Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing

Monday, 9 November 2020 – Friday, 13 November 2020
Nursing and Midwifery Council**,** 2 Stratford Place, Montfichet Road, London, E20 1EJ

&

Monday, 16 November 2020
Virtual Hearing

Name of registrant:	Gabriel Gorgovan	
PIN:	13L0390C	
Part(s) of the register:	Registered Nurse – Sub-part 1 Adult Nursing (18 December 2013)	
Area of registered address:	England	
Type of case:	Misconduct	
Panel members:	John Brookes Allison Hume John Vellacott	(Chair, Lay member) (Registrant member) (Lay member)
Legal Assessor:	Nigel Mitchell	
Panel Secretary:	Philip Austin	
Nursing and Midwifery Council:	Represented by Ruth Alabaster, Case Presenter	
Mr Gorgovan:	Not present and not represented in absence	
Facts proved:	All charges	
Facts not proved:	None	
Fitness to practise:	Currently impaired	
Sanction:	**Striking-off order**	
Interim order:	**Interim suspension order – 18 months**	

Decision and reasons on service of Notice of Hearing

At the start of this hearing, the panel noted that Mr Gorgovan was not in attendance, nor was he represented in his absence.

The panel was informed that notice of this hearing was sent by email to the address that the Nursing and Midwifery Council ("NMC") had for Mr Gorgovan on the WISER system on 9 October 2020. The panel noted that the emergency statutory instrument in place allows for electronic service of the notice of hearing to be deemed reasonable in the current circumstances, involving COVID-19.

Ms Alabaster, on behalf of the NMC, submitted that the service by email 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 time, date and venue of the hearing and, amongst other things, information about Mr Gorgovan's right to attend, be represented and call evidence, as well as the panel's power to proceed in his absence.

In light of the information available, the panel was satisfied that Mr Gorgovan had 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 Gorgovan

The panel next considered whether it should proceed in the absence of Mr Gorgovan. It had regard to Rule 21 (2) which states:

(2) Where the registrant fails to attend and is not represented at the hearing, the Committee—

(a) shall require the presenter to adduce evidence that all reasonable efforts have been made, in accordance with these Rules, to serve the notice of hearing on the registrant;

(b) may, where the Committee is satisfied that the notice of hearing has been duly served, direct that the allegation should be heard and determined notwithstanding the absence of the registrant; or

(c) may adjourn the hearing and issue directions.

Ms Alabaster referred the panel to an email chain between the NMC case officer and Mr Gorgovan.

Ms Alabaster submitted that Mr Gorgovan responded to the notice of hearing on 10 October 2020, informing the NMC case officer that he will not be able to attend the hearing as he has left the country. The NMC case officer then followed this up with an email on 12 October 2020, asking Mr Gorgovan whether he would like to participate in this hearing remotely, or whether he would like a postponement of this matter, or whether he would like the panel to proceed in his absence. A response from Mr Gorgovan was not forthcoming, so the NMC case officer sent a further email to Mr Gorgovan on 16 October 2020, asking for him to respond. Mr Gorgovan then responded to this email on the same day stating *"I left the country on the 7 of the september You can cary on with the hearing in my absence no vidiolink…"*[sic].

In taking account of the above, Ms Alabaster submitted that Mr Gorgovan has indicated that he does not want to participate in this hearing in any of the ways offered to him, and he has invited the panel to proceed in his absence. She submitted that Mr Gorgovan has not requested an adjournment of this hearing, nor is there any reason to believe that an adjournment would secure his attendance on some future occasion.

Ms Alabaster informed the panel that eight witnesses have been warned to give oral evidence to this panel, and delaying this matter further may have an adverse effect on their recollection in relation to the charges, which date back to 2017. She submitted that the public interest elements of this case suggest that this matter should be dealt with expeditiously.

Ms Alabaster submitted that whilst there may be some prejudice to Mr Gorgovan in proceeding in his absence today, the panel can have regard to the written representations he has made throughout the course of the NMC's and the University Hospitals of Derby and Burton NHS Foundation Trust's ("the Trust") investigation. Furthermore, she submitted that the panel can test the evidence of the witnesses that are being called on behalf of the NMC, which lessens the amount of prejudice caused to Mr Gorgovan.

Ms Alabaster invited the panel to proceed in the absence of Mr Gorgovan on the basis that he has voluntarily absented himself. She submitted that there is no good reason for the panel to adjourn this hearing today.

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 Gorgovan. In reaching this decision, the panel has considered the submissions of Ms Alabster 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:

- Mr Gorgovan has provided a clear indication that he will not be attending the hearing, as evidenced in his emails dated 10 October 2020 and 16 October 2020;
- Mr Gorgovan gave his consent for the panel to proceed in his absence at this hearing in the email dated 16 October 2020;
- No application for an adjournment has been made by Mr Gorgovan;
- There is no reason to suppose that adjourning would secure Mr Gorgovan's attendance at some future date;
- Mr Gorgovan has provided written representations in response to the NMC's and the Trust's investigation;
- Eight witnesses have been warned to give oral evidence;
- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the patients or those who need their professional services;
- The charges relate to events that occurred as far back as 2017;
- 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 Gorgovan 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 oral 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 Gorgovan'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, appropriate and proportionate to proceed in the absence of Mr Gorgovan. The panel will draw no adverse inference from Mr Gorgovan's absence in its findings of fact.

Details of charge

That you, a registered nurse,

1. On 8 April 2017 did not provide safe patient care to Patient A by failing to administer insulin and dextrose to him.

2. On 9 April 2017 did not provide safe patient care to Patient B by administering dexamethasone directly into Patient B's vein rather than using a cannula.

3. In acting as alleged at charge 2 above, you acted outside the scope of your competence.

4. On 13 April 2017 behaved in an inappropriate manner towards Colleague 1 by,
    a. Aggressively shouting towards him "you fucking idiot! You don't know how we do things in Romania".
    b. Calling him "fucking stupid".
    c. Standing over him and waving your fists.
    d. Grabbing hold of a chair as if you were about to pick it up and throw it at him.

5. On 19 April 2017 moved Patient C from her bed to her chair on your own despite her care plan stating two members of staff and a rotunda are required to move her.

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

NMC Opening

The NMC received a referral from the Trust on 5 December 2017, in relation to Mr Gorgovan.

Mr Gorgovan commenced employment at The Royal Derby Hospital ("the Hospital") on 30 January 2017, where he worked on Ward 311 ("the Ward") from 2 February 2017. The Ward was a 28 bedded acute medical ward which provided care for older people. Mr Gorgovan benefitted from an induction period in advance of commencing on the Ward which included successful completion of a 'drug assessment workbook'.

It is alleged that on 8 April 2017, Mr Gorgovan did not provide safe patient care to Patient A by failing to administer insulin and dextrose to him.

Patient A was a male patient with complex care needs, admitted to the Ward on 9 March 2017. Among other conditions, he suffered from hyperkalaemia, a condition causing potentially harmful levels of potassium to build up in the body.

It is alleged that Ms 1 was on duty during the day and commenced providing the treatment to Patient A. She handed over to Mr Gorgovan when he began his shift at 19:00 hours, that she had begun the treatment by preparing and requesting some of the medication from the pharmacy, but made it clear that he must administer the prescribed medication, namely intravenous ("IV") Insulin Actrapid and Glucose.

However, it is alleged that when Ms 1 attended for her shift the following morning, she received a hand over from Mr Gorgovan, who informed her that he had not given the medication to Patient A because he had carried out blood monitoring and determined it was not necessary.

It is also alleged that on the night shift on 9 April 2017, Mr Gorgovan was on duty with Ms 2, when he informed her that he needed to provide dexamethasone intravenously to

Patient B. They allegedly discussed the process for ordering a cannula, which was necessary for the administration of the medication at around 22:30 hours.

Later that night, Mr Gorgovan allegedly spoke again with Ms 2, when he confirmed he had administered dexamethasone intravenously to Patient B. Ms 2 allegedly asked him how he had done this when Patient B did not have a cannula inserted, to which Mr Gorgovan is said to have replied that he had administered the medication directly in to Patient B's vein, as this was his usual practice.

This method of administration was allegedly contrary to the local guidelines for administration of IV medications, as it states that IV administrations ought to be carried out via a cannula.

Furthermore, it is alleged that Mr Gorgovan had not been signed off as competent to administer IV medications at the time he administered dexamethasone to Patient B. Mr Gorgovan had allegedly received some training including attending an 'IV study day', but in order to be confirmed as competent to do this, Mr Gorgovan would have had to have administered IV medication whilst subject to supervision on 10 separate occasions before he could be deemed competent to administer this by himself.

Colleague 1 was asked to speak to Mr Gorgovan at a meeting in order to investigate and identify particular areas of support for him, following the concerns referred to above. However, during this conversation, Colleague 1 describes how he tried to work with Mr Gorgovan on a plan to deal with his nursing competencies, but observed him move from a disengaged demeanour to being 'very angry'. Ms 3 was also on shift during this incident, and whilst she did not witness Mr Gorgovan's alleged behaviour, she had said that he was behaving in an agitated manner.

It is alleged that on 19 April 2017, Ms 4, a Healthcare Assistant, was providing care to Patient C, and was aware of her manual handling plan. This manual handling plan required Patient C to be moved by two people, using an item of equipment called a

‘rotunda’ and this advice was in place in the days leading up to 19 April 2017. This information was also allegedly handed over and was on a poster behind Patient C’s bed.

Later on that same shift, Ms 4 allegedly noticed that Patient C had moved from her bed to a chair. Ms 4 asked Mr Gorgovan how Patient C had moved from her bed to a chair, as there was no one else in the bay, and there was no rotunda present. Mr Gorgovan allegedly responded by saying words to the effect of “*She just did it”* or “*She just got in the chair”*.

Ms 4 considered this to be ‘shocking’ as Patient C can be *“difficult, agitated or aggressive”* at times and generally required a lot of time and encouragement to be moved. This is also supported by Ms 5, who had earlier tried to move Patient C using the correct method with the rotunda and the assistance of Ms 4, but had been unable to do so due to Patient C’s non-compliance and ill-health.

Ms 5 expressed disbelief that Patient C had moved from the bed to a chair in the way described by Mr Gorgovan, due to her substantial cognitive impairment. Ms 5 stated that the rotunda was in another area of the Ward at the time that Mr Gorgovan indicated Patient C had moved.

Decision and reasons on application to hear all witness evidence by video link

The panel heard an application made by Ms Alabaster to allow all of the witnesses called on behalf of the NMC to give oral evidence via video link. She referred the panel to Rule 31 of the Rules and submitted that the panel can admit oral, documentary, or any other evidence insofar as it is fair and relevant.

Ms Alabaster drew the panel’s attention to an email dated 28 October 2020, which was sent by the Trust to the NMC case officer. She submitted that in this email, the Trust raise concerns about their staff having to travel to the hearing venue in person, as they state:

"We are concerned that this number of staff are required to travel to London given the risk of transmission of covid to staff travelling on public transport. A number of these staff still work in one area and releasing them clinically is a challenge if they subsequently have to isolate due to contacts whilst away, we would have to consider closing beds at a very difficult time operationally if this occurred. We are aware a number of your hearings have been undertaken virtually and would urge that this one be facilitated in that way.

We could facilitate a secure place within the Trust for witnesses to present and can assure that we would follow your directions regarding restrictions to staff meeting post / pre giving evidence. This would be less of a burden on our clinical services and present less of a risk to the service for the coming weeks."[sic].

Ms Alabaster reminded the panel that the witnesses being called on behalf of the NMC are frontline healthcare workers and the majority of them still work for the Trust. She invited the panel to have particular regard to the fact that the Trust would have to consider closing beds should the witnesses need to self-isolate subsequently, at a very difficult time operationally.

Ms Alabaster submitted that whilst this approach was canvassed with Mr Gorgovan, to which he did raise a question, there is no discernible unfairness to him in hearing the witnesses' evidence by way of video link. She submitted that it is not clear whether Mr Gorgovan understands that the NMC are calling live witnesses to give oral evidence to the panel, as he states in an email dated 29 October 2020 "*No vidiolink please take the case by statements*"[sic]. She submitted that the NMC case officer then attempted to clarify the position around calling live witnesses to give oral evidence at the hearing in an email dated 29 October 2020, to which Mr Gorgovan responds "*Doesn't seam right if the panel ask the wrong question i will be the one to blame .I will let the panel decide what is best for me…*"[sic].

Ms Alabaster submitted that there is limited prejudice to Mr Gorgovan in having the witnesses give their evidence by video link as he has voluntarily absented himself from this hearing in any event. She submitted that the panel will be able to see and hear from all of the witnesses when they give their evidence; it will be able to assess their demeanour and be in a position to cross-examine them in order to test their veracity.

Ms Alabaster submitted that it would be fair and appropriate to hear all of the witnesses' evidence via video link, taking account of the national restrictions in place, and the need to avoid unnecessary travel during the current pandemic. She submitted that hearing the evidence of the witnesses virtually will ensure their safety is maintained, and this is a good and cogent reason to hear the oral testimony by video link.

The panel heard and accepted the advice of the legal assessor.

The panel considered the evidence of all of the witnesses to be relevant to the charges it was being asked to deliberate on. It then moved on to consider whether it would be fair in the particular circumstances of this case to hear the evidence of all of the witnesses by way of video link.

The panel was of the view that whilst it is preferable to have witnesses attend in person to give oral evidence, there is an ongoing global pandemic, and the government has imposed restrictions on unnecessary travel around the UK, if it can be avoided.

The panel was also aware that the witnesses the NMC were intending to rely on are all frontline healthcare workers; seven of them still supporting clinical care at the Trust. It acknowledged the email from the Trust that requiring them to attend the hearing venue in person would disrupt the care delivered to patients on the frontline. The panel noted that all of the witnesses were willing to engage with the process and give oral evidence at this hearing by way of video link.

Whilst Mr Gorgovan had raised some questions in having the witnesses give oral evidence by way of video link, the panel considered there to be some confusion on his part, as he appeared to be under the impression that the panel would be assessing the evidence based on the paperwork alone. However, the NMC case officer clarified the position with Mr Gorgovan in an email and, whilst he again responded citing some unfairness, this seemed to focus on the witnesses being called to give oral evidence to the panel in general, instead of opposing the particular method by which it was being suggested that their oral evidence is heard.

In any event, the panel determined that there would not be any undue prejudice caused to Mr Gorgovan in having the witnesses give their oral evidence by way of video link. The panel noted that it would be able to see each witness individually on the television screen, and it would be able to test the veracity of their evidence and assess their demeanour throughout the duration of their oral evidence.

Therefore, in having regard to the above, the panel determined that it would be fair to hear the evidence of all of the NMC witnesses by video link in the particular circumstances of this case. It considered the ongoing pandemic and the national restrictions in place to be a sufficient and cogent reason for proceeding in this way. In addition, the Trust had also raised concerns about the disruption it could cause to patient care, in requiring a number of staff members to attend the hearing venue. In granting Ms Alabaster's application, the panel determined that it would take steps to ensure that fairness is maintained to all parties involved in this hearing, including Mr Gorgovan.

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

During Colleague 1's oral evidence, Ms Alabaster, made a request that parts of the hearing be held in private on the basis that proper exploration of this case may involve reference to his health. This application was made pursuant to Rule 19 of the NMC (Fitness to Practise) Rules 2004, as amended ("the Rules").

Ms Alabaster invited the panel to enter into private session when matters were raised relating to Colleague 1's health. She submitted that any public interest in these parts of the case being aired in public session is outweighed by the need to protect his privacy in this respect.

The legal assessor reminded the panel that while Rule 19 (1) of the Rules 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 noted that Rule 19 states:

> 19. (1) Subject to paragraphs (2) and (3) below, hearings shall be conducted in public.
>
> (2) Subject to paragraph (2A), a hearing before the Fitness to Practise Committee which relates solely to an allegation concerning the registrant's physical or mental health must be conducted in private.
>
> (2A) All or part of the hearing referred to in paragraph (2) may be held in public where the Fitness to Practise Committee—
>
> (a) having given the parties, and any third party whom the Committee considers it appropriate to hear, an opportunity to make representations; and
> (b) having obtained the advice of the legal assessor, is satisfied that the public interest or the interests of any third party outweigh the need to protect the privacy or confidentiality of the registrant.

(3) Hearings other than those referred to in paragraph (2) above may be held, wholly or partly, in private if the Committee is satisfied—

(a) having given the parties, and any third party from whom the Committee considers it appropriate to hear, an opportunity to make representations; and
(b) having obtained the advice of the legal assessor, that this is justified (and outweighs any prejudice) by the interests of any party or of any third party (including a complainant, witness or patient) or by the public interest.

(4) In this rule, "in private" means conducted in the presence of every party and any person representing a party, but otherwise excluding the public.

Having heard that there may be reference to Colleague 1's health, the panel determined to hold such parts of the hearing in private. The panel determined to rule on whether or not to go into private session in connection with these matters as and when such issues are raised.

Decision and reasons on facts

In reaching its decisions on the facts, the panel took into account all the oral and documentary evidence in this case, together with the submissions made by Ms Alabaster, on behalf of the NMC.

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

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

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

The panel heard oral evidence from the following witnesses called on behalf of the NMC who, at the time of the alleged events, were employed in the following roles:

- Ms 1: Band 5 and Band 6 Registered Nurse at the Hospital
- Ms 2: Band 5 Registered Nurse at the Hospital on the Stroke Rehabilitation Unit (Ward 312)
- Ms 3: Senior Sister on the Ward at the Hospital
- Ms 4: Healthcare Assistant on the Ward at the Hospital
- Ms 5: Healthcare Assistant on the Ward at the Hospital
- Ms 6: Sister on the Ward at the Hospital
- Ms 7: Acting Interim Matron for the London Road Hospital, part of the Community Road Hospitals

- Colleague 1: Educator for Integrative Care and Medicine in the Professional Development Unit

The panel first considered the overall credibility and reliability of the witnesses in the order it had heard from them. It made the following conclusions:

The panel found Ms 1 to be a clear, credible, and straightforward witness who attempted to assist the panel to the best of her knowledge and belief. It considered Ms 1 to have a good recollection of the incident for which she was called to give evidence on, and to have demonstrated good knowledge relating to that specific area of clinical practice.

The panel found Ms 2 to be a straightforward witness who appeared to have some difficulty in understanding the questions asked of her by the panel. The panel considered her answers to have lacked focus on the areas of concern, and it considered her to have been of limited assistance as she had minimal contact with Mr Gorgovan over the course of two night shifts. Ms 2 was unable to expand greatly upon her NMC witness statement, however, she was able to make it clear to the panel that she was not on shift to supervise Mr Gorgovan's nursing practice.

The panel found Ms 3 to be a credible witness who attempted to assist the panel to the best of her knowledge and belief. However, the panel considered her oral evidence to be unclear at certain times, possibly due to the passage of time that had lapsed since the alleged incidents. Nonetheless, the panel was of that view that Ms 3 had been fair and balanced during her oral evidence, in that she accepted when she was not able to recollect certain events. The panel did not consider her to have attempted to embellish her evidence and she did not appear to have borne any ill-will towards Mr Gorgovan. The panel noted that Ms 3's nursing experience was limited to the Trust as she had not worked anywhere else in a nursing capacity. Therefore, she was unable to comment more generally on nursing procedures outside of the Trust's remit.

The panel found Ms 4 to have provided limited evidence to it in respect of charge 5, noting as it did, that she was unable to recollect her involvement in the care of Patient C either before or subsequent to this alleged incident. Whilst the panel considered Ms 4's evidence to be helpful in describing the background to this particular incident, she was not able to expand greatly upon her NMC witness statement, so the panel considered her to be of limited assistance in assessing the evidence relating to charge 5.

The panel also found Ms 5 to have been of limited assistance in providing evidence relating to charge 5. The panel noted that this was Ms 5's first ever shift at the Trust on 19 April 2017, but she was unable to recollect whether she had cared for Patient C subsequent to this. Ms 5 was also unable to expand upon the evidence contained within her NMC witness statement as she could only comment on a very particular incident. However, the panel did have some reservations in respect of Ms 5's evidence, as she had told the panel that it would not have been possible for Patient C to have stood up on her own accord. The panel determined that this would have been a difficult judgment to make having only worked one shift with Patient C and in not remembering subsequently.

The panel found Ms 6 to be a credible, reliable and straightforward witness who attempted to assist the panel to the best of her knowledge and belief. The panel noted that Ms 6 was the shift coordinator on the night shift of 9 April 2017, and that she did not have much direct evidence to offer the panel. Nonetheless, the panel found Ms 6's evidence to be helpful.

The panel found Ms 7 to have been a helpful, credible and reliable witness. It noted that Ms 7 had been asked to conduct the internal investigation into these incidents on behalf of the Trust. The panel considered Ms 7 to have a good recollection of the events, and to have provided clear and accurate evidence in relation to the questions asked of her. It was of the view that Ms 7 had attempted to assist it to the best of her knowledge and belief.

The panel found Colleague 1 to be a credible and reliable witness who attempted to assist the panel to the best of his knowledge and belief. It noted that Colleague 1 was a direct witness to the incidents alleged in charge 4 and, by his own admission, the event had a significant impact on him. The panel considered Colleague 1 to have been emotionally invested in the incident, and to have provided his genuine recollection of it. The panel did not consider Colleague 1 to have attempted to mislead or deceive it in any way. Whilst the panel noted that there was some inconsistencies in his oral evidence to that of Ms 3, these inconsistencies did not affect his overall credibility.

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

Charge 1

1. On 8 April 2017 did not provide safe patient care to patient A by failing to administer insulin and dextrose to him.

This charge is found proved.

In reaching this decision, the panel took account of the evidence of Ms 1, Ms 3, Ms 6 and the written representations made by Mr Gorgovan.

The panel took account of Ms 1's NMC witness statement, in which she had stated:

> *"On 8 April 2017, I was on duty in Ward 311 and had been caring for Patient A all day. The patient had received a blood test which showed an update of his hyperkalaemia and a doctor prescribed the care bundle (Exhibit RW/1). I started the calcium part but not the insulin and glucose. Gabriel then came on duty at 19:00 and I verbally handed over to him that "I've given him [Patient A] calcium to protect his heart and I've prepared the glucose and made an emergency call to the*

pharmacy for insulin". I also told Gabriel that he must give the glucose and the insulin to Patient A. I asked Gabriel to confirm to me that he understood that he must give the patient glucose and insulin (the second half of the care bundle). Gabriel confirmed to me that he understood. There was no written handover, there is a printed sheet which is hand held but this contains only basic information about a patient such as diet, mobility etc.

There was no specific time that the registrant needed to administer the insulin and glucose to my knowledge however I did state to him that it was a priority therefore it should have been given to the patient as such. The calcium was to be reviewed 6 hours after administration and so the insulin and glucose could have been given at that point.

In relation to ordering more insulin, I did this by writing a carbon copy form and sending a healthcare assistant to deliver it to level 1 pharmacy as well as bleeping the pharmacist that the medication was needed urgently. The medication would then be prioritised and made ready within 30-40 minutes. I would then receive a call from the pharmacist stating that the medication was ready for collection. If there is a delay then I would chase the pharmacy by calling. Medication equipment such as pumps are easily obtained. In Patient A's case, the syringe and pump was all set up and ready for use...".

The panel also took account of Ms 3's NMC witness statement, in which she had stated:

"…He had to complete a drug assessment as part of the Trust induction process. He was given a booklet to work through and had to complete practice assessments with a registered practitioner who is competent to teach and assess…".

The panel also took account of Ms 6's NMC witness statement, in which she had stated:

"…That the medication for Patient A was ordered and had to be administered as soon as it arrived because it is emergency medication…".

In establishing whether there was a 'failure' in this case, the panel first considered whether there was a duty imposed on Mr Gorgovan to have administered insulin and dextrose to Patient A.

The panel noted that this treatment was handed over to him specifically by Ms 1, another registered nurse who was finishing her shift. The necessity for this treatment was also contained in the generic handover report, so the panel determined that Mr Gorgovan could not have been in any doubt that this treatment was required for Patient A at that time.

Whilst the panel had evidence before it to suggest that Mr Gorgovan had not had all of his competencies signed off to administer this medication without the supervision of another registered nurse, it nonetheless considered it to have been his responsibility to have found a supervisor to have assisted him in the administration of insulin and dextrose to Patient A. As Mr Gorgovan was a registered nurse on shift at the time, there was a duty imposed on him to provide safe patient care to Patient A in administering insulin and dextrose to him albeit under supervision.

The panel noted that Mr Gorgovan does not appear to accept that he took any incorrect action in failing to administer insulin and dextrose to Patient A in his written representations. The panel considered this to be in direct conflict with his responses given at the Investigation Interview on 9 June 2017, as Mr Gorgovan initially stated that he had forgotten to undertake this task.

In his first reflection, Mr Gorgovan states that he took the decision not to administer the medication after consulting with two other nurses, which included Ms 2. However, during Ms 2's oral evidence, she was clear in that she had not had this conversation with Mr Gorgovan, and that she was under the impression that he was going to arrange for this medication to be administered to Patient A.

Furthermore, Mr Gorgovan appears to later contradict this assertion, as in his second reflection, he states that he spoke to a doctor about not giving the medication to Patient A as there were delays in obtaining the medication from the pharmacy, so the decision not to administer was not made by him alone. However, the panel had no other evidence to support this assertion made by Mr Gorgovan. The panel noted that an entry had been recorded in Patient A's care notes confirming that a blood test had been conducted on Patient A at approximately 02:00 hours on the night shift of 8 April 2017, but it is unclear as to who had done this. There was no entry indicating that there had been a clinical change to Patient A's treatment in his care plan, and the panel would have expected such an entry to have been recorded had this decision been made, especially as Patient A had a potentially life-threatening diagnosis at this point.

The panel received evidence that the system in place at the Hospital to request a patient review involved logging an entry on an IT system, and there was no evidence of this having been done. Furthermore, there was no contemporaneous note made by anyone associated with Patient A's care, confirming that a decision had been made not to administer this medication.

The panel also took account of Mr Gorgovan's explanation in the Investigation Interview dated 9 June 2017 (the notes of which were sent to him following the interview for him to make any corrections/amendments and he duly returned the signed and amended notes on 22 June 2017). Mr Gorgovan was asked at the Investigation Interview "*Why did you not administer prescribed medication?*" and Mr Gorgovan answered "*because I could not find the Baxter pump.*"

The panel determined that there was no evidence to suggest that there had been a change in Patient A's treatment plan, so the insulin and dextrose should have been administered to Patient A.

In taking account all the above, the insulin should have been administered to Patient A by Mr Gorgovan with appropriate supervision, and by his failure to do so, he did not provide safe patient care to Patient A.

Therefore, the panel found charge 1 proved on the balance of probabilities.

Charge 2

2. On 9 April 2017 did not provide safe patient care to Patient B by administering dexamethasone directly into Patient B's vein rather than using a cannula.

This charge is found proved.

In reaching this decision, the panel took account of the evidence of Ms 2 and the written representations of Mr Gorgovan.

The panel took account of Ms 2's NMC witness statement, in which she had stated:

> *"At around 04:00 hours I asked Gabriel if they had come to put the patients cannula in, he said they hadn't. I told Gabriel to chase the job and to escalate it if he needed to, as the patient was still waiting. Next he told me that he had administered the dexamethasone, he seemed quite confident when he told me. I asked him if he had really administered it and how because the patient didn't have a cannula. This is when he told me that he had administered the medication directly into the patient's vein…*
>
> *…I asked Gabriel why he administered the medication directly into the vein, as this wasn't correct protocol because the medication needs to be administered via a cannula. I exhibit a copy of the Trust's IV Guidelines, Gabriel potentially breached this policy under IV administration, exhibit MID/1. Gabriel said "It's okay, I normally*

administered the medication like this.". I think he may have been talking about how he practised in Romania as it could have been common practice there. I was so surprised at Gabriel's actions and what he had said; I wondered why he had given the medication anyway as it needed to be double checked before administration. I said to Gabriel this isn't correct procedure at the Trust and he needs to inform a matron or a sister about his actions. We both went to see [Ms 3] which is when Gabriel told her, I don't know what happened after this but before I went home from that shift I went to the patient in 7b and noticed a puncture wound on their right hand. There was no cotton wool or plaster present.

It was wrong for Gabriel to administer the medication directly into the patient's vein as it is not practised here in the UK and the guidelines clearly show to use a cannula. Injecting directly into the vein can be fatal especially if you don't know the side effects of the medication. The risk to the patient was further bleeding and developing anaphylactic shock if they were allergic. I was interviewed by the Trust as part of the investigation and I exhibit a copy of my local statement that is true to the best of my knowledge, exhibit MID/2…".

The panel noted from the Infusion Therapy Guidelines that all IV substances are administered via a cannula at the Trust. Mr Gorgovan had also only had two documented supervised IV administrations, when he was required to have undertaken 10 instances of supervised practice before he was assessed and then permitted to do this without supervision.

In his first reflective piece, Mr Gorgovan accepts that he administered this medication directly into Patient B's vein without a cannula, but seems to rely on the fact that this was common practice for him in previous roles outside of the UK. In his second reflective piece, he states that *he "did perform and IV and using a butterfly needle and syringe…I did what I think was best for the patient"*[sic]. In addition, the panel had regard to the Investigation Interview notes made on 9 June 2017, where he said that he had explained to the patient what he was going to do and the patient agreed. He administered the

medication into the patient's vein with a butterfly device. He also said that *"I had the skills so I thought why not"*. Mr Gorgovan was asked by Ms 7, *"Are you aware that that in administering IV's directly into a vein is not Trust practice?"*[sic] to which Mr Gorgovan replies *"Yes"*.

The panel noted that whilst no harm was caused to Patient B in administering the dexamethasone directly into Patient B's vein, this was contrary to the Trust's policy and is not accepted practice within the UK. The panel determined that Patient B could have been exposed to an unwarranted risk of harm and discomfort in having the medication administered directly into his vein, and noted that Mr Gorgovan did not have the Trust's permission to undertake this task, with or without a cannula, unless he was directly supervised in any event.

In the circumstances, the panel determined that Mr Gorgovan did not provide safe patient care to Patient B by administering dexamethasone directly into Patient B's vein.

Therefore, the panel found charge 2 proved.

Charge 3

3. In acting as alleged at charge 2 above, you acted outside the scope of your competence.

This charge is found proved.

In reaching this decision, the panel took account of the evidence of Colleague 1, Ms 2, Ms 3, Ms 7 and written representations of Mr Gorgovan.

The panel took account of Ms 7's NMC witness statement, in which she had stated:

"Gabriel received training for intravenous ("IV") therapy and this was all documented in my investigation report (exhibit SB/12) which shows the dates he received the training on. The information and slides from the training day are included in the report too (exhibit SB/13). I believe Gabriel received adequate training because of the information given to me for the investigation. His personal file reflected that he attended all the relevant training days and induction, he was also signed off in his medication administration. As part of his induction he would have completed a local induction and a general hospital induction. I think the local induction was done on the Ward and would have been given by [Ms 3], during the induction she would have gone through the policies and procedures with Gabriel. Gabriel would have received training on manual handling as part of his mandatory training too.

I believe Gabriel would have received enough training at the Trust and if he felt he needed more he would have had the opportunity to bring this to the Trust's attention and would have been put on additional training. He received the same amount of training as all of the other new starters in his cohort and he did not miss any training.

Gabriel would have been aware that he was not competent to administer IV medications as this is more or less drilled into you when you commence with the Trust. It is made very clear that you have to complete 10 IVs under supervision before you are deemed competent to administer IV medications by yourself. It is very strict as you need to protect the public and yourself, so if you are not competent you should not be administering. You also have to go on a refresher course every two to three years to keep up to date with your competency. From memory Gabriel had not completed this or was not officially signed off, therefore, he would not be able to complete any IV therapies alone without supervision. It is the responsibility of the individual and the nurse manager to ensure the supervised practice is completed and signed off as per the IV therapy Guidelines and the Hospital policy."

The panel noted that both Colleague 1, Ms 3 and Ms 7 had all indicated that Mr Gorgovan was not signed off as competent to administer IV medication and thus should not have been attempting to administer it to patients without being supervised. This was also corroborated by the Infusion Therapy Workbook and the Infusion Therapy Guidelines in place at the Trust.

The panel noted that whilst Mr Gorgovan had completed an 'IV study day' on 2 February 2017, this alone did not render him competent to administer medication. Ms 3 had stated that during the IV study day, delegates are told that they must be signed off as competent to administer medication independently, which includes various competency elements including practical examples and completion of a workbook. Ms 3 confirmed during her oral evidence that Mr Gorgovan had only completed two aspects of supervised IV administration, so he had not at that point satisfied the other requirements of the workbook to be able to administer IV medication without supervision. The panel had sight of Mr Gorgovan's Infusion Therapy Workbook, which confirmed that his competence training was incomplete.

The panel had regard to the Investigation Interview notes made on 9 June 2017, in which Mr Gorgovan initially states that he thought he was competent to administer dexamethasone directly into the vein of a patient, and this view was endorsed in his first reflective piece. However, he also recognised that he had not undertaken the 10 supervised practice requirements as stipulated in his Infusion Therapy Workbook. Ms 7 had asked Mr Gorgovan *"Did you knowingly administer IVs knowing you were not competent?"* to which Mr Gorgovan replied *"Yes"*. Furthermore, Mr Gorgovan went on to say *"What I did I was fully aware and I did it against the Trust policy and I accept the consequences"*.

The panel determined that irrespective of Mr Gorgovan's training and previous practice, he had not been signed off as competent to perform this task at the Trust, and this should have resonated with him as he was aware of the need to be supervised and then signed off as competent.

In administering dexamethasone directly into Patient B's vein without the use of a cannula, the panel considered Mr Gorgovan to have acted outside his scope of competence, as he should have administered this medication via a cannula with appropriate supervision.

Therefore, the panel found charge 3 proved.

Charge 4

4. On 13 April 2017 behaved in an inappropriate manner towards colleague 1 by,
    a. Aggressively shouting towards him "you fucking idiot! You don't know how we do things in Romania".
    b. Calling him "fucking stupid".
    c. Standing over him and waving your fists.
    d. Grabbing hold of a chair as if you were about to pick it up and throw it at him.

This charge is found proved in its entirety.

In reaching this decision, the panel took account of the evidence of Colleague 1, Ms 3 and written representations of Mr Gorgovan.

The panel took account of Colleague 1's NMC witness statement, in which he had stated:

> *"I agreed to meet with Gabriel on 13 April 2017, the purpose of the meeting was regarding the email from [Ms 3] and to provide support to Gabriel. I was concerned that Gabriel had injected medication directly into a patient's vein instead of using a cannula, was injecting IV medication without being competent and was not following Trust protocol and guidelines.*

Gabriel was told about the meeting in advance, he knew I was coming and knew the reason I was going to speak to him. Gabriel did not raise any concerns regarding the meeting or speaking with me prior to the meeting taking place…

I had already drafted a plan for him to become competent. The plan was to stop him administering IV antibiotics and oral drugs, complete the booklet, and for the Sisters and myself to work with under supervision and assist him. Then he could be reassessed again but he refused to accept that he needed support and to train before he was considered competent.

Initially Gabriel was disengaged, it was not until I began going through the plan with him and asking him whether he had seen anyone practise in the same way he did within the Trust his behaviour began to change. I asked whether Gabriel had seen other nurses or doctors practising in this way as if this is the case he needs to tell us so we can re-educate everyone.

It was at this point Gabriel became very angry, his language became rude and he stood up. He started screaming and shouting in an aggressive manner repeating "You fucking idiot! You don't know how we do things in Romania!" and said if he was in the same position again regarding the dextrose he would do the same thing. He said that we are all "fucking stupid" and challenged me on whether I knew how to treat a patient with hyperkalaemia which I explained I was not there to discuss.

He was being aggressive, looked like he was going to become physical and cornered me. The room is a rectangle shape about three metres wide and seven metres long. There are two desks and two desk chairs stationed with the desks, a computer desk on left side and another on the right side. Then there is one comfy chair in the middle which is where I was sat. He was by the door in one of the desk chairs before he stood up.

Gabriel then began waving his fists and stood over me whilst I was sitting down. I froze, I did not do anything as I was so scared. To calm him down I kept reminding him of his NMC Code and asking him to calm down but he would have none of it. I explained that he needs to be supervised, become competent and when he is the information would be logged by me so he could work independently. I stated that by not doing this he was contravening the NMC code of conduct and NMC guidelines and showed him the Trust guidelines…

Gabriel remained stood over me, waving his fists in the air and took steps toward me whilst I was sitting down. He then started grabbing the chair and holding onto it as if he was going to pick up the chair and throw it at me, then [Ms 3] burst into the room. I felt like if he had a few more seconds he would have hit me or strangled me.

Gabriel's threatening behaviour lasted about fifteen minutes before [Ms 3] came into the office which she did because she could hear Gabriel screaming and shouting. Even when she walked in Gabriel was calling me an idiot and swearing at me. As soon as she came in he left in a huff straight away, I said to [Ms 3] that he was verbally aggressive and did not accept what I was telling him..."

Whilst the panel noted that the only direct evidence in relation to this charge comes from Colleague 1, the panel believed his version of events, on the balance of probabilities, that the incident had happened as he had stated.

The panel noted that it had found Colleague 1 to have been emotionally invested in the incident, and it had considered it to have had a significant impact on him. The panel had found his account to have been compelling and convincing, despite having no corroborative evidence to support it. Ms 3 was only able to confirm to the panel that she had seen the aftermath of the event, where Mr Gorgovan had appeared agitated and was attempting to leave the Ward.

The panel noted that Mr Gorgovan denies the charges identified in charge 4. In his first reflective piece, Mr Gorgovan states "*I never did what [Colleague 1] is saying*". The panel also noted that in the Investigation Interview notes on 9 June 2017 that Mr Gorgovan denied behaving in an inappropriate and threatening manner, he denied raising his fists, and he denied swearing. He said *"No I would not do that. I am not that sort of person"*. However, in the same interview, Mr Gorgovan had stated *"I did get mad I opened the door and left"*.

In taking account of the evidence it had received, the panel preferred the evidence of Colleague 1, to that of Mr Gorgovan. In determining this, the panel was in no doubt that Mr Gorgovan's actions would be viewed as inappropriate, as his conduct was in no way acceptable for a registered nurse.

Therefore, the panel found charge 4 proved in its entirety.

Charge 5

5. On 19 April 2017 moved patient C from her bed to her chair on your own despite her care plan stating two members of staff and a rotunda are required to move her.

This charge is found proved.

In reaching this decision, the panel took account of the evidence of Ms 3, Ms 4, Ms 5 and the written representations of Mr Gorgovan.

The panel took account of Ms 4's NMC witness statement, in which she had stated:

> *"[Ms 5] and I were on shift with Gabriel at the time of the incident. I had been showing [Ms 5] around as it was her first day, then we assisted a patient. After, we went over to the bay with the patient who had a manual handling plan, I can't*

remember her name or her background. I exhibit a copy of her care plan, exhibit LA/1. Her care plan shows that she has always been moved by two people using the rotunda, for when she is moved for example to a chair, commode or bed. A rotunda is a piece of equipment that is used as an aid to help the patient stand. The patient sits on the edge of their bed, they put their feet in the middle of the circle and their hands on the handle to help them stand up. Then when the patient is steady you can turn them to the commode or chair. The rotunda was used for this patient to give her support and keep her safe, as she was wobbly. The plan also shows that she is moved in bed using a slide sheet. She couldn't really move independently but I can remember that she could roll herself in bed to make herself comfortable. She was only really mobile with the assistance of two and the rotunda. I don't know if she could walk, as I only followed the instructions on the care plan.

When [Ms 5] and I went over to the bay, Gabriel pulled back the curtain and he was behind it stripping the patient's bed. The patient had moved from her bed to the chair and there was no one else in the bay, and the rotunda wasn't present. I asked him "How did you do that?", as he was by himself and there was no rotunda. I remember he replied to me with something along the lines of "She just did it." or "She just got in the chair.". I was shocked as she was a difficult, agitated and aggressive patient at times. She was also difficult to roll in bed, which is why I was shocked that he had got her out of bed on his own, as she needed a lot of time and encouragement to be moved.

Gabriel had left the patient in a mess, so [Ms 5] and I went to find the rotunda to move the patient and clean her up. There was only one rotunda on the ward at the time and it was normally kept in the bathroom, which is where we found it. Gabriel saw us getting the rotunda and said "Are you using the rotunda?" I replied "Yes, that's what you're meant to do.". This information had been handed over to us in the morning and was on the poster behind her bed.

Gabriel would have been aware of her care plan as it was discussed in the morning handover, he also had a sheet from the handover that states every patient's mobility needs, there was a poster behind her bed with her manual handling plan on it that he would have seen, and her care plan would have had a copy of her manual handling plan in it that he could have checked if he was unsure. I knew what Gabriel had done wasn't right or safe for either of them, especially the patient. Gabriel had put the patient at risk of a fall, being injured and could have torn her skin by grabbing her arm if he hadn't used the rotunda. I am not sure if Gabriel would have been able to move the patient without the rotunda, as we had never tried. I don't know if any harm was caused to the patient, but I went and reported the incident to [Ms 3] and can't remember what happened after that."

This was also supported by Ms 5's witness statement, as she had stated:

"On 19 April 2017, I came on shift and worked on Team One with another HCA called [Ms 4]. It was my first shift and [Ms 4] worked with me as a mentor to show me where things were kept and taught me about the ward routine. Our first task of the day was to give personal care to a lady in bay two, bed four. We tried to get her into the chair using the rotunda but she wasn't compliant. We did this by trying to get her to stand up using the rotunda, but she couldn't understand how to sit up in bed, let alone stand up using the rotunda. The rotunda is a turntable used to move patients, without the patients moving their feet. The patient places their feet onto the turntable and then they try to pull themselves up using the bar at the top. Next, we pull a lever to turn the patient. They have to pull themselves up and sit down, all we do is turn them. However, this patient couldn't understand the simple instructions we were giving her to use the rotunda, so we couldn't sit her in the chair…"

The panel noted that Ms 4 and Ms 5 were both unable to provide it with any detailed knowledge of Patient C during their oral evidence, as they could not remember whether they had provided care to her subsequently or not. Specifically, Ms 4 could not remember

whether she had cared for Patient C previously either. The panel noted that this was Ms 5's first shift at the Trust, and this would not have been applicable to her.

The panel also noted from Ms 3's NMC witness statement that she had stated:

> *"I requested Gabriel to come to my office and asked him to explain how he transferred the patient from the bed to the chair. He told me that he used the rotunda and the HCAs were only covering their own actions, as they hadn't repositioned the patient. He was trying to counterargue what the HCAs had told me. I asked Gabriel who assisted him with the patient as two members of staff were required, he couldn't answer this questions. The patient's manual handling plan was clearly stated on the handover sheet and on the patient's plan at the end of their bed. He said to me "I don't know why you are getting so concerned and stressed Rachel", I told him that it is because there has been a number of incidents and you aren't listening to me…"*

In his first reflective account, the panel noted that Mr Gorgovan stated *"[Patient A] transferred hereself into the chair using my hand as support and rotated hereself into the chair"*[sic]. In his second reflective piece, Mr Gorgovan then states *"I did move the patient against her care plan…the reason I did move here is that she did try to get up and sit in her chair…"*. However, in the Investigation Interview dated 9 June 2020, Mr Gorgovan gave the following account *"I was sitting in the bay writing something and I saw she wanted to get up. I asked her if she wanted to sit on the chair I told her to wait for me to get some help. Explained need to use rotunda. I went to get the rotunda and she got up and sat in the chair by the side of her bed herself…I did not hold her in any way. She moved herself entirely. I did not help her at all"*.

In taking account of the above, the panel was of the view that Mr Gorgovan had moved Patient C without the use of the rotunda, and without the assistance of a colleague despite his varying accounts of the incident.

Therefore, in having regard to all the evidence provided, the panel found charge 5 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 Gorgovan's fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's suitability to remain on the register unrestricted.

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

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

Submissions on misconduct

In her submissions, Ms Alabaster referred the panel to the case of *Roylance v GMC (No. 2) [2000] 1 AC 311* which defines misconduct as a *'word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.'*

Ms Alabaster invited the panel to take the view that Mr Gorgovan's conduct amounted to breaches of *The Code: Professional standards of practice and behaviour for nurses and midwives* (2015) ("the Code"). She then directed the panel to specific paragraphs and identified where, in the NMC's view, Mr Gorgovan's acts and omissions amounted to misconduct.

Ms Alabaster submitted that in respect of charges 1, 2 and 3, the panel may find that Mr Gorgovan's acts and omissions around the proper administration of medication to patients is particularly shocking. She submitted that whilst there is no evidence of actual harm being caused, there was a risk of unwarranted harm which could have had serious ramifications for the patients involved.

Specifically in respect of charge 1, Ms Alabaster submitted that the NMC witnesses appeared to find it particularly serious that Mr Gorgovan had failed to take steps to provide safe patient care to Patient A by not providing the treatment prescribed. More than one witness commented on the fact that this was an emergency medication that a doctor had prescribed following clinical assessment and delaying provision of the treatment over an entire shift was unacceptable. Furthermore, Patient A had a 'Do Not Resuscitate' ("DNR") order in place, which meant that he would not have been resuscitated had he suffered a cardiac arrest caused by the build-up of potassium in his body, something that was preventable by providing the prescribed medication.

In respect of charge 2, Ms Alabaster submitted that the NMC witnesses expressed serious concern for Mr Gorgovan's action in administering medication directly through a vein rather than a cannula in contravention of best practice. She submitted that the risks of this course of action were explained by a number of the NMC witnesses, which included risk of Phlebitis, potential for less efficacy of the medication and increased discomfort for the patient.

With respect to charge 3, Ms Alabaster submitted that the Trust had a tried and tested, robust training regime in place to ensure that those administering IV medication (including IV infusions) did so in accordance with the Trust policy, thereby ensuring patient safety. She submitted that as a result of Mr Gorgovan's disregard for the need to complete these medication competencies and adhere to the Trust's policy, before administering treatment without supervision, Patient B was placed at a risk of unwarranted harm by Mr Gorgovan acting outside his scope of competence.

In relation to charge 4, Ms Alabaster submitted that Mr Gorgovan's conduct towards Colleague 1 caused him great distress and had a profound effect upon him in the longer term. She submitted that Mr Gorgovan acted in an inappropriate manner by exhibiting the kind of behaviour that he did towards Colleague 1, someone Mr Gorgovan had never met before, and someone who was asked by the Trust to provide feedback and support to Mr Gorgovan in an attempt to improve his nursing practice. Ms Alabaster submitted that Mr Gorgovan was under an obligation to work constructively with Colleague 1, having regard to the Code.

Ms Alabaster, in respect of charge 5, submitted that with reference to the Code, the safe moving and handling of patients is a fundamental aspect of safe and effective care. She submitted that Mr Gorgovan's decision to move Patient C in contravention of her care plan placed her at an unwarranted risk of harm as the proper method and equipment were not used. Ms Alabaster submitted that this risk was obvious and of concern to both Ms 4 and Ms 5, despite neither of them being registered nurses themselves.

Ms Alabaster submitted that whilst misconduct is ultimately a matter for the panel to determine, in the NMC's submission, all of the facts found proved can separately amount to serious professional misconduct. Nonetheless, she submitted that if the panel considered the facts found proved cumulatively, there is a suggestion of a pattern of conduct whereby Mr Gorgovan disregarded proper instructions, patients' care plans and the Trust's policy. She submitted that Mr Gorgovan had demonstrated a general reckless attitude towards Trust policies and patient safety.

Submissions on impairment

Ms Alabaster 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 *Meadow v GMC [2006] EWCA Civ 1390* and *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant [2011] EWHC 927 (Admin)*.

Ms Alabaster submitted that registered nurses occupy a position of trust in society. The reputation of the profession is upheld by ensuring that there is a proper professional standard which is applicable to all registered nurses and that there is an effective regulatory process, which will take action when conduct which could put patients at risk is brought to its attention. She submitted that the public rely on registered nurses to provide clinical care to patients who can be extremely vulnerable and/or dependent on that care, which is to a good and safe standard. The effective adherence by registered nurses to clear instructions from doctors in respect of clinical care, policies, procedures, and the Code, all of which are specifically designed to ensure patient safety, are all matters which will improve the public's confidence and trust in the profession.

Ms Alabaster submitted that it therefore follows that a registered nurse who, on multiple occasions, appears to impulsively, recklessly and willfully disregard direct instructions, established policies and best practice as and when it suits him to do so, brings the profession in to disrepute. She submitted that a member of the public hearing about such instances could be deterred from seeking medical help or delay doing so, because they may be concerned that a nurse providing treatment to them may similarly decide to depart from best practice without clinical justification and put them at unnecessary or increased risk. Ms Alabaster submitted that this behavior is capable of bringing the profession in to disrepute.

Ms Alabaster submitted that Mr Gorgovan had breached fundamental tenets of the nursing profession as he did not prioritise people, practice effectively and preserve safety. Furthermore, she submitted that there is a suggestion of an underlying attitudinal issue which underpins these facts, and this could also be said to breach the tenet of promoting professionalism and trust.

Ms Alabaster referred the panel to the case of *Cohen v General Medical Council [2008] EWHC 581 (Admin)*, and invited it to consider whether the concerns identified are capable of remediation, whether they have been remediated, and whether there is a risk of repetition of the incidents occurring at some point in the future.

Ms Alabaster submitted that ordinarily, matters of clinically deficient practice are ones which a panel may consider are eminently remediable. For example, clinical deficiencies in areas of medication management and administration are capable of being remedied by targeted and focused training or re-training, learning, assessment and supervision in practice. However, she submitted that the above is true only where the individual concerned is appropriately motivated to address their failings. Ms Alabaster submitted that the panel has received evidence to suggest that Mr Gorgovan is not motivated to address his clinical failings, most noticeably when Colleague 1 attended a meeting with him to discuss the support that could be offered.

At this stage, Ms Alabaster invited the panel to take account of a determination made by the Investigating Committee ("IC") at an interim order hearing on 29 January 2019. She submitted that at this hearing, a panel of the IC replaced the interim conditions of practice order with an interim suspension order as there was some information to suggest that Mr Gorgovan was in breach of his interim conditions of practice order. Ms Alabaster submitted that whilst the factual elements of this case had not been established at the time of the interim order hearing, this is further evidence of Mr Gorgovan demonstrating a flagrant disregard for authority, this time towards his regulator, which may lend to an assessment of his insight and risk of repetition.

In taking account of the above, Ms Alabaster submitted that such underlying attitudinal issues are considered to be more difficult to remediate than clinical nursing concerns, which can be objectively and tangibly addressed through re-training and assessment.

Ms Alabaster submitted that there is no evidence that Mr Gorgovan has undertaken targeted and focused remediation in respect of these clinical concerns in any event. She

submitted that Mr Gorgovan does appear to have obtained employment as a registered nurse at a nursing home subsequently to his employment at the Trust, albeit that for at least some of this time, he would have been subject to restriction on his practice. Ms Alabaster submitted that the panel does not know whether Mr Gorgovan had been attempting to address these concerns, as he does not appear to have sent any reports to assist the IC panel's deliberation at the interim order hearing on 29 January 2019.

Notwithstanding this, Ms Alabaster submitted that attitudinal concerns are often more difficult to remediate than clinical nursing concerns, and there is also no evidence to suggest that Mr Gorgovan has reflected on these. To the contrary, she submitted that Mr Gorgovan's conduct during his time on the Ward and reactions to attempts to improve his standard of practice suggest that he does not acknowledge that he has made any mistakes, does not recognise the need to follow policies and procedures, and does not respond positively to feedback designed to be constructive.

In having regard to all the above, Ms Alabaster submitted that there remains a high likelihood of Mr Gorgovan repeating his conduct, should he be permitted to practice as a registered nurse in future.

Therefore, Ms Alabaster invited the panel to find Mr Gorgovan's fitness to practice as a registered nurse to be currently impaired on the grounds of public protection and public interest.

Decision and reasons on misconduct

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

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 Gorgovan's acts and omissions did fall significantly short of the standards expected of a registered nurse, and it considered them to amount to multiple breaches of the Code. Specifically:

*"**Prioritise People***
You put the interests of people using or needing nursing or midwifery services first. You make their care and safety your main concern and make sure that their dignity is preserved and their needs are recognised, assessed and responded to. You make sure that those receiving care are treated with respect, that their rights are upheld and that any discriminatory attitudes and behaviours towards those receiving care are challenged.

1 Treat people as individuals and uphold their dignity
To achieve this, you must:
1.2 make sure you deliver the fundamentals of care effectively
1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay

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

Practise effectively
You assess need and deliver or advise on treatment, or give help (including preventative or rehabilitative care) without too much delay, to the best of your abilities, on the basis of best available evidence. You communicate effectively, keeping clear and accurate records

and sharing skills, knowledge and experience where appropriate. You reflect and act on any feedback you receive to improve your practice

6 Always practise in line with the best available evidence

To achieve this, you must:

6.1 make sure that any information or advice given is evidence based including information relating to using any health and care products or services

6.2 maintain the knowledge and skills you need for safe and effective practice

8 Work co-operatively

To achieve this, you must:

8.1 respect the skills, expertise and contributions of your colleagues, referring matters to them when appropriate

8.2 maintain effective communication with colleagues

8.4 work with colleagues to evaluate the quality of your work and that of the team

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

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

To achieve this, you must:

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

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

10 Keep clear and accurate records relevant to your practice

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

To achieve this, you must:

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

Preserve safety

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

13 Recognise and work within the limits of your competence

To achieve this, you must, as appropriate:

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

13.5 complete the necessary training before carrying out a new role

18 Advise on, prescribe, supply, dispense or administer medicines within the limits of your training and competence, the law, our guidance and other relevant policies, guidance and regulations

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

Promote professionalism and trust

You uphold the reputation of your profession at all times. You should display a personal commitment to the standards of practice and behaviour set out in the Code. You should be a model of integrity and leadership for others to aspire to. This should lead to trust and

confidence in the professions from patients, people receiving care, other health and care professionals 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

24 Respond to any complaints made against you professionally

To achieve this, you must:

24.2 use all complaints as a form of feedback and an opportunity for reflection and learning to improve practice"

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel went on to consider each charge individually in determining whether Mr Gorgovan's acts and omissions were sufficiently serious so as to amount to misconduct.

In these particular circumstances, the panel decided that Mr Gorgovan's acts and omissions in charges 1, 2, 3 and 4 fell significantly short of the standards expected so as to justify a finding of misconduct. The panel did not consider Mr Gorgovan's actions in charge 5, namely, moving Patient C from her bed to her chair on his own in the circumstances described, despite her care plan stating two members of staff and a rotunda are required to move her, to be sufficiently serious so as to amount to misconduct.

In respect of charge 1, the panel noted that Patient A had been exposed to an unwarranted risk of harm in failing to administer insulin and dextrose to him, as this could have had a significant impact on his potentially life-threatening diagnosis. The panel had

established that a duty was imposed on Mr Gorgovan to ensure that the medication was administered to Patient A, and he did not ensure that this was carried out. Instead, Mr Gorgovan seemed to make a unilateral decision not to administer this medication contrary to Patient A's care plan. Furthermore, Patient A had a DNR order in place, which meant that had his condition deteriorated as a result of him not receiving his prescribed medication, he would not have been resuscitated. Therefore, the panel determined that Mr Gorgovan's omission would be considered to be deplorable by other members of the profession, and it was in no doubt that in failing to administer insulin and dextrose to Patient A, his omission was sufficiently serious so as to amount to misconduct.

In respect of charge 2, the panel noted Patient B did have dexamethasone administered to him as was prescribed. However, the mischief in this charge relates to Mr Gorgovan administering this medication when he was not signed off as competent to perform this task by the Trust, and also in administering this medication via an incorrect method. The panel noted that it had found Mr Gorgovan to be aware of the fact that he was not signed off as competent to administer IV medication by himself, and it was concerned that he did not find a second registered nurse to check the medication and ensure that he was properly supervised. Mr Gorgovan could have made a mistake in administering this medication to Patient B, without taking adequate steps to safeguard him, which could have resulted in Patient B suffering actual harm. Furthermore, the panel considered Mr Gorgovan to have shown a blatant disregard for the Trust's policy, and the advice of a more senior registered nurse on duty, in administering dexamethasone without the use of a cannula. The panel was satisfied that Mr Gorgovan's actions in charge 2 were sufficiently serious so as to amount to misconduct.

In respect of charge 3, the panel noted that the mischief here is inextricably linked to Mr Gorgovan's conduct in charge 2, and that it had found him to have administered dexamethasone to Patient B when he was not signed off as competent to do so, something that Mr Gorgovan would have been aware of. The panel noted that this was routine medication administered to Patient B, and that immediate intervention was not required by Mr Gorgovan as this was not an emergency situation. Patient B could have

been properly treated by a registered nurse who had been signed off as competent to administer this medication with the use of a cannula. Therefore, the panel considered Mr Gorgovan to have exposed Patient B to a risk of unwarranted harm in acting outside of his competence, which is sufficiently serious so as to amount to misconduct.

In respect of charge 4, the panel determined that in behaving in the way identified towards Colleague 1, Mr Gorgovan acted in a completely inappropriate and unprofessional manner for someone who is a registered nursing practitioner. Mr Gorgovan had engaged in aggressive and threatening behaviour in the workplace, and he had caused Colleague 1 to apprehend immediate personal violence. The panel noted that Colleague 1 had never met Mr Gorgovan before and he had been asked by the Trust to assist Mr Gorgovan in improving his nursing performance, by way of devising an action plan and other methods of support. It also noted that Colleague 1 had articulated the long-lasting effect that Mr Gorgovan's behaviour had on him during his oral evidence. The panel considered Mr Gorgovan's conduct in each of the sub-charges in charge 4 to be sufficiently serious so as to amount to misconduct.

In respect of charge 5, the panel noted that it had found that Mr Gorgovan had moved Patient C from her bed to her chair on his own, despite her care plan stating two members of staff and a rotunda are required to move her. Mr Gorgovan had given a number of different accounts as to what had happened. Nonetheless, in the particular circumstances of this case, the panel considered this to have been a minor breach of Trust policy, and it noted that Patient C was transferred from her bed to her chair without suffering any actual harm. The panel was of the view that Mr Gorgovan's conduct in moving Patient C from her bed to her chair on his own, despite her care plan stating two members of staff and a rotunda are required to move her, was not sufficiently serious to meet the threshold to amount to serious professional misconduct.

In conclusion, the panel found that Mr Gorgovan's acts and omissions in charges 1, 2, 3 and 4 did fall seriously short of the conduct and standards expected of a registered nurse

and amounted to misconduct. However, it did not find that Mr Gorgovan's actions in relation to charge 5 amounted to misconduct.

Decision and reasons on impairment

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

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

The panel considered limbs a, b and c to be engaged, both as to the past and to the future.

The panel had found patients in Mr Gorgovan's nursing care to have been exposed to an unwarranted risk of harm, in particular Patient A, who required insulin and dextrose to be administered to him to treat his potentially life-threatening health condition. It had also found Mr Gorgovan to have breached fundamental tenets of the nursing profession and to have brought its reputation into disrepute by virtue of his acts and omissions.

The panel noted that Mr Gorgovan's misconduct occurred in the workplace whilst he was on shift as a registered nurse, and that it relates to both his clinical nursing practice and his conduct and behaviour.

In assessing Mr Gorgovan's level of insight, the panel noted that Mr Gorgovan had accepted some of the concerns in the Investigation Interview on 9 June 2017 and also in his initial response to the charges put to him by the NMC. However, Mr Gorgovan then appears to retract these concessions, and instead attempts to rationalise his behaviour by

justifying his acts and omissions, and deflecting the blame on to others. The panel noted that Mr Gorgovan had provided a number of conflicting accounts, both in his written representations, and in his responses to questions put to him by Ms 7 at the Investigation Interview on 9 June 2017.

In summary, the panel considered Mr Gorgovan to have demonstrated limited insight into his misconduct, as he has not reflected on the extent of his acts and omissions on patients, colleagues, the nursing profession and the wider public. It was of the view that Mr Gorgovan has not fully accepted the concerns identified and is now attempting to minimise his misconduct. Mr Gorgovan has not identified what went wrong in his nursing practice, what he should have done instead, or what he will do in the future should he be faced with a similar set of circumstances.

The panel had regard to the case of *Cohen*, and considered whether the concerns identified in Mr Gorgovan's nursing practice are capable of remediation, whether they have been remediated, and whether there is a risk of repetition of the incidents occurring at some point in the future.

The panel considered the concerns identified in respect of Mr Gorgovan's clinical nursing practice to be capable of remediation, in principle. However, there was some suggestion of an underlying attitudinal concern identified in Mr Gorgovan's nursing practice, based on his blatant disregard for Trust policy, as well as his general demeanour, as reported by the NMC witnesses. This was further supported by the evidence adduced by Ms Alabaster at the impairment stage of the proceedings, as Mr Gorgovan had allegedly breached his interim conditions of practice order by failing to inform the NMC that he had been suspended from a nursing home subsequent to his employment at the Trust. Whilst the panel noted that Mr Gorgovan had not been charged with having breached the terms contained within his interim conditions of practice order at this hearing, the panel considered this to be further demonstrative evidence of him not following directions, first given by the Trust, and now by his regulator, in attempting to preserve patient safety. The panel only placed limited weight on this new piece of evidence, but determined all the

same that there was an emerging pattern of behaviour exhibited by Mr Gorgovan to indicate that he may have an issue with authority.

In any event, the panel determined that no evidence had been provided by Mr Gorgovan to demonstrate that he had remediated any of the clinical or attitudinal concerns identified, or that he was willing to do so in future.

The panel had not been provided with any positive testimonials attesting to Mr Gorgovan's good character or his clinical nursing abilities, nor has it been provided with any evidence of retraining, despite the fact that Mr Gorgovan had obtained a further nursing post which would have provided him with the opportunity to begin remediation and demonstrate evidence of the same. It had nothing before it to suggest that Mr Gorgovan is currently a safe and effective nursing practitioner.

In light of the above, the panel had no evidence before it to allay its concerns that Mr Gorgovan may currently pose a risk to patient safety. It considered there to be a real risk of repetition of the incidents found proved and a risk of significant harm to patients in his care, should adequate safeguards not be imposed on Mr Gorgovan's nursing practice. Therefore, the panel decided that a finding of impairment is necessary on the grounds of public protection.

The panel bore in mind that the overarching objectives of the NMC are to protect, promote and maintain the health safety and well-being of the public and patients, and to uphold/protect the wider public interest, which 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 considered there to be a high public interest in the consideration of this case. It was of the view that a fully informed member of the public would be seriously concerned by the panel's findings on facts and misconduct. It concluded that public confidence in the nursing profession would be undermined if a finding of impairment was not made in this

case. Therefore, the panel determined that a finding of impairment on public interest grounds was also required.

Having regard to all of the above, the panel was satisfied that Mr Gorgovan'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 NMC Registrar to strike Mr Gorgovan off the NMC register. The effect of this order is that the NMC register will show that Mr Gorgovan has been struck off the NMC register.

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

Submissions on sanction

Ms Alabaster took the panel through aggravating factors which, in the NMC's view, were present in this case. She also invited the panel to take account of any contextual factors which may have given rise to mitigation.

Ms Alabaster informed the panel that the NMC had informed Mr Gorgovan of its sanction bid prior to this substantive hearing, and this was a striking-off order. However, she submitted that this is no way meant to usurp the function of the panel in having considered all of the evidence in this case.

Ms Alabaster submitted that as there is a continuing risk to patient safety, no further action would be inappropriate, nor would a caution order, in the particular circumstances of this case.

Ms Alabaster also submitted that a conditions of practice order would not be a sufficient sanction to reflect the severity of Mr Gorgovan's misconduct and underlying attitudinal issues. She submitted that whilst the clinical concerns identified may be capable of remediation, the SG makes it clear that a conditions of practice order is only suitable for when a registrant is motivated to engage with the NMC to address these concerns; thereby demonstrating a willingness to comply. However, Ms Alabaster submitted that Mr Gorgovan's insight into his misconduct is limited, which may prevent him from understanding the full extent of his acts and omissions, and then meaningfully addressing them in future.

Furthermore, Ms Alabaster submitted that the panel has received evidence to show that Mr Gorgovan has not responded positively to retraining in the past, as demonstrated by his conduct in charge 4, when Colleague 1 attempted to assist him in improving his nursing practice. She reminded the panel that subsequent to this incident, Mr Gorgovan may have also breached his interim conditions of practice order at an earlier stage of these proceedings, which could suggest that he would be unwilling to comply with directions made by his regulator.

In taking account of the above, Ms Alabaster submitted that an interim conditions of practice order would not be an appropriate way to manage these concerns.

Ms Alabaster invited the panel to consider whether Mr Gorgovan's behaviour is incompatible with him remaining on the NMC register. She submitted that concerns are so serious that the panel should consider whether temporary removal from the NMC register is sufficient to address the public protection and public interest elements of this case. She submitted that in the NMC's view, someone who has exhibited a blatant disregard for authority and patient safety runs a risk of being removed from the NMC register. Ms

Alabaster submitted that Mr Gorgovan does not appear to recognise the obligations imposed on him in being a registered nurse, and there is also no evidence before the panel to suggest that he is willing to address the concerns identified or that he would be willing to engage with the NMC in future. She submitted that it is difficult to find an evidential basis to suggest that Mr Gorgovan would not continue to pose further risks to patients and colleagues.

Therefore, Ms Alabaster submitted that judging by the nature of Mr Gorgovan's misconduct, temporary removal from the NMC register may be insufficient, as his actions may be incompatible with him remaining on the NMC register. She submitted that this is the most serious of sanctions, but it does not mean that it is not appropriate in certain circumstances, as long as it is used proportionately. Ms Alabaster submitted that the public interest requires Mr Gorgovan's misconduct to be marked in this way, to the extent that the other sanctions available would not be an effective means to address the concerns identified.

Ms Alabaster submitted that it is a matter for the panel as to what sanction is appropriate and proportionate in the particular circumstances of this case.

Decision and reasons on sanction

The panel heard and accepted the advice of the legal assessor.

Having found Mr Gorgovan'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.

As regards aggravating factors, the panel has considered the following as relevant:

- Mr Gorgovan's misconduct was serious, multiple and wide-ranging.
- Mr Gorgovan has exposed patients in his nursing care to a risk of unwarranted harm, specifically Patient A, who had a potentially life-threatening health condition.
- Mr Gorgovan had repeatedly disregarded instructions from the Trust at a local level, and there was also some evidence to suggest that he had breached a direction from his regulator.
- Mr Gorgovan has demonstrated only limited insight into his misconduct as he has not accepted his failings, nor has he provided any evidence of remorse or remediation.
- Mr Gorgovan's conduct is suggestive of an ongoing attitudinal issue.

The panel did not consider there to be any mitigating factors relevant to this case. It noted that Mr Gorgovan was relatively new to his role at the Trust and was undertaking his first night duty, but concluded that this would not excuse him for behaving in the way that he did.

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

Next, in considering whether a caution order would be appropriate in the circumstances, the panel took into account the SG, which 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 was of the view that Mr Gorgovan's misconduct was not at the lower end of the spectrum of fitness to practise 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 a conditions of practice order on Mr Gorgovan's nursing registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable.

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. Whilst the panel considered there to be some identifiable practical areas of retraining for Mr Gorgovan to embark on, it noted that it had found there to be an underlying attitudinal issue present in this case, which may prevent him from reflecting upon the extent of his acts and omissions on patients, colleagues, the nursing profession and the wider public, as well as demonstrating a willingness to respond positively to addressing these concerns.

The panel noted that the NMC witnesses had all attested negatively to Mr Gorgovan's attitude towards constructive. The panel also considered that Mr Gorgovan's actions in charge 4 to be wholly inappropriate taking account of the fact that Colleague 1 was asked to assist and support him in improving his nursing practice. There was also a suggestion that Mr Gorgovan had breached his interim conditions of practice order, which had been imposed on his nursing registration by the NMC.

In taking account of the above, the panel determined that placing a conditions of practice order on Mr Gorgovan's nursing registration would not adequately address the seriousness of this case, nor would it satisfy the public interest considerations.

The panel then went on to consider whether a suspension order would be an appropriate sanction.

The panel noted that Mr Gorgovan had engaged in multiple instances of misconduct across a wide-range of areas involving medication administration, as well as his conduct and behaviour towards authority. It had found him to have attempted to minimise the concerns identified in his nursing practice, and determined that he had sought to deflect

blame on to other members of staff. The panel noted that Mr Gorgovan had breached numerous standards of the Code, as well as fundamental tenets of the nursing profession.

Mr Gorgovan had only offered limited evidence by way of insight into his misconduct, as well as little attempt to alleviate any outstanding concerns in respect of his general nursing practice; despite having a substantial amount of time to reflect on his conduct and behaviour. The panel noted that Mr Gorgovan had worked in a nursing home subsequent to his employment at the Trust, and he could have taken steps to remediate the concerns. However, evidence of this has not been forthcoming, so the panel concluded that Mr Gorgovan had not addressed any of the concerns identified, nor had he understood the full consequences of his acts and omissions. He has not provided evidence to assure this panel that he does not have an underlying attitudinal issue, or that he would not act in a similar way again in future.

Taking account of the above, the panel determined that Mr Gorgovan's misconduct was not merely a serious departure from the standards expected of a registered nurse and a serious breach of the fundamental tenets of the nursing profession, it was fundamentally incompatible with him remaining on the NMC register. In the panel's judgment, to allow someone who had behaved in this way to maintain his NMC registration would undermine public confidence in the nursing profession and in the NMC as a regulatory body.

In reaching its decision, the panel bore in mind that its decision would have an adverse effect on Mr Gorgovan both professionally and personally. However, the panel was satisfied that the need to protect the public and address the public interest elements of this case outweighs the impact on Mr Gorgovan in this regard.

Balancing all of these factors and after taking into account all the evidence before it, the panel determined that the appropriate and proportionate sanction is that of a striking-off order. Having regard to the effect of Mr Gorgovan's misconduct 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.

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 is in Mr Gorgovan's own interest until the suspension order takes effect.

Submissions on interim order

Ms Alabaster invited the panel to impose an interim suspension order for a period of 18 months. She submitted that this interim order is necessary on the grounds of public protection and it is also in the public interest, having regard to the panel's findings.

Decision and reasons on interim order

The panel heard and accepted the advice of the legal assessor.

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. Owing to the seriousness of the misconduct in this case and the risk of repetition identified, it determined that Mr Gorgovan's acts and omissions were sufficiently serious to justify the imposition of an interim suspension order until the striking-off order takes effect. In the panel's judgment, public confidence in the regulatory process would be damaged if Mr Gorgovan would be permitted to practise as a registered nurse prior to the substantive order coming into effect.

The panel decided to impose an interim suspension order in the circumstances of this case. To conclude otherwise would be incompatible with its earlier findings.

The panel therefore imposed an interim suspension order for a period of 18 months.

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

That concludes this determination.