Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 15 December 2025 – Friday, 19 December 2025

Hybrid Hearing

Nursing and Midwifery Council
2 Stratford Place, Montfichet Road, London, E20 1EJ

&

Virtual Hearing

Name of Registrant:	Razvan Luca
NMC PIN:	14F0494C
Part(s) of the register:	Nurses part of the register – Sub Part 1 RN1: Adult nurse, Level 1 – 25 June 2014
Relevant Location:	Kent
Type of case:	Misconduct
Panel members:	John Kelly (Chair, Lay member) Kate Richards (Lay member) Tiago Horta Reis da Silva (Registrant member)
Legal Assessor:	Ashraf Khan
Hearings Coordinator:	Daisy Sims
Nursing and Midwifery Council:	Represented by Maham Malik, Case Presenter
Mr Luca:	Present and unrepresented
Facts proved by admission:	Charges 2(a), 2(b), 3, 4(a), 4(b) and 4(c).
Facts proved:	Charges 1(a), 1(b) and 5(a).
Facts not proved:	Not applicable
Fitness to practise:	Impaired

Sanction:	**Suspension order (9 months)**
Interim order:	**Interim suspension order (18 months)**

Details of charge (as amended)

That you, a Registered Nurse:

1. in or around December 2021, you:
    a. Failed to lock medication trolleys; **[PROVED]**
    b. Failed to keep the keys for the medication trolleys secure. **[PROVED]**

2. On 7 April 2022, in relation to Resident A, you:
    a. Failed to report 30mg of Citalopram that was missing; **[PROVED BY ADMISSION]**
    b. administered 100 micrograms of Fludrocortisone instead of 200 micrograms. **[PROVED BY ADMISSION]**

3. On 9 April 2022, in relation to Resident B, you administered 10mg of Memantine instead of 20mg. **[PROVED BY ADMISSION]**

4. On 9 April 2022, in relation to Resident C, you administered:
    a. 60mg of Monomil XL instead of 30mg; **[PROVED BY ADMISSION]**
    b. 25mg of spironolactone instead of 12.5mg; **[PROVED BY ADMISSION]**
    c. 50mg of sertraline instead of 25mg. **[PROVED BY ADMISSION]**

5. On 9 April 2022, in relation to Resident E you failed to follow proper procedures for discharging Resident E to hospital in that you:
    a. Left their medication box unsecured. **[PROVED]**

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

Decision and reasons on application to amend the charge

At the outset of the hearing, Ms Malik, on behalf of the Nursing and Midwifery Council ('NMC') made an application to amend charge 5.

The proposed amendment was to remove sub charges a and b from charge 5 and add the following words to the stem of the charge. The proposed amendment is as follows:

> That you, a Registered Nurse:
> […]
> 5. On 9 April 2022, in relation to Resident E you **failed to follow proper procedures for discharging Resident E to hospital in that you:**
> ~~a. Failed to handover medication to paramedics;~~
> ~~b. Failed to update the MAR chart;~~
> c. Left the**ir** medication box unsecured.
>
> And in light of the above, your fitness to practise is impaired by reason of your misconduct."

It was submitted by Ms Malik that the proposed amendment would narrow the scope of this charge and improve its particularity. She submitted that the original charge does not adequately reflect the mischief. She submitted that Resident E's medication should not have been given to the paramedics unless directly requested. Additionally, she submitted that this is being requested at the beginning of the hearing, so there is limited prejudice to you.

You stated that you do not agree with the application and stated that it is unfair but did not expand on why you thought this to be the case.

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

The panel was of the view that such an amendment, as applied for, was in the interest of justice. The panel was satisfied that there would be no prejudice to you and no injustice would be caused to either party by the proposed amendment being allowed because this amendment reduces the scope of the charge. It was therefore appropriate to allow the amendment, as applied for, to ensure clarity and accuracy.

Decision and reasons on application to admit the evidence of Witness 1 as hearsay.

The panel heard an application made by Ms Malik under Rule 31 to allow the written statement and the corresponding exhibits of Witness 1 into evidence. Witness 1 is the Home Manager for a care home under BUPA Healthcare. Witness 1 is not present at this hearing.

Ms Malik took the panel through correspondence between Witness 1 and the NMC. On 2 December 2025 Witness 1 emailed the NMC and stated that they would not be able to attend the hearing as they were travelling [PRIVATE]. There were further phone calls on 3 December 2025 in which Witness 1 explained that it would not be appropriate for them to join this hearing virtually as [PRIVATE]. Witness 1 provided flight details to the NMC showing that they would be out of the country from 12 December 2025 until 20 December 2025.

Ms Malik submitted that there is a good and cogent reason for the absence of this witness and she submitted that Witness 1 informed the NMC in good time. She submitted that the evidence of Witness 1 is not the sole evidence but is decisive for charges 2, 3, 4 and 5. Ms Malik informed the panel that Witness 1 was responsible for undertaking a local investigation. She submitted that the charges relate to medication errors and the local investigation report exhibited by Witness 1 is a summary of that investigation which was forensic in nature. She submitted that the evidence is therefore reliable and that this is not a case in which the evidence is based on recollection. She added that the exhibits of Witness 1 are supported by the evidence of Witness 2.

Ms Malik submitted that if the panel is not minded to admit the witness statement of Witness 1, it ought to admit the exhibits of Witness 1 as this evidence can be tested through Witness 2.

You explained that you object to some of the evidence. You said that the evidence overall is linked to other issues arising from the same nursing home. You submitted that the evidence was selective and parts were left out and you never understood this.

The panel heard and accepted the legal assessor's advice on the issues it should take into consideration in respect of this application. This included that Rule 31 provides that, so far as it is 'fair and relevant', a panel may accept evidence in a range of forms and circumstances, whether or not it is admissible in civil proceedings.

The panel considered the evidence of Witness 1 subject of the application to be relevant in that it relates directly to the charges in this case. It went on to consider whether it would be fair to admit the evidence as hearsay.

The panel determined that Witness 1's evidence is not the sole evidence in relation to the charges but it is decisive. However, there is other evidence before it in relation to each of the charges.

It then considered whether the evidence is demonstrably reliable or capable of being tested. It determined that it is capable of being tested as Witness 2 also provides documentary evidence which can be used in cross reference with the evidence of Witness 1. In addition, the panel can test some of the factual assertions by reference to the evidence of Witness 3 and Witness 4. The panel observed that the majority of Witness 1's statement refers to factual issues also covered in contemporaneous records.

Whilst the panel noted that you indicated that there are areas of Witness 1's evidence that you disagree with, you could not explain what particular areas these were.

The panel noted the record of a phone call between you and the NMC on 4 December 2025 in which you stated that you did not want to speak to any of the witnesses. You added that you did not see a point in questioning the witnesses. The panel considered that this call log shows that you had notice of the non-attendance of Witness 1. Additionally, the panel concluded that your comments indicate that the level of challenge that you would potentially make to Witness 1's evidence is limited.

There has been no suggestion, nor could the panel identify any reason for Witness 1 to fabricate or embellish their evidence or statement. It determined that the charges in this case are serious because they involve vulnerable residents and a series of medication errors and noted the possible implications for your career.

The panel determined that there is a good reason for Witness 1's non-attendance. Having learned of Witness 1's need to travel abroad at short notice, the NMC took steps, unsuccessful in the event, to secure their attendance virtually from abroad.

In balancing all of these circumstances, the panel came to the view that it would be fair and relevant to accept Witness 1's evidence into evidence, but would give what it deemed appropriate weight once the panel had heard and evaluated all the evidence before it. The panel had regard to the factual nature of Witness 1's evidence and the extent to which it could be tested by reference to documents and other witnesses.

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

Ms Malik made a request that this case be held in private on the basis that proper exploration of your case may involve reference to [PRIVATE]. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

You agreed with this application.

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

The panel determined to rule on whether or not to go into private session in connection with [PRIVATE] as and when such issues are raised in order to maintain your privacy.

Background

You worked as a registered nurse at the BUPA Fountains Lodge Nursing Home ('the Home') from 15 November 2021 to 17 March 2022.

It is alleged that during the night shift of 11-12 December 2021, you left the keys to a medication trolley in the treatment room instead of keeping the key on your person. It is also alleged that you left one of the medication trolleys unlocked and unattended, which is in breach of the BUPA's Medicines Management Policy ('the Policy').

On 18 March 2022, you transferred to another BUPA care home, Warrens Lodge ('the second Home') where you worked until 14 April 2022. It is alleged that between 5 and 9 April 2022, you breached the Policy by: failing to report missing medications and administering incorrect doses of medication to three residents.

It is also alleged that you failed to follow proper procedures when one of the residents was transferred to hospital in that you left the resident's medication box unsecured contrary to the Policy.

Decision and reasons on facts

At the outset of the hearing, you made admissions to charges 2(a), 2(b), 3, 4(a), 4(b) and 4(c).

The panel therefore finds charges 2(a), 2(b), 3, 4(a), 4(b) and 4(c) proved, by way of your admissions.

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 Malik on behalf of the NMC and by you.

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 2: Clinical Manager employed by BUPA
- Witness 3: Regional Quality Manager at BUPA Healthcare
- Witness 4: Registered Nurse and Residential Unit Manager at the Home
- Witness 5: Registered Nurse and Residential Unit Manager at the Home

The panel also heard evidence from you under oath.

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 both the NMC and you.

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

Charge 1

That you, a Registered Nurse:

1. In or around December 2021, you:
    a. Failed to lock medication trolleys;
    b. Failed to keep the keys for the medication trolleys secure.

This charge is found proved.

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

You were working at the Home as a registered nurse in December 2021.

The panel noted that the evidence of Witness 1 was admitted as hearsay and so approached this evidence with caution. The panel gave greater weight to the aspects of Witness 1's evidence that were borne out by other witnesses or related to undisputed factual matters. The panel noted that the Policy was exhibited by Witness 1 and was of the view that this is a factual document also referred to by Witness 4, Witness 5 and you in evidence. The panel therefore attached weight to this Policy.

The panel considered the following extract of the Policy:

Security and Access to Medications

• *The treatment room must always remain locked when not in use*

• Access to medication storage areas should be restricted to those with designated medication management responsibilities or people with the right to access these areas

• Keys for the medication storage areas will be kept separate from other keys

• Staff who are responsible for the medication keys on a shift are required to do this diligently and always know who has the keys

• Medication (including fridge keys) keys must be handed over at shift handover to next person in charge of medication management

• […] *Keys should remain with the nominated staff member throughout the shift when not in use and should not be stored elsewhere.* […]

• […]

• […]

Storage of Medication

[…]

- *All medication must be stored in locked storage areas e.g. cupboards, medication trolleys, medication room, medication refrigerator or CD cabinet (not applicable for Dom Care).* […]
- […]
- *If medication is stored in a medication trolley, the trolley must be secured to a wall when not in use.*
- *If the medication trolley is in use and staff are called away – the unattended trolley must be locked.*

[…]'

The panel heard from Witness 4 and Witness 5 that this Policy was operational at the time of the events. It also heard in oral evidence from these witnesses that the nurse in charge of the home is required to keep the medication keys on their person at all times and that employees were encouraged to read this Policy.

The panel noted evidence before it that you underwent a BUPA competence assessment

for medication management and administration between 21 to were 24 November 2021. It had sight of the assessment report which showed you were signed off as competent. Witness 4 told the panel that she carried out the assessment and you agreed that you had undergone it. The assessment report criteria specifically noted, under the subheading 'safety' that:

'*Staff member:*

- *Always ensures sight of an open medication trolley.*
- *Locked the trolley each time they walk away from the medication trolley, ensuring the keys are kept on their person*
- *Ensures that the medication is never left with a resident to take later, policy is followed if a resident chooses not to take their medication at that time […]'*

Based on this evidence, the panel was satisfied that you had a duty to lock medication trolleys and keep the keys secure and on your person. It also determined that you were aware of this duty because of your assessment.

The panel heard evidence from Witness 4 and Witness 5 that the medication trolleys were kept in a treatment room which was secured by a code lock. Both witnesses explained that not just one person had this code and it was not restricted to named persons. They explained that this code was known by other staff members who were not in charge of medication management.

The panel noted the NMC witness statement of Witness 5 which states:

> *'I worked with Razvan on a number of shifts and noticed that he was always leaving medication trollies* [sic] *unlocked in the treatment room. There were also times when he would leave the trolley open in communal areas when he took it out for medication rounds.'*

It also noted Witness 5's oral evidence. When asked as to the number of times that they had observed you doing this, they were unable to recall but stated that it was certainly more than one occasion.

It noted the following from of Witness 5's statement:

> *'I do not recall the exact dates on which he did this but he must have repeated it on 11 December 2021 because I had a discussion with him in my capacity as the Unit Manager of the Home'.*

The panel noted Witness 5's oral evidence that this refers to a supervision meeting with you on 11 December 2021. The panel saw the record of that supervision meeting, signed by you and Witness 5 and dated 11 December 2025. You told the panel in evidence that you had seen and signed the record.

It noted the record states that you will '*make sure medication trolley and cupboards are locked'.* Witness 5 told the panel that the issue of medication security was a key aspect of the meeting but that other matters were also discussed, including your own wellbeing at the time.

Whilst the panel noted in oral evidence you stated that the supervision meeting was concerned with your [PRIVATE], not medicines security and that you signed but did not read the document before doing so. The panel considered this implausible and an attempt on your part to distance yourself from the issue of your approach to medicines management and your responsibilities. The panel accepted the evidence of Witness 5 and the contemporaneous supervision meeting notes with your signature on. The panel was therefore satisfied that, after a series of failures following your assessment during November 2021, you were reminded of your duty to secure medication trolleys on 11 December 2021 by a supervision meeting.

The panel has had sight of a local statement from Witness 4 dated 13 December 2021 and a note of an interview with Witness 4 as part of the local investigation, dated 30 December 2021. Witness 4 described the events of the early hours of 12 December 2021 in that they came to the Home to take a handover from you and when they asked for the medication keys you said that the keys were on top of the medication trolley in the treatment room. Witness 4 went into the treatment room and found the keys on top of the medication trolley and noted that the door to the trolley was left ajar, and therefore unlocked. When interviewed as part of the local investigation on 30 December 2021 Witness 4's account, confirmed in oral evidence, was that they told you at the time that they keys should not have been left unattended but did not say more because you were keen to leave after a long shift.

The panel noted that there is no evidence before it of any reason for Witness 4 or Witness 5 to fabricate or embellish their account which are supported by contemporaneous documents. The panel therefore preferred their evidence to your own.

You consistently said that you kept the keys with you and that you handed the keys to Witness 4 that night. The panel noted that you suggested that the evidence of Witness 5 was fabricated but gave no indication as to why this was the case.

Based on all of the above, the panel determined, on the balance of probabilities, that in or around December 2021, you failed to lock medication trolleys and you failed to keep the keys for the medication trolleys secure by them being on your person during the shift.

Charge 5a)

5. On 9 April 2022, in relation to Resident E you failed to follow proper procedures for discharging Resident E to hospital in that you:

a. Left their medication box unsecured.

This charge is found proved.

In reaching this decision, the panel had regard to the Policy, Witness 4 and Witness 5's evidence and your own evidence. The panel noted that this charge relates to the period when you were working as the second Home as a registered nurse.

In your oral evidence you stated that whilst in the process of discharging Resident E to hospital you left Resident E's medication box on top of the medication trolley and that you did not put it inside as you were busy with paperwork. You stated that you left the box on the trolley inside the treatment room but not locked in the medication trolley. You stated that everything was secure because there was a code lock on the door of the treatment room.

Witness 4 and Witness 5 both explained that the Policy states that medication boxes must be securely locked away at all times inside the medication trolley. Both witnesses described the treatment room as being under the security of a code lock but not such that access was completely restricted. The panel therefore determined that the medication box, whilst it was in the treatment room, was not secured as per the requirements of the Policy.

In light of the above, the panel determined on the balance of probabilities that on 9 April 2022, in relation to Resident E you failed to follow proper procedures for discharging Resident E to hospital in that you left their medication box unsecured.

Decision and reasons on proceeding in the absence of Mr Luca

Ms Malik submitted that as of midday on Thursday 18 December 2025, prior to handing down its decision on facts, Mr Luca stopped engaging with the NMC. Ms Malik submitted

that service of notice of hearing is not an issue for this application as Mr Luca was priorly engaging.

[PRIVATE]. She informed the panel that the NMC has not been able to gain any further information about [PRIVATE]. Ms Malik referred the panel to a call log showing timings and descriptions of the communications attempts from the NMC to Mr Luca. She outlined to the panel that the last email sent to him at 15:01 had read receipts attached to the email and there is no further information confirming that Mr Luca has opened that email. In relation to that email Ms Malik submitted that the NMC has taken a kind and caring approach and stated that the tone of that email was deliberately sympathetic and open minded.

Ms Malik submitted that the panel needs to consider fairness in this case. She submitted that the panel has already waited four to five hours today. She emphasised the public interest in having these matters dealt with expeditiously. She reminded the panel that the charges relate to events during 2021 to 2022.

Ms Malik stated that the panel has already made its decision on facts and is now moving on to the misconduct and impairment stage. She submitted that there is no interim order on Mr Luca's registration. She submitted that it is important for these matters to be dealt with as soon as possible.

Ms Malik submitted that proceeding in the absence of Mr Luca is in the interests of justice.

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 decided to proceed in the absence of Mr Luca. In reaching this decision, the panel considered the submissions of Ms Malik, and the advice of the legal assessor. It

had regard to the factors set out in the decision of *R v Jones* and *General Medical Council v Adeogba* [2016] EWCA Civ 162 and to the overall interests of justice and fairness to all parties.

Mr Luca attended this hearing and engaged from day one, Monday 15 December 2025 up until 11:58 on day four, Thursday 18 December 2025. The panel had sight of a summary of email and telephone call communication attempts made by the NMC to Mr Luca on Thursday 18 December 2025. The panel noted that Mr Luca attended a preliminary meeting with the legal assessor at 10:00 on Thursday 18 December 2025 on the hearings link. In this meeting, Mr Luca was informed that the panel will likely be ready to hand down its decision on facts from 11:00 onwards. Mr Luca was seen in the lobby for the hearings link at 11:58 but he then left before being admitted into the hearing. Following this, multiple calls were made to Mr Luca with no response from 12:00 to 14:00. The panel had sight of an email sent to Mr Luca at 14:46 querying his attendance at the hearing, [PRIVATE], informing him that the NMC will be making an application to proceed in his absence if no response is received by 16:00 and sending the panels decision on facts.

The panel noted that:

- There is no issue with service of notice for this hearing because Mr Luca previously attended this hearing;
- Mr Luca was informed of the schedule for the hearing on Thursday 18 December 2025;
- Mr Luca was sent an email encouraging him to join the hearing link and explaining that the NMC would apply to proceed in his absence if no contact was made by 16:00;
- Mr Luca is aware of how to contact the NMC;
- There is no evidence of any explanation for Mr Luca's non-attendance;
- There is no evidence that formally adjourning this hearing will secure Mr Luca's attendance in the future;

- The charges against Mr Luca are serious and all of these charges have been found proved, either by admission or by the panel;
- The charges relate to issues that arose nearly five years ago; and
- There is a strong public interest in the expeditious disposal of this case.

Having taken account of all of the above, the panel determined that given the lack of explanation for Mr Luca's sudden non-attendance, the public interest in the expeditious disposal of this case outweighs any unfairness to Mr Luca in adjourning this case to secure his attendance. The panel will take steps to continue to contact Mr Luca and inform him of the schedule of each remaining day of this hearing so that he may reattend if he wishes.

The panel will draw no adverse inference from Mr Luca's absence in its findings.

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 Luca's fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC Guidance at DMA-1 defines fitness to practise as a registrant's ability to practise kindly, safely and professionally.

The panel, in reaching its decision, 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 therefore exercised its own professional judgement.

The panel adopted a two-stage process in its consideration. First, the panel must determine whether the facts found proved amount to misconduct. Secondly, only if the facts found proved amount to misconduct, the panel must decide whether, in all the

circumstances, Mr Luca's fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct and impairment

Ms Malik invited the panel to take the view that the facts found proved amount to misconduct. She referred to the terms of '*The Code: Professional standards of practice and behaviour for nurses and midwives 2015'* (the Code) in making its decision. She submitted that Mr Luca's conduct breached paragraph 18, 18.4 and 19, 19.1 of the Code. She submitted that these breaches are particularly serious. Ms Malik added that paragraph 14 and 14.2 of the Code are engaged in this case due to Mr Luca's lack of candour but submitted that having regard to these paragraphs of the Code, the breach was limited.

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

Ms Malik submitted that Mr Luca's past behaviour placed residents at an unwarranted risk of harm albeit that there is no evidence of actual harm to residents. She submitted that Mr Luca showed a pattern of behaviour with his misconduct starting in the winter of 2021 and continuing to the spring of 2022. She submitted that his actions were repeated in the same area of safe medication practice. She reminded the panel that Mr Luca received a formal warning by way of a supervision meeting due to his failure to keep the keys for the medication trolley secure and after he was transferred to the second Home, errors continued. She submitted that there were clear and unambiguous processes in place that were not followed.

Ms Malik submitted that administration of the correct dose of medication to residents is a basic tenet of the nursing profession.

Ms Malik addressed the panel on the context of the errors. She reminded the panel that it heard evidence of the [PRIVATE] at the time. She submitted that the panel can take this into account and accepted that this would have impacted his practice. She submitted that it is unclear as to whether that situation has improved.

Ms Malik submitted that there is no evidence to suggest that the working environment was particularly problematic.

Ms Malik submitted that Mr Luca admitted charges 2, 3 and 4 in their entirety at the outset of this hearing, however he has not shown any real insight into the charges. She submitted that Mr Luca attempted to distance himself from these issues and that his insight is limited.

Ms Malik submitted that as Mr Luca is not currently engaging, the panel cannot be confident that there is any strengthened practice in the area of safe medication practice. She submitted that this was not a one off clinical incident and there is no evidence to suggest a decrease in the risk of repetition. Ms Malik submitted that a finding of impairment is required on public protection grounds.

Ms Malik submitted that a finding of impairment is required to uphold proper professional standards and maintain public confidence in the profession.

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. 311, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), and *General Medical Council v Meadow* [2007] QB 462 (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.

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.'*

The panel was of the view that Mr Luca's actions fell significantly short of the standards expected of a registered nurse, and amount to serious breaches of the Code. Specifically:

> ***'14 Be open and candid with all service users about all aspects of care and treatment, including when any mistakes or harm have taken place***
>
> ***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:*
> *[…]*
> ***18.4*** *take all steps to keep medicines stored securely*
>
> ***19 Be aware of, and reduce as far as possible, any potential for harm associated with your practice***
> *To achieve this, you must:*
> ***19.1*** *take measures to reduce as far as possible, the likelihood of mistakes, near misses, harm and the effect of harm if it takes place*
> ***19.2*** *take account of current evidence, knowledge and developments in reducing mistakes and the effect of them and the impact of human factors and system failures*
> *[…]*

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 was of the view that paragraph 14 is engaged but in a limited manner. The panel accepted that it is engaged on the basis that Mr Luca failed to be open and candid about his medication errors and his failure particularly to report matters relating to residents meant that an open and honest conversation could not take place about the errors with residents and their families at the time.

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel was of the view that Mr Luca's errors were not minor or trivial. It was of the view that each of the charges represents a significant departure from the standards set out in the Code. The panel heard evidence of the risks posed to residents as a consequence of each of the failings, particularly the risk of harm in relation to under and over administrating medications.

The panel determined that each of these departures were serious and compounded given that Mr Luca went through a competency assessment in November 2021 in medications management and was reminded of his responsibilities during a supervisory meeting on 11 December 2021 which was triggered by a breach of the Policy. Mr Luca's breaches of the Code continued over an extended period of time.

The panel noted that in relation to charge 1, Mr Luca breached the standards set out in the Code just hours after the supervisory meeting with his manager. The panel determined that this fell significantly short of the standards expected.

The panel noted that fellow professionals in evidence described Mr Luca's actions as serious departures from the standards expected. The panel agreed with this and was of the view that other professionals would also view his actions in the same way.

The panel therefore found that Mr Luca's actions fell significantly short of the standards expected of a registered nurse and, in relation to each charge and sub charge, amount to misconduct.

Decision and reasons on impairment

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

In coming to its decision, the panel had regard to the NMC Guidance on *'Impairment'* (Reference: DMA-1 Last Updated: 03/03/2025) in which the following is stated:

> *'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 and to maintain professional boundaries. 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.

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 considered that all three of these limbs are engaged as to the past. In relation to the first limb the panel determined that Mr Luca's misconduct reflected in each of the charges clearly put residents at a risk of harm.

There was an obvious risk in Mr Luca's failure to secure the medication trolley and medication box, by over and under administering medications and failing to promptly report any discrepancies.

The panel considered that Mr Luca's misconduct brings the reputation of the profession into disrepute and determined that Mr Luca's misconduct breached fundamental tenets of the nursing profession, particularly in relation to preserving safety.

The panel then considered whether Mr Luca's conduct is remediable. The panel determined that medication errors are capable of remediation, though it noted that Mr Luca would need to put in significant effort to do so.

The panel considered whether Mr Luca has remediated his misconduct. The panel also considered the context of the charges. The panel heard from Mr Luca that the Home and the second Home were particularly busy working environments and that he worked an extended day on 11 December 2021 in that he worked an 18 hour shift. The panel also heard from Mr Luca about [PRIVATE]. The panel noted that there is no supporting evidence of these issues. The panel has no evidence of how Mr Luca is [PRIVATE] or potentially impact on his practice.

The panel noted Mr Luca's admissions. However, it considered that beyond these admission, Mr Luca provided no information to suggest that he understands the seriousness of the charges. In relation to charge 5, Mr Luca said during cross examination that he did not consider that he had done anything wrong. However, he later said that in future he would handle the medication box differently, and would secure it in the medication trolley. This was the only aspect of Mr Luca's evidence in which he accepted a need to act differently. The panel considered that this is not sufficient to satisfy it that Mr Luca has any understanding of the seriousness and potential impact of his misconduct on residents, other professionals or the profession overall. The panel had no evidence of any steps taken to address the concerns highlighted in this case, to strengthen his practice or

ensure that his misconduct is not repeated. The panel determined that Mr Luca's insight, despite his admissions to some of the charges, is limited.

There is no evidence before the panel as to what nursing work Mr Luca has done since 2022 and whether he has taken any steps to improve his practice. The panel also had no evidence of [PRIVATE]. The panel determined that based on its finding of a lack of insight together with no evidence of strengthening practice, that there remains a risk of repetition.

Having regard to Mr Luca's lack of insight, evidence of strengthened practice and reflection, the panel determined that his misconduct has not been remediated and that there remains a risk of repetition of it. The three limbs of the Grant test above are therefore engaged as to the future.

The panel therefore concluded 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 of the extent of Mr Luca's failings and his lack of insight. In addition, the panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case.

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

Sanction

The panel decided to make a suspension order for a period of nine months. The effect of this order is that the NMC register will show that Mr Luca's registration has been suspended.

Submissions on sanction

Ms Malik submitted that given the panel's findings on misconduct and impairment, it would be appropriate to impose a six month suspension order. Ms Malik informed the panel that in the Notice of Hearing, dated 5 November 2025, the NMC had advised Mr Luca that it would seek the imposition of a suspension order for a period of six months if it found Mr Luca's fitness to practise currently impaired.

Ms Malik referred to the panel's finding that there is a risk of repetition of Mr Luca's misconduct and that his insight is limited. She submitted that the aggravating features are: that this was a pattern of misconduct over a period of time including issues of medication storage which continued over two different employments; that the misconduct put people receiving care at risk of harm albeit there is no evidence of actual harm; there is a high risk of repetition.

In terms of mitigation, Ms Malik referred the panel to Mr Luca's submissions regarding [PRIVATE]. However, she submitted that in the absence of any evidence to suggest that this is no longer an issue, this would support the imposition of a suspension order and may be in Mr Luca's own interest.

Ms Malik referred to Mr Luca's limited insight and submitted that whilst this does not amount to a deep seated attitudinal concern, it is something he needs to work on.

In light of the above, Ms Malik submitted that a suspension order is required to protect the public and meet the public interest in upholding the standards of the profession.

Ms Malik referred the panel to a letter from the Disclosure and Barring Service ('DBS') to the NMC dated 8 February 2024. This shows that on 13 January 2024 Mr Luca was subject to barring from working with children and adults. She submitted that the NMC has been making efforts to seek information from DBS as to why Mr Luca is barred, but no information has been forthcoming. She submitted that this panel cannot speculate as to the reason for this DBS bar being in place.

She submitted that if the panel is not minded to impose a suspension order, the DBS barring means that a conditions of practice order would not be appropriate.

Decision and reasons on sanction

Having found Mr Luca's fitness to practise currently impaired, the panel went on to consider what sanction, if any, it should impose in this case. The panel 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 regard to the SG. The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel considered the DBS letter dated 8 February 2024. It heard from Ms Malik that this barring is currently in place. It noted that there is no further detail before it for the reason for this bar.

The panel took into account the following aggravating features:

- Mr Luca's lack of insight and no steps to strengthen his practice;
- His pattern of misconduct over a period of time;
- He acted with a lack of candour in relation to his medication errors;
- His actions placed vulnerable residents at risk of harm, particularly because of the type of medication involved.

The panel also took into account the following mitigating features:

- Mr Luca's early admissions to charges 2, 3 and 4.

The panel acknowledged Mr Luca's evidence regarding [PRIVATE], however given the type of misconduct in this case the panel gave less weight to this. Additionally, the panel noted that there was no actual harm to residents, however the panel gave this no weight in terms of the potential mitigation in this case because the risk of harm remained. It was of the view that the fact that no harm came to any residents was simply good fortune.

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

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict Mr Luca's practice would not be appropriate in these 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 Luca's misconduct is 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 Luca'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 which identifies a non-exhaustive list of criteria which indicate when a conditions of practice order may be appropriate as follows:

- *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;*
- *Potential and willingness to respond positively to retraining;*
- *The nurse or midwife has insight into any health problems and is prepared to agree to abide by conditions on medical condition, treatment and supervision;*
- *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 took into account the NMC Guidance at SAN-3c. It was of the view that whilst some of the criteria in this list may be applicable in this case, it determined that given Mr Luca's lack of insight a conditions of practice order would not be appropriate to meet the public interest or to manage the public protection concerns identified in this case. The panel noted that Mr Luca repeated his actions after being addressed by management through different formal procedures and disregarding clear policy. It therefore was of the view that the evidence before it does not suggest that Mr Luca would comply with a conditions of practice order. The panel then noted that Mr Luca is currently barred from working as a registered nurse due to being barred by DBS. The panel therefore determined that imposition of a conditions of practice would not be workable in this case.

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

- *A single instance of misconduct but where a lesser sanction is not sufficient;*
- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *No evidence of repetition of behaviour since the incident;*

- *The Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour;*
- *[…]*

The panel was satisfied that in this case, the misconduct is not fundamentally incompatible with remaining on the register. In addressing the points above, the panel considered that whilst this was not a single instance of misconduct, the events occurred during a relatively short period of time of Mr Luca's employment with BUPA. Whilst the panel accepted the submission on behalf of the NMC that there is no evidence of a harmful deep seated personality issues, it was concerned with Mr Luca's attitude towards established policy and procedures and his misconduct. The panel noted that whilst there is no evidence of this misconduct being repeated since the events, it had no information before it as to Mr Luca's practice since the charges arose. It also noted that Mr Luca has been barred from working as a registered nurse as a result of a DBS finding as of 30 January 2024. The panel is satisfied that Mr Luca has shown some insight by reason of his admissions to three of the five charges against him and his acknowledgment in relation to charge 5 that he would act differently going forward. However, the panel has concluded that there remains a risk of repetition of Mr Luca's misconduct.

It went on to consider whether a striking-off order would be proportionate but, taking account of all the information before it, the panel concluded that it would be disproportionate because it found that Mr Luca's misconduct is not such that it is incompatible with remaining on the register, and its earlier finding that his misconduct is remediable. Additionally, the panel determined that public confidence in the profession could be maintained without removing Mr Luca from the register and determined that a striking-off order is not the only order that would adequately protect the public and maintain the public interest. Whilst the panel acknowledges that a suspension may have a punitive effect, it would be unduly punitive in Mr Luca's case to impose a striking-off order.

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

The panel noted the hardship such an order will inevitably cause Mr Luca. However this is outweighed by the public interest in this case.

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

The panel determined that a suspension order for a period of nine months was appropriate in this case to mark the seriousness of the misconduct and to maintain public confidence. The panel was of the view that nine months would allow Mr Luca sufficient time to develop insight and strengthened practice.

At the end of the period of suspension, another panel will review the order. At the review 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 reviewing this case would be assisted by:

- Evidence of improved reflection including a reflective piece from Mr Luca;
- Evidence of strengthened practice and developed insight;
- Evidence that Mr Luca has kept up his knowledge of nursing practice and Continuous Professional Development (‘CPD’);
- Any other information that Mr Luca believes would assist a future reviewing panel.

This will be confirmed to Mr Luca in writing.

Interim order

As the suspension order cannot take effect until the end of the 28-day appeal period, the panel exercised its power to impose an interim order in this case. It noted that 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 Luca's own interests until the suspension sanction takes effect. The panel heard and accepted the advice of the legal assessor.

The panel determined that an interim order is necessary for the protection of the public and is otherwise in the public interest. The panel had regard to the seriousness of the facts found proved and the reasons set out in its decision for the substantive order in reaching the decision to impose an interim order.

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive order. The panel therefore imposed an interim suspension order for a period of 18 months due to adequately protect the public and maintain public interest over the appeal period.

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

That concludes this determination.