(PUBLIC) DETERMINATION: Sanction
MEDICAL PRACTITIONERS TRIBUNAL: 21 February 2018
Dr Valerie MURPHY (6104053)

Dr Murphy:
1. Having determined that your fitness to practise is impaired by reason of your misconduct, the Tribunal has now addressed what action, if any, to take in relation to your registration. In doing so, the Tribunal has borne in mind the submissions made by Ms Fairley on behalf of the General Medical Council (GMC) and those made by Mr Partridge on your behalf.

Further Evidence
2. The Tribunal was presented with a supplementary bundle D4 which contained the following:

- Your reflective statement, signed and dated 15 February 2018;
- Certificate of attendance at ePEX (An Electronic Computerised Record Keeping System) training;
- ePEX Manual and Index;
- Emails regarding the yellow card epilepsy form;
- Epilepsy In Psychiatric Inpatient Settings Audit;
- Yellow card Audit;
- Email regarding epilepsy care;
- Email regarding Directions for Future Research; and
- Testimonials.

3. In your reflective statement, you state: *'This has been a very long process having commenced in the summer of 2014. I agree that it has taken me that length of time to fully accept my role in the death of [Patient A]. I can say that I was able to accept my failings in their various forms in different stages of these proceedings but it is only at this stage that I have been able to accept all my failings. …'*

4. You go on to state that, while you were employed by the Trust, you were asked by senior management not to communicate directly with Patient A's family. You expressed your apology in these terms:

> *'Words cannot express the remorse I feel at how my failings have contributed to the death of [Patient A]. I am sorry that I did not seek to meet with [Patient A's] mother and her family and that this has left them feeling like I did not care. Nothing is further from the truth. I have made apologies but I do agree that reading these now, they appear general and do not address an apology for my personal failings. I would like to set out in no uncertain terms, that I do*

apologise for my own personal failings and the role these had in the death of [Patient A] …

I believe I was distracted by trying to control other clinical situations I perceived to be dangerous and I really did `take my eye off the ball' in this case. I do not think in hindsight, that I gave this case enough of my time. I was too distracted by issues in my own life to cope with such a complex working environment and I should have in hindsight, have taken time off work to consider this situation. …

I believe that part of my difficulty facing up to my role in this case is that it involves me facing up to the fact that I am responsible for causing the death of a much loved child and causing so much pain for a mother and family. I do believe that the enormity of this realisation has prevented me from fully accepting my responsibility. I do agree with the panel, that prior to these proceedings, I had only partial insight and I was `blinkered' to a certain extent on my full responsibilities …

After the inquest, I made appointments to meet with Dr Mary Kelly, my mentor to reflect on the findings. I was determined to learn from mistakes that had been made and to not only improve my knowledge and skills, but review systems where I worked so that such mistakes could not be repeated. My focus was firmly on patient safety and to ensure that I work towards improving care for those with epilepsy. Dr Kelly gave me valuable insight into presentations of epilepsy and helped me understand even in the structure of the unit as it was then, I was responsible for the overall care of the patient. Even then, I don't think I fully understood how my actions had resulted in the death. It is only through this current process have I understood this.

Addressing my failings in this case did not stop when I took up my current post. I undertook a programme of reflection and private study, whilst meeting with colleagues and reflecting on current systems in place in Ireland. I reviewed literature and updated my knowledge of guidelines. I reviewed a number of key papers in the area of epilepsy care.

As part of my realisation of my failings in this case, I realised that those with challenging behaviour were not having the possibility of seizures considered. I volunteered to help the faculty of intellectual disabilities in the Irish College of Psychiatry write guidelines for challenging behaviour …

I presented the yellow card at the International Conference of Integrated Care in May 2017 as a poster. This was aimed at disseminating the need for a tool to flag risk for those with epilepsy in psychiatric settings but also a chance to get peer feedback.

My aim from this whole project, is to focus on patient safety in any setting, to prevent avoidable harm and to raise awareness in light of my failings in this area of care. I continue to be open about my personal failings in any conversations I have about this project with other professionals to flag the potential devastating outcomes.'

5. You then addressed the areas where this Tribunal found you to be lacking, namely your failure to arrange best interests meetings following assessments of incapacity, failure to undertake risk assessments and failures in record keeping. You concluded your reflective statement by re-iterating your remorse at the role your failings had in the death of Patient A, and the effect that this has had on his family.

Your Oral Evidence

6. The Tribunal also heard oral evidence from you at this stage of the proceedings. You confirmed that you have not worked since August 2017. You confirmed on oath the matters set out in your reflective statement. You stated that after the Inquest you had met with Dr Kelly, your mentor to discuss the findings. You told the Tribunal that after that meeting you wrote the document that is at pages 31-33 in bundle D3, which sets out your own reflections and learning points.

7. In relation to the yellow card scheme, you stated that the idea behind it was your realisation, starting at the inquest, that no single person was "tying everything together" in Patient A's case. You said that you then started to speak to different people to look at the toolkits available. You said that you realised you had to produce something which was 'visible and easy to use'. You then spent a lot of time to get people on board with the yellow card scheme. You told the Tribunal that you organised a conference to explain your findings and you received feedback from an audit which showed that it had made a massive difference. You also received verbal feedback that showed "100% use in Cork". You stated that the scheme is clearly working but that it still has a way to go and that it needs someone to drive it forward. You told the Tribunal that you intend to drive forward the yellow card system as you want to make it safer for patients. You explained that you tell other professionals that you failed to recognise seizure activity, that you failed to do risk assessments and that as a result a young man had died.

8. In cross-examination you were asked about your attendance on the ePEX training course, to which you responded that it was the findings of this Tribunal that pointed out the deficiencies in your electronic notetaking so you thought you would do something about it. You stated that your intention when you see a patient is to write a physical note and to then transfer it to a computer record but that you have not put that into practice yet as you have not been working with an electronic records system in Ireland.

9. In response to questions as to acceptance of responsibility, you confirmed that you now accept that you failed to make proper risk assessments and that you had overall responsibility for Patient A's care. You also accepted that it was not until this hearing that you accepted your own responsibility and that even at the beginning of the hearing you were still seeking to minimise your involvement.

10. In Tribunal questions you were asked if you had challenged the instruction from the Trust to not speak to and or apologise to the family of Patient A. Your response was that you felt it was the wrong thing at the time but that you were told not to speak to the family and that only senior members of the Trust were dealing directly with them. You were asked if you had written a letter of apology to the family, to which you replied that you had not, as it had been made clear that you

were not to communicate with the family in any way. When asked why you have never directly apologised to the family, you said "*I am immensely sorry for their son's death, I'm sorry I made them feel like I didn't care".* When asked what your thoughts were now about the absence of an apology from you to Patient A's family, you said that that it is *"unacceptable, I should have spoken to the family …it was a very big mistake and I know now that they thought I didn't care. I would hate for another family to think that."*

Submissions of Counsel
For the GMC

11. Ms Fairley submitted that the only appropriate sanction in this is that of erasure. She stated that that submission is made with the acknowledgement that the Tribunal must consider the least restrictive sanction first and that erasure is clearly the ultimate sanction available. She referred the Tribunal to the Sanctions Guidance ('SG') (May 2017) and drew the Tribunal's attention to a number of its paragraphs.

12. Ms Fairley reminded the Tribunal of its finding that despite the fact that Patient A was a vulnerable young patient with significant risk factors you did not carry out any risk assessments and that is a failure of the most fundamental kind, which resulted in the most serious and tragic consequences. She submitted that this was not a case of a single breach or an isolated failing as there were multiple breaches of GMP relating to basic clinical care that were found by the Tribunal. Ms Fairley submitted that you failed to protect the health of Patient A and the extent and gravity of your failings fundamentally undermine public confidence in the profession. She reminded the Tribunal that you missed two major red flag opportunities; these were key signs which the GMC submit is representative of a reckless disregard for patient safety. Ms Fairley contended that your failings are not compatible with you remaining on the medical register.

13. As to insight, Ms Fairley referred the Tribunal to paragraphs 129-132 of the SG and submitted that you have shown a persistent lack of insight and that it is only very recently that you have accepted your responsibility and demonstrated remorse. She submitted that you have throughout the course of the history of this case been defensive and reluctant to accept your own failings. Ms Fairley reminded the Tribunal that in 2015, having had a period of time to reflect, your evidence before the inquest still did not acknowledge there had been two potential seizures before the date of Patient A's death. Further, she said that in your statement following the inquest there was a marked absence of recognition of the seriousness of your own failings and the consequences; and there was still an attempt to shine a spotlight on other areas such as nurse management. Ms Fairley submitted that even in these proceedings, your initial reflective statement showed limited insight and that it was not until you were challenged by the Tribunal that the more fundamental failings were accepted. Ms Fairley stated that the pattern of defensiveness and partial admissions gives serious concern as to whether you have truly developed insight. Further, the fact that you have still not apologised to the family, despite multiple opportunities where you could have made a full and frank apology, and your reluctance to accept full responsibility, must put in question the remediation put forward.

14. Ms Fairley submitted that patient safety and public confidence in the profession are paramount and that the remediation put forward is of some concern. In relation to record keeping, she submitted that you have only made partial and very recent attempts to address that aspect. Ms Fairley submitted that your reluctance to acknowledge your failings must temper the extent to which the Tribunal and the wider public could have confidence that you have learnt from your mistakes.

15. Ms Fairley submitted that the extent of the breaches of GMP, the seriousness of the failings and the limited insight and remediation demonstrated are such that the only appropriate sanction to mark the seriousness of those breaches and in order to maintain public confidence in the profession is to conclude this case with erasure.

On Your Behalf

16. Mr Partridge submitted that at the heart of this case is the fact that you have found it very difficult to process your actions and the consequences, knowing that you are responsible for the loss of a child. He submitted that great store is placed on insight but that a doctor is not always blessed with it straight away, and in this case your development of insight has been a very painful process. He said the starting point was the Inquest into the death of Patient A, following which there were some constructive efforts made by you in recognition of your leadership failures, which is a reflection of your constructive approach to criticism. Mr Partridge submitted that your identification of your personal failings was set out in thoughtful detail after the inquest and that document was not written for the benefit of the GMC.

17. Mr Partridge submitted that when looking at the failings, which are accepted as being serious and not reckless as suggested by the GMC, they can be said to amount to a single clinical incident, albeit with multiple failings. He argued that the failings should be seen in the context of a long and unblemished career where there have been no previous errors and no repetition. He referred the Tribunal to the testimonials and submitted that they all speak of a doctor who is very capable, competent, helpful, hard-working and a valued colleague. He highlighted the two testimonial writers who mention that they wish to utilise your services in the future.

18. Mr Partridge referred to your oral evidence being "utterly genuine and heartfelt" and with reference to your demeanour submitted that you have been emotionally "broken" by these events. He submitted that you do "genuinely care" about your patients and that intellectual disability is a specified difficult area where you have great expertise, hence the driving forward of the yellow card scheme. He submitted that often actions speak louder than words and the yellow card scheme was a genuine attempt by you to correct your own practice and that of others to ensure that the errors made in relation to Patient A are not repeated.

19. Mr Partridge submitted that you have been very candid with the majority of the charges being admitted at the outset. He referred to the SG and submitted that the GMC submission for erasure would be disproportionate given the active and positive steps you have taken to ensure you and others do not repeat the errors made. He contended that this is a case where suspension would be a proportionate sanction, the length of which is matter for the Tribunal. He concluded that given

your development of insight it would be appropriate to have a review hearing at the end of that process.

Tribunal's Decision

20. In reaching its decision, the Tribunal has borne in mind the submissions made by Ms Fairley for the GMC and those made by Mr Partridge on your behalf. It has taken account of the further evidence presented, including your oral evidence given at this stage of the proceedings. The Tribunal has exercised its own judgement as to the appropriate sanction, if any, to impose on your registration. The Tribunal has taken into account its detailed determinations on facts and impairment during its deliberations. It has borne in mind that the purpose of any sanction is to protect the public, which includes:

- protecting the health, safety and wellbeing of the public
- maintaining public confidence in the profession
- promoting and maintaining proper professional standards and conduct for the members of the profession.

21. Throughout its deliberations, the Tribunal has applied the principle of proportionality, weighing your interests with the public interest. It has kept in mind that the purpose of sanctions is not to punish doctors, although any sanction may have a punitive effect. The Tribunal first considered the aggravating and mitigating factors in your case. The aggravating factors are:

- 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.

22. The mitigating factors are as follows:

- You now accept fully the criticisms made of you and the findings of facts and impairment;

- You have now expressed regret and apologised, albeit not directly to Patient A's mother and family;

- Positive and supportive references and testimonials have been adduced which attest to your ability as a doctor;

- You have no history of previous, or subsequent, adverse findings against you by your regulator;

- At the time of these events you were a young consultant in the difficult field of adult learning difficulties;

- You were distracted by other clinical commitments, including the fact that the Trust would admit out of county patients at all hours of the day, who would usually be extremely challenging with complicated presentations;

23. There were a number of errors made by you. They span from 19 March 2013, the date of Patient A's admission to the STATT, when you did not ensure appropriate cover when you were away; a failure to undertake risk assessments either on or after your return to work on 9 April; the failure to pick up two red flag incidents (biting of tongue on 20 May and the nose bleed in the bath on 16 June). As a result of your errors, you failed to ensure Patient A's proper care. There were 4 or 5 separate incidents where you failed to do things which could have prevented the death of patient A. Had action been taken at any one of those points the likelihood is the circumstances that led to Patient A's death on 4 July would have been avoided, as you would have been more alert to the requirement for constant observations when he was bathing. These are acts and omissions that collectively do require serious action in terms of a sanction.

INSIGHT

24. The Tribunal has considered your subsequent behaviour since the death of Patient A. As to your failure to give an apology to the family, you have agreed that this was unacceptable, although this failure may be partly explicable by the stance taken by the Trust for you not to contact the family while you were employed by it. It is concerning that you did not try to stand up to that decision and to press those more senior to find some way to apologise to the family in accordance with paragraph 55b of 2013 GMP, or subsequently when you were no longer employed by the Trust. Nevertheless, you have now at this sanction stage fully accepted that you got things wrong and have apologised to this Tribunal, albeit not yet directly to Patient A's mother and family, for your failings.

25. It is concerning that your development of insight is so late. At the beginning there was denial and defensiveness on your part. However, at the fact finding stage of these proceedings when Tribunal questions were asked, the penny started to drop regarding the identification of seizures, and your overall responsibility in Patient A's case. Upon realisation of your failings you were visibly devastated.

26. Although the Tribunal found aspects of your evidence given at the Inquest to be worrying, it is now of the view that you have come a long way in your realisation

and acceptance of matters. You have had time to reflect since the handing down of the impairment determination in November 2017 and there now appears to be a wholehearted acceptance of your failings. It is clear that you are still deeply troubled by the death of Patient A and still trying to come to terms with it. It is abundantly clear by your demeanour at this stage that you are wracked with guilt. Your drive to implement the yellow card scheme both in Ireland and in England can be viewed as a determined effort to try to put right the wrong. This in itself is a powerful demonstration of insight into the gravity of one aspect of your failings. In the particular circumstances of this case, you are not just trying to salvage your own position, but are trying to help other doctors avoid making the errors you made in your care of Patient A.

27. The stance you took at the time of the Verita Investigation and at the Inquest was defensive where you did not acknowledge your failings and the part they played in the death of Patient A. At that stage you did not have insight. At the outset of these proceedings you admitted a large part of the allegation against you but some of the admissions have come very late. The development of insight has been slow. It is surprising that the Tribunal did not hear from you at the impairment stage but it notes the evidence of your personal circumstances and understands the reasons for your absence at that stage. More cogent insight has now been demonstrated in your latest reflective statement and in your oral evidence. Also there is now a clearer expression of apology, albeit that apology has not been directed to the family of Patient A. Your insight is regarded to be at the early stages of development. However, since the last hearing in November 2017 there appears to have been a sea change in the development of your insight. You have also demonstrated a determination to not just learn for yourself from what happened but more importantly to use your failings as a means by which others can learn and avoid repetition of what happened with Patient A. That is, in the view of this Tribunal, a matter of some importance.

28. The Tribunal has had regard to the SG and has considered the sanctions available to it, starting with the least restrictive.

No action

29. In reaching its decision as to the appropriate sanction, if any, to impose in your case, the Tribunal first considered whether to conclude the case by taking no action. The Tribunal determined that this is not a case where there are exceptional circumstances which might justify taking no action. Taking no action would be wholly inappropriate and would not maintain public confidence in the profession.

Conditions

30. The Tribunal next considered whether it would be sufficient to impose conditions on your registration. It has borne in mind that any conditions imposed need to be appropriate, proportionate, workable and measurable. The Tribunal had regard to the non-exhaustive list of factors set out in paragraph 84 of the SG which might lead a Tribunal to conclude that a period of conditional registration is workable. This included 'identifiable areas of their practice are in need of assessment or retraining.'

31. The Tribunal accepted that your failings in relation to Patient A are capable of remediation. However, this is not just a case concerning clinical errors. Your previous attitudes, and the stances taken at the Verita Investigation and at the Coroner's Inquest, are also relevant to the level of sanction.

32. The Tribunal bore in mind the context in which these failures occurred, and has carefully considered the issues of patient safety and the wider public interest. Given the seriousness of the failings combined with the limitations on the development of your insight at this stage, the Tribunal has determined that conditions would not be an appropriate or proportionate sanction in your case.

Suspension

33. The Tribunal then considered whether it would be appropriate to order that your registration be suspended. The Tribunal has borne in mind the paragraphs of the SG that deal with suspension. It has noted that suspension will be appropriate where the intention is to signal to the doctor, the profession and the public at large, that the misconduct involved is unacceptable, but falls short of being fundamentally incompatible with continuing registration.

34. The safety of patients can be protected, and the public interest upheld, by removing or restricting the registration of doctors who do not perform to the level of competence expected from them. However, this Tribunal recognises that doctors are human, and can make mistakes. Systems in place may prevent or alleviate the effects of mistakes of doctors. Nevertheless, the Tribunal also recognises that systems are not infallible. It considers that the public interest also requires doctors not to be defensive, but rather to acknowledge mistakes they have made; to learn from them; and to demonstrate that they have taken concrete steps to avoid repetition. It is also in the public interest for the wider medical profession to learn from the past experience of an individual doctor's case as the practice of medicine is not a static discipline.

35. The Tribunal considered that a period of suspension would give you the opportunity for further careful reflection on the Tribunal's findings and time to continue the process of remediation. It should also allow you to develop further insight into all the areas of your failings, and their impact on patient safety and the reputation of the profession. The Tribunal considered that the public interest can be served with a sanction other than erasure, given your acknowledged desire to ensure other doctors learn from the mistakes you made in your care of Patient A, and the efforts you have made to put into effect a means for other doctors to avoid making similar mistakes. Although there is still a lot of work to be done, the Tribunal has concluded that suspension would be a sufficient sanction in this case and that complete removal from the register would be a disproportionate response.

Duration

36. Having determined that suspension is appropriate, the Tribunal then considered its duration. Given the gravity of the findings and the late and so far limited development of insight at this stage the Tribunal considers it necessary and proportionate to suspend your registration for the maximum period of 12 months. The Tribunal considers that the full 12 months is required both in the public interest and in order to provide an appropriate length of time for you to demonstrate that

you have reached a point where you can, once again, competently practise with or without restriction in this country. To allow you sufficient time to reflect further on your misconduct, the Tribunal has also determined it is appropriate and proportionate to direct the Registrar to suspend your registration for the maximum period of 12 months. In reaching that decision, the Tribunal has balanced the need for the protection of the public and the public interest, with the impact of the suspension on you.

Review

37. Before the end of the period of suspension, a Medical Practitioners Tribunal will review your case and a letter will be sent to you about the arrangements for the review hearing, which you will be expected to attend. At the review hearing that Tribunal may be assisted by the following:-

- A reflective account addressing what you have learned and done in respect of the Tribunal's findings of facts, impairment and sanction demonstrating your level of insight;

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

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

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

- Evidence of how you have maintained your clinical skills and medical knowledge; and

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

38. The effect of the foregoing direction is that, unless you exercise your right of appeal, your registration will be suspended for a period of 12 months beginning 28 days from when notification of this decision is deemed to have been served.