

May 2009

External Review into the Case of Roy Murray

FAQs

What are the background facts of the case?

In August 2002, Dr Roy Murray was suspended from practice as a general practitioner (GP) following allegations of indecent assault on female patients. He was subsequently convicted on 23 counts in September 2004. St Helens Primary Care Trust (PCT) immediately commissioned an internal learning review and implemented an action plan to ensure that the appropriate systems were in place to protect patients. The former Cheshire and Mersey SHA commissioned an external independent review, in July 2005, to examine the reasons for the failure of the systems to protect patients during 1980 – 2002 and to contribute to restoring the confidence in local health services.

Who commissioned this review?

The investigation had been established by a former SHA in response to the concerns of the women and their families.

Who reviewed the case for the Strategic Health Authority (SHA) and what are its implications?

Dr Sharon Hopkins and Mrs Heather Limbach were commissioned to undertake the review. This was an extensive piece of work and their investigation and report raises serious issues which are relevant today. For example it is clear that there were opportunities to report Roy Murray to the General medical council (GMC). As an SHA we need to ensure that lessons such as this are learned.

Sadly there will always be rare occasions when professionals abuse the trust of patients. By listening to the people involved, in this case, both the women and the staff, it is possible to gain a greater understanding of how to protect patients and respond quickly when concerns are raised. We would like to thank the women who found the courage to give evidence to the review. A patient's story can have a profound effect on the actions of healthcare staff. We would like to thank the staff who agreed to co-operate with the review.

How will the report be published?

The review will be published on the SHA's and the PCT's websites www.northwest.nhs.uk and www.haltonandsthelenspct.nhs.uk after it has been received by the board of the SHA on Wednesday 6th May 2009.

Will the women concerned have the opportunity to comment on the review?

Yes, the SHA has arranged a private meeting on Thursday 18th June 2009 with the women involved to go through the report in more detail and to answer their questions.

How long has it taken to publish this review?

It has taken 4 years to publish the review. The review was started in July 2005 and the report was submitted in draft form in 2007 to the SHA.

Why has the process taken so long?

The review team faced many challenges in completing an investigation of this size and scope. Some records could not be located; there had been several NHS re-organisations (for example the original organisation who commissioned this report no longer exists). Some individuals, staff and patients, did not wish to participate in the investigation and we are not able to compel them to do so because it is not a legal process.

It is also important that the SHA acts in a consistent way and applies the principles of patient safety and public interest described in this report regardless of when the investigations were commissioned. Therefore a series of due diligence checks were undertaken and professional and legal advice sought to assure the SHA that due process had been followed.

A key part of the process is to enable factual accuracy checks on the report and compliance with the terms of reference. It has taken time to work through these issues, distinguishing between factual accuracy based on evidence, the opinion of the reviewers and the perception and experience of those involved.

Why has the review been anonymised?

It is important to confirm that the SHA is committed to improving patient safety and is adopting a principled approach to undertaking serious incident independent investigations. This includes the SHA's decision to anonymise this report. The report has been anonymised by the SHA, not the reviewers. The decision has been taken after careful consideration of the wider public interest and acknowledging that some other health and social care authorities are adopting a similar approach.

To understand the reasons for anonymisation, it is necessary to consider the purpose of the investigations and developments in our understanding of patient safety.

Establishing a strong patient safety culture requires leadership throughout the healthcare system and whilst we cannot change the past we can influence the future. Therefore on the publication of this important external review the SHA has adopted a number of principles based on the National Patient Safety Agency guidance for this and all future reviews/reports in order to best serve the public interest

The prime purpose of the investigation is to establish the patient safety lessons, ensure that they are shared and put into practice. The investigations need to be rigorous, constructively critical and give a full account of the patient's experience

To be open with patients and families and give them a full explanation of what has happened. Apologising when things have gone wrong but also acknowledging when care has been of a high standard.

The reviews/reports will be published but anonymised. This is consistent with the development of a just patient safety culture and should give patients and staff the support, courage and confidence to participate fully in the investigations. It also provides the public with a detailed account of the process and outcome.

The SHA incident investigations are not to determine culpability or negligence. These issues need to be addressed but will be handled through other well established legal and regulatory procedures and the SHA will cooperate fully and fulfil its statutory responsibilities.

What are the review's findings?

The report gives an outline of Murray's early career, a more detailed account of his work as a single handed GP in St Helen's, a locum and out of hours GP and his specialist practice in a local hospital. During that time he held a number of influential committee positions including the chairmanship of the Local Medical Committee (LMC). He did not employ any practice staff other than his receptionist and therefore practised in isolation. He attended educational events and was considered to be up to date in his professional practice.

There was evidence of problems within his practice, for example, his list size was falling. He was often late for surgeries and brusque with patients. His victims were young women seeking contraceptive advice for the first time or a first pregnancy and so they did not know what to expect. He subjected them to long and painful examinations, frequently repeated and sometimes on a home visit.

A small number of women made formal complaints and others told friends, relations and other hospital staff about their experience. However this happened at a time when the unswerving response was that 'he was the doctor' and he should be respected. In relation to the complaints the health bodies did not feel able to take action given the Department of Health guidance applicable at the time, although the LMC did visit him in 1987 to advise him to use chaperones.

The former St Helen's PCT was alerted to Murray's activities in 2002 following a chance conversation between a practice manager and a counsellor. The PCT acted swiftly and contacted the police. The ensuing inquiry led to more women coming forward and he was sentenced to 6 years imprisonment.

The review team was asked to provide assurance that the PCT had taken steps to minimise the risk of a similar scenario. The PCT had presented regular reports to the board and whilst the PCT had made progress on a number of issues, integrated governance (where all strands of governance are drawn together e.g. corporate and clinical) was at an early stage and the review team was unable to give that assurance as at September 2006.

The Review team has undertaken a detailed analysis of all the relevant policies in place at the time to consider whether action could have been taken. They compare the actions of a neighbouring FHSA. The circumstances were different in that the FHSA received a complaint that had been made to the police about the conduct of a local GP and had received two similar complaints themselves. The concerns were escalated to board level and it was agreed that the FHSA would support the other women to gain their consent and make the referral to the GMC on their behalf. The GP was struck off by the GMC

The report concludes that:

- there was scope for action by the health bodies in the late 1980s to the mid 1990s under the existing guidance and by the mid 1990s there was sufficient evidence that all was not well

- one serious failing could constitute evidence of serious professional misconduct and he could have been reported to the GMC in 1987

- the complaints system was too complicated and adversarial. Support for complainants was limited and it was difficult for patients to question a doctor.

- there were no mandatory chaperone policies available

- although much has changed, there is always the potential for practitioners to abuse the trust placed in them by patients.

If there was scope for action in the late 1980s to mid 1990s why didn't the Health Authorities act sooner?

The reviewers identify three main contributory factors:

- Individuals and organisations failed to bring the pieces of information together to form the whole picture

- Secondly individuals believed that they required knowledge of more than one incident before they could take action.

- NHS officers believed that certain issues were out with their responsibility.

When did the PCT respond?

The former St Helen's PCT was alerted to Murray's activities in 2002 following a chance conversation between a practice manager and a counsellor. The PCT acted swiftly and contacted the police. The ensuing inquiry led to more women coming forward and Murray was sentenced to 6 years imprisonment.

Can patients be reassured by the PCT that there will not be a recurrence of such criminal behaviour?

In 2006 the reviewers concluded that they were unable to provide assurance that there would not be a recurrence. The report confirmed that the former St Helen's PCT had made progress in implementing the learning review action plan but there were weaknesses and integrated governance was at an early stage. Halton and St Helens PCT replaced St Helen's PCT in the 2006 NHS 'Commissioning for a Patient-led NHS' reorganisation. The Chief Executive of St Helen's PCT did ensure that the new Halton & St Helen's Board, when established in October 2006, was fully briefed on the learning review action plan and ongoing development of integrated governance.

The new Halton and St Helen's PCT has made significant progress in addressing the concerns expressed in the external review report. Appendix 3 provides a response

from the PCT to the review report recommendations. That response is supported by evidence provided by the PCT. There are now robust governance and board assurance systems in place, the national policies for complaints, information governance and professional performance have been implemented and the learning from the review has been embedded into their serious untoward incident policies. Mersey Internal Audit Agency (an external organisation) has been working with the PCT to provide assurance that the policies are in place and fully implemented. The introduction of the GP contract and the Quality Outcome Framework ensures that there is much greater scrutiny of the GP practices and the use of more sophisticated monitoring systems provides detailed progress monitoring reports.

The PCT are aware that patients need to have confidence in the GP services and that if an incident occurs it will be responded to quickly and sensitively. The PCT is working with the GPs to ensure that the chaperone policy is in place and working and there is also counselling support for those affected by the release of the report.

The SHA will be working with all PCTs to ensure that the lessons are shared, learned and implemented.

What patient safety lessons have been learned?

Despite the limitations of the documentary evidence, the report gives an account of what happened and indicates that action could have been taken which would have resulted in an earlier referral to the GMC. Professionals who abuse their position are rare, but sadly there is always the risk that others will be attracted to the health care services because they provide the opportunity to abuse the trust of patients and colleagues.

What is important is to recognise abusive behaviour quickly and take appropriate action. Therefore it is vital to understand how Murray was able to continue for so long without challenge, why the women found it so difficult to complain and why staff felt unable to take action.

The report identifies the weaknesses of the policies and systems that were in place at the time. These were recognised in the Shipman, Ayling Neale and Kerr Haslem inquiries and the Chief Medical Officer's response in 'Good doctors safer patients' and 'Tackling Concerns Nationally and Locally' will strengthen appraisal which will be part of the revalidation process, overseen by responsible doctors. There will be a duty to share and investigate information about professional performance concerns including soft intelligence.

Together with the changes in the GP contract, the introduction of the Quality and Outcomes Framework, and the Performers List regulations there is much greater scrutiny of GP practice. The National Clinical Advisory Service (NCAS) supports the early assessment of performance concerns and there is a system of alert notices to protect patients until the regulators can take action. The complaints process has been reviewed, the whistle blower's policy introduced and most importantly patient safety has become a national priority.

Effective processes are the first step; they need to be used effectively. There are a number of 'human factors' within the report which are important safety lessons

Murray obtained positions of influence. He undertook a number of locums, worked for the hospice, regularly attended educational events. He was known to be difficult and aggressive. He worked in isolation with no practice team and was therefore in a position to avoid scrutiny and resist challenge.

There was evidence of problems in his earlier career history; his references did not include recent GP practice partners. However, he presented as someone well qualified and the FPC were pleased to appoint him. Careful checks should always be made before GPs are placed on local performers lists by PCTs

The women who complained found the complaints system confusing and unresponsive. It takes courage to come forward, and complaints need to be taken seriously. Women who are already distressed need considerable support to take such a complaint forward.

The GP and counsellor were concerned not to breach the confidentiality of their patient; their prime concern was for the patient's welfare. This creates a difficult dilemma for professional staff who have to balance patient confidentiality against the greater good and the risk to others. The FHSA staff worked within the limited policies of the time and felt that without evidence there was little action they could take other than advise contacting the police. Clear policies would have supported escalation. It is always important to raise concerns, resolve the uncertainty and consider the risk and options

The collation and investigation of soft intelligence is essential. People see what they expect to see and a partial picture leads to alternative explanations. In hindsight it will look self evident but unless all possibilities are considered the implications will be missed.

Protecting patients requires leadership, the courage to have difficult conversations and the resilience to follow the process through. It is not easy to do and that is why it is important to create a just culture where people feel safe to come forward and disclose concerns without fear of reprisals, prejudice or unfair treatment of colleagues

If the same incident were to happen today, how would it be handled differently by the PCT and SHA?

The PCT has access to stronger data about practices and can spot trends that may emerge from analysis of complaints; quality outcomes; poor performance to support much faster identification of problems. The PCT has a strong culture in encouraging whistle-blowing and making sure that people are supported if they take this step. The PCT would report the incident on the NHS North West STEIS system where serious untoward incidents are tracked and actions performance managed. The SHA would work with the PCT to oversee handling of the incidents and subsequent investigations and action plans.

How have policies and practices been changed in order that such an incident can be dealt with immediately?

If the incident came to light as a complaint from a patient, the PCT has strong systems in place to respond. This would include immediate investigation of the allegations, suspension from the local performer's list (if that was indicated) and referral to the police and General Medical Council.

There was scope for action in the late 1980s to mid 1990s yet the health authorities failed to act. Has anyone, or will anyone be disciplined for failing to act?

There has been no disciplinary action for failure to act. The report will be reviewed to see if any disciplinary action is indicated on this basis and would be followed through by the relevant employer.

What implications does the report have on the relevant health service bodies?

The report provides clear recommendations for continuous improvement of patient safety. The implications for health service bodies are that they must review their governance and other policies and systems against the recommendations to make sure that best practice is adopted across the North West.

Following publication of this report, are there any other steps that the SHA will be taking?

The SHA will be taking action to put the recommendations into an assurance framework that all primary care trusts will be asked to complete by July 2009. This will be used to assess continual improvement against any areas of weakness demonstrated through this process.

What action is going to be taken by the PCT in response to the report?

The PCT have produced a status report that shows how their systems have already developed and what action they are going to take. This report will be available on the PCT website at www.haltonandsthelenspct.nhs.uk. It is also available on the [NHS North website](#).

Is there any further help or advice for anyone concerned about the issues raised in this report?

Two helplines has been established for members of the public who have concerns, these numbers are:

0151 495 5290 – this number is for members of the public who would like to raise general enquiries, complaints and concerns with NHS Halton & St. Helens – **operational from May 5, 2009;**

0800 531 6090 – this number is a 24 hour confidential helpline run by AXA and is for patients who require counselling support; as necessary AXA will be able to manage referrals into a face-to-face service – **operational from May 4,2009.**