Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Meeting
Monday 11 December 2023

Virtual Meeting

Name of Registrant:	Narcis Apostol
NMC PIN	14K0336C
Part(s) of the register:	Registered Nurse – Sub Part 1 Adult Nursing (Level 1) – 13 November 2014
Relevant Location:	Shoreham-by-Sea
Type of case:	Misconduct & Caution
Panel members:	Sue Heads (Chair, Lay member) Linda Tapson (Registrant member) Jayanti Durai (Lay member)
Legal Assessor:	Gillian Hawken
Hearings Coordinator:	Hazel Ahmet
Facts proved:	Charges 1, 2a, 2b, 3, 5a, 5b, 6a, Criminal Caution
Facts not proved:	Charges 4a, 4b, 5c, 5d, 6b, 6c
Fitness to practise:	Impaired
Sanction:	Striking-off order
Interim order:	**Suspension order (18 months)**

Decision and reasons on service of Notice of Meeting

The panel was informed at the start of this meeting that that the Notice of Meeting had been sent to Mr Apostol's registered email address by secure email on 13 September 2023.

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Meeting provided details of the allegation; the reasons why the NMC proposed a meeting rather than a hearing; that the meeting would be heard on or after 19 October 2023; and offering Mr Apostol the opportunity to request a hearing.

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

Details of charge

'That you, a registered nurse, whilst employed at Kingsland House Care Home between May 2019 and February 2021;

1) On 4 June 2019 left one or more used syringes unattended on top of the medication trolley.

2) On 21 December 2020:
a) at around 11a.m. inaccurately recorded 'N' for not required, in MAR charts for;
i) Resident H's PRN Lorazepam due at 2p.m.
ii) Resident I's Ibuprofen gel PRN due at 2p.m.
iii) Resident J's Paracetamol PRN due at 2p.m.

b) Left unattended on the medication trolley:
i) 4 Medicine Pots;

ii) One or more sachets of Laxido;
iii) One or more sachets of Cosmocol.

3) Your actions in one or more charge 2) a) i), 2 a) ii) & 2 a) iii) above were dishonest, in that you sought to represent that one or more residents did not require medication before their allocated/due time.

4) On an unknown date:
a) Inserted a catheter into Resident G to obtain a urine sample;
i) Contrary to Resident G's care plan;
ii) Without any clinical justification.
b) Did not record that you had performed the catheterisation of Resident G.

5) On 10 February 2021 following Resident E dislocating their jaw, did not follow Resident E's care plan, in that you:
a) Relocated/manipulated Resident E's jaw outside of your scope of competence;
b) Did not escalate Resident E's dislocation to a qualified healthcare professional/emergency services/paramedic;
c) Relocated/manipulated Resident E's jaw without waiting 20 – 60 minutes after Resident E had been administered 2mg of Diazepam.
d) Did not record that you had administered;
i) Diazepam to Resident E
ii) A warm compress to Resident E's jaw.

6) Around December 2020 and January 2021 failed to follow Resident F's care plan, in that you;
a) Flushed Resident F's catheter.
b) Did not roll Resident F to the side.
c) Did not offer Resident F fluids.

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

'That you, a Registered Nurse, on 19 March 2021, were cautioned for the following offence:

1. Theft from the person of another – On 18 February 2021 at Kingsland House, Kingsland Close Shoreham-By-Sea, West Sussex stole prescribed medication and medical supplies, of a value unknown, belonging to Kingsland House Care Home. Contrary to section 1 (1) and 7 of the Theft Act 1968.

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

Mr Apostol faces allegations both in relation to misconduct and a criminal caution. In accordance with Rule 29(2) of the Rules, the panel first considered and determined the allegations of misconduct; it then considered and determined the allegations relating to a criminal caution.

Background to the misconduct charges

The panel was provided with a Statement of Case by the NMC, which set out the background to this matter, as follows:

'The NMC received a self-referral from you on 26 May 2021.

You were employed at Barchester Health Care, Kingsland House ('the Home') but resigned from your role as a staff nurse on 1 April 2021.

Concerns in relation to your clinical practice were raised, as follows:
• An alleged incident in 2019 where used insulin syringes, a potted tablet and some medication sachets were left on the top of the medication trolley resulting in a 12 month written warning;

On 10 February 2021 you were suspended by the Home in relation to the following allegations:
• You gave one resident's inhaler to another resident;
• You disregarded instructions not to manipulate a resident's jaw if it became dislocated;

• *You flushed a resident's catheter against instructions;*
• *You failed to maintain care documentation and ensure this was in place;*
• *You obtained a urine sample by inserting a catheter into a female bedridden resident with dementia rather than the obtaining the sample via the normal process;*
• *; The Home commenced a disciplinary investigation, and an investigation meeting was held with you on 31 March 2021. Following this meeting, you resigned on 1 April 2021.'*

Decision and reasons on facts

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 was provided with signed witness statements from:

Witness 1: Clinical Development Nurse for Barchester Health Care

Witness 2: General Manager of the Home, [registered nurse]

Witness 3: Deputy Manager of the Home, [registered nurse]

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor. It considered the documentary evidence provided by the NMC. The panel was not provided with any documentation from Mr Apostol for the purposes of this meeting.

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

Charge 1

1) On 4 June 2019 left one or more used syringes unattended on top of the medication trolley.

This charge is found proved.

In reaching this decision, the panel took into account the Accident and Incident Report Form from 4 June 2019, where there was a discussion with Mr Apostol regarding his actions of leaving his syringes on the trolley. The panel further considered Mr Apostol's local statement where he acknowledged his actions at the time, which the panel considered to be an admission:

'It all happened today 4-6-19, I was doing morning medication round, around 10AM. I had given prescribed insulin to a resident came back and left syringe on the trolley without being disposed a should have been. I'm aware that action was a potential hazard to residents on ward which could have ended up badly, followed by certain injuries. I'm most regretful for being distracted in such a way; people I'm supposed to look after might have gone through unnecessary trouble, they wouldn't ever be responsible of.' [sic]

In light of the evidence before it, the panel was satisfied on the balance of probabilities, that Mr Apostol left one or more used syringes unattended on top of the medication trolley on 4 June 2019.

The panel therefore found this charge proved.

Charge 2)

On 21 December 2020:

a) at around 11a.m. inaccurately recorded 'N' for not required, in MAR charts for;
i) Resident H's PRN Lorazepam due at 2p.m.
ii) Resident I's Ibuprofen gel PRN due at 2p.m
iii) Resident J's Paracetamol PRN due at 2p.m.

This charge is found proved.

The panel determined that on the balance of probabilities, this charge is found proved. The panel noted the email sent at 1:15pm, dated 21 December 2020 from Witness 1, who

stated that she had checked the MAR charts at 11am, which were forward signed in respect of PRN [as required] medication which was due at 2pm if the residents required it.

The panel accepted the evidence of Witness 1's email and NMC statement in which she states which residents were found to have the code *'N'* documented, *'to indicate that the medication administration was not required'*, and that she had reviewed all MAR charts at approximately 11am. The panel considered Witness 1's written evidence, in which she stated *'[…] a month later in December 2020 he was forward signing the MAR charts again.'* The panel only saw evidence of Resident J's MAR chart as Witness 1 could not locate the MAR charts of Residents H or I. However, the panel took into account the role of this witness as a Senior Clinical Development nurse, and the fact that checking the MAR charts was a routine part of her role. Consequently, the panel accepted Witness 1's evidence that Resident H, Resident I, and Resident J's charts had been forward signed.

The panel, therefore, found this charge proved.

Charge 2b)

b) Left unattended on the medication trolley:
i) 4 Medicine Pots;
ii) One or more sachets of Laxido;
iii) One or more sachets of Cosmocol.

This charge is found proved.

In reaching this decision, the panel took into account the contemporaneous evidence of Witness 1 contained in an email sent to the general manager at 1.15 on the 21.12.20.

In her email she stated: "*I also found four medicine pots, with tablets in on top of the medication trolley as well as sachets of Laxido, Cosmocol. I spoke to Nic (Mr Apostol) about the tablets and the sachets and he shrugged. I said he knew he was not supposed to do what he was doing. He said he knew but then walked off and was called to a resident who was poorly'.*

Witness 1's written NMC statement is consistent with her email. In this she clarified further that Mr Apostol had left the medication unattended. The panel considered the fact that the witness statement was made by an experienced clinical development nurse who would be expected to have good knowledge of the policies and procedures.

The panel therefore found this charge proved.

Charge 3)

3) Your actions in one or more charge 2) a) i), 2 a) ii) & 2 a) iii) above were dishonest, in that you sought to represent that one or more residents did not require medication before their allocated/due time.

This charge is found proved.

In reaching this decision, the panel had regard to the test for dishonesty set out by Lord Hughes in paragraph 74 of *Ivey v Genting Casinos UK Ltd t/a Crockfords [2017] UKSC 67.*

The Court held that they:

- '*Must first ascertain (subjectively) the actual state of the individual's knowledge or belief as to the facts. The reasonableness or otherwise of his belief may evidence whether he held the belief, but it is not an additional requirement that his belief must be reasonable; the question is whether it is genuinely held*.'

Once that had been established, they:

- must determine '*whether his conduct was dishonest by applying the objective standards of ordinary decent people. It is not necessary for the individual to appreciate that what he has done is, by those standards, dishonest.'*

Applying the subjective part of the test, the panel considered that Mr Apostol was aware that his recording was not accurate and that he was seeking to represent that one or more residents did not require medication before their allocated/due time.

In reaching this decision, the panel took into account the witness statement of Witness 1. Witness 1 reports that Mr Apostol had previously forward signed MAR charts in November

2020. Following this Mr Apostol successfully completed a medications competencies test. The panel was of the view that he would have known that forward signing MAR charts is unacceptable practice and is in breach of local and national policy.

The panel noted that Mr Apostol had acknowledged completing the MAR charts at or before 11am, stating that the PRN medication would not be required at 2pm. The panel determined that Mr Apostol would have been aware that this was untrue. It further noted that there was no evidence provided to the panel, or explanation for an alternative reason, for Mr Apostol's forward signing of the charts.

The panel then went on to consider whether Mr Apostol's conduct was dishonest by applying the standards of ordinary decent people. The panel determined that ordinary decent people would find it dishonest to sign a patient record, knowing that what he was signing was inaccurate and with a view to giving the impression that one or more residents did not require medication before their allocated/due time. Mr Apostol has not provided any reason for forward signing the documentation as he did.

As such, this charge is found proved.

Charge 4a)

On an unknown date:
a) Inserted a catheter into Resident G to obtain a urine sample;
i) Contrary to Resident G's care plan;
ii) Without any clinical justification.

This charge is found NOT proved.

In reaching this decision, the panel acknowledged the investigation from 21 December 2021, in which Mr Apostol clearly remembered the identity of Resident G and had stated that she could have done with a catheter, but the family had stated that it was *'too painful'* for the resident, and so he wasn't to insert it.

The panel determined that Mr Apostol had the intention to insert the catheter into Resident G, however, concluded that there is insufficient evidence that he actually did insert it.

The panel considered the witness statement of Witness 2, in which she had stated that *'there was no evidence that I could see that he had performed the procedure.'* She further stated, *'he told me that he told the relative that he was thinking of carrying out an in out catheter'.*

The panel highlighted that it did not have had access to the care plan or notes of Resident G and therefore, did not have supporting evidence as to whether the catheterisation was or was not carried out. The panel concluded that it is unclear if Mr Apostol was prevented from inserting the catheter, or chose not to do so, but was satisfied that there was insufficient evidence to support a case that Mr Apostol had inserted a catheter into Resident G to obtain a urine sample.

The panel therefore found this charge not proved.

Charge 4b)

On an unknown date:
b) Did not record that you had performed the catheterisation of Resident G.

This charge is found NOT proved.

In reaching this decision, having found allegation 4a not proved, the panel did not go on to consider Charge 4b. Having determined that there was insufficient evidence to support a case that Mr Apostol had inserted a catheter into Resident G to obtain a urine sample, the panel further determined that there would be no requirement to record it.

The panel therefore found this charge not proved.

Charge 5a)

5) On 10 February 2021 following Resident E dislocating their jaw, did not follow Resident E's care plan, in that you:
a) Relocated/manipulated Resident E's jaw outside of your scope of competence;

This charge is found proved.

In reaching its decision, the panel took into account Resident E's Plan of Care that details the management plan should Resident E's jaw become dislocated. The Plan of Care stated that *'only the health professional person should relocate the jaw back in place.'*

The panel considered Witness 2's evidence, where she stated, *'the qualified health professional referred to in the Plan, would be either the Community Matron […], or someone at the hospital.'*

The panel had regard to the Investigation Report completed by Witness 3 on 7 June 2021. In this report, there is reference to *'item 2',* which is an allegation that *'. . . without training or authorisation placed the resident at serious risk of injury'*. It is stated in the report that this occurred on 10 February 2021 (the date of the misconduct alleged in Charge 5); however, it does not specifically mention Resident E.

The panel also took into account the investigation meeting notes of Witness 3's meeting with the registrant on the 31 March 2021 at 3.10pm, Mr Apostol is asked about the allegation, referred to as *'item 2'* and responded with the following:

'I have done it before . . . so I just did it . . . the guy on nights just handed it over to me saying I know you can do this so just do it'. Later in the same meeting notes, Mr Apostol is recorded as saying, *'The jaw was my mistake'* […] '*I agree it was wrong the jaw'*. Whilst the panel accepted that the evidence did not directly link the incident with Resident E's jaw, taken collectively, it determined that it was more likely than not referring to this incident on 10 February 2021.

The panel considered Witness 1's evidence, a Senior Nurse, in which she stated the following:

'Early morning on 10 February 2021, the jaw of "Resident E" became dislocated. During the morning handover, the nurse working the night shift, Colleague 1 said that Nick had told him that he had manipulated Resident E's jaw back into position. I said to Colleague 1 that I hope Nick had not done this as it was against guidance for Resident E. Colleague 1 said that he was not in the room when Nick had allegedly done this, and when I asked

Nick, he denied doing so. Colleague 1 later denied that Nick had told him he had manipulated Resident E's jaw. Neither Nick nor Colleague 1 had documented that Resident E's jaw had been manipulated following dislocation. There was no entry in Resident E's progress notes, nor was there an incident report. I felt like Nick and Colleague 1 were lying but I could not prove it. Resident E was unable to tell me what had happened as she has dementia.'

Witness 1 clearly states that Resident E had dislocated their jaw on the 10 February 2021 and that she had been told by Colleague 1 that Mr Apostol had told them that he had relocated it. While the staff member later retracts what they had said and Mr Apostol denied doing it at the time, the panel determined that, taking Witness 1's statement alongside Witness 3's, that it was more likely than not that Mr Apostol had not followed resident E's care plan and had relocated/manipulated Resident E's jaw outside the scope of his competence.

Mr Apostol had told Witness 2 that he was competent:

'Nick had previously said to me that he did not see why we were sending Resident E, an elderly woman, to hospital when her jaw became dislocated. He told me that going to hospital was distressing her and that he had been trained to relocate jaws if they became dislocated. I asked him at the time whether he had been trained in this country or his home country. I think he just shrugged his shoulders and said in his home country. I have worked in A&E and medical assessment units, and I am pretty certain that, we would not relocate a dislocated jaw. It is not a procedure we would do in a nursing home setting in case it went wrong. Ultimately, it is about safety and following the process.'

In her witness statement, Witness 2 further stated:

'Nick may have thought he was qualified to relocate Resident E's jaw, but we had no evidence in his file of qualifications to suggest that he was. I am an experienced nurse myself, but I would not have attempted this procedure in a nursing home setting even if I was qualified. Simply being a registered nurse does not mean you are automatically qualified to do the procedure.'

The panel also had sight of the Interim Order panel decision from the 22 June 2021. In this determination, it is recorded that, *'You accept the allegation that you manipulated a resident's jaw and disregarded instructions in so doing. You told the panel that you knew what you were doing and were concerned as the resident had been to hospital and had missed morning medication, breakfast and lunch. You told the panel that you were trying to be helpful and you were confident in what you were doing at the time. You said that no harm was caused to that patient.'*

The panel was mindful that it did not have access to the transcript of the hearing. As such, it placed limited weight on this determination. However, since it had been adduced as evidence by the NMC, the panel considered this aspect of it to be corroborative of Mr Apostol's response in the local meeting on 31 March 2021.

Having regard to all the evidence before it, the panel determined that there is sufficient evidence to prove that it was more likely than not that this charge did occur.

The panel therefore find this charge proved.

Charge 5b)

b) Did not escalate Resident E's dislocation to a qualified healthcare professional/emergency services/paramedic;

This charge is found proved.

In reaching this decision, the panel took into consideration the Plan of Care which states *'[…] the jaw could be put back in place by the qualified health professional. However, if the health professional is not available to attempt, then 999 call should be made and ask for paramedics' assistance.'*

The panel considered Witness 2's evidence, in which she stated that it would have been *'appropriate for Nick [Mr Apostol] to have called [Community Matron] to see if she had availability to attend the Home to see to Resident E.'*

The panel noted Witness 2's account of what Mr Apostol had said to her: *'Nick had previously said to me that he did not see why we were sending Resident E, an elderly woman, to hospital when her jaw became dislocated.'*

Having found that Mr Apostol had relocated the jaw himself, the panel found that it is more likely than not that he did not escalate Resident E's dislocation as alleged in Charge 5b.

Therefore, the panel found this charge proved.

Charge 5c)

c) Relocated/manipulated Resident E's jaw without waiting 20 – 60 minutes after Resident E had been administered 2mg of Diazepam.

This charge is found NOT proved.

In reaching this decision, the panel took into account that there is no evidence that 2mg of Diazepam was administered to Resident E.

The panel therefore found this charge not proved.

Charge 5d)

d) Did not record that you had administered;

i) Diazepam to Resident E

ii) A warm compress to Resident E's jaw.

This charge is found NOT proved.

In reaching this decision, the panel considered that, given the conclusion of Charge 5c, this charge also cannot be proven, as there is no evidence of diazepam or warm compress having been administered.

The panel considered the evidence of Witness 2, whereby she stated, *'There was no record of Nick having administered diazepam, sat Resident E up, or applied a warm compress.'*

The panel therefore find this charge not proved.

Charge 6a)

6) Around December 2020 and January 2021 failed to follow Resident F's care plan, in that you;
a) Flushed Resident F's catheter.

This charge is found proved.

In reaching this decision, the panel took into account the Investigation Meeting from 31 March 2021 which quotes Mr Apostol; *'flushing […] did it last time with [Colleague 2]'*, to which he continued and stated, *'What is the difference with the normal flushing?'*, and further admitted *'In Dec & Jan I signed the MAR chart that I did it.'*

The panel considered the evidence of Witness 2, in which she said, *'Resident F used to have an ordinary catheter' […] '[the] catheter could not be flushed regularly due to the risk of infection', and 'all nurses were made aware as it was spoken about at handovers, and it was written in a care plan. The catheter needed changing every 12 weeks and this would have been recorded in the diary.'*

The panel further took into account the Deputy Manager, Witness 3's statement, in which she highlighted *'it is not in the care plan instructions [to flush the catheter]'*.

Consequently, the panel accepted that there was a care plan and that the changing of the catheter every 12 weeks was written in this and that this had been discussed at hand overs. The panel concluded that, although it has not had access to the care plan, it accepts the witness evidence of Witness 2, the General Manager of the Home, and determined that Mr Apostol failed to follow the care plan.

This panel therefore found this charge proved.

Charge 6b, 6c)

b) Did not roll Resident F to the side.
c) Did not offer Resident F fluids.

This charge is found NOT proved.

In reaching this decision, the panel took into account that there is no evidence that Mr Apostol did not roll Resident F to his side or offer him fluids.

In the evidence given by Witness 2, she stated *'For Resident F specifically, if you rolled him on his side for a while, sometimes the sediment would move and free the catheter.'* The panel further considered that, although Witness 2 stated that this was something that could be done, she did not expressly say that this was in the Care Plan. There is also no evidence before the panel as to whether Mr Apostol had rolled Resident F on his side or offered him fluids.

The panel therefore found this charge not proved.

Charge: Caution

'That you, a Registered Nurse, on 19 March 2021, were cautioned for the following offence:

1. Theft from the person of another – On 18 February 2021 at Kingsland House, Kingsland Close Shoreham-By-Sea, West Sussex stole prescribed medication and medical supplies, of a value unknown, belonging to Kingsland House Care Home. Contrary to section 1 (1) and 7 of the Theft Act 1968.'

Background from NMC Statement of Case

'The registrant self-referred to the NMC on 21 May 2021. He reported that he had

been arrested on suspicion of theft and had been taken to Worthing Police station. He stated that he was given a caution, although he did not know what that meant at the time.

The alleged facts are that Mr Apostol had been suspended by the Home on 10 February 2022 following the allegations about his practice. He attended the Home on 18 February 2021 stating that he wanted to collect his belongings from his locker and the fridge. He was escorted whilst he collected his belongings but opted not to go to his locker but only to go to the fridge. This raised suspicion and his locker was searched after he had left the building. Items of medication and medical supplies were found and the Home reported the suspected theft of items to the police.

On 19 March 2021 the Police attended at Mr Apostol's home address and arrested him. The police officers searched his accommodation and found other items of medication and medical supplies.

The registrant was taken to the police station and interviewed under caution. He stated in interview that the medication was there for when he needed it for residents and when it was put to him that items were found at his home address, he said it was there for when/if he needed it. He accepted a criminal caution for theft on 19 March 2021.'

Having been provided with a copy of the Record of Caution from SXP Custody Suite Crawley, the panel was satisfied that the facts set out in this Charge 1, are proved. The panel noted that the record of caution was signed by Mr Apostol on 19 March 2021. By accepting this caution Mr Apostol has agreed to the facts behind the Charge and these facts cannot now be challenged by Mr Apostol at this NMC substantive meeting.

The panel therefore found this charge proved.

Fitness to practise, Decision on Statutory Grounds

Having reached its determination on the facts of this case, the panel then moved on to consider whether Mr Apostol's fitness to practise is currently impaired. There is no

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

The panel was mindful that the NMC alleges that Mr Apostol's fitness to practise is currently impaired both in relation to the misconduct-related charges under Article 22(1)(a)(i) of the Nursing and Midwifery Order 2001, and also in relation to his caution for a criminal offence under Article 22(1)(a)(iii). The panel considered both of these avenues of alleged impairment separately. In reaching its decisions, the panel has recognised its statutory duty to protect the public and maintain public confidence in the profession. Further, it has borne 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 accepted the advice of the legal assessor.

Decision and reasons on misconduct allegations

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 Apostol's fitness to practise is currently impaired as a result of that misconduct.

When determining whether the facts found proved amount to misconduct, the panel had regard to the terms of the Code *[Professional standards of practice and behaviour for nurses, midwives and nursing associates, 2018].*

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

> ***1. 'Treat people as individuals and uphold their dignity***
> *1.1 Treat people with kindness, respect and compassion*
> *1.2 Make sure you deliver the fundamentals of care effectively*
> *1.3 Avoid making assumptions and recognise […] individual choice*

2. Listen to people and respond to their preferences and concerns

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

2.2 Recognise and respect the contribution that people can make to their own health and wellbeing

2.3 Encourage and empower people to share in decisions about their treatment and care

2.4 Respect the level to which people receiving care want to be involved in decisions about their own health, wellbeing and care

2.5 Respect, support and document a person's right to accept or refuse care and treatment

4. Act in the best interests of people at all times

4.1 Balance the need to act in the best interests of people at all times with the requirement to respect a persons right to accept or refuse treatment

6. Always practise in line with the best available evidence

8. Work co-operatively

8.1 Maintain effective communication with colleagues

8.2 Respect the skills, expertise and contributions of your colleagues, referring matters to them when appropriate

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

8.6 Share information to identify and reduce risk

10. Keep clear and accurate records relevant to your practice

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

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

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

13. Recognise and work within the limits of your competence

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

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

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

18.4 Take all steps to keep medicines stored securely

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

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

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

20. Uphold the reputation of your profession at all times

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'

The panel accepted that breaches of the Code do not automatically result in a finding of misconduct. However, the panel was of the view that in this case, the breaches of the Code did result in a finding of misconduct, in relation to the charges found proved.

Charge *1)* *On 4 June 2019 left one or more used syringes unattended on top of the medication trolley.*

The panel concluded that this charge amounted to serious professional misconduct as Mr Apostol's actions could have led to real harm of a resident if a resident were to have accessed the used syringes which were left unattended. The panel determined that a registered nurse is expected to follow local and national policy by disposing of used syringes safely into a sharps box, immediately after use; Mr Apostol did not do this.

Consequently, this charge amounts to serious professional misconduct.

Charge 2a, 2b) *On 21 December 2020:*

a) *at around 11a.m. inaccurately recorded 'N' for not required, in MAR charts for;*
i) Resident H's PRN Lorazepam due at 2p.m.
ii) Resident I's Ibuprofen gel PRN due at 2p.m.
iii) Resident J's Paracetamol PRN due at 2p.m.

b) *Left unattended on the medication trolley:*
i) 4 Medicine Pots;
ii) One or more sachets of Laxido;
iii) One or more sachets of Cosmocol.

The panel determined that Charge 2a amounts to serious professional misconduct. The panel concluded that Mr Apostol showed a disregard for residents' wellbeing. The resident group involved in the misconduct were particularly vulnerable. Some of the medication was pain relief and could have left residents in discomfort. Therefore, the misconduct as found proved, in Charge 2a, amounts to serious misconduct.

The panel determined that in relation to Charge 2b, there is evidence of serious professional misconduct. The panel did consider the context in which the misconduct occurred in that Mr Apostol was the only nurse working within an intense and busy environment. However, the panel concluded that, a registered nurse would be expected to escalate any staffing issues or other concerns that would impact on resident safety, including to external agencies, if they feel that the issue is not being dealt with locally.

The panel concluded that leaving medicines unattended placed residents at risk of harm, particularly with the resident group he was caring for.

Consequently, this charge amounts to serious professional misconduct.

Charge 3) *Your actions in one or more charge 2) a) i), 2 a) ii) & 2 a) iii) above were dishonest, in that you sought to represent that one or more residents did not require medication before their allocated/due time.*

The panel determined that a registered nurse is expected to practise in an honest manner, and that the dishonesty involved in this charge amounts to serious misconduct. There was no alternative explanation put forward by Mr Apostol. The panel concluded that the actions in this charge could have endangered both residents and colleagues, and ultimately, breached a fundamental tenet of the nursing profession.

Consequently, this charge amounts to serious professional misconduct.

Charge 5) *On 10 February 2021 following Resident E dislocating their jaw, did not follow Resident E's care plan, in that you:*

- ***a)*** *Relocated/manipulated Resident E's jaw outside of your scope of competence;*
- ***b)*** *Did not escalate Resident E's dislocation to a qualified healthcare professional/emergency services/paramedic;*

The panel concluded that this charge does amount to serious misconduct as Mr Apostol did not follow Resident E's Care Plan and acted outside of his own scope of professional competence, placing Resident E, at significant risk of harm.

Consequently, this charge amounts to serious professional misconduct.

Charge 6) *Around December 2020 and January 2021 failed to follow Resident F's care plan, in that you;*

- ***a)*** *Flushed Resident F's catheter.*

The panel found that Mr Apostol's actions did fall seriously short of the conduct and standards expected of a registered nurse and amounted to misconduct. It took into consideration the fact that Mr Apostol did not follow the Care Plan allocated to Resident F, or what was required for particular resident safety. In turn, the panel determined that Mr Apostol put Resident F at risk of infection and actual harm. Mr Apostol did not practise in line with the best available evidence.

Consequently, this charge amounts to serious professional misconduct.

Decision and reasons on impairment for misconduct allegations

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

In coming to its decision, the panel had regard to the Fitness to Practise Library, specifically the NMC's *Guidance on Impairment (DMA-1),* updated on 27 March 2023, which states:

> *'The question that will help decide whether a professional's fitness to practise is impaired is:*
> *"Can the nurse, midwife or nursing associate practise kindly, safely and professionally?"*
> *If the answer to this question is yes, then the likelihood is that the professional's fitness to practise is not impaired.'*

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

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

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

a) *has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*

b) *has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*

c) *has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*

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

The panel found that residents were put at risk of harm as a result of Mr Apostol's misconduct. Mr Apostol's misconduct has breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. Therefore, the panel was satisfied that confidence in the nursing profession would be undermined if its regulator did not find the relevant charges, and charges relating to dishonesty, as amounting to impaired fitness to practise.

The panel found all four limbs in the Dame Janet Smith *'test'* engaged.

The panel found that Mr Apostol had a cavalier attitude, in that he continued to put residents at risk by failing to follow care plans. It determined that Mr Apostol presented attitudinal concerns and breached a number of fundamental tenets of the nursing profession.

The panel took into account the guidance provided in *Cohen v General Medical Council [2008] EWHC 581* and considered whether Mr Apostol's actions giving rise to the

misconduct established are easily remediable; whether the conduct has been remedied; and whether it was highly unlikely to be repeated.

Although mindful that dishonesty is often said to be difficult to remediate, the panel was of the view that both the clinical misconduct and the dishonest conduct in this case are, on the face of it, remediable. It considered that a registrant could, with appropriate reflection, come to an understanding of why he had acted as he did, develop appropriate insight and appropriate strategies to prevent repetition.

The panel determined that Mr Apostol hasn't provided any relevant training in relation to the charges and he has provided limited evidence of insight, understanding or remorse. Mr Apostol has bought the profession into disrepute and has breached a number of the fundamental tenets of the profession and there is no evidence of strengthening of his practice before the panel. Consequently, there is a high risk of repetition in this case.

The panel concluded that Mr Apostol's fitness to practise is currently impaired on the ground of public protection.

The panel next 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.'*

[PRIVATE].

The panel also noted that one witness who worked with Mr Apostol described him as *'loving and caring',* and another described him as *'going the extra mile for residents.'* However, the panel is of the view that there is a risk of repetition based on the dishonesty

issues involved in this case, and Mr Apostol's attitudinal concerns. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

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

The panel determined that a finding of impairment on public interest grounds is required. A member of the public would expect Mr Apostol's practice to be found impaired, given his misconduct, dishonesty, attitudinal concerns and lack of insight or remorse.

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

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

Decision and reasons on Criminal Caution

The panel was satisfied, based on the Record of Caution relating to the offence of theft of prescribed medications and medical supplies belonging to the Home, that the statutory ground of caution is engaged.

Having announced its findings on the facts, the panel then considered whether, on the basis of the facts found proved, Mr Apostol's fitness to practise is currently impaired by reason of Mr Apostol's caution.

Decision and reasons on impairment on the caution charge

The panel noted that Mr Apostol's conduct which resulted in the criminal caution – namely, theft of prescribed medication and medical supplies from the Home - was serious, being directly connected to his employment as a registered nurse. Mr Apostol, in the panel's

view, breached a fundamental tenet of the profession, specifically, that he must ensure that his conduct justifies the public's trust and confidence in him and that he had transgressed the laws of the UK. The panel determined that Mr Apostol's conduct and the resulting criminal caution, had clear implications in terms of the wider public interest in maintaining public confidence in the profession and was in no doubt that he had brought his profession into disrepute.

In coming to its decision, the panel had regard to the Fitness to Practise Library, specifically the NMC's *Guidance on Impairment (DMA-1).*

The panel determined that given the nature of this charge, Mr Apostol's fitness to practise is impaired on the basis of caution.

The Panel took into account the guidance provided in *Cohen v General Medical Council [2008] EWHC 581* (paragraph 65) and considered whether Mr Apostol's actions giving rise to the criminal caution of theft are easily remediable; whether the conduct has been remedied; and whether it was highly unlikely to be repeated. Although mindful that dishonesty-related conduct is often said to be difficult to remediate, the panel was of the view that Mr Apostol's theft of medication was, on the face of it, remediable. It considered that a registrant cautioned for such an offence could, with appropriate reflection, come to an understanding of why he had committed such offences and thereafter develop insight into his behaviour, together with appropriate strategies to prevent repetition.

The panel noted Mr Apostol's response during his police interview on 19 March 2021, at Worthing Custody Centre, *' […] didn't [sic.] not consider theft of medication actual theft and believed that due to the amount of medication that was being thrown away that he was saving it. He did say that he knew of the dangers of using un-prescribed and out of date medication but said that ''NOT ALL UN-PRESCRIBED MEDICATION IS DANGEROUS, IT'S LIKE IT'S OVER THE COUNTER'' and ''OF COURSE I KNOW THAT, IM A NURSE, I KNOW WHAT IM DOING'' […]'*

The panel was of the view that there is a risk of repetition based on Mr Apostol's response to the caution charge and his limited understanding of the significance of his dishonesty. Mr Apostol had stated that he did not consider the taking of medication and medical

supplies from the home to be theft, which the panel considered to be an attitudinal concern. Therefore, it was decided that a finding of impairment is necessary on the grounds of public protection.

The panel bore in mind the overarching objectives of the NMC 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 determined that, in this case, a finding of impairment on public interest grounds was required. A well-informed member of the public would expect a registered nurse facing a caution involving the theft of medications and medical supplies, to have their fitness to practise found to be impaired.

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

Decision and reasons on sanction

Having found Mr Apostol'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 Sanctions Guidance (SG), in particular, *SAN-2*, Considering Sanctions for Serious Cases. The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel accepted the advice of the legal assessor.

The panel took into account the following aggravating features:

- The residents involved within Mr Apostol's case were particularly vulnerable;
- Mr Apostol abused the position of trust given to him as a registered nurse;

- There is a pattern of misconduct over a period of time;
- Mr Apostol's conduct put residents at risk of harm;
- Mr Apostol presented attitudinal concerns;
- Mr Apostol has presented very limited insight.

The panel also took into account the following mitigating features:

- Mr Apostol self-referred following his caution;
- Mr Apostol presented some level of remorse.

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

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict Mr Apostol's practice would not be appropriate in the circumstances.

The SG states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that Mr Apostol's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the seriousness of the case. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on Mr Apostol's registration would be a sufficient and appropriate response. The panel is of the view that there are no practical or workable conditions that could be formulated, given the nature of the charges in this case. Whilst the panel considered that the clinical failings could potentially be addressed by conditions of practice, the dishonesty identified in this case was not something that can be addressed through retraining. Furthermore, the panel concluded that the placing of conditions on Mr Apostol's registration would not adequately address the seriousness of this case and would not protect the public.

The panel then went on to consider whether a suspension order would be an appropriate sanction. The SG states that suspension order may be appropriate where some of the following factors are apparent:

- *A single instance of misconduct but where a lesser sanction is not sufficient;*
- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *No evidence of repetition of behaviour since the incident;*
- *The Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour;*
- *In cases where the only issue relates to the nurse or midwife's health, there is a risk to patient safety if they were allowed to continue to practise even with conditions; and*
- *In cases where the only issue relates to the nurse or midwife's lack of competence, there is a risk to patient safety if they were allowed to continue to practise even with conditions.*

The conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. The panel noted that the serious breach of the fundamental tenets of the profession evidenced by Mr Apostol's actions is fundamentally incompatible with Mr Apostol remaining on the register. The panel further noted the fact that a suspension order would merely temporarily stop Mr Apostol from practising, which would not fully address the concerns in this case.

The panel further highlighted that Mr Apostol, during the period of his interim suspension order, has not made any efforts to provide insight or remorse; his dishonesty and attitudinal concerns have therefore not been remediated.

In this particular case, the panel determined that a suspension order would not be a sufficient, appropriate or proportionate sanction.

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

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

The panel determined that Mr Apostol's actions were significant departures from the standards expected of a registered nurse and raised fundamental questions about his professionalism. The panel was of the view that Mr Apostol's conduct was fundamentally incompatible with remaining on the register.

The panel was of the view that the findings in this particular case demonstrate that Mr Apostol's actions were serious and to allow him to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body.

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

The panel considered that this order was necessary to mark the importance of maintaining public confidence in the profession, and to send to the public and the profession a clear message about the standard of behaviour required of a registered nurse.

This will be confirmed to Mr Apostol in writing.

Interim order

As the striking-off order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order is required in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is necessary for the

protection of the public, is otherwise in the public interest or in Mr Apostol's own interests until the striking-off sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Decision and reasons on interim order

The panel was satisfied that an interim order is necessary for the protection of the public and is otherwise in the public interest. The panel had regard to the seriousness of the facts found proved and the reasons set out in its decision for the substantive order in reaching the decision to impose an interim order. The panel highlighted that there is a significant risk of harm and that an interim order is required on the basis of public protection and in the public interest.

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive order. The panel therefore imposed an interim suspension order for a period of 18 months in order to cover the time of a possible appeal.

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

That concludes this determination.