Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday 14 February 2022 – Thursday 17 February 2022
and Monday 21 February 2022

Nursing and Midwifery Council
Virtual Hearing

Name of registrant:	**Eugene Peter Michael Briody**
NMC PIN:	07F3085E
Part(s) of the register:	Registered Nurse – Sub Part 1 Mental Health Nursing – September 2007
Area of registered address:	Warwickshire
Type of case:	Misconduct
Panel members:	David Crompton (Chair, Lay member) Michael Glickman (Lay member) Mary Jane Scattergood (Registrant member)
Legal Assessor:	John Moir
Hearings Coordinator:	Elena Nicolaou
Nursing and Midwifery Council:	Represented by Yvonne Ferns, Case Presenter
Mr Briody:	Not present and unrepresented
Facts proved:	Charges 1a, 1b, 2, 3, 4, 5 and 6
Facts not proved:	None
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 Briody was not in attendance and that the Notice of Hearing letter had been sent to Mr Briody's registered address by first class delivery on 6 January 2022.

The panel had regard to the Royal Mail 'Track and trace' printout which showed the Notice of Hearing was delivered to Mr Briody's registered address on 6 January 2022. It was signed for against the printed name of 'Briody'.

The panel took into account that the Notice of Hearing provided details of the allegation, the time, dates and virtual link to the hearing and, amongst other things, information about Mr Briody's right to attend, be represented and call evidence, as well as the panel's power to proceed in his absence.

Ms Ferns, 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 accepted the advice of the legal assessor.

In the light of all of the information available, the panel was satisfied that Mr Briody 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 Briody

The panel next considered whether it should proceed in the absence of Mr Briody. It had regard to Rule 21 and heard the submissions of Ms Ferns who invited the panel to continue in the absence of Mr Briody. She submitted that Mr Briody had voluntarily absented himself.

Ms Ferns submitted that there had been no engagement by Mr Briody since his email to the NMC, dated 20 August 2021, in relation to these proceedings and, as a consequence, there was no reason to believe that an adjournment would secure his attendance on some future occasion. She submitted that there has been no request for an adjournment or postponement of the hearing from Mr Briody, and there is no information to suggest an adjournment would serve any useful purpose in this case. She submitted Mr Briody was aware of the hearing and that he has voluntarily absented himself. She submitted that there is public interest in the expeditious disposal of this hearing, and public protection issues.

Mr Briody's email to the NMC, dated 20 August 2021, stated that:

> *'…I will not be attending and have no legal representation… and no case to answer…'.*

The panel accepted the advice of the legal assessor.

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 *R v Jones (Anthony William) (No.2) [2002] UKHL 5.*

The panel has decided to proceed in the absence of Mr Briody. In reaching this decision, the panel has considered the submissions of Ms Ferns and the advice of the legal assessor. It has had particular regard to the factors set out in the decision of *R v Jones* and *General Medical Council v Adeogba [2016] EWCA Civ 162* and *Thorneycroft v Nursing and Midwifery Council [2014] EWHC 1565 (Admin),* 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 Briody;

- Mr Briody has not engaged with the NMC since his email to the NMC, dated 20 August 2021, and has not responded to any of the letters sent to him about this hearing;
- There is no reason to suppose that adjourning would secure his attendance at some future date;
- One witness has attended today to give live evidence, others are due to attend;
- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- The charges relate to events that occurred in 2019;
- Further delay may have an adverse effect on the ability of witnesses accurately to recall events; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Mr Briody in proceeding in his absence. Although the evidence upon which the NMC relies will have been sent to him at his registered address, he has made no response to the allegations. He 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 Briody's decisions 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.

In these circumstances, the panel has decided that it is fair, appropriate and proportionate to proceed in the absence of Mr Briody. The panel will draw no adverse inference from Mr Briody's absence in its findings of fact.

Decision and reasons on application to amend the charge

The panel heard an application made by Ms Ferns to amend the wording of charge 4, following oral evidence that had been heard from Witness 1.

The proposed amendment was to amend the wording of charge 4 to remove the word 'controlled'. It was submitted by Ms Ferns that the proposed amendment would provide clarity as a result of the oral evidence heard by Witness 1. She submitted that no injustice or prejudice would be caused to Mr Briody, and that he would not suffer any disadvantage, should this proposed amendment be made. The proposed amendment would instead read:

4. *Whilst working at Canning Court Care Home, failed to administer and/or sign for ~~controlled~~ drugs on at least 5 occasions;*

The panel accepted the advice of the legal assessor and had regard to Rule 28 of 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The panel considered that although Mr Briody is not present at this hearing or represented, there would be an element of unfairness and disadvantage, should he not be given an opportunity to make any observations on the proposed amendment to charge 4 as it would now be possible to find the charge proved which may not have been the case with the original charge.

The panel considered Mr Briody's email to the NMC, dated 20 August 2021, in which he stated that there was no case to answer, indicating that he had given his view on the charges. It was of the view that should Mr Briody had been present and/or represented at this hearing, submissions would have been made on the proposed amendment of the charge and it considered that, out of fairness to him, he should have an opportunity to comment.

The panel noted that its role is to consider the wider public interest and public protection issues present, and the nature of the actions and misconduct as stated within the charges. The panel raised its concerns to Ms Ferns and suggested that it would be fair to make attempts at contacting Mr Briody via the contact details the NMC have for him, with a cut off time of 12:00 noon on Tuesday 15 February 2022, for a response prior to making its decision on the application.

The panel did not go any further with the application at this stage.

On Tuesday 15 February 2022, at 12:10pm, the panel reconsidered the application to amend charge 4. Ms Ferns informed the panel that attempts had been made by the NMC on Monday 14 February 2022 via telephone and email, as well as further attempts made on Tuesday 15 February 2022. Ms Ferns stated that the NMC had not received a 'bounce back' email from Mr Briody's email address, or any responses from him in relation to this matter. She highlighted that it would be Mr Briody's responsibility to keep his contact details with the NMC up to date.

The panel considered the information it had received in relation to this matter and the multiple attempts that had been made to contact Mr Briody. On Monday 14 February 2022 during its first consideration of the application, the panel felt that it would not be possible to make an amendment to charge 4 without a degree of prejudice to Mr Briody, as he is not present and/or represented at this hearing. The panel had concerns about fairness towards Mr Briody as well as having to balance its wider remit with taking into account the public protection issues present in this case.

Following on from this, the panel decided that such an amendment, as applied for, was in the interest of justice. The panel considered the attempts made by the NMC at making contact with Mr Briody, and as no responses had been received from him, it was satisfied that it gave him the opportunity to make observations and that it would be both fair and reasonable for the proposed amendment to be allowed. It was therefore appropriate to allow the amendment of charge 4, as applied for, to ensure clarity and accuracy.

Once the panel began to make its decision on the facts of the case, another issue was raised in relation to the wording of the stem of charge 1, in particular the words *'related to second checking'*.

The panel was of the view that this wording was superfluous and unhelpful in relation to sub-charge 1a, as it related more to the context of sub-charge 1b. The panel was of the view that by removing these words, it would provide greater clarity and accuracy. This proposed amendment would not cause any disadvantage or prejudice to either party, as it is simply a matter of removing the unnecessary wording in order to provide more accuracy to the charge. The proposed amendment would instead read:

'That you, a registered nurse:

1. *Whilst working at Canning Court Care Home, failed to follow controlled drug policies ~~relating to second checking~~, in that;'*

The panel accepted the advice of the legal assessor and had regard to the Rules.

After taking instructions from the NMC, Ms Ferns submitted that she had discussed the panel's proposed amendment to the stem of charge 1 and the NMC had stated they understood why the panel had suggested such an amendment. She submitted the NMC do not have any objections to the proposed amendment and confirmed that there is no injustice caused to either party, and that it would provide greater clarity.

It was therefore appropriate to allow the amendment of the stem of charge 1, as applied for, to ensure clarity and accuracy.

Details of charge (as amended)

That you, a registered nurse:

1. Whilst working at Canning Court Care Home, failed to follow controlled drug policies, in that;

    a. Failed to remove prescribed patches containing Fentanyl on at least 3 occasions; **[PROVED]**
    b. Failed to obtain a second signature and/or witness when administering controlled drugs on at least 3 occasions; **[PROVED]**

2. Whilst working at Canning Court Care Home, replicated a colleague's signature on the controlled drug register on at least 3 occasions; **[PROVED]**

3. Your conduct at charge 2 above was dishonest in that you intended anyone reading said signatures to believe that your colleague had signed the controlled drug register; **[PROVED]**

4. Whilst working at Canning Court Care Home, failed to administer and/or sign for drugs on at least 5 occasions; **[PROVED]**

5. Whilst working at Stratford Bentley Nursing Home, failed to disclose that you were subject to a disciplinary investigation; **[PROVED]**

6. Your conduct at charge 5 above was dishonest in that you intended for Stratford Bentley Nursing Home to believe that you were not subject to disciplinary investigation; **[PROVED]**

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

Decision and reasons on facts

In reaching its decisions on the disputed facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Ms Ferns.

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

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:

- Witness 1: Former Home Manager, Canning Court Care Home;
- Witness 2: Former Registered Nurse, Canning Court Care Home;
- Witness 3: Former Home Manager, Stratford Bentley Nursing Home.

Background

The charges arose whilst Mr Briody was employed as a registered nurse at Canning Court Care Home ('the Home') run by BUPA UK.

The charges relate to a number of concerns that occurred within the Home, including a breach of the controlled drug (CD) procedure by failing to remove old patches containing Fentanyl when applying new ones on residents, on at least three occasions.

It is alleged that Mr Briody did not seek a second signature/witness when administering a CD, on at least three occasions, and falsified signatures of another colleague in the CD book on at least three occasions. Mr Briody also failed to sign for drugs on at least five occasions for residents that had medications due whilst he was on shift.

It is alleged that during Mr Briody's employment at Stratford Bentley Nursing Home, he failed to inform the employer that he was subject to an internal disciplinary investigation by the Home.

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 by the NMC.

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

Charge 1a

1. Whilst working at Canning Court Care Home, failed to follow controlled drug policies, in that;

    a. Failed to remove prescribed patches containing Fentanyl on at least 3 occasions;

This charge is found proved.

In reaching this decision in relation to charge 1a, the panel took into account all of the documentary and oral evidence before it. The panel was of the view that old patches had been left on residents' bodies after 72 hours, on three occasions.

In relation to the first occasion, the panel considered the photograph of a patch on Resident C that remained on their body from 17 August 2019 to 20 August 2019 (the

appropriate period for the effective use of the patch). The patch should have been removed by Mr Briody on application of the new patch, on 20 August 2019. It considered that the patch was left on Resident C's body until 13 September 2019, when the photograph had been taken. This information also corresponds with Witness 1's statement.

In relation to the second occasion, the panel considered the Patch Application Record for Resident B and noted that a new patch had been applied on 2 September 2019. The old patch had not been removed at this point and the Medication Administration Record (MAR) chart had confirmed that Mr Briody was the nurse on shift that day and was responsible for the administration of medication for this resident. The photograph of the patch on resident B, taken on 13 September 2019, confirmed that the old patch had not been removed on 2 September 2019. This information also corresponds with Witness 1's statement.

In relation to the third occasion, the panel considered that the old patch on Resident A should have been removed on 8 September 2019 before a new one had been applied. The MAR chart had also confirmed that Mr Briody was the nurse on shift that day and was responsible for the administration of medication for this resident. The photograph of the patch on Resident A confirmed that the old patch had not been removed.

This information also corresponds with Witness 1's statement. The panel was of the view that Witness 1 was a reliable and credible witness, and that her oral evidence was consistent with her witness statement.

Based on all of the evidence before it, the panel concluded that it was more likely than not that Mr Briody failed to follow controlled drug policies, in that he failed to remove prescribed patches on at least three occasions.

The panel therefore finds charge 1a proved.

Charge 1b

b. Failed to obtain a second signature and/or witness when administering controlled drugs on at least 3 occasions;

This charge is found proved.

In reaching its decision in relation to charge 1b, the panel considered all of the documentary and oral evidence before it.

The panel considered that there is clear evidence that some signatures for Witness 2 were falsified on at least three occasions. Witness 2 was very clear in his evidence that some signatures were false and also highlighted that he was not on duty for some of those particular shifts. Witness 2 was clear in that, at the relevant times on the relevant days of the shifts, he was the only other registered nurse available within the Home's policy for witnessing the administration of these particular drugs, and that he did not sign this himself. Witness 2 also took the panel to the particular shifts where he had signed off drugs in the CD book to demonstrate what his genuine signature looked like.

The panel considered the roster that clearly shows Mr Briody was on duty for the shifts in question, and that in accordance with the Home's policy he had the only keys for the drugs room containing the CD book. Mr Briody would also have been the nurse in charge for administering the required medications for the residents.

The panel was of the view that Witness 2 was a reliable and credible witness, and that his oral evidence was consistent with his witness statement.

Based on the evidence before it, the panel concluded that on the balance of probabilities, it was more likely than not that Mr Briody had failed to obtain a second signature and/or witness when administering controlled drugs on at least three occasions.

The panel therefore finds charge 1b proved.

Charge 2

2. Whilst working at Canning Court Care Home, replicated a colleague's signature on the controlled drug register on at least 3 occasions;

This charge is found proved.

In reaching this decision, the panel took into account all of the evidence before it, that was similar to that of charge 1b.

Witness 2 was clear in his evidence that on those particular occasions, he had not signed for those drugs and he was not on duty for some of those shifts. It is clear from the roster that on 3 September 2019, Witness 2 was not on duty. On 9 September 2019, Witness 2 was on duty but he stated that the signature in the CD book was not his. This corresponds with Witness 2's statement.

Witness 2 took the panel to the particular shifts on 14 and 15 September 2019, where he had signed off drugs in the CD book, to demonstrate what his signature looked like and how it differed from the falsified ones. This also corresponds with Witness 2's statement.

The panel considered the roster that clearly shows Mr Briody was on duty for the shifts in question, and that he had the only keys for the drugs room containing the CD book. Mr Briody would also have been the nurse in charge for administering the required medications for the residents.

The panel was of the view that Witness 2 was a reliable and credible witness, and that his oral evidence was consistent with his witness statement.

Based on the evidence before it, the panel concluded that Mr Briody replicated a colleague's (Witness 2) signature on the controlled drug register on at least three occasions.

The panel therefore finds charge 2 proved.

Charge 3

3. Your conduct at charge 2 above was dishonest in that you intended anyone reading said signatures to believe that your colleague had signed the controlled drug register;

This charge is found proved.

In reaching this decision, the panel took into account all of the oral and documentary evidence before it.

The panel was of the view that Mr Briody must have known that Witness 2 had not signed the CD book, and that he was aware that he was falsifying somebody else's signature which was not an appropriate action to take. This is especially concerning as a registered nurse would have had specific training in relation to this and would be aware of the importance of the appropriate management of CDs, as errors could result in harm to a resident.

The panel was of the view that Mr Briody knew it was a requirement for a registered nurse undertaking the CD process to have a suitable second witness. The panel considered that Mr Briody could have left the boxes blank, but he chose to ensure there was a signature in the second witness box, albeit falsified and not his own name, to make it appear the CD policy had been complied with.

Witness 2 was clear in his evidence that these were not his signatures and even made a formal complaint to his manager about it. No other member of staff could have had access to the CD book, or even the drugs cupboard, as heard in oral evidence from Witness 1 and 2. Mr Briody would have been aware that this action was inappropriate as correct procedure for administering CDs was a clear Home policy, underpinned by law, that he was aware of but had chosen not to comply with.

The panel decided that it was Mr Briody's intention to mislead and make anyone reading the CD book think that he had obtained a second witness signature, in particular Witness 2's signature.

Any reasonable member of the public would also perceive these actions as dishonest.

The panel was of the view that Witness 2 was a reliable and credible witness, and that his oral evidence was consistent with his witness statement.

Based on the information before it, the panel concluded it was more likely than not that Mr Briody's conduct at charge 2 above was dishonest in that he intended anyone reading said signatures to believe that his colleague (Witness 2) had signed the controlled drug register.

The panel therefore finds charge 3 proved.

Charge 4

4. Whilst working at Canning Court Care Home, failed to administer and/or sign for drugs on at least 5 occasions;

This charge is found proved.

In reaching this decision, the panel took into account all of the documentary and oral evidence before it.

The panel considered the oral evidence of Witness 1 in which she pointed out the obvious omissions that had been highlighted on the MAR charts for the particular residents. Based on this, it is clear from this evidence that the medication had not been signed for or administered.

The roster provided in evidence and the oral evidence of Witness 1 confirmed that Mr Briody was the only registered nurse working on the unit/floor for these shifts and therefore accountability for effective medicine administration rested solely with him. No signatures can be seen in the relevant boxes on the MAR charts, at the times the medication should have been administered.

This corresponds with Witness 1's statement and oral evidence, and is also evident from the residents' MAR charts:

- Resident D's MAR chart, which shows that Lorazepam and Timodine had not been administered at bedtime on 11 September 2019.
- For Resident E, Mirtazapine had not been administered at bedtime on 11 September 2019, as this shows a signature has been crossed out and not replaced, and from Witness 1's oral evidence, this would suggest a medication had not been administered. For Resident E, Docusate had not been administered at bedtime on 9 and 11 September 2019, and Paracetamol had not been administered on 11 September 2019.
- For Resident F, Atorvastatin and Trazodone had not been administered at bedtime on 11 September 2019.
- For Resident G, Baclofen had not been administered at bedtime on 11 September 2019.
- For Resident H, Mirtazapine and Hylo-Forte had not been administered at bedtime on 11 September 2019.

The panel considered the Home's policy and evidence given by Witness 1 in which she stated that medication should be taken directly to residents' bedsides and their MAR charts should be completed as appropriate.

The panel was of the view that Witness 1 was a reliable and credible witness, and that her oral evidence was consistent with her witness statement.

Based on the clear information before it, the panel concluded it was more likely than not that Mr Briody failed to administer and/or sign for drugs on at least five occasions.

The panel therefore finds charge 4 proved.

Charge 5

5. Whilst working at Stratford Bentley Nursing Home, failed to disclose that you were subject to a disciplinary investigation;

This charge is found proved.

In reaching this decision, the panel took into account all of the documentary and oral evidence before it from Witness 3.

Witness 3 was clear in her evidence that Mr Briody had ample opportunity to mention to his employer that he was subject to an internal investigation by the Home. Witness 3 stated in her evidence that Mr Briody had commenced his employment with Stratford Bentley Nursing Home on 24 September 2019, and that he worked three shifts during his two-week induction period, on one of which Mr Briody was directly shadowed by Witness 3. Witness 3 was clear that Mr Briody had contact with her on multiple occasions and failed to inform her of the internal investigation with the Home.

It is clear in Witness 1's statement that Mr Briody was suspended on 17 September 2019 when he did not attend his disciplinary meeting, which predates him commencing work at Stratford Bentley Nursing Home. Following Witness 3's conversation with one of the management team at the Home who had informed her of Mr Briody's disciplinary investigation, Witness 3 had contacted him and asked him directly about the investigation, which Mr Briody flatly denied. Witness 3 stated that Mr Briody had told her that this was "not correct" and that he had left the Home on his own accord.

Although there is no documentary evidence that supports Witness 3's oral evidence, it is consistent with her NMC witness statement. The panel was of the view that Witness 3 was a reliable and credible witness.

In the absence of an alternative explanation for the circumstances in relation to Mr Briody's investigation, the panel concluded on the balance of probabilities that it was more likely than not that whilst working at Stratford Bentley Nursing Home, he failed to disclose that he was subject to a disciplinary investigation.

The panel therefore finds charge 5 proved.

Charge 6

6. Your conduct at charge 5 above was dishonest in that you intended for Stratford Bentley Nursing Home to believe that you were not subject to disciplinary investigation;

This charge is found proved.

In reaching this decision, the panel took into account all of the documentary and oral evidence before it from Witness 3.

The panel was of the view that Mr Briody flatly denied his disciplinary investigation with the Home when Witness 3 had asked him about it directly, telling her that this was “not correct” and that he had left the Home of his own accord. The panel decided that Mr Briody’s state of mind at the time must have been that he was attempting to conceal the facts at Stratford Bentley Nursing Home, so he could continue to work there. It considered that Mr Briody was deliberately dishonest.

The panel considered that Mr Briody had a fixed date for a disciplinary meeting, which he did not attend, and so he was aware of the meeting due to take place. The date of the disciplinary meeting predates the conversation that Witness 3 had with Mr Briody in relation to the investigation, when he was directly asked about it and denied it.

This evidence directly corresponds with Witness 3’s statement. The panel was of the view that Witness 3 was a reliable and credible witness, and that her oral evidence was consistent with her witness statement.

Based on the information before it, the panel concluded that Mr Briody’s conduct at charge 5 above was dishonest in that he intended for Stratford Bentley Nursing Home to believe that he was not subject to disciplinary investigation.

The panel therefore finds charge 6 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 Briody’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 Briody'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.'*

Ms Ferns invited the panel to take the view that the facts found proved amount to misconduct. She provided the panel with written submissions which are as follows:

> *'Having found the facts proved for all the charges, the panel should now consider whether the facts amount to misconduct and, if so, whether the Registrant's fitness to practise is currently impaired.*
>
> *This is a two-stage process:*
>
> 1) *The panel must determine whether the facts found proved amount to misconduct*

2) *and then only if the facts found proved amount to misconduct, decide whether in all the circumstances, the registrant's fitness to practise is currently impaired as a result of that misconduct*

Misconduct, in the regulatory context, must amount to serious professional misconduct.

There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practice as a Registrant's suitability to remain on the register unrestricted.

The panel in reaching its decision, has a statutory duty to protect the public and maintain public confidence in the profession. There is no burden or standard of proof at this stage and the panel should therefore exercise its own professional judgement.

Background

As you have heard all the evidence in this case, a very brief background of this case is as follows:

The Registrant was employed as Registered Nurse at Canning Court Care Home from 28 January 2019 until 24 September 2019.

The charges found proved arose whilst Mr Briody was employed as a registered nurse at Canning Court Care Home ("the Home") run by BUPA UK. The charges relation a number of concerns that occurred within the Home, including a breach of the controlled drug (CD) procedure by failing to remove old patches containing Fentanyl when applying new ones on residents, on at least three occasions. In addition, not seeking a second signature/witness when administering a CD, on at least three occasions, and falsifying signatures of another colleague in the CD book on at least three occasions. Failing to sing for drugs on at least five occasions for

residents that had medications due whilst he was on shift and lastly failing to inform his employer at Stratford Bentley Nursing Home that he was subject to an internal disciplinary investigation by the Home. The panel concluded in their determination on the facts, that it was more likely than not that Mr Briody's conduct at Charge 2 was dishonest in that he intended anyone reading the signature (in the 'witnessed by box') would believe that his colleague (witness 2) had signed the controlled drug register.

The panel also concluded that Mr Briody's conduct at charge 5 was dishonest in that he intended for Stratford Bentley Nursing Home to believe that he was not subject to disciplinary investigation.

I submit that the Registrant's repeated actions of dishonesty are extremely serious and fall short of what would be expected of a Registered Nurse in the circumstances. The areas of concerns identified relate to two allegations of dishonesty and a significant number of other failings relating to record keeping and medication administration and involves a serious departure from expected standards and put patients at risk of harm and submitted that these failings are likely to cause risk to patients in the future.

Further it raises concerns about the basics of his professionalism, as well as the public's ability to trust the profession. The prolonged period of these failings elevates the seriousness of this case.

I invite the panel to take the view that the facts found proved amount to misconduct.

I refer the panel to The Code: Professional standards of practice and behaviour for nurses and midwives (2015) (the Code).

I submit that the following paragraphs of the 2015 NMC Code of Conduct have been breached:

1 Treat people as individuals and uphold their dignity

To achieve this, you must:

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

10 Keep clear and accurate records relevant to your practice

This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.

To achieve this, you must:

10.1 complete records at the time or as soon as possible after an event, recording if the notes are written some time after the event

10.3 complete records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements

18 Advise on, prescribe, supply, dispense or administer medicines within the limits of your training and competence, the law, our guidance and other relevant policies, guidance, and regulations

To achieve this, you must:

18.2 keep to appropriate guidelines when giving advice on using controlled drugs and recording the prescribing, supply, dispensing or administration of controlled drugs

18.3 make sure that the care or treatment you advise on, prescribe, supply, dispense or administer for each person is compatible with any other care or treatment they are receiving, including (where possible) over-the-counter medicines

20 Uphold the reputation of your profession at all times

20.1 keep to and uphold the standards and values set out in the Code

I submit that the Registrant's actions amount to misconduct.

I refer the panel to the case of Roylance v GMC (No. 2) [2000] 1 AC 311 where misconduct was defined by Lord Clyde as:

"a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be found by reference to the rules and standards ordinarily required to be followed by a [medical] practitioner in the particular circumstances".

I submit that the Registrant's actions were extremely serious and inappropriate both individually and collectively and fall seriously short of the conduct of a registered nurse and amount to misconduct.'

Submissions on impairment

Ms Ferns 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).*

Ms Ferns provided written submissions which are as follows:

> *'If you conclude that the Registrant's actions amount to misconduct, you should then move on to consider whether on the basis of the facts found proved, the Registrant's fitness to practise is currently impaired by reason of his misconduct.*
>
> *On the issue of impairment, there is need to have regard to protecting the public and the wider public interest. This includes the need to declare and maintain proper standards and maintain public confidence in the nursing profession and in the NMC as a regulatory body. Therefore, in considering the Registrant's fitness to practise the panel should remind itself of its duty to protect and satisfy the wider duty to protect the public interest which includes declaring and upholding proper standards of conduct and behaviour, and the maintenance of public confidence in the profession and the regulatory process.*
>
> *I refer the panel to the case of Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant [2011] EWHC 927 (Admin), where Mrs Justice Cox 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 of the judgment in Grant, Mrs Justice Cox approved of the approach formulated by Dame Janet Smith 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 she/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.*

d) *has in the past acted dishonestly and/or is liable to act dishonestly in the future.'*

I submit that limbs a, b, c, and d above are engaged.

In the absence of any remediation, or current safe practice, there remains a risk to the health, safety and wellbeing of the public should the Registrant return to unrestricted practice.

The Registrant has had limited engagement with the NMC and has demonstrated no insight as he has denied the charges and denied that his fitness to practise is currently impaired by reason of his misconduct in all the charges.

In Cohen v GMC [2007] EWHC 581 (Admin), the court set out three matters which it described as being 'highly relevant' to the determination of the question of current impairment:

1. *Whether the conduct that led to the charge(s) is easily remediable*
2. *Whether it has been remedied*
3. *Whether it is highly unlikely to be repeated*

The three questions set out in Cohen (above) can be answered as follows:

1. *The regulatory concerns in this case involve two allegations of dishonesty and a significant number of other failings relating to record keeping and medication administration and display attitudinal concerns in his desire to cut corners and avoid essential protocols and policies. The dishonesty in this case involves a 'deliberate' attempt by the Registrant to mislead others and is premeditated, systematic and somewhat longstanding method of minimising work for the Registrant and avoiding necessary safeguards. I submit that it is difficult to remediate such conduct and behaviour.*

2. *The Registrant has failed to show any insight or remorse or provide evidence of remediation, and this coupled with the attitudinal nature of the concerns, only serves to increase the risk of repetition. Further Mr Briody has denied the allegations in full and seeks to blame a disgruntled "ex-partner". I submit that it is a matter for the panel to determine whether the Registrant has already remediated his conduct in relation to the charges before them and refer the panel to the case of Meadow v GMC (2007) EWCA Civ 1390.*

The question for you is whether in light of the above, due to his misconduct and no evidence of remediation, the Registrant is liable in the future to repeat the behaviour and conduct. In considering whether the Registrant is liable to repeat

matters found proved in the future, you may wish to consider the extent of the Registrant's remorse, remediation, and insight which I submit is completely absent.

You may also wish to consider whether the reputation of the nursing profession would be damaged if the Registrant be permitted to practise unrestricted: the public expect nurses to be honest at all times.

I submit that you may find that the Registrant' actions are so serious and bring the nursing profession into disrepute. Nurses occupy a position of privilege and trust in society and are expected at all times to be professional. I submit that the Registrant's failings relate to core nursing requirements of honesty and integrity and in light of these failings, a finding of current impairment is necessary to declare and uphold proper standards. I submit for the reasons outlined that the Registrant's fitness to practice is currently impairment is necessary to declare and uphold proper standards. I submit for the reasons outlined that the Registrant's fitness to practice is currently impaired, both on the grounds of public protection and the wider public interest. I also submit that a finding of impairment is also necessary to maintain public confidence in the profession and the NMC as a regulator.

I further submit that the Registrant has breached fundamental tenets of the profession relating to honesty and integrity and therefore brought its reputation into disrepute. The public expect nurses to be honest and public confidence in the profession is undermined by dishonest behaviour.

For the reasons above, the Registrant's fitness to practise is currently impaired, both on the grounds of public protection and the wider public interest.

I submit that the Registrant's actions are so serious that a finding of current impairment is required in order to maintain public confidence in the profession and the NMC and to uphold proper professional standards. The public confidence in the profession and the NMC as regulator would, be undermined if that behaviour

was allowed to pass effectively unmarked. You may therefore form the view that the Registrant's misconduct was so serious and that there is a need to declare and uphold the professional standards expected of a registered nurse and to maintain public confidence in the profession and the NMC as regulator.

The question for the panel is whether the Registrant fitness to practise is impaired as of today's date and I refer the panel to the case of Ronald Jack Cohen v General Medical Council [2008] EWHC 581 (Admin).

The overarching objectives of the NMC are to protect, promote and maintain the health, safety, and well-being of the public and patients, to uphold and protect the wider public interest, which includes promoting and maintaining public confidence in the nursing profession and upholding the proper professional standards for members of that profession.

Given the seriousness of this case and the failings identified, I submit that the panel may conclude in the circumstances of this case, a finding of impairment on both grounds of public protection and the wider public interest and that the Registrant's fitness to practice is currently impaired.'

The panel accepted the advice of the legal assessor.

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 Briody's actions did fall significantly short of the standards expected of a registered nurse, and that Mr Briody's actions amounted to a breach of the Code. Specifically:

‘1 Treat people as individuals and uphold their dignity

To achieve this, you must:

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*

10 Keep clear and accurate records relevant to your practice

This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.

To achieve this, you must:

10.1 *complete records at the time or as soon as possible after an event, recording if the notes are written some time after the event*

10.3 *complete records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements*

18 Advise on, prescribe, supply, dispense or administer medicines within the limits of your training and competence, the law, our guidance and other relevant policies, guidance, and regulations

To achieve this, you must:

18.2 *keep to appropriate guidelines when giving advice on using controlled drugs and recording the prescribing, supply, dispensing or administration of controlled drugs*

18.3 *make sure that the care or treatment you advise on, prescribe, supply, dispense or administer for each person is compatible with any other care or treatment they are receiving, including (where possible) over-the-counter medicines*

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'*

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 in relation to charge 1a, this does amount to misconduct as this was not a single isolated incident and was a pattern of repeated behaviour by Mr Briody. The incidents related to CDs and there could have been potential harm caused to residents if old patches remained on the skin after new patches had been applied, in particular an overdose of medication. In relation to charge 1b, there were multiple failures to obtain a second signature/witness and there would be no reasonable explanation as to why Mr Briody failed to undertake this and follow the policy. It is clear from the evidence that has been provided that this occurred on at least three occasions. The panel considered this to be misconduct.

In relation to charge 2, the replication of a colleague's signature would not have occurred by accident and indicated a pattern of repeated behaviour. This was a deliberate act as opposed to simply an omission and was a serious departure from the standards expected of a registered nurse. This would be seen as completely unacceptable by members of the public and the panel considered it to be misconduct.

In relation to charge 3, it was clear that Mr Briody intended to mislead people and that he knew his actions were dishonest. This was a deplorable action and there could be no reasonable explanation as to why Mr Briody undertook this other than a deliberate attempt to mislead others reading the CD book. A registered nurse acting without integrity is a very serious breach of the Code. The panel considered this to be misconduct.

In relation to charge 4, this indicates a repeated pattern of behaviour over a period of months. This is very serious and could have put residents at risk of harm if they did not

receive vital medication that was due. It is unclear as to whether these residents received this medication or not, and if they had, Mr Briody's actions could have put them at risk of overdose if further medication had been administered unwittingly. The panel found that an isolated failure to administer or sign for drugs would not meet the threshold for misconduct. However, the repetition of this behaviour was a serious departure from the standards expected of a registered nurse.

The panel heard evidence from Witness 1 that there had been concerns raised locally about Mr Briody's management of medicines administration. She gave evidence that she had undertaken competence assessment with Mr Briody and was satisfied that his skills and knowledge were adequate. The panel therefore determined that his conduct arose from a disregard for policy not a lack of competence.

The panel noted that there were other missing signatures by other members of staff in the Home, which suggested a possible culture of carelessness and record keeping. However, it considered that this did not detract from the seriousness of the attitudinal issues identified above. The panel therefore considered this amounted to misconduct.

Charge 5 relates to Mr Briody's integrity and his failure to disclose the disciplinary investigation to his new employer. Mr Briody had a duty to disclose this information when he was asked directly by Witness 3, but he had flatly denied it. It was Mr Briody's intention to conceal this information from his employer and this could have caused potential harm to residents and colleagues. The panel therefore considered this amounted to misconduct.

In relation to charge 6, it was clear that Mr Briody intended to mislead people regarding his disciplinary investigation and that he knew he was being dishonest. This was a deplorable action and there would be no reasonable explanation as to why Mr Briody concealed this information other than a deliberate attempt to mislead others. A registered nurse without integrity is a very serious breach of the Code. The panel therefore considered this amounted to misconduct.

The panel found that Mr Briody's actions did fall 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 Briody'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) *has in the past acted dishonestly and/or is liable to act dishonestly in the future.'*

The panel finds that residents were put at risk as a result of Mr Briody's misconduct. Mr Briody's misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. It was satisfied that confidence in the nursing profession would be undermined if its regulator did not find charges relating to dishonesty extremely serious.

The panel was of the view that all four limbs of *Grant* are engaged in this case.

In relation to remorse and insight, Mr Briody has not provided any evidence of this and he has not engaged with the NMC since August 2021. In Mr Briody's last email to the NMC, dated 20 August 2021, he was of the view that there was *'no case to answer'*, apparently indicating that he had denied the charges. The panel considered that dishonesty is difficult to remedy, however there is no evidence that any attempts have been made to do so. The panel has no evidence that Mr Briody has recognised his wrongdoings or acknowledged the impact that they could have had on patients, colleagues, the profession and the public.

The panel considered that forging signatures was an intentional action he chose to undertake, which raises concerns about attitudinal issues. Mr Briody failed to follow the appropriate procedures/policies in relation to medication administration and tried to conceal his actions and subsequently his disciplinary investigation. Mr Briody's actions could have caused significant harm to residents, as excess patches that remained on the body following the application of new ones, could have caused an overdose of medication. Mr Briody also failed to follow procedures for the administration of CDs, as required by the Home's policy and national legislation. This placed residents at serious risk as any medication errors would not have been identified.

The panel decided that a significant likelihood of repetition is still present in the absence of any further information or evidence from Mr Briody, and that there would be a real risk of harm to the public. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

The panel bore in mind 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.

The panel determined that a finding of impairment on public interest grounds is required as a well-informed member of the public would be concerned to learn of Mr Briody's actions, and that public confidence in the profession would be undermined if a finding of impairment were not made in this case. The panel therefore also finds Mr Briody's fitness to practise impaired on the grounds of public interest.

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

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 Briody off the register. The effect of this order is that the NMC register will show that Mr Briody 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

Ms Ferns informed the panel that in the Notice of Hearing, dated 6 January 2022, the NMC had advised Mr Briody that it would seek the imposition of a striking-off order if it found Mr Briody's fitness to practise currently impaired.

Ms Ferns provided written submissions which are as follows:

> *'The position of the NMC in relation to the sanction bid at this stage of the proceedings is that a Striking-off order should be imposed.*
>
> *The NMC has considered the NMC's Sanctions Guidance ('the guidance'), bearing in mind that it provides guidance and not firm rules. In coming to this view, the NMC kept in mind the principle of proportionality and the principle that sanctions are not intended to be punitive.*
>
> *The sanction bid has been considered by the NMC and in my submission is the only suitable sanction to address the regulatory concerns.*
>
> *The sanction guidance contained in the fitness to practise library provides that the purpose of a sanction is to protect the public and maintain public confidence, this is*

made clear in the NMCs overriding objectives contained in the statutory framework. Any sanction decision is of course subject to the test of proportionality.

At this stage in the proceedings where the registrant's fitness to practice has been found currently impaired on both public protection and public interest grounds, other factors should also be taken into consideration.

The aggravating factors in this case include:

- *Multiple failings over a prolonged period of time*
- *Multiple residents*
- *Risk of actual harm*
- *Dishonesty over a period of time*
- *Lack of insight, remorse, and remediation*

The mitigating factors in this case include:

- *Systemic issues at the Home*

Previous fitness to practice history

There is no fitness to practice history in relation to this registrant.

Sanctions in ascending order

The panel must deal with the appropriate sanctions in ascending order of seriousness.

Taking no further action

The panel should consider whether to take no further action.

I submit that taking no further action would be wholly inappropriate in view of the seriousness of Mr Briody's misconduct and the finding of current impairment on the grounds of public interest and public protection. His misconduct has brought the nursing profession into disrepute, and he has breached a fundamental tenet of nursing. I submit that it would be neither proportionate nor in the public interest to take no further action. This sanction would not protect the public or to secure the trust of the public.

I submit that as you found Mr Briody's fitness to practise is currently impaired on the grounds of public protection and public interest and considering that his misconduct has the aggravating factors identified above, which are very serious, taking no further action is not a suitable sanction in the circumstances.

A Caution Order

A Caution Order would not restrict Mr Briody's practice, it would not provide any protection to the public against the risks that arise from Mr Briody's dishonest behaviour and clinical failings combined with his misconduct.

A Caution Order is in effect used to address concerns at the lower end of the spectrum. The sanction guidance which states:

"A caution order is only appropriate if the Fitness to Practise Committee has decided there's no risk to the public or to patients requiring the nurse's practice to be restricted, meaning that the case is at the lower end of the impaired fitness to practice, however the Fitness to Practise Committee wants to mark that the behaviour was unacceptable and must not happen again".

I submit that as you found Mr Briody's fitness to practise is currently impaired on the grounds of public protection and public interest and, considering that his

misconduct has the aggravating factors identified above which are serious, a Caution Order is not a suitable sanction in the circumstances.

A Conditions of Practice Order

The panel should consider whether a Conditions of Practice Order would be appropriate. The failings in this case relate to two allegations of dishonesty and include a deliberate act of forgery and together with his deliberate intention to mislead people increases the seriousness. This clearly raises fundamental questions about Mr Briody's trustworthiness and candour. I submit that the seriousness of the attitudinal issues identified coupled with his dishonesty is difficult to remedy and that no Conditions of Practice could be formulated to address this.

There are also a significant number of other failings relating to record keeping and medication administration which show a repeated pattern of behaviour over a period of months.

Further it raises concerns about the basics of his professionalism, as well as the public's ability to trust the profession. The prolonged period of these failings elevates the seriousness of this case. These concerns mean that a Conditions of Practice Order is inadequate in dealing with this case and would not be appropriate.

In my submission there are insufficient conditions which could address the serious attitudinal issues identified. Your finding, that Mr Briody's fitness to practise is impaired on the grounds of public protection and public interest means that a conditions of practice order will not be an appropriate sanction.

Suspension Order

The panel should consider whether a Suspension Order would be appropriate. I submit that a Suspension Order would not be appropriate in this case. The

Registrant's conduct suggests serious attitudinal issues, underpinned by concerns surrounding his professionalism, and trustworthiness. If Mr Briody were to stay on the register, this would risk substantially undermining public confidence in the profession, given the nature of the dishonesty, namely forging a colleague's signature on multiple occasions, and deliberately hiding a disciplinary investigation.

Mr Briody's blatant disregard and failure to follow procedures for the administration of CD's as required by the Home's policy and national legislation placed the residents at serious risk as any medication errors would not have been identified. In addition, there is the dishonesty in providing a false picture of his employment history that hid all the clinical concerns.

It is fair to say that there were systemic issues in the Home which has been duly noted by the panel in their determination on impairment, as there were other missing signatures by other members of staff in the Home, which suggests a possible culture of carelessness and record keeping. However, it is submitted that although this mitigates, it does not excuse or detract from the seriousness of the attitudinal issues identified.

Mr Briody has shown attitudinal concerns in his desire to cut corners and avoid essential protocols and policies. The forging of signatures was an intentional action he chose to undertake, which raises concerns about attitudinal issues which I submit cannot be easily remedied. Further Mr Briody has denied the allegations in full and seeks to blame a disgruntled "ex-partner". Mr Briody has failed to show any insight or remorse or provide evidence of remediation, and this coupled with the attitudinal nature of the concerns, only serves to increase the risk of repetition.

Your finding, that Mr Briody's fitness to practise is impaired on the grounds of public protection and public interest means that a Suspension Order would be inappropriate. Public confidence in the profession and the NMC's roles as an

effective regulator would not be maintained if a Suspension order was made. For all these reasons a Suspension Order would not be a suitable sanction.

Striking-off Order

The panel should consider whether a Striking-off Order would be appropriate. I submit that this is the only sanction appropriate in the circumstances. There is a substantial concern that public confidence would be drastically undermined by allowing the Registrant to remain on the register. As per NMC guidance, Striking-off is likely to be appropriate when fundamental questions are raised as to a Registrant's professionalism, whether public confidence can be maintained if they are not removed from the register, and whether Striking-off is the only sanction sufficient to maintain professional standards.

The NMC guidance on seriousness refers to, inter alia, cases involving dishonesty. The dishonesty in this case involves a premeditated, systemic, and somewhat longstanding method of minimising work for the Registrant and avoiding necessary safeguards. Moreover, the Registrant was dishonest in his withholding of information to Stratford Bentley Nursing Home. In tandem, these counts of dishonesty show a complete failure of the Registrant's duty of candour and raise serious questions as to his professionalism and trustworthiness.

I submit that Mr Briody's repeated failings and complete lack of insight raise considerable attitudinal concerns as to the Registrant's approach to care and nursing generally. You have made a finding, that Mr Briody's fitness to practise is impaired on grounds of public protection and public interest.

Public protection and public confidence in the profession and the NMC's roles as an effective regulator would not be maintained if a Striking-off order was not made here today. The aggravating factors as outlined above, justify the imposition of a Striking-off Order to protect the public, maintain public confidence in the profession

and declare and uphold proper standards of conduct and performance. I therefore invite you to impose a sanction of a Striking-off Order today.'

Decision and reasons on sanction

Having found Mr Briody'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:

- Multiple failings over a prolonged period of time
- Multiple residents involved
- Risk of actual harm
- Dishonesty over a period of time
- Lack of insight and remorse
- Placing colleagues at risk of professional harm by forging their signatures
- Failure to engage with the NMC since August 2021

The panel also took into account the following mitigating features:

- Possible systemic issues at the Home

The panel first considered whether to take no action but concluded that this 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 take no further action, and that it does not address Mr Briody's ability to practise in circumstances where there is clearly a risk of harm.

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 Briody'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 Briody'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, nor would it adequately protect the public.

The panel next considered whether placing conditions of practice on Mr Briody's registration would be a sufficient and appropriate response. The panel is of the view that there are no practical or workable conditions that could be formulated, given the nature of the charges in this case, and that this is not a matter of competence, skills or knowledge that can be appropriately addressed by conditions of practice in the workplace. The misconduct and dishonesty identified in this case was not something that can be addressed through retraining. Mr Briody had disregard for the appropriate policies/procedures. Furthermore, the panel concluded that the placing of conditions on Mr Briody's registration would not adequately address the seriousness of this case and would not adequately protect the public.

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 conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. This was not a single incident of misconduct and there are clearly attitudinal issues present. There is evidence of a repeated pattern of behaviour in relation to Mr Briody's actions. The panel has no evidence before it of any remorse, insight or acknowledgment by Mr Briody of his actions and the impact they could have had on patients and colleagues. Dishonesty is very difficult to remedy, however the panel has no evidence of any attempts to do so by Mr Briody, and he has been dishonest on more than one occasion. The panel noted that the serious breach of the fundamental tenets of the profession evidenced by Mr Briody's actions is fundamentally incompatible with Mr Briody remaining on the register.

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 Briody's actions were significant departures from the standards expected of a registered nurse, and are fundamentally incompatible with him remaining on the register. The panel was of the view that the findings in this particular case demonstrate that Mr

Briody'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.

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. Having regard to the effect of Mr Briody'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.

The panel considered that this order was necessary to protect the public, 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 Briody's own interest until the striking-off sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Submissions on interim order

The panel took account of the submissions made by Ms Ferns. She submitted that an interim suspension order would be necessary on both public protection and public interest grounds, for a period of 18 months, in order to cover the 28-day appeal period. She submitted that patients would be placed at an unwarranted risk of harm should Mr Briody be permitted to practise unrestricted.

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 concluded that an interim conditions of practice order 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, on the grounds of public protection and public interest, to cover the 28-day appeal period.

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

This will be confirmed to Mr Briody in writing.

That concludes this determination.