Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
14, 15, 16, 17, 18, 21 and 22 August 2023

Virtual Hearing

Name of Registrant:	**Conor Deeney**
NMC PIN	98B0112C
Part(s) of the register:	Registered Nurse – Mental Health Nursing
Relevant Location:	Mid Ulster
Type of case:	Misconduct
Panel members:	Fiona Abbott (Chair – Lay member) Anne Rice (Lay member) Susan Tokley (Registrant member)
Legal Assessor:	Trevor Jones
Hearings Coordinator:	Vicky Green
Nursing and Midwifery Council:	Represented by Ryan Ross, Case Presenter
Mr Deeney:	Not present and not represented
Facts proved:	Charges 1, 2, 3)b), 3)c), 4)a), 4)b), 5)a). 5)b) and 5)c)
Facts not proved:	Charge 3)a)
Fitness to practise:	Impaired
Sanction:	Striking off order
Interim order:	Interim suspension order – 18 months

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Mr Deeney was not in attendance and that the Notice of Hearing letter had been sent to his notified email address by secure email on 13 July 2023.

Mr Ross, on behalf of the Nursing and Midwifery Council (NMC), submitted that it had complied with the requirements of Rules 11 and 34 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The panel noted that there was no screenshot of Mr Deeney's registered contact details and invited submissions from Mr Ross on this matter.

Mr Ross submitted that the NMC received an email in January 2022 from Mr Deeney requesting that they send all future email communications to a different email address to that which is registered. While Mr Deeney made this request, he did not formally update his NMC registration with his new email address and therefore a screenshot of his registration contact details would show a different email address. Mr Ross submitted that the Notice was sent to the email address most recently supplied by Mr Deeney and he had been using this email address in all recent communications with the NMC. He therefore invited the panel to find that service had been effected.

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Hearing provided details of the allegation, the time, dates and that the hearing was to be held virtually, including instructions on how to join and, amongst other things, information about Mr Deeney's right to attend, be represented and call evidence, as well as the panel's power to proceed in his absence.

In the light of all of the information available, the panel was satisfied that Mr Deeney has been served with the Notice of Hearing in accordance with the requirements of Rules 11 and 34.

Decision and reasons on proceeding in the absence of Mr Deeney

The panel next considered whether it should proceed in the absence of Mr Deeney. It had regard to Rule 21 and heard the submissions of Mr Ross who invited the panel to continue in the absence of Mr Deeney. He referred the panel to the Proceeding in Absence bundle which contained an email dated 27 June 2023 from the NMC to Mr Deeney. In this email the NMC had attached copies of the substantive hearing bundles, Mr Ross drew the panel's attention to Mr Deeney's response by email on 28 June 2023 in which he stated the following:

> *'I'll will not be opening any more files. I've had enough...'*

Mr Ross submitted that whilst Mr Deeney had been engaging with the NMC, he has not made an application for an adjournment of these proceedings and he has not suggested that he would like to make such an application. Mr Ross submitted that there was no suggestion that Mr Deeney intended to attend this hearing. He submitted that Mr Deeney is aware of this hearing and he has chosen to absent himself. Mr Ross submitted that there is no evidence that an adjournment would secure Mr Deeney's attendance in the future. He submitted that it is in the public interest to deal with these matters expeditiously and invited the panel to proceed in Mr Deeney's absence.

Mr Ross accepted that there is a degree of disadvantage to Mr Deeney in proceeding in his absence as he would not be able to test the evidence or provide submissions. He informed the panel that five witnesses, one of whom is receiving additional support, have made themselves available to give evidence in this hearing. Mr Ross submitted that if this hearing was adjourned, the witnesses would be inconvenienced.

The panel accepted the advice of the legal assessor in which he referred the panel to the cases of *R v Jones (No.2) [2002] UKHL 5, General Medical Council v Adeogba* [2016] EWCA Civ 162 and *Davies v HCPC [2016] EWHC 1593 (Admin)*. He also referred the panel to the NMC guidance on *'Proceeding with hearings when the nurse, midwife or nursing associate is absent'* (Reference: CMT-8 (Last Updated 13/01/2023)).

The panel noted that its discretionary power to proceed in the absence of a registrant under the provisions of Rule 21 is not absolute and is one that should be exercised *'with the utmost care and caution'* as referred to in the case of *Jones.*

The panel has decided to proceed in the absence of Mr Deeney. In reaching this decision, the panel has considered the submissions of Mr Ross and the advice of the legal assessor. It has had particular regard to the factors set out in the decisions *Jones* and *Adeogba* and had regard to the overall interests of justice and fairness to all parties. It noted that:

- No application for an adjournment has been made by Mr Deeney.
- There is no reason to suppose that adjourning would secure his attendance at some future date.
- Two witnesses have made themselves available to give evidence today and a further three witnesses are due to give evidence this week.
- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services.
- There is a strong public interest in the expeditious disposal of the case.

The panel noted that the last email communication from Mr Deeney was in response to an email from the NMC containing the hearing bundles. In his email to the NMC dated 28 June 2023, the panel noted that Mr Deeney indicated that he would not be engaging in these proceedings and did not intend to open any further documents from the NMC.

The panel considered that in his last email communication to the NMC, Mr Deeney made it clear that he did not want to engage with the NMC or these proceedings. The panel also found that Mr Deeney had not requested an adjournment and given his most recent communication, the panel was satisfied that an adjournment would not secure his attendance in the future.

The panel was mindful of the overarching objectives of the NMC, namely to protect the public and to maintain public confidence in the professions and the regulator. The panel, having had sight of the charges, considered that the allegations in this case are serious and raise public protection concerns. The panel was also mindful that five witnesses, one of whom requires additional support, have made themselves available to give evidence in this hearing.

In these circumstances and balancing all of the factors set out above, the panel has decided that it is fair to proceed in the absence of Mr Deeney. The panel will draw no adverse inference from his absence in its findings of fact.

There is some disadvantage to Mr Deeney in proceeding in his absence. Although the evidence upon which the NMC relies will have been sent to him at his email address. Mr Deeney will not be able to challenge the evidence relied upon by the NMC in person and will not be able to give evidence on his own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. Furthermore, the limited disadvantage is the consequence of Mr Deeney's decision to absent himself from the hearing, waive his rights to attend, and/or be represented, and to not provide evidence or make submissions on his own behalf.

Details of charge (as amended)

That you, a registered nurse:

1) On 8 October 2020, refused to complete Future Nurse, Future Midwife mentorship training. **[PROVED]**

2) On 29 March 2021, incorrectly administered 5ml of lithium to Patient D instead of the prescribed 2.5ml. **[PROVED]**

3) Failed to adequately reflect on and/or address your medication error as set out in charge 2 above, in that:

a) On 15 April 2021 you refused to attend a mandatory supervision meeting. **[NOT PROVED]**
b) When asked by your employer to provide a reflective piece you provided an inadequate reflection. **[PROVED]**
c) You refused to complete medications training. **[PROVED]**

4) On 30 June 2021, removed Patient A from isolation, and moved him through a communal space to sit on your motorcycle:

a) Without a risk assessment having been conducted; **[PROVED]**
b) Without agreement and/or authorisation from the multidisciplinary team. **[PROVED]**

5) On the nightshift of 5-6 July 2021, in relation to an incident with Patient B, you:

a) Failed to adequately assist colleagues to de-escalate the situation when requested; **[PROVED]**

b) Shouted at and/or acted in an intimidating manner towards junior colleagues; **[PROVED]**

c) Told colleagues “let [Patient B fall]. So what if he falls” or words to that effect; **[PROVED]**

AND in light of the above, your fitness to practise is impaired by reason of your misconduct.

Decision and reasons on application to amend the charge

After the NMC had called all its witnesses and before it had closed its case Mr Ross made an application, pursuant to Rule 28 of the Rules, to amend the wording of charge number 2. Mr Ross submitted that having regard to the documentary evidence, and having heard the evidence of Mr 1, the quantities of lithium currently reflected in charge 2 are incorrect.

Charge 2 as it currently reads is as follows:

‘2) On 29 March 2021, incorrectly administered 300mg of lithium to Patient D instead of the prescribed 200mg.’

Charge 2, if the proposed amendments were made, would read as follows:

‘2) On 29 March 2021, incorrectly administered ~~300mg~~ 5ml of lithium to Patient D instead of the prescribed ~~200mg~~ 2.5ml.’

Mr Ross submitted that the proposed amendment can be made without injustice to any party. He submitted that Mr Deeney was put on notice that the charge was relating to a medication error, where he is alleged to have administered more lithium to Patient D than was prescribed on 29 March 2021. Mr Ross submitted that with the proposed amendment, the severity and substance of the charge remains the same. He therefore invited the panel

to allow the application to amend charge 2 as the proposed amendment would provide clarity and more accurately reflect the evidence.

After hearing Mr Ross' submissions the panel asked whether Mr Deeney had been put on notice of the proposed amendment to charge 2.

Mr Ross informed the panel that Mr Deeney had not been put on notice of this proposed amendment, but that he had been given sufficient notice of the charge involving a medication error and the evidence the NMC relied upon.

The panel accepted the advice of the legal assessor and had regard to Rule 28 of the Rules in relation to the proposed amendment. He also gave further advice in relation to whether Mr Deeney needed to be informed about this application in which he referred the panel to the case of *Sanusi v GMC [2019] EWCA Civ 1172* and the NMC guidance on *'Proceeding with hearings when the nurse, midwife or nursing associate is absent'* (Reference: CMT-8 (Last Updated 13/01/2023)).

Having regard to the legal advice and the NMC guidance, the panel was satisfied that as Mr Deeney had voluntarily absented himself, and that it had decided to proceed in his absence, there was no duty upon the NMC or the panel to notify him of this application.

The panel noted that the proposed amendment did not change the substance or severity of the charge and it reflected the evidence more accurately. The panel noted that Mr Deeney had been provided with the charge sheet and informed that there is a charge that he had administered a higher quantity of lithium than had been prescribed to Patient D on 29 March 2021. The panel also noted that he had been provided with the evidence bundle and witness statements in relation to this allegation.

Given that the evidence in the bundle and witness statement of Mr 1 sets out the correct amounts of lithium, the panel was of the view that the amendment, as applied for, was in the interests of justice. The panel was satisfied that there would be no prejudice to Mr

Deeney and no injustice would be caused to either party by the proposed amendment being allowed. It was therefore appropriate to allow the amendment, as applied for, to ensure accuracy and clarity.

Extraneous evidence

At the outset of the hearing the panel noted that the witness statement bundle and the exhibit bundle contained some extraneous evidence that did not appear to be relevant to the charges before it.

At the close of the NMC case, Mr Ross addressed the panel on this extraneous evidence and submitted that the panel should only consider the evidence relating to the live charges in this case. He provided the panel with an evidence matrix and invited the panel to only have regard to the relevant evidence.

The panel accepted the advice of the legal assessor in which he referred the panel to the case of *R (on the application of Chief Constable Thames Valley) v Police Appeals Tribunal [2016] EWCA Civ 1315* and the NMC guidance (Reference: DMA-6 (Last Updated 01/07/2022) as to who decides what is admissible and which states:

> *'They can put the information out of their minds when making a decision about what happened.'*

The panel was satisfied that, as an experienced panel, it could consider the live charges without taking into account the extraneous evidence. Whilst the panel considered that this information should have been redacted by the NMC before being handed up, it was of the view that it could proceed without injustice, confining itself only to consideration of the evidence relating to the charges set out above.

Background

On 26 October 2021 the NMC received a referral from Southern Health and Social Care Trust, Northern Ireland (the Trust). The referral related to concerns about Mr Deeney's attitude, patient care and his treatment of colleagues. The charges arose whilst Mr Deeney was employed by the Trust as a band 5 staff nurse working at Gillis Memory Centre (Gillis) at St Luke's Hospital.

Gillis is a secure dementia assessment unit, caring for up to 18 patients who were admitted for intervention and treatment until they could return to a nursing home or to their own home. Due to the debilitating nature of dementia, and the stress this causes to patients, a number of them can become confused and distressed and this can sometimes lead to aggressive behaviour.

It is alleged that on 8 October 2020, when Mr Deeney was asked by Ms 4 to complete his Future Nurse, Future Midwife (FNFM) mentorship training, which is one of the NMC standards for education and training, he refused to complete it.

It is alleged that on 29 March 2021, Mr Deeney administered an incorrect dose of lithium to Patient D. It is further alleged that following the incorrect dose of lithium being administered to Patient D, Mr Deeney failed to adequately reflect on and address the medication error.

In June 2021, Patient A was admitted into Gillis. Following admission to Gillis, patients were required to be kept in isolation for a two week period to minimise the spread of COVID-19 to other patients and staff. Patient A was a vulnerable patient who was detained under the Mental Health Act and there was a risk of him absconding. Patient A was also subject to police and safeguarding investigations following reports of him sexually assaulting females in the community. Given the potential risk to female patients and staff, one-to-one care and observation was assigned to Patient A. It is alleged that on 30 June 2021 Mr Deeney allowed Patient A to leave the isolation area, taking him through

a communal area and outside to sit on a motorcycle. It is alleged that Mr Deeney took this course of action without carrying out a risk assessment and without prior agreement and/or authorisation from the multidisciplinary (MDT) team.

Patient B had cerebral palsy and therefore had poor mobility and was prone to falls. Patient B was known to be aggressive towards staff and had punched female staff in the face. It was recorded that Patient B would often respond better to de-escalation carried out by male staff. In Patient B's care plan as of 18 June 2021, the following was recorded:

> *'where immediate danger exists or situations warrant immediate action, ensure any necessary medical assistance is sought.'*

During the nightshift of 5-6 July 2021, it is alleged that Patient B became aggressive towards two Healthcare Assistants (HCA) and started shouting at them. Patient B was incontinent and was reported as slipping off the bed. It is alleged that Patient B was punching, spitting and shouting at the two HCAs and Ms 3 while they were trying to stop him from falling from the bed. It is alleged that Mr Deeney, although he came to the door of the room, did not go to assist with Patient B or try to deescalate the situation. It is further alleged that Mr Deeney shouted *"what are you all doing? Just leave him alone and walk away".* It is alleged that Dr Deeney acted in an intimidating manner towards the junior colleagues who were trying to de-escalate the situation. It is also alleged that Mr Deeney told his colleagues to *"let [Patient B] fall. SO what if he falls"* or words to that effect.

Decision and reasons on facts

In reaching its decisions on the facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Mr Ross on behalf of the NMC.

The panel has drawn no adverse inference from the non-attendance of Mr Deeney.

The panel was aware that the burden of proof rests on the NMC, and that the standard of proof is the civil standard, namely the balance of probabilities. This means that a fact will be proved if a panel is satisfied that it is more likely than not that the incident occurred as alleged.

The panel heard live evidence from the following witnesses called on behalf of the NMC:

- Mr 1: Band 6 Deputy Charge Nurse at Gillis Memory Centre.
- Ms 2: Community Dementia Coordinator at Southern Health and Social Care Trust.
- Ms 3: Band 6 deputy manager at Gillis Ward, St Luke's Hospital.
- Ms 4: Ward Sister at Gillis Memory Centre.
- Ms 5: Dementia Coordinator at Gillis Memory Centre.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor. It considered the witness and documentary evidence provided.

The panel then considered each of the disputed charges and made the following findings.

Charge 1):

1) On 8 October 2020, refused to complete Future Nurse, Future Midwife mentorship training.

This charge is found proved.

In reaching this decision, the panel had particular regard to the oral and documentary evidence provided by Ms 4 and Ms 5.

The panel had sight of Ms 4's witness statement in which she stated the following:

'On 30 September 2020 I asked Conor to complete his Future Nurse, Future Midwife (FNFM) mentorship training, which is one of the NMC standards for education and training. Conor replied to say he would not complete the training…'

The panel also had sight of an email from Mr Deeney to Ms 4 dated 8 October 2020 in which he stated the following:

'I will not be completing the fnfm training because over this past number of years I have come to the opinion that I cannot in my right conscious mind encourage anyone to waste their lives in this profession. Indeed my intentions would be to discourage potential students from wasting their energy and efforts in this rhetorical inactive pseudo supportive environment. Sincerely Conor'

The panel had regard to the witness statement of Ms 5 in which she stated the following:

'The other training Conor required was Future Nurse Future Midwife training. This was to enable Conor to supervise student nurses; all nurses were required to do this as they all needed to supervise students. Conor told me he did not want students and that he would not be completing this training. Both training needs

were mandatory, and I explained this to Conor. Conor told me he had neither faith nor respect for management and that he would not be doing the training.'

In Ms 4 and Ms 5's oral evidence, both witnesses confirmed that Mr Deeney had not completed the FNFM training to their knowledge.

Having regard to the evidence of Ms 4 and Ms 5, and to the email sent by Mr Deeney on 8 October 2020, the panel determined that it was more likely than not that Mr Deeney refused to complete the required training course on 8 October 2020. The panel therefore found this charge proved.

Charge 2):

2) On 29 March 2021, incorrectly administered 5ml of lithium to Patient D instead of the prescribed 2.5ml.

This charge is found proved.

In reaching this decision, the panel took into account the oral and documentary evidence provided by Mr 1, Ms 3 and Ms 4.

The panel had sight of a Datix SHSCT Adverse Incident Reporting (IR2) Form (the Datix) relating to an incident that occurred on 29 March 2021. It noted the following:

'When Patient D was recently admitted to CAH the medical team changed his Priadel to liquid form. He was prescribed 2.5mls morning and night. [Patient D] received 2.5mls in CAH on the morning of 29/03/2021. He was discharges back to Gillis that evening and was to receive a further 2.5mls at night time. However he was written up for priadel liquid 5mls at night to commence on 30/03/2021. It would appear on the medication Kardex that Patient D was administered 5mls of priadel

on the night of the 29/03/21 instead of 30/03/21, this was signed off by staff nurse CD on the 29/03/21 but in the 30/03/21 Colum[sic]'

The panel noted that the Datix was completed on the day that this medication error was made and it was therefore a contemporaneous record. The panel also had regard to the witness statement of Mr 1 in which he stated the following:

'On 30 March 2021 I was copied into an email from RN [Ms 3], which explained that Conor had made a medication error the previous day. This had been reported on a datix incident report form,'

The panel had sight of Ms 4's witness statement in which she stated the following:

'At the end of March 2021 I was made aware of a medications error made by Conor.'

The panel also had sight of an email from Ms 3 to Ms 4 dated 30 March 2021 in which Ms 3 makes Ms 4 aware of the medication error. The panel had regard to a reflective statement completed by Mr Deeney in which he appears to acknowledge that he made the error and that in the future he would *'Pay more attention to commencement dates.*'

Taking all of the above into account, the panel was satisfied that it was more likely than not that on 29 March 2021 Mr Deeney incorrectly administered 5ml of lithium to Patient D instead of the prescribed 2.5ml. It noted that the Datix was contemporaneous evidence supported by the consistent oral and documentary evidence of Mr 1, Ms 3 and Ms 4. The panel therefore found this charge proved.

Charge 3)a):

3) Failed to adequately reflect on and/or address your medication error as set out in charge 2 above, in that:

a) On 15 April 2021 you refused to attend a mandatory supervision meeting.

This charge is found not proved.

In reaching this decision, the panel had regard to the evidence of Ms 5. The panel had sight of Ms 5's witness statement in which she stated the following:

> *'On 15 April 2021 I emailed Conor to say I would have a supervision meeting with him that day. Conor had recently made a medications error and part of the Trust process to manage this was through supervision. Conor was working night shifts and I explained I would stay on to speak with him when he got to work. Conor initially agreed to the meeting, then later rang the ward supervisor to say he would not be attending the meeting…*
>
> *… Conor initially refused to have the supervision meeting with me, telling me that he needed more notice and wanted the meeting at a time that suited him...*
>
> *... Conor subsequently returned to the office to speak with me.'*

In her oral evidence, Ms 5 told the panel that whilst it was delayed and Mr Deeney may not have regarded the meeting as a supervision meeting, she covered everything she would have normally covered in a supervision meeting, and therefore in her view the supervision meeting was held.

The panel noted that although Mr Deeney initially refused to attend the mandatory supervision meeting at the beginning of his night shift on 15 April 2021, this was completed at the end of his night shift on 16 April 2021. The panel therefore found this charge not proved.

Charge 3)b):

3) Failed to adequately reflect on and/or address your medication error as set out in charge 2 above, in that:

b) When asked by your employer to provide a reflective piece you provided an inadequate reflection.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Mr 1, Ms 4 and Mr Deeney's reflective statement.

The panel had sight of Mr Deeney's reflective statement as set out below:

'Reflective Discussion (using Gibbs Model)
Medication Error.

Description
Wrong Date of commencement.

Feelings
Failure.

Evaluation
It could have been worse.

Analysis
An easy mistake.

Conclusion

Endeavour to follow medication guidelines.

Action Plan
Pay more attention to commencement dates.'

The panel had regard to Ms 4's witness statement in which she stated the following:

> *'It appeared that Conor took no interest in or time over his reflective piece, since he provided minimal reflection in it, just single sentence answers. This was a very poor attempt at a reflection and suggested that Conor did not take the medication error seriously and did not take his responsibilities to learn and improve as a nurse as seriously as he should have.'*

In their oral evidence Ms 4 and Ms 5 confirmed that they did not consider that Mr Deeney's reflection to be adequate. Ms 4, in her oral evidence, stated that she thought that this was the opposite of reflection and learning as he provided no detail and he did not give it proper consideration.

The panel also had regard to the evidence of Mr 1. It had sight of an email dated 11 April 2021 from Mr 1 to Ms 4 in which he stated that: *'attached is Conor's reflection piece, I was going to use that as supervision however there is no information on it.'*

The panel was satisfied that Mr Deeney did have a duty to complete adequate reflection following his medication error to ensure that this error would not be repeated and to strengthen his practice. The panel determined that Mr Deeney's reflective statement was inadequate as it was so sparse and it did not properly address the medication error that took place on 29 March 2021. The panel found that Mr Deeney's reflection appeared to be abrupt and lacking in detail, insight and reflection. The panel therefore found this charge proved.

Charge 3)c):

3) Failed to adequately reflect on and/or address your medication error as set out in charge 2 above, in that:

c) You refused to complete medications training.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Ms 4 and Ms 5.

The panel had sight of Ms 5's witness statement and noted the following:

'I spoke with Conor about the additional training he needed to do. The medications training was necessary because of Conor's recent error. Conor's rationale was that his medications training was not out of date and therefore he didn't need to do any further training, despite the error. Conor had initially agreed to do further medications training after he had made the error, but subsequently changed his mind and refused. Further training, a reflective practice piece and supervision would have been needed, depending on the seriousness of the error.'

In their oral evidence, Ms 4 and Ms 5 both confirmed that to the best of their knowledge, Mr Deeney did not complete the medications training following his medication error.

Having regard to all of the above, the panel was satisfied that there was a duty on Mr Deeney to complete the medications training after his medication error and he did not. Accordingly, the panel found this charge proved.

Charge 4)a):

4) On 30 June 2021, removed Patient A from isolation, and moved him through a communal space to sit on your motorcycle:

a) Without a risk assessment having been conducted;

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Ms 2 and Patient A's care plan and Nursing Prog Notes. The panel had sight of what appeared to be notes of a meeting that took place in the course of a Trust investigation, this document is entitled *'Respondent Statement'* dated 29 July 2021. In this document there is a record of what appears to be Mr Deeney's responses made during the meeting. However, as he declined to sign it, the panel considered that it could place limited, if any, weight on this statement.

As set out in the background, the panel noted in respect of charge 4 that Patient A was a vulnerable patient who was detained under the Mental Health Act, and he presented a risk to himself and others. The panel also had regard to the infection control procedures in place, namely a two week isolation period, to minimise the spread of COVID-19 and reduce the risk to other patients and staff.

The panel had sight of Patient A's Nursing Prog Notes, in particular an entry made by Mr Deeney on 30 June 2021 in which the following was recorded:

> *'[Patient A] was in a settled form at suppertime watching tennis. Accepted medications and an opportunity to view a motorcycle, the style of which he professed to owning at one time (Harley Davidson). His story was guarded [sic] without revealing too much information. He did show some skill in mounting the machine and was very thankful for the opportunity to "view such a fine vehicle*

again". He returned to isolation without prompting and appeared content. Currently in bed awake and thanked me again for "letting me see the Harley".'

The panel also had sight of the Trust's *'Respondent Statement'* in which Mr Deeney is recorded as stating the following:

'It was pointed out to me that this patient had not been risk assessed and he could have fallen off the bike or absconded. In addition, this patient was in isolation due to covid risk. I indicated that I had taken precautions and that I could see the patient had the ability to get on the bike and that I had no concerns about that. If the patient didn't return with me then I would have reported this. I indicated that had the band 6 challenged me I would have returned. On reflection in future I will ensure there is a risk assessment.'

The panel had regard to the witness statement of Ms 2 in which she stated the following:

'Conor's response did not grasp the seriousness of the situation; he wasn't able to identify the concern that we continued to have and he continued to talk about Patient A and how he enjoyed seeing the bike, rather than considering the potential for the patient falling or absconding. Conor was initially indignant that his conduct had been challenged. Conor was only able to say in hindsight that he should not have done this and that he should have sought a risk assessment.'

Having regard to all of the above the panel was satisfied that it was more likely than not that on 30 June 2021 Mr Deeney removed Patient A from isolation, through a communal space to sit on a motorcycle without a risk assessment having been conducted as alleged. The panel therefore found this charge proved.

Charge 4)b):

4) On 30 June 2021, removed Patient A from isolation, and moved him through a communal space to sit on your motorcycle:

b) Without agreement and/or authorisation from the multidisciplinary team.

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Ms 2 and Patient A's care plan, Nursing Prog Notes and Mr Deeney's respondent statement dated 29 July 2021.

The panel had sight of Ms 2's witness statement in which she stated the following:

'It would not have been Conor's place to undertake a risk assessment of Patient A on his own, under any circumstances. Any decision to move Patient A should have been taken after a MDT discussion and as part of a care plan. There would have been a need to assess the risks and it would have been highly unlikely that Patient A would have been allowed out of isolation.'

The panel also had regard to the Nursing Prog Notes and Mr Deeney's respondent statement. It found that there was no record of Mr Deeney seeking agreement or authorisation from the MDT before removing Patient A from isolation, through the communal area to view his motorcycle. The panel therefore found this charge proved.

Charge 5)a):

5) On the nightshift of 5-6 July 2021, in relation to an incident with Patient B, you:

a) Failed to adequately assist colleagues to de-escalate the situation when requested;

This charge is found proved.

In reaching this decision, the panel had regard to the evidence of Ms 3, Patient B's care plan and the Trust's *'Respondent Statement'* dated 29 July 2021.

The panel had sight of Patient B's Patient care plan which set out that he was admitted to the ward due to aggressive behaviours and safeguarding issues with other residents. He was on 1:1 special observations.

The panel had sight of an email from Ms 3 to Ms 4 dated 6 July 2021 in which the following was stated:

> *'Incident.*
> *At approx.. 03:00 I was on 1:1 observations with […]. I heard [Patient B] raise his voice and shouting coming from the yellow dorm. HCA [HCA 1] and [HCA 2] where [sic] in the room. I heard banging and [Patient B] shout 'I will do you'. This went on for several minutes and I felt [HCA 1] and [HCA 2] where [sic] struggling due to [Patient B] level of aggression. When I entered the room [Patient B] was half sitting on the end of the bed, at risk of sliding off onto the floor. He had been incontinent and required assistance to get to the bathroom. When [HCA 1] or [HCA 2] came close to [Patient B] he was shouting insults, punching out, kicking and spitting over staff. Without intervention [Patient B] was going to slide from the bed and fall to the floor. At this point [Mr Deeney] entered the dorm. He said with his voice raised, 'What are you all doing?' 'Just leave him alone and walk away'. [HCA 2] replied, 'How can we do that? He is going to fall!'*
> *[Mr Deeney] said,*
> *'So what if he falls. Let him fall onto the floor'. [HCA 2 replied again,*

‘He is on 1:1 obs so we can’t just leave him. He has been incontinent and he needs help’. Again [Mr Deeney] said, ‘Let him fall. So what if he does.’
[HCA 1] said to [Mr Deeney],‘No I won’t just leave him. This man is in hospital for a reason and it is my job to care for him’.
[Mr Deeney] left the room without providing any assistance.
Staff nurse arrived after [Mr Deeney] left and provided assistance with myself. PRN was given and the situation was deescalated by 04:00. [Patient B] continued to shout loudly at staff from 3-4am, [Mr Deeney did not come back into the dorm.’

In her oral evidence, Ms 3 told the panel that she made a note of what Mr Deeney said at the time as she was so shocked. The panel found Ms 3’s witness statement and oral evidence to be consistent and in accordance with her contemporaneous note and email sent shortly after the incident.

The panel also had sight of the Trust’s *‘Respondent Statement’* in which Mr Deeney is recorded as stating the following:

‘I responded to indicate that I felt the best way to deal with the situation was to walk away and I believed that the patient would calm down if we walked away...’

As stated previously, Mr Deeney declined to sign these meeting notes and the panel therefore attached limited, if any, weight to these notes.

The panel determined that Mr Deeney would have been aware of the risks associated with Patient B. The panel found Ms 3’s evidence to be consistent, reliable and credible and found that Mr Deeney failed to adequately assist colleagues in de-escalating the situation when requested. The panel therefore found this charge proved.

Charge 5)b):

5) On the nightshift of 5-6 July 2021, in relation to an incident with Patient B, you:

b) Shouted at and/or acted in an intimidating manner towards junior colleagues;

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Ms 3.

The panel had regard to the contemporaneous note and email sent by Ms 3 to Ms 4 on 6 July 2021. It also had regard to her witness statement in which she stated the following:

> *'I recall what was said by Conor and our colleagues at the time as I was so shocked by Conor's behaviour that I wrote down what had been said word for word as soon as Patient B was under control. I thought I would need to remember exactly at some time and wanted to record Conor's words while they were fresh in my memory. I spoke with the other staff following the incident. I was shocked that not only had Conor behaved with blatant disregard towards a patient and his own colleagues, but he'd done it in front of me as ward manager.'*

In her oral evidence, Ms 3 told the panel that Mr Deeney raised his voice in an aggressive and angry tone when communicating with her and the 2 HCAs. She also told the panel that she was so shocked by Mr Deeney's behaviour, she wrote a note of the words he used at the time of the incident to assist her in recalling the events later.

The panel found Ms 3's evidence to be consistent, reliable and credible. Taking all of the above into account, the panel determined that whilst Mr Deeney may have had to raise his voice to be heard over Patient B, he did this in an aggressive and intimidating way and this

was directed at the HCAs as alleged in this charge. Accordingly, the panel found this charge proved.

Charge 5)c):

5) On the nightshift of 5-6 July 2021, in relation to an incident with Patient B, you:

c) Told colleagues “let [Patient B fall]. So what if he falls” or words to that effect;

This charge is found proved.

In reaching this decision, the panel took into account the evidence of Ms 3 and Patient B’s care plan. The panel also had sight of the Trust’s *‘Respondent Statement’* which contained Mr Deeney’s responses dated 29 July 2019.

The panel had regard to the contemporaneous note of Ms 3 and her email sent by her to Ms 4 on 6 July 2021. It also had regard to Ms 3’s witness statement and oral evidence. As previously stated, Ms 3 in her witness statement and in her oral evidence, told the panel that she was so shocked that she made a note of what happened and the specific words used by Mr Deeney during the incident.

The panel had sight of Mr Deeney’s response in the Trust’s investigation meeting notes dated 29 July 2021. He is recorded as stating the following:

‘I however denied that I had indicated “just let him fall”.’

As stated previously, Mr Deeney declined to sign these meeting notes and the panel therefore attached limited, if any, weight to this denial.

Given that Ms 3 made a contemporaneous note, sent an email shortly after the incident and her evidence before this panel which has been consistent, the panel determined that it was more likely than not that Mr Deeney told colleagues *"let [Patient B fall]. So what if he falls"* or words to that effect. The panel therefore found this charge proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether Mr Deeney's fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's suitability to remain on the register unrestricted.

The panel, in reaching its decision, has recognised its statutory duty to protect the public and maintain public confidence in the profession. Further, it bore in mind that there is no burden or standard of proof at this stage and it has therefore exercised its own professional judgement.

The panel adopted a two-stage process in its consideration. First, the panel must determine whether the facts found proved amount to misconduct. Secondly, only if the facts found proved amount to misconduct, the panel must decide whether, in all the circumstances, Mr Deeney's fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct

In coming to its decision, the panel had regard to the case of *Roylance v General Medical Council (No. 2)* [2000] 1 AC 311 which defines misconduct as a *'word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.'*

Mr Ross invited the panel to take the view that the facts found proved amount to misconduct. The panel had regard to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015)' (the Code) in making its decision.

Mr Ross identified the specific, relevant standards where Mr Deeney's actions amounted to misconduct.

Mr Ross submitted that in respect of charges 1 and 3, Mr Deeney's failure to undertake mandatory training, share knowledge and skills, reflect properly on his practice and improve his performance fell seriously short of what is expected of a registered nurse.

In respect of charge 4, Mr Ross submitted that in allowing a patient out of isolation without undertaking a risk assessment with the MDT, Mr Deeney failed to recognise and work within the limits of his competency and he failed to take account of his own personal safety, as well as the safety of those in his care.

Mr Ross submitted that charge 5 is the most serious charge. In respect of this charge, Mr Ross submitted that Mr Deeney's failure to intervene to assist colleagues in the de-escalation of Patient D fell far below the standards expected of a registered nurse. He submitted that Mr Deeney, as a senior nurse, should not have shouted and acted in an intimidating manner towards junior colleagues. He further submitted that telling colleagues to allow a vulnerable and distressed patient to fall to the floor falls far below the standards expected of a registered nurse.

He submitted that Mr Deeney's actions and omissions in respect of charges 1, 3, 4 and 5 fell seriously short of what was expected from a registered nurse.

Mr Ross addressed the panel on charge 2. He conceded that taken on its own, this charge relating to Mr Deeney administering the incorrect dosage of lithium does not amount to a serious falling short of the standards expected of a registered nurse.

Submissions on impairment

Mr Ross moved on to the issue of impairment and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. This included reference to the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin).

Mr Ross submitted that there is no evidence of insight, remorse or what Mr Deeney has done since the charges arose to demonstrate strengthened practice. He submitted that Mr Deeney's engagement with the NMC has been limited and that he has recently disengaged. Mr Ross submitted that the charges relate to multiple patients and raise public protection concerns. Mr Ross submitted that a fully informed, ordinary member of the public would be concerned if a finding of impairment was not found in this case given the seriousness and nature of the charges found proved. He therefore invited the panel to find that Mr Deeney's practice is impaired on public protection and public interest grounds.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments and NMC Guidance concerning misconduct. He also referred the panel to the NMC guidance on *'Impairment'* (Reference DMA-1 (Last Updated 27/03/2023)), *'Can the concern be addressed?'* (Reference FTP-13a (Last Updated 01/07/2023)) and *'Has the concern been addressed?'* (Last Updated 29/11/2022)).

Decision and reasons on misconduct

When determining whether the facts found proved amount to misconduct, the panel had regard to the terms of the Code.

The panel was of the view that Mr Deeney's actions fell seriously short of what was expected of a registered nurse, and that his actions amounted to wide ranging breaches of the Code. Specifically:

*'**1 Treat people as individuals and uphold their dignity***

To achieve this, you must:

***1.1** treat people with kindness, respect and compassion*

***1.2** make sure you deliver the fundamentals of care effectively*

***1.4** make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay*

6 Always practise in line with the best available evidence

To achieve this, you must:

***6.2** maintain the knowledge and skills you need for safe and effective practice*

8 Work co-operatively

To achieve this, you must:

***8.2** maintain effective communication with colleagues*

***8.4** work with colleagues to evaluate the quality of your work and that of the team*

8.5 *work with colleagues to preserve the safety of those receiving care*

9 Share your skills, knowledge and experience for the benefit of people receiving care and your colleagues

To achieve this, you must:

9.2 *gather and reflect on feedback from a variety of sources, using it to improve your practice and performance*

9.3 *deal with differences of professional opinion with colleagues by discussion and informed debate, respecting their views and opinions and behaving in a professional way at all times*

9.4 *support students' and colleagues' learning to help them develop their professional competence and confidence*

13 Recognise and work within the limits of your competence

To achieve this, you must, as appropriate:

13.4 t*ake account of your own personal safety as well as the safety of people in your care*

15 Always offer help if an emergency arises in your practice setting or anywhere else

To achieve this, you must:

15.2 *arrange, wherever possible, for emergency care to be accessed and provided promptly*

15.3 *take account of your own safety, the safety of others and the availability of other options for providing care*

16 Act without delay if you believe that there is a risk to patient safety or public protection

To achieve this, you must:

16.5 *not obstruct, intimidate, victimise or in any way hinder a colleague, member of staff, person you care for or member of the public who wants to raise a concern*

19 Be aware of, and reduce as far as possible, any potential for harm associated with your practice

To achieve this, you must:

19.1 *take measures to reduce as far as possible, the likelihood of mistakes, near misses, harm and the effect of harm if it takes place*

19.2 *take account of current evidence, knowledge and developments in reducing mistakes and the effect of them and the impact of human factors and system failures*

19.3 *keep to and promote recommended practice in relation to controlling and preventing infection*

19.4 *take all reasonable personal precautions necessary to avoid any potential health risks to colleagues, people receiving care and the public*

20 Uphold the reputation of your profession at all times

To achieve this, you must:

> ***20.1*** *keep to and uphold the standards and values set out in the Code*
>
> ***20.2*** *act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment*
>
> ***20.3*** *be aware at all times of how your behaviour can affect and influence the behaviour of other people*
>
> ***20.5*** *treat people in a way that does not take advantage of their vulnerability or cause them upset or distress*

25 Provide leadership to make sure people's wellbeing is protected and to improve their experiences of the health and care system

To achieve this, you must:

> ***25.1*** *identify priorities, manage time, staff and resources effectively and deal with risk to make sure that the quality of care or service you deliver is maintained and improved, putting the needs of those receiving care or services first*
>
> ***25.2*** *support any staff you may be responsible for to follow the Code at all times. They must have the knowledge, skills and competence for safe practice; and understand how to raise any concerns linked to any circumstances where the Code has, or could be, broken'*

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel was of the view that both individually and cumulatively, the charges found proved fell seriously short of what was expected and amounted to misconduct.

The panel found that Mr Deeney's refusal to undertake mandatory FNFM training to support student nurses and his failure to undertake training and adequate reflection following a medication error raise attitudinal concerns. A nurse is expected to share knowledge and to be able to reflect on mistakes in order to strengthen their practice.

In respect of the charges relating to Patient A, the panel found that Mr Deeney failed to follow infection control procedures and the patient's care plan. The panel found that in deviating from infection control procedures and the plans in place in respect of Patient A, Mr Deeney had a disregard for patient and public safety and his actions fell seriously short of what is expected of a registered nurse. The panel was of the view that Mr Deeney's behaviour in respect of this charge also raised attitudinal concerns.

The panel was of the view that Mr Deeney's failure to assist colleagues during the incident relating to Patient B was serious given the potential risk of harm to the patient and staff. The panel noted that Patient B had a history of aggression towards staff. The panel also noted the evidence of Ms 3 who recounted 19 incidents where Patient B had punched female staff in the face with a clenched fist. In her evidence, Ms 3 also told the panel that Patient B rarely repeated this behaviour with male staff, and it was known that any incidents involving Patient B could be de-escalated by male staff members more quickly than by female staff members. The panel found that Mr Deeney's treatment of his colleagues during this incident was inappropriate and unprofessional and fell seriously short of what is expected of a registered nurse. The panel also found that in instructing his colleagues to let Patient B fall, given the risk of harm to the patient, fell seriously short of what is expected of a registered nurse.

Taking all of the above into account, the panel found that Mr Deeney's actions fell seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct, Mr Deeney's fitness to practise is currently impaired.

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. To justify that trust, nurses must be honest and open and act with integrity. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

In this regard the panel considered the judgment of Mrs Justice Cox in the case of *CHRE v NMC and Grant* in reaching its decision. In paragraph 74, she said:

> *'In determining whether a practitioner's fitness to practise is impaired by reason of misconduct, the relevant panel should generally consider not only whether the practitioner continues to present a risk to members of the public in his or her current role, but also whether the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances.'*

In paragraph 76, Mrs Justice Cox referred to Dame Janet Smith's "test" which reads as follows:

> *'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or*

determination show that his/her/ fitness to practise is impaired in the sense that S/He:

a) *has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*

b) *has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*

c) *has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*

d) *...'*

The panel found limbs a, b and c engaged in this case.

The panel found that in administering an incorrect amount of lithium and subsequently failing to undertake medication training and provide adequate reflection, Mr Deeney placed patients at a risk of harm. The panel also found that Mr Deeney's actions placed Patient A, other patients, staff, himself and the community at risk of harm. In not following infection control procedures, the panel found that Mr Deeney placed patients at risk of harm through potential exposure to COVID-19. The panel noted that Patient A had been suspected of sexually assaulting females in the community and by taking him out of isolation, the panel was of the view that this placed patients and staff at a risk of harm, and if he absconded, members of the community would have been at risk of harm. The panel also found that in taking Patient A to his motorcycle without a risk assessment and consultation with the MDT, Mr Deeney placed Patient A, himself and the public at a risk of harm. The panel also found that Mr Deeney, in failing to appropriately respond to the incident involving Patient B, placed Patient B at a risk of harm.

Having found misconduct in respect of all of the charges found proved, the panel found that Mr Deeney's actions and omissions brought the nursing profession into disrepute. The panel was of the view that nurses are expected to undertake mandatory training to ensure best practice and patient safety. In breaching infection control procedures, creating a potentially dangerous situation for Patient A and other patients and staff, the panel found that Mr Deeney's actions brought the profession into disrepute. The panel also found that Mr Deeney's response to the incident in respect of Patient B, in failing to assist, directing anger and shouting at junior colleagues and telling them to let the patient fall, brought the profession into disrepute.

The panel found that Mr Deeney's refusal to complete mandatory training, strengthen his practice following a medication error, placing patients at a risk of harm and acting unprofessionally breached fundamental tenets of the profession.

The panel considered whether the misconduct in this case is remediable and capable of being addressed. The panel was of the view that when taking all of the charges together, there appears to be a pattern of behaviour which raises some attitudinal concerns. The panel noted that Mr Deeney appears to have a disregard for policy and procedure and failed to take steps to reflect and address a medication error. The panel also noted Mr Deeney's behaviour in respect of the incident involving Patient B and was of the view that failing to assist colleagues in de-escalation, acting in an intimidating and aggressive manner and telling his colleagues to take action that could potentially harm a patient raises serious attitudinal concerns. The panel noted that, whilst not impossible, concerns that are attitudinal in nature are inherently difficult to remediate.

The panel noted that Mr Deeney, who had recently disengaged with the fitness to practise process, had not provided any reflection or meaningful responses to the charges. The panel was of the view that in the absence of any insight, remorse or evidence of how Mr Deeney has addressed the concerns identified in his practice, there is a high risk of repetition of the conduct and a consequent risk of harm to patients, colleagues and the

public. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

The panel bore in mind that the overarching objectives of the NMC; to protect, promote and maintain the health, safety, and well-being of the public and patients, and to uphold and protect the wider public interest. This includes promoting and maintaining public confidence in the nursing and midwifery professions and upholding the proper professional standards for members of those professions.

In addition, the panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case given the nature and seriousness of the charges found proved and the public protection concerns identified. The panel therefore also finds Mr Deeney's fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that Mr Deeney's fitness to practise is currently impaired.

Decision and reasons on application for hearing to be held in private

Before making submissions at the sanction stage, Mr Ross made an application pursuant to Rule 19 of the Rules for parts of this hearing to be held in private. He submitted that he will be making some reference to Mr Deeney's health during his submissions on sanction. Mr Ross referred to the principle of open justice and the public interest in these hearings being held in public. However, he submitted that Mr Deeney's right to keep matters relating to health in private outweighed the public interest in having these parts of the hearing in public. Mr Ross submitted that matters relating to Mr Deeney's health are sufficiently distinguishable so it would be possible to go into private session for these parts of the hearing.

The legal assessor reminded the panel that while Rule 19(1) provides, as a starting point, that hearings shall be conducted in public, Rule 19(3) states that the panel may hold hearings partly or wholly in private if it is satisfied that this is justified by the interests of any party or by the public interest.

Having heard that matters relating to Mr Deeney's health can be separated out, the panel determined to hear these parts of the hearing in private in order to protect his right to privacy.

Sanction

The panel has considered this case very carefully and has decided to make a striking-off order. It directs the registrar to strike Mr Deeney's name off the NMC register. The effect of this order is that the NMC register will show that Mr Deeney has been struck-off the register.

In reaching this decision, the panel has had regard to all the evidence that has been adduced in this case and had careful regard to the Sanctions Guidance (SG) published by the NMC. The panel accepted the advice of the legal assessor.

Submissions on sanction

Mr Ross informed the panel that the NMC sanction bid is that of a striking off order. He referred the panel to the SG, and submitted that balancing all of the factors in this case, a striking off order is the most appropriate and proportionate sanction. Mr Ross identified a number of aggravating and potentially mitigating features of this case. He referred the panel to the NMC guidance on *'Striking off order*' (Reference: SAN-3e Last Updated 10/01/2020) and invited the panel to have particular regard to the following key considerations:

> *'-Do the regulatory concerns about the nurse, midwife or nursing associate raise fundamental questions about their professionalism?*
>
> *-Can public confidence in nurses, midwives and nursing associates be maintained if the nurse, midwife or nursing associate is not removed from the register?*
>
> *-Is striking-off the only sanction which will be sufficient to protect patients, members of the public, or maintain professional standards?'*

Mr Ross submitted that Mr Deeney's attitudinal concerns appear to be deep-rooted and his behaviour is fundamentally incompatible with him continuing to practise as a registered nurse. He submitted that a striking off order is the only order that would sufficiently protect the public and maintain public confidence in professional standards.

Decision and reasons on sanction

Having found Mr Deeney's fitness to practise currently impaired, the panel went on to consider what sanction, if any, it should impose in this case. The panel has borne in mind that any sanction imposed must be appropriate and proportionate and, although not intended to be punitive in its effect, may have such consequences. The panel had careful

regard to the SG. The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features:

- Mr Deeney demonstrated a lack of ownership of and a lack of insight into his failings.
- He showed an absence of remorse and demonstrated a lack of willingness to address the concerns in his practice.
- Mr Deeney's misconduct did not arise during an isolated incident, it occurred on multiple occasions over a significant period of time (between October 2020 and July 2021).
- The misconduct, although wide-ranging, presented a common thread of attitudinal concerns.
- Mr Deeney placed vulnerable patients, colleagues and the public at a risk of serious harm.
- Mr Deeney's actions in intimidating junior members of staff was in the panel's judgement wholly unacceptable and presented a risk to workplace culture and to patient safety.

The panel gave careful consideration to any potentially mitigating features in this case and it concluded that there were none. [PRIVATE].

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness and nature of the case. Furthermore, having found that there is a real risk of repetition of the misconduct and Mr Deeney's fitness to practise currently impaired on public interest grounds, the panel determined that an order that does not restrict his practice would place patients and the public at a risk of serious harm. The panel decided that it would be neither proportionate nor in the public interest to take no further action.

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict Mr Deeney's practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that Mr Deeney's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the seriousness of the case. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on Mr Deeney's registration would be a sufficient and appropriate response. The panel determined that whilst some of the charges found proved are clinical in nature, and could potentially be addressed through retraining, Mr Deeney's lack of engagement, insight and deep-seated attitudinal concerns mean that there are no practical or workable conditions that could be formulated. As identified previously, Mr Deeney has been unwilling to reflect on his misconduct, address failings or engage fully with his regulator. The panel therefore found that a conditions of practice order would not adequately protect the public or satisfy the public interest in this case.

The panel then went on to consider whether a suspension order would be an appropriate sanction. The SG states that suspension order may be appropriate where some of the following factors are apparent:

- *'A single instance of misconduct but where a lesser sanction is not sufficient;*
- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *No evidence of repetition of behaviour since the incident;*
- *The Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour:'*

The panel found that the misconduct did not arise during an isolated incident, it occurred on multiple occasions over a significant period of time (between October 2020 and July 2021). The panel also found that although wide-ranging, attitudinal concerns were a common thread and inextricably intertwined with the charges. The panel determined that in refusing to undertake mandatory training, completing inadequate reflection, refusing to put concerns right, contravening policy and procedure and his treatment of patients and colleagues, there is clear evidence that Mr Deeney has a deep-seated attitudinal problem. Furthermore, the panel was of the view that Mr Deeney's disengagement from these fitness to practise proceedings demonstrates a disregard for his regulator and the profession.

The panel noted that Mr Deeney has been subject to an interim suspension order and has been prevented from practising as a registered nurse while the NMC carried out its investigation. There is no evidence of repetition of the behaviour, however, the panel could not be satisfied that had he not been subject to an interim suspension order, Mr Deeney would not have repeated the misconduct. The panel found that Mr Deeney has no insight into his failings and as previously identified, there is a real risk of repetition of the misconduct and a consequent risk of serious harm to patients, colleagues and the public.

In this particular case, the panel determined that a suspension order would not be a sufficient, appropriate or proportionate sanction.

Finally, in looking at a striking-off order, the panel took note of the following paragraphs of the SG:

- *Do the regulatory concerns about the nurse or midwife raise fundamental questions about their professionalism?*
- *Can public confidence in nurses and midwives be maintained if the nurse or midwife is not removed from the register?*
- *Is striking-off the only sanction which will be sufficient to protect patients, members of the public, or maintain professional standards?*

Mr Deeney's actions were serious departures from the standards expected of a registered nurse, and are fundamentally incompatible with him remaining on the NMC Register. The panel was of the view that the findings in this particular case demonstrate that Mr Deeney's actions were serious and to allow him to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body.

Given its findings in respect of Mr Deeney having a deep-seated attitudinal issue, that there is real risk of repetition of the misconduct and a consequent risk of serious harm to patients, colleagues and the public, the panel determined that a striking off order is the only sanction sufficient to protect patients, colleagues and the public. Having regard to the effect of Mr Deeney's actions in bringing the profession into disrepute by adversely affecting the public's view of how a registered nurse should conduct himself, the panel has concluded that nothing short of this would be sufficient in this case.

Balancing all of these factors and after taking into account all the evidence before it during this case, the panel determined that the appropriate and proportionate sanction is that of a striking-off order.

The panel considered that this order was both necessary to protect the public and to mark the importance of maintaining public confidence in the profession, and to send to the public and the profession a clear message about the standard of behaviour required of a registered nurse.

Interim order

As the striking-off order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order is required in the specific circumstances of

this case. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in Mr Deeney's own interests until the striking-off order takes effect.

The panel accepted the advice of the legal assessor in which he referred the panel to the NMC guidance on *'Interim orders after a sanction is imposed'* Reference: SAN-5 Last Updated 03/02/2021).

Submissions on interim order

The panel took account of the submissions made by Mr Ross. He invited the panel to impose an interim suspension order to cover the appeal period. Mr Ross submitted that an interim suspension order is necessary to protect the public and to address the public interest in this case. He submitted that it would be unusual, given the panel's findings and public protection issues identified to not impose an interim suspension order in the circumstances.

Decision and reasons on interim order

The panel was satisfied that an interim order is necessary for the protection of the public and is otherwise in the public interest. The panel had regard to the seriousness of the facts found proved and the reasons set out in its decision for the substantive order in reaching the decision to impose an interim order. The panel has found that there is a real risk of repetition of the misconduct so that an interim suspension order is necessary to protect the public as well as being in the public interest.

The panel considered whether to impose an interim conditions of practice order but determined that it would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive order. The panel therefore imposed an interim suspension order for a period of 18 months to cover any appeal period.

If no appeal is made, then the interim suspension order will be replaced by the striking off order 28 days after you are sent the decision of this hearing in writing.

That concludes this determination.

This will be confirmed to Mr Deeney in writing.