Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 15 July 2024- Monday, 29 July 2024

Virtual Hearing

Name of Registrant:	**Emanuel-Catalin Costinescu**
NMC PIN	16B0470C
Part(s) of the register:	RN1: Adult Nurse Level 1 – 20 February 2016
Relevant Location:	Belfast
Type of case:	Misconduct
Panel members:	Catherine Devonport (Chair, registrant member) Kiran Bali (Lay member) Matthew Wratten (Lay member)
Legal Assessor:	Justin Gau (15-25 July 2024) Peter Jennings (26-29 July 2024)
Hearings Coordinator:	Hanifah Choudhury
Nursing and Midwifery Council:	Represented by Raj Joshi, Case Presenter
Mr Costinescu:	Not present and not represented
Facts proved:	Charges 1a, 1b, 2a, 2b, 3a, 3b, 3c, 3d, 4a, 4b, 4c, 4d, 4e, 5, 6, 7 and 9
Facts not proved:	Charges 2c and 8
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 Costinescu was not in attendance and that the Notice of Hearing letter had been sent to Mr Costinescu's registered email address by secure email on 17 June 2024.

Mr Joshi, 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 allegations, the time, dates and that the hearing was to be held virtually, including instructions on how to join and, amongst other things, information about Mr Costinescu'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 Costinescu 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 Costinescu

The panel next considered whether it should proceed in the absence of Mr Costinescu. It had regard to Rule 21 and heard the submissions of Mr Joshi who invited the panel to continue in the absence of Mr Costinescu. He submitted that Mr Costinescu had voluntarily absented himself.

Mr Joshi submitted that there had been no engagement at all by Mr Costinescu with the NMC in relation to these proceedings since his email dated 17 May 2024 and, as a consequence, there was no reason to believe that an adjournment would secure his attendance on some future occasion.

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.'*

The panel has decided to proceed in the absence of Mr Costinescu. In reaching this decision, the panel has considered the submissions of Mr Joshi 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 had regard to the overall interests of justice and fairness to all parties. It noted that:

- No application for an adjournment has been made by Mr Costinescu;
- Mr Costinescu has not engaged with the NMC since his email dated 17 May 2024 and has not responded to any of the subsequent emails sent to him about this hearing;
- There is no reason to suppose that adjourning would secure his attendance at some future date;
- Seven witnesses are due to attend to give live evidence;
- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- The charges relate to events that occurred in 2021 and 2022;
- Further delay may have an adverse effect on the ability of witnesses accurately to recall events; and
- The charges in this case are serious and there is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Mr Costinescu in proceeding in his absence. Although the evidence upon which the NMC relies has been sent to him at his registered address, Mr Costinescu has made no response to the allegations. He will not be able to challenge the evidence relied upon by the NMC in person 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 Costinescu's decisions to absent himself from the hearing, waive his rights to attend, and/or be represented, and to not provide evidence or make submissions on his own behalf.

In these circumstances, the panel has decided that it is fair to proceed in the absence of Mr Costinescu. The panel will draw no adverse inference from Mr Costinescu's absence in its findings of fact.

Details of charge

That you, a registered nurse, whilst working at Faith House Eventide Home ('the Home'):

1) On the night shift of 13-14 December 2021, in relation to Resident H, who suffered an unwitnessed fall and eye injury, did not:
   a) Contact the out of hours GP and/or escalate to emergency services.
   b) Carry out hourly observations after carrying out the first post fall observations.

2) On the night shift of 14-15 October 2022, in relation to resident D, on being told they were chesty and flushed:
   a) Did not carry out timely and/or adequate clinical and/or physical observations.
   b) Shrugged your shoulders and/or said "you would inform the day staff" or words to that effect.
   c) Handed over that "they were fine and/or didn't have a temperature" or words to that effect.

3) On the night shift of 2-3 December 2022, in relation to Resident E:
   a) Did not change their catheter bag.

b) Did not carry out and/or record a full set of clinical observations on being told they were struggling to breath.

d) Handed over that “Resident E’s catheter had not drained overnight” or words to that effect but recorded in their notes that “SRC patent and draining well”.

e) Handed over that “they didn’t want to get up and/or were tired” or words to that effect.

4) On the night shift of 6-7 December 2022, in relation to Resident F:

a) Did not record any figures in relation to their catheter input and output.

b) Did not flush and/or replace the catheter and/or check for blockage.

c) Did not carry out a pain assessment.

d) Did not carry out any clinical observations.

e) Handed over that “Resident F’s catheter was not draining a lot” or words to that effect but recorded in their notes that “SRC patent and draining”.

5) On or before 28 October 2022, in relation to Resident A and/or B, instructed care assistants to administer and/or remove prescription patches.

6) On an unknown date, in relation to Resident G, did not provide palliative care drugs which would have been appropriate in light of Resident G’s clinical presentation.

7) Routinely failed to take appropriate action when residents sounded their buzzers.

8) Your actions at charge 2c above were dishonest in that you knew your handover was inaccurate and/or did not represent an accurate picture of Resident D's clinical presentation.

9) Your actions at charge 3d above were dishonest in that you knew your handover was inaccurate and/or did not represent an accurate picture of Resident E’s clinical presentation.

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

Decisions and reasons on hearing Witness 3's evidence

Mr Joshi informed the panel that Witness 3 was now available to give oral evidence. Witness 3 had previously not responded to any of the communication from the NMC in regards to this hearing.

Mr Joshi told the panel that the emails from the NMC had gone to an email address for Witness 3 that was not current so she was unaware of these proceedings. Mr Joshi further told the panel that Witness 3 had only found out about the hearing from a conversation with another witness on the first day of this hearing.

Mr Joshi told the panel that there is no written statement from Witness 3 and Mr Costinescu had not been informed of her attendance.

The panel accepted the advice of the legal assessor.

The panel carefully considered the application to hear Witness 3's oral evidence. The panel noted that there is no statement from Witness 3 nor has Mr Costinescu been informed of the nature of Witness 3's evidence. The panel was of the view that Mr Costinescu would be disadvantaged if the panel was to hear the oral evidence of Witness 3 as he does not have prior knowledge nor would he be able to challenge the evidence. The panel also noted that Witness 3's evidence was not the sole and decisive evidence upon which the NMC was relying.

The panel took into consideration that if Witness 3 was to provide a formal written statement to the NMC then this would mean a delay in proceedings in order to follow the correct procedure in admitting Witness 3's statement into evidence and notifying Mr Costinescu of this.

In these circumstances the panel came to the view that it would not be fair to allow Witness 3 to give evidence.

Decision and reasons on application to admit hearsay evidence

The panel heard an application made by Mr Joshi under Rule 31 to allow the local statements of Witnesses 3 and 4 into evidence. Witnesses 3 and 4 were not present at this hearing and, whilst the NMC had made sufficient efforts to ensure that these witnesses were present, Witness 4 was unable to attend today. He submitted that the NMC followed the correct procedure in trying to obtain the evidence from these witnesses.

Despite knowledge of the nature of the evidence from Witnesses 3 and 4, Mr Costinescu made the decision not to attend this hearing. On this basis Mr Joshi advanced the argument that there was no lack of fairness to Mr Costinescu in allowing Witnesses 3 and 4's local fact-finding statements into evidence.

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

The panel gave the application in regard to Witnesses 3 and 4 serious consideration. The panel considered whether Mr Costinescu would be disadvantaged by the change in the NMC's position of moving from reliance upon the oral testimony of Witnesses 3 and 4 to that of local fact-finding meeting notes.

In reaching its decision the panel took into account the seriousness of the charges and the impact which any adverse finding may have on Mr Costinescu. The panel noted that whilst the charges are serious the evidence of Witnesses 3 and 4 was not the sole and decisive evidence the NMC was relying upon.

The panel noted the correspondence from the NMC to Witnesses 3 and 4. The panel was satisfied that the NMC had made proper efforts to secure Witnesses 3 and 4's attendance.

In these circumstances, the panel came to the view that it would be fair and relevant to accept into evidence the local fact-finding notes of Witnesses 3 and 4, but would give what it deemed appropriate weight once the panel had heard and evaluated all the evidence before it.

Background

In March 2020 Mr Costinescu commenced his employment as a night nurse at Faith House Eventide Home (the Home).

On 14 December 2021, during a night shift at the Home, Resident H had an unwitnessed fall and injuries were sustained to their head and face. Mr Costinescu allegedly instructed staff to put Resident H back to bed. When the day nurse came on duty, they called the GP who advised that Resident H should be taken to hospital.

During the night shift on 14 October 2022, it is alleged that Mr Costinescu did not provide adequate nursing interventions to Resident D who was reported as unwell. Carers reported that Resident D was chesty and flushed. Mr Costinescu allegedly did not carry out any checks on Resident D overnight and did not perform any clinical observations. At the end of the shift, Mr Costinescu allegedly handed over that Resident D was fine and did not have a temperature.

On 28 October 2022 the Home's manager met with Mr Costinescu to conduct a competency assessment review. The Home's manager reminded Mr Costinescu to support staff, to not write his entries in the patient's notes too early and to make sure his notes accurately reflected what was handed over orally.

During the night shift on 2 December 2022, carers reported to Mr Costinescu that Resident E was feeling very unwell and struggling to breathe. Mr Costinescu allegedly did not carry out any clinical assessments and told the resident to get some sleep.

At 08:00 on 3 December 2022 Mr Costinescu reported to the day staff that Resident E was tired and did not want to get up. Mr Costinescu did not record Resident E's deterioration or decline in breathing in the patient's notes. The resident died within 20 minutes of day staff coming on duty.

During the night shift on 6 December 2022, the care assistants reported to Mr Costinescu that Resident F's catheter had not drained any urine overnight and that Resident F was agitated and in pain. Mr Costinescu allegedly administered paracetamol to Resident F but did not carry out any assessment of the pain, any clinical observations or attempt to flush the catheter or check for blockages.

At handover to the day shift, Mr Costinescu orally reported a problem with Resident F's catheter. However, Mr Costinescu recorded in the patient notes that Resident F's catheter was patent and draining well. Once the staff nurse on the day shift had flushed the catheter, the bag filled twice with urine and the resident was then settled.

On 12 December 2022, Mr Costinescu was suspended pending an investigation. Mr Costinescu attended an investigation meeting with the Home's manager on 12 January 2023. On 31 January 2023, Mr Costinescu attended a disciplinary hearing and was dismissed.

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 Mr Joshi.

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

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 oral evidence from the following witnesses called on behalf of the NMC:

- Witness 1: Care assistant at the Home
- Witness 2: Senior Staff Nurse at the Home
- Witness 5: Manager at the Home
- Witness 6: Staff Nurse at the Home
- Witness 7: Sister at the Home
- Witness 8: Staff Nurse at the Home

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor. It considered the witness and documentary evidence provided by the NMC including the record of Mr Costinescu's local fact-finding meeting conducted by Witness 5 on 12 January 2023 where Mr Costinescu was accompanied by a union representative.

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

Charge 1a)

1) On the night shift of 13-14 December 2021, in relation to Resident H, who suffered an unwitnessed fall and eye injury, did not:
    a) Contact the out of hours GP and/or escalate to emergency services.

This charge is found proved.

In reaching this decision, the panel took into account the written statement from Witness 5, Resident H's progress notes, accident form and care plan. The panel gave particular regard to Witness 5's statement which stated:

> *'Emanuel recorded in ("Resident H") progress notes and in an accident report form that Resident H had a fall at 03:00 on 14 December 2021. Emanuel recorded that observations had been done and that Resident H's right eye was swollen and bruised…*
>
> *…Resident H was on anticoagulant therapy which meant that if she had an unwitnessed fall and a head injury, Emanuel should have contacted the out of hours GP for further advice. However, Emanuel did not do so…*
>
> *…Resident H had a care plan in place for falls so Emanuel should have been aware that the resident was at risk of falls. I expected Emanuel as registered nurse to know from his nurse training that if a resident has a fall and is on anticoagulant therapy that he should contact the out of hours GP. I also expected Emanuel to be aware as a registered nurse of the risks associated with a fall and head injury.'*

In her oral evidence Witness 5 confirmed that escalation to the GP or out of hours doctor would be the expected action to be taken by any trained nurse. The panel also noted that there had been no indication of a shortage of staff when the fall took place and noted that anticoagulants are blood thinners. Patients who are on blood thinners who have falls are at a raised risk of bleeding and require increased observations.

Having read Witness 5's statement, which was corroborated by her oral evidence, the panel was satisfied that Mr Costinescu did not escalate Resident H's injuries to the out of hours GP or emergency services. The panel therefore found this charge proved.

Charge 1b)

1) On the night shift of 13-14 December 2021, in relation to Resident H, who suffered an unwitnessed fall and eye injury, did not:
    b) Carry out hourly observations after carrying out the first post fall observations.

This charge is found proved.

In reaching this decision, the panel took into account Resident H's progress notes and care plan. The panel noted that Resident H's care plan said:

'Resident H is a high risk of falls.'

The panel also noted that in Resident H's patient notes there were limited entries with the first entry after the fall at 03:35 and the next entry not until noon. Resident H's patient notes said:

'03:35- checked hourly, med given as prescribed…
…12 noon- Daughter of Resident H informed of fall…'

The panel also considered the statement of Witness 5 which said:

'I expected Emanuel as registered nurse to know from his nurse training that if a resident has a fall and is on anticoagulant therapy that he should contact the out of hours GP. I also expected Emanuel to be aware as a registered nurse of the risks associated with a fall and head injury.'

The panel further took into account the oral evidence of Witness 5. She said that all clinical observations undertaken should be recorded in the patient notes.

The panel was confident that Mr Costinescu would have been aware of Resident H's care plan and high risk of falls and taken this into consideration in his care for Resident H. The panel was also satisfied that Mr Costinescu would have been aware that Resident H required hourly observations after the fall. This was not done as evidenced in the patient notes. On this basis the panel was satisfied that Mr

Costinescu did not carry out hourly observations of Resident H after the first post fall observations. Therefore this charge is found proved.

Charge 2a

2) On the night shift of 14-15 October 2022, in relation to resident D, on being told they were chesty and flushed:
    a) Did not carry out timely and/or adequate clinical and/or physical observations.

This charge is found proved.

In reaching this decision, the panel gave particular consideration to the statement of Witness 1 and her oral evidence.

In her statement Witness 1 stated:

> *'I received a handover at the start of the shift, Emanuel was also present as he was the night nurse on duty. During the handover, Home Manager Witness 5 came to door and said that she had been in with Resident D and that he said he was feeling unwell and asked to go to bed early…*
>
> *…During the night Resident D was sleeping but his chest sound bubbly, his face was red, he was warm and he did not look well. I told Witness 4 about Resident D and asked her to see Emanuel and tell him that Resident D was getting worse.*
>
> *Witness 4 came back and said she told Emanuel but that he shrugged his shoulders and said there's nothing we can do. Emanuel said that he would inform the day staff.*
>
> *When Witness 4 went to Emanuel, I expected him to get up and come to look at Resident D, do a physical observation and a set of clinical observations including temperature and blood pressure.'*

This was corroborated by Witness 1's oral evidence. She said that one of her colleagues went to tell Emanuel of Resident D's physical state but Mr Costinescu did not come and check on Resident D.

The panel also took into account Witness 5's statement which stated:

> *'The progress notes recorded by Emanuel did not reflect what the care staff were saying…There was no evidence in the progress notes that Emanuel had gone to see the resident at any point. There was nothing recorded of any actions that Emanuel took such as taking the resident's temperature, any repositioning or what was handed over to day staff.'*

The panel also had regard to the notes from the local fact-finding meeting with Witness 7, which took place on 3 January 2023. The notes said:

> *'The information given at handover wouldn't match up with the documentation recorded overnight.'*

The panel also had sight of Resident D's progress notes which said:

> *'03:40- checked hourly, med given as prescribed, a bit chesty, settled over night, slept well, fluids=1000ml.'*

The panel noted that no clinical observations had been recorded by Mr Costinescu in Resident D's progress notes nor was there any reference to informing the day staff about Resident D's physical state.

On this basis the panel was satisfied that Mr Costinescu was aware that Resident D was unwell, and upon staff members reporting that Resident D was getting worse, did not carry out adequate observations on Resident D. This charge is therefore found proved.

Charge 2b)

2) On the night shift of 14-15 October 2022, in relation to resident D, on being told they were chesty and flushed:

b) Shrugged your shoulders and/or said “you would inform the day staff” or words to that effect.

This charge is found proved.

In reaching this decision the panel took into account of the hearsay evidence of Witness 4 which it gave appropriate weight in all of the circumstances.

The notes of the local fact-finding meeting with Witness 4 said:

> *‘Witness 5 mentioned that night before handover that Resident D hadn’t been too well. Witness 1 went to check on him around 22:00, not sure if that is the right time, and came back to tell me that he wasn’t well and would I report it to Emanuel. When I spoke to Emanuel about it, he said oh well, I will put it in the diary for the day staff to ring GP.’*

The panel also took into account Witness 1’s statement which stated:

> *‘Witness 4 came back and said she told Emanuel but that he just shrugged his shoulders and said there’s nothing we can do. Emanuel said that he would inform the day staff.’*

The panel determined that there is sufficient evidence that Mr Costinescu shrugged his shoulders and said he would inform the day staff about Resident D. This charge is therefore found proved by the panel.

Charge 2c)

2) On the night shift of 14-15 October 2022, in relation to resident D, on being told they were chesty and flushed:

c) Handed over that “they were fine and/or didn’t have a temperature” or words to that effect.

This charge is found NOT proved.

In reaching this decision, the panel took into account the progress notes of Resident D which said:

> ‘*03:40- checked hourly, med given as prescribed, a bit chesty, settled over night, slept well, fluids=1000ml.’*

The panel accepted that as there were no observation records in Resident D’s progress notes no observations were in fact undertaken by Mr Costinescu.

The panel also took into account the oral evidence of Witness 5. Witness 5 said that the handover was done orally. It was common practice of the Home that handover notes were not kept. Therefore there were no physical records and notes of the handover available. In addition there was no oral evidence from any of the witnesses that Mr Costinescu handed over to them.

Taking this into consideration, the panel determined that there is insufficient evidence that Mr Costinescu handed over that Resident D was fine and did not have a temperature or words to that effect. The panel was not satisfied that the NMC had provided sufficient evidence to discharge its burden of proof in respect of this charge. The panel therefore found this charge not proved.

Charge 3a)

3) On the night shift of 2-3 December 2022, in relation to Resident E:

a) Did not change their catheter bag.

This charge is found proved.

In reaching this decision the panel took into account the statement of Witness 1. Witness 1's statement said:

> *'On a date I do not recall, I was working a night shift at the Home and Emanuel was the night nurse on duty. After putting a female resident to bed, at approximately 23:30, I walked past Resident E's room and checked in on him… Resident E was still awake which was unusual for him. He asked me to empty his catheter and I saw that the catheter bag was extremely full and heavy which meant that it was pulling on him. Resident E said that Emanuel had been in with him and that Emanuel had said he would get one of the girls to change it. I do not know why Emanuel did not empty the catheter bag himself.'*

In oral evidence Witness 1 stated that she emptied Resident E's catheter bag after Mr Costinescu had checked on him. Furthermore, she stated that at no point after Mr Costinescu had checked on Resident E did he ask her whether the catheter bag had been emptied.

The panel also took into account the witness statement of Witness 5 which said:

> *'Emanuel wrote in the resident's notes that Resident E's catheter is draining well. However, there is nothing recorded in the fluid balance chart to indicate that the catheter was draining well.'*

The panel therefore found this charge proved.

Charge 3b)

3) On the night shift of 2-3 December 2022, in relation to Resident E:

b) Did not carry out and/or record a full set of clinical observations on being told they were struggling to breath. [sic]

This charge is found proved.

In reaching this decision, the panel took into account the progress notes of Resident E which said:

> *'03:10- Hourly checked, med given as prescribed, SRC patent and draining well, settled over night, slept well. Fluids=800ml.'*

The panel took into consideration Mr Costinescu did not record a full set of observations in Resident E's progress notes.

The panel also took into account the statement of Witness 2 which stated:

> *'When I got to his room, Witness 8 was coming out of the room. Witness 8 said that Resident E appears to be struggling to breathe. I went into Resident E's bedroom and saw straightaway that he was struggling to breathe, there was no verbal communication and thought that he was close to dying…*
>
> *…If Emanuel was informed of Resident E's breathing diffculties,[sic] he should have recorded a full set of clinical [sic] observations including blood pressure, temperature, pulse, respiration and oxygen levels.*
>
> *Emanuel should have been informed during his induction where he should record in the progress notes. This is also the general practice that staff follow at the Home so Emanuel should have been aware that he had to record an entry in the progress notes.'*

The panel also took into account the notes from the local fact-finding meeting with Witness 8 which said:

> *'I went to tell Witness 2 immediately after I changed him, that he was short of breath and gasping. Witness 2 came right away. He passed away before I got to him again.'*

The panel also gave regard to the hearsay evidence of Witness 4 in the form of notes of a local fact-finding meeting which it gave appropriate weight. The notes said:

> *'Resident E slept well that night until about 6am when I checked him and he was gasping and short of breath. I immediately reported this to Emanuel and he came up and stood at the door. Resident E murmured something about not being fit to get up. Emanuel said not to worry it wasn't time to get up. Emanuel checked Resident E's pulse and said that he would check him again at 7am. I asked him was he sure that Resident E was alright after we left the room. Emanuel replied that Resident E was just anxious. Later Emanuel said that when he had checked him he was sleeping and didn't want to wake him.'*

The panel also had regard to Witness 5's statement which stated:

> *'If a carer is concerned about a resident and they report concerns, Emanuel should go and see the resident and do clinical observations as well as observing them physically. If Emanuel does not do clinical observations then he cannot tell how well the patient is by just looking at them.'*

On this basis the panel was satisfied that Mr Costinescu would have known that he should have recorded full clinical observations for Resident E in his progress notes after being informed of his breathing difficulties but did not do so. Therefore the panel found this charge proved.

Charge 3c)

3) On the night shift of 2-3 December 2022, in relation to Resident E:

c) Handed over that "Resident E's catheter had not drained overnight" or words to that effect but recorded in their notes that "SRC patent and draining well".

This charge is found proved.

In reaching this decision the panel took into account the progress notes of Resident E which said:

> *'03:10- Hourly checked, med given as prescribed, SRC (self-retaining catheter) patent and draining well, settled over night, slept well. Fluids=800ml.'*

The panel also took into account the written statement of Witness 2 which stated:

> *'Emanuel said that Resident E's urinary output was not as normal and that the catheter had not drained anything overnight. I thought this was strange because Resident E always had a good urinary output. Also, Resident E's catheter had just been changed the day before so it was unlikely to be blocked.'*

This was supported by Witness 2's oral evidence. She said that at that time there would have been a fluid balance chart and when she came on duty as part of the day shift it was handed over to her that Resident E's fluid output was poor. Witness 2 said there was nothing in the progress notes to reflect Resident E's poor fluid output.

Having read Witness 2's statement, which was corroborated by her oral evidence, the panel was satisfied that Mr Costinescu had handed over that Resident E's catheter had not drained overnight but had recorded in the progress notes that the catheter was draining well. This charge is therefore found proved.

Charge 3d)

3) On the night shift of 2-3 December 2022, in relation to Resident E:

d) Handed over that "they didn't want to get up and/or were tired" or words to that effect.

This charge is found proved.

In reaching this decision, the panel took into account the statement of Witness 2 which stated:

> *'Emanuel handed over that a resident, ("Resident E") was not up that morning as Resident E had said that he was tired and wanted a lie in. I thought that this was strange, as few months earlier I was aware of one shift where Resident E was not washed and dressed and he was cross with the day staff. Resdient E [sic] liked to be up and dressed…*
>
> *… It was approximately 10 to 15 minutes after handover before I went to Resident E's room…*
>
> *… I went into Resident E's bedroom and saw straightaway that he was struggling to breathe, there was no verbal communication and thought that he was close to dying…*
>
> *… It was apparent from my quick observation that Resident E was not tired but that he was unwell…*
>
> *…I found it strange from what I had witnessed when I went into Resident E's room to what Emanuel handed over. Emanuel said that Resident E was tired but I did not think that Resident E could have said he was tired from how he appeared when I saw him.'*

In her oral evidence Witness 2 said that the only information handed over by Mr Costinescu in relation to Resident E was that he was feeling tired and his catheter had not drained well. She also said that Mr Costinescu did not tell the day staff that Resident E was having trouble breathing or that he had noticed a decline in his overall condition.

The panel accepted Witness 2's evidence, in that she had only been told by Mr Costinescu that Resident E was tired and did not want to get up. The panel therefore found this charge proved.

Charge 4a)

4) On the night shift of 6-7 December 2022, in relation to Resident F:

a) Did not record any figures in relation to their catheter input and output.

This charge is found proved.

In reaching this decision, the panel took into account the progress notes for Resident F which said:

> *'05:25: Checked hourly, med given as prescribed, SRC patent and draining, unsettled over night, slept on/off. Fluids=950ml, very vocal, paracetamol given for comfort.'*

The panel also took into account the written statement of Witness 2 which stated:

> *'During handover, Emanuel handed over information about a resident, Resident F. Emanuel said Resident F's catheter had not drained a lot overnight in relation to his intake. When a resident has a catheter, you record their input and output. If a resident takes in a litre of fluids then you expect there to be approximately a litre of output. Emanuel did not give any figures in relation to input or output.'*

Further, the panel had regard to the written statement of Witness 6 which stated:

> *'The registrant Emanuel Costinescu commented verbally to me that the output being 50 ml, as the registrant was leaving. It was found in the residents progress notes that SRC patent and draining.'*

In her oral evidence Witness 6 confirmed that Mr Costinescu had told her Resident E had a fluid output of 50ml.

The panel determined that whilst Mr Costinescu had recorded the fluid intake for Resident E he had not recorded the fluid output in the progress notes. The panel therefore found this charge proved.

Charge 4b)

4) On the night shift of 6-7 December 2022, in relation to Resident F:

b) Did not flush and/or replace the catheter and/or check for blockage.

This charge is found proved.

In reaching this decision, the panel took into account Witness 2's written statement which stated:

> *'It was well known amongst staff at the Home that Resident F had kidney problems and catheter problems. Staff at the Home were aware of this and his catheter was flushed once or twice a week.*
>
> *As a result of not flushing the catheter, this can cause pain and discomfort to the resident because the bladder was not draining. It also increases the risk of infection.*
>
> *Emanuel should have known from his catheter training that he needed to flush or change the catheter. Nurses at the Home attend catheter training which is a standard training provided [sic] by the local trust. It is a nurse's resposniblity [sic] to attend the training if you have not done it for a while. Some nurses lack confidence with catheter and often go on training for male catheterisation because it is more difficult.*
>
> *If Emanuel did not feel competent or confident to flush or replace the catheter, he could have called the out of hours for help or advice. They may have sent a district nurse out. The district nurses previously attended to Resident F when he was in the residential section of the Home. Staff at the Home were aware of this as it was set out in his medical history when he moved to the*

nursing section of the Home. Also, Resident F was prescribed catheter flushes.'

The panel also took into account the notes of the local fact-finding meeting with Witness 6 which stated:

'During the morning Resident F was very distressed and showing signs of discomfort. On checking his catheter, I remembered that he often needed it flushed in Residential. I asked Witness 2 if I could flush it and she agreed. When I flushed it, it flushed easily, but the bag filled twice immediately. It seemed to indicate that the catheter hadn't been emptied in quite some time.'

The panel also gave regard to the notes of the local fact-finding meeting with Witness 4. Witness 4 had said:

'I was putting Resident F to bed and normally he loves going to bed and goes straight to sleep. This night he was unsettled and shouting. I checked his catheter, and it hadn't drained anything. His pad was dry as well. I reported this to Emanuel and he came to check. He said to me that if Resident F could tell him he was in pain, he would give him medication, but otherwise he couldn't.'

On this basis the panel determined that Mr Costinescu had not flushed Resident E's catheter. This charge is therefore found proved.

Charge 4c)

4) On the night shift of 6-7 December 2022, in relation to Resident F:

c) Did not carry out a pain assessment.

This charge is found proved.

In reaching this decision, the panel took into account the progress notes for Resident F which stated:

‘05:25: Checked hourly, med given as prescribed, SRC patent and draining, unsettled over night, slept on/off. Fluids=950ml, very vocal, paracetamol given for comfort.’

The panel also took into account the written statement of Witness 6 which stated:

‘In relation to resident F’s pain assessment. There is no evidence in the progress notes, and I don’t recall seeing a pain chart for resident F.’

This statement was corroborated by Witness 6’s oral evidence. She said that the pain chart would be located in the medication trolley and on this occasion there was no pain chart in the medication trolley for Resident F.

The panel also gave regard to the notes of the local fact-finding meeting with Witness 4. Witness 4 had said:

‘He said to me that if Resident F could tell him he was in pain, he would give him medication, but otherwise he couldn’t.’

The panel determined that there was no pain chart for Resident F. The panel therefore found this charge proved.

Charge 4d)

4) On the night shift of 6-7 December 2022, in relation to Resident F:

d) Did not carry out any clinical observations.

This charge is found proved.

In reaching this decision, the panel took into account the written statement from Witness 6 and her oral evidence. Witness 6’s statement said:

‘There is nothing recorded in the progress notes and there is no evidence found relating to the clinical observations.’

In her oral evidence Witness 6 said that if any observations were undertaken they would have been recorded in the progress notes and in the patient records that were found in the medication trolley.

Having read Witness 6’s statement, which was corroborated by her oral evidence, the panel determined that Mr Costinescu had not carried out any clinical observations. This charge is therefore found proved.

Charge 4e)

4) On the night shift of 6-7 December 2022, in relation to Resident F:

e) Handed over that “Resident F’s catheter was not draining a lot” or words to that effect but recorded in their notes that “SRC patent and draining”.

This charge is found proved.

In reaching this decision, the panel took into account the progress notes for Resident F which said:

‘05:25: Checked hourly, med given as prescribed, SRC patent and draining, unsettled over night, slept on/off. Fluids=950ml, very vocal, paracetamol given for comfort.’

The panel also took into account the written statement for Witness 2 which said:

‘During handover, Emanuel handed over information about a resident, Resident F. Emanuel said Resident F's catheter had not drained a lot overnight in relation to his intake. When a resident has a catheter, you record their input and output. If a resident takes in a litre of fluids then you expect there to be approximately a litre of output. Emanuel did not give any figures in relation to input or output.’

The panel also took into account Witness 1's written statement which said:

> *'I was coming into the Home for my shift and Emanuel was sitting by the front door waiting for his wife to finish her day shift. Emanuel stopped me and proceeded to talk to me about Resident F. Emanuel said there had been some sort of problem or issue with Resident F's catheter the night before but stated that the carers who were on shift had not informed him of any issues.'*

The panel also had regard to Witness 6's oral evidence. She said that Mr Costinescu had told her that Resident F had a fluid output of only 50ml.

On this basis the panel determined that Mr Costinescu was aware of the issues Resident F was having with his catheter despite recording in the progress notes that the catheter was patent and draining. The panel therefore found this charge to be proved.

Charge 5)

5) On or before 28 October 2022, in relation to Resident A and/or B, instructed care assistants to administer and/or remove prescription patches

This charge is found proved.

In reaching this decision, the panel had regard to Witness 1's statement which said:

> *'I asked Emanuel about Resident A's patches. Emanuel tried to hand me the patches to put on Resident A. I explained to him that I had been told that I am not allowed to put them on. Emanuel said that he does not like to physically touch a female resident that has capacity. I found this comment bizarre but did not go into it further.'*

In her oral evidence Witness 1 said that Resident A did say that Mr Costinescu does not like doing patches as he has a sore hand.

The panel also took into account the written statement of Witness 5 which said:

> *'A resident at the Home, Resident A was prescribed a Lidocaine patch, which is administered for pain relief. On a date I do not recall, the care staff said that Emanuel had been asking them to apply the resident's patches…*
>
> *…At our meeting on 28 October 2022, mention was made to the importance of ensuring carers are not asked to apply any patches it should always be done by nurse.*
>
> *The concern regarding Patient A was then addressed at the investigatory meeting with Emanuel on 12 January 2023. It did not appear that Emanuel understood the concern regarding applying patches although staff did advise me that he was applying them himself following my discussion with him on 28 October 2022…*
>
> *… Emanuel should not have asked the care staff to do this as any prescribed medication should be administered by the nurse on duty. Medication is prescribed by GP and nurses are responsible for administering medication and witnessing the medication being taken. The NMC code of conduct for medication should be followed by Emanuel which say that nurses witness and sign for medication to ensure it is getting to the right patient.'*

Further, the panel had regard to the letter addressed to Witness 5 raising concerns. The letter stated:

> *'**Application and removal of prescription patches:***
>
> *It is our understanding that this is the responsibility of the RN, and these patches are signed for. We have been repeatedly asked either to administer or remove these patches.'*

The panel determined that Mr Costinescu had asked care assistants at the Home to administer prescription patches to residents. The panel therefore found this charge to be proved.

Charge 6)

6) On an unknown date, in relation to Resident G, did not provide palliative care drugs which would have been appropriate in light of Resident G's clinical presentation.

This charge is found proved.

In reaching this decision, the panel took into account the written statement of Witness 1 which said:

> *'Resident G was on end of life care and her family were at the Home with her…*
>
> *…Around midnight the family pressed the buzzer. I went to the resident's room and the family were concerned because they felt Resident G's condition was deteriorating. I knew Resident G was epileptic, and she appeared to be holding her breath and looked distressed. I said that I would inform the nurse in charge, Emanuel.*
>
> *I told Emanuel what was happening, that the family were distressed and that Resident G was distressed. Emanuel just shrugged his shoulders and did nothing. Resident G was at end of life care and there was access to palliative drugs such as pain relief and also medication to settle agitation to make residents more comfortable. However, Emanuel did not bother and just looked at me, shrugged his shoulders and walked off.'*

The panel determined therefore, that Mr Costinescu did not provide palliative drugs to Resident G who was at end of life. This charge was therefore found proved.

Charge 7)

7) Routinely failed to take appropriate action when residents sounded their buzzers.

This charge is found proved.

In reaching this decision, the panel took into account the notes from the local fact-finding meeting with Mr Costinescu in which he said:

> *'It is not my job to answer buzzers if the carers are staying in their chairs. I will not go.'*

The panel also took into account the notes from the local fact-finding meeting with Witness 4 in which she said:

> *'He also presses buzzers for very simple requests instead of doing it himself. … buzzed one night to ask for water and he pressed the buzzer and walked out of the room and told the care assistant that was responding.'*

The panel also considered the written statement of Witness 5 and her oral evidence. Witness 5's statement said:

> ***'***I reminded Emanuel that he had to ensure that he was being supportive to care staff and helping them to answer buzzers. I reminded Emanuel that his role was not just to check the carers work but to work alongside them and help them. Emanuel did not agree that there was any particular issue or concern.'

In her oral evidence Witness 5 said that it was the responsibility of all staff members to answer the buzzers and there is an expectation that it is a *'team effort'* supporting a resident who is looking for help.

The panel noted from Witness 5's oral evidence that there was no shortage of staff when the incidents of the buzzers were reported.

The panel determined that Mr Costinescu did not routinely take appropriate action when residents sounded their buzzers. The panel therefore found this charge to be proved.

Charge 8)

8) Your actions at charge 2c above were dishonest in that you knew your handover was inaccurate and/or did not represent an accurate picture of Resident D's clinical presentation.

This charge is found NOT proved.

In reaching this decision, the panel took into account that it found charge 2c not proved and it concluded that it could not find that Mr Costinescu's handover for Resident D was dishonest.

Consequently, the panel determined that this charge is not proved.

Charge 9)

9) Your actions at charge 3d above were dishonest in that you knew your handover was inaccurate and/or did not represent an accurate picture of Resident E's clinical presentation.

This charge is found proved.

In reaching this decision, the panel took into account its decision and reasons at charge 3d.

The panel had no information from Mr Costinescu in terms of his reasonings in providing an inaccurate handover of Resident E.

In reviewing the evidence in relation to charge 3d, the panel considered the oral and written evidence from Witness 2. The panel heard from Witness 2 and considered the written evidence which stated:

> *'I found it strange from what I had witnessed when I went into Resident E's room to what Emanuel handed over. Emanuel said that Resident E was tired but I did not think that Resdient E [sic] could have said he was tired from how he appeared when I saw him. It is diffcult [sic] to say how long Resident E had difficulty with breathing. However, Resident E is normally washed and dressed between 06:00 and 07:00 and good practice would have been for Emanuel to check on him again before coming to handover.*
>
> *As Resident E passed away, I read his notes from the night before… Emanuel recorded that Resident E had "slept well". This was a typical phrase used by Emanuel in his entries. The sleep chart was also blank with regards to the 07:00 check.'*

The panel considered whether there was any alternative explanation for why Mr Costinescu had handed over that Resident E did not want to get up, such as the Home being busy. However, it took account of the oral evidence from Witness 5 who said that the Home was well staffed and therefore Mr Costinescu faced no difficulty or delay in his responsibility to care for Resident E.

The panel noted that Mr Costinescu was not asked any questions in relation to his involvement with Resident E during his local fact-finding meeting. However, the panel considered that Mr Costinescu was an experienced nurse, in a position of trust and would have been expected to know the implications of failing to provide an accurate handover of a patient's condition. This was indicative of his state of mind in not providing a fair and accurate picture of Resident E's condition.

Having regard to all the evidence, the panel determined, Mr Costinescu's actions in relation to charge 3d would be regarded as dishonest by the standards of an ordinary person. Accordingly, the panel found that Mr Costinescu's actions at charge 3d were dishonest in that he intended to mislead colleagues in handing over to them

that Resident E was still tired and did not want to get out of bed. The panel therefore found charge 9 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 Costinescu'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 Costinescu's fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct

Mr Joshi invited the panel to take the view that the facts found proved amount to misconduct.

Mr Joshi submitted that the behaviour demonstrated by Mr Costinescu is serious enough to suggest that he was neglecting vulnerable adults in terms of the actions he did and did not do.

Mr Joshi identified the specific, relevant standards in 'The Code: Professional standards of practice and behaviour for nurses and midwives 2015 (the Code)' where the NMC alleges that Mr Costinescu's actions amounted to misconduct.

Submissions on impairment

Mr Joshi moved on to the issue of impairment and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body.

Mr Joshi submitted that the panel should find Mr Costinescu's fitness to practise impaired on grounds of public protection. He submitted that Mr Costinescu failed to practise basic standards of nursing in prioritising people, preserving safety and promoting professionalism and trust.

With regard to whether the concerns have been remediated, Mr Joshi submitted that there was no evidence that Mr Costinescu had shown any insight or remorse in relation to any of the charges and nor has he taken any steps to address the concerns.

Mr Joshi also invited the panel to find Mr Costinescu's fitness to practise impaired on grounds of public interest in order to uphold proper professional standards and conduct and maintaining public confidence in the profession. He submitted that Mr Costinescu's conduct damaged the reputation of the nursing profession and would undermine public confidence in the profession.

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

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

To achieve this, you must:

1.2 make sure you deliver the fundamentals of care effectively

1.3 avoid making assumptions and recognise diversity and individual choice

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

2 Listen to people and respond to their preferences and concerns

To achieve this, you must:

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

2.6 recognise when people are anxious or in distress and respond compassionately and politely

3 ***Make sure that people's physical, social and psychological needs are assessed and responded to***

To achieve this, you must:

3.1 pay special attention to promoting wellbeing, preventing ill health and meeting the changing health and care needs of people during all life stages

3.2 recognise and respond compassionately to the needs of those who are in the last few days and hours of life 8 Professional standards of practice and behaviour for nurses, midwives and nursing associates. All standards apply within your professional scope of practice.

3.4 act as an advocate for the vulnerable, challenging poor practice and discriminatory attitudes and behaviour relating to their care

4 Act in the best interests of people at all times

6 ***Practise effectively***

You assess need and deliver or advise on treatment, or give help (including preventative or rehabilitative care) without too much delay, to the best of your abilities, on the basis of best available evidence. You communicate effectively, keeping clear and accurate records and sharing skills, knowledge and experience where appropriate. You reflect and act on any feedback you receive to improve your practice.

8 Work co-operatively

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

8.3 keep colleagues informed when you are sharing the care of individuals
with other health and care professionals and staff

8.5 work with colleagues to preserve the safety of those receiving care

8.6 share information to identify and reduce risk

9 Share your skills, knowledge and experience for the benefit of people receiving care and your colleagues

To achieve this you must:

9.2 gather and reflect on feedback from a variety of sources, using it to improve your practice and performance

9.3 deal with differences of professional opinion with colleagues by discussion and informed debate, respecting their views and opinions and behaving in a professional way at all times

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:

10.1 complete records at the time or as soon as possible after an event, recording if the notes are written some time after the event

10.2 identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need

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

10.4 attribute any entries you make in any paper or electronic records to yourself, making sure they are clearly written, dated and timed, and do not include unnecessary abbreviations, jargon or speculation

11 Be accountable for your decisions to delegate tasks and duties to other people

To achieve this you must:

11.1 only delegate tasks and duties that are within the other person's scope of competence, making sure that they fully understand your instructions

11.2 make sure that everyone you delegate tasks to is adequately supervised and supported so they can provide safe and compassionate care

Preserve safety

You make sure that patient and public safety is not affected. You work Within the limits of your competence, exercising your professional 'duty of candour' and raising concerns immediately whenever you come across situations that put patients or public safety at risk. You take necessary action to deal with any concerns where appropriate.

13 Recognise and work within the limits of your competence

To achieve this must:

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

13.2 make a timely referral to another practitioner when any action, care or treatment is required

13.3 ask for help from a suitably qualified and experienced professional to carry out any action or procedure that is beyond the limits of your competence

13.4 take account of your own personal safety as well as the safety of people in your care

14 Be open and candid with all service users about all aspects of care and treatment, including when any mistakes or harm have taken place

To achieve this must:

14.1 act immediately to put right the situation if someone has suffered actual harm for any reason or an incident has happened which had the potential for harm

14.2 explain fully and promptly what has happened, including the likely effects, and apologise to the person affected and, where appropriate, their advocate, family or carers

14.3 document all these events formally and take further action (escalate) if appropriate so they can be dealt with quickly

17 Raise concerns immediately if you believe a person is vulnerable or at risk and needs extra support and protection

To achieve this must:

17.1 take all reasonable steps to protect people who are vulnerable or at risk from harm, neglect or abuse

17.3 have knowledge of and keep to the relevant laws and policies about protecting and caring for vulnerable people

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:

18.2 keep to appropriate guidelines when giving advice on using controlled drugs and recording the prescribing, supply, dispensing or administration of controlled drugs

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

To achieve this, you must:

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

20 Uphold the reputation of your profession at all times

To achieve this, you must:

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

20.2 act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment

20.3 be aware at all times of how your behaviour can affect and influence the behaviour of other people

20.8 act as a role model of professional behaviour for students and newly qualified nurses, midwives and nursing associates to aspire to

25 Provide leadership to make sure people's wellbeing is protected and to improve their experiences of the health and care system

To achieve this, you must:

25.1 identify priorities, manage time, staff and resources effectively and deal with risk to make sure that the quality of care or service you deliver is maintained and improved, putting the needs of those receiving care or services first

25.2 support any staff you may be responsible for to follow the Code at all times. They must have the knowledge, skills and competence for safe practice; and understand how to raise any concerns linked to any circumstances where the Code has, or could be, broken

When considering the seriousness of the charges the panel also had regard to the NMC Guidance on How we determine seriousness (FTP-3 (a-c)). The panel gave particular regard to the following:

- *'conduct or poor practice which indicates a dangerous attitude to the safety of people receiving care,…*
- *breaching the professional duty of candour to be open and honest when things go wrong, including covering up, falsifying records,…*
- *being directly responsible (such as through management of a service or setting) for exposing people receiving care to harm or neglect, especially where the evidence shows the nurse, midwife or nursing associate putting their own priorities, or those of the organisation they work for, before their professional duty to ensure the safety and dignity of people receiving care.*

Protecting people from harm, abuse and neglect goes to the heart of what nurses, midwives and nursing associates do. Failure to do so, or intentionally causing a person harm, will always be treated very seriously due to the high risk of harm to those receiving care, if the behaviour is not put right. Where professionals are shown to be involved in serious neglect or abuse outside their professional practice, there is likely to be a risk of harm to people receiving care. Such behaviour also has the potential to seriously undermine the public's trust and confidence in the professions we regulate.'

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

However, the panel was of the view Mr Costinescu's actions did fall seriously short of the conduct and standards expected of a nurse and therefore amounted to misconduct.

Having considered the charges as a whole, the panel determined that Mr Costinescu's misconduct was serious, in particular the dishonesty and the incidents involving Resident E and F. The panel was of the view that Mr Costinescu's misconduct was tantamount to a failing in fundamental nursing skills and caused patients to be at serious risk of harm. The panel took into consideration that Mr Costinescu was caring for vulnerable elderly residents, some of whom had communications difficulties, were very ill or were receiving end of life care at the Home. The panel noted that some of the residents under Mr Costinescu's care had care plans, but he failed to follow these, resulting in further significant harm being caused to residents. The panel found Mr Costinescu's misconduct to be neglectful, lacking in kindness and compassion and breaching the fundamental tenets of the Code.

The panel concluded that Mr Costinescu's actions were extremely serious and unprofessional to the extent that they would be seen as deplorable by other members of the profession.

Decision and reasons on impairment

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

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

> *'The question that will help decide whether a professional's fitness to practise is impaired is:*
> *"Can the nurse, midwife or nursing associate practise kindly, safely and professionally?"*

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

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional 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/ 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) *has in the past acted dishonestly and/or is liable to act dishonestly in the future.'*

The panel first considered whether any of the limbs of the Grant test were engaged in the past. It was of the view that at the time of the incidents, Mr Costinescu's misconduct was neglectful and placed residents at an unwarranted risk of harm.

The panel determined that Mr Costinescu's misconduct constituted serious breaches of the fundamental tenets of the nursing profession as he failed to uphold the standards and values of the nursing profession, thereby bringing the nursing profession into disrepute. The panel had also found a charge of dishonesty proved against Mr Costinescu.

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

The panel first considered whether Mr Costinescu's misconduct is capable of being addressed. It took into account that Mr Costinescu's actions amounted to neglect and physical harm being caused to elderly vulnerable residents in his care. The panel was of the view that his actions including his dishonest conduct were suggestive of deep-seated attitudinal concerns. It therefore decided that the concerns are extremely difficult to remediate due to their serious and dishonest nature.

The panel then went on to consider whether the concerns had been addressed by Mr Costinescu. Regarding insight, the panel was of the view that Mr Costinescu has failed to show insight into his conduct. It noted that during the local investigation

conducted by the Home, Mr Costinescu failed to take accountability for his actions, sought to justify his conduct and failed to demonstrate remorse. The panel also considered that Mr Costinescu had not provided it with any information by way of reflective pieces to show that he had insight into his actions. The panel also concluded that there is a risk of repetition as Mr Costinescu had not provided the panel with any information that he had taken steps to strengthen his practice.

The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

The panel bore 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.

The panel had regard to the serious nature of Mr Costinescu's misconduct and determined that public confidence in the profession would be undermined if a finding of impairment were not made in this case, particularly as this misconduct involved the neglect of elderly vulnerable residents and dishonesty. It was of the view that a fully informed member of the public, aware of the proven charges in this case, would be very concerned if Mr Costinescu were permitted to practise as a registered nurse without restrictions. For this reason, the panel determined that a finding of current impairment on public interest grounds is also required. It determined 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 the proper professional standards for members of the nursing profession.

Having regard to all of the above, the panel was satisfied that Mr Costinescu'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 Costinescu off the register. As a result of this order the NMC register will show that Mr Costinescu has been struck off the register.

Submissions on sanction

Mr Joshi invited the panel to impose a striking-off order. He reminded the panel of Mr Costinescu's misconduct and stressed his attitude during these incidents of misconduct. He submitted that a striking-off order is the only order appropriate to maintain public safety and confidence in the profession.

Decision and reasons on sanction

Having found Mr Costinescu'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 decision on sanction is a matter for the panel independently exercising its own judgement.

In reaching its decision, the panel has had regard to all the evidence that has been adduced in this case and to the submissions of Mr Joshi. It took account of the passages in the document which record Mr Costinescu's views. The panel also had careful regard to the Sanctions Guidance (SG) published by the NMC. The panel accepted the advice of the legal assessor concerning its powers and the approach it should take in determining sanction.

The panel took into account the following aggravating features:

- As the registered nurse in charge of the shift, Mr Costinescu failed in his obligations towards vulnerable residents who had communication issues, were very ill or receiving end of life care, and to his colleagues.

- Mr Costinescu placed vulnerable residents at risk of physical harm through his failure to deliver basic fundamental care and failure to keep accurate records which properly reflected the conditions of the residents under his care.
- Mr Costinescu's misconduct took place over a significant period of time, from December 2021 to December 2022. Despite an intervention by his manager the conduct continued, resulting in members of staff formally raising concerns about his practice.
- Mr Costinescu was dismissive of the concerns raised by colleagues and failed to take opportunities to listen to their alerts and to take necessary action.
- Mr Costinescu's lack of remorse or insight into his conduct including its impact on the residents, his colleagues, the nursing profession and the wider public.

The panel considered all of the information before it, including Mr Costinescu's response during the Home's local investigation. The panel found that there were no mitigating features in this case. It was satisfied there were no extenuating circumstances, such as shortage of staff. There was no evidence of strengthening of practice from Mr Costinescu nor were any character or other references provided.

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

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

The panel next considered whether placing conditions of practice on Mr Costinescu's registration would be a sufficient and appropriate response. In the panel's judgement Mr Costinescu's misconduct and lack of insight were too serious for conditions of practice to be an adequate or appropriate order. Also, the panel was of the view that the misconduct identified in this case could not be addressed through retraining and was extremely difficult to remediate. In the panel's view Mr Costinescu's misconduct revealed deep-seated attitudinal problems including dishonesty. It determined that, given the seriousness of the concerns, the deep-seated attitudinal problems and Mr Costinescu's lack of insight into the impact of his actions on residents, his colleagues, the nursing profession and the wider public, there were no proportionate and workable conditions that could be formulated. Accordingly, a conditions of practice order would not address the high risk of repetition, and this poses a risk of harm to patients' safety and to the public. In addition, there is no indication that Mr Costinescu would be willing to engage with any conditions. Consequently, the panel decided that a conditions of practice order 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 states that a 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;*

In relation to the dishonesty, the panel recognised that this was a single incident that does not appear to have been repeated. However, having regard to all of the misconduct and all of the evidence, this was outweighed by the seriousness of the charges, the breach of duties in failing to provide the necessary care to residents and Mr Costinescu's deep-seated attitudinal problems towards residents and

colleagues and what in the panel's view is a total absence of evidence of any sort of insight. The panel took into account that there was no evidence before it to indicate that Mr Costinescu had taken any steps to remediate his misconduct. The panel considered that, whilst a period of suspension would protect the public from harm while it is in force, it would not satisfy the wider public interest.

The conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. In the panel's judgement the serious breach of the fundamental tenets of the profession evidenced by Mr Costinescu's actions is fundamentally incompatible with Mr Costinescu remaining on the register and the panel determined that a suspension order would not be a sufficient, appropriate or proportionate sanction.

Finally, in looking at a striking-off order, the panel took note of the following paragraphs of the SG:

- *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 seriously concerned about Mr Costinescu's attitude to his role as a nurse at the Home. Mr Costinescu was the practitioner in charge on his shifts, during which he failed to provide a basic level of care towards residents, to keep accurate records and to act on the concerns brought to him by colleagues about residents. He inappropriately delegated nursing tasks to care staff and failed to respond appropriately, or in some cases at all, to incidents affecting residents or to developments in their condition. The panel considered the vulnerability of the residents Mr Costinescu was taking care of, some of whom had speech and communication issues, were very ill or were receiving end of life care.

Mr Costinescu should have shown kindness and provided compassionate care to the residents and should have taken steps to minimise their discomfort. The panel concluded that instead Mr Costinescu had over a period of a year, failed to practise kindly, safely and professionally as a registered nurse, putting residents at serious risk of harm. In the panel's judgement this reflected not simply a series of occasional errors or shortcomings but rather an entirely unsatisfactory attitude to the residents in his care and to nursing as a profession.

Mr Costinescu's actions were significant departures from the standards expected of a registered nurse and are fundamentally incompatible with him remaining on the register. The panel was of the view that the findings in this particular case demonstrate that Mr Costinescu's actions were serious and to allow him to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body.

In reaching its decision the panel bore in mind the impact that its order will have on Mr Costinescu. Balancing all of these factors and after taking into account all the evidence before it during this case, the panel determined that the appropriate and proportionate sanction is that of a striking-off order. The panel has concluded that nothing short of this 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 declare to the public and the profession the standard of behaviour required of a registered nurse.

This will be confirmed to Mr Costinescu 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 until the striking-off sanction takes effect. 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 is in Mr Costinescu's own interests. The

panel heard and accepted the advice of the legal assessor concerning the approach it should take to the making of an interim order.

Submissions on interim order

The panel took account of the submissions made by Mr Joshi. He submitted that an interim suspension order for a period of 18 months is necessary on the grounds of public protection and is otherwise in the public interest. He also submitted that the length of the interim suspension order should cover any potential period of appeal.

Mr Costinescu's observations in the bundle did not make any express submissions on this point.

Decision and reasons on interim order

In reaching the decision to impose an interim order, the panel had regard to the NMC Guidance, the seriousness of the facts found proved and the reasons set out in its decision for the substantive order. It was 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. The panel was satisfied that this was necessary in order to protect the public and that it was otherwise in the public interest. It was of the view that the length of the order is necessary to cover any possible delays during the appeal process. The panel determined that not to impose an interim suspension order would be inconsistent with its earlier decisions.

The panel had regard to the impact that an interim order will have on Mr Costinescu. It was satisfied that this order, for this period, was proportionate and fairly balanced

the need to protect the public and the public interest with the effect on Mr Costinescu.

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

That concludes this determination.