Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday 6 November – Thursday 9 November 2023

Virtual Hearing

Name of Registrant:	**Ionut Aurelian Necula**
NMC PIN:	11A0018C
Part(s) of the register:	Registered Nurse – Sub Part 1 Adult Nursing – January 2011
Relevant Location:	Hampshire
Type of case:	Misconduct
Panel members:	Susan Thomas (Chair, Lay member) Helen Chrystal (Registrant member) James Hurden (Lay member)
Legal Assessor:	Nigel Ingram
Hearings Coordinator:	Eyram Anka
Nursing and Midwifery Council:	Represented by Adjoa Adjei-Ntow, Case Presenter
Mr Necula:	Not Present and not represented at this hearing.
Facts proved:	Charges 1a, 1b, 1c, 2a, 2c, 4a, 4b, 5a
Facts not proved:	Charges 2b, 2d, 3, 5b
Fitness to practise:	Impaired
Sanction:	**Conditions of practice order (12 months)**
Interim order:	**Interim conditions of practice order (18 months)**

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Mr Necula was not in attendance and that the Notice of Hearing letter had been sent to Mr Necula's registered email address by secure email on 2 November 2023.

Ms Adjei-Ntow, 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.

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

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

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

Ms Adjei-Ntow referred the panel to an email from Mr Necula's former representative at the Royal College of Nursing (RCN) dated 2 November 2023 stating:

'Please find attached confirmation that the RCN are to be removed as the registrant's legal representative. Please ensure Counsel's details are also removed, and the registrant is now contacted directly regarding the hearing. The registrant has also informed me they will not be attending the hearing.'

Ms Ajei-Ntow also referred the panel to an email from Mr Necula dated 4 November 2023 which states, *'I'm not attending the virtual hearing next week. I agree to the panel proceeding.'*

Ms Adjei-Ntow submitted that Mr Necula has not made an application for adjournment therefore there is no reason to suppose that an adjournment would secure his attendance at a future date. She further submitted that there is a strong public interest in the expeditious review of the case.

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 Necula. In reaching this decision, the panel has considered the submissions of Ms Adjei-Ntow and the advice of the legal assessor. It has had particular regard to the factors set out in the decision of *R v Jones (Anthony William)* (No.2) [2002] UKHL 5 and *General Medical Council v Adeogba* [2016] EWCA Civ 162 and had regard to the overall interests of justice and fairness to all parties. It noted that:

There was a preliminary meeting on 1 November 2023 at Mr Necula's request to consider an application to postpone the substantive hearing set to start on 6 November 2023. An

email dated 27 October 2023 was sent to the NMC from Mr Necula's former representatives (RCN) stating:

> *'After speaking with the registrant yesterday, we kindly write to request a postponement of the hearing currently listed for 06 November 2023 – 10 November 2023 and 13 November 2023.*
>
> *The NMC are aware that the RCN have had difficulties with engagement with the registrant since the NMC Case Conference had taken place. The RCN have since managed to reach the registrant to arrange a case conference which was due to take place this Tuesday. Unfortunately, the case conference did not go ahead, and thus the registrant has still not been advised effectively regarding the hearing and preparations which need to be made. It came to light yesterday that the registrant does not have the listed hearing dates off from his employer.*
>
> *As the NMC case hearing is due to begin on 06 November 2023, without the registrant having been appropriately advised and minimal time to obtain relevant documentation, we kindly request the current hearing to be postponed until some future date / in 2024 at a time when Mr Necula has been able to appropriately engage and be advised.*
>
> *We request this postponement request be considered as a matter of urgency by the NMC.'*

Mr Necula was not present at the Preliminary Meeting but was represented by the RCN. His representative submitted that he wanted to attend the substantive hearing but was unable to get time off for the duration of the hearing… [PRIVATE].

The panel noted that the application was rejected by the chair. The chair in preliminary meeting concluded that the public interest grounds would not be met if the case was postponed until sometime in 2024. Additionally, the chair was mindful of the witnesses and

the arrangements they had made to attend the hearing and determined that postponement would impact them and likely cause their memories of the alleged incidents to fade even more.

- Mr Necula has informed the NMC that he has received the Notice of Hearing and confirmed he is content for the hearing to proceed in his absence.
- There is no reason to suppose that adjourning would secure his attendance at some future date.
- He has disengaged from his counsel.
- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services.
- In accordance with the NMC code, Mr Necula has a duty to attend but has decided against that.
- 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 Necula 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 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 Necula'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 to proceed in the absence of Mr Necula. The panel will draw no adverse inference from Mr Necula's absence in its findings of fact.

Details of charge

That you, a registered nurse

1) *On 5 September 2019 in relation to Resident A, failed to:*
   a) *Record in the care notes that he was suffering from expectorate phlegm post cough.* ***[PROVED]***
   b) *Record observations for temperature and/or pulse and/or breathing.****[PROVED]***
   c) *Provide a handover for the next shift.* ***[PROVED]***

2) *On 20 September 2019 in relation to Resident B:*
   a) *Failed to check for a urinary tract infection as requested by Colleague A, Or, in alternative.* ***[PROVED]***
   b) *Failed to record a check for urinary tract infection in Resident B's care notes.* ***[NOT PROVED]***
   c) *Failed to call the GP about Resident B's deteriorating condition as requested by Colleague A,* ***[PROVED]***
   d) *Recorded in the care notes that you informed the GP about Resident B's condition when you did not.* ***[NOT PROVED]***

3) *Your conduct in charge 2(d) was dishonest because you knew you had not called the GP and intended a future reader of the care notes to believe you had.* ***[NOT PROVED]***
4) *On or before 19 October 2019 failed to:*
   a) *Complete care plans.* ***[PROVED]***
   b) *Complete wound care records.* ***[PROVED]***

5) *On 18 November 2019, in relation to Resident C:*
    a) *Failed to check Resident C's glucose levels before administering insulin, Or, in the alternative.* ***[PROVED]***
    b) *Failed to record Resident C's glucose levels on her notes before administering insulin.* ***[NOT PROVED]***

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

Background

Mr Necula was referred to the NMC on 8 December 2019 by the Compliance Manager of Hazeldene House (Hazeldene) where he was employed as a registered nurse.

On 6 September 2019 concerns were raised to Witness 1 regarding the care Mr Necula was providing to Resident A. It is alleged that Mr Necula did not monitor Resident A who suffered from expectorate phlegm post cough. Mr Necula allegedly did not record any baseline observations which would have enabled Resident A's condition to be monitored and any deterioration detected in a timely way. Mr Necula also failed to provide a handover to the next shift which would have ensured Resident A's condition to be monitored accurately. He was given a verbal warning by the Witness 1 in relation to the alleged failures in Resident A's care. Mr Necula allegedly apologised for the error and said he did not have time to record the information for handover. On 15 September, it was identified again that information was missing from Mr Necula's notes.

On 20 September 2019 Mr Necula was asked to monitor Resident B and call a GP to attend because it was suspected Resident B had a urinary tract infection (UTI). Witness 1 became aware later that day that Mr Necula had allegedly not taken any action. Witness 1 asked why he had not acted, and he reportedly said he had called the GP, but they did not

have the capacity to attend. It is alleged that he had not told the GP that Resident B's health had deteriorated and they would require a GP's assessment.

On 19 October 2019 Witness 1 noticed that care plans and wound care records had not been completed by Mr Necula. He allegedly stated that he did not have time to complete some of the records. He allegedly did not inform Witness 1 about the lack of time to complete the records.

On 18 November 2019 Witness 2 noted Resident C looked pale and unwell. She gave Resident C sugared water and called a nurse who took Resident C's blood sugar. It was documented that Mr Necula had administered insulin earlier that day at 17:36 and it was allegedly identified that this was done without checking Resident C's blood glucose levels. This led to Resident C becoming hypoglycaemic and corrective action had to be taken. Mr Necula allegedly did not inform the family.

On 4 December 2019 Mr Necula was dismissed from Hazeldene because he allegedly failed to meet the necessary standard during his probationary period.

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 Adjei-Ntow on behalf of the NMC.

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

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: Registered Nurse, Deputy Manager at Hazeldene House
- Witness 2: Health Care Assistant at Hazeldene House

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)

"That you, a registered nurse, on 5 September 2019 in relation to Resident A, failed to:

a) *Record in the care notes that he was suffering from expectorate phlegm post cough."*

This charge is found proved.

In reaching this decision, the panel took into account the documentary and oral evidence before it, including the written witness statement and corresponding exhibits of Witness 1as well as her oral evidence and contemporaneous care notes. The panel had regard to exhibit MI/12 in the exhibit bundle in which it is established in witness 1's entry at 17:13 that there was a burden and a duty on Mr Necula to record and monitor Resident A's condition. The panel saw in exhibit MI/12 and heard evidence from Witness 1that there was no entry or observations recorded in the care notes regarding Resident A.

The panel was of the view that the contemporaneous care notes from Witness 1 were well documented and concise therefore it could be relied upon. It also determined that all the other documentary and oral evidence provided in relation to this charge supports witness 1's account. Therefore, the panel concluded that there is sufficient evidence adduced by the NMC to find charge 1a proved, on the balance of probabilities.

Charge 1b)

"On 5 September 2019 in relation to Resident A, failed to:

b) *Record observations for temperature and/or pulse and/or breathing."*

This charge is found proved.

In reaching this decision, the panel took into account the same evidence as charge 1a. It determined which there is no records of Mr Necula observing Resident A in exhibit MI/12.

The panel noted that it had no information before it from Mr Necula to contradict the dispute or contradict witness 1's evidence. The panel therefore concluded that on the balance of probabilities, charge 1b stands.

Charge 1c)

"On 5 September 2019 in relation to Resident A, failed to:

c) Provide a handover for the next shift."

This charge is found proved.

In reaching its decision, the had regard to the to the contemporaneous staff notes by Witness 1 in exhibit MI/03 dated 15 September 2019, which states:

> *'I have discussed this morning with Ionut about handover, all duty managers staff day and night has to be on GF @ 7:45 am for handover, it is very important to know what is going on with out residents, if any problems, etc. Also I have asked Ionut to record a daily note everything about residents, discussion with health professional, family, after I asked Ionut to supervision today.' [sic]*

The panel heard from Witness 1 that this contemporaneous supervision note was written subsequent to a conversation that was had with Mr Necula in which he allegedly told Witness 1 that he did not have time to attend handover. Witness 1 told the panel that there were other staff members who could have been of help to Mr Necula which would have allowed him the free time to provide handover for the next shift, but he did not ask for help. The panel also noted that there was no evidence of Mr Necula providing a handover in the documents provided.

On the basis of the evidence before it and the balance of probabilities, the panel found charge 1c proved.

Charge 2a)

"On 20 September 2019 in relation to Resident B:

a) *Failed to check for a urinary tract infection as requested by Colleague A,*
Or, in the alternative"

This charge is found proved.

In reaching its decision, the panel considered all the evidence before it particularly Witness 1's care notes in exhibit MI/13 dated 20 September 2019 and Witness 1's contemporaneous staff notes dated 21 September 2019 in exhibit MI/06. The panel noted that in the care notes the is no entry by Mr Necula, however, there is an entry by Witness 1 asking Mr Necula to *'monitor Resident B'* and *'call his GP about the challenging behaviour and suspect[ed] UTI'.* The panel further noted that this is corroborated by Witness 1's contemporaneous staff note in which she states,

> *'Ionut was nurse on duty Friday, 20/09/19 when I have asked him to take action for resident B. I have asked Ionut to monitor, check urine and inform the Doctor… No action was taken, till 5pm when resident granddaughter come to complain to me because she did not understand why his[sic] grandfather did not have medication in place for treat UTI…'*

The panel found the evidence above, Witness 1's written statement and oral evidence to be reliable and consistent with each other. It was of the view that the evidence above makes it clear that Witness 1 did ask Mr Necula to monitor Resident B but there is no evidence in the form of records or care notes to show that Mr Necula did the check.

Therefore, on the balance of probabilities, the panel decided that charge 2a is found proved.

Charge 2b)

"*On 20 September 2019 in relation to Resident B:*

a) *Failed to record a check for a urinary tract infection in Resident B's care notes."*

This charge is found NOT proved.

In light of the panel's decision regarding charge 2a, it determined that this charge falls away because it is charged as an alternative to charge 2a.

Charge 2c)

"*On 20 September 2019 in relation to Resident B:*

b) *Failed to call the GP about Resident B's deteriorating condition as requested by Colleague A,"*

This charge is found proved.

In reaching its decision took into account all the evidence before it, including the care notes in exhibit MI/12 dated 20 September 2019 and Witness 1's contemporaneous staff notes dated 21 September 2019 in exhibit MI/06.

The panel was of the view that Mr Necula may have called the GP as requested but it determined that he did not give the correct clinical information to the GP surgery for them to make the decision. The panel concluded that the failure arises because Mr Necula, as a registered nurse, should have communicated Resident B's deteriorating condition adequately for another clinician to be able to make the proper decision and then recorded it in the care notes for his colleagues to be properly informed.

The panel noted that in Witness 1's contemporaneous staff note regarding this incident it states, *'Ionut said to me he called the GP but they said is no more space for GP visit, Ionut did not inform GP via email of resident health condition.'* The panel determined that this conversation with Witness 1 is the only recorded confirmation that Mr Necula had called the GP and noted that there is no entry by him in the care records in exhibit M1/12 to indicate that he called the GP.

Witness 1 explained to the panel that there was a backup system whereby a carer could contact the GP via email if they were concerned about a resident's deterioration which Mr Necula failed to use.

In light of this, it concluded on the balance of probabilities that this charge is found proved.

Charge 2d)

"*On 20 September 2019 in relation to Resident B*

b) Recorded in the care notes that you informed the GP about Resident B's condition when you did not."

This charge is found NOT proved.

The panel determined that the NMC has not discharged the burden of proof for this charge to be found proved. In reaching its decision, the panel carefully considered the care notes in exhibit MI/12. It determined that there is nothing in the care notes written by Mr Necula recording that he called and informed the GP about Resident B's condition. The panel concluded that the charge is fundamentally undermined by the evidence presented by the NMC. Therefore, on the balance of probabilities charge 2d is not found proved.

Charge 3)

"Your conduct in charge 2(d) was dishonest because you knew you had not called the GP and intended a future reader of the care notes to believe you had."

This charge is found NOT proved.

In reaching its decision, the panel had regard to the advice of the legal assessor which made reference to the NMC guidance about dishonesty and inferences, in particular DMA-6 and DMA-7. The legal assessor informed the panel that the guidance essentially echoes the position set out in *Ivey v Genting Casinos (UK) Ltd t/a Crockfords* [2017] UKSC 67. The legal assessor set out the following points for the panel to consider:

A. The panel must first determine subjectively the actual state of the Mr Necula's knowledge and belief as to the facts. The reasonableness of that belief is not an additional requirement.

B. Once that is established, the panel must determine that the standards determined whether his conduct was dishonest. The standards need to be that of ordinary and decent people. It is not a requirement for Mr Necula to appreciate that what he has done by those standards is dishonest.

The panel relied on the advice of the legal assessor and the same evidence and reasons as it did for charge 2d. It concluded that since charge 2d was not found proved, this charge must fall away because Mr Necula cannot be found dishonest in relation to conduct that has been found not proved.

Charge 4

"On or before 19 October 2019 failed to:

a) Complete care plans.
b) Complete wound care records."

These charges are found proved.

The panel considered all the evidence before it, in particular Witness 1's contemporaneous staff notes in exhibit MI/09 dated 19 October 2019 which states:

> *'I did spoke with Ionut today regarding outstanding review for care plans, wound care. Was many days when was not done on his shift, the last one was this week when he was on duty on Ground Floor, I did asked Ionut what the outstanding review for care plans has not been done on his shift, he said he done some but was a lot , I have asked why wound care plans has not been done on his shift, he said he done, I have cheeked and was not done , he said he take a photo for wound but may be the computer , internet connection because he did , also in the same day was 2 residents reviewed by dietitian and I advice him to update nutrition care plan with dietitian advice, this also was not done. Ionut said he did not had enough time to do all…'* [sic]

The panel had regard to Witness 1's oral evidence, where she said that Mr Necula told her that he did not complete the care plans because problems with the internet, however, he took photographs but was unable to upload them because of problems he had with the internet. However, the panel found nothing in the care plans to show that he had taken photographs.

The panel was of the view that Witness 1's oral evidence, her written statement dated 9 February 2021 and her contemporaneous staff notes are consistent and therefore reliable. It determined that there is enough evidence to conclude that charges 4a and 4b are found proved on the balance of probabilities.

Charge 5a)

"On 18 November 2019, in relation to Resident C:

a) *Failed to check Resident C's glucose levels before administering insulin, Or, in the alternative."*

This charge is found proved.

In reaching its decision, the panel took into account Witness 1 and 2's oral evidence and their written statements as well Resident C's care notes in exhibit MI/11. The panel, whilst carefully considering Resident C's care notes determined that Mr Necula recorded giving insulin to Resident C at 17:36, but there is no entry to indicate that he checked Resident C's glucose level before administering the insulin. The panel determined that this could have caused serious harm to Resident C and noted that intervention from other staff members was required. The panel had regard to Witness 2's written statement dated 6 December 2019 confirming Resident C's health deteriorated that evening because of her low blood glucose. Witness 2's written statement states:

> *'…I saw the care workers were around her* [Resident C], *she was seating and looking white. I know she has Diabetes. I alerted the Nurse. I managed to wake up, and gave her sugared water…'*

The panel further noted that Witness 2's oral evidence was very consistent with her signed NMC witness statement dated 1 February 2021 in relation to how she discovered why Resident C's health has deteriorated. In her oral evidence she told the same information as is in her NMC statement which states:

> *'I checked Resident C's records and saw that the registrant had not recorded her blood sugar levels before administering insulin earlier in the afternoon which is possibly why her blood sugar levels were low…'*

The panel had regard to another section of Resident C's care notes which demonstrates the correct way to use the system to record glucose levels and administer insulin. The panel determined that in comparison, Mr Necula's entry just recorded that he had

administered insulin and there was no record that he had checked Resident C's blood sugar prior to administration.

Based on the evidence the panel considered, including both Witness 1and 2's oral and written evidence and a care plan signed by Mr Necula saying he administered insulin, the panel concluded on the balance of probabilities that charge 5a is proved.

Charge 5b)

"On 18 November 2019, in relation to Resident C:

a) *Failed to record Resident C's glucose levels on her care notes before administering insulin."*

This charge is found NOT proved.

In light of the panel's decision regarding charge 5a, it determined that this charge falls away because it is charged as an alternative to charge 5a.

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 Necula'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 ability to practise kindly, safely and professionally.

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 determined whether the facts found proved amount to misconduct. Secondly, only if the facts found proved amount to misconduct, the panel then decided whether, in all the circumstances, Mr Necula'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 Adjei-Ntow invited the panel to take the view that the facts found proved amount to misconduct. The panel had regard to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015' the Code) in making its decision.

Ms Adjei-Ntow identified the specific, relevant standards where Mr Necula's actions amounted to misconduct. She submitted that the facts found proved amount to misconduct on the grounds of public protection and also otherwise in the wider public interest.

Ms Adjei-Ntow submitted that looking at the proven incidents separately and together the issues raised do fall well below the standards expected of a nurse and are serious enough to amount to misconduct as patients were put at risk in situations where the risk was avoidable.

Ms Adjei-Ntow submitted that Mr Necula's conduct falls below the standard of the NMC code. She submitted that the Professional standards of practise and behaviour for nurses and midwives' states that a nurse, midwife or nursing associate must pay attention to your well-being as well as your treatment and care. She referred the panel to the four themes of the NMC Code and submitted that Mr Necula did not prioritise patients and there was a

repeated theme of him not asking for help which demonstrates that he did not practise effectively or preserve patient safety.

Ms Adjei-Ntow further submitted that by the actions demonstrated as established by the proven facts, Mr Necula's behaviour falls below the standard expected of a registered nurse in his position, and as such amount to misconduct.

Submissions on impairment

Ms Adjei-Ntow 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 case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2).*

Ms Adjei-Ntow submitted that by reason of Mr Necula's misconduct there is a need to have regard to protecting the public and the wider public interest, and this includes the needs to declare and maintain proper standards and public confidence in the profession and in the NMC as a regulator. She submitted that in relation to all the charges found proved, Mr Necula's failures put the residents at risk of significant harm.

Ms Adjei-Ntow further submitted that Mr Necula's level of insight is a matter for the panel to judge. However, she drew the panel's attention to the fact that apart from some training certificates, Mr Necula has not provided any information regarding his strengthened practice. She submitted that he has not provided information about his currently employment which could have given insight into whether he still poses a risk. She invited the panel to consider all the information before it with regards to future risk.

Ms Adjei-Ntow submitted that as the concerns are of a clinical nature they may be addressed through strengthened practise by way of training and supervision. However, she submitted that despite receiving some training certificates from Mr Necula, the

information is not enough to demonstrate that the concerns have been addressed. Therefore, she submitted that Mr Necula's fitness to practise is impaired.

Mr Necula provided training certificates dated 1 April 2020, 3 April 2020, 16 April 2020 and 17 April 2020.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 31, *Grant* [2011] EWHC 927 (Admin) and *Calhaem v GMC* [2007] EWHC 2606 (Admin).

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 Necula's actions did fall significantly short of the standards expected of a registered nurse, and that Mr Necula'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.

2 Listen to people and respond to their preferences and concerns

To achieve this you must:

2.1) work in partnership with people to make sure you deliver care effectively

*'**6 Always practise in line with the best available evidence***

To achieve this, you must:

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

*'**8 Work co-operatively.***

To achieve this, you must:

8.2) maintain effective communication with colleagues

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

8.6) share information to identify and reduce risk.

*'**10 Keep clear and accurate records relevant to your practice***

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 sometime after the event

*'**13 Recognise and work within the limits of your competence***

To achieve this, you must:

13.1) accurately identify, observe and assess signs of normal or worsening physical and mental health in the person receiving care

*'**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:

18.1) prescribe, advise on, or provide medicines or treatment, including repeat prescriptions (only if you are suitably qualified) if you have enough knowledge of that person's health and are satisfied that the medicines or treatment serve that person's health needs.

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel noted that Mr Necula's conduct spanned all of the themes of the code in that he consistently failed to adequately keep any clinical records, he failed to do basic observations of a resident in his care, he tried to work outside his apparent competence, and he did not work cooperatively with colleagues.

The panel determined that, based on the evidence, Mr Necula put residents at risk of harm which could have been avoided if he asked for assistance. It noted that serious harm to residents was only likely averted by the other staff members around that intervened.

The panel considered the advice of the legal assessor, who referenced *Calhaem v GMC* [2007] stating, *'nevertheless and depending on circumstances, negligent acts and omissions which are particularly serious may amount to misconduct.'* In view of this advice and all the evidence before it the panel found that Mr Necula'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 Necula's fitness to practise is currently impaired.

In coming to its decision, the panel had regard to the Fitness to Practise Library, updated on 27 March 2023, which states:

> *'The question that will help decide whether a professional's fitness to practise is impaired is:*
> *"Can the nurse, midwife or nursing associate practise kindly, safely and professionally?"*
> *If the answer to this question is yes, then the likelihood is that the professional's fitness to practise is not impaired.'*

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

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

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

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

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

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

d) …'

The panel found that, based on the evidence before it, limbs (a) to (c) of the *Grant* test, as laid out above, were engaged. The panel finds that residents were put at risk and were caused physical harm as a result of Mr Necula's misconduct. Mr Necula's misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute.

Regarding insight, the panel was of the view that Mr Necula provided no evidence to demonstrate that he had reflected on and had remedied his failings. The panel was satisfied that the misconduct in this case is capable of being addressed. Therefore, the panel carefully considered the evidence before it in determining whether or not Mr Necula has taken steps to strengthen his practice. Although Mr Necula provided various training certificates the panel determined that they were effectively historic in context and did not address the full spectrum of his deficient practice.

The panel noted that because Mr Necula was previously represented by the RCN, he would have been told about the importance of providing detailed information to the panel regardless of attendance. The panel determined that the information before it from Mr Necula was minimal and provided no context regarding the strengthening of his practice.

The panel is of the view that there is a risk of repetition based on the absence of any evidence to show that Mr Necula has strengthened his practice. The panel determined that it had a no information before it to counterbalance the allegations that Mr Necula lacks the ability to work collaboratively and that he does not communicate well. However, the panel acknowledged that, unprompted, Witness 1 told the panel on more than one occasion in her oral evidence that Mr Necula has the potential to be a good nurse if he asked for support when he needed it.

Nevertheless, the panel determined based on all the evidence before it that after Mr Necula was given a verbal warning in September 2019 regarding the incident with Resident A, he did not address the concerns which contributed to the incidents regarding Residents B and C. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

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

The panel determined that a finding of impairment on public interest grounds is required because all the charges relate to clinical failures spanning all of the themes of the NMC code. Considering all the evidence, the panel determined that Mr Necula's practice was lacking, and he put residents at risk of significant harm. Further, it was of the view that the reason there were no serious consequences was not due to his actions but to the alertness and intervention of his colleagues. The panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case and therefore also finds Mr Necula's fitness to practise impaired on the grounds of public interest.

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

Sanction

The panel has considered this case very carefully and has decided to make a conditions of practice order for a period of 12 months. The effect of this order is that Mr Necula's

name on the NMC register will show that he is subject to a conditions of practice order and anyone who enquires about his registration will be informed of this order.

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 Adjei-Ntow informed the panel that in the Notice of Hearing, dated 2 November 2023, the NMC had advised Mr Necula that it would seek the imposition of a conditions of practice order if it found Mr Necula's fitness to practise currently impaired.

Ms Adjei-Ntow referred the panel to the Fitness to Practise Guidance on Sanction which states: 'The sanction must not go any further than it needs to meet the objective of protecting the public. She submitted that no further action is not appropriate for this case. She submitted that a caution order would also not be appropriate because it is usually imposed for cases at the lower end of the spectrum. She submitted that although some of the charges may reflect some lower end concerns, cumulatively, the charges are serious.

Ms Adjei-Ntow submitted that there has not been any evidence of deep-seated personality or attitudinal problems however, there are identifiable areas of Mr Necula's practice in need of assessment and training. She submitted that when considering evidence of general incompetence and whether there's been some potential and willingness to respond positively to retraining it is hard to assess because Mr Necula has not engaged with the NMC process. Nevertheless Ms Adjei-Ntow submitted that conditions will protect patients during the period they are in force and conditions can be created that can be monitored and assessed. Having considered that, she submitted that there are relevant, proportionate, workable and measurable conditions which may be put in place to protect the public.

However, Ms Adjei-Ntow submitted that the conditions would only be workable if Mr Necula starts to engage with the process and shows signs of insight into his failings. She submitted that therefore a conditions of practice order would be a sufficient and appropriate response to address the public interest concerns as there would be an ongoing risk to the public if Mr Necula was permitted to practise without restriction.

The panel accepted the advice of the legal assessor.

Decision and reasons on sanction

Having found Mr Necula'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, in particular SAN-3c. The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features:

- The panel has no information to demonstrate insight or remorse into his failings.
- There is a pattern of misconduct over a period of time which put patients at risk of suffering harm.

The panel also took into account the following mitigating feature:

- Mr Necula's colleague (Witness 1) told the panel during her oral evidence that he has the potential to be a good nurse with the right support and further training.

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the clinical risk. The panel decided that it would be neither proportionate nor in the public interest to take no further action.

It then considered the imposition of a caution order but again determined that, due to clinical concerns and the public protection issues identified, an order that does not restrict Mr Necula'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 Necula's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the issues identified. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on Mr Necula's registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. The panel took into account the SG, in particular:

- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *Identifiable areas of the nurse or midwife's practice in need of assessment and/or retraining;*
- *Patients will not be put in danger either directly or indirectly as a result of the conditions;*
- *The conditions will protect patients during the period they are in force; and*
- *Conditions can be created that can be monitored and assessed.*

The panel determined that it would be possible to formulate appropriate and practical conditions which would address the failings highlighted in this case.

Balancing all of these factors, the panel determined that that the appropriate and proportionate sanction is that of a conditions of practice order.

The panel was of the view that to impose a suspension order or a striking-off order would be wholly disproportionate and would not be a reasonable response in the circumstances of Mr Necula's case.

Having regard to the matters it has identified, the panel has concluded that a conditions of practice order will mark the importance of maintaining public confidence in the profession and will send to the public and the profession a clear message about the standards of practice required of a registered nurse.

The panel determined that the following conditions are appropriate and proportionate in this case:

'For the purposes of these conditions, 'employment' and 'work' mean any paid or unpaid post in a nursing, midwifery or nursing associate role. Also, 'course of study' and 'course' mean any course of educational study connected to nursing, midwifery or nursing associates.

1. You must limit your employment to one substantive employer. This must not be an agency.

2. You must not be the sole registered nurse in charge until deemed competent by another registered nurse, equivalent to a Band 6.

3. You must ensure that you are supervised by another registered general nurse any time you are working. Your supervision must consist of:
    a) Working at all times on the same shift as, but not always directly observed by, a registered nurse equivalent to a Band 6 or above until deemed competent.

4. You must work with your supervisor to develop a work plan which address the charges with particular regard to:
   a) Record keeping
   b) Improving communication skills
   c) The care of a deteriorating patient
   d) The care of a diabetic patient.

5. Meet monthly with supervisor to assess progress against the care plan in condition 4.

6. You must keep the NMC informed about anywhere you are working by:
   a) Telling your case officer within seven days of accepting or leaving any employment.
   b) Giving your case officer your employer's contact details.

7. You must keep the NMC informed about anywhere you are studying by:
   a) Telling your case officer within seven days of accepting any course of study.
   b) Giving your case officer the name and contact details of the organisation offering that course of study.

8. You must immediately give a copy of these conditions to:
   a) Any organisation or person you work for.
   b) Any employers you apply to for work (at the time of application).
   c) Any establishment you apply to (at the time of application), or with which you are already enrolled, for a course of study.

9. You must tell your case officer, within seven days of your becoming aware of:
    a) Any clinical incident you are involved in.
    b) Any investigation started against you.
    c) Any disciplinary proceedings taken against you.

10. You must allow your case officer to share, as necessary, details about your performance, your compliance with and / or progress under these conditions with:
    a) Any current or future employer.
    b) Any educational establishment.
    c) Any other person(s) involved in your retraining and/or supervision required by these conditions.

The period of this order is for 12 months.

Before the order expires, a panel will hold a review hearing to see how well Mr Necula has complied with the order. At the review hearing the panel may revoke the order or any condition of it, it may confirm the order or vary any condition of it, or it may replace the order for another order.

Any future panel reviewing this case would be assisted by:

- A reflective statement.
- Evidence of relevant training that addressed the charges.
- Testimonials.

This will be confirmed to Mr Necula in writing.

Interim order

As the conditions of practice 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 Necula's own interests until the conditions of practice 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 Adjei-Ntow who invited the panel to impose an interim conditions of practice order for 18 months in order to cover any potential appeal period. She submitted that such an order was necessary on the grounds of public protection and is otherwise in the public interest.

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 the only suitable interim order would be that of a conditions of practice order, as to do otherwise would be incompatible with its earlier findings. The conditions for the interim order will be the same as those detailed in the substantive order for a period of 18 months to cover any potential appeal period.

If no appeal is made, then the interim conditions of practice order will be replaced by the substantive conditions of practice order 28 days after Mr Necula is sent the decision of this hearing in writing.

That concludes this determination.