paramedics and attended A&E. Julien admitted to using IV fentanyl but denied any suicidal intent. He was discharged into the care of his GP with no further psychiatric input. He re-attended on the 30.04.2016 following a further respiratory arrest. It was noted that he was receiving care from a private psychiatrist. The Trust have investigated both attendances and confirm that they were aware of Julien's use of fentanyl and that they knew this was the third respiratory arrest in a short space of time. After the first attendance, Julien was reviewed by the Psychiatry Liaison Team. His depression history was noted and that he was being seen for this by his GP. Julien's father was present at the psychiatric review. There was evidence of insight. Julien expressed that it was an accidental overdose and he had not intended to take his life His father reassured the attending team that everything was in hand and that they were able to look after him (source: investigation report, Dr P, September 2018).

After the second attendance, no specialist psychiatric review was arranged. The recent Trust 5 admission was noted along with a recent diagnosis of pulmonary embolism. Julien's ongoing psychiatric care with a private psychiatrist (Dr A at Hospital 2) was noted as well as a soon upcoming date for CBT on the 3.5.16. The A/E consultant noted Julien's insight, his intention not to self-harm and that his partner was going to be with him throughout the weekend. Julien was discharged with the provisos that his partner would inform Dr A of the recent attendance. However, Dr A was not made aware of the second attendance at Trust 4 (see 1.6 in this section).

1.3 Trust 5.

On the 31.03.2016, a day after attending A/E at Trust 4, Julien had a further respiratory arrest. It wasn't clear what the cause of the arrest was. Julien was also found to have a pulmonary embolism.

1.4 Occupational Health (OH)

Julien completed an application form for occupational health at Trust 1 on the 22.05.10 where he denied the use of recreational drugs. He was applying for a FY2 rotation in A/E, general medicine and trauma and orthopaedic surgery. Julien self-referred to OH on the 17.06.2013 following an episode of fentanyl use. He was seen by Dr F on the 19.06.2013 and regularly thereafter whilst recovering from this episode of sickness and awaiting the outcome of the GMC hearing and up to June 2014 before leaving the Trust in August 2014.

Whilst the focus of the interviews was on Julien's fitness to work and discussion of his mental health and well-being took place, there was no screening for drug misuse as it was assumed that the GMC would be monitoring this. Julien continued to see OH when he moved Trust 2 but did not continue when he moved to Trust 3.

1.5 Practitioner Health Programme (PHP)

(Source: Coroner's Inquest; statement to coroner – Practitioner B)

Julien was a patient of the NHS Practitioner Health Programme (PHP). PHP is a confidential health service for doctors and dentists with mental health and/ or addiction problem. It was established in 2009. Most of the patients have mental health (that is depression, anxiety, adjustment disorder) problems, though some have problems relating to addiction. PHP is an integrated mental health service, with practitioners located on a single site (in Vauxhall), sharing patients, learning and a single electronic record. The full PHP team included general practitioners with special clinical interest, psychiatrists with specialism in addiction, forensic and general, psychotherapists and specialist addiction nurses. Julien, as an outside London resident, was not eligible for the full range of PHP services. He was however able to self-refer to PHP under a contractual arrangement with the HEE, allowing him access up to 8 sessions of CBT.

1.5.1 First treatment episode

Julien first presented to PHP on 21.06.2013. All patients self-refer to PHP as opposed to being referred via a third party. Julien reported a long history of low mood and depression, describing himself as always being unhappy, but able to tolerate the symptoms and self-manage. He first presented to his GP in Oxford in 2004. He was started on anti-depressants and his mood lifted, but he later stopped taking them due to side effects. He reported a further episode of low mood in 2009 when in his final year of medical school. He was restarted on antidepressant medications and paid for private psychotherapy which he reported to not find very helpful. Once he began working as a doctor, he found the role protective to his mental health but suffered a further episode of low mood in 2011 following the breakdown of a relationship. He told PHP that his mood had been particularly low since February 2013. Prior to his depression in February 2013 he also stated that he had no difficulties with drugs or alcohol. With his most recent

depressive episode he noted that he had increased his alcohol intake to help his mood and aid sleep from 10-20 units per week to 30 units per week.

Julien told PHP how he injected himself with fentanyl. He reported that he did this approximately eight times. There was also one occasion where he also took ketamine, again to help him sleep. There was also one occasion where he took diamorphine (this was an intravenous solution which he drank) - this had no effect whatsoever. Julien did not report any escalation of use and reported that his use was limited to when he felt most desperate.

Corroborative evidence obtained from texts and emails after Julien's death confirm that he underplayed his involvement with drugs, particularly recreational drugs which he used intermittently from 2011 onwards (and occasionally before that).

Following the first assessment it was felt that Julien was suffering from a depressive illness and was already receiving medication from his GP and that he had used drugs intermittently to self-manage his depression in a non- dependent manner. He did not appear to use drugs continuously. On the 05.07.2013 Julien commenced a course of Cognitive Behavioural Therapy. He was seen throughout 2013, the last appointment being on 10.12.2013. This appointment was requested by Julien. He reported that his mood had picked up and his local psychiatrist had suggested increasing his venlafaxine to 225mg daily. At this meeting, PHP agreed they would take a hair sample and fund the analysis of this. This was agreed as Julien wished to prove his abstinence between tests for his next GMC hearing. The sample was taken and sent to Alere Toxicology. The sample was tested for amphetamine, methamphetamine, benzodiazepines, methadone, cannabis, mephedrone, cocaine, opiates, ketamine, and fentanyl. The sample was negative for all substances.

1.5.2 Second treatment episode

Julien telephoned PHP on 07.04.16 asking to re-refer himself. He was seen for his assessment on 14.04.16. At this assessment, Julien reported that he had not used any drugs between his last contact with PHP up to December 2015 when he suffered a' collapse at work' due to his use of remifentanil (a potent, short acting, synthetic opioid analgesic). However, this was not the case and unequivocal evidence confirms that Julien had taken drugs during this period. He did volunteer that his mood was lowered and that he had been drinking more alcohol. Julien had further CBT on the 03.05.2016, 17.05.2016 and 01.06.2016. He was at that time under the care of a private psychiatrist (Dr A) although he had last seen him on the 12.04.2016.
Julien told the PHP that his family had suggested that he attended the Hospital 2 for in-patient rehabilitation, but he was against this option as he did not self-identify as an addict and questioned why his family wanted him to go to rehabilitation when he no longer used drugs. However, his family say it was more complicated than this. They informed the moderator of the Sick Doctors Trust group, Mr S, of the respiratory arrests. He also worked at the PHP. He agreed that he would speak to Practitioner B, the CPN Julien was seeing at the PHP and tell Practitioner B that Julien had now had 4 respiratory arrests. Julien had said that if Practitioner B told him he should attend inpatient rehabilitation, he would do. Practitioner B misunderstood Mr

S, and he thought Julien had had only two respiratory arrests. According to the family, Practitioner B did not encourage Julien to choose this option (source, Robin W)

In the statement to the coroner, Practitioner B states:
"Dr Warshafsky emailed me on (27 /06/16) following his return from his own wedding informing me that he had been in contact with the PHP administration office and was offered the next available appointment on 19th, July. He was asking if he could be seen sooner. I offered him an earlier session on the 13th, July 2016, and asked if he was 'okay', to which he replied I'm doing fine .... Just keen to continue to progress despite my lack or organisation'. He accepted the earlier appointment and was also told by that he could speak to me via the telephone sooner if he needed".

PHP were aware of at least one of the respiratory arrests following use of fentanyl but were not made aware that there had been several episodes in a very short space of time.

In the statement to the coroner, Practitioner B states:

"Whilst I knew about the respiratory arrests, I was not aware of all of them and it was not until after his death that the other occasions came to light".

PHP believed that Julien had a primary diagnosis of depression and his substance misuse was secondary to periods of depression.

1.6 The Treating Psychiatrists – Trust 6

(Source: Coroner's Inquest, statement to coroner and clinical notes and letters)
Julien was seen by several treating psychiatrists between 2013 and 2016. None of these were specialists in addiction.

On the 15.08.2013 Julien was referred by his GP, Dr J to Dr I (Consultant Psychiatrist, Trust 6) requesting help with his depression. This was prompted also by the GMC, who required Julien to be under the care of a treating psychiatrist. An appointment was arranged for the 04.10.2013. Dr I's recommendation was to increase the antidepressant medication, noting that Julien was also under the care of the PHP. He also said in his letter "I would normally discharge back to your care, a patient at this stage of recovery. Moreover, he is seen in the context of the Practitioner Health Programme and there is a clear risk of "too many cooks." He also added "If instead my role were of controlling his abstinence for the GMC, this would be done more appropriately by a psychiatrist specialised in addiction". In a report to the GMC (16.12.2013) Dr I informed them that Julien was responding well to treatment for his depression and didn't require the care of a psychiatrist because his care needs were adequately provided for by his General Practitioner and Occupational Health department. Julien did make further contact with Dr I on the 05.12.2013 and was offered an appointment on the 07.02.2014 but he did not attend (this was the day that Julien was suspended by Trust 1 on suspicion of misappropriation of fentanyl).
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In January 2016 Dr J referred Julien to Dr N (Consultant Psychiatrist, Hospital 1). He agreed that Julien had a recurrent depressive disorder with secondary substance misuse. He was seen on one occasion with the recommendation to increase the venlafaxine MR to 225 mg once daily. No formal follow up was arranged. Julien was concerned that his disclosures would be copied to the GMC and chose not to accept the offer of follow up (source: statement to coroner, Dr N).

Dr J referred Julien to Dr A (Consultant Psychiatrist, Hospital 2) where he was seen on the 06.04.2016 and again on the 12.04.2016. Dr A was aware of the first respiratory arrest (Trust 4) and the following day a second respiratory arrest (Trust 5) although Julien told him that this collapse may have been caused by serotonin syndrome (source: telephone interview and statement to coroner, Dr A). In his letter to Dr J, Dr A said he was concerned that his depression might get worse after coming off Venlafaxine and recommended he starts Duloxetine 60 mg a day. He also recommended an Addictions Treatment Programme admission to Hospital 2 or the possibility of Day Care as Julien expressed some reluctance to an admission. He was seen for follow up a week later and reported that he was to have contact with the PHP but declined an inpatient addiction programme. Julien was asked to return for follow up at the end of April, but no appointment was made (source: statement to coroner, Dr A). Dr A was aware that Julien had contacted the Sick Doctors Trust, had an appointment to be reviewed by Practitioner B (PHP) and had given positive assurances about his mood and his up and coming wedding in June. A further respiratory arrest (the third) occurred on the 30.04.2016 and a fourth in France on the 20.05.2018. Dr A was not made aware of either of these events.

1.7 Other Psychiatric Assessments

(Source: Clinical notes)
Following the overdose of fentanyl on the 30.04.2016 when he attended Trust 5, Julien received a further assessment (Mental health Liaison Service Assessment,
Trust 6. It was noted that “Julien's drug misuse is all linked to overdosing on fentanyl - obtained both from the hospital and on the internet”. It was also noted that his thoughts were negative, confused in that he cannot understand his behaviours. This seems to be related to the fact that Julien could not explain his actions since he admitted that he knew the potential consequences and didn’t wish to die. Further follow up was not arranged because Julien was under the care of a private psychiatrist.

Reflecting on the psychiatric care offered by Trust 6, Dr T (Chief Medical Officer) in his letter states:

“Julien was seen by one of our Consultant Psychiatrists in October 2013 following referral by his GP as part of the GMC requirements. His depression and substance use were both explored. The Recurrent Depressive Disorder was addressed in the care plan. It was felt that if specific treatment for his substance use was required then an Addictions Psychiatrist should be sought. Julien was not taken on for further management by the Community Mental Health Team as he was already with the Practitioner’s Health Programme. Julien was discharged back to his GP.

Julien was re-referred to the Community Mental Health Team in April 2016 but was being seen by the Hospital 2 at that time so was not taken on."

1.8 Practice 1 (General Practitioner)

(Source: Significant event statement, GP Clinical notes, Coroners statement)

Dr J was the registered General Practitioner. He first met Julien in August 2013, and then reviewed Julien periodically, providing treatment, reports to the GMC and generally felt that he was progressing well with his treatment. He was seen five or six times in 2013 and in 2014, in 2015 three and in 2016 a further five face to face contacts. His GP was aware of the events in December 2015 and the subsequent respiratory arrests. Dr J was copied into correspondence but did not receive any information from the GMC.

During the consultations there was no record of a discussion of further drug misuse until 05.01.2016 when the circumstances of the use of fentanyl at Trust 3 were discussed. Julien was last seen by another GP at the Practice (not Dr J) one month before his death when it was noted that he was struggling with depression and the dose of duloxetine was increased.

1.9 Support organisations

Julien reported that he had contacted the Sick Doctor's Trust[7] and one Narcotics Anonymous meeting. His family does not have records of this (letter from Dr A to GP Dr J 18th April 2016)

2 The collusion of anonymity

The 'collusion of anonymity' was a phrase used by Balint to describe the taking (or not) of important decisions, without anyone feeling ultimately responsible for them. Tis is explained further in this YouTube video[8].This is always more likely to occur when several different providers of care are involved in the care of a patient. It is not difficult to see why decisions are either delayed or not made because a clinician believes someone else is responsible for that decision. Whilst it is sometimes the GP who acts as the "care coordinator", it is more difficult when specialist services are involved, since not unreasonably, a GP may expect the specialist service to lead in these circumstances. For example, the GP would have been aware of the respiratory arrests, but at that time Julien was already receiving care from the PHP and a private psychiatrist.

It is possible that Julien either did not consider he had an addiction or was in denial (a common feature of an addictive illness) and appeared reluctant at times to seek help for this aspect of his illness. The family also felt that there was no one person they could go to for advice, guidance and support.

[7] http://sick-doctors-trust.co.uk/
[8] https://www.youtube.com/watch?v=qwnqVKIDTQI

3 The involvement of the family

There was no support available for members of the family during the period Julien was undergoing investigation. The views of the family were not sought. This, in hindsight, was a significant omission and meant that valuable information was not included. For example. Mariana was aware that the tests the GMC were undertaking did not include fentanyl. She was also aware that Julien was self-testing. At that time, she didn't appreciate the true reasons why Julien was undertaking these tests and did not know how she could disclose this information confidentially. In July 2015 she was aware that Julien had taken further fentanyl (whilst he was at Trust 2) but did not feel that she could disclose this without betraying Julien. Julien had reassured her that this was a "one-off" and at that time, Mariana was herself dealing with an unexpected family bereavement.

The views of Robin, Wendy, Gabriel or Mariana (the family) were never sought. They too held useful information that may have been helpful to the GMC and the supervising psychiatrists. For example, Julien would only tell the supervising and treating psychiatrists what he thought would reduce the risk of closer scrutiny. He would not attend appointments with a family member because he was selective with the information he wished to disclose. Too much reliance on self-disclosure is unlikely to provide robust evidence for decision making in doctors who have an addiction.

There was also very little involvement of the family members whilst Julien was receiving treatment. The family felt that there was an over reliance on them as a "medical family" in supervising Julien's care particularly after the discharge from hospital following his respiratory arrests. Their professional approach also contributed to their feeling that they did not feel they could not challenge or question the decisions that were made for Julien by his healthcare professionals.

Contributory factors

There are several factors that could have contributed to the events that eventually led to Julien's passing. Some of these are more significant than others. What has been particularly difficult to judge is how these factors, either individually or collectively, would have placed him at additional risk and how they contributed to his death. A number of these factors will be discussed in the following section.

1 Personal and Personality Factors

1.1 Personal Characteristics/Risk Factors

Age/Gender

36% of doctors in the study were in the age band 30-39, the greatest proportion for any age band. *Doctors who commit suicide while under GMC fitness to practise investigation, S Horsfall 14.12.2014* [9] "In anaesthetists illicit drug use is more common under the age of 40 years, and 80% of cases are male. *AAGBI 2011*[10]

Julien was in the highest at-risk age group amongst anaesthetists for illicit drug use. Risk taking behaviour also tends to be highest in his age group across most of the domains that have been studied[5].

Profession/Subspecialty

"Drug abuse is more common than alcohol abuse in trainees." *R Mayall 2011*[4]

"Anaesthetists are more likely than other doctors to abuse narcotics as a drug of choice, to abuse drugs intravenously and to be addicted to more than one drug. Studies from the US and Australia have reported a 0.4 – 2% prevalence of drug dependence in anaesthetic trainees. *R Mayall 2011*[4]

"Anaesthetists are at a greatly increased risk of suicide and drug-related death compared to matched controls in the general population, and the time of highest risk is in the first five years following graduation." R Mayall 2011[4]

[9] https://www.gmc-uk.org/-/media/documents/Internal_review_into_suicide_in_FTP_processes.pdf_59088696.pdf
[10] https://www.aagbi.org/sites/default/files/Pages%20from%20CSQ-Bulletin70-1.pdf
[5] https://academic.oup.com/psychsocgerontology/article/69/6/870/545646

Access and familiarity with a substance play a significant part, exemplified in that anaesthetists are more likely to abuse drugs than alcohol, to abuse narcotics, and to abuse drugs intravenously. *R Mayall 2011*[4]

Julien was an anaesthetist in training and had access to narcotics. He used IV fentanyl on many occasions, presumably misappropriated from hospital sources. This dated from at least 2012. When this source was no longer made available, he purchased acetyl fentanyl from the internet. Anaesthetists are more likely than other doctors to misuse narcotics. This has implications for doctors in training and will be discussed further in this report.

1.2 Personality characteristics

"A further US study found that physicians were more likely to show traits of dependency, pessimism, passivity and self-doubt. Another study highlighted that doctors also tended to be perfectionists. Perfectionism may lead to conscientiousness during medical school and to a thorough clinical approach but it may also breed an unforgiving attitude when mistakes inevitably occur."

"The high-risk doctor has been described as driven, competitive, compulsive, individualistic, ambitious and often a graduate of a prestigious school."

Doctors who commit suicide while under GMC fitness to practise investigation, S Horsfall 14.12.2014[11]

His father said that Julien was very intelligent, very curious, a risk taker, easily bored, and driven to excel. He mastered a considerable number of non-medical technical skills including cooking, welding and metal working and carpentry. He also found anaesthetics at times stressful, particularly whilst studying for exams. Anaesthetic training, particularly at ST3 level is acknowledged to be a particularly challenging step in a junior doctor's career pathway (source: Coroner's Inquest 2018).

Whilst Julien was very intelligent, charming and charismatic, he would also use these characteristics to downplay some of his symptoms, and significantly, conceal his addictive illness from his family and others, for the most part very successfully.

Julien's intellectual interest, amongst others, focused on pharmacology and especially psychopharmacology. He had developed an expert understanding of drugs. Amongst his effects were materials for building complex molecular models, chemistry equipment for synthesis and reagents for testing compounds for psychopharmacologic content. (Robin W, father). This expert knowledge meant that Julien felt confident in his ability to take drugs perhaps without detection and with minimal risk to himself.

1.3 Being a sick doctor

"Many addicted doctors find it difficult to seek help and tend to become isolated." *AAGBI 2011*

[11] https://www.gmc-uk.org/-/media/documents/Internal_review_into_suicide_in_FTP_processes.pdf_59088696.pdf

Julien found it incredibly difficult to seek medical help when needed. This was probably compounded by being in a medical family. He found it difficult to form trusting therapeutic relationships. He found it difficult to follow through on treatment plans once given owing to the ease with which he could research and challenge the medical care (Source: Robin W, father). But there was also the shame that Julien felt in being a sick doctor and a doctor with an addictive illness. He made positive effort to hide this from everyone (source: interview Mariana W, wife). There were also times when Julien willingly sought help for his addiction. This will be further discussed in section 5.1.

2. Diagnostic Uncertainty

The family has concerns regarding the diagnosis of Julien's health problems. It is probable that he had a dual diagnosis, a primary mental health disorder and a drug addiction. The family believe that neither were satisfactorily diagnosed, in a timely manner, nor were they adequately treated. The addictive disorder was almost certainly underestimated by most clinicians he met. For reasons already outlined, Julien found it difficult to give a true account either because of the illness, the guilt he felt, the implications for his career or perhaps the realisation that the drugs that he had experimented with provided more help than those that had been prescribed to him.

Except for Dr A, who was aware of the use of fentanyl, most clinicians involved in treating Julien concentrated on his depressive illness and underestimated the significance of his previous (and current) use of drugs.

This is illustrated by the following quotes taken from the clinical record:

Dr U (Occupational Health) 21/06/2013
'There was no indication of addiction or other unhealthy coping mechanisms.'

Dr D (Practitioner Health Programme) 15/07/2013
'…no past, or indeed current, history of drug dependence.'

Dr G (GMC Health Assessor) 19/08/2013
'He also has a diagnosis of mental and behavioural disorders due to the use of opioids harmful use which under the ICD-10 Classification is classified as F11.1.'

Dr H (GMC Health Assessor) 22/08/2013
'There is no indication that he has an underlying problem with opiates. His use was intermittent, he did not become dependent and there were no withdrawal symptoms.'

Dr I (NHS Treating Psychiatrist) 04/10/2013
'I am going to discharge Mr Warshafsky back to your care. If you feel that he needs to be seen again, please contact us.'

DF (Occupational Health) 24/12/2013

‘You will recall he was returning to work after an absence in July after misappropriating controlled drugs to self-medicate during an episode of depression.’

Dr J (General Practitioner) 19/12/2013
‘As you see from the enclosed letter from Dr I, the consultant psychiatrist, he does not feel he needs ongoing psychiatric care and I would completely agree with this on clinical grounds.’

Mr B (Cognitive behavioural Therapist, PHP) 31/12/2013
‘Dr Warshafsky's drug use was limited to quite a short period of time and was an unhelpful method of self controlling his symptoms of depression and insomnia. For this reason, PHP have not suggested that Dr Warshafsky engage in any NA meetings or attend the BDDG, as they do not seem appropriate or necessary… The PHP team are of the opinion that Dr Warshafsky’s continued good health can be safely and appropriately managed by his GP.’

Dr J (General Practitioner) 27/06/14
‘This is to confirm that Dr Warshafsky has treated, depression and he continues to see me every eight weeks to collect his prescription. I have had no concerns about his mental health for many months and would consider him to be in a completely stable condition.’

Dr U (Occupational Health) 11/08/2014
‘He does not require any ongoing mental health support or treatment and he has been discharged from any specialist care. I recommend he is reviewed in the occupational health department six monthly.’

Dr G (GMC Medical Supervisor) 06/10/2014
‘At present the General Medical Council have agreed for the occupational health adviser and his clinical supervisor to supervise his prescribing habits. In my opinion he should be able to prescribe without restriction in his present job. It would be impossible for him to work as an anaesthetist without the ability to be able to prescribe drugs.’

Dr U (Occupational Health) 13/10/2014
‘I noted again that he was positive, keen to comply with the GMC orders, he had no signs or symptoms suggesting any mental health problem, any use of opiates or abuse of any other substances… I have no evidence to suggest he represents a risk to himself or to patients under his care, and nothing to suggest a current risk of relapse.’

Dr J (General Practitioner) 21/10/2014
‘I saw him again today and his mental health has been unchanged for some time now. He has no depressive symptoms whatsoever and describes a good mood and is enjoying his work.’

Dr U (Occupational Health) 16/02/2015 ‘He does appear to have successfully moved on from his past difficulties and I have no current concerns about his fitness for work as an anaesthetist.’

Dr U (Occupational Health) 10/08/2015
‘I am unaware of any issues or concerns relating to his practice, and I am not expecting any. He has not been referred to me by his employer since my last report, and he has not asked to see me…’

Dr J (General Practitioner) 05/01/2016

"I do feel that his overall problem is one of depression rather than addiction and do feel that this is contributed to significantly by the pressures of hospital medicine as well as him not being unduly happy within his job"

During this time Julien was misusing drugs. Not all were used to manage his depression. Some of the use was recreational and experimental. Julien was reluctant to disclose too much information about his true feelings, particularly to psychiatrists for fear that these would be reported to the GMC. For the same reason, he would not volunteer any information about his drug misuse. In fact, he took active steps to conceal this from his work colleagues and his family. This is not surprising. A feature of an addictive illness is to conceal the truth from others. Julien was very plausible, and people believed him. With the reassurance of negative drug testing results that were available to the clinicians that treated him there was less reason to disbelieve Julien's account.

Although it has become apparent that Julien was experimenting with and using several substances during the time he was an anaesthetic trainee, it is not known how often he would use fentanyl.

2.1 Primary Mental Health Disorder

Julien's Diagnosis

Julien appeared to develop a mood disorder in early adulthood. A GP put him on citalopram. This was not effective. More recently when the drug misuse came to light, he was started on venlafaxine. Because of side effects, in 2016 this was changed to duloxetine.

None of these agents seemed to have offered sustained benefit on Julien's mood or any other aspects of his mental health, certainly not his self-esteem. Countering this, he exhibited features of obsessiveness and seemed much pressured on frequent occasions (source: Robin W). The family began to wonder about other diagnoses, particularly bipolar disorder. In fact, after starting duloxetine it almost seemed to the family that there would be almost manic episodes followed by a sudden drop in mood during which a near fatal overdose would ensue. Without an easy way to convey concerns to treating clinicians, the family were concerned that this was overlooked. After the fourth respiratory arrest (30/04/2018), that followed an evening of seemingly "manic" thought and speech, his father gained consent from Julien to attend the next appointment with his treating psychiatrist, Dr A. Unfortunately, this appointment did not take place.

2.2 Addiction Disorder

"Fentanyl can lead to physical addiction in as little as six weeks of use, but more commonly comes to light after at least six months. Consequently, the sequelae of opiate addiction are seen in a much younger age group than alcohol abuse." *R Mayall 2011*

Substance misuse harms a person's health. Dependence occurs when there is physical and/or psychological addiction, and the person will have withdrawal symptoms if they do not use the substance. Their lives are dominated by getting and using the substance. Addiction changes a person's behaviour. It is common for example to find that the person is:

- more concerned with getting their substance than dealing with other things
- angry if confronted about their substance use
- secretive and evasive
- more often intoxicated, or appears to be under the influence of something
- tired, irritable and looks less well
- less interested in everyday things
- unable to say 'no' and has a powerful desire for the substance
- using more and more of the substance to get the same effect
- anxious, depressed or shows symptoms of other mental health problems.

Julien demonstrated most of these behavioural changes from time to time. However, it was only belatedly that the family really came to understand that Julien had an opioid addiction problem.

Julien in his MDU Statement, June 2013 said:

"in a moment of desperation and extreme ill-judgement I stole and used the remnants of a vial of fentanyl I had given to a patient sometime in April. I used fentanyl to numb my symptoms on a few occasions until I was caught stealing it on the 31st of May. I also took a small amount of ketamine on one occasion." Document 2013.06.24 Julien to Dr 1 MDU STATEMENT

It is possible that the statements "on a few occasions" are a downplaying of the quantity of use. Julien told Practitioner B (PHP) that he had taken fentanyl on 8 occasions. Texts on Julien's mobile phone confirm his use as early on as 2012. With continued use, the drug can quickly become addictive. Fentanyl misuse can be very difficult to halt, based both on its intensity as a pain-relieving drug and its high addiction potential. In many cases, the individuals who are addicted to this drug may be extremely hesitant to stop use because of either pain issues or fear of extreme withdrawal symptoms. Physical addiction as early as May of 2013 or before cannot therefore be ruled out.

Mariana found used needles hidden in the flat where they lived. Nobody can be sure how frequently Julien was taking fentanyl. His father explained that when Julien was recovering from another respiratory arrest in France, he regarded riding his motorcycle as "too risky" but could not explain why he didn't regard taking fentanyl as extremely dangerous. All his family were only too aware of the risk. It is certainly plausible that addiction would explain why a doctor chose to inject himself at work, risking his registration and disregarding the risks to him, his family, his colleagues and his patients. His family can see no other explanation for this behaviour other than addiction. This would be consistent with the risk-taking behaviours common amongst those addicted to harmful substances.

Julien did not exhibit the normal signs of addiction (source: Dr D, Coroner's inquest, 2018). There is also evidence that Julien hid his drug taking behaviour as texts and emails obtained after his death confirmed that he continued to take psychoactive substances throughout this period.

Julien was offered day case and inpatient addiction treatment, but he did not wish to pursue those options at the time they were offered (source: Dr A, Coroner's Inquest 2018). There are well established programmes for this problem based on the 12 step programme that usually starts with inpatient rehabilitation and then followed by attendance at day centres.

3 Family Issues

3.1 The Role of the Family

(Source: Robin W, personal reflections; interview Robin and Wendy W).

There are several issues regarding the role of the family that require consideration:

1. The members of the family felt they were just as much patients as the affected individual. This did not appear to receive recognition. They were unclear who they should contact for support. When they approached individuals for advice or to pass on information this was not responded to positively.

2. The family was not sufficiently involved in the diagnosis and treatment planning for both their own reassurance and to ensure compliance with the treatment plan for Julien. They heard what Julien told them but were not involved with the GMC supervising psychiatrist or any other treating psychiatrist. There is some evidence to suggest that Julien would not have always welcomed this.

3. The family held an important source of collaborative information which without there was a high risk of diagnostic and therapeutic failure. The family's subsequent discussions with Julien's various treating practitioners have revealed just how selective and manipulative Julien was in the divulgence of his medical history and communicating back to the family (source: Robin W).

During the latter part of 2013 Mariana (at that time Julien's fiancée) came to realise that the GMC were not testing for fentanyl. In a new relationship with Julien she didn't feel that she could disclose this to anyone without betraying Julien and almost certainly jeopardising their relationship. She was unaware of any confidential arrangement to disclose such information and she was the only person that knew about this, other than Julien.

After the collapse at Medway in June 2015 Julien told Mariana that he had taken fentanyl but reassured her it was a one off. His own self-test was positive in July 2015.

3.2 The "Medical Family"

The family were concerned that as a medical family (Julien an anaesthesia trainee, Mariana an ITU nurse, Robin a GP), that various treating professionals, especially those in the various A&Es

where he was taken after the respiratory arrests, over relied on a perceived ability for the family to manage this problem of Julien's ongoing drug misuse.

Whilst the family felt they were certainly better placed to manage the acute emergency of respiratory arrest than most, they were in no way able to manage the chronic issue of the mental health disorder and drug addiction without more support.

Although the "medical family" had more understanding than most, they also felt that they should behave in a professional way and felt that those that looked after Julien would not welcome interjections from concerned relatives. It was difficult for them to play the role of the relative as well as the role of the professional, a dilemma which is well known to all healthcare professionals.

For doctors and nurses as carers maintaining empathy in work and outside work can be a challenge. The carer's clinical knowledge may not be applicable to the relatives' clinical issues and sometimes this is not recognised by either party. The GMC guidance about treating family obviously applies but maintaining that position can be difficult.

The other issue, not unique to the medical family, is how disclosure or intervention on the part of the relative may be perceived by the patient and the effect that may have on their immediate and long-term relationship.

4 The skills to acquire and synthesise drugs

Julien had a considerable interest in chemistry and pharmacology. He had the intellectual and technical skills to acquire the equipment and substrates necessary to synthesise drugs. The email trails from the beginning of January 2016 indicate the purchase of chemical equipment and agents. It is not known how successful he may have been.

The record also shows that he was dependent on obtaining drugs from illicit internet sources, both on the open web as the emails show, and via the dark web as he divulged to the family and this must have been the source of the acetyl fentanyl that killed him.

After being excluded from the work place, a source of drugs was not available. Beginning in February 2016 he began to order items over the internet to satisfy his need. The email trails for the shows that he ordered psychoactive cacti and cannabis seeds for growing and set up a germinating box in his flat.

4.1 Tianeptine

Additionally, through February 2016 he was ordering tianeptine over the internet. This is an antidepressant, approved for clinical use in many countries, including many European countries, but not, critically, the UK. Whilst there is certainly potential for abuse due to its anxiolytic effects, it may have been of interest to Julien for actual therapeutic reasons. It is reported to be as effective as SSRIs, but with less side effects. Julien suffered several side effects from his SSRI antidepressants, but specifically sexual dysfunction, not specified. Tianeptine has been used to treat erectile dysfunction.

4.2 U-47700[12]

While Julien was seeking tianeptine over the internet, he was also looking to replace his source of opioid. During February 2016 again, he was ordering this substance over the licit web. U47700 is a synthetic opioid that has never been tested on humans and therefore not for therapeutic use. On the other hand, it seems to be freely available over the licit web, in the UK, as the email trails demonstrate.

4.3 Acetyl fentanyl[13]

Julien confessed to his family after the first two respiratory arrests that he was obtaining this compound over the dark web using bitcoin to purchase it. The toxicology report on the substance found in the flat on 28 June confirms that it was acetyl fentanyl.

4.4 Emails and texts

At the inquest the coroner shared with the court some of the emails and texts that had been discovered on Julien's devices. Reference has already been drawn to these. They do demonstrate an active interest in recreational and drug related activities at least as far back as 2011.

5. Current Treatment of Addiction Illness amongst Doctors

5.1 Difficulties in treating Doctors with Mental Health Problems and Addiction

"The issue of doctors who become mentally unwell can be especially complex given the relationship doctors have with patients and the requirements of doctors under their GMC responsibilities. This means that expert services should be set up to provide accurate advice, sign posting and liaison with relevant bodies." *S Horsfall 2014*[14]

It is well recognised that doctors have difficulty in engaging with care for any health problem[10], but for these types of problems this is even more difficult. When they do they are wary, circumspect and distrustful, especially in the situation where there is a regulatory body involved. Addiction is a powerful force which deters the doctor from seeking help.

"There is currently considerable misunderstanding about requirements for referral to the regulator of health professionals with health problems. This may lead to the misapprehension among some doctors working with or treating doctors that any doctor with a mental health problem needs to be referred to the GMC. In most cases this is not required. This point is extremely important because health professionals will continue to be reluctant to admit to a health problem if they expect immediate referral to the regulator. Health

[12] http://www.vad.be/assets/2915
[13] https://www.cdc.gov/mmwr/volumes/66/wr/mm6643e1.htm
[14] https://www.gmc-uk.org/-/media/documents/Internal_review_into_suicide_in_FTP_processes.pdf_59088696.pdf
[10] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2441513/

professionals with health problems who do need to be referred to the regulator should expect to be managed in a way which is fair and objective and which protects their confidentiality as far as possible, while at the same time ensuring the safety of patients and protection of the public"

Invisible patients - Report of the Working Group on the health of health professionals, Department of Health 2010[15]

Julien constantly felt that the professionals treating him, especially the treating psychiatrists reporting to the GMC, were more concerned about fulfilling their obligations to the GMC than looking after him. He felt there was a conflict of interest and found it extremely difficult to engage. Doubtless he was not disclosing the severity of his mood disorder and despair at most times with professionals, and not at all likely his drug use (source: Robin W, father).

The family sought private psychiatric help for Julien, not realising that this too would have to be disclosed to the GMC. The first psychiatrist, at least as perceived by Julien, was explicit in making that disclosure known to Julien. Julien refused to see them again. This made it difficult to develop a trusting therapeutic relationship (source: Robin W, father).

The specific needs of doctors with alcohol and drug dependency issues have been recognised for many years[16] but it is only in the last 10 years a dedicated service has been available in the London area[17], and only recently extended nationally for General Practitioners[18]. Julien would not have had access to a comprehensive treatment and recovery programme.

Striking the right balance between risk, regulation and inspection is always difficult in these circumstances. Investigations will always need to be undertaken and assessments will always have to be made. The impact this has on the individual and their health should not be underestimated. This is discussed further in this section in relation to the GMC.

5.2 Attitudes of other health professionals

This year, the American Society of Addiction Medicine has redefined addiction emphasizing that it is a primary brain disorder and not a behavioural problem. *R Mayall 2011*

Despite efforts to raise awareness and improve education on the subject, talk of addiction still makes for an awkward topic of conversation. *R Mayall 2011*

Julien reported to his wife, Mariana that when he had his induction to Trust 3, the College Tutor told him that if he took medications again from theatre the Trust would notify the police. The perception was that the College Tutor was acting more in the interests of the Trust in this regard (source: Robin W, father)

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[15] http://webarchive.nationalarchives.gov.uk/20130123201334/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_113540

[16] https://www.bmj.com/content/316/7129/405

[17] http://php.nhs.uk/

[18] http://gphealth.nhs.uk/

Reporting a colleague to the police for theft (for instance, using drugs obtained from work) leads to houses being searched, court appearances, and much additional stress. A criminal record can cause problems with visa and mortgage applications. An addict is only usually dishonest in the context of their active addiction and, once well again, will **not** exhibit an ongoing probity issue. *R Mayall 2011*

Unfortunately, many employers still insist on reporting the doctor to the police for theft, and pursue the disciplinary route, which causes much added distress with court appearances and future difficulties with visa applications and working overseas.

RM Mayall, BJA Education, Volume 16, Issue 7, 1 July 2016, Pages 236–241[19]

Mariana also reported that when paramedics attended after the first respiratory arrest, one of them turned to Julien and said, “Look what you are doing to your fiancée.” (source: Robin W, father, Mariana W, wife). This was upsetting and highlighted the lack of understanding and compassion that still exists within some healthcare professions for people with substance misuse problems.

6 Confidentiality and Autonomy

Both mental health and addiction issues pose significant challenges to current concepts of patient autonomy and confidentiality. This is made acutely worse when the patient is a highly trained and experienced health care professional with knowledge of the diagnostic criteria for various mental health conditions. However, this can make it more difficult fully understanding the clinical picture and executing an achievable and safe management plan.

The view held by some clinicians supervising Julien was that his request for confidentiality concerning his health issues made it more difficult to detect any drug seeking behaviours since few working colleagues were aware of his addictive illness. The family believe that there should be sufficient awareness within the profession to detect changes in behaviour in colleagues that could indicate drug seeking or drug taking behaviour. From a treating perspective, Julien would not be as open and honest with those professionals offering to help him because of the fear of repercussions for his medical career.

“I need to know what you are trying to achieve for my son and how you are planning to do it. I need to understand the treatment that he is receiving so that I can play my part in his recovery programme. What I do not need to know are the personal details of what takes place between him and the professionals concerned.” (quote from a member of Rethink whose son has a serious mental illness)

Carers and confidentiality in mental health, leaflet produced by the Royal College of Psychiatrists[20]

The lack of involvement of the family as carers is another important and complex issue. This has already been discussed under the heading of “Family Issues”. Information sharing, and disclosure between the healthcare professional, the patient and the carer are sensitive issues but shouldn’t be a barrier to exchanging vital information. It is, for example, quite possible to

[19] https://academic.oup.com/bjaed/article/16/7/236/2196385
[20] https://www.rcpsych.ac.uk/healthadvice/informationforcarers/carersandconfidentiality.aspx

negotiate partial disclosure and agree the limits of any information sharing. It is not known whether all those involved in that role discussed this in any depth. The Royal College of Psychiatrists give helpful guidance on this and other issues that carers may face[21]. Rethink Mental Illness also have useful advice for carers (and professionals) on this topic[22].

7 The GMC

In 2007, 66% of the General Medical Council (GMC) annual caseload involved health problems – 43% involved alcohol abuse, 20% abuse of other substances and 26% involved affective disorders. *R Mayall 2011*

Whilst Julien did not self-harm during the GMC investigation evidence obtained from correspondence and from accounts provided by his family confirm that he was fearful of the GMC and found the process very stressful Julien spent his last 24 hours preoccupied with the GMC investigation and scrutiny. Robin's last conversation with Julien was at about 10pm on 27.06.16. The conversation was focused what Julien was going to do about the GMC. Julien was conflicted with respect to resigning or trying to hold on to his registration. He despised the process and the scrutiny but felt compelled to persist because of the 13 years of his life he had given to medicine and the possibility that retaining registration could facilitate a non-clinical career where his medical training would be advantageous (source: Robin W, father)

The family believe the overly legalistic, process driven management of doctors under investigation was a factor that impaired Julien's recovery. There is evidence that this led to periods of personal stress for Julien.

7.1 Communication from the GMC

As each part of the process was completed, documentations were generated and issued to the doctor and other relevant parties. This meant that the doctor often received multiple correspondence dated at the same time or within a matter of days.

Several other participants described communication from the GMC as overly negative, accusatory and judgmental; they felt that the GMC implied they were a 'bad' doctor rather than an 'ill' doctor who might need treatment and support.

While these participants recognised the need for a regulator, they argued that processes employed by the GMC and the communication style used were often distressing, confusing and impacted negatively on their mental health and ability to return to work.

Some of the GMC's correspondence with the doctors under review reflected these shortcomings. They were clearly written from a legal perspective and did not show compassion, nor did they reflect sufficiently the fact that some of these doctors were being assessed under health procedures. In short some of this correspondence did not acknowledge the fact that the doctor was ill or undergoing treatment; it simply outlined the next step of the process and detailed the next course of action.

In particular the GMC has looked at the way it corresponds with doctors and others and has sought to reduce legal language and references and to be more sensitive in the way it words its letters. However,

[21] https://www.rcpsych.ac.uk/healthinformation/informationforcarers/alcohol,drugsandaddiction.aspx
[22] https://www.rethink.org/carers-family-friends/what-you-need-to-know/confidentiality-for-family-friends

the responses of external agencies and those outside the organisation suggest that many still believe the GMC is a process driven organisation focused on protecting the public and that the doctor can become marginalised with little interpersonal communication, support or compassion.

Doctors who commit suicide while under GMC fitness to practise investigation Internal review Sarndra Horsfall, Independent Consultant 14.12.2014[23]

Julien was afraid of the GMC and disliked the process, especially the way the GMC communicates and the language that it uses. Julien discussed this with his father on the telephone the night before he died. He was upset and agitated as he had received a chasing email from his lawyer that day to discuss the GMC process (source: Robin W, father). *"During this last 3 years Julien had told me that he found it very difficult to believe that therapy would help him as every time he had it (even if the therapist/psychiatrist was different) he was reminded that the therapist would have to report back to the GMC. This situation made it impossible for Julien to be completely honest about his relationship with drugs and his mental state." (source: Mariana W, wife)*

Julien received numerous communications from the GMC in a style he found unsympathetic in language, tone or sensitivity. Some of the correspondence was copied widely which added to his distress.

7.2 Inadequate drug testing

The GMC did not manage its own drug testing regimen and the medical supervision to the standards that it should have. This meant that opportunities to detect continued substance misuse were missed. This is one of the most concerning aspects of this case because Julien was still misusing misappropriated fentanyl whilst still in work treating patients and anaesthetising them. It is by some fortune that no patients came to any harm. This gave his medical supervisors as well as those treating him the false reassurance that Julien was fentanyl free.

Julien was aware that the GMC testing regimen was lax and did not include fentanyl. From the evidence collected since Julien's death it is possible that his continued fentanyl misuse was encouraged by failures in the monitoring regimen. Although Julien did not disclose this fact to the GMC. This gives further clues to his true dependence on this drug and the effect that this addiction had on his behaviour.

7.3 Medical Supervision

There can be no disagreement that the drug testing regimen was flawed. However, the level of medical supervision was also inadequate. Julien met face to face with his Medical Supervisor just once. The other meetings were by telephone contact. This did not allow for any physical examination nor did it enable non-verbal cues to sensitive questioning to be assessed.

[23] https://www.gmc-uk.org/-/media/documents/Internal_review_into_suicide_in_FTP_processes.pdf_59088696.pdf

7.4 Failure to investigate anonymous concerns

The GMC also missed opportunities to investigate concerns from an anonymous caller who reported continued misappropriation of fentanyl in December 2014. Had this been investigated further, this may have led to a review of the supervising arrangements. No such action took place. Such were the importance of these allegations, it cannot be regarded as at all satisfactory that these were not followed-up in some form.

7.5 Attendance at support group/individual counselling and regular psychiatric care

There is further evidence that the agreed undertakings were not properly monitored by the GMC. This meant that Julien was still using fentanyl during this period. As far as his family was aware, Julian never attended a support group meeting during 2014 and 2015. Julien did receive an episode of care from a treating psychiatrist but did not receive care from a psychiatrist specialising in addiction even though the psychiatrist wrote to the GMC suggesting this (email from Dr I Consultant Psychiatrist to GMC 05.12.13).

8 Junior Doctor Issues

There is evidence from emails that Julien and his colleagues found anaesthetic training stressful. Frequent changes of location, examination pressures and an ongoing national contractual dispute added to the pressures of a junior doctors working life. How much of this was a factor in his illness is of course difficult to quantify.

9 The Role of the Acute Trusts

The Acute Trusts undertook two roles. The first was that of an employer. The second was in the treatment they provided after Julien had collapsed.

9.1 Detection of continued drug misuse

Trust 1 first detected the misappropriation of fentanyl in May 2013. They carried out a further investigation In February 2014 into the suspicion of drug seeking behaviour but were unable to find evidence for this. At the time of that investigation, the Trust's conclusions took some assurance that the hair testing was clear of fentanyl (although there was a delay of 1 month between the incident and the testing for Fentanyl). They would not have been aware that Julien was self-testing and treating his hair to avoid detection.

Julien collapsed in theatre at Trust 2 on 21.06.15. Although he attended A&E, drug misuse was not suspected and therefore not tested for. Nor was there any communication with the GMC or Julien's Responsible Officer about this incident. In hindsight, this was a missed opportunity to detect his continued fentanyl use.

There were no further opportunities to suspect continued drug misuse until October - November 2015 when colleagues at the Trust 3 noticed a change in demeanour and some odd behaviours.

Shortly after that Julien collapsed in theatre in December 2015 when it was confirmed that he was continuing to misuse fentanyl.

9.2 The management of the respiratory arrests

Julien attended Trust 3 (twice) and the Trust 5 with life threatening respiratory arrests within a short period of time (one month). Further psychiatric support was not offered at Trust 6 because Julien was receiving care from a private psychiatrist and planning to re-engage with the PHP. Dr P in his report for this investigation acknowledged a formal psychiatric review at the second ED attendance could have provided an additional opportunity for mental health services to communicate the acuity of the problems ongoing with Julien but it is doubtful if such a review would have changed the discharge decision. The Trust also considered that *"over reliance on Julien's family to both ensure support for him and that health services were in place may be seen as unwise and perhaps over trusting. Assumptions perhaps were being made in respect to the medical training and expertise of the family that could have caused role conflict both for Julien's family and the treating clinician.*" They concluded that *"such over-reliance could have negative bias on patient care where normal processes may be deemed unnecessary or transferred to a family member."*

It is surprising that the system as a whole did not respond more emphatically. However, his treating psychiatrist at that time had an incomplete knowledge of the developing chronology, and in particular the number of respiratory arrests that had taken place. This is discussed further in section 11 Case management of the Sick Doctor – the collusion of anonymity and communication issues. Another contributory factor was the way Julien would present (and in some instances misrepresent) his true feelings and disguise his relationship with drugs. This would have made any risk assessment more difficult.

10 Health Education England

HEE has a key role to play in the monitoring and support of trainees in difficulty. HEE is a designated body and has statutory duties under the Responsible Officer regulations[24,25] to ensure that these are in place. Although there was no suggestion that any patients were harmed, there were clinical situations where patients could have been exposed to risk. Case management was not as robust as it could have been, and this has since been improved (see lessons learned).

[24] http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

[25] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/456666/RO_guida nce_consultation_doc.pdf

11 Case management of the Sick Doctor – the collusion of anonymity and communication issues

There was an extensive list of professionals involved in the care of Julien between 2013 and 2016, but it is the opinion of the family that no one person was acting proactively, or with enough vigour, to ensure that Julien remained involved with treatment and recovery. This meant that the nature and gravity of his illness was not appreciated due to this lack of oversight. Julien had difficulty in accessing the correct psychiatric care for his needs. Most of the doctors involved in his assessment and treatment underestimated the seriousness of his condition except for Dr A who made it very clear to Julien the risks he was taking (source: coroner's inquest, letter to Dr J) As can be seen, there were numerous organisations who had several types of interactions with Julien for different purposes. They can be broadly divided into those who were caring for Julien's health problems and those who were regulating and monitoring his fitness to practise. Additionally, Julien was a trainee doctor and so there was an educational and welfare aspect to address (HEE was Julien's designated body). From at least the family's perspective, what appeared to be lacking was one coordinating individual to receive all intelligence from all parties, including all organisations, treating individuals, A&E departments and critically, as a point of contact for the family to pass on crucial information. In the three months before his death Julien saw Practitioner B (PHP), Dr A (Consultant Psychiatrist) and his GP. During that time, he was preparing for his marriage and spent some time abroad.

Practice 1 undertook a significant event review and concluded:

"For the last few months of his life, he was registered with the practice at his parents address but living in another county so was physically remote from his primary care provider. The patient had seen various consultants in both the private sector and in the NHS but, never seems to have seen an addiction specialist.
Despite his cardiorespiratory arrests, no appointments were pro-actively arranged in primary care, and no follow up was arranged in secondary care. Assessed by psychiatric team in the NHS 7/4/16 and diagnosed with "Recurrent depressive disorder" and again on 12/4/16 in the private sector, no definite diagnosis was made but in-patient treatment was offered, but not insisted".

It is perhaps not surprising that in a review of this nature involving so many individuals and organisations that communication issues feature as a contributory factor. These were responsible, at least in part for not detecting Julien's drug dependence at an earlier stage.

The investigation has established that no proactive appointments were made in primary care to discuss the respiratory arrests with Julien, and that his treating psychiatrist at the time was not informed of the third or the fourth respiratory arrest. His GP would not have been aware of this and may have assumed that such communication would have taken place.

12 The application of the Mental Health Act 1983 (amended 2007)[26] and the Mental Capacity Act 2005

An individual is free to make their own choices unless their judgement is impaired either by mental illness or by a reduction in their mental capacity. This is explained further below.

The misuse of alcohol or drugs is not considered to be a mental disorder within the current Mental Health Act in its own right and there are no grounds for detaining a person in hospital for the sole treatment of their alcohol or drug dependence. However, whilst 'dependence on alcohol or drugs' is excluded from the provisions of the Act this exclusion does not rule out the possibility of a person being detained on the grounds of a mental disorder arising from, or suspected to arise from, alcohol or drug dependence. In other words if a person is suffering from a mental disorder, which pre-exists, or is prompted by, the use of alcohol or drugs, he/she should be assessed in the usual way. Drug and alcohol use can contribute to both acute and chronic mental health problems.
There are four groups of people who fall under the umbrella of dual diagnosis. The first is those who develop mental health problems and have a history of substance use which has a bearing on their clinical presentation. The second group includes those whose first episode or recurrence of mental disorder is precipitated by substance use. The third group is those whose mental disorder leads to substance use. Additionally, mental disorder may exist in parallel to substance use without having any causal interaction. For practitioners it is often necessary to acknowledge uncertainty between what is cause, what is effect, and what is coincidence.

Co-existing Problems of Mental Disorder and Substance Misuse (dual diagnosis) Sube Banerjee, Carmel Clancy and Ilana Crome 2002[27]

The evidence suggests that Julien had a dual diagnosis and he fell into the third or possibly the fourth group that Professor Banerjee describes. But it was never considered that his mental illness was of such severity, or his mental capacity sufficiently impaired to require involuntary admission for assessment or treatment.

His father explains the dilemma they faced:
"If a person such as Julien, with a history of four known near death experiences due to respiratory arrest induced by self-injection of a very dangerous opioid such as fentanyl, had said, "Yes, I am trying to kill myself and I will inject again," then it is quite likely that he would be detained for assessment and treatment involuntarily. In this case, health care professionals would intervene to prevent the individual from doing what they wish to do.

[26] http://webarchive.nationalarchives.gov.uk/20130124043828/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_088163.pdf

[27] https://www.rcpsych.ac.uk/pdf/ddipPracManual.pdf

If on the other hand, as in Julien's case, all the above applied, except that he said, "No, I am not trying to kill myself, but I will likely inject again and it might result in fatal respiratory arrest," as he did say to his family, then health care professionals would not intervene to prevent an event that the individual does not wish to occur".

The family believe Julien slipped into a gap between these two acts. There are problems with the application of these acts, particularly in relation to dual diagnosis. Their view is:

- They were dependent on Julien's account which may or not be accurate.
- They were applied in the moment for the most part without extrapolating backwards or forwards in time. Julien displayed repeated, very serious self-harming behaviour. It was not clear whether this was considered by any professionals treating him, especially on subsequent presentations after the respiratory arrests.
- There seemed to be too much emphasis put on the individual's response to the interview rather than what their behaviours indicate. Julien's behaviours were at odds with his responses to assessments of suicide intent.
- None of the family members were interviewed as a part of these assessments.

Julien's family believe that he lacked capacity at those times of intense drug need and so could have been treated involuntarily. Given the extreme risk he was exposing himself to, they believe that an escalation of treatment was warranted particularly after four respiratory arrests.

Root causes

"That some individuals are more prone to developing addiction is generally agreed. There is no single determining factor, but usually a combination of biological, psychosocial and environmental factors – a mixture of nature and nurture."
RM Mayall, 2011 and 2016 Substance abuse in anaesthetists[28]

The root cause of Julien's death was attributable to a disorder known as addiction. Addiction is a condition in which a person engages in use of a substance or in a behaviour for which the rewarding effects provide a compelling incentive to repeatedly pursue the behaviour despite detrimental consequences. Julien's father confirms that his low self-esteem led to depression with a profound sense of despair. He self-medicated with injected opioids at times of stress to relieve those feelings.

The coroner concluded that this was an accidental death after Julien self-administered acetyl fentanyl intravenously. The circumstances surrounding his death led to the coroner believing an accidental death was the more likely explanation. The evening before he died Julien had received correspondence from his solicitor which he found very stressful. This may have led him

[28] https://bjaed.org/article/S2058-5349(17)30106-3/fulltext

to use acetyl fentanyl on this occasion. There were almost certainly other occasions when Julien was misusing fentanyl or acetyl fentanyl which didn't lead to respiratory arrests, but how frequently this occurred remains unknown.

Following Julien's death investigation of his texts and emails to friends provided further evidence about his continued use of illicit drugs to at least as far back as 2011 (source: coroner's inquest, 2018). This included ketamine in 2011, fentanyl in 2012 and other drugs. Where all these medicines were obtained from is unknown. The texts also give an example of Julien's successful attempts to deceive the hair testing regime. These activities were kept secret and largely hidden from his family. Only Julien would have known the full extent of his addiction which was never revealed to his family or anyone else involved in caring or treating him.

Julien's relationship with drugs was not straightforward. Some drug taking was recreational and experimental (source: texts from Julien) whilst some was more likely to be used to relieve anxiety and stress. Julien didn't present in the normal way that doctors with substance misuse behave. The Practitioner Health Programme (PHP) in the UK have the greatest experience of managing doctors with substance misuse problems and over a 10-year period have not encountered a doctor presenting in such similar circumstances (source: personal communication, Dr D 10/08/2018). Julien was also able to stop using substances when he was concerned about detection (source: text messages from Julien).

There were failings in the regulatory system that have been acknowledged. If these had not occurred, it might have been possible to obtain a clearer picture much sooner about Julien's continued substance misuse. It would have made all the family aware of this earlier than December 2015. A career in anaesthetics would not have been an option if the true extent of his relationship with drugs was known to all at an earlier stage.

Julien was intelligent, persuasive, charming and a risk taker. His relationship with drugs was such that he either did not perceive this as a risk or more probably, couldn't avoid the risk. Julien was offered help for his substance misuse at various times, but he did not feel ready to accept treatment, possibly because he hadn't acknowledged the true extent of the illness himself.

The health system was unable keep Julien safe. The law as it stands does not allow an individual to be detained involuntarily for assessment or treatment for an alcohol or drug related illness unless they do not have the mental capacity to make decisions or they are suffering from a mental disorder. Alcohol or drug misuse for the purposes of the mental health act is not considered a mental disorder and Julien was not considered to have a mental disorder where his safety required involuntary admission to hospital.

Lessons learned

Individuals and organisations were asked to provide their reflections on events and consider what could have been done differently for Julien. Organisations were supplied with the BMJ article entitled "Julien Warshafsky: how this doctor died and what it tells us about the system that failed him"[29]. Not all organisations attended the coroner's inquest and may wish to consider further actions after reading the review.

General Medical Council

The GMC acknowledge that they failed in their duty to provide proper monitoring of a sick doctor (source: GMC significant event review, coroner's inquest). They have already made some changes which are described in the following section:

"In summary, we have made the following changes to our processes in recent years, either as a direct result of learning from this case or as a result of other concurrent work streams:

1. We have significantly reviewed and improved guidance and procedures for chemical testing:
    a. We now undertake chemical testing of doctors in our health procedures in-house
    b. We have a contract with a private company to undertake drug testing on a standard rolling 3-monthly basis
    c. We have widened the pool of drugs that are tested for as standard in all health cases (including fentanyl) and the pool of drugs is kept under review;

2. We have established the Associate Appraisal and Training team which provides annual dedicated training and produces training literature for GMC associates. Training for Medical Supervisors in recent years has focused on testing and the combination of bringing this in house, testing for a wider range of drugs with three monthly frequency, and more effectively managing the risks associated with relapse;

3. We have developed Standards, a Handbook and a Fact Sheet for Medical Supervisors to ensure consistency in how the role is performed;

4. We regularly audit supervision reports received and feedback is provided to Medical Supervisors on the quality of reports submitted;

5. We undertook a very extensive work programme to improve the way we engage with vulnerable doctors in our system, following the review in 2016 by Professor Appleby. We have implemented many of his recommendations which has resulted in significant improvements to our processes, including:

[29] BMJ 2018;361:k2564 doi: 10.1136/bmj.k2564 (Published 14 June 2018)

a. We revised the tone of voice of written correspondence to all doctors, to help strike an appropriate balance and to remove 'legalistic' language;
b. We introduced a 'single point of contact' process to simplify the communications that vulnerable doctors receive from the GMC;
c. We introduced a process to pause an investigation to allow very unwell doctors time to seek urgent treatment;
d. We created the 'Specialist Investigations Team' who now manage cases relating to a doctor's health, who deliver tailored communications to unwell doctors;
e. We have commenced a pilot scheme for an enhanced role for medical supervisors, in which they act as the main hub of information for the GMC investigation to allow the doctor to have less direct contact with the GMC. This pilot will be evaluated in due course.

We have reflected significantly on this case and are confident that the changes we have implemented will have a real impact on how we manage fitness to practise cases involving substance misuse going forward."

This case has highlighted the difficulties organisations have in undertaking an appropriate risk assessment if health information is not shared with responsible officers. The GMC have considered this but have not changed their advice to Case Examiners:

"After careful consideration we have not made any changes to our guidance for Case Examiners on the circumstances in which conditions of practice might include sharing of specific information. We concluded that we could not routinely share confidential health information with others and are restricted to sharing information with the consent of the doctor or in line with undertakings agreed with the doctor or without consent where there is a risk of imminent harm to the doctor (or others)."

Allegations of further opiate abuse and inappropriately accessing confidential patient information of well-known patients were made by an anonymous complainant but this was closed at the triage stage by the GMC. The GMC have reconsidered their position on how this should be managed in the future:

"The pilot evaluating the proposed enhanced role of medical supervisors is underway and will be evaluated in due course. The issue of their role in considering soft intelligence will be considered in that context. Since then we have introduced specific guidance in relation to handling anonymous complaints; where appropriate our process will involve contacting the relevant Responsible Officer in order to seek clarification or reassurance."

Trust 2

Following discussion with College Tutor and Departmental Consultants and on reflection, the Trust felt that there should be more sharing of information with the local Trust by all external bodies who are involved in supporting trainees. Under the instruction to maintain Julien's right to confidentiality they felt that they were compromised in their ability to look after him appropriately and protect their patients. They also felt that if the senior leadership of the Trust including the Medical Director and Director of Medical Education had been informed of the anonymous call to the GMC then the Trust would have warned senior theatre staff to monitor Julien's behaviour and report anything suspicious. The Trust felt that the management of Julien's collapse however would be unlikely to have been managed differently as there was no reason to inform the ED of his substance misuse history. The Trust believe that being allowed to more actively monitor and manage Julien through a joint plan agreed with Julien might have reduced the risk of him being able to access opiates. However, they point out that is very difficult in a specialty such as anaesthetics where opiates are used legitimately on every patient.

The Trust feel there should be more robust discussions about the progress and concerns by the HEE School of Anaesthesia with the trainee to agree who should be informed and how best to monitor trainees in this situation. The lack of reporting to the Trust (the employer) by external organisations they felt was regrettable in hindsight. The Trust felt that the employers were placed in a very difficult position as vital information was not shared under the guise of maintaining confidentiality. The Trust had three meetings with the GMC ELA during the year and Julien was discussed on all occasions, but no reports from anonymous callers or concerns were raised by the ELA and the need for confidentiality was emphasized.

The Trust also felt that consideration should be given as to whether Julien should have been allowed to continue as an anaesthetic trainee as it allows easy and ready access to the medication and as they become more senior it is more difficult to supervise them in the workplace.

Trust 4

The following learning points were shared with NHS England:

On both interactions with ASPH Julien had members of his family present and each time Julien was noted to have insight and no intention of self-harm. However, ED attendance 1 was the first episode and ED attendance 2 was the third such episode. By the second attendance he had engaged with formal private psychiatric services and did go on to attend CBT on 3.5.16 after discharge.

A formal psychiatric review at ED attendance 2 could have provided an additional opportunity for mental health services to communicate the acuity of the problems ongoing with Julien but I would be unsure if such a review would have changed the discharge decision on 30.4.16 with all

the support that appeared to be already in place along with the reassurances of Julien and his family. Dr 2 felt after his consultation and discussion with Julien and the support in place from Julien's partner that there was minimal and acceptable risk to discharge and as such made that decision.

Over reliance on Julien's family to both ensure support for him and that health services were in place may be seen as unwise and perhaps over trusting. Assumptions perhaps were being made in respect to the medical training and expertise of the family that could have caused role conflict both for Julien's family and the treating clinician. Such over-reliance could have negative bias on patient care where normal processes may be deemed unnecessary or transferred to a family member.

With the full case review published, and along with any learning points highlighted, we will look at our mental health and safeguarding referral processes and policies to see how we may minimise any risk of a repeat of such a tragic outcome occurring again particularly with a focus on trainee doctors in need of additional support.

Trust 6

Dr T has had two meetings with Julien's father Robin in July 2017 and February 2018 and recognises this was a difficult case involving multiple agencies and people, all of whom were trying to their best for Julien however were not all aware of the complete picture (source: letter from Dr T, Chief Medical Officer, Trust 6). Dr T felt the lack of awareness of the complete picture is in part secondary to issues around confidentiality and a product of working across different agencies who have different remits. He says:

"Ultimately, and with the value of hindsight things may have turned out differently had the various agencies been clearer about Julien's status as a person with comorbid substance misuse issues and depression as well as his status as both a patient and a professional."

Julien's father, Robin has been proactive and met with several organisations with a view to learning from this case. Trust 6 have agreed that Robin will attend one of the Clinical Grand Rounds sessions where they will discuss this case and highlight the main issues and difficulties around confidentiality, duty of care, communication and a joined-up system

"I have spoken with the Consultant involved in Julien's care when he was with our service and do not believe there were specific learning points for the team or service. We have also conducted our own table top Serious Incident Review following Julien's death. I believe the learning is systemic and is around how we treat health care professionals with mental health or addictions problems. I hope our Clinical Grand Round will promote open discussion amongst clinicians about such issues and that your review will also promote further learning."

HEE and the relationship with the providers of education

In their submission to NHS England (Lessons learned from the JW case, October 2018), HEE describe several changes that have occurred within their organisation since this case. Some of these were a direct consequence. The introduction of a Quality and Regulation Team and a strengthened Case Management team which represents the RO function and supports the RO to carry out their legislative and statutory duties, liaising with the GMC and Trusts is welcomed.
HEE say that "*During Dr Warshafsky's time in training in the Anaesthetics Training Programme, these workstreams were not represented and functioning via these teams as they are now. Trainees who have any difficulties in training are now managed much more robustly and effectively via the RO function and their training environment is monitored on a regular basis."*

All HEE faculties now have a Training Programme Director (TPD). Whilst these roles existed whilst Julien was training in HEE, the support element has been enhanced and the lines of accountability made more robust since his death. This is supported by the Case Management Team's role which works with all the HEE TPD trainee in difficulty leads.

There has been a greater recognition of trainee's in difficulty and the need to deal with these doctors proactively. There have also been steps put in place nationally by HEE to ensure that the frequent movement of trainees across several training units and Trusts across a wide geography are kept to a minimum. Health Education England has launched a supported return to training strategy and investment plan which details ten commitments to ensure that trainees are supported on return to their training pathway.
Communication between all parties is seen as an area that is recognised as needing review. This report would certainly support that. The possibility of introducing a case conference approach in complex cases involving multiple stakeholders is worthy of further consideration.

The Practitioner Health Programme (PHP)

The PHP advocates a multidisciplinary approach to sick doctors particularly those with a history of substance misuse. Their experience over the past 10 years allows them to offer a range of treatments tailored to the individual. There are two things which they have learnt from this case. Firstly, they no longer provide a CBT only option in cases where substance misuse present. This, they feel limits their options. Secondly, they involve family members in their assessment, treatment and recovery programmes to provide a further source of information about the sick doctor.

Surgery 1 (General Practitioner)

The GP Surgery provided a report to the coroner where they made several observations and drew some conclusions. They noted that Julien seemed to interact well, kept appointments and seemingly responded well to treatments for his depression. They provided "annual reports for the GMC detailing a clean bill of health and no worries regarding on going issues that would prevent him working as a doctor."

“Julien had seen various consultants in both the private sector and in the NHS but, never seems to have seen an addiction specialist. Despite his cardiorespiratory arrests, no appointments were pro-actively arranged in primary care, and no follow up was arranged in secondary care.”

In their significant event review the Practice concluded:

1. Being under investigation and waiting for a hearing with the GMC is a significant suicide risk, regardless of the nature of the charges involved.

2. Anaesthetists are at an increased risk of opiate abuse

3. Anaesthetists who re-offend following opiate or opioid use have a high risk of death

4. Doctors being investigated by the GMC should have a set assessment, treatment and monitoring process.

5. The patients GP will not routinely be involved in this process, or be informed of results of testing
6. Doctors are very aware of the questions used to assess depression and addiction and may be able to “Give all the right answers” to questions

7. Recurrent hospital admissions with symptoms of drug usage are likely to be associated with a diagnosis of addiction rather than other mental health issues

The Practice also noted several actions that might be helpful in the future. These included raising the awareness of these issues such that colleagues should be made aware of the above points and to make it a practice policy to proactively follow up colleagues undergoing GMC issues. Whilst most GPs are familiar with the management of patients with addiction illnesses, for some Practices patients with substance misuse (drugs) are not encountered that frequently. The GP Practice have suggested that teaching session for clinical staff from local addiction services would improve understanding, assessment and treatment of the addicted patient.

Common themes and factors identified

Understanding addiction as an illness

During the investigation it was apparent that not all individuals or organisations understood the nature of addiction. Although the incidence of drug and alcohol dependence is low in anaesthetists, it is not insignificant. A study in 2000 commissioned by the Association of Anaesthetists of Great Britain and Ireland suggested that over one anaesthetist per month

presented with significant alcohol or drug misuse in the UK and Ireland over the previous 10 years[30].

Approximately 10–14% of all doctors will become substance-dependent over their lifetime; the incidence in anaesthetists being 2.7 times greater than other physician groups. Including alcohol, studies describe 0.86–2% of anaesthetic trainees and 1.3% of consultants being addicted; if alcohol is excluded, drug addiction occurs in 1.6% of trainees and 1% of non-training grades. Sixty-two per cent of residency programme directors in the USA reported at least one trainee with a substance abuse problem and a worrying progressive increase in incidence was noted, being highest over the 10 yr since 2003. RM Mayall, BJA Education, Volume 16, Issue 7, 1 July 2016, Pages 236–241[31]

In 1964 a WHO Expert Committee introduced the term ‘dependence’ to replace the terms ‘addiction’ and ‘habituation’. The Tenth Revision of the International Classification of Diseases and Health Problems (ICD-10) defines the dependence syndrome as being a cluster of physiological, behavioural, and cognitive phenomena in which the use of a substance or a class of substances takes on a much higher priority for a given individual than other behaviours that once had greater value. A central descriptive characteristic of the dependence syndrome is the desire (often strong, sometimes overpowering) to take the psychoactive drugs (which may or not have been medically prescribed), alcohol, or tobacco. There may be evidence that return to substance use after a period of abstinence leads to a more rapid reappearance of other features of the syndrome than occurs with nondependent individuals[32].

However, there is a lack of agreement on the best definition, with different organisations offering further clarifications. The American Society of Addiction Medicine[33] refers to this as: “Addiction is a primary, chronic disease of brain reward, motivation, memory and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviours.
Addiction is characterised by inability to consistently abstain, impairment in behavioural control, and craving, diminished recognition of significant problems with one’s behaviours and interpersonal relationships, and a dysfunctional emotional response. Like other chronic diseases, addiction often involves cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death.

[30] C. B. Berry, I. B. Crome, M. Plant and M. Plant, Anaesthesia, 2000, 55, pages 946±952
[31] https://academic.oup.com/bjaed/article/16/7/236/2196385
[32] http://www.who.int/substance_abuse/terminology/definition1/en/

[33] https://www.asam.org/for-the-public/definition-of-addiction

The term addiction is still in common and in its broadest sense, would include the repeated involvement with a substance or activity, despite the substantial harm it now causes, because that involvement was (and may continue to be) pleasurable and/or valuable to the individual.

Most cohort studies show mortality rates in the range of 1–2% per year among problem drug users. After 10 years, up to 20% of the participants in a study may have died. Mortality for drug users is roughly 10 to 20 times that of the general population of the same age and gender.
Based on the available data, an estimated 10 000 and 20 000 problem opioid users die every year in Europe. Many of these deaths could be prevented. Four broad categories of causes of deaths among drug users have been identified: overdoses, diseases, suicide and trauma.
Roughly, between one-third and half of deaths among drug users are due to overdose, while between one-fifth and two-fifths are due to suicide and trauma, and less than a tenth are due to HIV/AIDS.

European Monitoring Centre for Drugs and Drug Addiction: Annual report 2011: the state of the drugs problem in Europe[34]

The mortality amongst anaesthetists in the cohorts studied are based on American studies and range from 3% – 22% overall with relapse rates of between 29%-58%. Most deaths are related to substance misuse[35]. An Australian study reporting in 2005 identified a mortality rate in anaesthetists with a substance use disorder of 21% over a 10 year period (Fry,R 2005[36]).

A greater understanding of the nature of addiction, the course of the illness and the support required would benefit all those who are in a training or clinical leadership role.

Communication and Confidentiality

With so many individuals and organisations involved at various times it is not surprising that not everyone considered they were sufficiently informed about Julien. The Trusts did not feel they had enough information to make an appropriate risk assessment about the risks to patient safety. The family felt that they were poorly informed about Julien's care.

An important aspect of this case was getting the right balance between confidentiality and disclosure. Julien's wish to limit disclosure of his health conditions was understandable, but it meant that some of his colleagues were unsighted, and in the most part they were unaware of his illness. This led to two important consequences. Firstly, colleagues of Julien were not primed to watch for signs of behavioural changes that may have indicated substance misuse. This led to a delay in detecting continued use. Secondly, patients were placed at unnecessary risk.

[34] http://www.emcdda.europa.eu/publications/selected-issues/mortality_en#downloads

[35] https://jamanetwork.com/journals/jama/fullarticle/1787405

[36] https://pdfs.semanticscholar.org/a66e/d8702a11bf9097fe9a03f18a3ce18fd2f3a5.pdf

Involvement of family members

The family play a very important part in supporting a relative through recovery. But they also bring important perspectives and insights which can either be missed or not volunteered by the substance misuser and aid the assessment. In this case, the family had valuable information that could have alerted the Medical Supervisor and the GMC that the account Julien was providing was not a true reflection of events and that their drug testing regimen was ineffective if there had been a confidential mechanism to relay such sensitive information.
Whilst involvement of the family is to be welcomed, it also needs to be recognised that over reliance on the family, and especially the "medical family" may be detrimental, and not achieve the intended outcome.

Diagnosis and management of Julien's disorder

All parties involved in assessing or treating Julien concentrated on his depressive illness and most underestimated the significance of his previous and continuing use of drugs. The designated body, employing organisations and providers of care need to have a heightened awareness of the illness of addiction and ensure that they provide adequate support and treatment.

Doctors with substance misuse issues have specific needs and whilst not all will recover and be well enough to continue in their chosen specialty, some do and can return to work. The principles underlying the correct management of a substance use disorder are similar to those which are adhered to in other complex areas of medicine, such as cancer care. The correct diagnosis and the treatment plan depend on a comprehensive multidisciplinary assessment with full involvement of the doctor patient and their family. And like cancer care, if you wish to get the best outcomes, you are more likely to get this by attending a dedicated substance misuse service with experience of treating doctor patients. It makes sense that all doctors with a history of substance misuse should see a specialist team who are experts in the management of this disorder and are able to monitor the patient carefully. The recovery (defined as abstinence and return to the pre-treatment medical practice at 2 to 5 years) rates are in the region of 75-90% for doctors entering dedicated programmes[37].

Return to work

After the first incident where Julien admitted taking fentanyl (Trust 1, May 2013), Julien was excluded from work but returned in September 2013. This was prior to seeing a treating psychiatrist and completing his CBT sessions. There was no multidisciplinary risk assessment. The family felt that this return to work was too early and did not give enough time for Julien to address his behaviours.

[37] https://ncphp.org/wp-content/uploads/2018/03/PHPs-A-Model.pdf

There are mixed views on whether an anaesthetist should return to the workplace with a substance misuse history[38]. Anaesthetists access drugs such as fentanyl daily. It is difficult to provide the controls that are necessary without restricting their clinical practice. Yet, with the appropriate support, successful recovery can take place and anaesthetists can return to practice. However, this case and the literature on this confirm that without appropriate assessments, support, recovery and periodic risk profiling the risks of further relapse are substantial.

Perhaps it is possible to draw some tentative conclusions from the literature[39] that is available on this which is largely based on studies from the United States. Whilst each case needs to be considered individually, without the appropriate support, monitoring and risk assessments in place, it would be unwise for the trainee to return to anaesthesia. They would be better advised to choose an alternative career in medicine. If there are the facilities available for regular risk assessment, monitoring and recovery within the department, then a career in anaesthesia remains an option open to the doctor.

[38] https://www.aagbi.org/sites/default/files/drug_and_alcohol_abuse_2011_0.pdf

[39] https://academic.oup.com/bjaed/article/16/7/236/2196385

Post-investigation risk assessment

Since Julien's death there have been some changes made by the GMC. More effective case management, a greater awareness and sensitivity to the needs of the sick doctor, an overhaul of the role of the Medical Supervisor and closer scrutiny of the drug monitoring arrangements will reduce the risk to some extent.

The level of awareness amongst provider organisations involved in Julien's care and some have or intend to make changes in their clinical practice. This case has also been discussed at the regional Responsible Officers network.

There have been some positive changes in how sick doctors are supported and managed, for example the Practitioner Health Programme[40] based in London is now commissioned to provide a national service for all GPs[41], but not all doctors, and anaesthetists living outside London may have difficulty accessing their multidisciplinary services.

Whilst these are all positive steps in the right direction, the review has identified communication within and between organisations as a barrier to providing effective support and monitoring of doctors affected by health issues.

Further recommendations have been made which should reduce the risk further but there are still wider issues around confidentiality and disclosure, the role of the regulator and the treatment services and how they interact, as well as the involvement of family members in these cases. Risk can be managed, it can be reduced but it cannot be eliminated.

A Potential Severity (1-5)	B Likelihood of recurrence at that severity (1-5)	C Risk Rating (C = A x B)
5	2	10

[40] http://php.nhs.uk/
[41] http://gphealth.nhs.uk/

CONCLUSIONS:

Julien's death was an accident. Circumstances suggest that Julien did not intend to end his life. The extent of his illness remained unrecognised during his time as an anaesthetic trainee. Julien was not given the help and support he needed to manage his addictive illness. There were opportunities to have detected his continuing dependence on psychoactive substances during his placements as an anaesthetic trainee, but some of these were missed. The GMC have acknowledged that the case highlighted shortcomings in their supervision and have changed their processes. We can never be sure if Julien's continued reliance on drugs had been identified sooner it would have changed the outcome.

Julien did not appear to some to acknowledge his addictive illness. He was secretive and took steps to conceal his addiction from his family and his work colleagues. At times, he appeared to lack the motivation to change, even though he had experienced several life-threatening episodes. It is hard to explain this unless one appreciates the way this illness alters the decision making and behaviours of those addicted to and dependent upon psychoactive substances. Julien also avoided disclosing the full extent of his addiction and mental health issues because every doctor he engaged with was obliged to tell the GMC.

Undoubtedly the regulatory process contributed to his personal distress. Although he was a most able trainee, he grew to dislike his career choice and recognised that a future in medicine even if he could retain a license to practise would not bring him happiness or satisfaction.

It was fortuitous that no patients came to harm. In this instance the regulatory system (the GMC and Responsible Officer[42]) did not achieve one of its overarching aims of responding appropriately to concerns and providing adequate protection to patients. There were many different people involved in either caring or supervising Julien. None had anything like a complete enough picture. Concerns about confidentiality seem to have prevented those involved from sharing information, including speaking to family members who could have provided important detail and background and become more informed about the support Julien required.

This case highlights some of the difficulties faced by sick doctors, doctor-patients, their families and those that are caring and supervising them. It raises some very fundamental questions about confidentiality and disclosure, the understanding of addiction in doctors and how closely those doctors should be supported, monitored and cared for.

This review cannot conclude that Julien's death would have been avoided if the addiction was detected earlier. Nor can it say that given more time Julien would have engaged successfully with addiction services and stopped misusing fentanyl and its derivatives. But to regard Julien's death as inevitable would also be incorrect given some of the missed opportunities identified in this case. We will never know what would have happened if these had been identified and

[42] http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

managed differently. When a similar case occurs, these opportunities must be identified and acted upon.

Recommendations

Recommendations

Following the publication of this review NHS England (Southeast), HEE and the local Trusts met and discussed these findings and identified further learning and recommendations arising from this case for individuals and organisations[43].
It was established that any action plan has a wider audience than just anaesthetists although they are one of the higher risk groups. The recommendations are written with doctors in mind, but the same principles apply to other health care professionals who are affected by substance use disorder.

1. In the case of trainees, HEE, working with the Trusts should agree their approach to information sharing, including the limits of confidentiality that can be safely managed in a training post.

2. Trusts should raise the level of awareness amongst their staff/members about the risks of addiction amongst colleagues, including trainees. Each Trust department should nominate a consultant responsible for trainee welfare. The Academy of Medical Royal Colleges and the Royal College of Anaesthetists should raise the level of awareness amongst their staff/members about the risks of addiction, in particular amongst anaesthetists as one of the higher risk groups.

3. HEE, NHSE-I and the GMC should agree their approach to the trainee (and other doctors) with a history of substance use disorder returning to clinical practice following an episode of substance misuse. Regular risk assessments should take place using an agreed format.

4. All information necessary to protect patient and doctor safety including arrangements for supervision and risk assessment guidance, should be shared by the GMC with the doctor's employer and responsible officer, prior to their return to work.

5. Responsible Officers should liaise with the GMC Medical Supervisor and consider health factors when risk assessing a doctor's safe return to the workplace.

6. All doctors with substance use disorder should be assessed and supervised by a specialist in addiction. If undertakings require the doctor to be under the care of a treating psychiatrist this should be a psychiatrist specialising in addiction.

7. The doctor should be encouraged to consent to involvement of an appropriate friend, colleague, or family member to support them in their monitoring and care plan.

[43] Meeting by video conference 8th October 2020

8. The trainee with a health problem that raises concerns about their fitness to practise is likely to be in contact with GMC Case Examiners, a GMC appointed Medical Supervisor, an Educational Supervisor / College Tutor at the employing Trust, the Occupational Health Department, their GP, a treating psychiatrist and the Responsible Officer (or their representative) at HEE. Those involved will be working to different agendas, but there should be a named individual who is by agreement the overall “case manager” and acts as the single point of contact. NHSE-I recommend that this is undertaken by the doctor’s Responsible Officer.
9. Responsible Officers, Medical Directors and Heads of Departments should ensure that they and their colleagues are able to detect, support and manage a colleague who develops substance use disorder and that all are provided with the necessary training.

Arrangements for Shared Learning

This case has already been discussed at one of the regional Responsible Officer training events and has been reported in the British Medical Journal. Robin has been proactive in this regard and has met with many individuals from the organisations involved in his son's care.

Whilst this case illustrates some of the difficulties around confidentiality, duty of care and communication, it also portrays the difficulties sick doctors and their families encounter in returning to medical practice and recovering from addiction.

Distribution List

The review will be sent to all individuals and organisations involved in the supervision and care of Julien. It is the families wish that the learning from this case is widely disseminated.

Action Plan

This needs to be developed and agreed across the local health system. Recommendations have been made, but these are not exhaustive, and through further discussion these may change. Ownership is important, but one individual must be responsible overall and accountable for tracking the progress, keeping others informed, ensuring timely action steps are occurring and adjusting the actions accordingly. Each objective should be clear and actionable, and each action step needs to have one person responsible.

Further References

Drug and Alcohol Abuse amongst Anaesthetists - Guidance on Identification and Management 2011 The Association of Anaesthetists of Great Britain and Ireland

https://www.bmj.com/content/361/bmj.k2564

Appendices

Information and evidence gathered

Statement - Dr. R. Warshafsky produced for the coroner. Serious incident investigation into the death of Dr Julien Alexander Ransom (Carmo) Warshafsky on 28th June 2016

This report was authored by Robin and provides extensive material, analysis and reflection as well as identifying root cause and contributing factors. This report was requested by DC 3, the investigating detective and includes material derived from Julien's doctors.org email account which he used for professional and personal correspondence. Over
500 relevant emails and over 150 relevant documents, including several generic "contextual" documents enabled Robin to provide both context and insight into Julien's behaviours and actions.

Emails, letters and investigations

- Email from Dr C, Medical Director, Trust 3 to family offering condolence 10.07.16
- Correspondence between Trust 2 and family regarding collapse on 19.06.2016
- Statement from witness – removal of fentanyl from operating theatre 31.05.13
- Case investigation report into the allegation of taking fentanyl from theatre (Trust 1) 30.05.13 incident
- Case investigation report into unusual behaviour in theatre (Trust 2) 05.02.14 incident
- Letters from Trust 1 to Julien (2013-2014)
- Witness statements responding to unusual behaviour in theatre (Trust 1) 13.02.14
- Letter from CEO explaining the events of the 19.06.15 and progress and supervision at Trust 2 08.12.2017
- Letter to Julien 08.04.16 – Letter from Professor O Director of Professional Standards (Trust 3)
- Significant event review - GP Practice
- Letters from PHP to Eastwoods (medicolegal representatives of Julien)
- Detailed chronology of events provided by the family
- Toxicology certificates (Alere toxicology; Cansford Laboratories)
- Post-mortem report
- Toxicology report (post-mortem)

GMC

- GMC Correspondence 2013-2016
- GMC Assessment (Dr G, Consultant Psychiatrist) 19.08.13
- Letter to GMC from Dr H (GMC Assessment) 22.08.13
- Email from Dr I Consultant Psychiatrist to GMC 05.12.13
- Correspondence from the GMC to the family answering their concerns
- Significant event review – GMC

Health records from the following organisations:

- Trust 6
- GP
- Trust 2 19.06.15 Clinical notes of the “collapse” whilst on duty.
- Trust 5
- Trust 1 Occupational Health
- Trust 3
- Trust 4
- Clinical letters from the Hospital 2 (Dr A Consultant Psychiatrist)
- Paramedic Notes 28.06.2016

Letter to coroner from the following organisations / individuals:

- Dr D, Practitioner Health Programme
- Family of Julien 19.11.16
- Family of Julien 01.06.17
- Dr H GMC Assessing Psychiatrist 21.08.17 13.10.16
- Dr J (GP)
- Professor Q Postgraduate Dean Health Education.This letter also includes a detailed log of activity and actions.
- GMC
- Dr P Consultant Anaesthetist, Trainee Programme Director for Trainee Support KSS
- Dr A Consultant Psychiatrist Priory Hospital 1 10.10.17
- Dr L, Consultant Anaesthetist and College Tutor. Trust 3 10.10.17

- Dr G GMC Medical Supervisor
- Paramedics who attended Julien 30/04/2016
- Practitioner B, Practitioner Health Programme.
- Mariana Warshafsky, wife of Julien 28.10.16

The Coroner's Inquest

Transcript Coroner's Inquest 15.03.18

Attendance at the Coroner's Inquest 10.05.2018 and 18.06.2018 – 20.06.2018

Responses from those involved in Julien's care to NHS England

Telephone interview with Practitioner B and Dr D 10.08.2018

Response from Trust 2 – Medical Director

Telephone Interview with Dr V Consultant Anaesthetist and Deputy Medical Director Trust 2 24.08.2018

Telephone Interview with Professor Q HEE 17.08.2018

Telephone Interview with Dr W, Deputy Medical Director Trust 1 17.08.2018

Response from Dr J – GP Surgery

Response from GMC – Mr X, GMC Employment Liaison Adviser
Response from Dr T, Chief Medical Officer, Trust 6

Response from Dr P Trust 4 Deputy Medical Director

Telephone interview with Dr A 22.10.2018

Response from HEE Lessons learnt from JW Case October 2018
Appendix A Thresholds and Categorisation for the Management of Trainees in Difficulty and/or Requiring Additional Support
Appendix B The wellbeing of Junior Doctors in Training - Preventing, Acting and supporting after the sudden Death of Junior Doctors whilst In Training - Statement of Intent from HEE
Appendix C Enhancing training and the support for learners

Summary of Laboratory Tests

	Date of collection	Laboratory	Period covered by hair segment	Fentanyl tested?	Result	Ordered by	Collected by
1	09.07.13	Cansford	10.04.13 – 03.07.13	Yes	0.08ng/mg	Not known	Not stated
2	21.08.13	Concateno – TrichoTech	Beginning July 2013 to beginning Aug 2013	No	N/a	Dr H	
3	10.12.13	Alere	07.09.13 – 01.02.13	Yes	negative	B, PHP	R Jones, PHP
4	15.02.14	Cansford	26.12.13 – 09.02.14	Yes	Negative	Julien	Not stated
5	28.02.14	Cansford	09.12.13 – 22.02.14	Yes	Negative	Julien	Not stated
6	10.03.14	Cansford	03.01.14 – 04.03.14	Yes	Negative	Not known	Not known
7	27.09.14	Cansford	23.06.14 - 21.09.14	Yes	Negative	Julien	Not stated
8	17.10.14	The Doctors Laboratory	03.07.14-03.10.14	No	N/a	G	
9	20.02.15	The Doctors Laboratory-Synergy	08.11.14 – 06.02.15	No	n/a	(known to GMC)	"Sample collected by the customer"
10	27.07.15	Cansford	07.05.15 – 21.07.15	Yes	0.03ng/mg	Julien (peace of mind test)	Not stated
11	27.07.15	Cansford	07.05.15 – 21.07.15	Yes	0.06ng/mg	Julien ("peace of mind test")	Not stated
12	31.07.15	DNA Legal	?	No	N/a	Reported to GMC	"Marianne Massey in Crowborough"

Key:
Yellow: "visible" tests, ie, known to the GMC
White: "invisible" tests, ie, arranged by Julien and not known to anyone but him
Red text: visible tests where fentanyl was actually ordered
NB: test of 10.03.14 likely a false negative as Julien chemically treated his hair after exclusion from the work place on 10.02.14 and corroborated by the negative tests he arranged on 15.02.14 and 28.02.14 and the text found on his mobile

12 tests of which 7 (between 09.07.13 and 31.07.15, 2 years) known to the GMC of which only 3 had requested fentanyl testing; 5 different labs used
5 tests done by Julien, used only 1 lab, always requested fentanyl testing

Conclusion: of the 12 tests, only two tests were visible to the GMC that had any validity then, those of 09.07.13 and 10.12.13, the first a reliable true positive and the other a reliable true negative.