Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 3 March 2025 – Wednesday, 12 March 2025

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

Name of Registrant:	**Angel Roman**
NMC PIN	15C0126C
Part(s) of the register:	Registered Nurse – Sub part 1 Adult Nursing (Level 1) – 4 March 2015
Relevant Location:	Daventry
Type of case:	Misconduct
Panel members:	Graham Gardner (Chair, lay member) Mary Karasu (Registrant member) Paul Hepworth (Lay member)
Legal Assessor:	Guy Bowden
Hearings Coordinator:	Stanley Udealor
Nursing and Midwifery Council:	Represented by Bibi Ihuomah, Case Presenter
Mr Roman:	Not present and unrepresented at the hearing
Facts proved:	Charges 2a and 2c
No evidence offered:	Charge 2b
Facts not proved:	Charges 1a and 1b
Fitness to practise:	Impaired
Sanction:	**Striking-off order**

Interim order: **Interim suspension order (18 months)**

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Mr Roman was not in attendance and that the Notice of Hearing letter had been sent to Mr Roman's registered email address by secure email on 21 January 2025.

Ms Ihuomah, 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 venue of the hearing and, amongst other things, information about Mr Roman'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 Roman 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 Roman

The panel next considered whether it should proceed in the absence of Mr Roman. It had regard to Rule 21 and heard the submissions of Ms Ihuomah who invited the panel to continue in the absence of Mr Roman.

Ms Ihuomah referred the panel to the email from Mr Roman to the NMC dated 13 February 2025, which stated:

'Just I want to bring to your attention that from 01 March to 05 of March I am not in the country. Please inform the panel to organised the meeting after that time.' (sic)

Ms Ihuomah informed the panel that the NMC, in response to Mr Roman's email, requested the purpose of the trip, when it was booked and to provide evidence that he was not in the country such as a flight itinerary. She referred the panel to the NMC emails dated 20 February 2025 and 28 February 2025 respectively. However, there was no further response from Mr Roman. Ms Ihuomah submitted that Mr Roman had sufficient notice of this hearing and there had been no engagement from him with the NMC since the time of the referral, apart from his email on 13 February 2025. She submitted that Mr Roman has voluntarily absented himself from today's hearing and that it was fair and appropriate for the hearing to proceed in his absence.

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.

The panel has decided to proceed in the absence of Mr Roman. In reaching this decision, the panel has considered the submissions of Ms Ihuomah, the proceeding in absence bundle and the advice of the legal assessor. It has had particular regard to the factors set out in the decision of *R v Jones* and *General Medical Council v Adeogba* [2016] EWCA Civ 162 and also had regard to the overall interests of justice and fairness to all parties. It noted that:

- Mr Roman's email dated 13 February 2025 indicated that he was aware of the dates of the hearing.
- Mr Roman indicated in his email to the NMC dated 13 February 2025 that he would not be in the country from 1 March 2025 to 5 March 2025

- In two respective emails dated 20 February 2025 and 28 February 2025, the NMC, in response to Mr Roman's email, requested details of his trip and for him to provide evidence that he was not in the country
- Mr Roman has not provided any evidence as requested by the NMC nor responded to the NMC since his email on 13 February 2025
- Mr Roman had requested an adjournment of the hearing until after 5 March 2025
- Mr Roman was provided with sufficient notice of this hearing on 21 January 2025
- Mr Roman had not engaged with the NMC until his email on 13 February 2025 and he has not further engaged with the NMC after that date
- There was no assurance from Mr Roman that he would attend the hearing after 5 March 2025, therefore, there is no reason to suppose that adjourning would secure his attendance at some future date
- Six witnesses are scheduled to give live evidence over the coming days
- Not proceeding may inconvenience the witnesses, their employers and, for those involved in clinical practice, the clients who need their professional services
- The charges relate to events that occurred in 2023 and 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 Roman in proceeding in his absence. Although the evidence upon which the NMC relies will have been sent to Mr Roman at his registered address, 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 Roman's decision 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 Roman. The panel will draw no adverse inference from Mr Roman's absence in its findings of fact.

Details of charge

That you, a registered nurse:

1. On or about 9 May 2023 you:
    a. Failed to identify Resident C as a medical emergency;
    b. Failed to escalate Resident C's deterioration urgently.

2. On 23 May 2023:
    a. Slapped Resident A on one or more occasions to the face;
    b. Took Resident A outside before seeking medical advice when their oxygen saturation was low.
    c. Failed to dispense and/or administer Pregablin 50mg to Resident B

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

Decision and reasons on application to offer no evidence with respect to charge 2b

The panel heard an application made by Ms Ihuomah to offer no evidence with respect to charge 2b.

Ms Ihuomah highlighted that, in limited circumstances, it may be appropriate for the NMC to use its power to offer no evidence. She submitted that this power was identified and confirmed in the case of *PSA v NMC & X* [2018] EWHC 20 (Admin) (see Appendix 5) at

paragraphs 55-57. She stated that when the NMC decides to apply to offer no evidence, it will always provide the evidence that has been gathered during its investigation to assist the panel in making its decision.

Ms Ihuomah referred the panel to the NMC Guidance in relation to offering no evidence (DMA-2). She stated that the relevant limb for the purpose of this application is *'it has become apparent that the case examiners' decision was made on an incorrect basis'*.

Ms Ihuomah submitted that there were significant evidential issues in relation to charge 2b, in that there was no evidence that Mr Roman should have sought medical advice before taking Resident A outside. She highlighted that Witness 1 did not raise any concerns in her witness statement or at the time of the incidents that Mr Roman had taken Resident A outside for fresh air before seeking medical advice when their oxygen saturation was low. On the contrary, in the local investigation interview held on 5 June, Witness 1 stated that *'AR then said to take him outside which I thought was a good idea as some fresh air may help'.*

Ms Ihuomah noted that the allegation in charge 2b was not raised nor was it put to Mr Roman in his local investigation interview which was held on 5 July.

Ms Ihuomah submitted that it is the position of the NMC that there was no evidence to support the charge that Mr Roman should have sought medical advice before taking Resident A outside when their oxygen saturation was low. She asserted that the Case Examiners erred in their decision to refer this concern to the Fitness to Practise committee. She submitted that there is therefore no realistic prospect of a properly directed panel finding any facts proved.

In conclusion, Ms Ihuomah invited the panel to grant the NMC application to offer no evidence with respect to charge 2b.

The panel accepted the advice of the legal assessor.

The panel had regard to the NMC Guidance in relation to offering no evidence (DMA-2) The panel carefully reviewed the NMC evidence before it. The panel decided that there was no evidence to support charge 2b and it therefore granted the application.

Background

The charges arose whilst Mr Roman was employed as a registered nurse by Elysium Healthcare (the Trust) at Badby Park Care Home (the Home). On 17 July 2023, Mr Roman was referred to the NMC by the Trust.

Mr Roman usually worked night shifts on [PRIVATE] but he also did overtime on day shifts on [PRIVATE]. On 23 May 2023, Mr Roman worked overtime on [PRIVATE] and was working alongside two other registered nurses and a team of healthcare assistants. Mr Roman and Witness 1 attended to Resident A, following concerns that he had deteriorated and upon further examination, he was found to be de-saturated. Whilst continuing their assessment of Resident A, Mr Roman and Witness 1 took him outside to enable him to receive air however the resident continued to deteriorate.

It was alleged that Mr Roman had slapped Resident A multiple times on his face in the presence of Witness 1. Although there were no injuries sustained as a result of Mr Roman's alleged actions, Witness 1 raised her concerns regarding Mr Roman slapping the resident to the management team. Mr Roman denied the allegation and requested that the Close Circuit Television (CCTV) coverage of the alleged incident be examined. However, when the CCTV was reviewed, it was reported that the CCTV did not cover the area where the alleged incident had occurred.

Other concerns were raised in relation to medication management and administration. It was reported that, on the morning of 23 May 2023, a dosage of Pregablin 50mg was

scheduled to be administered to Resident B by Mr Roman. It was alleged that Mr Roman failed to dispense and/or administer the medication to Resident B.

In addition, further concerns were raised in relation to Mr Roman's management and reaction to Resident C's deteriorating condition. It was alleged that Mr Roman did not recognise or respond to Resident C in a timely and appropriate manner as he called another nurse to manage the situation.

On 23 May 2023, Mr Roman was suspended by the Trust pending the commencement of the investigation by Witness 3. On 28 June 2023, the matter was referred to a disciplinary hearing. At the conclusion of the Trust disciplinary hearing on 5 July 2023, Mr Roman was dismissed from the Trust.

Decision and reasons on application to admit additional document into evidence

The panel heard an application made by Ms Ihuomah to admit the minutes of the suspension meeting between Witness 3 and Mr Roman held on 23 May 2023, into evidence.

Ms Ihuomah highlighted that Witness 3 had stated in her witness statement and during her oral evidence that, in an informal meeting with Mr Roman on 23 May 2023, he had initially admitted the allegation of slapping Resident A to her. Witness 3 further stated that she suspended him pending the conclusion of an investigation into the incident. Ms Ihuomah noted that Witness 3 had highlighted that there were minutes taken of that meeting and she had read out the minutes to the panel.

Ms Ihuomah submitted that the existence of the minutes of the meeting only came into light during the oral evidence of Witness 3 and it also supports her evidence of what

transpired during that meeting. Ms Ihuomah therefore submitted that it was relevant and fair to admit the minutes of the meeting into evidence.

The panel accepted the advice of the legal assessor.

The panel first considered whether the minutes of the meeting dated 23 May 2023 was relevant to this case. The panel took into account that Witness 3 had alleged that, during her meeting with Mr Roman, he had initially admitted the allegation of slapping Resident A but he later denied it. The panel noted that Witness 3 had highlighted that she had the minutes of that meeting to support her assertion. The panel was of the view that the minutes of the meeting would provide context as to whether Mr Roman had initially admitted the allegation when he was first told about it in the meeting with Witness 3. Accordingly, the panel determined that the minutes of the meeting dated 23 May 2023 are relevant to this case.

The panel next considered whether it would be fair to admit the minutes of the meeting into evidence. It was of the view that given that the minutes of the meeting provide clarification as to whether Mr Roman had initially admitted the allegation – and support Mr Roman's account, there will be no unfairness caused if it was admitted into evidence. Accordingly, the panel determined that it is relevant and fair to admit the minutes of the meeting dated 23 May 2023 into evidence.

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 Ihuomah.

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

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: Staff nurse at the Home at the time of the incidents
- Witness 2: Receptionist at the Home at the time of the incidents
- Witness 3: Interim Hospital Director at the Home at the time of the incidents
- Witness 4: Service Lead at the Home at the time of the incidents
- Witness 5: Service Lead at the Home at the time of the incidents.
- Witness 6: Hospital Director for the Avalon Centre at the time of the incidents.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor.

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

Charges 1a and 1b

1. On or about 9 May 2023 you:
    a. Failed to identify Resident C as a medical emergency;

b. Failed to escalate Resident C's deterioration urgently.

These charges are found NOT proved.

The panel took account of the witness statement of Witness 4 in which he stated:

> *'…there was one incident when I thought that Angel was too relaxed and didn't treat it as an emergency when I would have treated it as emergency. I was in a room with one patient when Angel came in and told me that another patient was suffocating. Angel didn't pull the emergency bell which we would use. I went with Angel to respond to the incident as I saw the charge nurse running and shouting 'I am calling an ambulance'. I responded to the incident and the signs of hypoxia and stabilized the patient. Angel was there to support me. The patient wasn't harmed as a result of the incident and I was happy with how it was managed but I felt that we should have acted more quickly as it was an emergency.'*

The panel took into consideration that in her witness statement dated 27 January 2025, Witness 5 stated:

> *'…Concerns were reported that Angel wasn't quick enough in his response to deteriorating resident and that he didn't follow the process. He did not call for help when the residents oxygen saturations were 80%, or attempt to reposition her, or administer oxygen. I believe his first action was to request a nebuliser…'*

The panel took into account that Witness 4 stated during his oral evidence that he had a debriefing session with Mr Roman after the incident in which Witness 4 expressed his frustration in how the situation was managed. Witness 4 highlighted during his oral evidence that Mr Roman had felt that he had taken the necessary steps in identifying Resident C as a medical emergency and escalating her deterioration urgently by calling for help at that time.

The panel bore in mind that it is one of the fundamental duties of a nurse to identify any deteriorating patient under their care as a medical emergency and to escalate such deterioration urgently. The panel took into consideration that Mr Roman had stated during his supervision meeting with Witness 5, as recorded in the Supervision Note dated 11 May 2023, that when he had noticed that Resident C sounded chesty and their airways were closed, he had first contacted Witness 4 who suggested that he should use a nebuliser on the resident. Mr Roman stated that he had used the nebuliser and conducted a saturation test which showed Resident C's oxygen saturation was 80%. Mr Roman stated that he had searched for the suction machine but he could not find it and he called for help by contacting the charge nurse, who was immediately outside Resident C's room, and Witness 4.

The panel noted that Witness 4 had expressed his frustration that Mr Roman did not ring the emergency bell and did not take steps in stabilising Resident C by clearing her airways. However, Witness 5 had highlighted in her oral evidence that ringing the emergency bell would not be necessary if the nurse had called for help by contacting other nurses. The panel accepted the position of Witness 5. It was of the view that the purpose of the emergency bell was to alert other nurses for assistance during emergencies and this was still achieved by Mr Roman through his action of contacting the charge nurse and Witness 4 for assistance at the time of the incident. In this regard, Mr Roman had therefore escalated Resident C's deterioration urgently.

The panel also considered the actions of Mr Roman in conducting the saturation test, using a nebuliser and searching for the suction machine as an indication that he had identified Resident C's situation as a medical emergency and had taken steps to stabilise her, before calling for help. The panel noted that Witness 4 had highlighted during his oral evidence that he did not regard the incident as so serious to be referred to a disciplinary process given that Mr Roman seemed to have learnt from it and had provided assistance in stabilising Resident C. Witness 4 concluded, '*They took the right steps, but could have done* more'.

Having considered the evidence before it, the panel was satisfied that, on or about 9 May 2023, Mr Roman had identified Resident C as a medical emergency and had escalated her deterioration urgently. It therefore found charges 1a and 1b not proved.

Charge 2a

2. On 23 May 2023:
    a. Slapped Resident A on one or more occasions to the face;

This charge is found proved.

The panel took account of the witness statement of Witness 1 in which she stated:

> *'The registrant then came back with another SATS machine and the resident's reading had dropped again to 81. The resident was getting irritated with the registrant as he wasn't explaining what he was doing or why….. The resident stopped making any noises but was still moving and conscious. Then, completely out of the blue, the registrant slapped the resident on the side of his face approximately five times…… I was completely shocked, there was no reason or justification for it. It was hard enough for the receptionist to hear who was around five metres away. It all happened so quickly, the resident didn't even have time to respond other than a grumble/shouting sort of noise.'*

The panel considered the witness statement of Witness 2 in which she stated:

> *'Angel then came outside and placed a saturations monitor on Resident A's finger… I then saw Angel hit Resident A on the face several times between 4-5 times. I heard Angel slapping the Resident A and then I turned my head and I saw Angel hitting Resident A The view was clear with no obstruction and I was about 5 steps away from the incident.'*

The panel took into account that Witnesses 1 and 2 were both clear and consistent in their oral and documentary evidence, including in their respective investigation meetings with Witness 3, that Mr Roman had slapped Resident A on his face. The panel further considered that the respective accounts of Witnesses 1 and 2 were also consistent with the account of the incident given by Mr 1 during his investigation meeting with Witness 3. The panel noted that, immediately following the incident, Witness 1 asked Witness 2 *'Oh my god, did you see it?*' (or words to that effect) and indicated her intention to report the matter. The panel determined that there was no evidence before it to suggest that there was any collusion among Witnesses 1, 2 and Mr 1 to fabricate the allegations, despite the assertions of Mr Roman to the contrary.

The panel took into account that, during the meeting between Mr Roman and Witness 3 dated 23 May 2023, it initially appeared that Mr Roman had admitted that he had slapped Resident A to rouse him. However, when Witness 3 further asked him about the incident during that same meeting, Mr Roman subsequently denied slapping Resident A on his face and maintained this position during the subsequent investigation meeting and disciplinary hearing.

The panel further noted that Witness 4 had stated during his oral evidence that, as he escorted Mr Roman from the premises, at the conclusion of his meeting with Witness 3 on 23 May 2023, Mr Roman admitted that he had slapped Resident A on his face, and he demonstrated a flat-handed '*tap*' several times to his cheek. Witness 4 demonstrated to the panel a gentle, one-handed slapping motion to the left-hand side of his face, to visualise what Mr Roman said he had done and how he did it. Witness 4 further told the panel that Mr Roman had stated that he knew he probably should not have done it but that he did it looking for a response from Resident A.

The panel took into consideration that Witnesses 3, 4 and 6 all confirmed during their respective oral evidence that there was no reasonable explanation for a registered nurse to slap a resident to the face as nurses are trained to utilise appropriate techniques to rouse a patient/resident. Witnesses 3 and 4 both confirmed that the appropriate technique

to rouse a patient or look for a response forms part of the basic training for registered nurses and that Mr Roman would have been trained in that regard.

Given the consistency of the respective accounts of Witnesses 1, 2 and Mr 1, the panel accepted their evidence. Based on the evidence before it, the panel was satisfied that it was more likely than not, that on 23 May 2023, Mr Roman had slapped Resident A on one or more occasions to the face. It therefore found charge 2a proved.

Charge 2c

2. On 23 May 2023:
   c. Failed to dispense and/or administer Pregabalin 50mg to Resident B

This charge is found proved.

In reaching this decision, the panel had regard to the Trust IRS, Medication Administration Record (MAR) chart and the Drugs Liable for Misuse (DLM) Record. The panel took into account that Witness 4 stated during his oral evidence that there was usually a stock check on medication undertaken at each shift handover at the Home. The panel noted that the stock check at the beginning of the day shift on 23 May 2023 showed that there were thirty-seven tablets of pregabalin at the night shift handover. However, at the end of the day shift, the stock check showed that there still remained thirty-seven tablets of pregabalin. This demonstrated that Resident B had not been given his day dosage of pregabalin on 23 May 2023.

The MAR chart for Resident B showed that pregabalin was to be administered to Resident B twice daily. The panel noted that, on 23 May 2023, the column to be signed to indicate that pregabalin had been administered to Resident B was crossed out. Witness 4 had told the panel that he could not provide an explanation for the crossing out of that column without reading the reverse side of the MAR chart as it contained the key for such information. The panel further noted that Witness 4 confirmed that Mr Roman was conducting the medication round on the day shift of 23 May 2023 and he was thus

responsible for the administration of medication to Resident B. Mr Roman had also administered other drugs to Resident B that morning.

Based on the evidence before it, the panel was satisfied that it was more likely than not, that on 23 May 2023, Mr Roman failed to dispense and administer pregabalin 50mg to Resident B. The panel therefore found charge 2c proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether Mr Roman's fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's suitability to remain on the register unrestricted.

The panel, in reaching its decision, has recognised its statutory duty to protect the public and maintain public confidence in the profession. Further, it bore in mind that there is no burden or standard of proof at this stage and it has therefore exercised its own professional judgement.

The panel adopted a two-stage process in its consideration. First, the panel must determine whether the facts found proved amount to misconduct. Secondly, only if the facts found proved amount to misconduct, the panel must decide whether, in all the circumstances, Mr Roman's fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct

Ms Ihuomah submitted that slapping or using force against a vulnerable resident is fundamentally incompatible with being a registered nurse and it raises fundamental concerns about Mr Roman's ability to uphold the standards and values of The Code: Professional standards of practice and behaviour for nurses and midwives 2018' ("the

Code"). She asserted that Mr Roman's actions were a serious departure from the standards expected of a registered nurse as his actions placed patients at a risk of harm.

Ms Ihuomah highlighted that, in relation to charge 2a, Resident A had an acute brain injury, cognitive impairment and was non-verbal. He was unwell and was subsequently transferred to hospital. Ms Ihuomah noted that Witness 6 had stated in his witness statement that although there did not appear to be any lasting physical harm to Resident A, there may have been a psychological impact on the resident. Furthermore, Witness 3, in her witness statement, stated that the incident could have caused some level of distress, trauma and upset to Resident A.

With respect to charge 2c, Ms Ihuomah submitted that Resident B had a brain injury and therefore, Mr Roman's action in not administering the required medication placed the resident at risk of being in pain, which posed a risk of harm to that resident. Moreover, Mr Roman's colleagues would have been left unassured that medications have been administered as prescribed. These risks were confirmed by Witness 4 in his evidence.

Ms Ihuomah submitted that there is a public interest in preserving confidence in the nursing profession by ensuring that registered nurses provide safe care to patients at all times, which by definition, excludes any use of force against a resident. She submitted that Mr Roman's conduct breached the following sections of the Code: 1.1 and 18. In conclusion, Ms Ihuomah invited the panel to find that charges 2a and 2c amounted to misconduct.

Submissions on impairment

Ms Ihuomah stated that the panel should consider the following question in deciding whether a professional's fitness to practise is impaired:

> *'Can the nurse, midwife or nursing associate practise kindly, safely and professionally?'*

Ms Ihuomah submitted that it was the position of the NMC that the answer to that question would be in the negative. She invited the panel to consider the test formulated By Dame Janet Smith in the *Fifth Shipman Report,* quoted in the case of *CHRE v NMC and Grant* [2011] EWHC 927 (Admin). She submitted that limbs a, b and c of the *Grant* test were engaged in this case when looking at past conduct.

Ms Ihuomah submitted that Mr Roman's conduct placed residents at unwarranted risk of harm. She asserted that the reputation of the nursing profession would be damaged if Mr Roman was to be permitted to practise unrestricted due to the seriousness of the misconduct. She emphasised that the public would expect nurses to provide adequate care to all patients under their care.

Ms Ihuomah further referred the panel to the test on impairment set out in the case of *Cohen v GMC [*2008] EWHC 581 (Admin). She submitted that if Mr Roman's misconduct was solely the issue of medication administration and management, as contained in charge 2c, it could have been easily remediable. However, when combined with Mr Roman's conduct in charge 2a, she submitted that it is the position of the NMC that Mr Roman's misconduct could not be easily remediated. Ms Ihuomah referred the panel to the NMC Guidance – Can the concern be addressed (FTP-15a), which provides examples of conduct which may not be possible to address and where steps such as training courses or supervision at work are unlikely to address the concerns. This includes incidents of violence towards all neglect or abuse of people receiving care children or vulnerable adults. Ms Ihuomah submitted that it is the position of the NMC that the misconduct in this case falls under this category.

Ms Ihuomah submitted that there was no evidence that Mr Roman had taken any steps to remediate his misconduct as there was no evidence of training or remedial action. She asserted that this demonstrated that there is a high risk of repetition. She highlighted that, in relation to charge 2a, Mr Roman has provided no explanation for his actions. She invited the panel to consider the conduct of Mr Roman after the incident as he had gone from providing an initial response of slapping to rouse Resident A, then to a blanket denial and then claiming that he had no recollection of the incident. She highlighted that Mr

Roman had made inconsistent responses in the disciplinary hearing with Witness 6 where he had expressed his view that witnesses had either colluded, were lying or that the evidence had in fact been negatively influenced in some way. Ms Ihuomah emphasised that these allegations have in fact been dismissed by this panel as it had earlier found that there was no evidence of any collusion among the witnesses. She argued that the conduct of Mr Roman was relevant in considering whether his misconduct had been remediated.

Ms Ihuomah submitted that Mr Roman has not engaged with the NMC, and it is the position of the NMC that his lack of engagement was evidence that he is still impaired. She asserted that there was no information relating to insight, reflection and understanding of the issues raised in the proven allegations. Ms Ihuomah therefore invited the panel to find that Mr Roman's fitness to practise is impaired on grounds of public protection.

Ms Ihuomah stated that nurses occupy a position of privilege and trust in society and are expected at all times to be professional whilst discharging their duties in an effective, efficient and safe manner. 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 exercise leadership skills, apply clinical skills and ensure that their conduct at all times justifies both their patients and the public's trust in the profession.

Ms Ihuomah invited the panel to bear in mind the overarching objectives of the NMC to protect, promote and maintain the health, safety, and well-being of the public and patients, and to uphold and protect the wider public interest. This includes promoting and maintaining public confidence in the nursing and midwifery professions and upholding the proper professional standards for members of those professions. Ms Ihuomah submitted that it is for these reasons that public confidence in the profession would be undermined if a finding of impairment was not made in this case.

In conclusion, Ms Ihuomah invited the panel to find that Mr Roman's fitness to practise is impaired on both public protection and public interest grounds.

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), *General Medical Council v Meadow* [2007] QB 462 (Admin), *Cohen v GMC* and *CHRE v NMC and Grant.*

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

> ***'1 Treat people as individuals and uphold their dignity***
> *To achieve this, you must:*
> ***1.1*** *treat people with kindness, respect and compassion*
> ***1.5*** *respect and uphold people's human rights*
>
> ***2 Listen to people and respond to their preferences and concerns***
> *To achieve this, you must:*
> ***2.6*** *recognise when people are anxious or in distress and respond compassionately and politely*
>
> ***8 Work cooperatively***
> *To achieve this, you must:*
> ***8.1*** *respect the skills, expertise and contributions of your colleagues, referring matters to them when appropriate*
> ***8.2*** *maintain effective communication with colleagues*
> ***8.5*** *work with colleagues to preserve the safety of those receiving care'*

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct.

With respect to charge 2a, the panel took into account that Mr Roman had initially stated during his meeting with Witness 3 on 23 May 2023 that he had slapped Resident A to rouse him. Nevertheless, the panel considered Mr Roman's conduct to be inappropriate, unprofessional and wholly unacceptable. It was of the view that there was no justification for Mr Roman's conduct as nurses are trained to utilise appropriate techniques to rouse a patient/resident. The panel noted that Resident A was a vulnerable resident, had an acute brain injury, cognitive impairment and was non-verbal. It was therefore of the view that Mr Roman's conduct posed a risk of harm and may have caused actual harm to Resident A in terms of emotional and psychological distress.

The panel concluded that Mr Roman's conduct would be seen as deplorable by other members of the profession as Witness 1 was so shocked by Mr Roman's conduct that she immediately reported the issue to the Trust. The panel determined that Mr Roman therefore failed to work with and communicate effectively with his colleague, at the time of the incident, in order to ascertain the best approach to assist Resident A. The panel considered Mr Roman's conduct as a serious breach of the fundamental standards of professional conduct and behaviour that a registered nurse is expected to maintain. It therefore determined that Mr Roman's conduct in charge 2a amounted to misconduct. The panel was of the view that Mr Roman's conduct was a reckless spur of the moment action to Resident A at the time of the incident and there was no evidence that there was a pattern of such behaviour towards Resident A by Mr Roman.

In relation to charge 2c, the panel had regard to the MAR chart of Resident B. it noted that Mr Roman had administered other medications to Resident B as prescribed save from the pregabalin. The panel took into account that there was no evidence to indicate that Mr Roman's conduct in charge 2c was a pattern of behaviour and he was not provided with the opportunity to respond to the allegation at the time. The panel took into consideration that although Resident B was a vulnerable resident with a brain injury and that pregabalin was prescribed as a pain relief, there was no known negative impact on Resident B as a

consequence of Mr Roman's conduct. The panel noted that in his witness statement, Witness 3 had stated:

> *'For a patient that is prescribed such medication and receives it several times a day, it is probable that the patient would still have the drug in their system. However, missing a dose could impact on patient being in pain, but there is a small chance of this having a big impact on the patient…'*

Having considered the circumstances of the incident, the panel was satisfied that Mr Roman's conduct was an isolated incident and amounted to an honest mistake on his part. The panel bore in mind that the NMC Guidance on Misconduct (FTP-2a) provides that not all poor practice amount to serious professional misconduct. Consequently, the panel determined that Mr Roman's conduct in charge 2c did not meet the threshold of seriousness as to amount to serious misconduct.

In conclusion, having considered the charges found proven individually and as a whole, the panel determined that Mr Roman's conduct in charge 2a did fall significantly short of the conduct and standards expected of a nurse and amounted to serious misconduct.

Decision and reasons on impairment

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

Registered nurses occupy a position of privilege and trust in society and are expected at all times to be professional. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. 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.

The panel had regard to the NMC Guidance on Impairment especially the question which states:

'*Can the nurse, midwife or nursing associate practise kindly, safely and professionally?'*

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 first considered whether any of the limbs of the Grant test were engaged in the past. The panel noted that Resident A was a vulnerable resident, had an acute brain injury, cognitive impairment and was non-verbal. It was therefore of the view that Mr Roman's conduct may have caused actual harm to Resident A in terms of emotional and psychological distress. The panel therefore determined that Mr Roman's misconduct had placed Resident A at an unwarranted risk of harm.

The panel determined that Mr Roman's misconduct constituted a serious breach of the fundamental tenets of the nursing profession as he failed to uphold the standards and values of the nursing profession, thereby bringing the reputation of the nursing profession into disrepute.

The panel therefore concluded that limbs a, b and c of the Grant test were engaged.

The panel next considered whether the limbs of the *Grant* test are engaged in the future. In this regard, the panel considered the case of *Cohen v GMC* where the court addressed the issue of impairment with regard to the following three considerations:

a. *'Is the conduct that led to the charge easily remediable?*

b. *Has it in fact been remedied?*

c. *Is it highly unlikely to be repeated?'*

In this regard, the panel also considered the factors set out in the NMC Guidance on Insight and strengthened practice (FTP-15).

The panel first considered whether Mr Roman's misconduct is capable of being addressed. The panel was of the view that it would be difficult to determine whether Mr

Roman's misconduct is capable of being addressed without any knowledge of the motivation for his conduct or any mitigating factors at the time of the incident.

The panel then went on to consider whether the concern had been addressed and remediated. It had regard to the NMC Guidance – Has the concern been addressed (FTP-15b). Regarding insight, the panel took into account that Witness 4 had stated during his oral evidence that, as he escorted Mr Roman from the premises, at the conclusion of his meeting with Witness 3 on 23 May 2023, Mr Roman admitted that he had slapped Resident A on his face. Witness 4 had further stated that Mr Roman had told him that he knew he probably should not have done it but that he did it looking for a response from Resident A. The panel concluded that this did not amount to any meaningful sign of remorse or insight into his actions.

The panel noted that there was no direct evidence of Mr Roman's insight into his behaviour. In contrast, Mr Roman had gone from initially making admissions in his meeting with Witness 3 on 23 May 2023 to subsequent denials of the incident at the Trust investigation meeting and then, an inability to recollect the incident at the disciplinary hearing, despite three witnesses present at the time of the incident. The panel was therefore concerned about Mr Roman's apparent lack of integrity and candour.

The panel noted that there was no evidence to indicate that Mr Roman had demonstrated insight into the seriousness of his misconduct nor had he reflected on the impact of his conduct on Resident A, his colleagues, the nursing profession and the wider public. Mr Roman did not provide any steps he would take if similar scenarios should occur in future. Consequently, the panel determined that Mr Roman has failed to demonstrate insight into his misconduct.

In considering whether Mr Roman had taken any step to remediate his misconduct, the panel noted that there was no evidence before it to indicate that he had. Mr Roman has not provided a reflective statement nor any evidence of apology, remorse or strengthened practice to the panel.

In light of this, the panel was not satisfied that Mr Roman's misconduct had been remediated nor has he strengthened his nursing practice. Accordingly, the panel determined that Mr Roman's misconduct is likely to be repeated, and limbs a, b and c of the *Grant* test are engaged in the future.

The panel was also of the view that the nature of Mr Roman's misconduct was such that it could discourage members of the public from seeking or accessing appropriate care when required for themselves or their vulnerable relations. Family members might well be reluctant to place their vulnerable relations in the care of healthcare providers if they felt that their dignity and wellbeing might be compromised in this way.

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 are 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 had regard to the serious nature of Mr Roman's misconduct and the public protection issues it had identified. It determined that public confidence in the profession, particularly as it involved a vulnerable resident, would be undermined if a finding of impairment were not made in this case. For these reasons, the panel determined that a finding of current impairment on public interest grounds is required. It decided that this finding is necessary to mark the seriousness of the misconduct, the importance of maintaining public confidence in the nursing profession, and to uphold proper professional standards for members of the nursing profession.

Having regard to all of the above, the panel was satisfied that Mr Roman's fitness to practise is currently impaired on both public protection and public interest grounds.

Sanction

The panel has considered this case very carefully and has decided to make a striking-off order. It directs the registrar to strike Mr Roman off the register. The effect of this order is that the NMC register will show that Mr Roman has been struck-off the register.

In reaching this decision, the panel has had regard to all the evidence that has been adduced in this case and had careful regard to the Sanctions Guidance (SG) published by the NMC.

Submissions on sanction

Ms Ihuomah reminded the panel that, in considering sanction, it should have regard to the principle of proportionality whilst weighing the interests of the public against the interests of Mr Roman. She submitted that the panel should attach greater weight to public interest and the need to maintain public confidence over the consequences to Mr Roman or the imposition of any particular sanction.

Ms Ihuomah submitted that there is no evidence that matters found proved by the panel have been addressed by Mr Roman. She highlighted that there was no evidence of reflection, training nor any remedial action done by Mr Roman. Ms Ihuomah submitted that, in the absence of any evidence of insight and strengthened practice, there is a real and significant risk of repetition.

Ms Ihuomah asserted that the charges found proven are serious and arguably show clear and possible deep-seated attitudinal issues, for example, using force on a vulnerable resident who was non-verbal and had to be transferred to the hospital as a result of low oxygen saturation. She submitted that Mr Roman’s conduct placed Resident A at risk of psychological and physical harm and this is more difficult to remediate.

Ms Ihuomah informed the panel that Mr Roman was placed on the Disclosure and Barring Service (DBS) Adults and Children barred list on 22 March 2024. She stated that Mr Roman had been barred as a result of these proceedings and he is currently on an interim suspension order imposed on 7 August 2023.

Ms Ihuomah submitted that Mr Roman's actions are fundamentally incompatible with him remaining on the register. She asserted that there are no conditions of practice which could be imposed in order to maintain public confidence in the profession and that confidence would be seriously diminished if Mr Roman were permitted to remain in practice.

In conclusion, Ms Ihuomah invited the panel to impose a striking-off order as the most appropriate and proportionate sanction in this case.

The panel accepted the advice of the legal assessor.

Decision and reasons on sanction

Having found Mr Roman's fitness to practise currently impaired, the panel went on to consider what sanction, if any, it should impose in this case. The panel has borne in mind that any sanction imposed must be appropriate and proportionate and, although not intended to be punitive in its effect, may have such consequences. The panel had careful regard to the SG. The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel identified the following aggravating features:

- Mr Roman's lack of remorse, reflection or any insight into his conduct including its impact on Resident A, his colleagues, the nursing profession and the wider public.
- No evidence of strengthened practice or remediation.

- Mr Roman's conduct placed Resident A at unnecessary risk of physical and psychological harm.
- Resident A was a vulnerable resident, who had an acute brain injury, cognitive impairment and was non-verbal.
- Mr Roman was an experienced nurse who should have utilised appropriate techniques and was aware of the vulnerable nature of Resident A.
- Mr Roman's lack of integrity and candour throughout the Trust investigation processes.
- Mr Roman's lack of active engagement with the NMC and these proceedings

The panel also identified the following mitigating features:

- Mr Roman's conduct was an isolated incident over an otherwise unblemished career as a registered nurse.

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the case. It had found that there remains a risk of repetition, that Mr Roman had breached fundamental tenets of the nursing profession, and that his misconduct would undermine the public's confidence in the nursing profession if he were allowed to practise without restriction. The panel therefore determined that it would neither protect the public nor be in the public interest to take no further action.

The panel 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 Roman's nursing 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 Roman's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the seriousness of the case. The panel

therefore determined that a caution order would neither protect the public nor be in the public interest.

The panel next considered whether placing conditions of practice on Mr Roman's registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be relevant, proportionate, measurable and workable. The panel took into account the SG (SAN-3c), in particular:

> *'Conditions may be appropriate when some or all of the following factors are apparent:*
>
> - *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;*
> - *No evidence of general incompetence;*
> - *Potential and willingness to respond positively to 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 was of the view that there was no evidence of deep-seated attitudinal concerns, and it noted that this was an isolated incident over his career. However, the panel bore in mind that it had found that it would be difficult to determine whether Mr Roman's misconduct is capable of being addressed without any knowledge of the motivation for his conduct at the time of the incident.

Given the lack of meaningful engagement by Mr Roman with the NMC and these proceedings, his lack of insight into the severity and impact of his misconduct as well as the lack of evidence of strengthened practice, the panel determined that there are no

relevant, proportionate, workable and measurable conditions that could be formulated. Accordingly, a conditions of practice order would not address the risk of repetition and this poses a risk of harm to patients' safety and the public. The panel had no evidence before it to suggest that Mr Roman would comply with any conditions of practice. Consequently, the panel determined that any conditions of practice order would not be workable or appropriate in this case and would not protect the public nor be in the public interest.

The panel then went on to consider whether a suspension order would be an appropriate sanction. The SG (SAN-3d) 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 noted that Mr Roman's misconduct was an isolated incident over his career and there was no evidence of repetition of behaviour since the incident. It had also found that there was no evidence of deep-seated attitudinal concerns. However, the panel noted that there was no evidence to indicate that Mr Roman had demonstrated any insight into the seriousness of his misconduct, nor had he reflected on the impact of his conduct on Resident A, his colleagues, the nursing profession and the wider public. Furthermore, Mr Roman had failed to actively engage with the NMC and these proceedings in order to assure the panel that he does not pose a significant risk of repeating his behaviour. The panel considered that Mr Roman has had the opportunity, since the incident occurred more than a year ago, to provide evidence to demonstrate insight and to strengthen his nursing practice, but he had not utilised such opportunity. Therefore, the panel was not satisfied that a period of suspension would serve any useful purpose. Accordingly, the

panel determined that a suspension order would not be a sufficient, appropriate or proportionate sanction. It would neither protect the public nor satisfy the public interest consideration in this case.

Finally, in considering a striking-off order, the panel took note of the following paragraphs of the NMC Sanctions Guidance on Striking-off (SAN-3e):

- *Do the regulatory concerns about the nurse or midwife raise fundamental questions about their professionalism?*
- *Can public confidence in nurses and midwives be maintained if the nurse or midwife is not removed from the register?*
- *Is striking-off the only sanction which will be sufficient to protect patients, members of the public, or maintain professional standards?*

The panel was of the view that all of the criteria as set out above are met in this case.

In considering this sanction, the panel took into account that this was an isolated incident. Notwithstanding, the panel had found that Mr Roman's conduct constituted a serious breach of fundamental standards of professional conduct and behaviour that a registered nurse is expected to maintain. The panel found that his behaviour was a significant departure from the standards expected of a registered nurse. The panel had no evidence before it that Mr Roman could practise kindly, safely and professionally as a registered nurse in future.

The panel concluded that the serious breach of fundamental tenets of the profession, evidenced by Mr Roman's conduct toward Resident A, is fundamentally incompatible with him remaining on the register. The panel was of the view that the findings in this particular case raises serious and significant questions about Mr Roman's professionalism and to allow him to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body.

Balancing all of these factors and after taking into account all the evidence before it, the panel determined that the appropriate and proportionate sanction is that of a striking-off order. Having regard to the effect of Mr Roman's actions in bringing the nursing profession into disrepute by adversely affecting the public's view of how a registered nurse should conduct himself, the panel has concluded that nothing short of a striking-off order would be sufficient in this case.

The panel considered that this order was 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 standards of behaviour expected and required of a registered nurse.

This will be confirmed to Mr Roman in writing.

Interim order

As the striking-off order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order is required in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in Mr Roman's own interests until the striking-off sanction takes effect.

Submissions on interim order

The panel took account of the submissions made by Ms Ihuomah. She submitted that, given the seriousness of the concerns and the panel's findings on sanction, an interim suspension order for a period of 18 months is necessary in order to protect the public and otherwise in the public interest, to cover the 28-day appeal period before the substantive order becomes effective. She submitted that an interim conditions of practice order would not be appropriate and proportionate in this case given the findings of the panel on misconduct, impairment and sanction.

The panel accepted the advice of the legal assessor.

Decision and reasons on interim order

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 was therefore satisfied that an interim order is necessary for the protection of the public and is otherwise in the public interest.

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 in order to protect the public and otherwise in the public interest, during any potential appeal period. The panel determined that not to impose an interim order would be inconsistent with its earlier decisions.

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

That concludes this determination.