Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Meeting
Tuesday 29 – Wednesday 30 March 2022

Virtual Meeting

Name of registrant:	**Mr Gheorghe-Sorin Voicu**
NMC PIN:	15G0436C
Part(s) of the register:	Registered Nurse Adult Nursing – 13 July 2015
Area of registered address:	North Somerset
Type of case:	Misconduct
Panel members:	Bernard Herdan (Chair, Lay member) Helen Chrystal (Registrant member) Alex Forsyth (Lay member)
Legal Assessor:	Nigel Pascoe QC (29 March) Justin Gau (30 March)
Hearings Coordinator:	Graeme King
Facts proved:	Charges 2a, 2b, 3a, 3b and 4
Facts not proved:	Charge 1
Fitness to practise:	**Impaired**
Sanction:	**Suspension order with a review (9 months)**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on service of Notice of Meeting

The legal assessor drew the panel's attention to the Notice of Meeting bundle.

The Notice of Meeting was sent by the Nursing and Midwifery Council (NMC) to the email address held for Mr Voicu on the NMC register on 28 February 2022. The panel noted that the Notice of Meeting had been sent on 28 February 2022, which was more than 28 days before this meeting. The panel was satisfied that there was good service of the notice of meeting in accordance with Rules 11a and 34 of the Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended.

The panel noted that, as this matter is being considered at a meeting, Mr Voicu would not be able to attend. However, Mr Voicu has been sent all of the evidence relating to this matter, and was informed that this meeting would take place on or after 23 March 2022. It also noted that Mr Voicu was asked to provide comment no later than 17 March 2022 by using the response form attached to the Notice of Meeting, if there was any information that he wished to be placed before the panel. Mr Voicu did not return any response form or provide any information for the panel to consider.

In light of the above, the panel considered that adjourning the meeting to allow Mr Voicu to provide written submissions would not be worthwhile as he has not engaged with the NMC at all in relation to these regulatory proceedings. It also considered that referring this matter to a substantive hearing would not serve any useful purpose. It had regard to the documentary evidence before it and determined that it had all the information necessary before it to reach a decision on this matter.

Details of charge

That you, a registered nurse:

1) On 8 November 2019, you did not provide appropriate care to Resident C in that you did not ensure that Resident C was monitored and/or observed on one or more occasions. **(Not proved)**

2) On 10 December 2019 you:

a) Failed to administer one or more doses of Levetiracetam to Resident A. **(Proved)**
b) Failed to administer Amlodipine to Resident B. **(Proved)**

3) On 11 December 2019 you:

a) Failed to administer Amlodipine to Resident B in a timely manner or at all. **(Proved)**
b) Did not provide one or more GP's with full and/or accurate information in that you did not report your failure to administer medication to Resident A. **(Proved)**

4) Acted with a lack of candour and/or integrity in respect of one or more sub-charges at charges 2 and/or 3, in that you did not report your medication administration failures. **(Proved)**

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

Background

Mr Voicu was referred to the NMC on 7 January 2020 by Sycamore Care Home North Somerset (the Home). Mr Voicu was employed as a Team Leader at the Home from May 2016 until his resignation on 23 December 2019.

The referral alleges that on 8 November 2019, Mr Voicu did not carry out, or arranged for, appropriate checks of a resident (Resident C) who had vomited in the Home's lounge. It is alleged that Mr Voicu instructed an agency nurse (Colleague A) to carry out these checks while he sought an observation kit. The referral alleges that Mr Voicu also then took a break and only on conducting a handover at the end of his shift did he realise that Nurse A had not checked on Resident C earlier in the shift. Upon checking, Mr Voicu found that Resident C had sadly passed away. Mr Voicu accepted that he did not manage the situation adequately. The cause of death for Resident C was later established to have been due to heart failure.

The referral further alleges that on 10 December 2019, Mr Voicu failed to administer at least two doses of Levetiracetam to a resident (Resident A) who needed it to treat her epilepsy. It is alleged that this medication error led to Resident A having two epileptic fits on 11 December 2019 and being hospitalised. The Home investigated this incident and it was discovered that Mr Voicu had also allegedly, on 10 and 11 December 2019, failed to administer two doses of Amlodipine to another resident (Resident B) who needed it to treat their high blood pressure. The referral alleges that Mr Voicu did not report these medication errors to his colleagues at the Home or to either patients' GP. Mr Voicu stated that he did not administer the medication as he believed the Home had no stock.

On 23 December 2019, prior to the Home holding a disciplinary meeting, Mr Voicu resigned from the Home.

Decision and reasons on facts

In reaching its decisions on the facts, the panel took account of all the documentary evidence adduced in this case. It heard and accepted the advice of the legal assessor.

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 noted that Mr Voicu has not responded to any of the charges against him. It therefore considered each of the charges and made the following findings:

Charge 1

1. On 8 November 2019, you did not provide appropriate care to Resident C in that you did not ensure that Resident C was monitored and/or observed on one or more occasions.

This charge is found not proved.

In considering this charge, the panel had regard to Colleague C's written statement dated 6 November 2020, Colleague A's local statement dated 21 November 2019, an Adverse Incident Form dated 8 November 2019, a Discussion Record dated 12 November 2019 and an undated local statement from Mr Voicu. The panel found that there was conflicting evidence from different witnesses.

The panel noted that Mr Voicu was the Team Leader on 8 November 2019 and that Colleague A was working with him as an agency nurse that day. It noted that Colleague C stated in her written statement that Colleague A '*was not unknown to the Home as she had done several shifts at the Home previously'* and that Mr Voicu '*would have been able to ask for her assistance in most things without too much of a problem'*.

The panel had regard to the Adverse Incident Form, in which Mr Voicu stated that he asked Colleague A to '*check her [Resident C's] obs and monitor her'*. It considered that Mr Voicu acted appropriately by delegating this task to Colleague A and the panel had no evidence before it to suggest that he should not have done so. The panel considered that a team leader delegating care to a qualified nurse colleague does constitute appropriate care and that it was not unreasonable for Mr Voicu to expect that his instructions were adhered to.

The panel also noted that in the Discussion Record, Witness C stated that Mr Voicu '*went on his break at a critical time'* after delegating Resident C's checks to Colleague A on 8 November 2019. However it also noted that in Colleague A's local statement she made no mention of Mr Voicu going on a break, rather that he '*went down to the ground floor to bring observation equipment to the second floor'*. In view of the lack of corroborative evidence, the panel was not satisfied that Mr Voicu did indeed take a break '*at a critical time*'.

The panel noted that there was a suggestion in the Adverse Incident Report, completed by Mr Voicu, that there had been a misunderstanding about which resident needed to be checked. Resident C and another resident had both vomited and Colleague A first went to check on the other resident as opposed to Resident C.

In any event, the panel only had evidence before it that Resident C had vomited, not that she was experiencing any more serious concerns. The panel therefore considered that, if Mr Voicu did go on a break, there is no medical evidence to suggest that this would have been inappropriate. The panel considered that, if there was a misunderstanding about which resident should have been checked, it was unclear from the evidence how this occurred.

In view of the above, on the balance of probabilities, the panel found charge 1 not proved.

Charge 2a

2. On 10 December 2019 you:

a) Failed to administer one or more doses of Levetiracetam to Resident A.

This charge is found proved.

In considering this charge, the panel had regard to Colleague B's written statement dated 26 September 2020, Colleague C's written statement dated 6 November 2020, Resident A's Medicine Administration Record (MAR) Chart for 10 December 2019, the Home's Notes from Investigation Meeting dated 12 December 2019.

The panel had first had regard to Colleague C's written statement that stated:

> *'When doing the medication round, if the nurse is not able to find medication in the trolley, the first thing to do would be check the resident's MAR Chart. The MAR Chart will state how many tablets were received with the last order, so if 56 tablets were signed in on the MAR Chart seven days ago and there are only three in the trolley, then it will be clear to the nurse that they will need to check the medication cupboard as the MAR Chart states the medication has been received.*
>
> *If medication is omitted during the round, the nurse is expected to record this on the MAR Chart by writing 'O' instead of signing it and to provide a reason for the*

omission on the back of the chart, such as resident sleeping, not needed or even no stock left.

[…]

[Mr Voicu] was aware of the medication administration procedure. He had been at the Home for several years and so would have gone to the medication cupboard to find extra medication in the past.'

The panel had regard to Resident A's MAR Chart for 10 December 2019 and noted that there were two '*O*'s marked on this entry, which Colleague C had outlined means that the medication was not administered. It had regard to Colleague B's written statement that stated:

'[Mr Voicu] had returned to the clinic by this point, and so I asked him why he had not given Resident A Levetiracetam and he said he thought we had run out. I opened the medication cupboard in the clinic and found the new boxes of Levetiracetam.'

The panel had regard to the Home's Notes of Investigation Meeting in which Mr Voicu accepted that he did not administer Levetiracetam to Resident A as he was under the impression there was no stock:

The Home – *'So given that you could see there were 56 (Levetiracetam tablets) signed in did you not go and try find them?'*

Mr Voicu – *'I put O, but I didn't look at the amount that was signed in or that part of the MAR. I looked in the cupboard but was unable to see it.'*

The panel was satisfied that Mr Voicu did not administer Levetiracetam to Resident A on 10 December 2019. It noted that Mr Voicu indicated that he did not do so on the basis he thought the Home did not have any Levetiracetam in stock. However, the panel considered that it was clear that the Home did have stock and that Mr Voicu would have known this had he followed the Home's Medicine Management policy.

In view of the above the panel found charge 2a proved.

Charge 2b

2. On 10 December 2019 you:

b) Failed to administer Amlodipine to Resident B.

This charge is found proved.

In considering this charge, the panel had regard to Colleague B's written statement dated 26 September 2020, Colleague C's written statement dated 6 November 2020, Resident B's MAR Chart for 10 December 2019, the Home's Notes from Investigation Meeting dated 12 December 2019.

The panel had regard to Colleague C's written statement that stated:

> *'On 12 December, [Colleague B] was completing the morning medication when he picked up that there had been another medication error. Resident B was prescribed to take medication for blood pressure and this had not been administered on 10 and 11 December 2019. [Mr Voicu] had been responsible for Resident B's medication on both days.*
>
> *[…]*
>
> *[Mr Voicu] would have known that this medication needed to be given as it was listed on Resident B's MAR Chart. We receive pre-printed MAR Charts from Lloyd's Pharmacy which has the prescription clearly written on it. It would have also been included in Resident B's tray in the medication trolley. [Mr Voicu] had been working at the Home for a long time and so was definitely aware of how to check what medication each resident should take.'*

The panel had regard to Resident B's MAR chart and noted that there was no entry on 10 December 2019.

The panel also had regard to the Home's Notes of Investigation Meeting in which Mr Voicu accepted that he did not administer Amlodipine to Resident B as he misread the MAR Chart:

> The Home – *'Unfortunately today there has been another medication error found, where you have not given medication to Resident B on Tuesday or Wednesday (10 and 11 December 2019). Can you tell me why?'*
>
> Mr Voicu – *'The medication is only to be given on the highlighted days on the weekend. It was not due to be given on those days.'*
>
> The Home – '*Can you see that in the medication description it says to give daily?'*
>
> Mr Voicu – '*Yes, I can see that now. But I thought it was just the highlighted days.'*
>
> […]
>
> The Home – '*But did you check the box on the left side MAR Chart where the medication is written and the instructions?'*
>
> Mr Voicu – '*No.'*
>
> The Home – '*or the box of medication?'*
>
> Mr Voicu – '*No.'*

The panel was satisfied that Mr Voicu did not administer Amlodipine to Resident B on 10 December 2019. It noted that Mr Voicu indicated that he was under the impression that this medication was not to be given on 10 December 2019 but the panel considered that, had he carried out the appropriate checks, Mr Voicu would have known that it should have been given daily.

In view of the above the panel found charge 2b proved.

Charge 3a

3. On 11 December 2019 you:

a) Failed to administer Amlodipine to Resident B in a timely manner or at all.

This charge is found proved.

In considering this charge, the panel had regard to Colleague B's written statement dated 26 September 2020, Colleague C's written statement dated 6 November 2020, Resident B's MAR Chart for 11 December 2019, the Home's Notes from Investigation Meeting dated 12 December 2019.

The panel had regard to Colleague C's written statement that stated:

> *'On 12 December, [Colleague B] was completing the morning medication when he picked up that there had been another medication error. Resident B was prescribed to take medication for blood pressure and this had not been administered on 10 and 11 December 2019. [Mr Voicu] had been responsible for Resident B's medication on both days.*
>
> *[…]*
>
> *[Mr Voicu] would have known that this medication needed to be given as it was listed on Resident B's MAR Chart. We receive pre-printed MAR Charts from Lloyd's Pharmacy which has the prescription clearly written on it. It would have also been included in Resident B's tray in the medication trolley. [Mr Voicu] had been working at the Home for a long time and so was definitely aware of how to check what medication each resident should take.'*

The panel had regard to Resident B's MAR chart and noted that there was no entry on 11 December 2019.

The panel also had regard to the Home's Notes of Investigation Meeting in which Mr Voicu accepted that he did not administer Amlodipine to Resident B as he misread the MAR Chart:

> The Home – *'Unfortunately today there has been another medication error found, where you have not given medication to Resident B on Tuesday or Wednesday (10 and 11 December 2019). Can you tell me why?'*
>
> Mr Voicu – *'The medication is only to be given on the highlighted days on the weekend. It was not due to be given on those days.'*
>
> The Home – '*Can you see that in the medication description it says to give daily?'*
>
> Mr Voicu – '*Yes, I can see that now. But I thought it was just the highlighted days.'*
>
> […]
>
> The Home – '*But did you check the box on the left side MAR Chart where the medication is written and the instructions?'*
>
> Mr Voicu – '*No.'*
>
> The Home – '*or the box of medication?'*
>
> Mr Voicu – '*No.'*

The panel was satisfied that Mr Voicu did not administer Amlodipine to Resident B on 11 December 2019. It noted that Mr Voicu indicated that he was under the impression that this medication was not to be given on 11 December 2019 but the panel considered that, had he carried out the appropriate checks, Mr Voicu would have known that it should have been given daily.

In view of the above the panel found charge 3a proved.

Charge 3b

3. On 11 December 2019 you:

b) Did not provide one or more GP's with full and/or accurate information in that you did not report your failure to administer medication to Resident A.

This charge is found proved.

In considering this charge, the panel had regard to Dr 1's written statement dated 10 February 2021 and Dr 2's written statement dated 23 February 2021.

The panel noted that Dr 1's written statement stated:

> *'I was Resident A's assigned GP, so I received a telephone call in the morning of 11 December 2019 in relation to her having a seizure.*
>
> *[…]*
>
> *I do not believe that missed medication was mentioned during the conversation. Although I cannot remember the details of the conversation, I would have recorded this is Resident A's notes if it had been discussed and I cannot see missed medication recorded in the notes.*
>
> *[…]*
>
> *I would have expected to be notified about Resident A missing Levetiracetam during this conversation as it was relevant to the fact Resident A had a seizure this time and the assumption otherwise was that the medication dose needs to be increased. I would have expected to be contacted when it was realised that any*

medication had been missed to give additional guidance as to how to manage the resident in view of this.'

The panel noted Dr 2's written statement that stated:

'On 11 December 2019, I was the on-call emergency GP in the afternoon and I received a telephone call at about 15:30 from [Mr Voicu]. [Mr Voicu] told me that Resident A had another seizure, having had one in the morning…

I then asked [Mr Voicu] if there was any reason for Resident A to be having seizures and if there had been any changes to their medication. This is a standard question to ask as, for example, it is possible that an out of hours doctor could have prescribed addition medication which we were not yet aware of but could have had an impact. [Mr Voicu] said there were no changes to Resident A's medication, failing to notify me at 15:30 that Resident A had missed two doses of Levetiracetam on the day before and one earlier in the day.'

The panel was satisfied that Mr Voicu did not advise either Dr 1 or Dr 2 about Resident A having missed her prescribed doses of Levetiracetam. It was also satisfied that Mr Voicu was aware that Resident A had not received her prescribed doses of Levetiracetam at the time he spoke to Dr 1 and Dr 2 as he had been the nurse responsible for not administering it.

In view of the above the panel found charge 3b proved.

Charge 4

4. Acted with a lack of candour and/or integrity in respect of one or more sub-charges at charges 2 and/or 3, in that you did not report your medication administration failures.

This charge is found proved.

In considering this charge, the panel had regard to its findings at charge 3b, Colleague B's written statement dated 26 September 2020 and Colleague C's written statement dated 6 November 2020

The panel noted Colleague B's written statement that stated:

> *'[Mr Voicu] had not mentioned any missing medication during the shift on 10 December 2019 or morning handover on 11 December or during handover at the end of the shift, so, until I reviewed the nurse diary, I had been completely unaware that Resident A had missed her epilepsy medication.'*

The panel also had regard to Colleague C's written statement that stated:

> *'[Mr Voicu] had several opportunities to inform us what happened, however he failed to do so.*
>
> *[…]*
>
> *[Mr Voicu] could have remedied his errors at several points, for example by telling us about the lack of medication on 10 December 2019.'*

The panel noted its finding that Mr Voicu did not inform either Dr 1 or Dr 2 of the medication errors. In so doing, it found that Mr Voicu failed in his duty of candour and integrity.

In view of the above the panel found charge 4 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 Voicu'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. Firstly, 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 Voicu's fitness to practise is currently impaired as a result of that misconduct.

Representations on misconduct and impairment

The panel had regard to the NMC's written submissions on misconduct, which read as follows:

> *'The comments of Lord Clyde in Roylance v General Medical Council [1999] UKPC 16 may provide some assistance when seeking to define misconduct:*
>
> > *'[331B-E] Misconduct is 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 [nurse] practitioner in the particular circumstances'.*
>
> *As may the comments of Jackson J in Calheam v GMC [2007] EWHC 2606 (Admin) and Collins J in Nandi v General Medical Council [2004] EWHC 2317 (Admin):*
>
> > *'[Misconduct] connotes a serious breach which indicates that the doctor's (nurse's) fitness to practise is impaired' And 'The adjective "serious" must be*

given its proper weight, and in other contexts there has been reference to conduct which would be regarded as deplorable by fellow practitioner'.

Where the acts or omissions of a registered nurse are in question, what would be proper in the circumstances (per Roylance) can be determined by having reference to the Nursing and Midwifery Council's Code of Conduct.

At the relevant time, Mr Voicu was subject to the provisions of The Code: Professional standards of practice and behaviour for nurses and midwives (2015) ("the Code"). We consider the following provisions of the Code have been breached in this case:

1 Treat people as individuals and uphold their dignity
To achieve this, you must:
1.1 treat people with kindness, respect and compassion
1.2 make sure you deliver the fundamentals of care effectively
1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay
1.5 respect and uphold people's human rights

8 Work co-operatively
To achieve this, you must:
8.6 share information to identify and reduce risk

11 Be accountable for your decisions to delegate tasks and duties to other people
To achieve this, you must:
11.1 only delegate tasks and duties that are within the other person's scope of competence, making sure that they fully understand your instructions
11.2 make sure that everyone you delegate tasks to is adequately supervised and supported so they can provide safe and compassionate care

19 Be aware of, and reduce as far as possible, any potential for harm associated with your practice
To achieve this, you must:

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

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

We consider the misconduct serious because Mr Voicu failed to provide appropriate care to Resident C and failed to administer medication to Resident A and Resident B. Mr Voicu also failed to provide accurate information to the GP. The conduct of Mr Voicu detailed in the charges fall far short of what would have been expected of a registered professional.'

The panel also had regard to the NMC's written submissions on impairment, which read as follows:

'Impairment needs to be considered as of today's date, i.e. whether Mr Voicu's fitness to practice is currently impaired as a result of misconduct. The NMC defines impairment as a registered professional's suitability to remain on the register without restriction. There is no burden or standard of proof to apply as this is a matter for the fitness to practice panel's own professional judgement.

We consider the following questions from the case of Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant [2011] EWHC 927 (Admin)) can be answered in the affirmative both in respect of past conduct and future risk:

1. Has [the Registrant] in the past acted and/or is liable in the future to act as so to put a patient or patients at unwarranted risk of harm; and/or
2. Has [the Registrant] in the past brought and/or is liable in the future to bring the [nursing] profession into disrepute; and/or
3. Has [the Registrant] in the past committed a breach of one of the fundamental tenets of the [nursing] profession and/or is liable to do so in the future

The panel must also consider the comments of Cox J in Grant at paragraph 101:

> *"The Committee should therefore have asked themselves not only whether the Registrant continued to present a risk to members of the public, but whether the need to uphold proper professional standards and public confidence in the Registrant and in the profession would be undermined if a finding of impairment of fitness to practise were not made in the circumstances of this case".*

Mr Voicu has clearly brought the profession into disrepute by the very nature of the conduct displayed. Nurses occupy a position of trust and must act and promote integrity at all times, which have been breached in this case. The public has the right to expect high standards of registered professionals.

With regard to future risk it may assist to consider the comments of Silber J in Cohen v General Medical Council [2008] EWHC 581 (Admin) namely (i) whether the concerns are easily remediable; (ii) whether they have in fact been remedied; and (iii) whether they are highly unlikely to be repeated.

We consider that the clinical concerns are remediable however Mr Voicu has displayed no insight.

We take this view because Mr Voicu has not engaged in the NMC process and has not shown any remorse or taken steps to remediate his behaviour. We consider Mr Voicu has not undertaken relevant training in respect of the issues of concern. Therefore the risk of repetition is high.

We consider there is a continuing risk to the public due to Mr Voicu's lack of full insight and having not demonstrated that he has strengthened practice through work in a relevant area. Mr Voicu's conduct has the ability to put more patients at risk. Mr Voicu has also failed to uphold proper standards of conduct and behaviour.

The public rightly expect nurses to demonstrate the skills and knowledge fundamental to a nursing practice, ensuring that those standards are upheld and adhered to. A finding of impairment is thus also essential to maintain public confidence in the profession.

It is submitted that a finding of impairment is necessary on public protection grounds and public interest.'

Decision and reasons on misconduct

The panel accepted the advice of the legal assessor, who advised it that a breach of professional duty must be serious if it is to amount to misconduct.

When determining whether the facts found proved amount to misconduct, the panel had regard to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015' (the Code).

The panel was of the view that Mr Voicu's actions did fall significantly short of the standards expected of a registered nurse, and it considered them to have amounted to several breaches of the Code. Specifically:

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

To achieve this you must:

1.4 - Make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay.

8 - Work co-operatively.

To achieve this you must:

8.6 - Share information to identify and reduce risk.

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

To achieve this, you must:

16.1 - raise and, if necessary, escalate any concerns you may have about patient or public safety, or the level of care people are receiving in your workplace or any other health and care setting and use the channels available to you in line with our guidance and your local working practices

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

To achieve this you must:

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

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, in these circumstances, the panel decided that Mr Voicu's actions in the charges found proved individually and collectively fell significantly short of the standards expected so as to constitute serious misconduct.

The panel considered that Mr Voicu's actions in charges 2a, 2b and 3a did place patients at risk of harm and it noted that Resident A had two epileptic fits after Mr Voicu failed to administer the medication used to treat her epilepsy. The panel considered that Mr Voicu would have been aware of the risks posed by not administering epilepsy medication as prescribed for her. It also noted from Colleague C's evidence that the failure to administer prescribed medication for Resident B could have caused '*a change in the way the blood moves around her body'* and could have made Resident B *'dizzier'* and '*more likely to fall'*. Further, it considered that to fail to administer medication, and then subsequently not escalate or document this, could have had a significant impact on Resident A's and Resident B's follow up care. The panel determined that Mr Voicu's repeated failure to escalate or document medication errors exacerbated the risk posed in this case.

The panel considered that Mr Voicu's actions in charge 3b, exacerbated the seriousness of his earlier drug error. It considered that to fail to advise Resident A's GP on two occasions of her missed medication posed a serious risk to her safety and could have impacted on her follow up care.

The panel considered that breaching the duty of candour and integrity will always result in a finding of serious misconduct. It could see no reason why Mr Voicu should have withheld his medication errors and considered that his failure to report these errors was a significant departure from the standards expected of him.

The panel noted that the concerns are not confined to an isolated incident and it considered that Mr Voicu's practice had repeatedly fallen below the standards expected and the panel was satisfied that his actions were sufficiently serious to amount to misconduct. The panel was satisfied that other members of the nursing profession would consider Mr Voicu's actions to be deplorable.

Therefore, the panel found that Mr Voicu's actions fell seriously short of the conduct and standards expected of a registered nurse and amounted to misconduct.

Decision and reasons on impairment

The panel next went on to decide if, as a result of his misconduct, Mr Voicu's fitness to practise as a registered nurse is currently impaired.

Registered 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. 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 *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin*)* in reaching its decision. In paragraph 74, she said:

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

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

> *'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her fitness to practise is impaired in the sense that s/he:*
>
> *a) has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*
>
> *b) has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*

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

d) …'

The panel considered limbs a, b and c to be engaged.

The panel determined that Mr Voicu had caused a real risk of significant harm to Resident A and Resident B as a result of his actions and it noted that Resident A required emergency treatment for her epilepsy after Mr Voicu had failed to administer her medication. It had regard to its earlier finding that Mr Voicu's actions in not escalating or reporting the medication errors heightened the risk of harm.

The panel determined that Mr Voicu's actions had brought the reputation of the profession into disrepute. It considered that patients and the public expect to be able to trust that patients will receive their prescribed medication at the appropriate time and that this did not happen. Further, members of the public expect registered nurses to follow their employers' policies to ensure they are practising safely and effectively.

The panel next determined that Mr Voicu had breached fundamental tenets of the nursing profession. It considered that Mr Voicu had breached his duty of candour and integrity by not putting his mistakes right, or taking steps to put them right. Further, it considered that Mr Voicu had failed in his duty to provide safe and effective care.

The panel considered whether the concerns identified are capable of remediation, whether they have been remediated, and whether there is a risk of repetition of the incidents occurring at some point in the future.

The panel considered that the misconduct identified is capable of being remediated. However, it had no evidence before it to suggest that Mr Voicu had taken any steps to strengthen his practice. The panel noted that Mr Voicu has not engaged with the NMC at all in relation to these regulatory proceedings. Further, it had no evidence before it to confirm if Mr Voicu has been employed in a healthcare capacity since 2019 and if/how he has strengthened and maintained his nursing practice.

The panel considered that Mr Voicu had demonstrated some insight into his misconduct at local level by way of expressing remorse and apologising for his actions. However, it had no evidence before it of that limited insight having developed since his resignation from the Home in December 2019.

In light of the above, the panel was not satisfied that Mr Voicu is currently capable of safe and effective practise. It noted that there is no evidence of Mr Voicu having strengthened his practice in response to the concerns being raised and the panel consequently considered there to be a real risk of the conduct being repeated. Therefore, the panel decided that a finding of impairment is necessary on the grounds of public protection.

The panel bore in mind that the overarching objectives of the NMC are to protect, promote and maintain the health, safety and well-being of the public and patients, and to uphold/protect the wider public interest, which 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 considered that a well-informed member of the public would be concerned if Mr Voicu was permitted to practise unrestricted without having demonstrated that he has addressed the concerns raised and is capable of safe and effective practise. It concluded that public confidence in the nursing profession would be undermined if a finding of impairment was not made in this case. Therefore, the panel determined that a finding of impairment on public interest grounds was also required.

Having regard to all of the above, the panel was satisfied that Mr Voicu's fitness to practise as a registered nurse is currently impaired.

Sanction

The panel has considered this case carefully and has decided to make a suspension order for a period of nine months with a review. The effect of this order is that the NMC register will show that Mr Voicu's registration has been suspended.

Submissions on sanction

The panel had regard to the NMC's written submissions on sanction:

'We consider the following sanction is proportionate:

- *3 month suspension order with a review*

The aggravating features in this case include:

- *No engagement with the NMC*
- *No insight, remorse or remediation*
- *Multiple incidents over a period of time involving more than one resident*
- *Acting with a lack of candour*
- *Was a nurse team leader and had a position of responsibility*

There are no mitigating factors in this case.

Taking the least serious sanctions first, it is submitted that taking no action and a caution order would not be appropriate in this case. NMC guidance states that taking no action will be rare at the sanction stage and this would not be suitable where the nurse presents a continuing risk to patients. In this case, the seriousness of the misconduct means that taking no action would not be appropriate. A caution order is the least restrictive sanction which will only be suitable where the nurse presents no risk to the public. Again, given the concerns highlighted in this review, a caution order would not be an appropriate outcome.

The clinical concerns in this case are remediable and a conditions of practice order would normally be appropriate. However, Mr Voicu has not engaged and there is no evidence to suggest that he would be willing to comply with conditions. These concerns mean that a conditions of practice order is inadequate in dealing with this case.

A striking off order would be disproportionate under these circumstances. The concerns raised are in relation to a short period of time and could be remediated.

Therefore, a short suspension order would be most appropriate and will allow Mr Voicu to re-engage with the NMC and demonstrate insight.'

Decision and reasons on sanction

The panel accepted the advice of the legal assessor.

Having found Mr Voicu'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 Sanctions Guidance ('SG'). The decision on sanction is a matter for the panel independently exercising its own judgment.

As regards aggravating factors, the panel has considered the following as relevant:

- Mr Voicu has not engaged with the NMC;
- No evidence of any insight or strengthening of practice;
- Multiple incidents over a period of time involving more than one resident;
- Mr Voicu acted with a lack of candour; and
- Mr Voicu was a nurse team leader and had a position of responsibility.

As regards mitigating factors, the panel has considered the following as relevant:

- Mr Voicu displayed remorse for his actions at local level.

The panel first considered whether to take no action but concluded that this would be wholly inappropriate in view of the seriousness of this case. Taking no further action would not place any restriction on Mr Voicu's nursing registration, and would therefore not protect the public. Further, the panel decided that it would be neither proportionate, nor in the public interest to take no action.

Next, in considering whether a caution order would be appropriate in the circumstances, the panel took into account the SG, which 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 Voicu's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the seriousness of the case. The panel decided that it would be neither proportionate, nor in the public interest to impose a caution order.

The panel next considered a conditions of practice order and, in all the circumstances, determined that such an order would be insufficient to protect the public and to meet the wider public interest considerations of this case. While the panel considered that Mr Voicu's clinical failings are capable of remediation, it noted that he has not engaged with these regulatory proceedings at all and it could not be satisfied that he would engage with a conditions of practice order. Further, it had no information before it of Mr Voicu's current employment status and whether or not he wishes to practise as a registered nurse in the United Kingdom. The panel therefore determined that placing conditions of practice on Mr Voicu's nursing registration would not be workable at present.

The panel next considered whether the seriousness of this case required temporary removal from the NMC register and whether a period of suspension would be sufficient to protect patients and satisfy the public interest. When considering seriousness, the panel took into account the extent of the departure from the standards to be expected of a registered nurse and the risk of harm to the public interest caused by that departure.

The panel determined that there had been clear breaches of fundamental tenets of the nursing profession and a significant departure from a number of the standards in the Code. It had no evidence before it to suggest that Mr Voicu has taken any steps to strengthen his practice, nor that he has any insight into how his conduct fell short of the standards expected of a registered nurse, and of its impact on colleagues, patients and the public.

Having previously determined that Mr Voicu's misconduct is capable of remediation, the panel determined that he should be afforded the opportunity to re-engage with the NMC and demonstrate that he has strengthened his practice and that his insight has developed.

The panel decided that a suspension order would be an appropriate and proportionate sanction in this case. It was satisfied that a suspension order for nine months would be the appropriate length of time, taking account of the public protection and public interest elements.

Furthermore, the panel noted that a period of nine months would provide Mr Voicu with sufficient opportunity to reflect on these regulatory proceedings and consider if he wishes to return to the nursing profession in the UK. The panel considered that this period of time would allow Mr Voicu to develop his insight and reflect on the consequences of his actions.

The panel went on to consider a striking off order but in the circumstances determined that it would be unduly punitive at this stage. While it noted Mr Voicu's abject non-engagement with the NMC, it had regard to its finding that the misconduct identified is capable of being addressed by Mr Voicu. The panel considered that to strike Mr Voicu off at this first meeting would be inappropriate but wished to make clear that, should he not have engaged with the NMC by the time this order is reviewed, that panel would have the option to consider a striking off order.

Balancing all of these factors the panel has concluded that a suspension order for nine months would be the appropriate and proportionate sanction.

The panel had no information before it to confirm what Mr Voicu's employment status is and it noted that this suspension order will prevent Mr Voicu from working as a registered nurse in the UK during the time in which it is in force. However, the panel determined that Mr Voicu's interests in working as a registered nurse were outweighed by the wider public interest in this respect in any event.

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

Before the end of the period of suspension, another panel will review the order. At the review meeting/hearing, the panel may revoke the order, or it may confirm the order, or it may replace the order with another order.

Any future panel may be assisted by evidence of:

- Mr Voicu's engagement with the NMC and attendance at, or submissions to, his review meeting/hearing.
- A reflective piece addressing the impact of Mr Voicu's clinical failings and their impact on patients, colleagues and the public.
- Evidence of any training undertaken to address the areas of concern, as well as any other professional development Mr Voicu has undertaken in order to keep his nursing skills up to date.
- Employment testimonials, whether in paid or unpaid employment.

Interim order

As the suspension 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 Voicu's own interests until the suspension order takes effect.

Submissions on interim order

The panel had regard to the NMC's written submissions on an interim order:

> *'If a finding is made that the registrant's fitness to practise is impaired on a public protection basis is made and a restrictive sanction imposed we consider an interim order in the same terms as the substantive order should be imposed on the basis that it is necessary for the protection of the public and otherwise in the public interest.*

If a finding is made that the registrant's fitness to practise is impaired on a public interest only basis and that their conduct was fundamentally incompatible with continued registrant we consider an interim order of suspension should be imposed on the basis that it is otherwise in the public interest.'

The panel accepted the advice of the legal assessor.

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. With regard to the seriousness of the misconduct in this case and the risk of repetition identified, the panel determined that an interim suspension order is necessary until the substantive suspension order takes effect. It considered that public confidence in the regulatory process would be undermined if Mr Voicu was permitted to practise as a registered nurse prior to the substantive order coming into effect.

The panel decided to impose an interim suspension order for a period of 18 months. It considered that any other interim order would be incompatible with its earlier findings.

If no appeal is made, then the interim suspension order will be replaced by the substantive suspension order, 28 days after Mr Voicu is sent the decision of this meeting in writing.

This will be confirmed to Mr Voicu in writing.

That concludes this determination.