ROYAL COLLEGE OF VETERINARY SURGEONS
DISCIPLINARY COMMITTEE INQUIRY RE:

DAVID HURLEY MRCVS

DECISION OF THE DISCIPLINARY COMMITTEE

---

1. Dr Hurley appeared before the Disciplinary Committee ("the Committee") to answer the following Charge:

THAT, being registered in the Register of Veterinary Surgeons and whilst in practice at Abbey Veterinary Centre, 2 Augusta Street, Grimsby, DN34 4TA ("the Practice"):

1. On 19 April 2022, when speaking with Person A in respect of Niffler, a pug who was admitted to the Practice that evening for overnight care:

a. during a consultation at the Practice, you told Person A that Niffler would be kept monitored and under observation all night, or words to that effect.
b. during a telephone call at around 22.04hrs, you told Person A that Niffler would be monitored and kept under observation throughout the night, or words to that effect.

2. Your conduct in relation to 1(a) and 1(b) above was:

a. Misleading.

b. Dishonest, in that you did not intend for Niffler to be monitored and/or observed throughout the night.

AND that in relation to the matters set out above, whether individually or in any combination, you are guilty of disgraceful conduct in a professional respect.

Background

2. Dr Hurley is a qualified Veterinary Surgeon and a member of the RCVS. He graduated from University College Dublin in 2019 and from August 2019 he started working at Abbey Veterinary Centre in Grimsby ("Abbey").

3. The allegations in the Notice of Inquiry arise from the attendance at Abbey on 19 April 2022 of a pug named 'Niffler', owned by PD and DH. Niffler was approximately 18 months old.

4. On the evening of 19 April 2022, around 7pm, Niffler started to become unwell, first by repeatedly vomiting and then very quickly starting to deteriorate to the point of collapse. PD and DH originally planned to take Niffler to their usual veterinary surgery, the Wolds Veterinary Clinic, but decided to go to Abbey because it was approximately 15 to 20 minutes closer and they were very concerned about the state of Niffler. During the journey Niffler is described by PD as breathing but unresponsive. They had not used this Abbey Practice before, nor met Dr Hurley before.

5. Niffler arrived at Abbey whilst PD's friend was on the phone to the Practice and Dr Hurley had already told her that it would be best to take Niffler to their own Veterinary Practice. In his written and oral evidence Dr Hurley made reference to what it says in the RCVS Code of Professional Conduct ("the Code"). He said that at Paragraph 3.45 of the supporting guidance to the Code it states *"A client of another veterinary surgeon or practice who requests an emergency consultation may be redirected to that veterinary surgeon or practice (or the emergency service provider for that veterinary surgeon or practice). The on-duty veterinary surgeon to whom the initial request has been made may decline to carry out the consultation. First aid and pain relief should, however, be provided to the animal if, for whatever reason, the owner cannot contact their usual veterinary surgeon or practice or the circumstances are exceptional and the condition of the animal is such that it should be seen immediately."* Dr Hurley said he therefore rang the person back and advised them to take the patient to their usual vet practice rather than bring it to Abbey. He said he thought he told them this was because they did not have the patient's

medical history. Dr Hurley said the person he spoke to refused and said that they were coming anyway.

6. At Abbey, Niffler was collected by a nurse and then examined, in the absence of PD and DH , by Dr Hurley. In due course Dr Hurley took Niffler's medical history and asked questions about the lead up to her becoming ill.

7. At around 7.30pm, PD and DH said that they were told by Dr Hurley that Niffler would be kept monitored and under observation all night. PD said she made it clear that money was not an issue and that Dr Hurley should do whatever was needed to save Niffler.

8. At around 10pm that evening, PD decided to call Dr Hurley on Abbey's emergency number. He answered straightaway. When asked how Niffler was doing, he replied that considering her condition on admission, she was doing really well, but he wanted to keep her on IV (intravenous) fluids overnight, just in case. PD said that Dr Hurley again said that they would keep Niffler under observation.

9. PD made that call with the phone on loudspeaker. It was overhead by DH and also SJ, PD's cousin. Both of their recollections about what was said by Dr Hurley were similar to 's.

10. There is no dispute that Niffler was not, in fact, monitored all night. Dr Hurley says he left the practice around 11pm and then returned between 8.30 and 9am. At that point he was told by the nursing staff at the Practice that Niffler had died.

11. PD phoned the practice shortly after 9am, when the practice opened, to find out how Niffler was. Dr Hurley broke the bad news. At one point he said, *"she must have died in the night",* whereupon PD realised that Niffler had not, in fact, been monitored throughout the night, as she had been expecting.

12. Dr Hurley denies lying to PD about the nature of the care that would be provided to Niffler overnight. With regards to Particular 1(a), Dr Hurley said that, whilst he could not say with certainty what he said to PD that evening, he did not tell her that Niffler would be monitored and observed all night. With regards to Particular 1(b), Dr Hurley's case is that he was specifically asked by PD whether Niffler would be monitored all night and he said that she would not be checked again until morning, although there were nurses on the premises if further checks were considered necessary.

13. There is no allegation in this case regarding the standard of care provided to Niffler.

Determination on the Facts

14. The Committee considered with care all the evidence relied on by the parties, together with the submissions made by Mr Micklewright on behalf of the College and Ms Ritchie, on behalf of Dr Hurley. The Committee accepted the advice of the Legal Assessor and bore in mind that it was for the College to prove the facts and to do so to the highest civil standard of proof, that is to say the Committee must be sure of the matters alleged in order to find them proved. In reaching its decision on the disputed facts the Committee took into account all the oral evidence together with the documents relied on by both parties. It also took into account Dr Hurley's good character, together with the character evidence he provided.

15. The Committee heard oral evidence from PD, DH and SJ, on behalf of the College. The Committee also heard oral evidence from Dr Hurley.

16. The Committee made the following findings on the Particulars:

1. On 19 April 2022, when speaking with Person A in respect of Niffler, a pug who was admitted to the Practice that evening for overnight care:

(a) during a consultation at the Practice, you told Person A that Niffler would be kept monitored and under observation all night, or words to that effect.

17. The College relied on the evidence of PD and DH, who both attended the Abbey Practice with Niffler. PD said she made it clear to Dr Hurley that money was not an issue, all that mattered was looking after Niffler. PD said that Dr Hurley asked where Niffler was registered and she told him it was Wolds. She said they could take Niffler to Wolds, but Dr Hurley said *"we will keep her monitored and under observation all night, and as soon as she is stable enough, we will do further tests and investigations and treat her as appropriate."*

18. PD confirmed that Dr Hurley used different phrasing during the course of their conversation. She said he used phrases such as *"we'll check her later", "we'll keep an eye on her",* and *"we'll see how she's getting on through the night"*. PD said that when she asked questions about what he would do, he said phrases such as *"we'll have to see how she progresses through the night"* and *"we'll have a look at it".* In PD's mind, the phrases used confirmed to her Dr Hurley's repeated statement that Niffler would be monitored and under observation all night and that he would carry out further investigations/tests and treatment when she was stable enough.

19. In her oral evidence, PD adopted the contents of her witness statement and said that on first speaking with Dr Hurley she asked lots of questions because she did not know what had happened with Niffler and the entire answer given by Dr Hurley was about his intention to work on her. She said she had not misunderstood what she had been told and would never have left Niffler at Abbey if she thought she was going to be left alone all night. PD was taken to her statement where she recorded that Dr Hurley had said *"we will keep her monitored and under observation all night and as soon as she is stable enough we will do further tests and investigations and treat her as appropriate."* She said those were his exact words and that he said them several times. PD said the impression given was that Niffler would be worked on all night with more tests carried out as soon as she became stable. She said she did not specifically ask Dr Hurley if Niffler would be looked after all night because it had been said by him so many times, nor did she ask who was going to be on shift overnight.

20. PD confirmed a conversation with Niffler's breeder, who expressed some robustly negative views about vets in general. She also confirmed that her impression of Abbey vets before attending was not a positive one, saying they did not have the best reputation in the area: she far preferred her own vets at the Wolds.

21. DH in his evidence said that he was very experienced with dogs and, having seen Niffler's condition, he did not expect her to survive. They were therefore surprised after about 20 minutes at Abbey, when Dr Hurley said Niffler had responded a bit and was relatively stable. He said this was a huge relief and in his statement went on to say that it was difficult for him to remember the details of what was said by Dr Hurley. He said:

> *"I think that Dr Hurley reassured us that Niffler was doing okay and had responded to him. We were very concerned about what he was going to do going forward. Dr Hurley said that he was going to do various tests, and that Niffler would be looked after throughout the night. He said that he would keep Niffler "under observation and monitored throughout the night". He said these words once. It was a great relief to know that Niffler would have 24-hour care. I have been asked whether Dr Hurley raised this point about overnight care, or if it was in response to a question from PD or me. I confirm that Dr Hurley raised it and it was not in response to a specific question."*

22. DH said that Dr Hurley was very adamant that Niffler would be kept under observation and monitored throughout the night, although this was only said once and not repeatedly as reported by PD. He said Dr Hurley was very reassuring. PD was panicking and said *"you will look after her, you will let me know if her condition changes?"* Dr Hurley was told they only lived five or six minutes away and to call them if there was any change or if Niffler died. DH added, *"Dr Hurley*

came across as a very capable vet and gave the impression that Niffler was in the best of care and that one way or another she would be looked after throughout the night." He added, *"Following the above conversations, I understood that Niffler would be observed and monitored throughout the night and that further tests would be done throughout the night once Niffler was well enough. I do not remember what tests Dr Hurley said he would do."*

23. In his oral evidence, DH adopted the contents of his witness statement and said he was certain Dr Hurley had said he would keep Niffler under observation and monitored throughout the night. He went on to say that Dr Hurley *"gave us the impression he would be present throughout the night."* DH said Dr Hurley said he would contact us if anything changed during the night. DH then said, *"We took from that he would be present throughout the night."* He agreed that PD was very distressed, but said that he was calm, although it was a worrying and troubling situation for him too. DH said he assumed Dr Hurley would be the one looking after Niffler.

24. Dr Hurley gave evidence. He said that having seen Niffler he could see that she was not in a normal state of consciousness and she was minimally responsive to external stimuli. He immediately proceeded to perform a clinical examination and initial diagnostics (Point-of-Care Ultrasound), but there were no obvious causes of her clinical signs. He then administered first aid with oxygen and IV fluids at shock rates and Niffler responded well to this. She regained consciousness and became more alert. Satisfied that she had become more stable, Dr Hurley took a blood sample and then performed an ultrasound scan of her heart and abdomen to screen for life threatening conditions such as cardiac tamponade and haemorrhage, but the scans revealed nothing of note.

25. Dr Hurley said he then went to speak to Niffler's owners, PD, and her partner, DH. He said that during the consultation PD was understandably in a great deal of distress and very panicky, but he tried his best to explain Niffler's condition and his recommendations for future treatment and investigation. Dr Hurley said he explained the investigations and treatment he had performed and that he still did not know what was wrong with Niffler. He told them she was in a serious condition and, whilst he wanted to perform a more in-depth investigation of her suspected chest pathology (including an electrocardiogram, a more in depth echocardiogram and some thoracic radiographs), it was not possible at that time as the *"stress of restraint may have caused her to decompensate a second time."* Dr Hurley said he therefore recommended a general blood panel and IV fluids to support perfusion (the flow of blood or fluid to tissue and organs) and that they keep Niffler in overnight for further investigation in the morning.

26. Dr Hurley said he told PD that they might perform some of the further tests recommended later that evening, in which case he would call her and let her know the results. He said he did not

recall whether he expressly said it to PD, but he meant they would do some further tests and contact her if Niffler did not stabilise on the IV fluids. Dr Hurley said that whilst Niffler's condition initially appeared serious, her good response to initial treatment made him think that she was not in any immediate danger.

27. In his statement, as confirmed in oral evidence, Dr Hurley went on to say, *"I am aware that PD has stated that I told her we would "keep her [Niffler] monitored and under observation all night"… Given the passage of time, I cannot quote with any certainty exactly what I said that night, but I can say that I did not tell PD that we would monitor and observe Niffler all night. … Abbey did not offer a 'waking 'night shift, so it would have made no sense for me to tell PD that Niffler would be monitored and observed all night. That evening I had several other patients in the clinic that required my attention, so I knew I was going to be there for a few more hours that evening and any comments I did make about monitoring and observing Niffler would have been made in reference to the next few hours whilst I was still at the practice. As I cannot recall precisely the words I used, I cannot rule out the possibility that what I said resulted in PD thinking that Niffler would be monitored and observed overnight, but I would never have intentionally given her that impression. If I did not make myself sufficiently clear I apologise."*

28. PD was clear in her evidence that she was told by Dr Hurley that Niffler would be under observation and monitored throughout the night. In his evidence, DH said he understood this to be the case from the conversations that were had. Dr Hurley, on the other hand, was equally adamant that he would not have said they would monitor and observe Niffler all night, as that was not a service Abbey provided. It was not easy for the Committee to reconcile these two varying accounts. In doing so, the Committee took into account the completely understandable distress PD was experiencing when she attended the Abbey Practice thinking Niffler might be dying and that this may have affected her ability to process information. DH was candid in his statement saying it was difficult for him to remember the details of what was said. Dr Hurley is unable to remember exactly what words he used, but says that any comments he did make about monitoring and observing Niffler would have been made in reference to the next few hours whilst he was still at the Practice.

29. Dr Hurley is a man of good character in that he has no criminal convictions and no previous disciplinary findings recorded against him. Furthermore, colleagues and friends have provided testimonials in which they describe him as a person of high ethical standards and unwavering honesty. They speak of his professionalism, dedication, compassion and absolute commitment and devotion to his patients. They also speak of his extensive voluntary work assisting the disadvantaged in the local community.

30. In order to find this Particular proved, the Committee would need to be satisfied so that it was sure that the College had proved Dr Hurley told PD that Niffler *would* be kept monitored and under observation *all night,* or words to that effect [our emphasis].

31. The Committee considered carefully PD's witness statement and oral evidence, which it found to be internally consistent, albeit inconsistent with some of the evidence given by DH on this Particular and SJ in relation to Particular 1(b). PD was forthright and certain in her evidence, with clearly entrenched views about what she believed Dr Hurley had said in that consultation. However, when considering the weight to attach to her evidence, the Committee approached it with some caution, since PD was prone to exaggeration. She used emotive language and talked about the *"cruelty"* of Dr Hurley and how "*he didn't even try to do anything for Niffler."* The Committee knows this was not the case and that Dr Hurley had taken a number of appropriate steps to stabilise Niffler and to investigate the cause of her collapse. The Committee reminded itself that there are no allegations of any clinical failings by Dr Hurley in this case. In addition, PD spoke about how Dr Hurley got other people to lie for him, but there was no evidence of this.

32. The Committee also took into account the risk of PD's evidence being tainted by her preconceived, negative view of the Abbey Practice and the element of animus she exhibited towards Dr Hurley, all of which could impact upon the reliability of her evidence, consciously or subconsciously. In addition, this was understandably a very stressful and distressing time for PD and this was likely to have impacted upon her ability to take in and comprehend everything that was said to her and to subsequently recall it accurately. Overall, the Committee considered that first consultation to have been a fertile ground for misunderstanding, given the understandable high level of emotion present.

33. DH' oral evidence was consistent with his witness statement. However, in his oral evidence he used phrases such as *"we took from that he meant …", "it gave us the impression that …"*, and *"I assumed he would look after her."* Accordingly, although he was adamant that Dr Hurley had used words to the effect that Niffler would be monitored and observed all night, the Committee took into account the fact that he described assumptions he had made and expectations he had had. Also, as with PD, the Committee took into account the animus he held towards the Practice and Dr Hurley, that could impact upon his reliability as a witness. In addition, although he said he was calm when attending Abbey, the Committee could not ignore the fact that Niffler was his beloved pet also, and so there was bound to have been an element of stress and emotion and that could have affected his precise recollection.

34. Dr Hurley, when giving evidence, was not, in the Committee's view, particularly helpful in that he was not very direct or clear in some of his answers and had a tendency to speak at length, in

detail and off the point. The Committee made some allowance for the fact that giving evidence when accused of serious, potentially career changing allegations, can be a most daunting task and that respondents react in differing ways under such pressure. However, it led the Committee to understand why there may have been some misunderstanding of quite what it was he was saying when speaking with PD and DH. The Committee was assisted by the near contemporaneous clinical records, although was surprised that no record had been made of what Dr Hurley referred to as his final check up on Niffler, around 11pm. He said there was no record as there had been no change since his last visit shortly before 10pm, but the Committee would still have expected there to have been a record to that effect. The Committee also noted that there were some inconsistencies between his oral evidence and his witness statement, most notably that in his oral evidence he said they could deal with complex emergencies, whilst in his witness statement he had said they could not.

35. However, overall his evidence was consistent with his clinical notes, albeit the timings were slightly out in relation to the phone call from PD, which he recorded as around 10.30pm, whereas it is confirmed evidence that it was around 10pm. The Committee went on to consider the possibility or plausibility that he would have said at this consultation that Niffler would be kept monitored and under observation all night, or words to that effect. The Committee considered it to be inherently improbable that he would have said such words due to the lack of any obvious benefit to anyone and in the knowledge that this was not a service that Abbey offered. The College's suggestion that it would give him an easier life made little sense if it was not going to happen and certainly did not accord with the action he took in the morning. If he had lied to PD and DH about the level of care Niffler would receive overnight, it was hard to see why the following morning he would expose that lie when he spoke with PD and explained how Niffler was found dead when the morning shift started at 8am.

36. The Committee did not doubt that PD and DH genuinely believed that Niffler was going to be monitored all night and that they acted accordingly. Had they not believed that, they would undoubtedly have taken some alternative action, such as taking Niffler home or to the Wolds, their regular vets. However, just because a belief is honestly held does not necessarily make that belief objectively reliable: confidence and vividness of recollection are not necessarily reliable proxies for accuracy. The Committee could see how some of the things PD said Dr Hurley had said, and which he accepted, could have led them to believe Niffler would get that level of care, but based on their own expectations and assumptions, rather than on what was actually said. For example some of the agreed phrases he used were *"we'll check her later", "we'll keep an eye on her" "we'll see how she is getting on through the night"* and *"we'll have to see how she progresses through the night"* and *"we'll have a look at it"*. These were comments all said at the

7.30pm meeting and many hours before Dr Hurley left the Practice, having monitored and observed Niffler between her arrival and when he left at 11pm.

37. In all the circumstances, the Committee was unable to rule out the possibility that the parties had been speaking at cross-purposes or that, in the stressful situation they found themselves, there had been some misunderstanding or miscommunication about the level or duration of care that was to be provided, based on assumptions and expectations rather than on Dr Hurley making a false or misleading statement.

38. The Committee took into account Dr Hurley's good character (as detailed above) and the improbability of him promising something that Abbey would not normally deliver, other than in exceptional circumstances, based on the vet's final assessment of their needs, and the lack of motive to lie or mislead about something that would not benefit anyone. If, as Mr Micklewright suggested, the motive was that he lied in some way to appease PD or to make his life easier, this made little sense. It would, in fact, have been much easier for him to have said they could not look after Niffler overnight, in which case PD would have taken Niffler elsewhere. Furthermore, if Dr Hurley had deliberately misled PD into believing he, and/or a veterinary nurse/other member of staff, was going to by Niffler's side all night, then he would have been unlikely to have said to her on the phone the following morning that Niffler had been found dead when the staff arrived at 8am. In addition, the Committee took into account the clinical records completed at the time and what was said on 20 April 2022 about the phone call received after PD had called and learned the Niffler had died. It states that PD's friend rang back and said that *"we told them she would be monitored all night"*, to which Dr Hurley wrote *"I did not say this"*.

39. The Committee acknowledged the tragic demise of Niffler and the heart-wrenching impact of her death on PD and DH. However, in all the circumstances, it could not be satisfied so that it was sure that Dr Hurley had said Niffler would be kept monitored and under observation all night, or words to that effect.

40. Accordingly, the Committee found Particular 1(a) not proved.

1. On 19 April 2022, when speaking with Person A in respect of Niffler, a pug who was admitted to the Practice that evening for overnight care:

(b) during a telephone call at around 22.04hrs, you told Person A that Niffler would be monitored and kept under observation throughout the night, or words to that effect.

41. For Particular 1(b), the College relied on the evidence of PD, DH and SJ

42. It was accepted evidence that around 10pm that evening, PD called Dr Hurley to provide further information and to check up on Niffler. Dr Hurley answered the call straight away and PD put it on speaker phone so that she, DH and SJ could all hear the conversation.

43. PD's evidence was that Dr Hurley said Niffler was sitting up a little bit, looking around, more responsive and definitely a bit better. He made reference to the blood test results and one of them being really high, but he thought that was the machine and so he planned to run it again in the morning. She went on to say, *"He said that there was nothing in the blood test results to indicate that it was a problem with her heart. He said that her glucose levels were not high and if they were it would have indicated heart failure. I told him about the cough and asked if that could indicate heart failure. He said no, he had done a scan and could not see any fluid around her heart, so it was not her heart. He said that if she had congestive heart failure, her heart would be bigger and it was relatively small. I asked if it was a problem that her heart was too small. He said no, and that he did not think that it was her heart."* He also said he did not think it was the result of a bee sting. PD described the call as a *"nice conversation between a client and vet."* She said she was really worried and really appreciated what he was doing.

44. PD said she asked Dr Hurley what he was going to do now that he had the blood test results and what the next step was. Dr Hurley said *"we're just going to keep her under observation and see how she goes. She's on a drip. As results come back through, we will continue to do things with her."* PD said that if Niffler was going to die to let her know as they only lived a few minutes away and Dr Hurley agreed to ring her if she died.

45. PD was adamant that Dr Hurley did not say that if a patient is stable at their last routine examination then they will not be checked again overnight (as claimed by Dr Hurley), although there was a nurse on the premises if further assessments were considered necessary. She said that if she had been in any doubt that Niffler would be alone for even five minutes she would have taken Niffler from Abbey to the Wolds or home. She acknowledged that on this call she had not actually asked Dr Hurley if Niffler would be monitored all night, as confirmed by DH and SJ.

46. DH said of the call that *"Dr Hurley said that Niffler had sat up of her own accord, which was really reassuring. PD asked lots of questions, including if Dr Hurley knew what it was (i.e. the problem making Niffler unwell). I do not think that he had done any tests yet apart from basic ones such as blood tests, which did not give a definitive answer. We were all hanging on to every word Dr Hurley said and were really excited to hear that Niffler had sat up. I can remember us all in the background, not speaking, but putting our thumbs up at each other. I put my arm around PD. It*

was a really positive phone call. I thought that it was fantastic news that Niffler was coming through it, and I felt uplifted afterwards."

47. DH said he had been asked if Dr Hurley mentioned overnight care during this phone call. He said, *"I confirm that he did. He said that Niffler would be monitored throughout the night. PD was really worried, and the main conversation during the call was PD reiterating to Dr Hurley that if anything happened at all in the night, Dr Hurley should ring one of us at any time. PD had calmed down a lot by this time. She said to Dr Hurley that even if Niffler dies or he thinks that she is going to die, please ring and we will drive the five minutes down the road no matter what the time is. She said that if Niffler was going to die, we would like to be there and see her pass. Dr Hurley agreed that that was all fine and said, 'I will ring if there's any change.'"*

48. In his oral evidence, DH said that the level of care for Niffler was mentioned on this call and that she would be monitored throughout the night. DH stated that he had understood from this that Niffler would be checked every 30 minutes or one hour, although he had not actually asked what would be done.

49. SJ, who was visiting PD, said in her evidence that she remembered three particular things about this incident. The first was when PD and DH came home that evening without Niffler and DH saying, *"they've got her at the vets. They're going to keep her under observation and monitored all night. They will ring as soon as they've got some news about what it is."* The Committee was mindful that this was SJ repeating what she had been told by PD, rather than having first-hand knowledge of what was or was not said.

50. The second instance she remembered was the phone call and the third was PD reaction on the phone the following morning on receiving the shocking news that Niffler had died.

51. With reference to the phone call, SJ said, *"The vet kept saying that someone will be with Niffler. His exact words were "she'll be watched all night". As described above, when PD had got home from the vets, she had said 'they're going to keep her under observation and monitored all night.' During this phone call, the vet used more lay language and said that Niffler would be 'watched all night'".* SJ added, "*It did not occur to me to ask who would be working during the night when he said that Niffler would be watched. My experience of vet practices with my own dogs is that they have nurse-based night cover and someone in the room if a patient is really unwell and the vet is on-call."*

52. In her oral evidence, SJ said she had made a contemporaneous note that same evening as she was worried. She had then used that note to assist in making her formal witness statement over two years later. She said she would be able to retrieve the contemporaneous note, but not in the

short term as she was away from home and not returning until later in the week. The Committee did not consider it appropriate or proportionate to delay proceedings to await the provisions of such notes, since that may well have jeopardised the completing of the case in the time allowed. However, the Committee was satisfied that SJ would have made such a note and this added some weight to her account, albeit her evidence could not be tested by reference to the note.

53. SJ also said she *"assumed a very sick animal would be monitored and you would get a horrible bill in the morning."* With reference to the comment *"she'll be watched all night"* said to have been made by Dr Hurley, SJ said she had not asked what that meant as based on her experience she had *"assumed a night rota with an on-call vet and on-call nurses"* so it did not occur to her to challenge it.

54. Dr Hurley said he had checked on Niffler less than ten minutes before PD called at around 10pm and that Niffler had returned to normal consciousness and mentation. He said that considering her condition on admission, she was doing really well, she had improved and he thought she was *"out of the woods".* However, he wanted to keep her on IV fluids overnight just in case, being mindful of the fact that she had presented in a collapsed state and had vomited. He added, *"I think my thinking at that time was that there may have been a blood pressure issue, but I was comfortable keeping her in overnight without any additional checks. Whilst I could have asked the nurses to check on Niffler during the night, sometimes additional checks can be counterproductive as they disturb the patient and my clinical decision was that they were not required."*

55. Dr Hurley said that when he spoke to PD on the phone he told her that Niffler was a lot better. He added, *"I remember that during the call PD also asked me whether Niffler would be monitored all night. I cannot remember exactly what words I used, but I informed her that if Niffler was stable at our last check then he* [sic] *would not be checked again until the morning, although there were nurses on the premises if further checks were considered necessary (or words to that effect). I am aware that PD disputes that I said this, but I would not have lied when she asked me whether Niffler would be monitored all night."*

56. Dr Hurley concluded, *"After the call with PD I went to my house next door for some food. By that time, I had been working around 13 hours and I was hungry. After I had eaten, I returned to the practice and did my final checks on the inpatients. This would have been around 11pm. Nothing had changed with Niffler: I was still happy to leave her overnight with no additional checks. Once I had finished my final checks I left the practice."*

57. Dr Hurley was adamant that when discussing overnight care with PD he did not expressly say that Niffler would be monitored and observed all night. He reiterated that he could not remember exactly what was said during the initial consultation, but said, *"it is possible Miss PD misunderstood some of the comments I made and thought I was referring to what would happen overnight, when I was talking about what would happen over the following few hours. If I did not make this sufficiently clear, I apologise for any misunderstanding."*

58. The accounts given by PD ,DH and SJ were all slightly different and appeared to be based on their own experiences and expectations of the care that they believed would be provided to Niffler overnight. All three witnesses made different assumptions about what the words they had heard meant. The Committee was in no doubt that all three genuinely and honestly believed that Niffler would be cared for overnight, whether that be by nurses carrying out regular checks or someone on a camp bed alongside Niffler, as was assumed by Ms Joseph. However, the witnesses confirmed that had not actually been discussed with Dr Hurley.

59. As with Particular 1(a), the Committee had to be sure that Dr Hurley had told PD that Niffler would be monitored and kept under observation throughout the night, or words to that effect. To be sure the Committee would have to rule out the possibility of there having been a miscommunication or misunderstanding of what had been communicated by Dr Hurley during that phone call. The Committee was unable to rule out such a possibility. As with Particular 1(a), the Committee considered the possibility or plausibility that Dr Hurley would have said during this phone call that Niffler would be kept monitored and under observation all night, or words to that effect. The Committee considered it to be inherently improbable that he would have said such words due to the lack of any obvious benefit to anyone and the fact that Abbey were not set up for such a level of care. By this time Dr Hurley had assessed Niffler, following various treatment and tests and made a clinical judgement, subject to his last check, that Niffler could be left until the morning. The near contemporaneous clinical notes largely supported this for the same reasons as given in relation to Particular 1(a) above.

60. As with Particular 1(a), the Committee took into account Dr Hurley's good character and the improbability of him promising something Abbey would not normally deliver, other than in exceptional circumstances, based on the vet's final assessment of their needs, and the lack of motive to lie or mislead about something that would not benefit anyone. If the motive was that he lied in some way to appease PD or to make his life easier, this made little sense. It would, in fact, have been much easier for him to have said on that call that they could not look after Niffler overnight, in which case 1- would have taken Niffler elsewhere. Furthermore, if Dr Hurley had deliberately misled PD into believing he, and/or a veterinary nurse/other member of staff, was going to by Niffler's side all night, then he would have been unlikely to have said to her on the

phone the following morning that Niffler had been found dead when the staff arrived at 8am. Had he been lying during that phone call, then his comment the next morning would have immediately exposed that lie. In addition, the Committee took into account the clinical records completed at the time and what was said on 20 April 2022 about the phone call received after PD had called and learned the Niffler had died. As already referred to above, it states that PD's friend rang back and said that *"we told them she would be monitored all night"*, to which Dr Hurley wrote *"I did not say this"*.

61. Accordingly, in all the circumstances, and taking into account the very high standard of proof required, the Committee concluded that the College had not persuaded it so that it could be sure Dr Hurley had told PD that Niffler would be monitored and kept under observation throughout the night, or words to that effect. Particular 1(b) was therefore found not proved.

2. Your conduct in relation to 1(a) and 1(b) above was:

a. Misleading.

62. This Particular was predicated on a positive finding in relation to Particular 1(a) and/or 1(b). Since the Committee had found both those Particulars not proved, it followed that this Particular was also not proved.

2. Your conduct in relation to 1(a) and 1(b) above was:

b. Dishonest, in that you did not intend for Niffler to be monitored and/or observed throughout the night.

63. This Particular was predicated on a positive finding in relation to Particular 1(a) and/or 1(b). Since the Committee had found both those Particulars not proved, it followed that this Particular was also not proved.

64. That concludes this case.

DISCIPLINARY COMMITTEE
20 July 2026