# Nursing and Midwifery Council
# Fitness to Practise Committee

**Substantive Hearing**
**22-26 January 2024**
**29-31 January 2024**
**1-2 and 5-6 February 2024**

**Virtual Hearing**

| | |
|---|---|
| **Name of Registrant:** | **Fernando Manuel Ansede Romay** |
| **NMC PIN** | 16D0958C |
| **Part(s) of the register:** | Registered Nurse – Sub Part 1<br>Adult Nursing – April 2016 |
| **Relevant Location:** | Jersey |
| **Type of case:** | Misconduct |
| **Panel members:** | Adrian Smith (Chair – Lay member)<br>Janine Ellul (Registrant member)<br>Christine Moody (Lay member) |
| **Legal Assessor:** | Ian Ashford-Thom (22 and 23 January 2024)<br>Charles Conway (24 January 2024 onwards) |
| **Hearings Coordinator:** | Vicky Green |
| **Nursing and Midwifery Council:** | Represented by Maeve Thornton, Case Presenter |
| **Mr Romay:** | Not present and not represented in his absence |
| **Facts proved:** | Charges 1, 2, 3, 4, 6, 7, 8, 9, 10, 11)a), 11)b), 12, 13, 14, 15, 18, 19, 21, 22, 23, 24, 26, 27, 28, 29, 30, 31 |
| **Facts not proved:** | Charges 5, 17, 25, |
| **No case to answer:** | Charge 16 |
| **Fitness to practise:** | Impaired |
| **Sanction:** | Suspension order (12 months) |

**Interim order:** Interim suspension order (18 months)

**Decision and reasons on service of Notice of Hearing**

The panel was informed at the start of this hearing that Mr Romay was not in attendance and that the Notice of Hearing letter had been sent to Mr Romay's registered email address by secure email on 14 December 2023.

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

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Hearing provided details of the allegations, the time, dates and that the hearing would be held virtually, including instructions on how to join and, amongst other things, information about Mr Romay's right to attend, be represented and call evidence, as well as the panel's power to proceed in his absence.

In the light of all of the information available, the panel was satisfied that Mr Romay has been served with the Notice of Hearing in accordance with the requirements of Rules 11 and 34.

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

Whilst making an application to proceed in the absence of Mr Romay, Ms Thornton also made an application for parts of the hearing to be heard in private pursuant to Rule 19 of the Rules. [PRIVATE].

The panel accepted the advice of the legal assessor.

The panel was mindful that Rule 19(1) of the Rules that hearings should be heard in public. The panel determined that in accordance with Rule 19(3), having heard that there will be reference to Mr Romay's health, the panel determined that his right to

privacy outweighed the public interest in hearings being held entirely in public. The panel therefore parts of the hearing in private where reference is made to Mr Romay's health.

**Decision and reasons on proceeding in the absence of Mr Romay**

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

Ms Thornton referred the panel to the cases of *R* v *Jones (Anthony William)* (No.2) [2002] UKHL 5 and *General Medical Council v Adeogba* [2016] EWCA Civ 162. She drew the panel's attention to the Proceeding in Absence bundle, in particular, the email dated 16 January 2024 from Mr Romay to the NMC in which he stated the following:

> *'Thank you for your email and phone call yesterday. Of course, I have no problem with the hearing being held in my absence, [PRIVATE].'*

Ms Thornton also drew the panel's attention to a subsequent email from the NMC to Mr Romay on 16 January 2024 which stated:

> *'If the hearing does go ahead, this means the panel will hear from the witnesses and won't be able to hear from you, and you won't be able to question the witnesses. If you have any questions, or any other documents you would like me to include in your registrant response bundle for the panel to see, please do let me know.'*
>
> *If you would like to attend in person at a date in the future, please let me know, and the panel will consider whether to postpone.'*

In answer to a panel question, Ms Thornton confirmed Mr Romay had not replied to this email.

Ms Thornton submitted that whilst it is not possible for Mr Romay to attend this hearing due to [PRIVATE], he has indicated that he is happy for the hearing to proceed in his absence. She submitted that Mr Romay has not requested an adjournment and there is no reason to conclude that adjourning this hearing would secure his attendance at a later date. Ms Thornton submitted that there is a strong public interest in the expeditious disposal of hearings. She submitted that any delay could negatively impact the recollection of witnesses who speak to charges that arose in 2021. Ms Thornton submitted that Mr Romay has provided some written responses to the charges and that it would be fair and appropriate to proceed.

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 *Jones.*

The panel has decided to proceed in the absence of Mr Romay. In reaching this decision, the panel has considered the submissions of Ms Thornton, Mr Romay's communications with the NMC and the advice of the legal assessor. It has had particular regard to the factors set out in the decision of *Jones* and *Adeogba* and had regard to the overall interests of justice and fairness to all parties. It noted that:

- No application for an adjournment has been made by Mr Romay.
- Mr Romay has informed the NMC that he has received the Notice of Hearing and confirmed he is content for the hearing to proceed in his absence.
- There is no reason to suppose that adjourning would secure his attendance at some future date.
- Nine witnesses have been warned to give live evidence.
- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;

- The charges relate to events that occurred in 2021 and any 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 Romay in proceeding in his absence. Although the evidence upon which the NMC relies was sent to Mr Romay and he has provided some written responses, he will not be able to cross examine the witnesses called by the NMC and he will not be able to give oral evidence. 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 a consequence of Mr Romay's decision to waive his right to attend, and/or be represented.

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

**Details of charge**

That you, a registered nurse:

1) On 16 January 2021, in relation to Resident I who was isolating, did not wear PPE whilst in Resident I's room. **[Proved]**

2) On 28 January 2021, in relation to Resident E, administered an incorrect dose of 500 micrograms of Ropinirole instead of 1 milligram. **[Proved]**

3) Administered medication via the Percutaneous Endoscopic Gastrostomy method without doing water flushes on one or more of the dates in Schedule 1. **[Proved]**

4) On 19/20 February 2021, failed to recognise that Resident H was showing signs of haematemesis and/or a deterioration in their health in that you did not escalate the matter to emergency services, when it would have been clinically appropriate to do so in the light of the colour of Resident H's vomit. **[Proved]**

5) Failed to record any entries and/or observations on Resident H's notes during your shift having been informed that Resident H was showing signs of haematemesis and/or a deterioration in their health. **[Not Proved]**

6) On 6 October 2021, in relation to Resident A, failed to use the aseptic technique when catheterising Resident A. **[Proved]**

7) On 10 October 2021, following delivery of new medications, signed recording that the MAR charts for unknown patients were correct when they were not. **[Proved]**

8) On 13 November 2021, did not let Resident B know that you were going to remove their pyjama top and/or proceeded to aggressively remove their pyjama top. **[Proved]**

9) On 13 November 2021, ripped an Allevyn dressing off Resident B's arm. **[Proved]**

10) On 13 November 2021, in relation to Resident B, washed a moist wound with saline. **[Proved]**

11) On 13 November 2021:

a) said “Fuck” in front of a resident or words to that effect; **[Proved]**

b) said “How dare you stop me from doing my job nobody has ever questioned my practice” or words to that effect to Colleague C. **[Proved]**

12) Failed to obtain patient consent on one or more of the dates in Schedule 2. **[Proved]**

13)Stored resident medication in pots before the medication was due to be administered on one or more of the dates in Schedule 3. **[Proved]**

14) On 17 December 2021, failed to sign Resident F’s MAR chart to show that 2 doses of Vitamin K had been administered. **[Proved]**

15) In or around January 2022, in relation to Resident J, pressured Colleague B whilst they were dispensing Midazolam in that you said to Colleague B “Come on Colleague B, faster, you can do this, hurry up” or words to that effect. **[Proved]**

16) Between January to March 2022, in relation to Resident D:

a) did not explain to Resident D what you were doing and/or comfort Resident D when taking their blood; **[No case to answer]**

b) slapped the inside of Resident D’s elbow when taking their blood; **[No case to answer]**

c) took Resident D’s bloods in a communal area when it would have been appropriate to use an empty room to take Resident D’s bloods to preserve their dignity. **[No case to answer]**

17) On 8 April 2022, in relation to Resident L, instructed Colleague B to scrub Resident L's foot when scrubbing was an inappropriate technique by which to clean Resident L's foot in the light of their presenting condition and pain. **[Not proved]**

18) On 8 April 2022, said "How dare you fucking do this without me" or words to that effect to Colleague B. **[Proved]**

19) On 8 April 2022, said "Fuck Colleague F she isn't here I am and I'm in charge" or words to that effect to Colleague B. **[Proved]**

20) On 8 April 2022, in relation to Resident K, instructed Colleague B to administer 5 ml of lactulose when the correct dose was 15ml of lactulose. **[Proved]**

21) On 16 April 2022, said "If you say anything, I will fuck your life up, anyone who speaks against me I will fuck their lives up too!" or words to that effect to Colleague B. **[Proved]**

22) On 16 April 2022, said "You know the monkies, hear no evil, see no evil, speak no evil" and/or "you see nothing, you say nothing" or words to that effect to Colleague B. **[Proved]**

23) On 20 April 2022, said "Who the fucking hell do you think you're talking to" or words to that effect to Colleague D in front of Resident A. **[Proved]**

24) On 28 April 2022, said to Resident C "I'm the boss of you, you need to do as you're told" or words to that effect. **[Proved]**

25) On 28 April 2022, in relation to Resident C, attempted venepuncture despite the patient indicating that they did not consent to this procedure. **[Not proved]**

26) On several unknown dates called Colleague A – "Barbie" or words to that effect. **[Proved]**

27) On an unknown date, pointed your phone camera at colleague A whilst on FaceTime and said things in Spanish about colleague A. **[Proved]**

28) On an unknown date said to Colleague B that “their bum and legs looked nice in leggings” or words to that effect. **[Proved]**

29) On an unknown date, pulled Colleague A’s face mask down and said “Eww you’re not barbie anymore” or words to that effect. **[Proved]**

30) On an unknown date swore in front of Resident G. **[Proved]**

31) Your actions at one or more of charges 26,28,29 harassed Colleague A and/or B in that:

a) your conduct was unwanted conduct of a sexual nature and/or related to a protected characteristic, namely sex. **[Proved]**
b) your conduct had the purpose or effect of:
i) violating Colleague A and or B’s dignity. **[Proved]**
ii) creating an intimidating, hostile, degrading, humiliating or offensive environment for Colleague A and or B. **[Proved]**

32) Your actions at charges 21 and/or 22 lacked integrity in that you intended to influence Colleague B such that she would not report your pre-potting as set out at charge 13 and/or any other poor practice she witnessed you undertaking. **[Proved]**

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

Schedule 1
16 January 2021
28 January 2021

Schedule 2

13 November 2021

January – March 2022

28 April 2022

Schedule 3

13 November 2021

16 April 2022

**Decision and reasons on application to admit the documentary evidence of Ms 6 and Ms 7 into evidence as hearsay**

Ms Thornton made an application for the documentary evidence of Ms 6 and Ms 7 to be admitted into evidence as hearsay pursuant to Rule 31 of the Rules. She referred the panel to the case of *Thorneycroft v Nursing and Midwifery Council [2014]* EWHC 1565 (Admin) and to the NMC Guidance on *'Evidence',* in particular *'Hearsay'* (Reference: DMA-6 Last Updated 01/07/2022).

In respect of Ms 6, Ms Thornton drew the panel's attention to a handwritten local statement dated 20 February 2021. She submitted that this local statement was made by Ms 6 following the incident involving Resident H. Ms Thornton informed the panel that efforts were made by the NMC to secure Ms 6 as a live witness, however, Ms 6 had left her employment without providing any contact details or a forwarding address.

In respect of Ms 7, Ms Thornton referred the panel to an email that was sent by Ms 7 to Ms 1 on 22 February 2021. She submitted that the evidence of Ms 7 is in relation to the incident involving Resident H and the handover that took place immediately prior to the nightshift on 19 February 2021. Ms Thornton submitted that the NMC did not take a formal statement from Ms 7 as Ms 4 and Ms 5 had provided witness statements and agreed to provide oral evidence in relation to this incident. She submitted that the NMC had decided that it would be disproportionate to obtain a witness statement and call Ms 7 as a further witness.

Ms Thornton submitted that the evidence of Ms 6 and Ms 7 is relevant to the charges and that it would be fair to admit it into evidence as hearsay. She submitted that Mr Romay had been provided with a copy of the exhibit bundle which contained the statements of Ms 6 and Ms 7 and he therefore had an opportunity to respond. Ms Thornton submitted that if the panel are minded to admit the evidence as hearsay, what weight to attach to the evidence is a matter for the panel.

The panel heard and accepted the legal assessor's advice on the issues it should take into consideration in respect of this application. This included that Rule 31 provides that,

so far as it is ‘fair and relevant’, a panel may accept evidence in a range of forms and circumstances, whether or not it is admissible in civil proceedings.

In respect of the evidence of Ms 6, the panel was of the view that this statement was relevant to charge 4 and it provides her perspective of what happened on the night in question. It noted that this evidence was not the sole or decisive evidence and that it supports the evidence of Ms 4 and Ms 5, both of whom had provided a witness statement to the NMC and attended to give oral evidence. In considering fairness to Mr Romay, whilst Ms 6 did not attend to give oral evidence, he had absented himself and would have been anyway unable to cross examine her. Further, the panel noted that Mr Romay had been sent a copy of Ms 6’s evidence and had had the opportunity to respond to it. Given the relevance of this evidence and that the NMC had made efforts to secure the attendance of Ms 6 and there was good reason for her non-attendance, the panel was of the view that it would be fair to the NMC to allow the documentary evidence into evidence as hearsay.

In respect of Ms 7, the panel considered that her evidence was relevant to charge 4 and provided some contextual information about Resident H. Mr Romay was aware that a fall that had occurred the day before that might have increased the risk that the discolouration in the vomit could have been blood. Having heard evidence from Ms 1, Ms 4 and Ms 5, the panel determined that the evidence of Ms 7 was not the sole or decisive evidence for charge 4. The panel accepted that the NMC had decided that in view of the other evidence, it considered that it would be disproportionate to call another witness. In considering fairness to Mr Romay, whilst Ms 6 did not attend to give oral evidence, he had absented himself and would have been anyway unable to cross examine her. Further, the panel noted that Mr Romay had been sent a copy of Ms 7’s evidence and had had the opportunity to respond to it. Given the relevance of this evidence, the panel was of the view that it would be fair to allow the documentary evidence into evidence as hearsay.

Having decided to admit the documentary evidence of Ms 6 and Ms 7 into evidence as hearsay, the panel will attach what weight it deems to be appropriate when assessing all of the evidence at a later stage.

**Decision and reasons on application to admit the evidence of Colleague D into evidence as hearsay**

Ms Thornton made an application for the witness statement of Colleague D to be admitted into evidence as hearsay pursuant to Rule 31 of the Rules. She referred the panel to the case of *Thorneycroft* and to the NMC Guidance on *'Evidence',* in particular *'Hearsay'* (Reference: DMA-6 Last Updated 01/07/2022).

Ms Thornton informed the panel that Colleague D was expected to give live evidence at this hearing. However, after the hearing had started Colleague D advised that she was unable to give evidence due to personal circumstances and that she gave permission for her witness statement to be used in her absence. Ms Thornton drew the panel's attention to an email that Colleague D sent to the hearings coordinator on 23 January 2024. She submitted that the NMC had made attempts to contact Colleague D by telephone and email but no response had been received.

Ms Thorton submitted that the evidence of Colleague D is relevant to charges 16 and 23. She submitted that Colleague D's evidence is the sole and decisive evidence in relation to charge 16 but that it was not the sole or decisive evidence in respect of charge 23. Ms Thornton submitted that it would be fair to admit the evidence of Colleague D and just because it is the sole and decisive evidence in respect of charge 16, this does not preclude the panel from admitting it into evidence as hearsay.

The panel accepted the evidence of the legal assessor who referred them to the case of *El Karout v NMC [2019] EWHC 28 (Admin).*

The panel found that the evidence of Colleague D was relevant to both charges 16 and 23. The panel accepted that the NMC had made reasonable efforts to secure the attendance of Colleague D, however it had been unsuccessful in doing so.

In respect of charge 23, the panel determined that the evidence of Colleague D was not the sole or decisive evidence. The panel noted that Mr Romay had been sent the

evidence of Colleague D and has had the opportunity to respond to it. Whilst the absence of Colleague D means that the panel will not have the opportunity to cross examine her, Mr Romay's non-attendance at the hearing means that he would not have been able to cross examine her in any event. The panel decided that it would be fair to admit the evidence of Colleague D that relates to charge 23 and determine what weight to be attached to it at a later stage of the hearing.

In respect of charge 16, the panel decided that, as it is the sole and decisive evidence, it would be fundamentally unfair to admit the evidence of Colleague D. Whilst Mr Romay has been sent the evidence of Colleague D and waived his right to attend and to cross examine her, the panel would not be able to question her. Given that the evidence of Colleague D is the sole and decisive evidence in respect of charge 16, and that this is a serious charge, the panel decided to not allow her evidence in as hearsay.

**Decision and reasons on application of no case to answer in respect of charge 16**

After the NMC had closed its case, and given its decision to not admit the evidence of Colleague D in respect of charge 16, the panel invited submissions about whether there is a case to answer in respect of charge 16 pursuant to Rule 24(7) of the Rules.

Ms Thornton accepted that the evidence of Colleague D was the only evidence to support this charge.

The panel accepted the advice of the legal assessor.

In reaching its decision, the panel has made an initial assessment of all the evidence that had been presented to it at this stage. The panel was solely considering whether sufficient evidence had been presented, such that it could find the facts proved and whether there was a case to answer in respect of charge 16.

Given that Colleague D was the only witness to the alleged facts of charge 16, and that It was decided that this evidence would not be admitted as hearsay, there is no case to answer as there was no evidence to support the charge.

## Background

The charges arose whilst Mr Romay was employed as nurse at Stewton House Nursing Home (the Home). A nurse's responsibilities include assessment, planning, implementing and evaluating the care of residents, providing advice and education to carers, caring for patients including medications, dressings and general nursing care. The Home is a 48 bedded residential and nursing home providing care to elderly residents, some of whom have complex needs including end of life care and Parkinsons disease.

## 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 Thornton on behalf of the NMC and the bundle of documents provided by Mr Romay.

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

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

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

- Colleague A: Senior carer at Stewton House Nursing Home.
- Colleague B: Student nursing associate at Stewton House Nursing Home.

- Colleague C: Staff nurse at Stewton House Nursing Home.
- Ms 1: Home manager at Stewton House Nursing Home.
- Ms 2: Nursing associate at Stewton House Nursing Home.
- Ms 3: Clinical lead at Stewton House Nursing Home.
- Ms 4: Care assistant at Stewton House Nursing Home.
- Ms 5: Care assistant at Stewton House Nursing Home.

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

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

**Charge 1**

1) On 16 January 2021, in relation to Resident I who was isolating, did not wear PPE whilst in Resident I's room.

**This charge is found proved.**

In reaching this decision, the panel had particular regard to the oral and documentary evidence of Ms 1 and Ms 2.

The panel had sight of Ms 2's witness statement in which she stated the following:

> *'PPE was hung up outside of Resident I's room. I was wearing full PPE before entering her room. I offered Mr Romay PPE outside the room, by picking up an apron and passing it to him. Mr Romay rolled his eyes and shook his head at me, did not take the apron from me or put on any PPE. He then proceeded to enter Resident I's room with no PPE on. He did not give me any reason for refusing to wear PPE.'*

In her oral evidence, Ms 2 told the panel that on 16 January 2021 she witnessed Mr Romay not wearing PPE in Resident I's room.

The panel also had sight of a local statement from Ms 1 dated 20 January 2021 in which she stated that Ms 2 had told her that Mr Romay had not worn PPE when going into the room of a resident who was isolating.

The panel found the evidence of Ms 1 and Ms 2 to be consistent, credible and reliable in respect of this charge. The panel therefore found that it was more likely than not that Mr Romay did go into Resident I's room without wearing PPE. Accordingly, this charge is found proved.

**Charge 2**

2) On 28 January 2021, in relation to Resident E, administered an incorrect dose of 500 micrograms of Ropinirole instead of 1 milligram.

**This charge is found proved.**

In reaching this decision, the panel had particular regard to the oral and documentary evidence of Ms 3.

The panel had sight of Ms 3's witness statement in which she stated the following:

> *'On 28 January 2021, I was doing a medication round with Mr Romay. I was observing Mr Romay administering medication to residents and ticking off certain criteria to determine whether he was competent or not. As clinical lead, part of my role was to tick off nurses as competent to administer medication in the Home…*
> *During this medication round, Mr Romay had to administer ropinirole to ("Resident E"). Mr Romay said to me that he found the instructions for ropinirole confusing, as the MAR chart (new dosage) said a different dose to the label (old dosage). Mr Romay told me that he had given a dose of 500 micrograms of ropinirole the previous night. It was unclear how many nights he had given Resident E that dosage and it was not recorded on the MAR chart…*
>
> *On investigation, I found that Resident E's dosage had been increased to 1 milligram on 23 December 2020 by the doctor. This was noted in the nursing records for Resident E, which is where I found the information that the dosage of ropinirole had been increased. I exhibit Resident E's professional visit sheet, nursing records and the updated MAR sheet. I showed Mr Romay this and also pointed out that if he had looked in the medication room at the most recent box of ropinirole, he would have found the correct current dosage to be given, as the new dose was on the label of the new box of medication.'*

The panel noted that this evidence was consistent with the written account of Ms 3 in the signed Medication Competence Assessment that she completed in regard to Mr Romay on 28 January 2021. The panel had sight of the Nursing Records and MAR charts for Resident E. The panel noted there was an entry dated 23 December 2020 which stated that *'Dose of ropinirole increased by GP'*. The panel also noted that in Resident E's new MAR chart 1mg had been prescribed on 23 December 2020.

In her oral evidence, Ms 3 told the panel that on 28 January 2021 Mr Romay incorrectly administered 500 micrograms to Resident E instead of 1mg as prescribed.

The panel found the evidence of Ms 3 to be clear, consistent, credible and reliable. It was of the view that it was more likely than not that on 28 January 2021, in relation to Resident E, Mr Romay administered an incorrect dose of 500 micrograms of Ropinirole instead of 1 milligram. The panel therefore found this charge proved.

**Charge 3**

3) Administered medication via the Percutaneous Endoscopic Gastrostomy method without doing water flushes on one or more of the dates in Schedule 1.

Schedule 1
16 January 2021
28 January 2021

**This charge is found proved (in relation to 28 January 2021)**

The panel had sight of the Nutrition and dietetics department guidelines and noted the following under 'General Instruction':

> *'Always flush the tube with 50ml of water at the beginning and end of each feed/dose of each medication to prevent tube blocking.'*

16 January 2021

The panel had regard to all of the evidence before it. It found no oral or documentary evidence that on 16 January 2021 Mr Romay administered medication via the PEG without flushing the tube with water.

28 January 2021

In reaching this decision, the panel had particular regard to the evidence of Ms 3.

The panel had sight of Ms 3's witness statement in which she stated the following:

> *'On 28 January 2021, I was doing a medication round with Mr Romay…*
>
> *During this medication round, I witnessed Mr Romay administering medication via the PEG method (percutaneous endoscopic gastrostomy) without doing water flushes. A water flush is when the tube is flushed before and after each time medication is administered to prevent clogging of the tube.'*

The panel also had sight of the Medication Competence Assessment completed by Ms 3 on 28 January 2021. The panel noted that in the handwritten notes, Ms 3 recorded that Mr Romay gave medication via the PEG without doing a water flush before or after.

In her oral evidence, Ms 3 told the panel that she witnessed Mr Romay administer medication via the PEG without flushing the tube with water before or after. The panel found the evidence of Ms 3 to be consistent, credible and reliable. Accordingly, the panel found this charge proved in respect of 28 January 2021.

**Charge 4**

4) On 19/20 February 2021, failed to recognise that Resident H was showing signs of haematemesis and/or a deterioration in their health in that you did not escalate the matter to emergency services, when it would have been clinically appropriate to do so in the light of the colour of Resident H's vomit.

**This charge is found proved.**

In reaching this decision, the panel had particular regard to the oral and documentary evidence of Ms 1, Ms 4 and Ms 5. It also had regard to the hearsay evidence of Ms 6 and Ms 7.

The panel had sight of Ms 5's witness statement and her local statement dated 20 February 2021. In her local statement Ms 5 stated the following:

*'Resident H was laying in bed I noticed there was a sick bowl on the table next to her bed. I look[sic] inside the sick bowl what appeared to be vomit and I also noticed it was black in colour also had a red areas[sic] in the sick bowl. Myself and [] stated to each other that it didn't look normal… we took the sick bowl to the nurse on duty [Mr Romay] and stated our concerns to him. [Mr Romay] stated that it is normal for her and that it was something she ate or drank throughout the day.'*

The panel had sight of Ms 4's witness statement in which she stated the following:

*'[Ms 5] told me that she was worried that a service user had vomited a few times and suspected that it contained blood. She informed me that she had spoken to Fernando but he was not overly concerned at the time. I encouraged [Ms 5] to also conduct further observations and safety checks if she was worried. I personally checked the service user but in my opinion, she was settled and asleep. If she was awake and in pain, then maybe we could have done more to confirm how she was feeling. I was not convinced that she needed urgent medical assistance, otherwise I would have escalated it. When I spoke to Fernando did not think the matter was serious and was not worried about the service user.'*

The panel had sight of the notes from the Investigatory hearing attended by Ms 1, Ms 3 and Mr Romay dated 22 February 2021 in which the following was stated:

*'He told me that he had been handed over that she had a fall the previous night and that she had sustained no injury. He said that [Ms 6] had told him she had vomited, he told us that he had seen the vomit and that he considered it to be normal vomit, consistent with drinking coffee. He told me that she vomited twice but was well in herself. I asked him if he had considered there was blood in the commit, he said he did not feel there was.'*

The panel was concerned with Mr Romay's explanation for the discolouration in the vomit being due to coffee as it heard oral evidence from Ms 4 and Ms 5 to the effect that Resident H did not drink coffee.

The panel noted the following in Ms 1's witness statement:

> *'The next day, I was shown a photograph by a carer who had worked the shift with Mr Romay of the vomit. I exhibit the photograph… It was obvious to me, as a registered nurse that there was blood in it. I was concerned that Mr Romay failed to notice or acknowledge this. Mr Romay should have noticed the blood and taken the appropriate action, which would be to call a doctor. I went to speak with Mr Romay about this immediately, but he refused to acknowledge that there was any blood in the vomit.'*

The panel found the evidence of Ms 1, Ms 4 and Ms 5 to be consistent, credible and reliable. It also found that the hearsay evidence of Ms 6 and Ms 7 was consistent with this evidence and therefore accepted it. The panel was satisfied that on 19/20 February 2021, Mr Romay, as a registered nurse, had a duty to and failed to recognise that Resident H was showing signs of haematemesis. The panel was also satisfied that Mr Romay having seen Resident H's vomit with blood in had a duty to escalate the matter to emergency services and he did not. The panel therefore found this charge proved.

**Charge 5**

5) Failed to record any entries and/or observations on Resident H's notes during your shift having been informed that Resident H was showing signs of haematemesis and/or a deterioration in their health.

**This charge is found not proved.**

In reaching this decision, the panel took into account all of the evidence before it. The panel noted that Mr Romay did not carry out any observations of Resident H and the vomit was brought to him. As Mr Romay had not identified signs of haematemesis or a

deterioration of health, the panel was of the view that he was not under a duty to record something he had not observed or undertaken. Accordingly, the panel found this charge not proved.

**Charge 6**

6) On 6 October 2021, in relation to Resident A, failed to use the aseptic technique when catheterising Resident A.

**This charge is found proved.**

In reaching this decision, the panel had particular regard to the oral and documentary evidence of Colleague B and Colleague C.

The panel had sight of Colleague C's witness statement in which she stated the following:

> *'On 6 October 2021. When I observed Mr Romay catheterise Resident A, he did not wash his hands or use any aseptic technique when preparing the catheter to be inserted, which was a concern to me as inserting a catheter is inserting a foreign body into a resident's body, therefore you must ensure that it is as sterile and clean as possible. If it is not sterile, there is a risk of infection, which can be very serious, especially for patients with low immunities, such as this gentleman. I was aware of the correct process due to catheterisation training I received whilst working for the NHS.''*

The panel also had sight of an incident form dated 6 October 2021 that was completed by Colleague C. The panel noted the following:

> *'He then stated[sic] to prepare for catheterising. His levels of aseptic technique were non existent.'*

The panel had regard to Mr Romay's response email dated 29 November 2021 in which he stated the following:

> *'When I proceed to perform urethral catheterization maneuvers[sic], I always follow the procedures correctly to minimize possible risks of infection.'*

The panel heard oral evidence from Colleague C. It found her evidence to be consistent, credible and reliable. It was satisfied that Mr Romay had a duty to ensure that he used an aseptic technique to reduce the risk of infection when he inserted a catheter into Resident A. The panel found that it was more likely than not that Mr Romay failed to use an aseptic technique when catheterising Resident A. The panel therefore found this charge proved.

**Charge 7**

7) On 10 October 2021, following delivery of new medications, signed recording that the MAR charts for unknown patients were correct when they were not.

**This charge is found proved.**

In reaching this decision, the panel had particular regard to the evidence of Ms 3.

It had sight of Ms 3's witness statement in which she stated the following:

> *'On 10 October 2021, the Home received a delivery of new medications. When medications come in, the nurse on duty begins checking and amending the MAR sheets to reflect any changes to medication following the delivery. The MAR sheets show what medication each resident has and the dosage that is to be given. If this is not finished by the time your shift ends, you are required to record how far you got, then the next nurse on duty will continue where you stopped.*

*Therefore, the nurse only signs to say all MAR sheets are correct if they have checked all medications.*

*Mr Romay had signed to say that the MAR sheets were all correct, following the delivery of new medications. I then checked and found several mistakes, as some medications had been discontinued, which was not reflected on the MAR sheets. Room 2 had had bisoprolol and omeprazole discontinued, but these were still on the MAR sheets. Moreover, some medications had not been written up on to the MAR sheets at all. Room 2 had been prescribed pantoprazole, but this had not been written up on the MAR sheets at the time that Mr Romay signed to say that all the MAR sheets were correct.'*

The panel had regard to the oral evidence of Ms 3 *w*ho was clinical lead at the relevant time. She stated that the MAR sheets need to reflect the medication administration correctly and that nurses were required to write up new medications and cross out any medications no longer being administered.

The panel found the evidence of Ms 3 to be consistent, credible and reliable. It found that it was more likely than not that on 10 October 2021, following delivery of new medications, Mr Romay signed recording that the MAR charts for unknown patients were correct when they were not. Accordingly, the panel found this charge proved.

**Charge 8**

8) On 13 November 2021, did not let Resident B know that you were going to remove their pyjama top and/or proceeded to aggressively remove their pyjama top.

**This charge is found proved.**

In reaching this decision, the panel had particular regard to the evidence of Colleague C.

The panel had sight of Colleague C's witness statement in which she stated the following:

> *'Mr Romay went to remove Resident B's pyjama top off, by holding onto the sleeve and pulling it, which caused Resident B to scream in pain. Mr Romay did not explain to Resident B what he was going to be doing.'*

Colleague C, in her oral evidence, had a good recollection of this incident and remembered Mr Romay did not let Resident B know that he was going to remove their pyjama top.

The panel had sight of an email from Mr Romay dated 25 November 2021 in which he denies this allegation, nonetheless, the panel accepted the oral evidence of Colleague C which the panel found this evidence of Colleague C to be consistent, credible and reliable in respect of this charge. However, the panel determined that Colleague C gave no evidence demonstrating that Mr Romay proceeded to aggressively remove Resident B's pyjama top.

The panel found that there was sufficient evidence to support that he did not inform Resident B that he would be removing their top but did not find sufficient evidence to support the element of the charge that he removed this aggressively. The panel therefore found this charge proved in respect of the first part.

**Charge 9**

9) On 13 November 2021, ripped an Allevyn dressing off Resident B's arm.

**This charge is found proved.**

In reaching this decision, the panel had particular regard to the evidence of Colleague C.

The panel noted the following in Colleague C's witness statement under the section relating to 13 November 2021:

> *'Mr Romay then leaned across Resident B's body and ripped the dressing from his arm, which stretched from his shoulder to his elbow. This caused Resident B to scream out in pain. I put my hand on the dressing, told Mr Romay to stop and said 'I will do this, you will not do this.' I slowly removed the rest of the dressing, which revealed a nasty skin tear which had already gone red where Mr Romay had torn the dressing off.'*

The panel also heard oral evidence from Colleague C. The panel found her evidence to be consistent, credible and reliable in respect of this charge. The panel was satisfied that on the balance of probabilities, on 13 November 2021, Mr Romay ripped an Allevyn dressing off Resident B's arm. Accordingly, the panel found this charge proved.

**Charge 10**

10) On 13 November 2021, in relation to Resident B, washed a moist wound with saline.

**This charge is found proved.**

In reaching this decision, the panel had particular regard to the evidence of Colleague C.

The panel noted the following in Colleague C's witness statement under the section relating to 13 November 2021:

> *'Mr Romay proceeded to wash Resident B's wounds with saline. This was of concern to me, as moist wounds are not supposed to be made wet and you should keep them as dry as possible… I asked Mr Romay not to apply saline to Resident B's wounds, but he continued to do so and then eventually left the room.'*

The panel also heard oral evidence from Colleague C. The panel found her evidence to be consistent, credible and reliable in respect of this charge. The panel found that it was more likely than not that on 13 November 2021, Mr Romay washed Resident B's moist wound with saline. Accordingly, the panel found this charge proved.

**Charge 11)a)**

11) On 13 November 2021:

a) said "Fuck" in front of a resident or words to that effect;

**This charge is found proved.**

In reaching this decision, the panel had particular regard to the evidence of Colleague C.

The panel noted the following in Colleague C's witness statement under the section relating to 13 November 2021:

> *'While pressing the buttons on the pump, Mr Romay got frustrated and said "fuck". It is rude and unprofessional to swear in front of residents and should have known that we are not supposed to, so this was also of concern to me.'*

The panel noted that Mr Romay denies this charge in his written responses. However, it accepted the evidence of Colleague C, it found her evidence to be consistent, credible and reliable. The panel accepted the evidence of Colleague C and was satisfied that it was more likely than not that on 13 November 2021, Mr Romay said "fuck", or words to that effect, in front of a resident. The panel therefore found this charge proved.

**Charge 11)b)**

11) On 13 November 2021:

b) said “How dare you stop me from doing my job nobody has ever questioned my practice” or words to that effect to Colleague C.

**This charge is found proved.**

In reaching this decision, the panel had particular regard to the evidence of Colleague C.

The panel noted the following in Colleague C’s witness statement under the section relating to 13 November 2021:

> *‘Mr Romay then began to shout at me, saying “how dare you stop me from doing my job; nobody has ever questioned by[sic] practice”.’*

The panel noted that Mr Romay denied this charge in his written responses. However, it accepted the evidence of Colleague C, who said that Mr Romay aggressively shouted at her. It found her evidence to be consistent, credible and reliable. The panel accepted the evidence of Colleague C and was satisfied that it was more likely than not that on 13 November 2021, Mr Romay said *“How dare you stop me from doing my job nobody has ever questioned my practice”* or words to that effect to Colleague C. The panel therefore found this charge proved.

**Charge 12**

12) Failed to obtain patient consent on one or more of the dates in Schedule 2.

Schedule 2
13 November 2021
January – March 2022
28 April 2022

**This charge is found proved.**

13 November 2021

The panel had regard to its earlier findings at charge 8. It had regard to the evidence of Colleague C and considered that a nurse who was going to remove clothing from a resident must inform and gain consent from the resident before doing so. Having found that Mr Romay removed Resident B's pyjama top without telling them he was going to, he failed to obtain consent.

January – March 2022

The panel had regard to all of the evidence before it and noted that these dates relate to charge 16 in respect of which the panel had found there was no case to answer. It therefore found that there was no evidence that Mr Romay failed to obtain consent during between January-March 2022.

28 April 2022

The panel had regard to the evidence of Colleague A. In her witness statement she stated the following:

> *'On 28 April 2022, I was working a day shift in my usual role as a carer. Mr Romay asked me to assist him in taking bloods from Resident C…*
>
> *…Mr Romay told Resident C "I need to take your bloods", as opposed to politely asking her for consent to do so.'*

The panel also heard oral evidence from Colleague A and Ms 2. Ms 2's evidence was that Resident C had concerns about how the procedure had been carried out, but gave no indication that she had not consented to having her bloods taken. The panel had no evidence before it about what would have constituted consent in these circumstances, it noted that there was no evidence that Resident C withheld her consent for bloods to be taken after Mr Romay informed her that he would be taking them. The panel could

therefore not be satisfied that Mr Romay did not obtain consent in respect of Resident C.

Having regard to all of the above, the panel found this charge proved on the balance of probabilities in respect of one of the dates set out in schedule 2, namely 13 November 2021. It however did not find this charge proved in respect of two of the dates set out in schedule 2, namely January – March 2022 and 28 April 2022.

**Charge 13**

13)Stored resident medication in pots before the medication was due to be administered on one or more of the dates in Schedule 3.

Schedule 3
13 November 2021
16 April 2022

**This charge is found proved.**

The panel had sight of the Home's 'Administration of medicines' policy, in particular the following:

> *'4.2.3. Procedure for Medicine Administration*
>
> *Medication should never be removed from the original container in which a pharmacist or dispensing doctor supplied it until the time of administration. The best way of administering medicines to a Service User is directly from the dispensed container; medication can be placed in a small pot after removing it from the dispensed container as a way of hygienically handing it to the Service User. Medication should never be secondary dispensed for someone else to administer to the Service User at a later time or date.'*

13 November 2021

In respect of this date, the panel had regard to the evidence of Colleague C. The panel had sight of her witness statement in which she stated the following under the section relating to 13 November 2021:

> *'Later on during the same shift, I was working downstairs and needed some assistance from another nurse, so I went upstairs to find Mr Romay to assist me. I went into the treatment room where medications were kept, and he was lining up medications in pots for all of the different residents…*
>
> *…I was told by Mr Romay that it was normal practice for him to get all medications out in one go and line them up in pots all at once.'*

16 April 2022

In respect of this date, the panel had regard to the evidence of Colleague B. The panel had sight of her witness statement in which she stated the following under the section titled 16 April 2022:

> *'We went into the medication room and he said 'you know the monkies, hear no evil, see no evil, speak no evil?' He then pointed to lots of medication pots that were on top of the medication trolley; he had potted the medication hours before they were needed and left them there.'*

The panel also had sight of Colleague B's local statement and heard oral evidence from her.

The panel noted that in his written responses, Mr Romay denies this charge, however, the panel accepted the evidence of Colleague B and Colleague C. The panel found the evidence of Colleague B and Colleague C to be consistent, credible and reliable. It was satisfied on that balance of probabilities that Mr Romay stored resident medication in pots before the medication was due to be administered on one or more of the dates in Schedule 3. The panel therefore found this charge proved in its entirety.

**Charge 14**

14) On 17 December 2021, failed to sign Resident F's MAR chart to show that 2 doses of Vitamin K had been administered.

**This charge is found proved.**

In reaching this decision, the panel had particular regard to the evidence of Ms 3.

The panel had sight of Ms 3's witness statement in which she stated the following under the section titled 17 December 2021:

> *'Resident F was prescribed vitamin K, to be taken sublingually, which means under the tongue…*
>
> *'I came on duty on the morning of 17 December 2021, which was when Mr Romay told me during handover that he had given two doses of vitamin K to Resident F during his shift. These had only been recorded in the nursing notes and no MAR chart had been written up still. The MAR chart is where you would look to see what medication had been given, therefore Mr Romay should have completed a MAR chart if he administered the medication and found that there was not already a MAR chart. I then reported this to the Home Manager.'*

The panel had sight of Resident F's MAR chart on the date in question and noted that Mr Romay had not recorded that he had administered two doses of vitamin K.

The panel heard oral evidence from Ms 3. The panel was satisfied that Mr Romay had a duty to record what doses of vitamin K he had administered to Resident F and he did not. The panel therefore found this charge proved on the balance of probabilities.

**Charge 15**

15) In or around January 2022, in relation to Resident J, pressured Colleague B whilst they were dispensing Midazolam in that you said to Colleague B “Come on Colleague B, faster, you can do this, hurry up” or words to that effect.

**This charge is found proved.**

In reaching this decision, the panel had particular regard to the evidence of Colleague B.

> *‘In or around January 2022, on a date I do not recall, I was working under Mr Romay’s supervision. Mr Romay was trying to rush me whilst dispensing medication. A resident at the Home (Resident J) was prescribed midazolam, to be taken via a syringe driver…*
>
> *Using a syringe driver was new to me and it is a complicated process to calculate the correct dosage to put in. The process involves measuring the medication dosage into a vial then working out how many millilitres of water you need to add to ensure that the volume of medication is correct. You then need to write down a record of the medication dispensed, with the correct batch number and expiry date. The medication is then put into a syringe, which is inserted into the soft tissue just under the skin, which drip feeds the resident’s the medication over a 24 hour period. Due to how complicated the measurement process is, I was ensuring that I was calculating everything thoroughly and did not want to rush the process.*
>
> *I was in the medication room with Mr Romay for approximately five minutes dispensing the medication. Mr Romay said ‘come on [Colleague B], faster, you can do this, hurry up’, pressuring me to work faster.’*

The panel also heard oral evidence from Colleague B. The panel found her evidence to be consistent, credible and reliable in respect of this charge. The panel was of the view

that it was more likely than not that In or around January 2022, in relation to Resident J, Mr Romay pressured Colleague B whilst they were dispensing Midazolam in that you said to Colleague B “Come on Colleague B, faster, you can do this, hurry up” or words to that effect. The panel therefore found this charge proved.

**Charge 17**

17) On 8 April 2022, in relation to Resident L, instructed Colleague B to scrub Resident L’s foot when scrubbing was an inappropriate technique by which to clean Resident L’s foot in the light of their presenting condition and pain.

**This charge is found not proved.**

In reaching this decision, the panel had particular regard to the evidence of Colleague B.

The panel had sight of Colleague B’s witness statement in which she stated the following under the section titled 8 April 2022:

> *‘I removed the bandages from Resident L’s foot and then went to ask Mr Romay, who was supervising me as the nurse on duty, which dressing to use going forward, [Colleague A] and I went into Resident L’s room and Mr Romay tried to tell me how to cleanse the wound. He was saying ‘scrub it, scrub it,’ I did not want to scrub the wound, as Resident L was clearly in pain and I did not want to cause her any further discomfort.’*

Whilst the panel accepted Colleague B’s evidence that Mr Romay instructed her to scrub the wound, it had no evidence about what the appropriate technique would have been in these particular circumstances. The panel therefore found this charge not proved.

**Charge 18**

18) On 8 April 2022, said “How dare you fucking do this without me” or words to that effect to Colleague B.

**This charge is found proved.**

In reaching this decision, the panel had particular regard to the evidence of Colleague B.

The panel had sight of Colleague B’s witness statement in which she stated the following under the section titled 8 April 2022:

> *‘Mr Romay started shouting at me for taking the dressing off originally without him being there. He shouted ‘how dare you fucking do this without me’.’*

The panel also heard oral evidence from Colleague B.

The panel had regard to the documentary evidence provided by Mr Romay in which he stated:

> *‘I called her attention for removing the bandages from a patient’s foot and taking the photographs without my presence and it is true that I called her to order.’*

The panel also had regard to Mr Romay’s response contained within the investigatory hearing notes dated 3 May 2022 in which the following is recorded:

> *‘[Mr Romay] said he was very angry about his[sic] as it was his shift and they had no business taking dressings down without his consent. He said that he had spoken to them very firmly about this.’*

During the investigatory hearing, Ms 1 responded to this by stating the following:

*‘he had no business using the language he did toward[sic] them. He should have explained to them why this was not acceptable in a calm way and he should have reported it…’*

The panel found the evidence of Colleague B to be consistent, credible and reliable in respect of this charge. The panel found that it was more likely than not that on 8 April 2022, Mr Romay said *“How dare you fucking do this without me”* or words to that effect to Colleague B. Accordingly, the panel found this charge proved.

**Charge 19**

19) On 8 April 2022, said “Fuck Colleague F she isn’t here I am and I’m in charge” or words to that effect to Colleague B.

**This charge is found proved.**

In reaching this decision, the panel had particular regard to the evidence of Colleague B.

The panel had sight of Colleague B’s local statement dated 8 April 2022 in which she stated the following:

*‘[Mr Romay] lost his temper with me and said he was now in charge and I don’t have to follow anyone else instruction as he is in charge. He said [Colleague F] can “fuck off as i’m in charge”.’*

As set out in charge 18, the panel also had regard to Mr Romay’s written responses and his and Ms 1’s documented responses during the investigatory hearing dated 3 May 2022.

The panel also heard oral evidence from Colleague B. The panel found the evidence of Colleague B to be consistent, credible and reliable in respect of this charge. The panel found that it was more likely than not that on 8 April 2022, Mr Romay said “Fuck

Colleague F she isn't here I am and I'm in charge" or words to that effect to Colleague B. The panel therefore found this charge proved.

**Charge 20**

20) On 8 April 2022, in relation to Resident K, instructed Colleague B to administer 5 ml of lactulose when the correct dose was 15ml of lactulose.

**This charge is found proved.**

In reaching this decision, the panel had particular regard to the evidence of Colleague B.

The panel had sight of Colleague B's witness statement in which she stated the following in the section titled 8 April 2022:

> *'The MAR chart said that Resident K was to have 15ml of lactulose.*
>
> *Mr Romay told me to only give Resident K 5ml of lactulose, as she was only "tiny" … I understood what Mr Romay had said, however the MAR chart was very clear and I did not want to go against it. I questioned him and showed him the MAR chart, which he refused to check.'*

The panel also had sight of Colleague B's local statement and heard oral evidence from her. The panel found her evidence to be consistent, credible and reliable in respect of this charge. It was satisfied that it was more likely than not that on 8 April 2022, in relation to Resident K, Mr Romay instructed Colleague B to administer 5 ml of lactulose when the correct dose was 15ml of lactulose. The panel therefore found this charge proved.

**Charge 21**

21) On 16 April 2022, said “If you say anything, I will fuck your life up, anyone who speaks against me I will fuck their lives up too!” or words to that effect to Colleague B.

**This charge is found proved.**

In reaching this decision, the panel had regard to the evidence of Colleague B. The panel had sight of Colleague B’s witness statement in which she stated the following under the section titled 16 April 2022:

> *‘Mr Romay gestured to the pots and said ‘if you say anything, I will fuck your life up. Anyone who speaks against me I will fuck up their lives too!’.*

The panel also had sight of Colleague B’s local statement and heard oral evidence from her. The panel found her evidence to be consistent, credible and reliable in respect of this charge. It was satisfied that it was more likely than not that on 16 April 2022, Mr Romay said *“If you say anything, I will fuck your life up, anyone who speaks against me I will fuck their lives up too!”* or words to that effect to Colleague B. The panel therefore found this charge proved.

**Charge 22**

22) On 16 April 2022, said “You know the monkies, hear no evil, see no evil, speak no evil” and/or “you see nothing, you say nothing” or words to that effect to Colleague B.

**This charge is found proved.**

In reaching this decision, the panel had particular regard to the evidence of Colleague B. The panel had sight of her witness statement in which she stated the following under the section titled 16 April 2022:

*‘We went into the medication room and he said ‘you know the monkies, hear no evil, see no evil, speak no evil?’ He then pointed to lots of medication pots that were on top of the medication trolley; he had potted the medication hours before they were needed and left them there.’*

The panel also had sight of Colleague B’s local statement and heard oral evidence from her.

The panel noted that in his written responses, Mr Romay denies this charge. However, the panel found the evidence of Colleague B to be consistent, credible and reliable. It was satisfied on that balance of probabilities that on 16 April 2022, Mr Romay said *“You know the monkies, hear no evil, see no evil, speak no evil”* and/or *“you see nothing, you say nothing”* or words to that effect to Colleague B. The panel therefore found this charge proved.

**Charge 23**

23) On 20 April 2022, said “Who the fucking hell do you think you’re talking to” or words to that effect to Colleague D in front of Resident A.

**This charge is found proved.**

In reaching this decision, the panel had particular regard to the evidence of Colleague D.

Having accepted Colleague D’s evidence as hearsay, it had to determine what weight to attach to it. In doing so it had regard to all of the evidence before it, it noted that in respect of this incident, Mr Romay’s responses at the investigatory hearing on 3 May 2022. The panel had particular regard to the following:

*‘[] asked FA about swearing in front of service user. FA said he didn’t do this, [Ms 1] reminded him of an incident at front desk where a staff member challenged him. FA accepted he did swear but that he is great friends with that resident and*

*he doesn't mind. [Ms 1] stated that was not the context of the swearing, FA had sworn at the staff member and asked her who the 'f***' did she think she was talking to' FA accepted this and shrugged his shoulders.'*

The panel had regard to Colleague D's witness statement in which she stated the following:

*'On 20 Aoril 2022, I was sitting at my desk on reception and [Resident A], was waiting with me for patient transport for collection for a hospital appointment . Mr Romay came down to reception to find out where Resident A's transport was and he swore… I said to Mr Romay 'please do not swear in front of the resident'. I had a perspex screen in front of my desk, due to Covid-19, which Mr Romay leant up against and said to me 'who the fucking hell do you think you're talking to.'*

Whilst the panel did not have the opportunity to question Colleague D, in light of the other supporting evidence, the panel decided to accept her evidence and give it considerable weight. It found that taking all of the evidence together, it was more likely than not that on 20 April 2022, Mr Romay said *"Who the fucking hell do you think you're talking to"* or words to that effect to Colleague D in front of Resident A. The panel therefore found this charge proved.

**Charge 24**

24) On 28 April 2022, said to Resident C "I'm the boss of you, you need to do as you're told" or words to that effect.

**This charge is found proved.**

In reaching this decision, the panel had particular regard to the evidence of Colleague A.

The panel had sight of Colleague A's witness statement in which she stated the following:

> *'It concerned me that she was begging him to stop and he would not. Mr Romay shouted at her and said "I'm the boss of you, you need to do as you're told".'*

The panel also heard oral evidence from Colleague A. She told the panel that Mr Romay *"was aggressive, intimidating, he raised his voice and Resident C was crying and upset."* The panel found the evidence of Colleague A to be consistent, credible and reliable. The panel was of the view that it was more likely than not that on 28 April 2022, Mr Romay said to Resident C *"I'm the boss of you, you need to do as you're told"* or words to that effect. Accordingly, the panel found this charge proved.

**Charge 25**

25) On 28 April 2022, in relation to Resident C, attempted venepuncture despite the patient indicating that they did not consent to this procedure.

**This charge is found not proved.**

In reaching this decision, the panel took into account all of the evidence before it. The panel noted that there was no evidence to support that no consent was given by Resident C. The panel therefore found that the NMC had not discharged its evidential burden and found this charge not proved.

**Charge 26**

26) On several unknown dates called Colleague A – "Barbie" or words to that effect.

**This charge is found proved.**

In reaching this decision, the panel had particular regard to the evidence of Colleague A.

In her witness statement Colleague A stated the following:

> *'Mr Romay used to call me 'barbie' every day that I saw him. He also did this in front of other people. I found this inappropriate, rude and intimidating.'*

The panel also had sight of an email dated 15 June 2022 from Mr Romay in which he stated the following:

> *'[Colleague A] is a Senior Carer, she is a pleasant woman to deal with, attractive and her hair is long and blonde. A long time ago we were in the clinic preparing the medication (she is the one for the residents) and I told her that if she celebrated something because that One day she came to work very pretty and jokingly and she accepted it, I told her that she reminded me of Barbie, she smiled and replied that she didn't have her "Kent" like the Barbie doll does. She told me not at all The term "Barbie" bothered her, which made her laugh. Surely the person who heard when I was able to say "Good morning Barbie", did not know that this was our usual greeting and that for us it was of no importance, it was simply a joke without further ado route.'*

The panel heard oral evidence from Colleague A. It found her evidence to be consistent, credible and reliable. The panel noted that Colleague A's evidence was corroborated by Mr Romay's response, in which he admitted to having called her *"Barbie".* The panel was satisfied that it was more likely than not that on several unknown dates called Colleague A – *"Barbie"* or words to that effect. The panel therefore found this charge proved.

**Charge 27**

27) On an unknown date, pointed your phone camera at colleague A whilst on FaceTime and said things in Spanish about colleague A.

**This charge is found proved.**

In reaching this decision, the panel had particular regard to the evidence of Colleague A.

The panel had sight of Colleague A's witness statement in which she stated the following:

> *'On another occasion, the date of which I do not recall, Mr Romay was on facetime to one of his Spanish friends. They were both speaking in Spanish. He pointed the camera at me and they were saying things in Spanish which I believed were about me. I found this very uncomfortable.'*

The panel also heard oral evidence from Colleague A. In her oral evidence she told the panel that after pointing the phone at her, he changed the camera from 'selfie-mode' and moved the camera up and down. The panel found the evidence of Colleague A to be consistent, credible and reliable. The panel was of the view that it was more likely than not that on an unknown date, Mr Romay pointed his phone camera at colleague A whilst on FaceTime and said things in Spanish about Colleague A. Accordingly, the panel found this charge proved.

**Charge 28**

28) On an unknown date said to Colleague B that "their bum and legs looked nice in leggings" or words to that effect.

**This charge is found proved.**

In reaching this decision, the panel had particular regard to the evidence of Colleague B.

The panel had sight of Colleague B's witness statement in which she stated the following:

*‘On a date I do not recall, I was involved in another incident with Mr Romay where he spoke to me inappropriately whilst we were on shift together. I was wearing black leggings and Mr Romay made a comment about my legs and bum looking nice in the leggings.’*

The panel also heard oral evidence from Colleague B. In her oral evidence, Colleague B told the panel that she wasn’t able to wear the trousers she usually wore for work and that Mr Romay commented on her bum and legs saying that they looked nice in the leggings. The panel found the evidence of Colleague B to be consistent, credible and reliable in respect of this charge. The panel therefore found this charge proved.

**Charge 29**

29) On an unknown date, pulled Colleague A’s face mask down and said “Eww you’re not barbie anymore” or words to that effect.

**This charge is found proved.**

In reaching this decision, the panel had particular regard to the evidence of Colleague A.

The panel had sight of Colleague A’s witness statement in which she stated the following:

*‘On one occasion, the date of which I do not recall, I had acne on my face. Mr Romay pulled my face mask down to look at my face and said “eww, you’re not barbie anymore.”’*

The panel also had sight of investigatory hearing notes dated 3 May 2022 in which the following was recorded:

*‘he had made a senior carer feel uncomfortable about pulling her mask down and making comments about her appearance, how he calls her a barbie doll. FA stated that staff joke and mess about with him so he didn’t see a problem.’*

The panel heard oral evidence from Colleague A. The panel found the evidence of Colleague A to be consistent, credible and reliable. It was of the view that it was more likely than not that Mr Romay pulled Colleague A’s face mask down and said *“Eww you’re not barbie anymore”* or words to that effect. Accordingly, the panel found this charge proved.

**Charge 30**

30) On an unknown date swore in front of Resident G.

**This charge is found proved.**

In reaching this decision, the panel had particular regard to the evidence of Ms 3.

The panel had sight of Ms 3’s witness statement in which she stated the following:

*‘We went into a resident's room, ("Resident G") and Mr Romay swore in front of the resident. This concerned me as swearing in front of residents is rude and inappropriate, especially in front of elderly residents because they are not used to that sort of language. Mr Romay should have been told at some point during his nursing training not to use bad language in front of residents or patients.’*

The panel also heard oral evidence from Ms 3. The panel found the evidence of Ms 3 to be consistent, credible and reliable in respect of this charge. It was of the view that it was more likely than not that Mr Romay swore in front of Resident G. The panel therefore found this charge proved.

**Charge 31)a)**

31) Your actions at one or more of charges 26,28,29 harassed Colleague A and/or B in that:

a) your conduct was unwanted conduct of a sexual nature and/or related to a protected characteristic, namely sex.

**This charge is found proved.**

In reaching this decision, the panel had regard to the evidence of Colleague A and Colleague B.

The panel considered that Mr Romay's actions were demeaning, humiliating and intimidating and therefore amounted to harassment. The panel heard evidence from both witnesses that Mr Romay's conduct was unwanted and discouraged. The panel was of the view that in commenting on Colleague A's appearance and Colleague B's *'bum and legs'*, Mr Romay's behaviour was unwanted conduct of a sexual nature and related to a protected characteristic, namely sex. Accordingly, the panel found this charge proved.

**Charge 31)b)**

31) Your actions at one or more of charges 26,28,29 harassed Colleague A and/or B in that:

b) your conduct had the purpose or effect of:
i) violating Colleague A and or B's dignity.
ii) creating an intimidating, hostile, degrading, humiliating or offensive environment for Colleague A and or B.

**This charge is found proved.**

In reaching this decision, the panel had regard to the evidence of Colleague A and Colleague B.

The panel considered that Mr Romay's actions were demeaning, humiliating and intimidating and amounted to harassment. In calling Colleague A Barbie and then saying that she is no longer Barbie violated her dignity. Colleague A told the panel that she did not like coming into work, this conduct made her feel like an object and it happened every day. The panel was also of the view that objectifying colleagues who were trying to carry out their role in a professional environment was intimidating, hostile, degrading, humiliating and offensive. The panel rejected Mr Romay's written responses in which he stated that this behaviour was just *"simply a joke".* The panel therefore found this charge proved.

**Charge 32**

32) Your actions at charges 21 and/or 22 lacked integrity in that you intended to influence Colleague B such that she would not report your pre-potting as set out at charge 13 and/or any other poor practice she witnessed you undertaking.

**This charge is found proved.**

In reaching this decision, the panel had regard to the evidence of Colleague B and its findings at charges 21, 22 and 13.

The panel was of the view that a nurse who breaches policies, tries to cover up poor practice and to attempts to influence a colleague to not report poor practice lacks integrity. A nurse must act with integrity at all times and Mr Romay's behaviour as set out in charges 21, 22 and 13, in the panel's view, lacked integrity. Accordingly, the panel found this charge 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 Romay's fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's ability to practise kindly, safely and professionally.

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

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

**Submissions on misconduct**

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

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

Ms Thorton identified the specific and relevant standards where, in the NMC's submissions, Mr Romay's actions amounted to misconduct. She submitted that Mr

Romay's actions and omissions were serious and fell far short of the standards expected in respect of the following:

- Improper handling of residents.
- Failure to wear PPE.
- Inappropriate communication with colleagues, sometimes in the presence of residents.
- Failure to properly administer medication.
- Poor practice in relation to medication management and administration.
- Not obtaining clear patient consent.
- Failure to use proper aseptic techniques when catheterising.
- Failure to treat colleagues with respect in that there was name calling and verbal threats in an attempt to stop colleagues from raising concerns about his poor practice.

Ms Thornton submitted that Mr Romay has breached fundamental tenets of the profession, and that his actions and omissions were serious and amounted to misconduct.

**Submissions on impairment**

Ms Thornton 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 case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin).

Ms Thornton referred the panel to Mr Romay's response bundle in which he denies that his practice is currently impaired. She submitted that there is no evidence that Mr Romay accepts the concerns about his practice or that he has reflected on his shortfalls and strengthened his practice. Ms Thornton submitted that Mr Romay has placed

patients and colleagues at an unwarranted risk of harm, brought the profession into disrepute and breached fundamental tenets of the profession.

Ms Thornton submitted that Mr Romay placed colleagues at a risk of harm through his inappropriate behaviour towards them. She submitted that Mr Romay also placed residents at an unwarranted risk of harm. Ms Thornton submitted that there appeared to be a pattern of dealing with residents in a rushed manner, the way in which a dressing was removed, failure to gain proper consent from residents and the management and administration of medication. She submitted that the risk of repetition and consequent harm to residents and colleagues was compounded by a potential underlying attitudinal problem. Ms Thornton submitted that the standards Mr Romay adopted, his malpractice and threats to colleagues to try to prevent them from reporting him raises both public protection and public interest concerns.

Ms Thornton submitted that in view of Mr Romay having little insight and there being no evidence that he has strengthened his practice, there remains a risk that he would repeat his conduct and place residents and colleagues at risk of harm. She invited the panel to find that Mr Romay's fitness to practise is impaired on public protection grounds.

In respect of public interest, Ms Thornton submitted that Mr Romay's conduct presents a risk to the health, safety and wellbeing of the public. She submitted that a fully informed member of the public would expect a finding of impairment in the circumstances.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311 and *CHRE v NMC and Grant [2011] EWHC 927 (Admin).*

**Decision and reasons on misconduct**

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

The panel determined that Mr Romay's actions did fall significantly short of the standards expected of a registered nurse, and that his actions and omissions amounted to a breach of the Code. Specifically:

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

To achieve this, you must:

**1.1** treat people with kindness, respect and compassion

**1.2** make sure you deliver the fundamentals of care effectively

**1.5** respect and uphold people's human rights

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

To achieve this, you must:

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

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

**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:

**8.2** maintain effective communication with colleagues

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

**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

**13 Recognise and work within the limits of your competence**

To achieve this, you must, as appropriate:

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

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

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

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

To achieve this, you must:

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

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

To achieve this, you must:

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

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

**20 Uphold the reputation of your profession at all times**

To achieve this, you must:

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

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

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

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

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

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel was of the view that Mr Romay's actions and omissions were wide ranging and occurred over a significant period of time, involving numerous residents and two colleagues.

In respect of Mr Romay's actions and omissions as set out below, the panel found that these were serious and amounted to misconduct. Mr Romay was an experienced nurse, in a position of trust caring for a particularly vulnerable group of elderly residents, some of whom lacked capacity. The panel was of the view that in not wearing PPE, Mr Romay showed a disregard for the health and wellbeing of vulnerable residents and colleagues during the COVID-19 pandemic. He could have spread the virus to residents who had a low immunity, and this could have had potentially fatal consequences. In failing to carry out catheterisation using an aseptic technique, the panel determined that this was serious as this could have caused an infection and harm to the resident. The panel determined that Mr Romay's failure to adhere to medication management and administrations policy was serious and placed residents at risk of harm. The panel concluded that the patient care issues were serious and demonstrated a pattern of poor practice and amounted to misconduct.

In respect of Mr Romay's behaviour and conduct towards his colleagues and residents, the panel determined that this fell far short of what is expected of a registered nurse. Mr Romay's conduct arose whilst he was acting in a position of power and trust, providing support to junior colleagues and student nurse associates, and care to vulnerable residents. The panel determined that harassing colleagues, making comments that were unwanted and sexual in nature, violating their dignity and creating an intimidating, hostile, degrading and offensive environment was very serious. The panel was also of the view that in seeking to silence a colleague from reporting his poor practice through

threatening behaviour was particularly serious and lacked integrity. The panel concluded that Mr Romay's behaviour in swearing at colleagues, swearing in the presence of residents and communicating in a threatening way with a resident was also particularly serious and fell far short of what is expected of a registered nurse.

Having regard to all of the above, the panel considered that a fellow nurse or a member of the public would find his conduct and behaviour to be shocking. The panel found that Mr Romay's actions fell seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

**Decision and reasons on impairment**

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

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

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

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

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

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

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

> *'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her/ fitness to practise is impaired in the sense that S/He:*
>
> a) *has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*
>
> b) *has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*
>
> c) *has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*
>
> d) *...'*

The panel found that vulnerable residents were put at unwarranted risk of harm. By not wearing PPE, failing to utilise aseptic techniques and not adhering to proper standards of medication management and administration, Mr Romay placed vulnerable residents at risk of physical harm. The panel was of the view that Mr Romay's conduct and behaviour also placed vulnerable residents and colleagues at risk of emotional harm. The panel determined that Mr Romay's misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute.

The panel was of the view that the clinical issues in this case are capable of being remediated. However, the panel was mindful that attitudinal concerns are inherently more difficult to remediate.

The panel carefully considered Mr Romay's responses and had regard to a bundle of documents he provided for the panel's consideration. It had sight of a number of historical certificates, however there was no evidence of any relevant training he had undertaken since the charges arose. It had particular regard to a reference from Les Charrieres Residential and Nursing (Les Charrieres) dated 26 October 2023. It noted that Mr Romay had been employed as a staff nurse at Les Charrieres since 1 June 2022. Mr Romay's registered manager wrote the following:

> *'Since having supervisions and meetings with Fernando regarding his medication administration, he has taken this on board and has listened to advise given, and applied this to his practice of medication, which is now his practice and medication administration has greatly improved and is following NMC guidelines and company policies...*
>
> *…Fernando's relationship with his work colleagues has been difficult at times due to his manner towards them. This has improved considerably but he does need to be reminded on his approach.'*

Whilst the panel acknowledged that there appears to have been some improvement in Mr Romay's practice in respect of medication administration, the panel noted that his

manager identifies some persistent underlying concerns about his relationships with and treatment of colleagues.

The panel found that Mr Romay has not provided any reflection, and there is no evidence of insight into his failings or behaviour. The panel was therefore not satisfied that he has taken steps to strengthen his practice or taken steps to ensure that the failings and his conduct would not happen again. The panel therefore concluded that there is a risk of repetition of the misconduct found and a consequent risk of harm to colleagues and residents. Accordingly, the panel determined that a finding of impairment is necessary on public protection grounds.

The panel bore in mind the overarching objectives of the NMC; to protect, promote and maintain the health, safety, and wellbeing 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. In view of the seriousness of the misconduct, the panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made and therefore also finds Mr Romay's fitness to practise impaired on the grounds of public interest.

In reaching the decisions set out above, the panel was mindful of the question *"Can the nurse, midwife or nursing associate practise kindly, safely and professionally?"*. The panel was of the view that Mr Romay failed to treat his colleagues and the residents in his care with proper respect, indeed his behaviour and actions were to the contrary. He subjected colleagues and residents to unkind behaviour that was potentially physically and emotionally harmful. The panel determined that Mr Romay's conduct was neither safe nor professional and, as set out earlier, fell far short of what is expected of a registered nurse. Given the lack of remediation and absence of insight, the panel concluded that Mr Romay is not currently capable of kind, safe and professional practise.

Having regard to all of the above, the panel was satisfied that Mr Romay's fitness to practise is currently impaired on both public protection and public interest grounds.

**Sanction**

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

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

**Submissions on sanction**

Ms Thornton submitted that the NMC sanction bid is that of a striking off order. She invited the panel to consider a number of features that were aggravating in her submission. Ms Thornton referred the panel to the NMC sanctions guidance. She submitted that Mr Romay's misconduct was wide ranging and occurred over a significant period of time. Ms Thornton submitted that the misconduct was serious and placed patients and colleagues at risk of harm. She submitted that the behavioural issues identified in this case reflected deep seated attitudinal concerns. Ms Thornton submitted that Mr Romay's conduct and behaviour is fundamentally incompatible with him remaining on the register.

Upon enquiries from the panel, Ms Thornton advised that Mr Romay has been subject to an interim conditions of practice order since 17 June 2022. She provided the panel with a copy of the interim conditions of practice order and informed the panel that Mr Romay had complied with the order.

**Decision and reasons on sanction**

Having found Mr Romay'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.

In respect of the new information provided to the panel about the interim conditions of practice order, the panel had regard to the NMC guidance on *'Factors to consider before deciding on sanctions'* (Reference: SAN-1 Last Updated 01/08/2023). It had particular regard to the following:

> *'If the nurse, midwife or nursing associate has followed the terms of the interim order, and made good progress under it, this can be relevant to questions about how much insight the nurse, midwife or nursing associate has shown, and how much of a risk they may present to the public in the future.'*

The panel noted that Mr Romay has followed the terms of the interim order and made some progress towards addressing the concerns identified in his practice.

The panel took into account the following aggravating features:

- There was a pattern of clinical and behavioural concerns that occurred over a period of time.
- Mr Romay's behaviour and conduct placed residents and colleagues at risk of suffering physical and emotional harm.
- Lack of insight into behaviour and failings.

The panel was of the view that there are no mitigating features in this case. Whilst there is information from Mr Romay's manager (as set out previously) about him complying with the terms of the interim conditions of practice order, and that he is making some good progress in relation to the clinical concerns, the panel found that there are still some outstanding concerns that need to be addressed in respect of his behaviour. The panel also found that even though there is evidence that Mr Romay has addressed some of the clinical concerns, it had not been provided with any up to date training certificates.

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the serious nature of the case. Furthermore, the panel has identified public protection concerns, and an order that does not restrict his practise would be therefore insufficient to protect the public. 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 Romay'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 Romay's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the issues identified. 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 Romay's registration would be sufficient and proportionate. The panel is mindful that any conditions imposed must be appropriate, measurable and workable. The panel had regard to the SG in relation to the circumstances in which a conditions of practice order could be both appropriate and proportionate. The panel is however of the view that there are no practical or workable conditions that could be formulated in this case. The panel acknowledged that Mr Romay has been subject to, and complying with, an interim conditions of practice order. However, given its findings on facts and impairment, the panel determined that a conditions of practice order would be inappropriate in view of the seriousness and nature of the charges found proved. The panel was not satisfied that a conditions of practice order could be devised to protect patients and the public in view of the attitudinal concerns which are yet to be fully reflected on and addressed by Mr Romay. Furthermore, the panel concluded that the imposition of an interim conditions of practice order would not adequately mark the seriousness of the misconduct or satisfy the public interest in this case.

The panel then went on to consider whether a suspension order would be an appropriate sanction and it had particular regard to the SG. The panel acknowledged that the charges found proved in relation to Mr Romay's behaviour are serious and raise concerns about his professionalism. However, the panel noted that Mr Romay had been working at Les Charrieres as a staff nurse since 1 June 2022 and complying with an interim conditions of practice order. The panel found that there is no evidence that Mr Romay has repeated the behaviour since the charges arose and has begun to take some steps to strengthen his practice. The panel also bore in mind that prior to the incidents in this case, Mr Romay had an unblemished lengthy career.

It did go on to consider whether a striking-off order would be proportionate but, taking account of all the information before it, the panel concluded that it would be disproportionate as it was not the only sanction that would protect the public and uphold and maintain professional standards. Whilst the panel acknowledges that a suspension may have a punitive effect, it would be unduly punitive in Mr Romay's case to impose a striking-off order at this stage.

Balancing all of these factors the panel has concluded that a suspension order would be the appropriate and proportionate sanction. It determined that a suspension order would protect the public for the period it is in force. The panel also determined that a fully informed member of the public would consider that a suspension order would be a sufficient response in the circumstances. The panel noted the potential hardship such an order could cause Mr Romay. However, in the panel's view, this is outweighed by the public interest in this case.

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

The panel determined that a suspension order for a period of 12 months was appropriate in this case to protect the public and to mark the seriousness of the misconduct.

At the end of the period of suspension, another panel will review the order. At the review hearing the panel may revoke the order, or it may confirm the order, or it may replace the order with another order. The panel noted that a striking off order will be available to the reviewing panel.

The panel acknowledged that reflection is more difficult in cases where a registrant denies charges that are found proved. However, the panel was of the view that it is still possible for Mr Romay to provide a detailed reflective statement on the charges found proved, focussing on the impact on patients, colleagues and the profession.

Any future panel reviewing this case would be assisted by:

- A detailed reflective statement.
- Evidence of professional development, including documentary evidence of completion of any relevant training courses (in relation to clinical practice and behaviour) and testimonials from a line manager or supervisor.

**Interim order**

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

**Submissions on interim order**

The panel took account of the submissions made by Ms Thornton who submitted that in light of the panel's findings and the seriousness of the charges found proved, an interim order is necessary to protect the public and to address the public interest in this case for the appeal period. She invited the panel to impose an interim suspension order for a period of 18 months to cover any appeal period.

The panel accepted the advice of the legal assessor who referred it to Article 31 of the Nursing and Midwifery Order 2001.

**Decision and reasons on interim order**

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

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive order. Having already determined that a suspension order is necessary to protect the public and to satisfy the public interest in this case, to not impose an interim suspension order to cover the appeal period would be inconsistent 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 substantive suspension order 28 days after Mr Romay is sent the decision of this hearing in writing.

This will be confirmed to Mr Romay in writing.

That concludes this determination.