Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Tuesday, 30 April 2024 – Friday, 10 May 2024
Monday, 20 May 2024 – Thursday, 23 May 2024
Tuesday, 28 May 2024 – Friday, 14 June 2024

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

Name of Registrant:	**Salvador Firtascu**
NMC PIN	15B0271C
Part(s) of the register:	Registered Nurse – RN1, Adult Nurse (February 2015)
Relevant Location:	London
Type of case:	Misconduct
Panel members:	Philip Sayce (Chair, registrant member) Richard Luck (Registrant member) Margaret Jolley (Lay member)
Legal Assessor:	Nigel Ingram
Hearings Coordinator:	Muminah Hussain
Nursing and Midwifery Council:	Represented by Alex Radley, Case Presenter
Mr Firtascu:	Not present and unrepresented
Facts proved (072999/2019):	Charges 1(a), 1(b), 1(c), 1(d), 1(e), 2(b), 2(c), 2(d), 3, 4, 5(a), 5(b), 5(c) & 6
Facts not proved (072999/2019):	Charge 2(a)
Facts proved (085901/2020)	Charges 1(a), 1(b), 1(c), 1(d), 1(e), 1(f), 1(g), 1(h), 1(i), 1(j), 1(k), 2(a), 2(b), 2(c), 2(d)(i), 2(d)(ii), 3, 4(a), 4(b), 4(c), 4(d), 4(e), 4(f), 4(g), 4(h), 4(i), 4(j), 4(k), 4(l), 4(m), 5(a), 5(b), 5(c), 5(d)(i), 5(d)(ii), 6, 7(a), 7(b), 7(c), 7(d), 7(e), 8(a), 8(b), 8(c), 8(d)(i), 8(d)(ii), 9, 10(a), 10(b), 10(c),

	11(a), 11(b), 11(c), 11(d), 11(e), 11(f), 11(g), 11(h), 11(i), 11(j), 12, 13 & 14
Facts not proved (085901/2020)	None
Facts proved (087971/2022)	Charges 1(a), 1(b), 1(c), 1(d)(i), 1(d)(ii), 1(d)(iii), 1(d)(iv), 1(e)(i), 1(e)(ii), 1(f), 2, 3(a), 3(b), 3(c)(i) & 3(c)(ii)
Facts not proved (087971/2022)	Charge 1(e)(iii)
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 Firtascu was not in attendance and that the Notice of Hearing letter had been sent to Mr Firtascu's registered email address by secure email on 28 March 2024.

Mr Radley, on behalf of the Nursing and Midwifery Council (NMC), submitted that it had complied with the requirements of Rules 11 and 34 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Hearing provided details of the allegation, the time, dates and venue of the hearing and, amongst other things, information about Mr Firtascu'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 Firtascu 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 Firtascu

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

Mr Radley submitted that there had been no engagement at all by Mr Firtascu with the NMC in relation to these proceedings 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'* as referred to in the case of *R* v *Jones (Anthony William)* (No.2) [2002] UKHL 5.

The panel has decided to proceed in the absence of Mr Firtascu. In reaching this decision, the panel has considered the submissions of Mr Radley 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 Firtascu;
- Mr Firtascu has not engaged with the NMC and has not responded to any of the emails sent to him about this hearing;
- There is no reason to suppose that adjourning would secure his attendance at some future date;
- Witnesses have attended to give live evidence throughout the duration of the hearing;
- 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 (2019, 2021 & 2022 to which the allegations relate);
- Further delay may have an adverse effect on the ability of witnesses accurately to recall events; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Mr Firtascu in proceeding in his absence. Although the evidence upon which the NMC relies will have been sent to him at his registered address, 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 Firtascu'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 Firtascu. The panel will draw no adverse inference from Mr Firtascu's absence in its findings of fact.

Details of charge

Case reference: 072999/2019

That you a registered nurse whilst employed as the Deputy Manager and Clinical Lead at Hampton Court Care Home (the 'Home'):

1. On 1 April 2019 having found food in Resident A's mouth, failed to;

    a. Document the incident in Resident A's care notes.
    b. Complete an incident report form.
    c. Complete the electronic care planning system.
    d. Raise a safeguarding alert.
    e. Complete a Care Quality Commission notification.

2. On or around 23 May 2019 failed to;

    a. Follow an instruction from the GP to ensure that Resident B was administered the liquid form of their anti-epileptic medication, Levetiracetam.
    b. Follow an instruction to investigate why Resident B had not been administered their anti-epileptic medication, Levetiracetam, between 17 May and 23 May 2019.
    c. Document the incident.
    d. Follow the process required when this incident occurred.

3. Between the 17 May and 23 May 2019 failed to ensure that Resident B's anti-epileptic medication, Levetiracetam, was in stock in order that it could be administered to Resident B between these dates.

4. On 28 May 2019 incorrectly administered 800U Cholecalciferol to Resident B, it having being stopped by the GP on 16 May 2019.

5. Between 14 May and 23 May 2019 failed to ensure that Resident C's Fragmin medication was in stock and/or available by not;

    a. Checking Resident C's MAR chart.
    b. Undertaking a mini stock check.
    c. Contacting the pharmacy to order the medication.

6. Between the 5 April and 31 May 2019 failed to ensure and/or order a bed extension and/or bed rails for Resident D upon it had been identified that Resident D had developed a skin tear in their right sole on 5 April 2019.

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

Case reference: 085901/2021

That you a registered nurse whilst employed as manager of Fern Gardens Care Home (the 'Home') between April and August 2021;

1. Behaved in an unprofessional and/or inappropriate manner towards Colleague A in that:

a. On one or more occasions made comments about Colleague A's chest by stating words to the effect of *'you have got nice boobs'* and/or *'they were soft'* and/or *'your husband is lucky'*.

b. On an occasion stated to Colleague A words to the effect of, *'what position do you like?'*
c. On one or more occasions stated to Colleague A words to the effect of, *'I feel like sleeping with you'*.
d. On one or more occasions stated to Colleague A words to the effect of, *'I feel like pressing your breasts'*.
e. On one or more occasions massaged Colleague A's shoulders.
f. On one or more occasions pinched Colleague A's arm.
g. On one or more occasions pull up Colleague A's bra strap.
h. On or around 29 June 2021 undid Colleague A's bra strap.
i. On or around 30 June 2021 followed Colleague A into the stationary room closing the door behind you.
j. On or around 30 June 2021 followed Colleague A into the toilet.
k. Having followed Colleague A into the toilet stated words to the effect of, *'imagine what the staff would say if they saw us leave the toilet together'*.

2. Your actions in charge 1 amounted to harassment of Colleague A in that:

a. It was unwanted and/or
b. It related to Colleague A's sex and/or
c. It was sexual in nature and/or
d. It had the purpose or effect of:
    i. Violating Colleague A's dignity, and/or
    ii. Creating an intimidating, hostile, degrading, humiliating or offensive environment for Colleague A.

3. Your actions in charge 1 were sexually motivated.

4. Behaved in an unprofessional and/or inappropriate manner towards Colleague B in that;

a. On one or more occasions poked Colleague B.
b. On one or more occasions pinched Colleague B.

c. On one or more occasions stated to Colleague B words to the effect of, *'you have nice boobs'*.
d. Stated to Colleague B when she was cleaning her office words to the effect of, *'are you making room for our bed'*.
e. On one or more occasions attempted to undo Colleague B's bra.
f. On an occasion grabbed Colleague B's breast.
g. Stated to Colleague B after grabbing her breast words to the effect of, *'I'm your manager, you can't tell me to piss off'*.
h. On an occasion pinched Colleague B's bottom.
i. Having pinched Colleague B's bottom stated words to the effect of, *'you've got a nice bum'*.
j. On an occasion placed your fingers in the V part of Colleague B's V neck top.
k. Having placed your fingers through Colleague B's V neck top, stated words to the effect of, *'you've got nice tits'*.
l. On an occasion followed Colleague B into the toilet.
m. Having followed Colleague B into the toilet and stated words to the effect of, *'I should go out like this'* whilst playing with the fly on your trousers.

5. Your actions in charge 4 amounted to harassment of Colleague B in that:

a. It was unwanted and/or
b. It related to Colleague B's sex and/or
c. It was sexual in nature and/or
d. It had the purpose or effect of:
    i. Violating Colleague B's dignity, and/or
    ii. Creating an intimidating, hostile, degrading, humiliating or offensive environment for Colleague B.

6. Your actions in charge 4, except charges 4a and 4b, were sexually motivated.

7. Behaved in an unprofessional and/or inappropriate manner towards Colleague C in that;

a. On an occasion stated to Colleague C in front of other colleagues words to the effect of, *'You are not good at your job'*.
b. On an occasion threatened and/or attempted to touch Colleague C's breast.
c. On one or more occasions stated to Colleague C words to the effect of, *'I'm going to touch your breasts'*.
d. On one or more occasions stated to Colleague C, *'you've got a big bum'*.
e. When Colleague C stated that your behaviour towards Colleague A and/or Colleague B was unprofessional stated to Colleague C words to the effect of, *'fuck off'*.

8. Your actions in charge 7 amounted to harassment of Colleague C in that:

a. It was unwanted and/or
b. It related to Colleague C's sex and/or
c. It was sexual in nature and/or
d. It had the purpose or effect of:
    i. Violating Colleague C's dignity, and/or
    ii. Creating an intimidating, hostile, degrading, humiliating or offensive environment for Colleague C

9. Your actions in charge 7b and/or 7c and/or 7d were sexually motivated.

10. Behaved in an unprofessional manner with Miss 1 in that;

a. On one or more occasions would kiss Miss 1 whilst at work.
b. On one or more occasions would hold Miss 1's hand whilst at work.
c. On one or more occasions would cuddle Miss 1 whilst at work.

11. Being the manager of the Home and having overall responsibility for patient care;

a. Failed to ensure that staff did not leave medication unattended and/or locked away.

b. Failed to ensure that staff documented MAR charts clearly preventing errors occurring with the administration of medication.
c. Failed to ensure that registered nurses worked in pairs when dispensing controlled drugs.
d. Failed to ensure that staff dispensed medication safely.
e. Failed to ensure that staff were PPE compliant.
f. Failed to ensure that your dog did not have access and/or the ability to approach residents.
g. Failed to ensure that care plans were detailed enough to safeguard against residents' mouths becoming dehydrated when being PEG fed.
h. Failed to ensure that staff did not barricade residents in their rooms.
i. Failed to ensure that cupboards containing cleaning fluids was always kept locked when unattended.
j. On one or more occasions failed to ensure that safeguarding incidents had been made when Resident A suffered a fall.

12. Having been informed by Colleague B what the carers were intending to say about a resident that had fallen, instructed Colleague B to tell the carers, by stating words to the effect of, *'they could not fucking write that in their statements as the home will be closed if they did'*.

13. Your actions in charge 12 were a dishonest attempt to persuade the carers into providing misleading accounts about the incident which you knew would not be a true reflection of what had happened.

14. Your actions in charge 12 lacked integrity in that you were attempting to cover up the incident for your and/or the Home's benefit.

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

Case reference: 087971/2022

That you a registered nurse:

1. Behaved in an unprofessional and/or inappropriate manner towards Colleague D in that;

    a. On 4 October 2021 stated to Colleague D words to the effect of, *'what makes me happy is to piss staff off'*.
    b. On 7 October 2021 blew kisses at Colleague D.
    c. On 8 October 2021, on one or more occasions, attempted to place and/or placed your hands on or around Colleague D's waist.
    d. On 12 October 2021, in a meeting with others present;
        i. Criticised Colleague D for failing to undertake fundraising tasks.
        ii. Was rude and/or aggressive towards Colleague D.
        iii. Stated to Colleague D words to the effect of, *'your activities department will be the reason why CQC inspection would fail the whole care home'*.
        iv. When discussing activities stated to Colleague D words to the effect of, *'if you are good at your job, you would know to do these'*.
    e. On 13 October 2021;
        i. Threw a pile of newspapers on top of the work that Colleague D was doing.
        ii. Stated to Colleague D words to the effect of, *'hand them out'*.
        iii. On one or more occasions gave Colleague D *'dirty looks'*.
    f. On one or more occasions on dates unknown referred to Colleague D by calling her *'darling'* or words to that effect.

2. On a date unknown behaved in an unprofessional and/or inappropriate manner by stating to Colleague D when referring about another colleague words to the effect of, *'she looks like she likes a good shag.'*

3. Your actions in charge 1 and/or charge 2 amounted to harassment of Colleague D in that:

    a. It was unwanted and/or
    b. It related to Colleague D's sex and/or was sexual in nature and/or was sexually motivated and/or,

c. It had the purpose or effect of:

ii. Violating Colleague D's dignity, and/or

iii. Creating an intimidating, hostile, degrading, humiliating or offensive environment for Colleague D.

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

Decision and reasons on application to amend the charge

Case reference: 085901/2021

The panel requested to amend charges 10 and 14 of case reference 085901/2021. The proposed amendment was to change 'Colleague D' to 'Miss 1', and in charge 14, the word 'was' to 'were'.

Mr Radley had no objection to this amendment.

"That you a registered nurse whilst employed as manager of Fern Gardens Care Home (the 'Home') between April and August 2021;

10. Behaved in an unprofessional manner with ~~Colleague D~~ **Miss 1** in that;

a. On one or more occasions would kiss ~~Colleague D~~ **Miss 1** whilst at work.

b. On one or more occasions would hold ~~Colleague D~~ **Miss 1**'s hand whilst at work.

c. On one or more occasions would cuddle ~~Colleague D~~ **Miss 1** whilst at work.

…

14. Your actions in charge 12 lacked integrity in that you ~~was~~ **were** attempting to cover up the incident for your and/or the Home's benefit."

The panel accepted the advice of the legal assessor and had regard to Rule 28 of the Rules.

The panel was satisfied that there would be no prejudice to Mr Firtascu and no injustice would be caused to either party by the proposed amendment being allowed. It was therefore appropriate to allow the amendment, as applied for, to ensure clarity and accuracy.

Case reference: 087971/2022

The panel heard an application made by Mr Radley, on behalf of the NMC, to amend the wording of all charges under the case reference 087971/2022.

The proposed amendment was to change Colleague A to Colleague D. It was submitted by Mr Radley that the proposed amendment would provide clarity of the witnesses and more accurately reflect the evidence.

"That you a registered nurse:

1. Behaved in an unprofessional and/or inappropriate manner towards Colleague D in that;

    a. On 4 October 2021 stated to Colleague ~~A~~ **D** words to the effect of, *'what makes me happy is to piss staff off*'.
    b. On 7 October 2021 blew kisses at Colleague ~~A~~ **D**.
    c. On 8 October 2021, on one or more occasions, attempted to place and/or placed your hands on or around Colleague ~~A~~ **D**'s waist.
    d. On 12 October 2021, in a meeting with others present;
        i. Criticised Colleague ~~A~~ **D** for failing to undertake fundraising tasks.
        ii. Was rude and/or aggressive towards Colleague ~~A~~ **D**.

iii. Stated to Colleague ~~A~~ **D** words to the effect of, *'your activities department will be the reason why CQC inspection would fail the whole care home'*.

iv. When discussing activities stated to Colleague ~~A~~ **D** words to the effect of, *'if you are good at your job, you would know to do these'*.

e. On 13 October 2021;

v. Threw a pile of newspapers on top of the work that Colleague ~~A~~ **D** was doing.

vi. Stated to Colleague ~~A~~ **D** words to the effect of, *'hand them out'*.

vii. On one or more occasions gave Colleague ~~A~~ **D** *'dirty looks'*.

f. On one or more occasions on dates unknown referred to Colleague ~~A~~ **D** by calling her *'darling'* or words to that effect.

2. On a date unknown behaved in an unprofessional and/or inappropriate manner by stating to Colleague ~~A~~ **D** when referring about another colleague words to the effect of, *'she looks like she likes a good shag.'*

3. Your actions in charge 1 and/or charge 2 amounted to harassment of Colleague ~~A~~ **D** in that:

a. It was unwanted and/or

b. It related to Colleague ~~A~~ **D**'s sex and/or was sexual in nature and/or was sexually motivated and/or,

c. It had the purpose or effect of:

i. Violating Colleague ~~A~~ **D**'s dignity, and/or

ii. Creating an intimidating, hostile, degrading, humiliating or offensive environment for Colleague ~~A~~ **D**.

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

The panel accepted the advice of the legal assessor and had regard to Rule 28 of the Rules.

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

Background

Case reference 072999/2019

The charges arose whilst Mr Firtascu was employed as a registered nurse and deputy home manager by Hampton Court Care Home (Hampton Court).

Resident A was being fed by a relative when they choked. This was witnessed by another member of staff. No harm came to Resident A, however there was an expectation of Mr Firtascu to complete an incident form; complete the electronic care planning system, send out a safeguarding alert and a Care Quality Commission (CQC) notification. Allegedly, Mr Firtascu did not do what was expected of him.

There are three separate incidents relating to Resident B:

- Mr Firtascu did not allegedly record the fact that Resident B had an epileptic seizure on 23 May 2019.
- Mr Firtascu did not allegedly ensure Resident B was administered the liquid medication Levetiracetam according to instructions provided by the GP between 17 and 23 May 2019.
- Mr Firtascu allegedly administered the medication Cholecalciferol to Resident B on 28 May 2019, despite it being stopped by the GP on 16 May 2019.

Resident C was not given their daily Fragmin injections as part of their regular treatment. There was an expectation from Mr Firtascu, as deputy manager, to check the MAR charts, conduct a mini count of medication and order stock as required each day.

The last incident relates to Resident D. Resident D required a bed extension because he was too tall for the bed, leading to his right foot rubbing the end of the bed, resulting in an ulcer developing on his foot. Mr Firtascu was responsible for ordering/obtaining the extended bed end, and he was aware of this however, did not allegedly order the bed end.

Mr Firtascu was referred to the NMC in June 2019. Mr Firtascu denies all charges in this case.

Case reference: 085901/2021

The charges arose whilst Mr Firtascu was employed as a home manager for Fern Gardens Care Home (Fern Gardens). He was employed during April 2021 and resigned in August 2021.

Mr Firtascu allegedly behaved in an unprofessional and inappropriate manner towards Colleague A, Colleague B and Colleague C. This behaviour was of a sexual nature, and created a hostile and offensive environment.

Furthermore, there were issues raised relating to patients falls, bruises and management of medication. There are also concerns that Mr Firstascu brought his dog into Fern Gardens.

Mr Firtascu was suspended from Fern Gardens in July 2021. He was subsequently referred to the NMC in October 2021.

Case reference: 087971/2022

The charges arose whilst Mr Firtascu was employed as a home manager for Gold Care Home Drayton Village (Gold Care).

Mr Firtascu allegedly behaved in an unprofessional and inappropriate manner towards Colleague D. This behaviour was both of a sexual nature and considered as bullying, as well as it creating a hostile and offensive environment.

Mr Firtascu was referred to the NMC in March 2022. He denies these allegations.

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

During the course of the hearing, Mr Radley made a request that this case be held in private on the basis that proper exploration of Mr Firtascu's case involves reference to [PRIVATE]. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

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

The panel determined when [PPRIVATE], the hearing will proceed in private.

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 Radley on behalf of the NMC.

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

The panel was aware that the burden of proof rests on the NMC, and that the standard of proof is the civil standard, namely the balance of probabilities. This means that a fact will be proved if a panel is satisfied that it is more likely than not that the incident occurred as alleged.

The panel heard live evidence from the following witnesses called on behalf of the NMC:

- Witness 1: Activities Coordinator at Gold Care (at the time of the incidents)
- Witness 2: Administrator at Fern Gardens (at the time of the incidents)
- Witness 3: Health Care Assistant at Fern Gardens (at the time of the incidents)
- Witness 4: Care Home Support Team Lead at Hounslow and Richmond Community Healthcare Trust (at the time of the incidents)
- Witness 5: Safeguarding Consultant Practitioner for London Borough of Hounslow (at the time of the incidents)
- Witness 6: Regional Support Manager at Bond Care (at the time of the incidents)
- Witness 7: Activities Coordinator at Gold Care (at the time of the incidents)
- Witness 8: Regional Manager at Gold Care (at the time of the incidents)

- Witness 9: Social Worker for the London Borough of Hounslow (at the time of the incidents)
- Witness 10: Operations Manager at Cranford Health Care (at the time of the incidents)
- Witness 11: Home Manager of Hampton Court (at the time of the incidents)
- Witness 12: Social Worker for Twickenham Locality Team (at the time of the incidents)
- Witness 13: Social Worker for the London Borough of Hounslow (at the time of the incidents)
- Witness 14: Deputy Home Manager for Fern Gardens (at the time of the incidents)

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor. It considered the witness and documentary evidence provided by both the NMC and Mr Firtascu.

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

Case reference: 072999/2019

Charge 1(a)

"That you a registered nurse whilst employed as the Deputy Manager and Clinical Lead at Hampton Court Care Home (the 'Home'):

1. On 1 April 2019 having found food in Resident A's mouth, failed to;

    a) Document the incident in Resident A's care notes."

This charge is found proved.

In reaching this decision, the panel took into account Witness 11's written statement and oral evidence, as well as Mr Firtascu's job description.

When asked in her oral evidence what the expectations of a nurse when a resident has choked, Witness 11 replied:

> *"… updated the care records … should have been reported and documented."*

When asked if the matter was recorded in Resident A's care notes, Witness 11 said "no."

In her written statement, Witness 11 noted:

> *"I understand it is said that he didn't record the incident onto the system: failed to update the care plan …"*

Mr Firtascu's job description entails:

- *"Organise the implementation of the planned programme of care as set out in the individual care plans, ensuring that it meets the totality of residents' care needs including their physical, psychological and spiritual needs, using the agreed model of care.*
- *Regularly evaluate the care plans and review their overall effectiveness. Initiate changes as required in agreement with the Registered Manager.*

- *Communicate with the residents as well as their family and friends to ensure the care plan details as much life history as possible."*

The panel determined that there were no care records for Resident A. It accepted the oral and written statement from Witness 11 which was that Mr Firtascu, as a manager and a registered nurse, had a duty to document the incident in Resident A's care notes. This is also mentioned in Mr Firtascu's job description. The panel determined that Mr Firtascu did not do this.

The panel therefore finds charge 1(a) proved.

Charge 1(b)

"That you a registered nurse whilst employed as the Deputy Manager and Clinical Lead at Hampton Court Care Home (the 'Home'):

1. On 1 April 2019 having found food in Resident A's mouth, failed to;

b) Complete an incident report form."

This charge is found proved.

In reaching this decision, the panel took into account Witness 11's written statement and oral evidence, as well as Mr Firtascu's undated statement in the registrants response bundle.

In her written statement, Witness 11 noted:

> *"I would have expected him to; discuss the incident immediately after with Nurse and care staff and to ensure that the information is also relayed to the night staff in order to minimise any further risks: completed incident report…"*

In her oral evidence, Witness 11 said:

"I completed the incident report form when asked to do so."

When asked if this was a process that Mr Firtascu should have followed, Witness 1 informed the panel that:

"Yes, the resident was not a high risk at that point, but he should have been reassessed after the incident."

In his statement, Mr Firtascu documents the incident relating to Resident A:

"I wrote an incident accident report in hard copy and I held an investigation meeting with all staff members in duty and asked them to give me a statement about the situation. All the paperwork I gave in hand to the interim manager …"

The panel determined that on the balance of probabilities, an incident report form was not completed. It noted Witness 11's written statement, that:

"During the meeting SF confirmed that he would update the system and contact the Safeguarding team, but this was never done."

The panel therefore finds charge 1(b) proved.

Charge 1(c)

"That you a registered nurse whilst employed as the Deputy Manager and Clinical Lead at Hampton Court Care Home (the 'Home'):

1. On 1 April 2019 having found food in Resident A's mouth, failed to;

c) Complete the electronic care planning system."

This charge is found proved.

In reaching this decision, the panel took into account Witness 11's oral evidence and written statement, as well as Mr Firtascu's job description.

Witness 11's written statement reads:

> *"… It should have been on the Home's system. The Home has a computer system. Residents have daily notes so everything should be recorded and updated against care plans accordingly. Furthermore, the Home should be able to download electronic care plans … SF refused to provide or assist in obtaining information when I asked."*

The panel also referred to Mr Firtascu's job description which stated:

- *Regularly evaluate the care plans and review their overall effectiveness. Initiate changes as required in agreement with the Registered Manager.*
- *Communicate with the residents as well as their family and friends to ensure the care plan details as much life history as possible."*

The panel determined that this meant the care plans should have been electronically recorded. Mr Firtascu had a duty, however did not carry out his duty.

The panel therefore finds charge 1(c) proved.

Charge 1(d)

"That you a registered nurse whilst employed as the Deputy Manager and Clinical Lead at Hampton Court Care Home (the 'Home'):

1. On 1 April 2019 having found food in Resident A's mouth, failed to;

d) Raise a safeguarding alert."

This charge is found proved.

In reaching this decision, the panel took into account Witness 11's oral evidence and written statement, as well as Mr Firtascu's job description.

Witness 11's written statement reads:

> *"… Having been made aware of the safeguarding alert, and the continuous requests made by the Safeguarding Team, SF failed and ignored to follow any form of conduct and procedures, ignoring all protocols…*
>
> *The local authority Safeguarding Team felt it necessary to re-open the case for further clarity, due to the lack of response and information given by SF."*

In her oral evidence, Witness 11 said:

> *"The incident should have been reported and documented. Lots of things should have been taken into consideration before it went to safeguarding."*

Mr Firtascu's job description entails:

- *"Has a basic knowledge of the following documents; Health & Social Care Act 2008 and accompanying regulations, Essential Standards of Quality & Safety and Local Multi Agency Guidelines on the Safeguarding of Vulnerable Adults*
- *The Deputy Manager must ensure that all regulations contained in the above mentioned documents are complied with at all times.*
- *Participate in external meetings in the absence of the Home Manager. This may include Clinical Governance, Safeguarding and any other external authority, as required."*

The panel determined that the evidence suggests that Mr Firtascu did not raise a safeguarding alert for Resident A, and also did not comply with the safeguarding team.

The panel therefore finds charge 1(d) proved.

Charge 1(e)

"That you a registered nurse whilst employed as the Deputy Manager and Clinical Lead at Hampton Court Care Home (the 'Home'):

1. On 1 April 2019 having found food in Resident A's mouth, failed to;

    e) Complete a Care Quality Commission notification."

This charge is found proved.

In reaching this decision, the panel took into account Witness 11's written statement and Mr Firtascu's job description.

Witness 11's written statement reads:

> *"The CQC notification would be completed, following the outcome or recommendation from the Safeguarding team."*

The panel determined that having found Mr Firtascu did not raise a safeguarding alert or complied with the safeguarding team, on the balance of probabilities, Mr Firtascu also did not complete a CQC notification.

The panel referred to Mr Firtascu's job description:

- *"Has a basic knowledge of the following documents; Health & Social Care Act 2008 and accompanying regulations, Essential Standards of Quality & Safety and Local Multi Agency Guidelines on the Safeguarding of Vulnerable Adults*
- *The Deputy Manager must ensure that all regulations contained in the above mentioned documents are complied with at all times.*

The panel therefore finds charge 1(e) proved.

Charge 2(a)

"That you a registered nurse whilst employed as the Deputy Manager and Clinical Lead at Hampton Court Care Home (the 'Home'):

2. On or around 23 May 2019 failed to;

    a. Follow an instruction from the GP to ensure that Resident B was administered the liquid form of their anti-epileptic medication, Levetiracetam."

This charge is found NOT proved

In reaching this decision, the panel took into account the safeguarding enquiry report dated 10 January 2020.

The safeguarding enquiry report dated 10 January 2020 stated:

> *"The pharmacy was unable to give me the date Levetiracetam tablets were changed from tablet to liquid form, but advised the liquid medication was delivered on the 23rd of May. GP confirmed he first prescribed Levetiracetam on the 22nd of May 2019."*

The panel determined that as the GP confirmed he had prescribed Levetiracetam on 22 May 2019, it was reasonable for this to have been delivered the next working day – 23 May 2019 – which it was.

Mr Firtascu, having ordered the medication at the time it was prescribed by the GP, had taken the necessary steps to ensure the medication was available for administration. The panel determined that it would be for the registered nurse on duty at the time the

medication was to be administered who would be responsible for its administration, and the panel had no evidence as to who that registered nurse was.

The panel therefore finds charge 2(a) not proved.

Charge 2(b), 2(c) and 2(d)

"That you a registered nurse whilst employed as the Deputy Manager and Clinical Lead at Hampton Court Care Home (the 'Home'):

2. On or around 23 May 2019 failed to;

    b. Follow an instruction to investigate why Resident B had not been administered their anti-epileptic medication, Levetiracetam, between 17 May and 23 May 2019.
    c. Document the incident.
    d. Follow the process required when this incident occurred."

These charges are found proved.

In reaching this decision, the panel took into account Witness 10's written statement, Witness 11's written statement, the safeguarding enquiry report dated 10 January 2020 and Mr Firtascu's job description.

Witness 10's written statement reads:

> *"… the incident wasn't properly recorded and because of that, it wasn't identified within the audit and therefore not followed up appropriately."*

Witness 11's written statement reads:

> *"When I spoke to him, and asked for information as to the incident report, he failed to do this and follow the incident up."*

The safeguarding enquiry report dated 10 January 2010 stated:

- *"The accident/investigation form also stated 07299/2019, which I believe is a reference to a staff member, was instructed to investigate the reason for omission but was unable to provide details and failed to document the incident and follow process.*
- *The accident /investigation report states a member of staff could offer no explanation to why the GP's requests had not been actioned."*

Mr Firtascu's job description entails:

- *"Demonstrate both clinical/care and managerial leadership to a team of nurses, carers and ancillary staff as appropriate allowing an opportunity for all staff to communicate openly and positively…*
- *Ensure that key clinical areas such as wound management, risk assessments, accident and incident reporting are accurately documented and reported according to company policy."*

The panel determined that there was a direction to investigate why Resident B had not been administered their medication, however Mr Firtascu did not follow up on it. It was of the view that this was his duty as manager, as is referred to in his job description for Hampton Court.

The panel determined that documenting the incident following the process required when the incidents occurred were reasonable requests at a clinical level. It noted that as well as being a manager, he was also a registered nurse at Hampton Court, therefore this was expected in his scope of capability.

The panel therefore finds charges 2(b), 2(c) and 2(d) proved.

Charge 3

"That you a registered nurse whilst employed as the Deputy Manager and Clinical Lead at Hampton Court Care Home (the 'Home'):

3. Between the 17 May and 23 May 2019 failed to ensure that Resident B's anti-epileptic medication, Levetiracetam, was in stock in order that it could be administered to Resident B between these dates."

This charge is found proved.

In reaching this decision, the panel took into account the safeguarding enquiry report dated 10 January 2020, Mr Firtascu's job description, Witness 10's oral evidence and Witness 11's written statement.

The safeguarding enquiry report dated 10 January 2020 stated:

> *"The staff recorded in the medication notes stating that medication was out of stock, but there is no record stating when the GP was made aware that Resident B medication had stopped taking the Levetiracetam in tablet form and awaiting the liquid form. There is also no recording of any attempts to take action sooner than 22nd May."*

The panel determined that Mr Firtascu had a duty to safely administer drugs to patients, which he failed, as it states in his job description:

- *"Be responsible for the safe administration and safekeeping of drugs and treatments as prescribed and in accordance with the CQC and NMC guidelines."*

In her written statement, Witness 11 stated:

> *"SF has the overall responsibility and accountability regarding medication management, which he failed to carry out as per the Company's policy and NMC guideline."*

In her oral evidence, Witness 10 informed the panel that:

> *"Medications management was his responsibility, he signed this in his contract."*

The panel determined that Mr Firtascu failed to ensure Resident B's medication was in stock so that it could be administered to him during the period 17 May and 23 May 2019.

The panel therefore finds charge 3 proved.

Charge 4

"That you a registered nurse whilst employed as the Deputy Manager and Clinical Lead at Hampton Court Care Home (the 'Home'):

4. On 28 May 2019 incorrectly administered 800U Cholecalciferol to Resident B, it having being stopped by the GP on 16 May 2019."

This charge is found proved.

In reaching this decision, the panel took into account the accident/incident form dated 8 July 2019, and Witness 10 and 11's written statements.

The accident/incident form dated 8 July 2019 stated:

> *"on the 16.05.19 – COLECALCEFIROL 800U (one to be taken in the morning) was stopped by the GP, information stated on the MAR chart.*
> *On the 28.05.19 – COLECALCEFIROL 800 U + 400 U was administered by 072999/2019.*
>
> *The error was noticed on the 29.05.19 – 072999/2019 was contacted by the Home Manager.*

072999/2019 was unable to explain or show any concerns regarding error."

Witness 10's written statement reads:

> *"The issue was that the correct procedure had not been followed. The correct procedure required that the registrant checked prescription prior to administering medication. If he had done so, he would have stopped and he wouldn't have given it… it raises concerns about his competency."*

Witness 11's written statement reads:

> *"I confirm the incident report completed regarding Cholecalciferol is true and correct … the registrant, as per signature recorded on the MAR chart. The error was noticed by the Nurse the following day, which was reported to me immediately.*
>
> *Due to growing concerns and increasing medication errors being made, I attempted to speak with SF … but he was unable to either explain, accept responsibility or accountability for his involvement…"*

The panel determined that on the balance of probabilities, Mr Firtascu did incorrectly administer medication to Resident B. It noted the contemporaneous notes which were escalated at the time, as well as the clear and cohesive evidence given by both Witness 10 and Witness 11.

The panel therefore finds charge 4 proved.

Charges 5(a), 5(b) and 5(c)

"That you a registered nurse whilst employed as the Deputy Manager and Clinical Lead at Hampton Court Care Home (the 'Home'):

5. Between 14 May and 23 May 2019 failed to ensure that Resident C's Fragmin medication was in stock and/or available by not;

a. Checking Resident C's MAR chart.
b. Undertaking a mini stock check.
c. Contacting the pharmacy to order the medication."

This charge is found proved

In reaching this decision, the panel took into account Witness 10's oral evidence and written statement, and Witness 11's oral evidence and written statement.

Witness 10's written statement reads:

> *"The registrant was aware that medication wasn't administered but he failed to contact the pharmacy to order it. [Witness 11] then spoke with the registrant and requested a statement be obtained from the nurse on shift regarding the missing fragmin injections. The registrant didn't complete this and was unable to explain why the medication was out of stock. It was his responsibility as deputy manager to check on the MAR charts, conduct a mini count of medication and order stock as required each day.*
>
> *… The registrant was unable to explain why stocks were not checked and why the process for requesting repeat prescriptions was not carried out."*

In her oral evidence, Witness 10 said:

> *"He had to coordinate and guide other nurses, and make sure other medication was available for administration to residents. His job description is that he is responsible for medications management."*

Witness 11's witness statement reads:

> *"I suggested that names for those administering medication, can be obtained from Staff rotas and MAR charts…*

It is SF's overall responsibility to ensure that the management of medication be carried out competent …"

In her oral evidence, Witness 11 stated:

"It was down to Salvador to ensure regular stock checks. It was his responsibility to do regular and random checks on medication, he was highly involved in administration and medication."

The panel noted that there is no physical evidence of a stock check having taken place, and determined that the reasonable action is that it should be done. Given Mr Firtascu's job description, and that he had a clinical responsibility, the panel determined that he was responsible for ordering the medication upon checking Resident C's MAR chart.

The panel therefore find charge 5 in its entirety, proved.

Charge 6

"That you a registered nurse whilst employed as the Deputy Manager and Clinical Lead at Hampton Court Care Home (the 'Home'):

6. Between the 5 April and 31 May 2019 failed to ensure and/or order a bed extension and/or bed rails for Resident D upon it had been identified that Resident D had developed a skin tear in their right sole on 5 April 2019."

This charge is found proved.

In reaching this decision, the panel took into account Witness 10's oral evidence and written statement, Witness 11's oral evidence and written statement, the accident/incident investigation form dated 8 July 2019, investigation overview for Resident D dated 14 November 2019, Resident D's safeguarding adults enquiry report dated 24 October 2019, Resident D's care plan and Resident D's patient notes.

Witness 10's written statement reads:

> *"Several staff members raised this a number of times with the registrant… They raised this with him because he was the deputy manager …*
>
> *Resident D's skin tear was initially identified by the GP on 05 April 2019. A referral was made for it and patient was seen by the Tissue Viability Nurse (TVN) on 17 April and 24 April 2019. The TVN specified the requirement to obtain a bed extension in the care plan. As a result of taking no action, the pressure sore developed into a pressure ulcer which progressed very quickly into a huge necrotic ulcer onto the patient's foot. This happened at a time when the registrant was in charge of the home. There was no manager at the time. The registrant kept telling staff that he'd ordered the bed extension and yet he hadn't.*
>
> *…*
>
> *It was the responsibility of the registrant to ensure that the bed end was ordered. He was the first point to report it to and there is evidence in the care plan that this was reported to him…"*

Witness 10's oral evidence corroborates her written statement.

Witness 11's written statement reads:

> *"A risk assessment together with a care plan, would need to have been completed and placed on the resident's file. Information as to who authorised or conducted the assessment can be found in these documents.*
>
> *Despite the risk to resident, SF failed to safeguard and protect the wellbeing of resident, in the delay with the purchase of the extended bed."*

In her oral evidence, Witness 11 informed the panel that:

"It was for Salvador to implement and ensure that the bed end was ordered, this is a straightforward action."

The accident/incident investigation form dated 8 July 2019 stated:

"Safeguarding raised by family due to a pressure sore on foot, which at time of admission was at Necrotic stage, acquired an infection of the bone and diagnosed by the Hospital with Sepsis.

Daily records state that on the 01.05, 04.05, 07.05, 12.05- 072999/2019 was informed of current situation and for the request that a bed extension be put in place. – This was not carried out."

The investigation overview for Resident D dated 14 November 2019 stated:

"Staff made the deputy aware of the situation and he told staff numerous times that a bed extension had been ordered for and that it was on the way. Staff have noted this in the care notes.

Salvador Firtascu did not escalate this to the manager or operations manager, the bed extension was not ordered…

The pressure ulcer worsened despite the home care team seeking external professional support and advice to manage the ulcer. This situation was made worse by Salvador Firtascu's lack of action and escalation of a serious situation."

Resident D's safeguarding adults enquiry report dated 24 October 2019 stated a timeline of the bed end:

"07/04/19 Request for bed made

11/04/19	*Conversation between nurse and maintenance person and Deputy Manager about the bed*
02/05/19	*(mum) has a discussion with a nurse in which she expressed her unhappiness about her son's bed. She is referred to the maintenance person*
04/05/19	*Nurse has a conversation with the maintenance person about the bed and informs the Deputy manager of this.*
12/05/19	*Nurse has a conversation with the maintenance person who states the extension to the bed is awaited.*
18/05/19	*Further conversation with maintenance person about the bed extension*
22/05/19	*Nurse has a conversation with the maintenance person about the bed*
06/06/19	*New bed is delivered"*

Resident D's care plan and Resident D's patient notes corroborate the evidence above.

The panel determined that this was a clinical issue, and should have been dealt with appropriately by Mr Firtascu. It noted his job description, and determined that whilst there was no manager, as the deputy manager this was his duty. The panel noted Witness 11's oral evidence, in which she said that she ordered the bed end herself to expedite the matter. Mr Firtascu failed to ensure a bed extension had been ordered for Resident D.

The panel therefore finds charge 6 proved.

Case reference: 085901/2021

Charge 1(a)

"That you a registered nurse whilst employed as manager of Fern Gardens Care Home (the 'Home') between April and August 2021;

1. Behaved in an unprofessional and/or inappropriate manner towards Colleague A in that:

    a. On one or more occasions made comments about Colleague A's chest by stating words to the effect of *'you have got nice boobs'* and/or *'they were soft'* and/or *'your husband is lucky'*."

This charge is found proved.

In reaching this decision, the panel took into account Witness 14's written statement, Witness 2's written statement and oral evidence, the investigation report and Witness 2's contemporaneous statements.

Witness 14's written statement reads:

> *"Salvador would often make comments about her breasts. For example, he would say that 'they were soft' … and he kept telling her, 'her husband was lucky to have her.' This was all very inappropriate."*

Witness 2's written statement reads:

> *"On one occasion Salvador began making comments about my chest. He was saying how good my chest looked that day."*

In her oral evidence, when asked about the comments Mr Firtascu made about her chest, Witness 2 said:

> *"He'd done it a couple times if I had worn a blouse, he would look at your chest before he would look at you and say things like 'nice chest [Witness 2]'."*

The investigation report stated:

> *"…Salvador when alone would say that she had nice "boobs"…"*

Witness 2's contemporaneous statement state:

> *"Since Salvador started he has always been very inappropriate in the way he speaks to me often mentioning how nice my "boobs" were or how lucky my husband was …"*

The panel determined that this behaviour was both unprofessional in respect of the expectations of a registered nurse and inappropriate as these actions fall outside of expected working practices.

The panel therefore find charge 1(a) proved.

Charge 1(b)

"That you a registered nurse whilst employed as manager of Fern Gardens Care Home (the 'Home') between April and August 2021;

1. Behaved in an unprofessional and/or inappropriate manner towards Colleague A in that:

   b. On an occasion stated to Colleague A words to the effect of, *'what position do you like?'"*

This charge is found proved.

In reaching this decision, the panel took into account Witness 14's written statement and the investigation report.

Witness 14's statement reads:

"…he would ask her '[Witness 2], what position do you like?'

The investigation report stated:

"Salvador behaviour stating … what kind of position do you like?"

The panel determined that this behaviour was both unprofessional in respect of the expectations of a registered nurse and inappropriate as these actions fall outside of expected working practices.

The panel therefore find charge 1(b) proved.

Charge 1(c)

"That you a registered nurse whilst employed as manager of Fern Gardens Care Home (the 'Home') between April and August 2021;

1. Behaved in an unprofessional and/or inappropriate manner towards Colleague A in that:

    c. On one or more occasions stated to Colleague A words to the effect of, *'I feel like sleeping with you'*."

This charge is found proved.

In reaching this decision, the panel took into account Witness 14's written statement.

Witness 14's written statement reads:

"Salvador would also say things like "I feel like sleeping with you …"

The panel determined that this behaviour was both unprofessional in respect of the expectations of a registered nurse and inappropriate as these actions fall outside of expected working practices.

The panel therefore find charge 1(c) proved.

Charge 1(d)

"That you a registered nurse whilst employed as manager of Fern Gardens Care Home (the 'Home') between April and August 2021;

1. Behaved in an unprofessional and/or inappropriate manner towards Colleague A in that:

    d. On one or more occasions stated to Colleague A words to the effect of, *'I feel like pressing your breasts'*."

This charge is found proved.

In reaching this decision, the panel took into account Witness 14's written statement and the investigation report.

Witness 14's written statement reads:

> *"Salvador would also say things like … I feel like pressing your breasts."*

The investigation report stated:

> *"…threatening to feel her breast and saying that they were soft …"*

The panel determined that this behaviour was both unprofessional in respect of the expectations of a registered nurse and inappropriate as these actions fall outside of expected working practices.

The panel therefore find charge 1(d) proved.

Charge 1(e)

"That you a registered nurse whilst employed as manager of Fern Gardens Care Home (the 'Home') between April and August 2021;

1. Behaved in an unprofessional and/or inappropriate manner towards Colleague A in that:

    e. On one or more occasions massaged Colleague A's shoulders."

This charge is found proved.

In reaching this decision, the panel took into account Witness 2's written statement and oral evidence, and Witness 2's contemporaneous statement.

Witness 2's written statement reads:

> *"On occasions, whilst I was sat down, Salvador would stand behind me and massage my shoulders. I never asked him to do this, he would just come up and do it."*

Witness 2's oral evidence corroborated her witness statement:

> *"He was more touchy feely, often he would come behind me and touch my shoulder. Compared to the other managers he was completely different."*

Witness 2's contemporaneous statement reads:

"He used to come into my office and massage my shoulders, I used to think this was strange and not really a thing a manager would do I would always shrug him off and tell him to get off."

The panel determined that this behaviour was both unprofessional in respect of the expectations of a registered nurse and inappropriate as these actions fall outside of expected working practices.

The panel therefore find charge 1(e) proved.

Charge 1(f)

"That you a registered nurse whilst employed as manager of Fern Gardens Care Home (the 'Home') between April and August 2021;

1. Behaved in an unprofessional and/or inappropriate manner towards Colleague A in that:

f. On one or more occasions pinched Colleague A's arm."

This charge is found proved.

In reaching this decision, the panel took into account Witness 2's written statement and oral evidence, Witness 3's oral evidence, Witness 2's contemporaneous statement and the investigation report.

Witness 2's written statement reads:

"Salvador also did things to me such as pinch my arm …"

Witness 2 and Witness 3's oral evidence corroborates the written statement.

Witness 2's contemporaneous statement reads:

"He then became physical in that he would start pinching my arms …"

The investigation report stated:

"…
3. Salvador did pinch both [Witness 2] and [Witness 3] …"

The panel determined that this behaviour was both unprofessional in respect of the expectations of a registered nurse and inappropriate as these actions fall outside of expected working practices.

The panel therefore find charge 1(f) proved.

Charge 1(g)

"That you a registered nurse whilst employed as manager of Fern Gardens Care Home (the 'Home') between April and August 2021;

1. Behaved in an unprofessional and/or inappropriate manner towards Colleague A in that:

    g. On one or more occasions pull up Colleague A's bra strap."

This charge is found proved.

In reaching this decision, the panel took into account Witness 2's written statement and oral evidence, and the investigation report.

Witness 2's written statement reads:

"Salvador also did things to me such as … pull up my bra strap."

Witness 2's oral evidence corroborated this:

> *"He would often ping your bra strap as he was walking past."*

The investigation report stated:

> *"[Witness 14] described Salvador behaviour stating "… he was always pulling [Witness 2]'s bra strap …"*

The panel determined that this behaviour was both unprofessional in respect of the expectations of a registered nurse and inappropriate as these actions fall outside of expected working practices.

The panel therefore find charge 1(g) proved.

Charge 1(h)

"That you a registered nurse whilst employed as manager of Fern Gardens Care Home (the 'Home') between April and August 2021;

1. Behaved in an unprofessional and/or inappropriate manner towards Colleague A in that:

   h. On or around 29 June 2021 undid Colleague A's bra strap."

This charge is found proved.

In reaching this decision, the panel took into account Witness 2's written statement and oral evidence, Witness 3's written statement, Witness 14's written statement, the investigation report and Witness 2's contemporaneous statement.

Witness 2's written statement reads:

"One day he actually undid my bra strap from underneath my top.

When he undid my bra strap, [Witness 3] and [Witness 14] were present when Salvador did this. This behaviour by Salvador undoing my bra strap made me feel intimidated. I recall that [Witness 14] intervened to stop Salvador."

Witness 2's oral evidence corroborated this:

"He undid my bra strap through my blouse in my office. He came in laughing and joking, he thought it was funny and just did it."

Witness 3's written statement reads:

"He would go behind her and undo her bra. I witnesses him doing these things to her."

Witness 14's written statement reads:

"On one occasion … Salvador loosened the clip of her bra. She looked embarrassed and was so upset."

Witness 3 and Witness 14's oral evidence corroborated this.

The investigation report stated:

"One morning he undid [Witness 2]'s bra I was outside in reception and I told him to leave her alone and I tried to chase him out of her office and he was just laughing about it…"

Witness 2's contemporaneous statement reads:

"On 29th June he was messing about in my office and actually undid my bra saying to [Witness 3] and [Witness 14] how clever he was what he could do that."

The panel determined that this behaviour was both unprofessional in respect of the expectations of a registered nurse and inappropriate as these actions fall outside of expected working practices.

The panel therefore find charge 1(h) proved.

Charge 1(i)

"That you a registered nurse whilst employed as manager of Fern Gardens Care Home (the 'Home') between April and August 2021;

1. Behaved in an unprofessional and/or inappropriate manner towards Colleague A in that:

    i. On or around 30 June 2021 followed Colleague A into the stationary room closing the door behind you."

This charge is found proved.

In reaching this decision, the panel took into account Witness 2's written statement and oral evidence, Witness 3's written statement and Witness 2's contemporaneous statement.

Witness 2's written statement reads:

> *"I also recall on 30 June 2021, I was trying to get stationary cupboard when Salvador came behind me into the room closing the door behind him.*
>
> *The room was tiny which meant Salvador was squashed in directly behind me and was touching me from behind and this made me feel very uncomfortable. I'm claustrophobic anyway but being confined in such a small room with him and the*

fact he closed the door made it worse. Again Salvador seemed to think this was all amusing."

Witness 2's oral evidence corroborated this:

"As I went into the stationary cupboard, he came in behind me, put his hands on my waist and shut the door. This made me feel insecure, he was slimy and I didn't feel comfortable."

Witness 3's written statement reads:

"He followed her into the toilet and cupboard."

Witness 2's contemporaneous statement reads:

"On 30th June I was getting stuff out of the stationary cupboard when he followed me in and closed the door I told him to get out and stop being so stupid."

The panel determined that this behaviour was both unprofessional in respect of the expectations of a registered nurse and inappropriate as these actions fall outside of expected working practices.

The panel therefore find charge 1(i) proved.

Charge 1(j)

"That you a registered nurse whilst employed as manager of Fern Gardens Care Home (the 'Home') between April and August 2021;

1. Behaved in an unprofessional and/or inappropriate manner towards Colleague A in that:

j. On or around 30 June 2021 followed Colleague A into the toilet."

This charge is found proved.

In reaching this decision, the panel took into account Witness 3's written statement, Witness 14's written statement, Witness 3's handwritten statement and Witness 2's contemporaneous statement.

Witness 3's written statement reads:

> *"He followed her into the toilet and cupboard."*

Witness 14's written statement reads:

> *"One time, [Witness 2] went to the toilets, Salvador chased her into the toilets. I asked him "what are you doing? She is trying to go to the toilet". [Witness 2] had to lock the door from the inside to keep him from following her into the toilets."*

Witness 3's handwritten statement reads:

> *"There was also a time I was going into the toilet in reception and he followed me in … he done the same to [Witness 2].*

Witness 2's contemporaneous statement reads:

> *"After that he followed me into the toilet and shut the door stating that imagine what the staff would say if they saw us leaving the toilet together…"*

The panel determined that this behaviour was both unprofessional in respect of the expectations of a registered nurse and inappropriate as these actions fall outside of expected working practices.

The panel therefore find charge 1(j) proved.

Charge 1(k)

"That you a registered nurse whilst employed as manager of Fern Gardens Care Home (the 'Home') between April and August 2021;

11. Behaved in an unprofessional and/or inappropriate manner towards Colleague A in that:

    k. Having followed Colleague A into the toilet stated words to the effect of, 'imagine what the staff would say if they saw us leave the toilet together'."

This charge is found proved.

In reaching this decision, the panel took into account Witness 2's contemporaneous statement and Witness 14's contemporaneous statement.

Witness 2's contemporaneous statement reads:

> *"After that he followed me into the toilet and shut the door stating that imagine what the staff would say if they saw us leaving the toilet together…"*

Witness 14's contemporaneous statement reads:

> *"I caught him coming out of the toilets with [Witness 2] laughing that he was up to no good in the toilet with her …"*

The panel determined that this behaviour was both unprofessional in respect of the expectations of a registered nurse and inappropriate as these actions fall outside of expected working practices.

The panel therefore find charge 1(k) proved.

Charges 2(a), 2(b), 2(c) and 2(2d)

“That you a registered nurse whilst employed as manager of Fern Gardens Care Home (the ‘Home’) between April and August 2021;

2. Your actions in charge 1 amounted to harassment of Colleague A in that:

    a. It was unwanted and/or
    b. It related to Colleague A’s sex and/or
    c. It was sexual in nature and/or
    d. It had the purpose or effect of:
        i. Violating Colleague A’s dignity, and/or
        ii. Creating an intimidating, hostile, degrading, humiliating or offensive environment for Colleague A.”

These charges are found proved in its entirety.

In reaching this decision, the panel took into account Witness 2’s written statement and oral evidence.

Witness 2’s written statement reads:

> *“We all told Salvador to stop but he didn’t. I felt that he didn’t stop because he was the Home manager that he felt that that gave him the right to do what he wanted. No woman should be placed in that position. We were all strong people so I hate to think how this could have affected someone who was not as strong.”*

Witness 2’s oral evidence corroborates this when she was asked about her comment on women not being placed in this position:

> *“I mean where you don’t feel safe being around somebody because you never know what he is going to do next. It puts you on edge. He’s my manager, I’m supposed to go to him.”*

The panel determined that the nature of all charges in charge 1 are sexual and amounted to harassment. It was of the view that Witness 2 gave compelling and cogent evidence about Mr Firtascu's behaviour, both in her written statement and her oral evidence. The panel noted that in her written statement, Witness 2 specifically referred to 'women' and how Mr Firtascu thought he could behave how he wanted because of the position of power he was in i.e. the home manager of Fern Gardens.

The panel determined that Mr Firtascu's behaviour in charge 1 violated Witness 2's dignity given that he was told many times by a few different colleagues to stop behaving how he was.

The panel then determined that Mr Firtascu's actions in charge 1 amounted to harassment, in that he was engaging in unwanted conduct (section 26, Equality Act 2010).

The panel then went on to consider that conduct and determined that Mr Firtascu actions created an intimidating, hostile, degrading, humiliating and an offensive environment for Witness 2 that it was unwanted and related to her sex. The panel in considering charge 2(c) determined that the words 'sexual in nature' meant any act including sounds, words, images and gestures that would reasonably be regarded by members of the public as sexual in nature.

In light of the above, the panel therefore finds charge 2 proved in its entirety.

Charge 3

"That you a registered nurse whilst employed as manager of Fern Gardens Care Home (the 'Home') between April and August 2021;

3. Your actions in charge 1 were sexually motivated."

This charge is found proved.

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

Witness 2's written statement reads:

> *"I believe Salvador's behaviour was sexually motivated. Doing what he did to us … makes me believe this. I was never interested in Salvador. I found him to be disgusting and slimy. He behaved as if everyone was interested in him but that was not the case. We all found him disgusting."*

The panel in considering charge 3 determined that the words 'sexually motivated' meant any act including sounds, words, images and gestures that would reasonably be regarded by members of the public as satisfying a sexual impulse.

The panel noted the lack of boundaries Mr Firtascu had in relation to his colleagues. The panel determined that Mr Firtascu's actions were an impulse to gratify his sexual needs, both through direct sexual activity i.e. grabbing his colleagues breasts, and through unrelated activities with the words he used which created a hostile environment.

The panel therefore finds charge 3 proved.

Charges 4(a) and 4(b)

"That you a registered nurse whilst employed as manager of Fern Gardens Care Home (the 'Home') between April and August 2021;

4. Behaved in an unprofessional and/or inappropriate manner towards Colleague B in that;

    a. On one or more occasions poked Colleague B.
    b. On one or more occasions pinched Colleague B."

These charges are found proved.

In reaching this decision, the panel took into account Witness 3's written statement and oral evidence and Witness 3's handwritten statement.

Witness 3's written statement reads:

> *"Firtascu first started by poking me in my side and pinching me."*

Witness 3's oral evidence corroborated this:

> *"Sometimes he would pinch my arm or poke me in the side with his finger."*

Witness 3's handwritten statement reads:

> *"Then he started poking me in my side and pinching my side or arms he would say it don't matter with me as I don't have anyone to explain the bruises too …"*

The panel determined that this behaviour was both unprofessional in respect of the expectations of a registered nurse and inappropriate as these actions fall outside of expected working practices.

The panel therefore finds charges 4(a) and 4(b) proved.

Charges 4(c) and 4(d)

"That you a registered nurse whilst employed as manager of Fern Gardens Care Home (the 'Home') between April and August 2021;

4. Behaved in an unprofessional and/or inappropriate manner towards Colleague B in that;

    c. On one or more occasions stated to Colleague B words to the effect of, 'you have nice boobs'.

d. Stated to Colleague B when she was cleaning her office words to the effect of, *'are you making room for our bed'*."

These charges are found proved.

In reaching this decision, the panel took into account Witness 3's written statement and oral evidence, the investigation report, and in Witness 3's handwritten statement.

Witness 3's written statement reads:

> *"He would make comments like "you have nice boobs". I was cleaning my office one day and he commented "are you making room for our bed." I just ignored him."*

Witness 3 corroborated this in her oral evidence and said:

> *"Because he always made comments, I ignored them."*

The investigation reports stated:

> *"…*
> *4. Salvador used inappropriate and unsolicited comments towards [Witness 2] and [Witness 3] …"*

Witness 3's handwritten statement reads:

> *"First he would make comments to me like you have nice boobs and when cleaning my office, he would say are you making room for our bed."*

The panel determined that this behaviour was both unprofessional in respect of the expectations of a registered nurse and inappropriate as these actions fall outside of expected working practices.

The panel therefore finds charges 4(c) and 4(d) proved.

Charges 4(e), 4(f) and 4(g)

"That you a registered nurse whilst employed as manager of Fern Gardens Care Home (the 'Home') between April and August 2021;

4. Behaved in an unprofessional and/or inappropriate manner towards Colleague B in that;

    e. On one or more occasions attempted to undo Colleague B's bra.
    f. On an occasion grabbed Colleague B's breast.
    g. Stated to Colleague B after grabbing her breast words to the effect of, 'I'm your manager, you can't tell me to piss off'."

These charges are found proved.

In reaching this decision, the panel took into account Witness 3's written statement and oral evidence, Witness 2's written statement, Witness 14's written statement, the investigation report, Witness 3's handwritten statement, and Witness 2's contemporaneous statement.

Witness 2's written statement reads:

> *"Salvador would try and undo my bra. There was one time, I was in the admin with [Witness 2] and he was trying to undo my bra. I backed myself onto [Witness 2] and we ended up in the corner. As I tried to get away, he grabbed my breast and I told him to "piss off". He said "I'm your manager, you can't tell me to piss off" and [Witness 2] replied that a proper manager does not behave like that."*

Witness 3 and Witness 2 both corroborate this in their oral evidence.

Witness 2's written statement reads:

"On another occasion I saw Salvador grab [Witness 3]'s breasts. I believe this happened on 29 June 2021. I was already in the office with [Witness 3] when Salvador entered. He walked up to [Witness 3] and grabbed her breasts. He had us trapped in the corner of the office. [Witness 14] came in and told Salvador to get out, we just tried to get him out of the office."

Witness 14's written statement reads:

"… he did touch her breast on one occasion."

The investigation reports stated:

"1. Salvador did grab [Witness 3] right breast."

Witness 3's handwritten statement reads:

"He would try and undo my bra and one day I was in the admin office with [Witness 2] and he tried to get my bra. I backed myself up to [Witness 2] and we ended up in the corner. I told him to piss off and he laughed and said I'm you manager you can't tell me to piss off. [Witness 2] said well a proper manager don't behave like that, as I went to get away he grabbed my right breast."

Witness 2's contemporaneous statement reads:

"The same day he grabbed [Witness 3]'s boob she told him to piss off but couldn't get away she could only back up and myself and [Witness 3] were trapped in the corner she told him to piss off again he found this all amusing and said he was our manager like that gave him authority to do this."

The panel determined that this behaviour was both unprofessional in respect of the expectations of a registered nurse and inappropriate as these actions fall outside of expected working practices.

The panel therefore finds charges 4(e), 4(f) and 4(g) proved.

Charges 4(h) and 4(i)

"That you a registered nurse whilst employed as manager of Fern Gardens Care Home (the 'Home') between April and August 2021;

4. Behaved in an unprofessional and/or inappropriate manner towards Colleague B in that;

    h. On an occasion pinched Colleague B's bottom.
    i. Having pinched Colleague B's bottom stated words to the effect of, 'you've got a nice bum'."

These charges are found proved.

In reaching this decision, the panel took into account Witness 3's written statement and oral evidence, and Witness 3's handwritten statement.

Witness 3's written statement reads:

> *"There was a time where I was walking down the corridor and he pinched my bottom and I said "oi" and he said "you've got a nice bum."*

This was corroborated in Witness 3's oral evidence.

In her handwritten statement, Witness 3 stated:

> *"Once we were walking down the corridor and he pinched my bottom I said oi he said cor you've got a nice bum."*

The panel determined that this behaviour was both unprofessional in respect of the expectations of a registered nurse and inappropriate as these actions fall outside of expected working practices.

The panel therefore finds charges 4(h) and 4(i) proved.

Charges 4(j) and 4(k)

"That you a registered nurse whilst employed as manager of Fern Gardens Care Home (the 'Home') between April and August 2021;

4. Behaved in an unprofessional and/or inappropriate manner towards Colleague B in that;

    j. On an occasion placed your fingers in the V part of Colleague B's V neck top.
    k. Having placed your fingers through Colleague B's V neck top, stated words to the effect of, 'you've got nice tits'."

These charges are found proved.

In reaching this decision, the panel took into account Witness 3's written statement and oral evidence, and Witness 3's handwritten statement.

Witness 3's written statement reads:

> *"There was another time where I was clocking in. I was wearing black trousers and a blue V neck top. Salvador put his fingers through the V and I said "What are you doing?" and he said "you've got nice tits"."*

This was corroborated in Witness 3's oral evidence.

Witness 3's handwritten statement reads:

"… he put his finger in the V part to pull it down I said do you mind what you doing and he laughed and said you have nice tits."

The panel determined that this behaviour was both unprofessional in respect of the expectations of a registered nurse and inappropriate as these actions fall outside of expected working practices.

The panel therefore finds charges 4(j) and 4(k) proved.

Charges 4(l) and 4(m)

"That you a registered nurse whilst employed as manager of Fern Gardens Care Home (the 'Home') between April and August 2021;

4. Behaved in an unprofessional and/or inappropriate manner towards Colleague B in that;

    l. On an occasion followed Colleague B into the toilet.
    m. Having followed Colleague B into the toilet and stated words to the effect of, 'I should go out like this' whilst playing with the fly on your trousers."

These charges are found proved.

In reaching this decision, the panel took into account Witness 3's written statement and oral evidence, Witness 2's written statement and oral evidence, Witness 14's written statement and oral evidence, Witness 3's handwritten statement and Witness 2's contemporaneous statement.

Witness 3's written statement reads:

"There was a time where I was going to the toilet and Salvador followed me into the toilet. I said "What are you doing? Get out". He shut the door, started

laughing and said "I should go out like this". He started playing with the fly of his trousers or jeans. It is a small toilet so he was literally invading my personal space. I said "so people can talk about me". He looked at me laughing. I felt really uncomfortable and I was scared."

Witness 2's written statement reads:

"He locked [Witness 3] in the toilet with himself once and said to her 'let's see what all the staff think when they see us coming out of the toilet together.' I was present, so was [Witness 14]."

Witness 14's written statement reads:

"He followed her into the toilets …"

Witness 2, 3 and 4 all corroborate this in their oral evidence, and their evidence was cogent and consistent with each other.

Witness 3's handwritten statement reads:

"There was also a time I was going into the toilet in Reception and he followed me in and closed the door I said what are you doing get out he laughed and said I should go out like that and he was playing with his flies on his trousers on jeans, I said what so people can talk about me and he said he done the same to [Witness 2]."

Witness 2's contemporaneous statement reads:

"After that he followed me into the toilet and shut the door stating that imagine what the staff would do if they saw us leaving the toilet together – he did the same to [Witness 3]."

The panel determined that this behaviour was both unprofessional in respect of the expectations of a registered nurse and inappropriate as these actions fall outside of expected working practices.

The panel therefore finds charges 4(l) and 4(m) proved.

Charges 5(a), 5(b), 5(c) and 5(d)

"That you a registered nurse whilst employed as manager of Fern Gardens Care Home (the 'Home') between April and August 2021;

5. Your actions in charge 4 amounted to harassment of Colleague B in that:

    a. It was unwanted and/or
    b. It related to Colleague B's sex and/or
    c. It was sexual in nature and/or
    d. It had the purpose or effect of:
        i. Violating Colleague B's dignity, and/or
        ii. Creating an intimidating, hostile, degrading, humiliating or offensive environment for Colleague B."

These charges are found proved in their entirety.

In reaching this decision, the panel took into account Witness 3's written statement and oral evidence, and Witness 3's handwritten statement.

Witness 3's written statement reads:

> *"I found it violating that Salvador would touch me in the way he did … I know for a fact that he lies a lot, so I thought if I reported it, it would be his word against mine and that he would lie his way out of it and I would not be believed.*
>
> *…*

The attitude that Salvador held was that management believed everything he said because they liked him. I did not feel like I would be believed and felt it was my word against his."

Witness 3's oral evidence corroborated this:

"The way he acted is not in a way I would expect a manager to behave in a nursing home, if you can do that to your staff you can do that to anyone."

Witness 3's handwritten statement reads:

"This made me feel very uncomfortable and is inappropriate behaviour on any level.

In addition to the above: … I told him this but he just laughed which made me feel angry. When he tried to undo my bra I was worried and embarrassed in case my bust fell out. When he grabbed my breast I felt violated and disgusted that someone in his position could behave in that manner."

The panel determined that the nature of all charges in charge 4 are sexual and amounted to harassment. It was of the view that Witness 3 gave compelling and cogent evidence about Mr Firtascu's behaviour, both in her written statement and her oral evidence. The panel noted that in her oral evidence, Witness 3 was visibly upset and iterated that a manager should not act in the way that Mr Firtascu did.

The panel determined that Mr Firtascu's behaviour in charge 4 violated Witness 3's dignity given that his actions made a woman feel uncomfortable in her work place by touching her in areas that he shouldn't have and made her feel unsafe. In her oral evidence, Witness 3 described Mr Firtascu's behaviour as *"creepy"* and said his actions made her feel *"violated, uncomfortable and embarrassed."*

The panel then determined that Mr Firtascu's actions in charge 4 amounted to harassment, in that he was engaging in unwanted conduct (section 26, Equality Act 2010).

The panel then went on to consider that conduct and determined that Mr Firtascu actions created an intimidating, hostile, degrading, humiliating and an offensive environment for Witness 3 that it was unwanted and related to her sex. The panel in considering charge 5(c) determined that the words 'sexual in nature' meant any act including sounds, words, images and gestures that would reasonably be regarded by members of the public as sexual in nature.

In light of the above, he panel therefore finds charge 5 proved in its entirety.

Charge 6

"That you a registered nurse whilst employed as manager of Fern Gardens Care Home (the 'Home') between April and August 2021;

6. Your actions in charge 4, except charges 4a and 4b, were sexually motivated."

This charge is found proved.

In reaching this decision, the panel took into account Witness 3's written statement and oral evidence.

Witness 3's written statement reads:

"I found it violating that Salvador would touch me in the way he did."

The panel noted the lack of boundaries Mr Firtascu had in relation to his colleagues. The panel determined that Mr Firtascu's actions were an impulse to gratify his sexual needs, both through direct sexual activity i.e. grabbing his colleagues breasts and

playing with his fly when walking out of the bathroom, and through unrelated activities with the words he used which created a hostile environment.

The panel in considering charge 6 determined that the words ‘sexually motivated’ meant any act including sounds, words, images and gestures that would reasonably be regarded by members of the public as satisfying a sexual impulse.

The panel therefore finds charge 6 proved.

Charge 7(a)

“That you a registered nurse whilst employed as manager of Fern Gardens Care Home (the ‘Home’) between April and August 2021;

7. Behaved in an unprofessional and/or inappropriate manner towards Colleague C in that;

    a. On an occasion stated to Colleague C in front of other colleagues words to the effect of, *‘You are not good at your job’*.”

This charge is found proved.

In reaching this decision, the panel took into account Witness 14’s written statement and oral evidence.

Witness 14’s written statement reads:

> *“He was always rude to me including in front of other staff members. He would call meetings at any time without any prior notice and put me down in front of other other nurses. He would say things like ‘I wasn’t good at my job’. Of course this was not true.”*

Witness 14’s oral evidence corroborated this.

The panel determined that this behaviour was both unprofessional in respect of the expectations of a registered nurse and inappropriate as these actions fall outside of expected working practices.

The panel therefore finds charge 7(a) proved.

Charges 7(b), 7(c) and 7(d)

"That you a registered nurse whilst employed as manager of Fern Gardens Care Home (the 'Home') between April and August 2021;

7. Behaved in an unprofessional and/or inappropriate manner towards Colleague C in that;

    b. On an occasion threatened and/or attempted to touch Colleague C's breast.
    c. On one or more occasions stated to Colleague C words to the effect of, 'I'm going to touch your breasts'.
    d. On one or more occasions stated to Colleague C, 'you've got a big bum'."

These charges are found proved.

In reaching this decision, the panel took into account Witness 14's written statement and oral evidence, and Witness 14's contemporaneous statement.

Witness 14's written statement reads:

> *"Salvador had one occasion threatened to touch my breast … he kept saying things like "I'm going to touch your breast … you've got a big bum". I think he didn't take it as far with me because he knew I wouldn't tolerate it and I'd speak out about it."*

Witness 14's oral evidence corroborated this.

Witness 14's contemporaneous statement reads:

"He threatened to grab my breast as well."

The panel determined that this behaviour was both unprofessional in respect of the expectations of a registered nurse and inappropriate as these actions fall outside of expected working practices.

The panel therefore finds charges 7(b), 7(c) and 7(d) proved.

Charge 7(e)

"That you a registered nurse whilst employed as manager of Fern Gardens Care Home (the 'Home') between April and August 2021;

7. Behaved in an unprofessional and/or inappropriate manner towards Colleague C in that;

    e. When Colleague C stated that your behaviour towards Colleague A and/or Colleague B was unprofessional stated to Colleague C words to the effect of, 'fuck off'."

This charge is found proved.

In reaching this decision, the panel took into account Witness 14's written statement and oral evidence, and in Witness 14's contemporaneous statement.

Witness 14's written statement reads:

"… he told me to "fuck off". Only staff witnessed the swearing on this occasion. However he swore a lot and he did this in front of anyone including residents … He had no respect for anyone. He really didn't care."

Witness 14's oral evidence corroborated this when asked if Mr Firtascu swore at her:

"Yes, he told me to "fuck off" multiple times. He was always in the admin office or walking around, smoking and saying inappropriate words."

Witness 14's contemporaneous statement reads:

"One time he locked [Witness 2] in the cupboard and I said this isn't funny anymore and he said fuck off to me."

The panel determined that this behaviour was both unprofessional in respect of the expectations of a registered nurse and inappropriate as these actions fall outside of expected working practices.

The panel therefore finds charge 7(e) proved.

Charges 8(a), 8(b), 8(c) and 8(d)

"That you a registered nurse whilst employed as manager of Fern Gardens Care Home (the 'Home') between April and August 2021;

8. Your actions in charge 7 amounted to harassment of Colleague C in that:

    a. It was unwanted and/or
    b. It related to Colleague C's sex and/or
    c. It was sexual in nature and/or
    d. It had the purpose or effect of:
        i. Violating Colleague C's dignity, and/or

ii. Creating an intimidating, hostile, degrading, humiliating or offensive environment for Colleague C”

These charges are found proved in its entirety.

In reaching this decision, the panel took into account Witness 14’s written statement and oral evidence, and in Witness 14’s contemporaneous statement.

Witness 14’s written statement reads:

> *“I feel disgusted and embarrassed by his behaviour. I feel like his behaviour is extreme and so embarrassing. Ober all my years of working in different nursing places, I’ve never experienced anything like it.”*

Witness 14, 2 and 3 all expressed in their oral evidence that Mr Firtascu’s behaviour was inappropriate and was sexual in nature. Witnesses 2 and 3 informed the panel that Witness 14 aware of what was happening in the home in regards to Mr Firtascu’s behaviour as she saw most of it and was also subject to it.

Witness 14’s contemporaneous statement reads:

> *“I think his behaviour is totally wrong and not professional or acceptable as a manager.”*

The panel determined that the nature of all charges in charge 7 are sexual and amounted to harassment. It was of the view that Witness 14 gave compelling and cogent evidence about Mr Firtascu’s behaviour, both in her written statement and her oral evidence. The panel noted that in her oral evidence, Witness 14 was supported by a witness liaison officer and iterated that a manager should not act in the way that Mr Firtascu did.

The panel determined that Mr Firtascu’s behaviour in charge 4 was meant to violate Witness 14’s dignity as he told her he wanted to touch her multiple times, however

Witness 14 in both her written statement and oral evidence informed the panel that she made it known to Mr Firtascu that she would not tolerate this.

The panel then determined that Mr Firtascu's actions in charge 7 amounted to harassment, in that he was engaging in unwanted conduct (section 26, Equality Act 2010).

The panel then went on to consider that conduct and determined that Mr Firtascu actions created an intimidating, hostile, degrading, humiliating and an offensive environment for Witness 14 that it was unwanted and related to her sex. The panel in considering charge 8(c) determined that the words 'sexual in nature' meant any act including sounds, words, images and gestures that would reasonably be regarded by members of the public as sexual in nature.

In light of the above, the panel found charge 8 proved in its entirety.

Charge 9

"That you a registered nurse whilst employed as manager of Fern Gardens Care Home (the 'Home') between April and August 2021;

9. Your actions in charge 7b and/or 7c and/or 7d were sexually motivated."

This charge is found proved.

In reaching this decision, the panel took into account Witness 14's written statement and oral evidence.

Witness 14's written statement reads:

"I think we should've called the police but at the time I didn't think about that."

The panel noted the lack of boundaries Mr Firtascu had in relation to his colleagues. The panel determined that Mr Firtascu's actions were an impulse to gratify his sexual needs through unrelated activities with the words he used which created a hostile environment.

The panel in considering charge 9 determined that the words 'sexually motivated' meant any act including sounds, words, images and gestures that would reasonably be regarded by members of the public as satisfying a sexual impulse.

The panel therefore finds charge 9 proved.

Charges 10(a), 10(b) and 10(c)

"That you a registered nurse whilst employed as manager of Fern Gardens Care Home (the 'Home') between April and August 2021;

10. Behaved in an unprofessional manner with Miss 1 in that;

    a. On one or more occasions would kiss Miss 1 whilst at work.
    b. On one or more occasions would hold Miss 1's hand whilst at work.
    c. On one or more occasions would cuddle Miss 1 whilst at work."

These charges are found proved.

In reaching this decision, the panel took into account Witness 2's written statement and oral evidence, and Witness 14's written statement and oral evidence.

Witness 2's written statement reads:

> *"I am also aware that Salvador was involved with [Miss 1], the house keeper… Miss 1 would often be in Salvador's office and they'd be messing around, kissing and holding hands."*

Witness 14's written statement reads:

> *"[Miss 1] whom I mentioned earlier was his girlfriend and rather than doing work, they'd often be seen kissing, cuddling, holding hands in the garden and everywhere in the home including in front of the residents.*
>
> *…*
>
> *Salvador would be calling his girlfriend [Miss 1] 'baby', kiss and cuddle her in front of residents and staff in the garden. He lived upstairs and they'd be holding hands around the home. I don't think that was professional behaviour at all in the workplace."*

Witness 2 and Witness 14's oral evidence corroborated this. The panel were informed that Miss 1 lived upstairs, and Mr Firtascu lived with her above Fern Gardens.

The panel determined that Mr Firtascu's behaviour was unprofessional in respect of the expectations of a registered nurse. It was of the view that there was a lack of boundaries which breached professionalism. Mr Firtascu was unable to separate his work life from his home life, not withstanding that his home life was attached to Fern Gardens.

The panel therefore finds charges 10(a), 10(b) and 10(c) proved.

Charge 11(a)

"That you a registered nurse whilst employed as manager of Fern Gardens Care Home (the 'Home') between April and August 2021;

11. Being the manager of the Home and having overall responsibility for patient care;

a. Failed to ensure that staff did not leave medication unattended and/or locked away."

This charge is found proved.

In reaching this decision, the panel took into account Witness 4's written statement and oral evidence, and Witness 14's oral evidence.

Witness 4's written statement reads:

> *"On one occasion I was in the nurses' room with the RN (Registered Nurse) and observed issues with medication… I spoke to the RN about it and she explained that it was left there from the night before …"*

Witness 14's oral evidence corroborated this, as did Witness 4's who said:

> *"I went into the nurses office which was small and not locked, there was a bowl with boxes of medication in there that had all patient identifiable information on."*

The panel determined that Mr Firtascu had managerial responsibility for the staff at Fern Gardens, by virtue of his job description, his leadership and managerial role as a registered nurse, and his general accountability for patient care and medication management.

Witness 4 in her oral evidence informed the panel Mr Firtascu was made aware that medication was left unattended/locked away from June 2021, however the problem still persisted. The panel accepted this evidence.

The panel therefore finds charge 11(a) proved.

Charge 11(b)

"That you a registered nurse whilst employed as manager of Fern Gardens Care Home (the 'Home') between April and August 2021;

11. Being the manager of the Home and having overall responsibility for patient care;

    b. Failed to ensure that staff documented MAR charts clearly preventing errors occurring with the administration of medication."

This charge is found proved.

In reaching this decision, the panel took into account Witness 4's written statement and oral evidence.

Witness 4's written statement reads:

> *"…had signed the MARR chart on the very edge of the paper, resulting it being unclear for the next shift.*
>
> *…*
>
> *I also had documentation concerns as the MARR charts weren't clear. There was duplication which could mean that a particular medication could be dispensed twice. There had multiple medication listed on MARR charts."*

Witness 4 corroborated this in her oral evidence.

The panel determined that Mr Firtascu had managerial responsibility for the staff at Fern Gardens, by virtue of his job description, his leadership and managerial role as a registered nurse, and his general accountability for patient care and medication management.

The panel therefore finds charge 11(b) proved.

Charge 11(c)

"That you a registered nurse whilst employed as manager of Fern Gardens Care Home (the 'Home') between April and August 2021;

11. Being the manager of the Home and having overall responsibility for patient care;

    c. Failed to ensure that registered nurses worked in pairs when dispensing controlled drugs."

This charge is found proved.

In reaching this decision, the panel took into account Witness 4's written statement and oral evidence.

Witness 4's written statement reads:

> *"When dispensing controlled drugs, RN's work in pairs to count the tablets and ensure the number corresponds with the tally in the book. This should occur at the handover of each shift, and when medication is given.*
>
> *I was told that in this case for handover, the RN's knees were too painful at the end of the shift for them to walk to the Treatment Room where the Controlled Drug cupboard was. I do not know who the night RN was. The day RN was … new to the role and still settling in. I was informed that due to the night RN's knee pain, they sent [Nurse 1] to collect the CD book, who then brought it to the office on the other unit where the night RN signed to say the drugs tallied with the book and then [Nurse 1] returned the book to the Treatment Room, without either of them counting the tablets. I raised this poor practice with Salvador."*

This was corroborated in Witness 4's oral evidence.

The panel determined that Mr Firtascu had managerial responsibility for the staff at Fern Gardens, by virtue of his job description, his leadership and managerial role as a registered nurse, and his general accountability for patient care and medication management.

The panel therefore finds charge 11(c) proved.

Charge 11(d)

"That you a registered nurse whilst employed as manager of Fern Gardens Care Home (the 'Home') between April and August 2021;

11. Being the manager of the Home and having overall responsibility for patient care;

    d. Failed to ensure that staff dispensed medication safely."

This charge is found proved.

In reaching this decision, the panel took into account Witness 4's written statement and oral evidence.

Witness 4's written statement reads:

> *"On another day, an issue I observed was when I was supporting an RN called [Nurse 2] doing the medication round. She was using disposable medicine pots, writing the residents initials on the pots and putting the medication into the pot. She would then repeat the process several times with different residents, stacked the pots up, put them in her pocket and approached each resident, handing them their tablets and a glass of water. I didn't think this was a safe way to dispense medication, I could see how she could be easily get distracted in the midst of a*

medication round, as she would often be the only RN on shift, so everybody would call out to her, hence I could see how she could end up mixing the pots.

I suggested that this wasn't good practice. I suggested that they did it one patient at a time, stacking them together could easily lead to mistakes particularly given the RN was very busy. I raised the issue with Salvador, I can't remember what he said."

This was corroborated in Witness 4's oral evidence.

The panel determined that Mr Firtascu had managerial responsibility for the staff at Fern Gardens, by virtue of his job description, his leadership and managerial role as a registered nurse, and his general accountability for patient care and medication management.

The panel therefore finds charge 11(d) proved.

Charge 11(e)

"That you a registered nurse whilst employed as manager of Fern Gardens Care Home (the 'Home') between April and August 2021;

11. Being the manager of the Home and having overall responsibility for patient care;

    e. Failed to ensure that staff were PPE compliant."

This charge was found proved.

In reaching this decision, the panel took into account Witness 4's written statement and oral evidence.

Witness 4's written statement reads:

"I noticed that many staff weren't complying with PPE. I remember Salvador wearing a shirt that was unbuttoned to mid chest and a pair of jeans. Back in June 2021, we were required to wear masks and correct PPE. I saw Salvador walk around without a mask or PPE. He was the leader and if he wasn't seen to be doing it then other staff would follow.

I spent time reminding staff to put their masks on. Salvador arranged for PPE dispensers to be put on the wall within 24 hours of the issues being raised for easy access and that helped with compliance. In all fairness to him, he had done this promptly."

This was corroborated in Witness 4's oral evidence.

The panel determined that Mr Firtascu had managerial responsibility for the staff at Fern Gardens, by virtue of his job description, his leadership and managerial role as a registered nurse, and his general accountability for patient care and infection control.

The panel therefore finds charge 11(e) proved.

Charge 11(f)

"That you a registered nurse whilst employed as manager of Fern Gardens Care Home (the 'Home') between April and August 2021;

11. Being the manager of the Home and having overall responsibility for patient care;

    f. Failed to ensure that your dog did not have access and/or the ability to approach residents."

This charge is found proved.

In reaching this decision, the panel took into account Witness 4's written statement and oral evidence, and Witness 5's written statement.

Witness 4's written statement reads:

> *"The thing that alarmed me the most in the home was that Salvador had a dog in the home… What really worried me was that the behaviour of such a dog is unpredictable and at 70kg he is going to weigh more than some of the residents.*
>
> *Some of the residents were also unpredictable due to various health conditions. The worry was that he could knock them or bite them. I raised this with Salvador and he got really angry with me and told me to leave."*

This was corroborated in Witness 4's oral evidence.

Witness 5's written statement reads:

> *"Salvador had brought a dog to the home at some point. It was a puppy. This was reported as a safeguarding issue. I wouldn't be able to tell you the breed of the dog. I went to the Home to assess whether it was safe for the dog to stay. I'm aware that CCG provided their view about this dog and the community nurses team also did. It was concluded that the dog couldn't stay in the home as it posed a potential health hazard for residents. This was because Residents with dementia could have challenging and unpredictable behaviours."*

The panel noted that there was strict NHS and RCN guidance on pets within care homes. It was of the view that as well as a dog being in the care home was a safeguarding issue, it was also a boundary issue as established earlier.

The panel determined that Mr Firtascu had managerial responsibility for the health and safety for residents at Fern Gardens, by virtue of his job description, his leadership and managerial role as a registered nurse, and his general accountability for patient health and safety.

The panel therefore finds charge 11(f) proved.

Charge 11(g)

"That you a registered nurse whilst employed as manager of Fern Gardens Care Home (the 'Home') between April and August 2021;

11. Being the manager of the Home and having overall responsibility for patient care;

    g. Failed to ensure that care plans were detailed enough to safeguard against residents' mouths becoming dehydrated when being PEG fed."

This charge is found proved.

In reaching this decision, the panel took into account Witness 4's written statement and oral evidence, and Witness 5's written statement.

Witness 4's written statement reads:

> *"I was also concerned about a resident who was being peg fed. The resident was unable to swallow for fear of choking so he was being fed through a tube. When a patient is being fed through a tube their mouth tends to dry out quite quickly, so they should be given water to ensure their mouth is kept hydrated. They were not really giving him fluid, his blood pressure was quite low, so I suggested he should be given more fluids. They seemed reluctant to do so at first, arguing that this was not detailed in the care plan. They eventually agreed to give him more fluid."*

This was corroborated in Witness 4's oral evidence.

The panel noted that the care plans were not part of the evidence bundle. It determined that on the balance of probabilities, the care plans were not detailed enough.

The panel determined that Mr Firtascu had managerial responsibility for the staff at Fern Gardens, by virtue of his job description, his leadership and managerial role as a registered nurse, and his general accountability for patient care and ensuring care plans were comprehensive.

The panel therefore finds charge 11(g) proved.

Charge 11(h)

"That you a registered nurse whilst employed as manager of Fern Gardens Care Home (the 'Home') between April and August 2021;

11. Being the manager of the Home and having overall responsibility for patient care;

    h. Failed to ensure that staff did not barricade residents in their rooms."

This charge is found proved.

In reaching this decision, the panel took into account Witness 4's written statement and oral evidence, Witness 5's written statement and oral evidence and the safeguarding meeting minutes.

Witness 4's written statement reads:

> *"… we saw a resident barricaded into his room.*
>
> *The resident was sat on his bed and there was a high chair blocking the way out. A mattress was on the other side of the room, propped up against the window. The resident required one to one, 24 hour care and the carer who was looking after him was sitting outside the room by the door, looking on their phone. We queried the scenario but that Salvador argued that the resident had only just*

returned from having their bath and had been left like this for only a short period of time. He disputed that the resident was blocked in his room but it was clear by the position of the furniture that this was the intention. The resident was clearly barricaded to stop them from leaving their room. I later learned that the resident had previous falls and the mattress that was propped up against the window had been on the floor was to prevent him from harming himself should he fall again."

Witness 5's written statement reads:

"When Salvador was asked about why the resident was barricaded in his room, he denied the resident was barricaded. The explanation he gave was that the chair was for the carer to sit on and they [the carer] might have moved it when they went on their break."

This was corroborated in Witness 4's and Witness 5's oral evidence.

The safeguarding meeting minutes read:

*"**Concern** - On the 11th of June, [Witness 4], Community Matron reported following concern after her visit to Fern Gardens completed on the 8 and 11th of June 2021: 'A resident who is at risk of falls and therefore is receiving one to one care. Was in his room with no care worker either inside or outside the room observing the resident. Furthermore, there was three chairs placed at the entrance of the room which effectively barricaded the resident in their room. In the event of a fire, it would have caused difficulty in evacuating the resident from the room. There was also a disused mattress which was discarded in the room.'"*

The panel determined that Mr Firtascu had managerial responsibility for the staff at Fern Gardens, by virtue of his job description, his leadership and managerial role as a registered nurse, and his general accountability for patient care.

The panel therefore finds charge 11(h) proved.

Charge 11(i)

"That you a registered nurse whilst employed as manager of Fern Gardens Care Home (the 'Home') between April and August 2021;

11. Being the manager of the Home and having overall responsibility for patient care;

    i. Failed to ensure that cupboards containing cleaning fluids was always kept locked when unattended."

This charge is found proved.

In reaching this decision, the panel took into account Witness 4's written statement and oral evidence.

Witness 4's written statement reads:

> *"There was a query over the cleaning products. One of the cupboards wasn't locked. Salvador said the cleaner had just nipped out. We told him he should make sure the cupboard door was always locked."*

This was corroborated in Witness 4's oral evidence.

The panel noted that Mr Firtascu did not dispute this in the safeguarding meeting minutes.

The panel determined that Mr Firtascu had managerial responsibility for the staff at Fern Gardens, by virtue of his job description, his leadership and managerial role as a registered nurse, and his general accountability for patient care and health and safety.

The panel therefore finds charge 11(i) proved.

Charge 11(j)

"That you a registered nurse whilst employed as manager of Fern Gardens Care Home (the 'Home') between April and August 2021;

11. Being the manager of the Home and having overall responsibility for patient care;

    j. On one or more occasions failed to ensure that safeguarding incidents had been made when Resident A suffered a fall."

This charge is found proved.

In reaching this decision, the panel took into account Witness 5's written statement and oral evidence, and safeguarding meeting notes.

Witness 5's written statement reads:

> *"We later received information that Resident A had sustained six falls during their time at the home, three falls of which we were not aware of. All falls should've been reported to safeguarding and Salvador should've known that the falls had to be reported to us. In the meeting, Salvador had claimed he had sent an email to request a one-to-one for Resident A however [Clinical Lead 1] at Hounslow Council carried out a check and found no emails from the Home or from Salvador. She also found no one-to-one care request from for Resident A."*

The safeguarding meeting minutes read:

> ***"Additional concerns found during enquiry stage. Resident A was found to have 6 falls, 3 of these being unwitnessed;***
>
> ***Daily Notes -***

Wednesday 2 Jun 2021, 17:26 *- "Oxygen level checked 96%. Remedial action taken Resident A was found sitting on the floor by [Witness 3] at around 4.45 pm, struggling to stand. Resident A was assisted to stand on his feet by [Nurse 3] and [HCA 1] he said he fell while trying to throw something into the dustbin. He was examined from head to toe with no injury sustained. Vital signs are within normal range. T364 p80 r20 b/p 120/69 spo2 96. Son was informed via phone"*

Saturday 5 Jun 2021, 23:25 *- "Was confused. Resident A was found with a trimmer putting it in his nose while lying down on the bed. took it from him. duration was for 15 minutes, in their room, was content."*

Sunday 6 Jun 2021, 00:04 *- "Had a fall, an unwitnessed fall, had a fall no injury sustained, in their room, was content"*

Sunday 6 Jun 2021, 00:08 *- "Had a fall found fresh wound on the middle of his nose informed nurse, had a fall minor injury sustained, an unwitnessed fall, in their room, was content."*

Sunday 6 Jun 2021, 00:29 *- "EO – Resident A had an unwitnessed fall @23:45pm, the career heard a bang and ran to check on the resident and found him on the floor . Resident A appears to have been walking unaided in his room and tripped on the cable of the fan in his room and fell on his side. Injuries sustained: bruise on his nose and back. No swelling but reported a bit of pain but paracetamol does not give straight away as last dose was given around 20:30pm. Resident A was reassured and closely monitored and placed on 1:1 to avoid any further falls as patient is high risk. Vital signs checked post fall. BP- 109/69 SATS 96% HR 68 Temp 35.9 RR - 16."*

Sunday 6 Jun 2021, 06:32 *- "Found to be wandering in other residents room in Juliet's room said he went to the toilet, causing unwelcome attention, was content."*

Monday 7 Jun 2021, 12:08 *- "Had a fall In the floor in his bedroom. a witnessed fall, in their room."*

Monday 7 Jun 2021, 12:56 *- "Had a fall ,lost his balance b and fell. Was able to get up with a assistance. a witnessed fall had a fall no injury sustained, in their room, was content."*

Monday 7 Jun 2021, 17:28 *- "Received Resident A in bed awake during handover. All due prescribed medication administered. had a witnessed fall and*

obs was stable. seen by the GP and advised that is going to referral him to neuro. settled day and nil concerns. family was informed Appears to have had a settled day. nil concerns."

This was corroborated in Witness 5's oral evidence.

The panel determined that Mr Firtascu had managerial responsibility for the staff at Fern Gardens, by virtue of his job description, his leadership and managerial role as a registered nurse, and his general accountability for patient care and how care is managed following incidents.

The panel therefore finds charge 11(j) proved.

Charge 12

"That you a registered nurse whilst employed as manager of Fern Gardens Care Home (the 'Home') between April and August 2021;

12. Having been informed by Colleague B what the carers were intending to say about a resident that had fallen, instructed Colleague B to tell the carers, by stating words to the effect of, 'they could not fucking write that in their statements as the home will be closed if they did'."

This charge is found proved.

In reaching this decision, the panel took into account Witness 3's written statement and oral evidence.

Witness 3's written statement reads:

"There was an incident where a resident had fallen. Staff was supposed to hoist the resident but they picked her up instead. Then when she was at the hospital,

they said the resident had a fracture. He sent me to the carers to tell them that they needed to write statements.

*When I asked them what happened and they told me, I went to Salvador and told him what they said they had done. He told me to go back and tell them that "they could not f***ing write that in their statements as the home will be closed if they did". I did not tell them this. I know they did provide statements but I do not know what was said in them. I did not see them."*

This was corroborated in Witness 3's oral evidence.

The panel determined that on the balance of probabilities, Mr Firtascu did state words to the effect of *'they could not fucking write that in their statements as the home will be closed if they did'.*

The panel therefore finds charge 12 proved.

Charges 13 and 14

"That you a registered nurse whilst employed as manager of Fern Gardens Care Home (the 'Home') between April and August 2021;

13. Your actions in charge 12 were a dishonest attempt to persuade the carers into providing misleading accounts about the incident which you knew would not be a true reflection of what had happened.
14. Your actions in charge 12 lacked integrity in that you were attempting to cover up the incident for your and/or the Home's benefit."

These charges are found proved.

The panel took into account what an honest and decent person would do in this situation. It also referred to the case of *Ivey v Genting Casinos* [2018] A.C.391.

The panel firstly ascertained the subjective state of Mr Firtascu's knowledge or beliefs as to the facts and the reasonableness of his belief. The panel determined that Mr Firtascu knew that by instructing staff to alter their statements, the facts around the fall of the resident would be misrepresented.

The panel then went on to determine whether Mr Firtascu's conduct was dishonest by applying the objective standards of ordinary decent people. The panel determined that an ordinary and decent person would know that by intentionally providing a misleading account about incidents pertaining to patient health, this would be dishonest.

The panel further determined that a person with integrity would be open and honest, and would not induce others to cover up any incidents relating to patient care.

In light of the above, the panel determined that Mr Firtascu was dishonest and lacked integrity.

The panel therefore finds charges 13 and 14 proved.

Case reference: 087971/2022

Before making a decision on the following charges, the panel reminded itself that it could no longer rely on the fact that Mr Firtascu had no previous regulatory findings. The panel noted that this was the third indictment against Mr Firtascu. It reminded itself to look at the evidence before it in regard to this case, but that it was open to the panel to take into account, as part of its decision making, Mr Firtascu's previous proved behaviour.

Charge 1(a)

"That you a registered nurse:

a. Behaved in an unprofessional and/or inappropriate manner towards Colleague D in that;

a) On 4 October 2021 stated to Colleague D words to the effect of, *'what makes me happy is to piss staff off'*."

This charge is found proved.

In reaching this decision, the panel took into account Witness 7's written statement and oral evidence, and Witness 7's email dated 15 November 2021.

Witness 7's written statement reads:

> *"On 4 October 2021, I was doing activities and asking residents what made them happy. Salvador was there and I asked what would make him happy and he said his answer would be that "what made him happy was to piss staff off"."*

Witness 7's oral evidence corroborated this.

Witness 7's email dated November 2021 stated:

> *"Monday 4th October 2021*
>
> *Asked Salvador if he would like to write a reason he smiles so can be added onto our Facebook page for an activity to celebrate national smile day, he declined but offered his reason to smile is he likes to piss the staff … Carer 1 (a carer) asked "do you mean pissing the staff off" as he laughed and agreed "I love pissing the staff here off" which I find unprofessional and incredibly insulting"*

The panel determined that Mr Firtascu behaved in an unprofessional and inappropriate manner. It was of the view that a manager of a home would not communicate in this manner about his staff under any circumstances.

The panel determined that this behaviour was both unprofessional in respect of the expectations of a registered nurse and inappropriate as these actions fall outside of expected working practices.

The panel therefore finds charge 1(a) proved.

Charge 1(b)

"That you a registered nurse:

1. Behaved in an unprofessional and/or inappropriate manner towards Colleague D in that;

    b) On 7 October 2021 blew kisses at Colleague D."

This charge is found proved.

In reaching this decision, the panel took into account Witness 7's written statement, Witness 1's written statement, Gold Care's code of conduct, Witness 8's written statement, Witness 7's text messages, and the grievance meeting minutes dated 26 November 2021.

Witness 7's written statement reads:

> *"Before I left, he started blowing kisses at me. I looked at him with disgust. I found it weird and inappropriate for a manager to be this overfamiliar and overfriendly."*

Witness 1's written statement reads:

> *"I have been asked if the registrant was allowed to blow kisses … I'm pretty sure we had got a staff code of conduct at work …"*

Gold Care's code of conduct stated:

"1. All staff working in the home should act at all times in a professional and competent manner and with the best interests of the home's residents in mind.

…

- *treat all residents, other staff, relatives, volunteers and visitors to the home with respect and courtesy"*

Witness 1's written statement reads:

"On 7 October 2021, I remember my colleague [Witness 7] phoning me to tell me about the behaviour of Salvador towards her in the Home. She told me that Salvador … was blowing kisses at her during her shift."

Witness 7's text messages to Witness 1 read:

"Blowing me kisses."

The grievance meeting minutes dated 26 November 2021 stated:

"He was standing near the exit to the car park and he started blowing me kisses. I found this strange …"

The panel determined that Mr Firtascu behaved in an unprofessional and inappropriate manner. It was of the view that a manager of a home would not act this way towards a member of staff.

The panel determined that this behaviour was both unprofessional in respect of the expectations of a registered nurse and inappropriate as these actions fall outside of expected working practices.

The panel therefore finds charge 1(b) proved.

Charge 1(c)

"That you a registered nurse:

1. Behaved in an unprofessional and/or inappropriate manner towards Colleague D in that;

    c. On 8 October 2021, on one or more occasions, attempted to place and/or placed your hands on or around Colleague D's waist."

This charge is found proved.

In reaching this decision, the panel took into account Witness 7's written statement and oral evidence, Witness 1's written statement, Witness 7's text messages, and the grievance meeting minutes dated 26 November 2021.

Witness 7's written statement reads:

> *"I was walking in the corridor on the first floor, and I saw Salvador walking towards me. It looked obvious that he wasn't going to let me pass to I moved myself to the other side of the corridor so he could continue working.*
>
> *He then walked towards me and began putting his hands around my waist so I stepped back to release his hands. He stepped forward and out his hands on my waist again. I got my left arm between his hand and my waist so as to get him to release his hands… I was in shock. It was a bit strange. Salvador started laughing and walking off."*

This was corroborated in Witness 7's oral evidence.

Witness 1's written statement reads:

"On 7 October 2021, I remember my colleague [Witness 7] phoning me to tell me about the behaviour of Salvador towards her in the Home. She told me that Salvador had placed his arms around her waist..."

Witness 7's text messages read:

"I'm only askin because he blew me kisses and tried to put his hands around my waist twice when I moved away..."

The grievance meeting minutes dated 26 November 2021 stated:

"… he was very arrogant in manner and how he walked so I moved to give space and avoid him as he walked past. He tried to put his hand around my waist. I told him to stop."

The panel determined that Mr Firtascu behaved in an unprofessional and inappropriate manner. It was of the view that a manager of a home would not act this way towards a member of staff.

The panel determined that this behaviour was both unprofessional in respect of the expectations of a registered nurse and inappropriate as these actions fall outside of expected working practices.

The panel therefore finds charge 1(c) proved.

Charge 1(d)

"That you a registered nurse:

1. Behaved in an unprofessional and/or inappropriate manner towards Colleague D in that;

   d) On 12 October 2021, in a meeting with others present;

i. Criticised Colleague D for failing to undertake fundraising tasks.
ii. Was rude and/or aggressive towards Colleague D.
iii. Stated to Colleague D words to the effect of, 'your activities department will be the reason why CQC inspection would fail the whole care home'.
iv. When discussing activities stated to Colleague D words to the effect of, 'if you are good at your job, you would know to do these'."

These charges are found proved in its entirety.

In reaching this decision, the panel took into account Witness 7's written statement and oral evidence, Witness 1's statement and oral evidence Witness 7's email dated 15 November 2021, and the grievance meeting minutes dated 26 November 2021.

Witness 7's written statement reads:

> *"Salvador began criticising I and [Witness 1]'s jobs. He was negative towards us. He was accusing me of having not done things and I replied that I was never told we had to do these things. He said for example that I should be doing newsletters, washing peoples cars to get donations for the hole and that this is what other care homes do to generate money. He said I should be going fundraising. I didn't understand this criticism as we were a private care home and I said I didn't know we had to fundraise. He spent about 45 minutes being negative towards [Witness 1] and myself."*

Witness 1's written statement reads:

> *"… Salvador began to shout and scream at us. Salvador was saying that we should be raising more money for activities eben though it is the resident's who are paying money to enjoy these activities. We were also accused of not doing our jobs properly. [Witness 7] and I had done nothing wrong, but Salvador kept shouting at us; I have never personally been spoken to like that from anyone in my life. It was horrendous."*

This was corroborated in both Witness 1 and Witness 7's oral evidence.

Witness 7's email dated 15 November 2021 stated:

> *"It was also suggested that we should have been fundraising for activities, again in the last 2 years I have never been told this is what we were required to do as I was told that our department is entitled to £450 per month from head office. As explained in the meeting to an abrupt reply of this is your job and my question to why we as a privately owned company should ask for donations when we were told that money is available to us (yet this is hard to actually receive even we a request is put in each month on time or earlier as required to be but not received) he implied that in a previous home he had the carers wash cars to raise £600 for the department but I believe this would take activities away from the residents especially as there is 2 of us in the*
> *department to offer this and I am unsure why we would or other said fundraisers as we have a budget for our department. When potential residents / next of kin enquire about residing at the Carehome it is advised that in the*
> *weekly payment for a room at the Carehome, activities are supplied in that quotation so I am shocked as to why we would need to fundraisers when we are entitled to money from the funds received from the residents staying at the Carehome, I myself was one of the relatives that was told when my family member was in the Carehome that our money was being put towards ALL departments and activities being one of them before I applied for a job at the Carehome. Throughout the conversation I was met by comments from Salvador as to "if you are good at your job, you would know to do these" this comment is highly offensive and completely untrue, I personally have received nothing but praise from management, staff, residents & relatives for the work I have provided."*

This was corroborated in the grievance meeting minutes dated 26 November 2021.

The panel determined that Mr Firtascu behaved in an unprofessional and inappropriate manner. It was of the view that a manager of a home would not act this way towards a member of staff, and determined that fundraising was not part of Witness 7's job.

The panel determined that this behaviour was both unprofessional in respect of the expectations of a registered nurse and inappropriate as these actions fall outside of expected working practices.

The panel therefore finds charge 1(d) in its entirety proved.

Charge 1(e)(i), and 1(e)(iii)

"That you a registered nurse:

1. Behaved in an unprofessional and/or inappropriate manner towards Colleague D in that;

    e) On 13 October 2021;
        i. Threw a pile of newspapers on top of the work that Colleague D was doing.
        ii. Stated to Colleague D words to the effect of, 'hand them out'."

These charges are found proved.

In reaching this decision, the panel took into account Witness 7's written statement and oral evidence, and Witness 7's email dated 15 November 2021.

Witness 7's written statement reads:

> *"On the next day, 13 October 2021, I was sitting on the ground floor and Salvador walked in and threw a pile of newspapers on top of what I was doing and said, "hand them out". I said that wasn't part of the activities that I had*

scheduled but he insisted that I should do it. I could see the negativity and hostility continuing."

Witness 7's oral evidence corroborated this.

Witness 7's email dated 15 November 2021 stated:

"Salvador came into a lounge I was in arranging the hairdresser list for the day, threw newspapers down in front of me on my paper work stopping me from writing and said "hand out" I asked if this was now part of the activities role as this is only allocated to us on a weekend when there is no office staff available, he said "yeah, [Business Manager 1] said you now hand it out" and I told him I would now be taking a note of all conversations with him then looking me up and down and walking out the room. I would like to state they did not ask my colleague to hand these out the following days on her shift only myself so clearly a bullying tactic…"

The panel determined that Mr Firtascu behaved in an unprofessional and inappropriate manner. It was of the view that this was not out of character for Mr Firtascu based on his past proved charges.

The panel determined that this behaviour was both unprofessional in respect of the expectations of a registered nurse and inappropriate as these actions fall outside of expected working practices.

The panel therefore finds charge 1(e)(i) and 1(e)(ii) proved.

Charge 1(e)(iii)

"That you a registered nurse:

1. Behaved in an unprofessional and/or inappropriate manner towards Colleague D in that;

e) On 13 October 2021;

iii. On one or more occasions gave Colleague D ‘dirty looks’.”

This charge is found NOT proved.

The panel determined that the wording of charge 1(e)(iii) is insufficient to particularise. It could not find evidence in support of this charge.

The panel therefore finds charge 1(e)(iii) not proved.

Charge 1(f)

“That you a registered nurse:

1. Behaved in an unprofessional and/or inappropriate manner towards Colleague D in that;

f) On one or more occasions on dates unknown referred to Colleague D by calling her ‘darling’ or words to that effect.”

This charge is found proved.

In reaching this decision, the panel took into account the grievance meeting minutes dated 26 November 2021 and Mr Firtascu’s reflective account form.

The grievance meeting minutes dated 26 November stated:

“He would say darling before and it was creepy, he had not done this to me before.”

In his reflective account form, Mr Firtascu stated:

"I understand that calling everyone darling can make people to feel offended and I would try to approach a more professional level of communication. I understand the education and the way I was raised in Europe is not like here."

The panel determined that Mr Firtascu behaved in an unprofessional and inappropriate manner. It noted that Mr Firtascu had himself said it was an unprofessional way to address his colleagues.

The panel determined that this behaviour was both unprofessional in respect of the expectations of a registered nurse and inappropriate as these actions fall outside of expected working practices.

The panel therefore finds charge 1(f) proved.

Charge 2

"That you a registered nurse:

2. On a date unknown behaved in an unprofessional and/or inappropriate manner by stating to Colleague D when referring about another colleague words to the effect of, 'she looks like she likes a good shag.'"

This charge is found proved.

In reaching this decision, the panel took into account Witness 1's written statement and oral evidence and the grievance meeting minutes dated 26 November 2021.

Witness 1's written statement reads:

"I cannot remember specific dates, but there were many instances in which I had heard that Salvador acted inappropriately towards staff members, and these occurrences happened on a near daily basis… a colleague had told me that

Salvador made sexual comments to her along the lines of "she looks like she likes a good shag."

The grievance meeting minutes dated 26 November 2021 notes:

"S.F said he she looks like she likes a good shag."

The panel determined that this behaviour was both unprofessional in respect of the expectations of a registered nurse and inappropriate as these actions fall outside of expected working practices.

Both Witness 1 and Witness 7 corroborated this in their oral evidence.

The panel therefore finds charge 2 proved.

Charges 3(a), 3(b) and 3(c)

That you a registered nurse:

3. Your actions in charge 1 and/or charge 2 amounted to harassment of Colleague D in that:

    a) It was unwanted and/or
    b) It related to Colleague D's sex and/or was sexual in nature and/or was sexually motivated and/or,
    c) It had the purpose or effect of:
        i. Violating Colleague D's dignity, and/or
        ii. Creating an intimidating, hostile, degrading, humiliating or offensive environment for Colleague D."

These charges are found proved.

In reaching this decision, the panel took into account Witness 7's written statement and oral evidence.

Regarding charge 3(a), the panel determined that Mr Firtascu's actions amounted to harassment in that it was unwanted. It noted Witness 7's oral evidence and the evidence before it, and was of the view that this was inappropriate.

In relation to charge 3(b), the panel determined that charges 1(b), 1(c) and 2 were sexually motivated. The panel noted Mr Firtascu's previous proved charges and determined that this was appear to be a repetition of his previous behaviour identified.

Witness 7's written statement reads:

> *"I believe his behaviour towards me was sexually motivated and I felt that his negativity was as a result of me rejecting him."*

This was corroborated in Witness 7's oral evidence.

Regarding 3(c), the panel outlined the chronology of events:

- Kisses blown at Witness 7
- Sexual advances made towards Witness 7 in that he touched her waist
- Advances rebuffed by Witness 7
- Witness 7 called into a meeting in which her performance was questioned
- Shouting at Witness 7 and delegating menial tasks to her which were not ordinarily part of her job, consequently creating an intimidating and hostile environment

The panel determined that Mr Firtascu's actions in charges 1 and 2 amounted to harassment.

The panel then determined that Mr Firtascu's actions in charges 1 and 2 amounted to harassment, in that he was engaging in unwanted conduct (section 26, Equality Act 2010).

The panel then went on to consider that conduct and determined that Mr Firtascu actions created an intimidating, hostile, degrading, humiliating and an offensive environment for Witness 7 that it was unwanted and related to her sex. The panel in considering charge 3(c) determined that the words 'sexual in nature' meant any act including sounds, words, images and gestures that would reasonably be regarded by members of the public as sexual in nature.

The panel therefore finds charge 3 in its entirety 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 Firtascu'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 Firtascu's fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct

In coming to its decision, the panel had regard to the case of *Roylance v General Medical Council (No. 2)* [2000] 1 AC 311 which defines misconduct as a *'word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.'*

Mr Radley invited the panel to take the view that the facts found proved amount to misconduct. The panel had regard to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015' (the Code) in making its decision.

Mr Radley identified the specific, relevant standards where Mr Firtascu's actions amounted to misconduct:

> *"The Panel will in the case of 'SF', no doubt, pay particularly attention to;*
>
> - *The period of time that the misconduct took place over,*
> - *The resulting serious outcome of the misconduct (E.g – skin damage to the bedridden patient)*
> - *The lack of professionalism in the behaviour and language used by 'SF' towards other staff in the workplace?*
> - *The lack of documentation, notes and rational for the decisions especially when persuading others to mislead.*
> - *The fact that the roles of this nurse was within a 'chain of causation' leading to the actual and ultimate behaviour exhibited*
> - *The findings of blatant dishonesty*
> - *The Role as an assistant or Manager in the care setting*
> - *The inappropriate sexual behaviour*
>
> *These factors can have a serious effect on patient safety if it is not dealt with effectively. This we say underpins the need to identify this behaviour as serious misconduct in the case of both Registrants."*

Submissions on impairment

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

Mr Radley submitted:

> *"SF – a denial of the allegations causing the witnesses to relive their experience (E.G especially witness [2 and 3]) and has not attended to explain his case. In fact the case presenter and the panel have been required to put the case in awkward circumstances to the witnesses.*
>
> *It is accepted that some evidence in the form of references, reflection and certificates have been sent in by the Registrant. Care should be taken when read because in reflection the Registrant blames others for some of the failings.*
>
> *There is little evidence that SF has addressed or taken steps to address any concerns or risks identified in the case The Registrant SF provided:*
>
> - *evidence of further relevant training and supervision references of some age*
> - *Some information relating to reflection and understanding of the issues raised in the proven allegations*
> - *No Acceptance of the insight / acceptance of the proven allegations*
> - *details of steps taken to address the concerns raised by the proven allegations*
> - *No current evidence from others as to current skills and fitness to practise (references 2019 and certificates 2022)"*

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), *General Medical Council v Meadow* [2007] QB 462 (Admin) and *Calhaem v General Medical Council* [2007] EWHC 2606 Admin.

Decision and reasons on misconduct

When determining whether the facts found proved amount to misconduct, the panel had regard to the terms of the Code.

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

> ***"1 Treat people as individuals and uphold their dignity*** *[in its entirety]*
>
> ***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*
>
> *3.3 act in partnership with those receiving care, helping them to access relevant health and social care, information and support when they need it, and*
>
> *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***

8 Work cooperatively *[in its entirety]*

10 Keep clear and accurate records relevant to your practice *[in its entirety]*

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 *[in its entirety]*

16 Act without delay if you believe that there is a risk to patient safety or public protection

16.4 acknowledge and act on all concerns raised to you, investigating, escalating or dealing with those concerns where it is appropriate for you to do so

16.5 not obstruct, intimidate, victimise or in any way hinder a colleague, member of staff, person you care for or member of the public who wants to raise a concern, and

16.6 protect anyone you have management responsibility for from any harm, detriment, victimisation or unwarranted treatment after a concern is raised.

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

To achieve this, you must:

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

19.2 take account of current evidence, knowledge and developments in reducing mistakes and the effect of them and the impact of human factors and system failures

19.3 keep to and promote recommended practice in relation to controlling and preventing infection, and

19.4 take all reasonable personal precautions necessary to avoid any potential health risks to colleagues, people receiving care and the public.

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

20.5 treat people in a way that does not take advantage of their vulnerability or cause them upset or distress

20.8 act as a role model of professional behaviour for students and newly qualified nurses and midwives to aspire to Nursing and Midwifery Council

25 Provide leadership to make sure people's wellbeing is protected and to improve their experiences of the healthcare 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, and

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."

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel was of the view that the breaches of the Code were substantial.

The panel determined through the charges found proved, that Mr Firtascu's actions included clinical failings, leadership failings, dishonesty failings, and inappropriate actions that sexual in nature. When considering misconduct, the panel referred itself to the NMC 'Reference: Serious concerns which are more difficult to put right FTP-3a.'

In regard to Mr Firtascu's clinical failings, the panel determined that there were numerous instances of medications mismanagement. It was of the view that this could have had a serious effect on patients long term health, and determined that all patients in the homes were at a risk of harm because of Mr Firtascu's failings. Furthermore, the panel found that Mr Firtascu had instructed a colleague to tell care staff to change their statements regarding an incident where a resident suffered a fall. FTP-3a states that *"breaching the professional duty of candour to be open and honest when things go wrong, including covering up, falsifying records, obstructing, victimising or hindering a colleague or member of the public who wants to raise a concern, encouraging others not to tell the truth, or otherwise contributing to a culture which suppresses openness about the safety of care;"* is an example of a serious concern that is difficult to put right.

The panel determined that some of Mr Firtascu's actions and behaviour was sexual in nature and amounted to serious sexual harassment. The panel was of the view that this behaviour would be found both deplorable and shocking by fellow professionals. It referred to FTP-3a which also states that *"harassment, including sexual harassment, and other forms of sexual misconduct whether it occurs inside or outside professional practice;"* is an example of a serious concern that is difficult to put right.

The panel determined that Mr Firtascu's role in a position of authority significantly facilitated his ability to sexually harass colleagues, who were of a junior position, which created a degrading environment for all the staff. The panel was of the view that this was so far removed from acceptable behaviour and completely out of the ordinary for anyone, let alone a registered nurse and a manager.

In regard to his leadership failings, the panel determined that the effect Mr Firtascu had on the culture at each of the homes he had worked at directly impacted the care that patients received, and the work that his colleagues undertook. The panel determined that Mr Firtascu's clinical actions, and his actions which resulted in sexual harassment were also leadership failings, as a manager is meant to be a role model for staff and, should be someone who can be approached by both staff and patients under all circumstances.

The panel noted that the dishonesty in charges 12, 13 and 14 (085901/2021) were serious and breached the duty of candour expected from a registered nurse. It determined that Mr Firtascu's dishonesty puts all patients under his care at risk, and he tried to misrepresent the nature of the incidents which could have been vital to patient care.

As such, the panel found that Mr Firtascu's actions did fall seriously short of the conduct and standards expected of a nurse, and, subsequently a manager, and amounted to misconduct.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct, Mr Firtascu'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 determined that all limbs of the Dame Janet Smith test were engaged.

The panel finds that patients were put at unwarranted risk of harm by Mr Firtascu's clinical failures, and his sexual misconduct in relation to his colleagues. The panel also finds that both his general harassment and sexual misconduct in relation to colleagues would appal fellow professionals. The panel further determined that his dishonesty would seriously undermine confidence in both the nursing profession and its regulator.

When considering insight, the panel determined, in the absence of any cogent evidence from Mr Firtascu, that the serious clinical concerns identified had not been addressed.

The panel noted that Mr Firtascu has not acknowledged the seriousness of the charges found proved which occurred a number of times involving different people in unconnected settings over a protracted period of time. The panel determined, therefore, that this was an indication of a deep seated attitudinal problem.

The panel was not satisfied that the misconduct in this case is capable of remediation by Mr Firtascu, in view of the fact it related particularly to both sexual misconduct and dishonesty.

The panel determined that there is a risk of repetition based on the charges found proved and that the concerns took place over a long period of time. There is limited, and in the panels view, unconvincing evidence to show that Mr Firtascu has sought to strengthen his practice at any stage prior to this hearing. It noted that sexual harassment concerns took place in two separate homes that Mr Firtascu worked at, with multiple female colleagues the object of his harassment. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

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

The panel determined that a finding of impairment on public interest grounds is required because of the scale of Mr Firtascu's misconduct. It determined that a member of the public would be seriously concerned to find Mr Firtascu practising unrestricted.

In addition, the panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case and therefore finds Mr Firtascu's fitness to practise is also impaired on the grounds of public interest.

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

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 Firtascu off the register. The effect of this order is that the NMC register will show that Mr Firtascu has been struck-off the register.

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

Submissions on sanction

Mr Radley submitted written representations:

> ***"Can the Regulatory concern be addressed?***
>
> *In emphatic terms the NMC say that in this case they cannot. The concerns are of an extremely serious nature. The conduct found proven by the panel calls into question the Registrants professionalism, honesty / integrity and raises concerns about their suitability to remain on the register.*
>
> *…*
>
> *When assessing whether a concern is serious the NMC look at whether the concern can be put right. The NMC say that the concerns found proven here are particularly serious because of the lack of honesty and integrity, the sexual harassment, the risk to patients and the failings in the duty of candour making it impossible to put right (FTP – 3 C).*
>
> *The representations on aggravating factors for Mr Firtascu are;*
>
> a. *Registered nurses occupy a position of privilege and trust and must maintain professional boundaries – Sexual Harassment of junior staff*
> b. *lack of insight into failings – Denials of the charges and a lack of legitimate demonstration of insight*
> c. *Impact on the profession – The trust and confidence in the profession has been damaged.*
> d. *The four limbs of the Grant test are engaged.*
> e. *Resident placed in unwarranted risk of harm/ physical distress.*

f. *Breaching fundamental tenets of the profession*
g. *Lack of understanding of the seriousness – Harassment/ acting Dishonestly*
h. *Lack of relevant up to date training/ reflection –*
i. *Public interest and public protection are both engaged in this case.*
j. *A previous regulatory or disciplinary finding has been relied upon in this case of a similar nature.*

The mitigating features for Mr Firtascu are;

a. *No previous regulatory or disciplinary findings*
b. *No direct lasting patient harm*
c. *Age and experience*
d. *Some references provided.*
e. *Some evidence of training of some age*

Proposed sanction for both Registrants

1. *Striking off*

- *Public Protection and Public Interest are both engaged*
- *lack of insight by both Registrants*
- *Hostile environment created*
- *Sexual impropriety – with females making the workplace hostile*
- *Sexual harassment over a number of locations*
- *Lack of acceptance of the wrong*
- *An unwillingness to rehabilitate shown by failures of engagement*
- *Huge impact on the Public Trust and confidence if the Registrants are permitted to continue to practice*

Conclusion

The Registrants have failed to maintain and promote good professional standards. In this case if the Registrants are permitted to practice, the NMC say

that this would have a devastating effect on the Public's Trust and confidence in the Profession. This case has raised questions about the ability of the Nurses to uphold the standards and values of the profession and the Code.

Clinical failings, sexual harassment, failing to priorities patients and dishonesty have no place in this respected profession. This is compounded by the lack of reflection, insight and no steps to put things right."

Decision and reasons on sanction

Having found Mr Firtascu'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:

- Abuse of a position of trust as manager
- Lack of insight into failings both clinical and managerial
- A pattern of misconduct over an extended period of time
- Conduct which put patients at risk of suffering harm

The panel has drawn no adverse inference from the non-attendance of Mr Firtascu, but noted that his non-attendance meant he could not inform the panel of any mitigating features of this case. The panel noted that Mr Firtascu is currently under a conditions of practice order, but noted that there is no evidence that he has complied with these conditions. The panel considered that he lacked engagement with the fitness to practice process, therefore it could not be certain that Mr Firtascu had insight into his failings.

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

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict Mr Firtascu'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 Firtascu's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the seriousness of the case. The panel 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 Firtascu's registration would be a sufficient and appropriate response. The panel is of the view that there are no practical or workable conditions that could be formulated, given the nature of the charges in this case. The misconduct identified in this case was not something that can be addressed through retraining. Furthermore, the panel concluded that the placing of conditions on Mr Firtascu's registration would not adequately address the seriousness of this case and would not protect the public.

The panel considered Mr Firtascu's conditions of practice order already in place, and noted that there was no evidence that he had complied with the conditions of practice order. It had not seen the reports from Mr Firtascu's current line manager, or any of the outcomes of his meetings with his manager as stated in his conditions. The panel determined that a conditions of practice would not mark the public interest in this case, neither would it be able to protect the public.

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;*
- *…*
- *In cases where the only issue relates to the nurse or midwife's lack of competence, there is a risk to patient safety if they were allowed to continue to practise even with conditions.*

The conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. The panel noted that the serious breach of the fundamental tenets of the profession evidenced by Mr Firtascu's actions is fundamentally incompatible with Mr Firtascu remaining on the register. The panel noted that Mr Firtascu's case dealt with serious concerns, and dishonesty which related to patient care. It noted that this was not a single incident of misconduct, and determined that Mr Firtascu had deep seated attitudinal concerns, with no understanding of insight into his failings. The panel determined that there was a high risk of repetition.

In this particular case, 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?*

Mr Firtascu'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 Firtascu'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.

The panel determined that Mr Firtascu's sexual misconduct poses a risk to colleagues, which indirectly affects their patient care. The panel noted that Mr Firtascu abused his position of trust, harassed colleagues who were distressed, and that his actions were not a one off. The panel determined that his sexual misconduct and dishonesty was not opportunistic, and that this was entrenched and pervasive behaviour for Mr Firtascu.

The panel further determined that Mr Firtascu's actions were fundamentally contrary to the Code that nurses are required to abide by. It noted that fellow professionals would be seriously concerned about his behaviour if this was not marked by a regulatory proceeding. The panel determined that Mr Firtascu's practice creates an unsafe environment for both colleagues and patients.

In *Parkinson v NMC* [2010] EWHC 1898 (Admin) Mr Justice Mitting said:

"A nurse found to have acted dishonestly is always going to be at severe risk of having his or her name erased from the register. A nurse who has acted dishonestly, who does not appear before the Panel either personally or by solicitors or counsel to demonstrate remorse, a realisation that the conduct criticised was dishonest, and an undertaking that there will be no repetition, effectively forfeits the small chance of persuading the Panel to adopt a lenient or merciful outcome and to suspend for a period rather than direct erasure."

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. Having regard to the effect of Mr Firtascu's actions in bringing the profession into disrepute by adversely affecting the public's view of how a

registered nurse should conduct himself, the panel has concluded that nothing short of 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 send to the public and the profession a clear message about the standard of behaviour required of a registered nurse.

This will be confirmed to Mr Firtascu in writing.

Interim order

As the striking-off order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order is required in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in Mr Firtascu's own interests until the striking-off 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 Mr Radley. He invited the panel to impose an interim order for a period of 18 months on the grounds of public protection and otherwise in the public interest. He submitted that as the suspension order will not take effect until after the 28-day period, an interim order is necessary to cover this intervening period to protect the public and meet the public interest in light of the panel's findings.

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 determined that to not put an interim order in place would be inconsistent with its earlier findings. The panel therefore imposed an interim suspension order for a period of 18 months to allow for the possibility of an appeal to be made and determined.

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

That concludes this determination.