

**Nursing and Midwifery Council
Fitness to Practise Committee**

**Substantive Meeting
Thursday, 2 October 2025 – Friday, 3 October 2025**

Virtual Meeting

Name of Registrant:	Ioan Adrian Laurentiu
NMC PIN:	11L0147C
Part(s) of the register:	Nurses Part of the Register – Sub Part 1 RN1: Adult Nurse, Level 1 (22 December 2011)
Relevant Location:	Causeway Coast and Glens Borough
Type of case:	Misconduct
Panel members:	Susan Ball (Chair, Registrant member) Lisa Holcroft (Registrant member) Lynne Vernon (Lay member)
Legal Assessor:	Hala Helmi
Hearings Coordinator:	Eleanor Wills
Facts proved:	Charges 1a, 1bi, 1bii, 2a (in relation to 1b) and 2b (in relation to 1b)
Facts not proved:	Charges 1ci, 1cii, 2a (in relation to 1c) and 2b (in relation to 1c)
Fitness to practise:	Impaired
Sanction:	Suspension order (12 months)
Interim order:	Interim suspension order (18 months)

Decision and reasons on service of Notice of Meeting

On reviewing the documentation provided the panel had regard to the Notice of Meeting and noted that it had been sent to Mr Laurentiu's registered email address by secure email on 12 August 2025.

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Meeting provided details of the allegation, the date from which the case was to be heard, that Mr Laurentiu could provide the panel with written representations, and the fact that this meeting was to be heard virtually.

In the light of all of the information available, the panel was satisfied that Mr Laurentiu has been served with notice of this meeting in accordance with the requirements of Rules 11A and 34 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Decision and reasons on admissibility of the Home's disciplinary hearing findings

The legal assessor referred the panel to the disciplinary hearing outcome letter from the Home to Mr Laurentiu dated 8 September 2023 in which St James's Lodge Nursing Home ("the Home") makes findings of fact in respect of the allegations. The panel heard legal advice in respect of the case of *Enemuwe v Nursing and Midwifery Council* [2013] EWHC 2081 (Admin) and [2016] EWHC 1881 (Admin).

The panel took into account 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. Having had regard to the case of *Enemuwe* the panel determined that the findings of the Home are not admissible, in order to prevent the potential for it to be influenced, even if only peripherally, by the decisions of the disciplinary hearing.

In these circumstances the panel disregarded the findings of the Home's disciplinary hearing in respect of the allegations.

Details of charge

That you, a registered nurse:

1. Between the dates of 17 and 19 August 2023:
 - a. Stored medication for multiple residents in an unlocked and/or accessible visitors/smoke room.
 - b. Falsely entered blood sugar readings for the following residents:
 - i. Patient A
 - ii. Patient B
 - c. Falsely and/or inadequately completed the patient medication charts for the Patients listed in Schedule 1 in that:
 - i. you completed all of the entries relating to these patients, within 9-minutes,
 - ii. all records stated "Medication as prescribed. Slept well overnight.
2. Your actions in charges 1b and/or 1c were dishonest in that:
 - a. you knew you had not reviewed patients sufficiently or at all, and/or had not provided care to patients
 - b. you sought to mislead others that you had done so.

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

Schedule 1

- Patient A
- Patient B
- Patient C
- Patient D
- Patient E
- Patient F
- Patient G

- Patient H
- Patient I
- Patient J
- Patient K
- Patient L
- Patient M
- Patient N
- Patient O
- Patient P
- Patient Q
- Patient R
- Patient S
- Patient T
- Patient U
- Patient V
- Patient W

Background

Mr Laurentiu was employed as a staff nurse at the Home. The Home made a referral to the NMC on 22 September 2023.

On 18 August 2023, Mr Laurentiu received the unit's monthly drugs for 24 residents. He told his colleague, Witness 2, at the end of his night shift, as he handed over to her on the morning shift, that he had placed them all in the visitors/smoke room with the door locked as there wasn't enough room in the treatment room. Witness 2 stated that she subsequently, sometime later, went to the visitors/smoke room and found the door unlocked with the medication inside and easily accessible.

It is alleged that on 18 August 2023, Mr Laurentiu made clinical entries for the unit's residents within the space of nine minutes.

One entry, documented on 19 August 2023, stated that Resident A had “*Medication as prescribed. Slept well overnight*” when in fact the resident in question was allegedly absent from the Home altogether, as they were in hospital.

On 17 and 18 August, Mr Laurentiu entered blood sugar readings for two diabetic residents. Entries were made on paper that blood glucose readings were taken. However, it is alleged that these were not corroborated by data from the Home’s glucometer. Mr Laurentiu claimed that he used his own glucometer to record the blood sugars, but he could not support this with evidence.

A disciplinary hearing took place on 5 September 2023.

Decision and reasons on facts

In reaching its decisions on the disputed facts, the panel took into account all the documentary evidence in this case together with the representations made by the NMC.

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 had regard to the written statements of the following witnesses on behalf of the NMC:

- Witness 1: Nursing Manager at the Home at the relevant time
- Witness 2: Staff Nurse at the Home at the relevant time

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.

Charge 1a

“1. Between the dates of 17 and 19 August 2023:

a. Stored medication for multiple residents in an unlocked and/or accessible visitors/smoke room.”

This charge is found proved

In reaching this decision, the panel took into account the witness statement of Witness 1 dated 17 June 2024 which provided a description of the ‘smoking room’.

“This is a small room originally designed for Residents to smoke in, although it has not been used for that purpose for some time. There are some chairs and a table in there, it is lockable with the home’s master key.”

The panel had regard to Witness 1’s witness statement in which they stated that:

“Adrian knew that the trolley was never kept anywhere else other than the treatment room.”

“Adrian said that he had left the drugs in the smoking room, because the treatment room was too full...He said that he had locked the door to the smoking room.”

The panel also had regard to Witness 2’s description of the ‘smoking room’ and the standard policy in relation to storing medication, provided in her witness statement dated 17 June 2024.

“The smoking room was originally meant to be for smoking residents, however, we had not had anyone who smoked in the Home for about eight years. The room is not in regular use. For some time, spare chairs have been kept in there. Staff members sometimes take families in there if someone is particularly unwell and they need some privacy to speak.”

At the relevant time I was aware of a policy in relation to the storage of medication only to be behind locked doors and I am confident that Adrian was aware that this was the standard practice at the Home. I had certainly never seen or heard of anyone storing medication in the smoking room before.”

The panel took into account Witness 2’s contemporaneous statement dated 18 August 2023 in which they stated that:

“Following handover this morning [Mr Laurentiu] advised that General’s [sic] monthly drugs had been received but he did not have time to count them all. [He] stated that he had placed them in the smoke room on the general unit and locked the door as he felt there was not enough room in the treatment for themAs some of the General’s drugs were required to replenish items on the trolley I went to the smoke room to get them, at this point I found the door to be unlocked providing access to the drugs that were stored there.”

The panel noted that Witness 2 in her witness statement stated that:

“I cannot remember the exact time I went to the smoking room, but it would have been before 10:30 as that is when I would finish my medication round.”

The panel took into consideration Mr Laurentiu’s explanation provided in his contemporaneous statement dated 25 August 2023.

“I put medication on [sic] the smoking room because wasn’t room enough on [sic] the treatment room. I locked the door with the key and I let [Witness 2] to [sic] know at the handover.”

The panel also took into account Mr Laurentiu’s explanation provided during the disciplinary meeting on 5 September 2023, in which he accepted that he put the medication in the smoke room but stated that he locked the door.

“He explained that there was not enough room in the treatment room for 2 trolleys...He took the trolley to the smoking room and locked the door...said the room was locked and that it was safe. He said he told [Witness 2]...[Witness 2] was the only one who had keys.”

Having had regard to the evidence before it, the panel was satisfied that the normal procedure in relation to storage and disposal of medication was to lock them in the treatment room.

The panel took into account that Mr Laurentiu’s accounts provided to Witness 1 and 2, in his contemporaneous statement and during the disciplinary meeting, are clear and consistent in that he did leave the medication in the smoke room but that he locked it at the time. The evidence was also clear and consistent that Mr Laurentiu informed Witness 2 during handover that he had locked the medication in the smoke room. The panel had regard to the fact that the NMC did not provide any evidence to the contrary.

The panel therefore determined that the NMC has not discharged its burden of proof that Mr Laurentiu stored the medication for multiple residents in an unlocked visitors/smoke room.

However, the panel when considering whether Mr Laurentiu stored the medication for multiple residents in an accessible visitors/smoke room had regard to Witness 1’s witness statement.

“The key for the smoking room is a master key. A few staff members have a copy of the master key – housekeeper/myself/nurses/owner of the home.”

“Even if the door had been locked, this was still unsafe practice as other staff members carried the master key and could have accessed the drugs.”

The panel also took into account Witness 2’s witness statement.

“Several people had master keys to the smoking room. I had one, another nurse on the floor had one and there were also cleaners and the owners who retained keys to that room.”

The panel therefore determined that Mr Laurentiu, on the balance of probabilities, stored medication for multiple residents in an accessible visitors/smoke room. The panel concluded that Mr Laurentiu stored the medication in the smoke room which he locked at the time, but due to the fact that the key to the smoke room was a ‘*master key*’, he stored the medication in a room accessible to various people. The panel was of the view that someone else could have unlocked the door between the end of Mr Laurentiu’s shift and Witness 2 finding the smoke room unlocked some two and a half hours later. The panel therefore determined that the medication was stored in a room accessible to various people.

The panel therefore found charge 1a proved, in part, on the balance of probabilities.

Charge 1bi and 1bii

“1. Between the dates of 17 and 19 August 2023:

b. Falsely entered blood sugar readings for the following residents:

i. Patient A

ii. Patient B

This charge is found proved

In reaching this decision, the panel took into account the witness statement of Witness 1 dated 17 June 2024.

“Adrian would usually work in the dementia care unit downstairs and he had not worked upstairs in a while, but he was asked to cover the general unit during his night shift between the 17 and 18 August 2023. There were three insulin dependent diabetic on the unit at this time, two of whom required input from the nurse on night shift. One received insulin prior to bed [Patient A] and one who required a blood

sugar check before bed [Patient B]. Adrian would have had to use a glucometer to take relevant readings for these Residents.”

The panel had regard to the insulin administration record for Patient A and noted that medication had been administered to Patient A on 17 August and 18 August at 21:00 and their blood glucose levels were recorded on these dates.

The panel also had regard to the alternate night blood sugar checks chart for Patient B and noted that on 17 August 2023 at 21:20 Patient B’s blood glucose level was recorded.

The panel took into account that Witness 1 carried out an investigation and stated that they *“could find no evidence of the recording recorded on the paperwork for 17/18 August 2023 on the glucometer.”* As a result, Mr Laurentiu was questioned and stated that he had used his own glucometer to take the readings. The panel noted that there was no guidance or Home policy stating that you could not use your own glucometer.

The panel took into account Witness 1’s contemporaneous statement dated 25 August 2023 in which they stated:

“Adrain [sic] came to the home at 11:45am with a large bag with him. From this bag he produced a blood glucose monitor in a box....asked Adrian to show him on the metre [sic] the entries from 17 and 18 Aug which matched those he recorded on the sheet for them nights.

Adrain [sic] tried to turn the monitor on, however was unable to do so. Adrian stated the machine must be broken.”

The panel also had regard to Witness 1’s witness statement in which they stated:

“As part of his response to the investigation Adrian brought his glucometer. He was asked to demonstrate that he had blood readings for the relevant residents on it, however, he was not able to turn the machine on. He had it in a box, but it did not have a battery in it. Adrian said that the glucometer was not working, so we were not able to see any readings recorded.”

The panel took into consideration Mr Laurentiu's explanation provided in his contemporaneous statement dated 25 August 2023.

"I chekt [sic] [Patient A] and [Patient B] blood sugar whit [sic] my own machine."

Additionally, the panel took into account Mr Laurentiu's explanation provided during his investigatory meeting dated 24 August 2023.

"Stated that he had his own machine, he explained that he had his own medical equipment which he used, blood pressure cuff and blood sugar machine, he wasn't a diabetic it was one he had got for work. He had his own things."

The panel took into account that Mr Laurentiu explained, during the local investigatory meeting, that he had used his own glucose monitor to record Patient A's and Patient B's blood glucose level. However, the panel had regard to the fact that when asked to evidence that he had in fact used his own glucose monitor he could not do so, stating that his machine was not working/broken.

The panel determined that Mr Laurentiu's explanation was implausible. In reaching this decision the panel took into account that Mr Laurentiu would usually work in the dementia care unit and therefore he would not normally be working on the general unit with diabetic residents who required blood glucose monitoring, making it less likely that he would have his own equipment for work purposes. The panel took into consideration that both Witness 1 and Witness 2 stated they were not aware of Mr Laurentiu having used his own personal equipment such as a glucometer. Furthermore, when asked to evidence that he had in fact used his own equipment he was unable to do so.

The panel therefore determined that it was more likely than not that Mr Laurentiu did not measure Patient A and Patient B's blood glucose levels as required between the dates of 17 and 19 August 2023. Accordingly, the panel concluded that he falsely entered blood sugar readings for Patient A and Patient B.

The panel therefore found charges 1bi and 1bii proved on the balance of probabilities.

Charge 1ci

“1. Between the dates of 17 and 19 August 2023:

c. Falsely and/or inadequately completed the patient medication charts for the Patients listed in Schedule 1 in that:

i. you completed all of the entries relating to these patients, within 9- minutes

This charge is found NOT proved

In reaching this decision, the panel took into account the progress notes for the patients listed in Schedule 1 dated 18 August 2023.

The panel noted the following times in respect of when Mr Laurentiu completed the progress notes for the patients listed in Schedule 1 on 18 August 2023.

- Patient D, 06:58
- Patient E, 06:58
- Patient F, 06:59
- Patient B, 07:00
- Patient G, 07:00
- Patient H, 07:01
- Patient I, 07:01
- Patient J, 07:02
- Patient K, 07:02
- Patient L, 07:02
- Patient M, 07:02
- Patient N, 07:03
- Patient O, 07:03
- Patient A, 07:04
- Patient P, 07:04

- Patient Q, 07:04
- Patient R, 07:05
- Patient S, 07:05
- Patient T, 07:05
- Patient U, 07:06
- Patient V, 07:06
- Patient W, 07:07
- Patient C – no record made by Mr Laurentiu

The panel took into account that these entries on the patients listed in Schedule 1 records were completed within 9 minutes. However, the panel noted that there was no entry was made for Patient C on 18 August 2023, therefore the panel could not determine that all the entries relating to the patients in Schedule 1 were completed within a 9-minute period.

The panel noted the additional entry for Patient C made at 06:45 on 19 August 2023, when they were in hospital. Although this entry could be false it fell outside the 9-minute period as stated in the charge.

The panel noted that this charge is found not proved in that not *all* entries relating to the patients in Schedule 1 were completed within a 9-minute period.

The panel considered that even if *all* the entries were made in a 9-minute period that there was insufficient evidence that the entries were falsely or inadequately completed. The reasons for how the panel came to this conclusion are set out below.

The panel had regard to Witness 1's witness statement dated 17 June 2024 in which they stated:

"I believe that it is unlikely that in a group of 24 residents they all just slept well and there were no issues whatsoever. It would be a rare occasion that all residents would have slept uneventfully all night and there would have been nothing else to report in the records. I would expect to see more information in these notes."

The panel also took into account Witness 2's witness statement dated 17 June 2024 in which they stated:

“Adrian’s records were not particularly detailed in general and that included his handover. There was very little information that he appeared to need to pass on to me on that particular morning. However, that could have been sufficient if there had simply been nothing much happening overnight.”

The panel took into account that during the disciplinary meeting on 5 September 2023 Mr Laurentiu when he was questioned regarding how he managed to write up the progress notes of 24 residents in 9 minutes on 18 August 2023, he stated that nothing had happened.

The panel had sight of the progress notes and noted that Mr Laurentiu included additional/different information in respect of Patients F and G, beyond *‘Medication as prescribed. Slept well overnight’*.

The panel determined that in the absence of any documentary evidence stating that the residents had any untoward events during the night shift of 17/18 August 2023 there is insufficient evidence to prove on the balance of probabilities that Mr Laurentiu *‘Falsely and/or inadequately’* completed the patient medication charts for the Patients listed in Schedule 1.

The panel therefore found charge 1ci NOT proved.

Charge 1cii

“1. Between the dates of 17 and 19 August 2023:

c. Falsely and/or inadequately completed the patient medication charts for the Patients listed in Schedule 1 in that:

i...

ii. all records stated ‘Medication as prescribed. Slept well overnight’”.

This charge is found NOT proved

The panel had regard to the wording of the charge in that it is alleged that Mr Laurentiu falsely and/or inadequately completed the patient medication charts for the patients listed in Schedule 1 in that *all* records stated *'Medication as prescribed. Slept well overnight'*."

The panel noted that in relation to Patient C's progress notes for 19 August 2023, Mr Laurentiu stated *"Medication as prescribed. Slept well overnight."* However, the panel concluded that this entry was false as at the time Patient C was not resident in the Home as they remained in the hospital.

The panel had regard to the fact that in relation to Patient F's progress notes for 18 August 2023, Mr Laurentiu stated:

"Medication as prescribed. awake all night refused to go to bed. In bed at 5:15am"

The panel took into account that in relation to Patient G's progress notes for 18 August 2023, Mr Laurentiu stated:

"Medication as prescribed. Slept well overnight. ABX for UTI started"

The panel having had regard to the wording of the charge concluded that although the majority of records stated *'Medication as prescribed. Slept well overnight'*, not *all* the records did.

The panel therefore found that charge 1cii is NOT proved.

Charges 2a and 2b

"2. Your actions in charges 1b and/or 1c were dishonest in that:

- a. you knew you had not reviewed patients sufficiently or at all, and/or had not provided care to patients.*
- b. you sought to mislead others that you had done so."*

This charge is found proved in respect of charge 1b

In reaching this decision, the panel had regard to its findings in respect of charge 1ci and 1cii and therefore only considered whether by falsely entering blood sugar readings for Patient A and Patient B, Mr Laurentiu's actions were dishonest.

The panel had regard to the legal principles as referred to by the legal assessor, established in the case of *Ivey v Genting Casinos (UK) Ltd t/a Crockfords* [2017] UKSC 67, *Lavis v Nursing and Midwifery Council* [2014] EWHC 4083 (Admin) and *Uddin v General Medical Council* [2012] EWHC 2669 (Admin).

The panel had regard to its previous findings that Mr Laurentiu's explanation in respect of having used his own blood glucose monitor was implausible. The panel also took into account that it determined that Mr Laurentiu did not measure Patient A and Patient B's blood glucose levels.

The panel having had regard to its findings at charge 1b, determined that Mr Laurentiu knowingly falsely entered the blood glucose readings for Patient A and Patient B. The panel determined that Mr Laurentiu knew he had not reviewed Patient A and/or B sufficiently or at all as he had not taken their blood glucose level. He therefore did not provide them with the appropriate care. The panel was satisfied that there was no evidence of an alternative innocent explanation and that this was not a genuine mistake. The panel determined that Mr Laurentiu knowingly falsely entered the blood sugar readings for Patients A and B and in doing so he sought to mislead his colleagues by creating the false impression that he had in fact taken Patients A and B's blood glucose levels. The panel considered that Mr Laurentiu's actions at charge 1b would be considered dishonest by the objective standards of ordinary decent people.

Accordingly, the panel found charges 2a and 2b proved on the balance of probabilities.

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 Laurentiu's fitness to practise is currently impaired. There is no statutory definition of

fitness to practise. However, the NMC has defined fitness to practise as a registrant's ability to practise kindly, safely and professionally.

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

The panel adopted a two-stage process in its consideration. First, the panel 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 Laurentiu's fitness to practise is currently impaired as a result of that misconduct.

Representations on misconduct and impairment

The NMC referred to the case of *Roylance v GMC (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 NMC also referred to the case of *Calheam v GMC* [2007] EWHC 2606 (Admin) and *Nandi v GMC* [2004] EWHC 2317 (Admin).

The NMC identified the specific provisions of The Code: Professional standards of practice and behaviour for nurses and midwives (2015) (the Code), which it considered Mr Laurentiu had breached.

The NMC submitted that the misconduct is serious for the following reasons. Storing medication in an unlocked and/or accessible visitors/smoke room, falsely entering blood sugar readings without proper checks, and falsely and/or inadequately completing the patient medication charts involved a serious departure from the fundamental principles of the Code of prioritising people, practising effectively, preserving safety and promoting professionalism and trust in the profession. The NMC submitted that this was a significant departure from the standards expected of a registered professional.

Furthermore, the NMC submitted that Mr Laurentiu's actions at charges 1b and/or c amount to dishonesty. The NMC submitted that honesty is of central importance to a nurse, midwife or nursing associate's practice. Therefore, allegations of dishonesty will always be serious.

The NMC requires the panel to bear in mind its overarching objective to protect 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. The NMC referred to the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant* [2011] EWHC 927 (Admin).

The NMC submitted that all four limbs of the *Grant* test can be answered in the affirmative.

The NMC submitted that Mr Laurentiu's action of storing medications in an unsecured/unlocked location put residents and other staff members at risk of harm. He also put residents at risk of harm by making entries in the charts which were not supported by proper medical checks. The NMC submitted that these actions fell so far below the standards expected of a nurse that have been, and continue to be, liable to bring the nursing profession into disrepute. By these actions, Mr Laurentiu breached the fundamental tenets of prioritising people, practising effectively, preserving safety and promoting professionalism and trust in the profession.

In addition, The NMC submitted that Mr Laurentiu has acted dishonestly. This was on more than one occasion and therefore there is a risk of future repetition.

The NMC submitted that Mr Laurentiu has displayed no insight. There has been no direct response from him in relation to the charges; he has not provided any insight or evidence of awareness of the effect of his actions. It is unknown whether Mr Laurentiu has worked since the issues of concern. The NMC submitted that there is a continuing risk to the public due to Mr Laurentiu's lack of insight or demonstration of strengthened practice through work in a relevant area.

Furthermore, the NMC submitted that there is a public interest in a finding of impairment being made in this case to declare and uphold proper standards of conduct and behaviour.

Mr Laurentiu's conduct engages the public interest because members of the public would be appalled to hear of a nurse failing in such basic nursing practices such as safe storing of medication and correct, adequate and not false entries on the medical charts, as well as breaching the professional duty of candour. The NMC submitted that such conduct severely damages and undermines public confidence in the nursing profession and the NMC, as the regulator.

The NMC therefore submitted that there is a public interest in a finding of impairment being made in this case to declare and uphold proper standards of conduct and behaviour.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments.

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 Laurentiu's actions breached the following provisions of the Code:

"1 Treat people as individuals and uphold their dignity

To achieve this, you must:

1.2 make sure you deliver the fundamentals of care effectively

10 Keep clear and accurate records relevant to your practice

This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.

To achieve this, you must:

10.3 complete records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements

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

20 Uphold the reputation of your profession at all times

To achieve this, you must:

20.1 keep to and uphold the standards and values set out in the Code

20.2 act with honesty and integrity at all times..."

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. The panel therefore considered whether each charge found proved, amounted to misconduct.

Charge 1a

The panel had regard to the context in which Mr Laurentiu actions at charge 1a occurred.

The panel had regard to its previous finding that Mr Laurentiu had locked the door to the smoke room at the time he stored the medication during his night shift. The panel took into account that Mr Laurentiu had stated that he had stored the medication in the smoke room due to fact that the treatment room was full at the time. The panel determined that the policy was not specific in relation to storing of medication only in the treatment room, it only stipulated that medication must be stored in a locked room.

The panel noted that Mr Laurentiu informed Witness 2, during handover, that he had stored the medication in the smoke room and locked the door. The panel took into account

that Witness 2 did not immediately move the medication, she went to the smoke room some two and half hours later and found the room unlocked.

The panel therefore concluded that Mr Laurentiu's actions at charge 1a would not be considered '*deplorable*' by fellow practitioners. However, the panel considered that fellow practitioners would consider this poor practice. Accordingly, the panel concluded that Mr Laurentiu's actions at charge 1a did not fall significantly short of the conduct and standards expected of a Registered Nurse and does not amount to misconduct.

Charges 1bi and 1bii

The panel had regard to its previous findings that Mr Laurentiu had not measured Patient A and Patient B's blood glucose levels and before falsely entering blood glucose readings on their records. The panel determined that there was a significant risk of harm to residents in that Mr Laurentiu not only failed to monitor Patient A and Patient B's blood glucose levels, but he also administered Insulin to Patient A without assessing their blood glucose levels in advance.

The panel therefore concluded that Mr Laurentiu's actions at charge 1bi and 1bii would be considered '*deplorable*' by fellow practitioners. In all the circumstances, the panel determined that Mr Laurentiu's actions at charge 1bi and 1bii did fall significantly short of the conduct and standards expected of a Registered Nurse and amounted to misconduct.

Charges 2a and 2b

The panel took into account that acting with honesty and integrity is a fundamental tenet of the nursing profession. By acting dishonestly Mr Laurentiu failed to promote professionalism and trust in the profession.

The panel therefore determined that Mr Laurentiu's actions at charges 2a and 2b did fall significantly short of the conduct and standards expected of a Registered Nurse and amounted to misconduct.

Decision and reasons on impairment

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

In coming to its decision, the panel had regard to the Fitness to Practise Library, reference 'DMA-1', updated on 3 March 2025, which states:

'The question that will help decide whether a professional's fitness to practise is impaired is:

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

If the answer to this question is yes, then the likelihood is that the professional's fitness to practise is not impaired.'

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

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

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

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

‘Do our findings of fact in respect of the doctor’s misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her/their fitness to practise is impaired in the sense that S/He/They:

- 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) has in the past acted dishonestly and/or is liable to act dishonestly in the future.’*

The panel was satisfied that all four limbs of the Grant test are engaged.

The panel determined that residents were put at risk of harm as a result of Mr Laurentiu’s misconduct. Mr Laurentiu’s misconduct breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. Having had regard to its findings at charge 2a and 2b the panel determined that Mr Laurentiu has in the past acted dishonestly.

The panel had regard to the case of *Cohen v GMC* [2008] EWHC 581. The panel took into account that dishonest conduct can be indicative of attitudinal concerns which are inherently difficult to remediate. The panel also took into account that Mr Laurentiu’s dishonest conduct was sustained, in that throughout the local investigation he continued to maintain that he measured Patient A and Patient B’s blood glucose levels on his own glucometer. However, the panel noted that the misconduct occurred on 17/18 August 2023, he attended an investigatory meeting on 24 August 2023 and the disciplinary meeting was held on 5 September 2023. The panel therefore concluded that the local

investigation and subsequent disciplinary meeting occurred over a short period of time. The panel also had regard to the fact that the misconduct occurred during one night shift and there is no evidence of a pattern of misconduct.

The panel therefore concluded that the misconduct could be remediable with sufficient insight and strengthening of practice. However, the panel had no evidence before it, of any insight, remediation and/or strengthening of practice due to Mr Laurentiu's lack of engagement.

The panel therefore concluded that there is a real risk of repetition and consequently a real risk of harm, in the absence of sufficient insight and strengthening of practice. Accordingly, the panel decided that a finding of impairment is necessary on the grounds of public protection.

The panel bore in mind that the overarching objectives of the NMC; 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 in order to declare and uphold the standards of conduct expected of a Registered Nurse and maintain public trust and confidence in the profession. The panel was of the view that the public's trust and confidence in the profession would be undermined if a finding of current impairment was not made, given the nature of the facts found proved, including dishonesty, and in the absence of sufficient insight and strengthening of practice.

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

Sanction

The panel has considered this case very carefully and has decided to make a suspension order for a period of 12 months. The effect of this order is that the NMC register will show that Mr Laurentiu's registration has been suspended.

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

Representations on sanction

The panel noted that the NMC had advised Mr Laurentiu in the Notice of the Meeting that it would seek the imposition of a striking-off order if it found Mr Laurentiu's fitness to practise currently impaired.

The NMC submitted that the only proportionate sanction in that of a striking-off order.

The NMC identified the aggravating and mitigating factors in this case.

The NMC submitted that taking no further action or a caution order are not suitable as there remains public protection and public interest concerns that require addressing. Conditions of practice order is also not appropriate. The NMC submitted that a conditions of practice order is more suited to cases where there are clinical concerns and identifiable areas so that the nurse can be supported to return to safe practice. In this case there is evidence of dishonesty and deep-seated attitudinal problems. Furthermore, the NMC submitted that the misconduct has not been remedied nor is remediable after the fact.

Regarding a suspension order the NMC submitted that there has been more than a single instance of misconduct, there is evidence of harmful deep-seated attitudinal problems and there is no evidence of insight.

The NMC submitted that a striking-off order is the only appropriate sanction, given the concerns regarding Mr Laurentiu's dishonest actions in respect of the blood sugar

readings and preparing medication records. The NMC submitted that this is suggestive of deep-seated behavioural and attitudinal issues, which suggests that the concerns would be more difficult to remediate. These concerns could also have led to an increased risk of harm to the patients. The NMC submitted that multiple acts of dishonesty indicate actions incompatible with continued registration and as such a striking off order be made.

Decision and reasons on sanction

Having found Mr Laurentiu'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 took into account the following aggravating features:

- Conduct which put vulnerable residents, receiving care, at risk of suffering harm
- Lack of any evidence of insight or remorse in relation to his dishonest actions
- No evidence of any remediation and/or strengthening of practice

The panel also took into account the following mitigating features:

- Incidents occurred over a short period of time, namely one night shift
- Mr Laurentiu had worked at the Home since 2011 with no prior concerns having been raised

The panel had regard to the NMC guidance titled '*sanctions for particularly serious cases*' reference 'SAN-2', last updated 6 May 2025.

The panel took into account that not all dishonesty is equally serious. The panel therefore considered the types of dishonesty which are most likely to call into question whether a nurse should be allowed to remain on the register. The panel determined that the dishonesty in this case did involve a deliberate breach of the professional duty of candour

by covering up when things have gone wrong, in that Mr Laurentiu sought to cover his wrongdoing by maintaining that he had taken Patient A and Patient B's blood glucose levels on his own glucometer. His dishonesty was also directly linked to his clinical practice and put vulnerable residents at direct risk of harm. However, the panel concluded that Mr Laurentiu's dishonesty was a one-off incident, there was no personal or financial gain, and it was not premeditated, systemic or long-standing. The panel therefore concluded that Mr Laurentiu's dishonesty was serious, but it was not at the highest end of the spectrum of seriousness when considering cases involving dishonesty.

The panel then considered what sanction, if any, to impose.

The panel determined that to take no action would be inappropriate and not proportionate in view of the seriousness of the case. The panel decided that to take no action would not sufficiently protect the public or adequately address the public interest concerns previously identified.

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 Laurentiu's practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that Mr Laurentiu's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate and not proportionate in view of the issues identified. The panel decided that to impose a caution order would not sufficiently protect the public or adequately address the public interest concerns previously identified.

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

- *No evidence of harmful deep-seated personality or attitudinal problems;*

- *Identifiable areas of the nurse or midwife's practice in need of assessment and/or retraining;*
- *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 determined that there was no evidence of harmful deep-seated attitudinal problems, in that Mr Laurentiu's dishonesty related to a one-off incident in an otherwise unblemished career. However, the panel concluded that the misconduct identified in this case was not something that can be addressed through retraining, in that there are not discrete identifiable areas of Mr Laurentiu's practice which need to be addressed. The panel took into account that due to Mr Laurentiu's lack of engagement there is no evidence of any willingness to comply with conditions. The panel was of the view that there were no relevant, practical, workable and measurable conditions that could be formulated, given the nature of the facts found proved in this case.

Furthermore, the panel concluded that the placing of conditions on Mr Laurentiu's registration would not sufficiently protect the public or adequately address the seriousness of this case and the public interest concerns previously identified.

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 took into account that there was no pattern of misconduct, this was a case of a single instance of misconduct which occurred during one night shift. The panel had regard to its previous finding that there was no evidence of harmful deep-seated attitudinal problems. The panel took into account that there was no evidence of repetition of the behaviours since the incident but noted that due to Mr Laurentiu's lack of engagement it had no information about whether he has continued to practise as a Registered Nurse. Additionally, the panel had no evidence of any insight, remediation and/or strengthening of practice.

However, having had regard to the nature of the facts found proved, the panel was satisfied that the misconduct was not fundamentally incompatible with remaining on the register. The panel determined that the misconduct could be remediable with sufficient insight and strengthening of practice and determined a period of suspension would give Mr Laurentiu an opportunity to engage with the NMC and demonstrate that he has addressed the areas of regulatory concern and is currently able to practice *'kindly, safely and professionally'*.

The panel 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. Whilst the panel acknowledges that a suspension may have a punitive effect, it would be unduly punitive in Mr Laurentiu's case to impose a striking-off order.

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

The panel noted the hardship such an order will inevitably cause Mr Laurentiu. 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 therefore determined that a suspension order for a period of 12 months with a review was appropriate in this case to mark the seriousness of the misconduct.

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:

- Mr Laurentiu's engagement with the NMC and proceedings
- Any evidence of insight, remediation and/or strengthening of practise, specifically in respect of the duty of candour
- An in-depth reflection relating to the misconduct
- Any evidence of testimonials from paid or unpaid employment
- Evidence of Mr Laurentiu's future intentions regarding his nursing practice

This will be confirmed to Mr Laurentiu in writing.

Interim order

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

Submissions on interim order

The panel took account of the submissions made by the NMC who invited the panel to impose an interim suspension order on the grounds of public protection and otherwise public interest

Decision and reasons on interim order

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

The panel concluded that 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 which was necessary to protect the public and address the public interest concerns previously identified, during the period of any appeal.

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

That concludes this determination.