Record of Determinations –
Medical Practitioners Tribunal

PUBLIC RECORD

Dates: 28/02/2019 - 28/02/2019

Medical Practitioner's name: Dr Valerie MURPHY

GMC reference number: 6104053

Primary medical qualification: MB BCh 2003 National University of Ireland

Type of case
Review - Misconduct

Outcome on impairment
Not Impaired

Summary of outcome
Suspension to expire

Tribunal:

Legally Qualified Chair	Mrs Laura Paul
Lay Tribunal Member:	Miss Mary (Ann) Robertson
Medical Tribunal Member:	Professor Jill Belch

Tribunal Clerk:	Miss Lorraine Curry

Attendance and Representation:

Medical Practitioner:	Present and represented
Medical Practitioner's Representative:	Mr Richard Partridge, Counsel, instructed by the MPS.
GMC Representative:	Mr Christopher Rose, Counsel, instructed by GMC legal.

Attendance of Press / Public

In accordance with Rule 41 of the General Medical Council (Fitness to Practise) Rules 2004 the hearing was held in public.

Determination on Impairment - 28/02/2019

Background

1. Dr Murphy's case was first considered by a Medical Practitioners Tribunal at a hearing which commenced on 07 August 2017 and went part heard on 18 August 2017. It reconvened on 5-6 & 11-12 November 2017 where matters were further considered, before going part heard. It reconvened on 19 February 2018 and concluded on 21 February 2018 ('the 2018 Tribunal').

2. At the time of the events Dr Murphy was employed as a Consultant Psychiatrist at Slade House, a Short Term Assessment Unit within Southern Health NHS Foundation Trust ('the Trust'). The facts found proved by the 2018 Tribunal can be summarised as follows:

- During the time Dr Murphy was employed at the Trust between January 2012 and June 2014, Patient A was admitted to the unit. He had been diagnosed with Kleinfelters mosaic, autism, learning disability and epilepsy. He had been admitted because his behaviour had become obsessive, unpredictable and violent.

- The risk assessments carried out in relation to Patient A were inadequate in that Dr Murphy failed to carry out any risk assessments and failed to comment on a risk assessment carried out by the nursing staff.

- Dr Murphy prescribed Risperidone to Patient A, and she failed to explain the benefits, risks and side effects of Risperidone to Patient A.

- Dr Murphy's completion of a mental capacity assessment form for Patient A, regarding his decision to remain on the ward as an informal patient, was inadequate in that she failed to arrange a best interest meeting.

- When Dr Murphy reviewed Patient A, she failed to make an assessment of his mental state and failed to formulate a diagnosis, an aetiology, and a risk assessment.

- In her record keeping of Patient's A consultations, Dr Murphy failed to make comprehensive notes and record adequate information regarding his symptoms, signs, diagnostic formulation, risk assessment or management plan.

- Dr Murphy failed to meet Patient A's clinical needs as she did not implement and/or develop an adequate care and detailed management plan, particularly regarding his epilepsy at the point of admission. Dr Murphy did not formulate any treatment plans and failed to meet Patient A's clinical needs specifically relating to his epilepsy and bathroom/shower needs. Dr Murphy did not acknowledge that he was at an increased risk of having a further epileptic seizure on the ward, carry out a risk assessment to identify the risks concerned with the condition or consider the implications of allowing him to have a bath on his own with staff observing him every 15 minutes.

- Dr Murphy did not follow the National Institute for Health and Care Excellence guidelines or Epilepsy Action advice which was referred to within the care plan that was prepared by the nursing staff.

- Dr Murphy failed to obtain a history of and record in Patient A's notes, his epilepsy presentation before, during and after a seizure, how long the seizures lasted and the effects these had on Patient A.

3. The 2018 Tribunal found that:

"The outcome of your failings in this case was catastrophic and resulted in the death of a vulnerable patient;

The failures in relation to this one patient span a period of three months from 9 April until 4 July 2013 and were not just in one area as they included failures of risk assessment, patient communication issues, capacity assessment and record keeping;

Patient A's death could and should have been prevented – you accepted that you lost sight of the basic principles in the care of Patient A. This includes the evidence you gave at the Inquest that you had no concerns about 15 minute bath checks in the circumstances of Patient A's case as you then, mistakenly, perceived them. It is clear that by focusing primarily only on psychiatric risks, you lost sight of basic medical care;

Until these proceedings you had attempted to deflect responsibility away from yourself and to blame others. This includes your evidence at the Inquest where you maintained that there was no failure in care on your part and in your witness statement to this Tribunal where you stated that the completion

of risk assessments was the responsibility of the nurses. You now accept that this was incorrect."

4. The 2018 Tribunal found that Dr Murphy's fitness to practice was impaired and she was suspended for 12 months. The Tribunal indicated that the following information would be helpful for the review of Dr Murphy's case:

- A reflective account addressing what Dr Murphy has learned and done in respect of the Tribunal's findings of facts, impairment and sanction demonstrating her level of insight;

- Evidence that she would be able to function effectively at consultant level in the area of her practice in the UK;

- Evidence that she can competently use a computerised record keeping system of the type in use in the UK;

- An indication as to her future plans in respect of the practice of medicine;

- Evidence of how she has maintained her clinical skills and medical knowledge;

- Current testimonials as to her character and conduct during the period of her suspension, written in the knowledge of her suspension by this Tribunal.

Today's review hearing

5. This Tribunal has today reviewed Dr Murphy's case and has considered, in accordance with Rule 22(1)(f) of the Rules, whether Dr Murphy's fitness to practise is impaired. In so doing it has considered the documentary evidence before it, the oral evidence from Dr Murphy and the submissions made by Mr Rose, Counsel, on behalf of the GMC and those made by Mr Partridge, Counsel, on behalf of Dr Murphy.

The evidence

6. The Tribunal has taken into account all the documentary evidence received during the hearing.

7. The Tribunal received the following evidence in advance of the hearing:

- GMC bundle which included the Record of Determinations dated 21 February 2018
- Defence bundle
- XXX

8. In her detailed reflective statement Dr Murphy states that she has further reflected and fully accepts her failings in relation to Patient A. She states that she has taken steps to "ensure others did not make the same mistakes I had and to generally improve standards, especially those related to improving risk assessment for epilepsy". She details the various areas of her practice which were deficient and how she has addressed these individually and improved her knowledge and skills.

9. Dr Murphy details that she attended the Epilepsy Ireland annual Conference in September 2018 and met parents of those with epilepsy, which gave her real insight into the fear of patients and their relatives of them dying whilst having a seizure. Dr Murphy stated "because of my poor clinical care, their [Patient A's family's] fear was realised". She states that she contacted the chair of the Intellectual Disability Faculty at the Royal College of Psychiatrists and asked his advice on identifying a mentor in epilepsy care. Following this she organised a clinical attachment with Dr B and wrote a perspective piece with Dr B and others which sets out "why epilepsy care in all its forms including risk assessments, are the psychiatrist's responsibility". Dr Murphy obtained another clinical attachment to help build upon her knowledge she had obtained from her attachment with Dr B.

10. In order to address the deficiencies outlined by the 2018 Tribunal in regards to her record keeping, Dr Murphy produced evidence that she underwent face-to-face and online training in note keeping and electronic note keeping.

11. Dr Murphy further states that "My failings in this case will inform my PDP on an ongoing basis for the foreseeable future. I will continue my work around promoting epilepsy awareness in psychiatric units and the importance of seizure profiles and risk assessments. I hope to contribute to patient safety systemically through this work on an ongoing basis. I will maintain an ongoing focus on good record keeping, communication, epilepsy care. And of foremost importance, I will ensure that my practice in every case is patient and carer focussed. I arranged a review of my work to date with my UK based mentor to discuss my progress over 2018 and formulate a PDP for 2019 – 20".

12. In her oral evidence Dr Murphy detailed her work around the development of a risk assessment tool namely the "yellow card" system which was centred around her failings

in epilepsy risk assessment. This involved visits to all the academic units in Southern Ireland and the enrolment into an audit programme which established current practice regarding risk assessment in patients with epilepsy and learning difficulties. Following the analysis and presentation of the results she completed the audit cycle by reassessing current behaviour. The aim of this was to improve patient safety and try to prevent similar incidents.

13. Dr Murphy detailed various CPD she has engaged in, clinical attachments, multi-disciplinary working and peer review groups and understanding of the benefits of working with others.

14. In addition to detailing the CPD, she explained her clinical attachments and the value of a mock appraisal in providing additional insight into her failings with Patient A. She further stated that she recognised her failings in relation to Patient A and has acted on these. She further expressed her remorse and sorrow for the family of Patient A.

Submissions on behalf of the GMC

15. On behalf of the GMC, Mr Rose submitted that the GMC is 'neutral' on the question of Dr Murphy's current impairment. He reminded the Tribunal of the submissions made by the GMC in the previous hearing and the findings made by the 2018 Tribunal. He submitted that the Tribunal should have regard to the overarching objective and all the new information provided to the Tribunal today. In relation to the evidence provided on behalf of Dr Murphy, Mr Rose accepted that Dr Murphy has put before the Tribunal various CPD documents and testimonials that are relevant to the misconduct previously found.

Submissions on behalf of the Practitioner

16. Mr Partridge submitted that the matter of impairment is one for the Tribunal. He submitted that Dr Murphy has addressed the areas of concern highlighted by the 2018 Tribunal and she has undertaken all the points of reflection and remediation that the Tribunal asked her to do when they directed a review.

17. Mr Partridge told the Tribunal that the concerns in this case are a "one off" and she has had an exemplary career, and no further concerns have been raised in relation to her practice. He submitted that given the level of remediation by Dr Murphy during her 12 months' suspension imposed by the 2018 Tribunal he invited the Tribunal to find that that Dr Murphy's fitness to practise is no longer impaired.

The relevant legal principles

18. The issue of whether Dr Murphy's fitness to practise is currently impaired is one for the Tribunal to determine, exercising its own judgement.

19. The Tribunal has taken into account the overarching objective, namely to protect and promote the health, safety and wellbeing of the public, to promote and maintain public confidence in the medical profession, and to promote and maintain proper professional standards and conduct for the members of the medical profession.

The Tribunal's determination on Impairment

20. The Tribunal considered all of the evidence adduced to support Mr Partridge's contention that Dr Murphy has done all that is possible to remediate her past misconduct. The Tribunal took account of the documentary evidence regarding how Dr Murphy has improved her knowledge in relation to the concerns raised and took account of the significant CPD activity undertaken, publications and evidence of clinical attachments which confirms Dr Murphy's high knowledge base. The Tribunal was also mindful of the numerous, positive testimonials that are before the Tribunal which demonstrate that Dr Murphy is now a competent and respected clinician, who is able to function effectively at Consultant level.

21. Dr Murphy discussed her future plans in relation to the practice of medicine and told the Tribunal that she had identified a new role that she could move into in the near future and that she wished to continue academic links with clinicians in the UK. The Tribunal considered that she had set herself realistic goals.

22. The Tribunal noted that Dr Murphy stated, when questioned by the Tribunal, that her learning not just related to epilepsy care but "fanned out" into other areas, which reassured the Tribunal that the learning was not restricted to one area. It considered that she has shown herself to be proactive and motivated in continuing with these initiatives and it is satisfied that there is little more that Dr Murphy could have been expected to do to improve upon her clinical knowledge during the period of suspension.

23. The Tribunal took account of the detailed reflective statement prepared by Dr Murphy. She apologises for her actions and clearly demonstrates her insight and understanding that her actions fell below the standards expected of a medical practitioner. The reflective statement is supported by an abundance of written evidence provided by Dr Murphy to demonstrate her involvement in appropriate CPD

courses, training, publications, clinical attachments and peer group working. All of this was reinforced by Dr Murphy's oral evidence which the Tribunal found to be honest and genuine. The Tribunal is satisfied that Dr Murphy fully appreciates the nature of her wrong doing, and its impact upon the family of Patient A.

24. In summary, the Tribunal has concluded that Dr Murphy has shown that she has appreciated the gravity of her misconduct, she has shown clear remorse and has apologised. She has now developed the necessary insight into her actions and the impact of her actions on others to fully remediate her misconduct. The Tribunal considers that the risk of any repetition of Dr Murphy's misconduct is low. The Tribunal has also concluded that Dr Murphy has done all that can reasonably be requested of her to reflect on her misconduct and undertaken appropriate and significant remediation. It is also satisfied that Dr Murphy has kept her clinical knowledge up to date and improved upon the areas which were deficient. In all these circumstances, the Tribunal has determined that Dr Murphy's fitness to practise is no longer impaired by reason of her misconduct.

25. The Tribunal concluded that a reasonable and well-informed member of the public, if provided with all the information before the Tribunal, would be satisfied with the steps Dr Murphy has taken to remediate her conduct, and maintain her clinical knowledge during her suspension. It therefore determined that public confidence in the medical profession would not be undermined if a finding of impairment was not made. Taking all of the above into account, the Tribunal is satisfied that Dr Murphy is safe to return to unrestricted practice.

26. The Tribunal has determined to make no order in relation to the suspension currently imposed on Dr Murphy's registration. In the light of the decision of the 2018 Tribunal that a period of 12 months suspension was required to promote and maintain both public confidence and standards and conduct for members of the profession, this Tribunal does not consider that it would be appropriate to revoke that period of suspension before its due date of expiry (22 March 2019).

27. That concludes this case.

Confirmed
Date 28 February 2019 Mrs Laura Paul, Chair