DETERMINATION: Facts
MEDICAL PRACTITIONERS TRIBUNAL: 18 August 2017
Dr Valerie MURPHY (6104053)

Dr Murphy:

Background

1. You qualified from the National University of Ireland in Cork with the qualification MB BCh, BAO in 2003 and began working as a Junior Doctor in Psychiatry, in Oxford. You went on to be appointed Consultant (Learning Difficulties) for Southern Health NHS Foundation Trust ('the Trust'), formerly known as the Ridgeway Partnership, in October 2011. Following this in January 2012, you took up the substantive Consultant Psychiatrist post for the same organisation. In 2014 you relinquished your licence to practice in the UK and returned to Ireland.

2. Whilst you were employed by the Trust as a Consultant Psychiatrist, Patient A was admitted into Slade House, a Short Term Assessment Unit within the Trust. Patient A was an 18 year old male who had been diagnosed with Kleinfelters mosaic, autism, learning disability and epilepsy. He was admitted to Slade House as his behaviour had become obsessive, unpredictable and quite violent, culminating in an incident where he hit his teacher. Slade House had a large specialist learning disability team of psychologists, nurses and support workers, which Patient A's mother felt was necessary for the care he required.

3. During Patient A's admission at Slade House, his mother and his family started to experience concerns regarding the level of care and treatment being given to Patient A. Patient A's mother maintained a blog to document her experience with her son's treatment. On 4 July 2013, Patient A had an epileptic seizure whilst bathing unsupervised. He was found unconscious, submerged under water, and was taken to hospital; however he never regained consciousness and died later that day.

4. The death of Patient A led to a report from Verita being commissioned in November 2013 by the Trust, which was produced in February 2014. Following the report Patient A's mother made a complaint to the GMC regarding your actions whilst Patient A was under your care, which has led to the allegation of misconduct against you.

Documentary evidence

5. The tribunal was provided with supporting documentation on behalf of the GMC and yourself including the following:

- Witness statements of Dr Sara Ryan, mother of Patient A, dated 4 August 2015 and 28 April 2017
- Witness statement of Dr Jane Adcock, dated 26 April 2017
- Expert reports of Dr Zahir Ahmed, dated 26 September 2014, 28 December 2015, 24 May 2016 and 30 September 2016
- Your witness statement, dated 7 August 2017

Witnesses

6. The tribunal heard oral evidence from the following witnesses:

- Dr Jane Adcock, Consultant Neurologist at John Radcliffe Hospital, Oxford since 2010.
- Dr Sara Ryan, mother of Patient A.
- Dr Zahir Ahmed, GMC Expert Witness and Consultant Neuropsychiatrist, University Hospital of Wales.
- You.

7. Dr Jane Adcock

The tribunal found Dr Adcock to be a credible and reliable witness in the information that she was able to recollect and provide. You said that you had had a telephone conversation with Dr Adcock seeking her advice about prescribing Risperidone to Patient A in April 2013. Dr Adcock did not remember any such conversation, but was able to say what she would do when asked for advice by a consultant colleague. The tribunal found her evidence helpful and her answers clear, honest and without any obfuscation.

8. Dr Sara Ryan (Patient A's mother)

The tribunal acknowledged that the last 4 years have been a very difficult time for Patient A's mother. The tribunal noted that the evidence was given from her perspective of the events and felt that her memory may have been affected by the major trauma she experienced in the loss of her son. The tribunal found her to be dignified and doing her best to assist the tribunal and believed her answers to be balanced and fair, particularly as she acknowledged when she could not recall something and conceded points during cross-examination. As such, the tribunal found her evidence to be credible.

9. Dr Zahir Ahmed

The tribunal found Dr Ahmed to be, overall, a credible witness. It did note that he focused on his own approach to clinical practice and only when questioned further did he acknowledge a different approach could be valid. The tribunal considered the opinions in his expert reports to be inflexible. However, in his oral evidence, he was able to make concessions about some of his earlier opinions and also to expand upon them in greater detail. The tribunal found his oral evidence helpful and believed this may have helped you to acknowledge what actions you had taken correctly or incorrectly.

10. You

The tribunal acknowledged that you have been on a difficult journey over the last four years and that you are clearly regretful regarding the failings in your clinical practice, that you now accept, surrounding Patient A's death. It noted that in some areas the focus of your witness statement was on what you believed you would have done, relying on your usual practice, rather than upon any actual memory of your actions in relation to Patient A. The absence of contemporaneous records concerning these matters made it difficult to place reliance on those parts of your evidence. It noted that you answered particularly difficult questions concerning your clinical actions and it appeared to the tribunal that you have accepted more responsibility for your actions now than you did at the time of the death of Patient A or in any other inquiries. This appeared particularly apparent when answering tribunal questions about your management of events concerning Patient A, and how those events may have affected levels of risk arising in his case. That being said, the tribunal detected some evasive answers and defensive responses to some other questions posed to you. You also now acknowledged that you had the ultimate responsibility for matters concerning Patient A's care both when he was detained under Section 2 Mental Health Act ('MCA') and then when he was an informal patient at Slade House.

Application to amend allegation

11. Ms Fairley, Counsel, on behalf of the General Medical Council (GMC), made an application to amend paragraph 6 of the allegation under Rule 17(6) of the GMC (Fitness to Practise) Rules 2004 ('the Rules'), as follows:

> *'6. ~~On 21 May 2013~~, your completion of a subsequent mental capacity assessment form for Patient A, regarding his consent to treatment was inadequate in that you failed to:*
> *…'*

12. Ms Fairley submitted that in your oral evidence you could not remember the date that the form referred to. She stated that amending the paragraph by removing the date would not result in any injustice to you and that it did not change the substance of the allegation.

13. Mr Partridge, Counsel, on your behalf, submitted that as the proposed amendment to paragraph 6 arose out of your oral evidence he did not oppose it.

14. Bearing in mind that Mr Partridge did not oppose the suggested amendment to the date in the stem of paragraph 6, the tribunal was satisfied that the amendment could be made without injustice and determined to accede to the application.

Tribunal's Approach

15. The tribunal has considered each of the paragraphs of the allegation separately. In doing so it has considered all of the evidence adduced in this case. It

has taken account of Ms Fairley's submissions on behalf of the GMC and those made by Mr Partridge on your behalf.

Tribunal's Decision

16. Bearing the above in mind, the tribunal has made the following findings of fact:

Paragraph 1
Between January 2012 and June 2014 you were employed by the Southern Health NHS Foundation Trust. **Has been Admitted and Found Proved.**

Paragraph 2
The risk assessments carried out in relation to Patient A were inadequate in that you failed to:

a. carry out any risk assessments; **Has been Found Proved.**

17. Ms Fairley submitted that you have acknowledged that you had the ultimate responsibility for Patient A during his period of residence at Slade House. In her submission, this responsibility extended to conducting risk assessments yourself. She stated that there was no record of a risk assessment being completed by you and she referred to Dr Ahmed's evidence, who she stated said this should have been done.

18. Mr Partridge submitted that the tribunal should appreciate the context of the charge and that there were three types of risk assessment: Psychiatric, Medical and Daily Living Activities (DLA) assessments. He stated that you would participate in the decision making regarding psychiatric risks and the need for observations of a patient who may be a risk to themselves or others. He referred to your decision to maintain level 2 psychiatric observations of Patient A and the subsequent decision on 3 June 2013 to reduce the level 2 observations to general observations. Mr Partridge submitted that, in relation to Medical risk assessments, you had already admitted that you did not carry out a risk assessment to identify the risks concerned with epilepsy and acknowledged this failure. Finally, Mr Partridge submitted that the DLA risk assessments were the responsibility of the nurses and pointed to evidence of risk assessment documents which had been completed by the nurses to support this.

19. The tribunal considered your documentary evidence, which states *'my understanding was that the completion of risk assessments were the responsibility of the band 5 nurses…I would not usually expect to get involved in those decisions and would not wish to interfere with the professional judgement of the nurses.'* Whilst DLA risk assessments could be carried out by nursing staff, this did not relieve you of responsibility for medical assessments. It noted that in your oral evidence you eventually accepted that you did have a duty to conduct some risk assessments and you had admitted your failure to comment on risk assessments conducted by the nursing staff.

20. The tribunal also considered the oral evidence of Dr Ahmed who stated *"I would have expected her [you] to carry out a risk assessment"* and further clarified

"a total risk assessment, not just the epilepsy aspect." The tribunal determined that as a Consultant Psychiatrist at Slade House, you had a duty to conduct and record risk assessments and that they were ultimately your responsibility.

21. In considering all those parts of the allegation where it is said that you *'failed'* to take a particular course of action, the tribunal interpreted failure in this context as meaning that you had not done something when there was a duty or requirement to do so, either generally, or at the point of the particular time referred to in a specific paragraph of the allegation.

22. The tribunal noted that you stated *'Although I would not usually get involved in these decisions, the assessment of ADL would be discussed at the CTM and signed off by those present.'* The tribunal determined that it was not sufficient just to discuss the ADL risk assessments of patients at a CTM alone. It determined that this did not satisfy the requirements for you to conduct the medical risk assessments.

23. The tribunal had sight of the RiO Standard Operating Procedure User Guide and noted that it was a clear operating procedure to be followed in relation to conducting risk assessments and the recording of the risk assessment. In your evidence you suggested that the risk assessments you conducted were implicit, however the tribunal determined that this was not following the specific procedure outlined in the guidance. It further noted that there is no recorded evidence of the assessments being conducted in the RiO notes. As there is no documentary evidence of medical risk assessments being conducted by you, or appropriately delegated, in accordance with the standard operating procedure, nor of them being recorded in the RiO notes themselves, the tribunal concluded that it could not consider a risk assessment to have taken place.

24. Accordingly, the tribunal found sub-paragraph 2a of the allegation proved.

b. comment on a risk assessment carried out by the nursing staff. **Has been Admitted and Found Proved.**

Paragraph 3
You failed adequately and appropriately to obtain consent from Patient A and/or his parents for the care and treatment you provided, in that:

a. Patient A was unable to understand information about remaining on the ward; **Has been Found Not Proved**

25. Ms Fairley submitted that from 16 April 2013 Patient A was no longer detained under Section 2 of the Mental Health Act and, as such, there was a requirement to obtain informed consent. She further submitted that, in your record, you did not indicate that you gave Patient A information about remaining on the ward and as you had concluded he did not have the capacity to make decisions, he was not able to understand the information given. In light of this, Ms Fairley submitted that this should have been discussed with Patient A's parents. She stated that there was no specific meeting to discuss Patient A's mental capacity with either

of his parents and submitted that efforts to communicate with them were inadequate.

26. Mr Partridge submitted that in the event effective consent was unable to be obtained from Patient A, then it could have been able to have been obtained from his parents. Mr Partridge directed the tribunal to the RiO notes on 8 April 2013 where you had anticipated Patient A's incapacity and engaged in a detailed discussion about his medication, specifically Risperidone.

27. The tribunal noted that the GMC's case in relation to this allegation as set out at paragraph 3b is that Patient A lacked capacity to consent to decisions about his care and treatment. In those circumstances, the tribunal considered there is an inherent contradiction in alleging that there was failure adequately and appropriately to obtain consent for care or treatment from Patient A himself if he was also said to lack capacity at that particular time. This contradiction undermines both paragraph 3a and 3b of the allegation insofar as it relates to obtaining consent from Patient A himself.

28. The tribunal noted that during Patient A's mother's evidence she was concerned with how she would manage the behaviour of Patient A if he were to return home at that time. The tribunal inferred that this meant Patient A's mother had been made aware that there was the possibility that Patient A could leave the ward.

29. The tribunal had regard to the minutes from a meeting where Patient A's return to school was discussed. The minutes dated 16 April 2013 state that *'Sara was reassured that both parents would be informed immediately should [Patient A] decide to leave the unit.*' The tribunal determined that there was evidence to suggest that, as you had determined that Patient A lacked the capacity to understand the information given to him regarding his stay on the ward, you had provided Patient A's parents with this information in his place and that they did consent to his continuing to stay at Slade House as an informal patient after his discharge from section 2 of the Mental Health Act detention on 16 April 2013. As such, the tribunal found sub-paragraph 3a not proved.

b. Patient A lacked the capacity to make this decision. **Has been Found Not Proved**

30. Ms Fairley submitted that your record indicates that Patient A did not have the capacity to give consent. She also stated that the notes were not clear on how you concluded he did not have the capacity to make this decision.

31. My Partridge submitted that as you had concluded that Patient A lacked the capacity to make the decision, you had instead involved his parents in the decision making process.

32. The tribunal noted Dr Ahmed's evidence in the Psychiatric Report. He stated *'Having deemed that Patient A lacked mental capacity Dr Murphy subsequently did not indicate that a best interest meeting was arranged to make decisions on behalf*

of Patient A.' The tribunal acknowledged that there had not been a specific meeting set up in order to address Patient A's best interests.

33. The tribunal had regard to the RiO entry dated 16 April 2013, which stated that you had *'discussed the situation with [Patient A's] mother and explained that while I do not feel that he is detainable under S3, I do feel that he should stay with us on STATT as an informal patient. [Patient A] is not actively trying to leave the ward at the moment but should he try to leave, I would suggest that he would not have the mental capacity to do so.'* The tribunal determined that Patient A's mother implicitly consented, on his behalf, to his remaining on the ward informally. As such, sub-paragraph 3b has been found not proved.

Paragraph 4

On 9 April 2013 you prescribed Risperidone to Patient A, and you failed to:

a. indicate that the symptoms Patient A was experiencing were due to significant clinical anxiety; **Has been Found Not Proved**

34. Ms Fairley submitted that your note of your communication with Patient A on 9 April 2013 is extremely brief and stated that it did not include a record that the symptoms Patient A was experiencing were due to significant clinical anxiety.

35. Mr Partridge submitted that you had noted that Patient A's symptoms were due to clinical anxiety and pointed to the CTM notes on 8 April 2013. He stated that the note had to be read in its entirety, from which a sensible view of what you were 'indicating' could be taken. He submitted that on the Maudsley NHS Foundation Trust prescribing guidelines in Psychiatry ('the Maudsley Guidelines') Risperidone was the only drug licensed for such a treatment in the context of autism and stated that Patient A's mother understood that clinical anxiety was being treated.

36. The tribunal considered the evidence of Dr Ahmed who, in regard to 9 April 2013, stated, *'Dr Murphy has not expressed what symptoms Patient A was presenting with to indicate that he had significant clinical anxiety.'* The tribunal determined it was unreasonable to expect you to include the entire history of Patient A's symptoms in the single note, and that the notes from the clinical record should be read in conjunction with each other and not in isolation.

37. The tribunal had sight of the note from Dr Johnson dated 19 March 2013, when Patient A was admitted into Slade House. The note states that 'there might be other treatment options including low dose Risperidone which might be helpful for rapid control of agitation…' The tribunal acknowledged that the note refers to 'agitation' rather than 'anxiety', but determined that it was valid to read them synonymously. It accepted that it was plausible a conversation had taken place between yourself and Dr Johnson when Patient A was admitted where medication had been discussed. The tribunal acknowledges that the note keeping requires much improvement, but it was clear that the symptoms experienced by Patient A were due to significant clinical anxiety.

38. The tribunal had regard to the notes of the CTM meeting on 8 April 2013. Concerning the introduction of Risperidone, the notes state that 'She [you] explained that we would be using it to treat his anxiety and that we have found it helpful in taking the edge off.' The tribunal determined that it was clear from these notes that you had indicated that Patient A was experiencing significant clinical anxiety as the introduction of Risperidone was to treat this. Accordingly, sub-paragraph 4a is found not proved.

b. explain the benefits, risks and side effects of Risperidone to Patient A; **Has been Found Proved**

39. Ms Fairley again submitted that your note of your communication with Patient A on 9 April 2013 is extremely brief and stated that it did not include a record that you had explained the benefits, risks and side effects of Risperidone to Patient A. Ms Fairley submitted that you have accepted that there is no clear record of this in the notes made on 9 April and, in her submissions, in the absence of any record of these matters there is no *"indication"* that it had occurred.

40. Mr Partridge submitted that *'part of the fabric'* of prescribing medication is to explain the benefits, risks and side effects to the patient. He directed the tribunal to your witness statement where you explained *that 'it is my usual practice to discuss the medication with the patient, giving usual side effects…'* He further advised the tribunal that you had provided Patient A with an easy read leaflet to assist the process.

41. The tribunal had regard to Dr Ahmed's report which states that *'Dr Murphy did not indicate that she had explained or tried to explain to Patient A about the benefits, risks and side effects of Risperidone.'* The tribunal gave weight to Dr Ahmed's report as it could not see any reference to this in the notes that you recorded on 9 April 2013.

42. Although you had already decided that Patient A did not have the capacity to understand the information being provided to him, the tribunal determined that you should have nevertheless attempted to explain the benefits, risks and side effects of Risperidone to Patient A. You said in your witness statement that you explained to Patient A's mother the risk of Risperidone lowering the threshold for seizures, however you have also failed to record this in your notes. In her evidence, Patient A's mother advised the tribunal that she could not recall a conversation with you about that, and she did not recall being given a leaflet explaining the risks, benefits or side effects of prescribing Risperidone.

43. The tribunal also had regard to 'Consent: Patients and Doctors Making Decisions Together' (2008), paragraph 75:

'75 In making decisions about the treatment and care of patients who lack capacity, you must:

…

c support and encourage patients to be involved, as far as they want to and are able, in decisions about their treatment and care

…'

The tribunal determined that the information you claimed to have provided to Patient A's mother in your oral evidence, in combination with giving Patient A an easy read leaflet does not amount to attempting to explaining the risks, benefits and side effects of Risperidone to Patient A as it does not satisfy the criteria to 'support and encourage patients to be involved, as far as they want to and are able.' Accordingly, the tribunal found sub-paragraph 4b of the allegation proved.

c. indicate whether lorazepam had been used and/or whether it was effective; **Has been Found Not Proved**

44. Ms Fairley submitted that within your notes there is no record that you gave any consideration to the use of Lorazepam or how it had been used in the previous treatment of Patient A. She stated there was a failure in the notes to detail what effect it had upon Patient A and whether it helped his condition.

45. Mr Partridge submitted that that *'indicate'* is the important word in the charge. He stated that this had been prescribed previously and as such it was not your responsibility to indicate whether lorazepam had been used as it should already have been indicated within Patient A's notes.

46. The tribunal considered Dr Ahmed's report which stated that *'Patient A was previously prescribed as required lorazepam, Dr Murphy did not indicate whether the lorazepam had been used and/or if it was effective.'* The tribunal noted that the Lorazepam had previously been prescribed by another practitioner and that there was no change to it being prescribed 'as required'. It noted that you had not made any notes about the use of Lorazepam, but acknowledged to do so would have been unnecessary as you were already aware that he was taking the drug when needed. It also noted Lorazepam was only effective for controlling anxiety on a short term basis. The tribunal determined that although you favoured the used of Risperidone to Lorazepam, this did not establish any duty on you to indicate whether lorazepam was effective or not. It is clear from the notes that Lorazepam had been used and was still being used when needed. Accordingly, the tribunal found sub-paragraph 4c not proved.

d. make a diagnostic formulation for its administration. **Has been Found Not Proved**

47. Ms Fairley submitted that your note of your communication with Patient A on 9 April 2013 did not reference a diagnostic formulation for the administration of Risperidone. Ms Fairley acknowledged that, from your oral and documentary evidence, you have stated that you conducted the diagnostic formulation internally, however it is the GMC's submission that as there is no record of these *'internal processes'* the tribunal cannot be confident that they were completed.

48. Mr Partridge submitted that this was not a charge about record keeping, but a charge regarding clinical action, diagnosing, formulating and exploring the causes of the conditions and assessing them. He stated that such activity is normally demonstrated by the clinician's notes, but in this case the notes should be combined

with all of the information in the records. In his submissions, this would lead to a 'sensible conclusion' as to what you were thinking and doing at the time.

49. The tribunal had regard to the notes of the CTM meeting, dated 8 April 2013 which record that you explained risperidone would be used to treat Patient A's anxiety and you would then look at *'weaning'* Patient A off fluoxetine. It had sight of Dr Ahmed's Psychiatric Report which stated '*Prescribing antipsychotic drugs with potential long-term side-effects on a symptomatic basis without a diagnostic formulation can be viewed as inappropriate use of medication.'* He continued to say that *'anxiety would be deemed to be a symptom rather than a diagnosis'*. The tribunal acknowledged that Dr Ahmed viewed anxiety as a symptom of another issue, however it appeared to the tribunal that your diagnosis was that Patient A's anxiety was a clinical condition, and not just a symptom. In your view, you had made a clinical decision to treat the anxiety and supplied medication to address it. As such, the tribunal found that you did make a diagnostic formulation for the administration of risperidone and accordingly, found sub-paragraph 4d not proved.

Paragraph 5
On 16 April 2013, your 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 you failed to:

a. make a contemporaneous assessment of his mental capacity; **Has been Found Not Proved**

50. Ms Fairley submitted that none of the language within the entries in the boxes of the Medical Capacity Assessment ('MCA') form indicated that you had completed the form contemporaneously. There is no record of you seeing Patient A on this day. In this instance she referenced the Psychiatric Report of Dr Ahmed who supported this claim, stating *'Dr Murphy makes a reference to "us" which suggests that Dr Murphy completed the mental capacity assessment form based on historical information.'*

51. Mr Partridge submitted that the tribunal should look at this charge with care and not be overly forensic when interpreting notes made for a clinical purpose. He drew the tribunal's attention to points within your notes when you had referred to Patient A's condition in the present tense. Mr Partridge also stated that you combined this with relevant historical evidence which would inform anyone checking the notes of Patient A's past condition.

52. The tribunal considered that there were parts of the MCA form completed on 16 April 2013 which pointed towards a contemporaneous assessment, namely that Patient A *'is currently unable to think through the consequences of him leaving the ward…[he] cannot understand this at the moment'*; and his *'high levels of anxiety is [sic] preventing him for [sic] weighing up the pros and cons'*.

53. The tribunal noted that within your RiO entry timed at 12:11 hours on 16 April 2013 you stated *'I intend discharging [Patient A] from S2 today.'* However, you had already signed the form discharging Patient A from detention under Section 2 MHA at 12:10 hours the same day. Whilst the tribunal noted that using the future tense

seemed unusual if you had made a contemporaneous mental health capacity assessment of Patient A, the tribunal could not conclude, with this evidence alone, that you had not done so.

54. The tribunal considered your oral evidence in which you stated that you had difficulty using the computer system which had been newly implemented at Slade House and that your 'turn of phrase' may not have indicated your exact thoughts. The tribunal was concerned that, as a clinician, you should be competent in using the system in which to record your patients' notes.

55. The tribunal determined that although there were some question marks regarding your *'turns of phrase'* that this did not demonstrate that you had not completed a contemporaneous mental capacity assessment. Accordingly, it found sub-paragraph 5a not proved.

b. arrange a best interest meeting to discuss the advantages and disadvantages to decide what was in his best interests. **Has been Admitted and Found Proved.**

Paragraph 6
~~On 21 May 2013~~, Your completion of a **subsequent** mental capacity assessment form for Patient A, regarding his consent to treatment was inadequate in that you failed to:

a. indicate any specific treatment; **Has been Found Not Proved**

56. Ms Fairley submitted that in your second MCA form completed between 21 May – 25 June 2013 you had not indicated any specific treatment for Patient A. She advised the tribunal to consider the Psychiatric Report of Dr Ahmed who she stated confirmed that he would have expected there to be an indication of each of the aspects identified at paragraph 6 a to f when completing the MCA. She stated that there was no record within the documentation where this information has been clearly recorded.

57. Mr Partridge submitted that the mental capacity assessment form should be taken as a whole. He stated that, in his oral evidence, Dr Ahmed accepted that this is the approach that should be taken. Furthermore, Mr Partridge submitted that the form does indicate specific treatment as it references risperidone.

58. During cross examination Dr Ahmed conceded that it was clear that the form related to treatment with Risperidone. The tribunal had regard to Dr Ahmed's oral evidence in which he stated *"I would expect to see a specific indication of the treatment…although risperidone is mentioned…you need to mention other drugs as well."* The tribunal noted that this seemed to be based on Dr Ahmed's opinion alone and that there was nothing to suggest that other drugs had to be mentioned as well.

59. The tribunal also had regard to the MCA form template. It noted that the form consists of a series of 'drop down' boxes in which the options you could select are limited. One of those boxes, identify the area for which capacity was being assessed,

was simply labelled 'consent to treatment'. It also noted that Dr Ahmed had not had experience of this template and therefore he might not realise the restrictions of it.

60. Furthermore, the tribunal noted that the on the form risperidone is referenced on two occasions and as such the tribunal determined that it was inaccurate to conclude that you did not indicate any specific treatment. Accordingly, the tribunal concluded that sub-paragraph 6a has been found not proved.

b. make a specific assessment of his mental capacity; **Has been Found Not Proved**

61. Ms Fairley submitted that there should have been more details provided regarding the assessment of Patient A's mental capacity and that the contents of the form are inadequate.

62. Mr Partridge submitted that the medical assessment form should be looked at in combination with the RiO notes.

63. The tribunal had regard to the MCA form dated 21 May 2013 and updated 25 June 2013. It noted that in each section you had completed the box to provide details regarding your answer. It did note that you had incorrectly selected 'no' to answer five, which you informed the tribunal you had done in error during your oral evidence. It determined that taken in context with the rest of the form, it was apparent that this had been done in error and it did not confuse the overall reading of the form.

64. It further noted that during cross examination Dr Ahmed conceded that it was clear that the form related to treatment with risperidone.

65. The tribunal found that the form was completed in detail and that the core questions of the form were all answered adequately. As such, the tribunal found sub-paragraph 6b not proved.

c. establish whether he was able to understand the advantages and disadvantages of taking psychotropic medication; **Has been Found Proved**

66. Ms Fairley submitted that in the absence of information recording advice given as to side-effects and risks of taking psychotropic medication and reference to his understanding of the advantages and disadvantages of taking such medication, the tribunal should conclude that you failed to establish Patient A's understanding of this aspect.

67. Mr Partridge submitted that establishing whether Patient A was able to understand the advantages and disadvantages of taking psychotropic medication was implicit as the conclusion records that *'[Patient A] would not communicate in any manner…'* He stated that this makes it clear that you had established that Patient A would be unable to understand the information being given to him.

68. The tribunal had regard to Dr Ahmed's oral evidence during cross examination in which he stated that he would not expect this information to be explicitly stated in the form. However, the tribunal noted that there was no reference to this in the RiO entry either.

69. The tribunal bore in mind the ethical framework which advises that a practitioner should assume that the patient has capacity, and some attempt should be made to explain relevant information to the patient. It determined that although you may have concluded that Patient A was not able to understand, there still should have been an attempt to explain these matters to him appropriately.

70. The tribunal had regard to your documentary evidence in which you stated *'I would have discussed medication with Patient A in terms that he would have been able to understand, I would have tried to explain the risks and benefits…'* however it felt that this evidence states what you believe you would have done, not that you did this.

71. The tribunal further noted that you had stated a leaflet detailing the information regarding psychotropic medication was provided to Patient A's mother, however in her evidence, Patient A's mother stated she did not remember this being given to her.

72. As this information is not detailed on the form and there is no RiO entry to confirm that this occurred, and you have no specific recollection of discussing these matters with Patient A, the tribunal could not in this instance conclude that you had done this. As such, sub-paragraph 6c has been found proved.

d. highlight whether any alternative drug was suggested; **Has been Found Not Proved**

73. Ms Fairley submitted that the MCA form should have indicated whether an alternative drug was suggested in place of Risperidone and pointed to Dr Ahmed's evidence where he confirmed he would have expected there to be an indication of this.

74. Mr Partridge submitted that the charge presupposes there was a reasonable alternative option that it was mandatory for you to consider, however he submitted that if the drug in use was effective and you believed there to be no viable alternative then there was no requirement to suggest an alternative drug. He also referred to the Maudsley Guidelines in the context of this part of the allegation.

75. The tribunal considered your evidence in which you stated you did not believe that there was an appropriate alternative. It determined that you did not have a duty to suggest any alternative drug, as Risperidone appeared to be working, and Lorazepam was already being used on a 'PRN' basis. Dr Ahmed accepted that the use of Lorazepam was only appropriate for the short term, due to patients building up resistance to the drug. The tribunal noted that Patient A had been prescribed Lorazepam on a 'PRN' basis already.

76. Accordingly, the tribunal found sub-paragraph 6d not proved.

e. explain the side-effects and risks of taking psychotropic medication; **Has been Found Proved**

77. Ms Fairley submitted that the MCA form you completed did not indicate you explained the side-effects and risks of taking psychotropic medication. She submitted that this should have been explained to Patient A.

78. Mr Partridge again submitted that you had explained the side-effects and risks of taking psychotropic medication by providing Patient A's mother with a leaflet explaining this information.

79. As referenced earlier in the determination, the tribunal noted that, during her oral evidence, Patient A's mother stated that she could not recall if a leaflet had been given to her or not. The tribunal considered that even if a leaflet had been supplied to Patient A's mother, this did not constitute an explanation to Patient A of the side-effects and risks of taking psychotropic medication. The tribunal also bore in mind the guidance of paragraph 75 of Consent: Patients and Doctors Making Decisions Together.

80. As there was no record of this being explained in the RiO notes or on the MCA form, and you have no specific recollection of discussing these matters with Patient A, the tribunal concluded that this had not been explained to him. As such, the tribunal found sub-paragraph 6e proved.

f. arrange a best interest meeting. **Has been Admitted and Found Proved.**

Paragraph 7
In your review of Patient A on the following dates:

a. 09 April 2013;
b. 30 April 2013;
c. 13 May 2013;
d. 20 May 2013;
e. 18 June 2013;
f. 1 July 2013;

you failed to:

i. make an assessment about his mental state; **Has been Found Proved (in relation to a) Has been Found Not Proved (in relation to b,c,d,e,f)**

81. Ms Fairley submitted that there was no clear documentation within the records of your reviews of Patient A on the dates listed detailing an assessment about his mental state. She stated that your explanation that you had difficulties

with access to the computer and recording information digitally was inadequate and did not withstand scrutiny.

82. Mr Partridge submitted that this was an allegation about diagnosing and formulating a plan exploring the causes of Patient A's mental state and assessing it. He submitted that the assessment would typically be addressed in the clinician's notes and that in this case, all of the notes should be looked at together.

83. The tribunal determined that there was not a requirement for you to make a mental assessment of Patient A every time you were in contact with him, but only when there was a 'trigger event', meaning when an incident occurred which called for the matters covered at either paragraph 7i or 7ii a-c to be reviewed. The tribunal considered that two of the dates above did fit this criteria: 9 April 2013, as this was your first interaction with Patient A following your return from leave; and 20 May as Patient A had bitten his tongue and there were concerns about whether he had suffered a seizure. As such sub-paragraph 7b, c, e and f were found not proved in relation to sub-paragraph 7i.

84. The tribunal had sight of the RiO entries on the dates listed above. On 9 April 2013, the tribunal could find no record of you making an assessment regarding the mental state of Patient A. It noted in your evidence that you stated your assessments were formulated internally, however the tribunal considered that, as a clinician, your record keeping is a large part of your responsibility. As there was no record of this assessment being done when you had only returned from leave the previous day and therefore assumed responsibility for the first time for Patient A's care as his responsible clinician, it concluded that there had been no assessment of those matters covered in paragraph 7i and ii a-c on that occasion. Accordingly, the tribunal found sub-paragraph 7a had been found proved in relation to 7i.

85. On 20 May 2013 the obligation on you was to assess whether Patient A had suffered a seizure, rather than to assess his mental state. Accordingly, the tribunal found sub-paragraph 7d was found not proved in relation to 7i.

ii. formulate:

a. a diagnosis;
b. an aetiology;
c. a risk assessment.

Has been Found Proved (in relation to a and d)
Has been Found Not Proved (in relation to b, c, e, f)

86. Ms Fairley submitted that there was no clear record that you had formulated a diagnosis, an aetiology or a made a risk assessment of Patient A on any of the dates listed above. She stated that your difficulties using the new system on the computer and recording information electronically were not an adequate explanation for not formulating a diagnosis, or failing to do so.

87. Mr Partridge submitted that in the CTM notes it is quite obvious that the team and yourself had assessed Patient A's mental state and reached a diagnosis, formulated an aetiology and completed a risk assessment.

88. Again, the tribunal considered the dates that they had highlighted as 'trigger events', namely 9 April 2013 and 20 May 2013. The tribunal determined that there was no need to formulate a diagnosis on the other mentioned dates as there was no significant change in Patient A's condition.

89. The tribunal considered the RiO entry dated 9 April 2013 and noted that there was no reference to a diagnosis being formulated on this date. The tribunal did acknowledge that Dr Johnson had previously formulated a diagnosis at the time of Patient A's admission and it considered your evidence that you had discussed this with Dr Johnson. However, the tribunal determined that as Patient A's Consultant Psychiatrist, it was your responsibility to formulate a diagnosis on your return and record this in your notes. As the tribunal could not find any evidence of this, the tribunal determined that sub-paragraph 7a was found proved in relation to 7ii (a-c).

90. The tribunal considered the RiO entry dated 20 May 2013. It noted that although you had recorded that Patient A had bitten his tongue, and were aware that this was potentially a sign of a seizure, you failed to complete a diagnosis, aetiology or a risk assessment. The tribunal was mindful of your evidence that these were processes that you completed internally, however the tribunal had no clear evidence to support this. It considered it a serious failing that you had not completed a diagnosis, an aetiology or a risk assessment of Patient A when he had potentially suffered a seizure. Accordingly, the tribunal found sub-paragraph 7d proved in relation to 7ii (a-c).

Paragraph 8

In your record keeping of Patient's A consultations, you failed to:

a. make comprehensive notes; **Has Been Admitted and Found Proved.**

b. record adequate information regarding his:

   i. symptoms; **Has Been Admitted and Found Proved.**

   ii. signs; **Has Been Admitted and Found Proved.**

   iii. diagnostic formulation; **Has been Admitted and Found Proved.**

   iv. risk assessment; **Has been Admitted and Found Proved.**

   v. management plan. **Has been Admitted and Found Proved.**

Paragraph 9

You failed to meet Patient A's clinical needs in that you did not:

a. implement and/or develop an adequate care and detailed management plan, particularly regarding his epilepsy, at the point of admission; **Has been Admitted and Found Proved.**

b. formulate any treatment plans, in that you did not specifically indicate:

   i. a working diagnosis; **Has been Admitted and Found Proved.**

   ii. the possible reasons for Patient A's presentation; **Has been Admitted and Found Proved.**

   iii. any specific treatment plan (save for the prescribing of risperidone). **Has been Admitted and Found Proved.**

Paragraph 10
You failed to meet Patient A's clinical needs specifically relating to his epilepsy and bathroom/shower needs in that you did not:

a. acknowledge that he was at an increased risk of having a further epileptic seizure on the ward; **Has been Admitted and Found Proved.**

b. carry out a risk assessment to identify the risks concerned with the condition; **Has been Admitted and Found Proved.**

c. consider the implications of allowing him to have a bath on his own with staff observing him every 15 minutes; **Has been Admitted and Found Proved.**

d. follow the:

   i. National Institute for Health and Care Excellence guidelines ('NICE guidelines'); **Admitted and found proved.**

   ii. Epilepsy Action advice which was referred to within the care plan that was prepared by the nursing staff on 24 April 2013. **Admitted and found proved.**

Paragraph 11
You failed to obtain a history of Patient A's epilepsy to include:

a. Patient A's presentation:

i. before a seizure; **Has been Admitted and Found Proved.**

ii. during a seizure; **Has been Admitted and Found Proved.**

iii. after a seizure; **Has been Admitted and Found Proved.**

b. the duration of seizures; **Has been Admitted and Found Proved.**

c. whether seizures made Patient A:

i. incontinent; **Has been Admitted and Found Proved.**

ii. bite his mouth or tongue; **Has been Admitted and Found Proved.**

iii. experience headaches; **Has been Admitted and Found Proved.**

iv. experience tiredness; **Has been Found Proved.**

91. Ms Fairley submitted that in Dr Ahmed's evidence he indicates that within the records, there is no mention that you obtained a detailed history regarding Patient A's epilepsy. She submitted that even within the nursing care plan, dated 24 May 2013, Dr Ahmed notes that there is no precise information regarding the seizures and whether Patient A experienced tiredness. She further submitted that it was your responsibility to obtain this information and Dr Ahmed considered it was vital to do so because *'epilepsy is associated with increased risk of injury and possible death'*.

92. Mr Partridge submitted that as you already knew that epilepsy would cause Patient A to experience tiredness there was no requirement to obtain the information.

93. The tribunal noted that in your documentary and oral evidence you stated that you did not take a history of this because you knew it already. You stated that experiencing tiredness after a seizure was obvious and as such, there was no need to record this information.

94. The tribunal also noted that on 21 May 2013 you received an email sent from Patient A's mother to a colleague, Ben Morris, which said that Patient A had been dozy when she visited the previous day. You had not obtained a history of Patient A's epilepsy before 20 May 2013. You did not follow that email up by making any further enquiries of Patient A's mother yourself.

95. The tribunal determined that having information about whether Patient A experienced tiredness after a seizure was important for understanding whether Patient A had suffered a seizure on 20 May 2013. It concluded this was an error on

your part as this aspect of the history had not been taken by you. Accordingly, the tribunal found that sub-paragraph 11c iv has been found proved.

v. need to sleep; **Has been Found Proved**

96. Ms Fairley again submitted that in the nursing care plan dated 24 May 2013 there was no detailed history regarding Patient A's epilepsy. She relied again on Dr Ahmed's Psychiatric Report and the evidence he gave, as outlined above.

97. Mr Partridge submitted that you did not use the phrase 'need to sleep' and he referred the tribunal to your documentary evidence in which he you state that a colleague had recorded that Patient A's mother *'had raised concerns that Patient A appeared sleepy which in her experience was a possible side effect of seizure activity.'* Mr Partridge submitted that there could be a subjective interpretation of sleepy and/or tired, but they meant the same thing.

98. The tribunal noted that you had failed to take a history in relation to the various side effects of Patient A's seizures. The tribunal determined that it would have been appropriate for you to ring Patient A's mother and query what the signifiers of a seizure would be.

99. The tribunal again determined that having this information would have assisted you when assessing whether Patient A had suffered a seizure on 20 May 2013 or not. It concluded that taking a detailed medical history is an integral part of your role as a clinician, especially in regard to indications of seizures. The tribunal determined it was an error that this had not been completed. Accordingly, the tribunal found that sub-paragraph 11c v has been found proved.

d. the recovery time after a seizure. **Admitted and found proved.**

Paragraph 12
You failed to obtain the information indicated at paragraph 11 during discussions with Patient A's:

a. family; **Admitted and found proved.**

b. neurologist. **Admitted and found proved.**

Paragraph 13
You failed to record the information as set out at paragraphs 11-12 above in Patient A's medical notes. **Admitted and found proved.**

100. Today is the last scheduled date for this hearing and therefore the hearing will be adjourned part-heard. Parties have been consulted and the following dates have been agreed by all concerned:

- Sunday 5 November 2013
- Monday 6 November 2013
  And
- Saturday 11 November 2013

- Sunday 12 November
  And
- Two further days that are yet to be agreed

When the tribunal reconvenes on Sunday 5th November, it will invite further submissions to be adduced at the impairment stage.