Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Thursday, 13 August 2026 – Friday, 21 August 2026

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

Name of Registrant:	Madeline Leonard
NMC PIN:	01I0383E
Part(s) of the register:	Registered Nurse (Sub Part 1) Adult Nursing Level 1 – 01 December 2005
Relevant Location:	Northamptonshire
Type of case:	Misconduct
Panel members:	Sarah Lowe (Chair, lay member) Suzanna Jacoby (Lay member) Sharon Peat (Registrant member)
Legal Assessor:	Paul Housego
Hearings Coordinator:	Samara Baboolal
Nursing and Midwifery Council:	Represented by Robert Rye, Case Presenter
Ms Leonard:	Not present and unrepresented
Facts proved:	Charges 1.1, 1.2, 1.3, 1.4, 1.6, 1.7, 1.8
Facts not proved:	Charge 1.5
Fitness to practise:	Impaired
Sanction:	**Suspension order (9 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 Ms Leonard was not in attendance and that the Notice of Hearing letter had been sent to Ms Leonard's registered email address by secure email on 14 July 2026.

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

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Hearing provided details of the allegation, the time, dates, venue of the hearing and, amongst other things, information about Ms Leonard's right to attend, be represented, and call evidence, as well as the panel's power to proceed in her absence.

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

Decision and reasons on proceeding in the absence of Ms Leonard

The panel next considered whether it should proceed in the absence of Ms Leonard. It had regard to Rule 21 and heard the submissions of Mr Rye who invited the panel to continue in the absence of Ms Leonard. He submitted that Ms Leonard stated that she will not be attending the hearing.

Mr Rye referred to email correspondence from Ms Leonard, dated 14 July 2026, which stated:

'[PRIVATE]'

Mr Rye made reference to a further email, dated 13 August 2026, received from Ms Leonard which stated:

'just got this now as had lost access to my email and all things google for nearly 10 days now, but anyway i have no intent on attending remotely as have my daughters here in ireland with me on holidays from school and quite clearly IM NOT IN THE UK' [sic]

Mr Rye invited the panel to proceed in the absence of Ms Leonard. He submitted that her correspondence has made clear that she will not be attending this hearing and is currently in Ireland.

The panel accepted the advice of the legal assessor.

The panel noted that its discretionary power to proceed in the absence of a registrant under the provisions of Rule 21 is not absolute and is one that should be exercised *'with the utmost care and caution'* as referred to in the case of *R* v *Jones (Anthony William)* (No.2) [2002] UKHL 5.

The panel determined to proceed in the absence of Ms Leonard.

The panel had regard to the factors and principles set out in the decision of *R v Jones* and *General Medical Council v Adeogba* [2016] EWCA Civ 162, and had regard to the interests of fairness to all parties. It noted that:

- No application for an adjournment has been made by Ms Leonard;
- Ms Leonard has informed the NMC that she does not wish to attend the hearing;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- Four witnesses have attended today 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;
- 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 disposal of the case without further delay.

There is some disadvantage to Ms Leonard in proceeding in her absence. Although the evidence upon which the NMC relies will have been sent to her at her registered address, she will not be able to challenge the evidence relied upon by the NMC in person and will not be able to give evidence on her own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. Furthermore, the limited disadvantage is the consequence of Ms Leonard's decisions to absent herself from the hearing, waive her rights to attend, and/or be represented, and not to provide evidence or make submissions on her own behalf.

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

Details of charges (as amended)

That you a registered nurse:

1. On 7 October 2021, in relation to Resident A, who was vulnerable and had a fall:

    1.1 Failed to complete neuro-observations upon them. [PROVED]

    1.2 Failed to consider their medications to assess the risks of possible internal bleeding. [PROVED]

    1.3 Failed to carry out an assessment upon Resident A to ascertain what part of the body they were feeling pain prior to the administration of pain relief. [PROVED]

    1.4 Failed to escalate the incident by: [PROVED]

        1.4.1 Calling for an Ambulance and/or
        1.4.2 Calling for the GP

1.5 Left them unattended, and/or ensure that they were not left unattended, after the fall. [NOT PROVED]

1.6 Failed to use and/or ensure a hoist was used when lifting / moving them from the floor. [PROVED]

1.7 Failed to document in Resident A's medical notes the reasons why: [PROVED]

1.7.1 No neuro-observations were required.
1.7.2 No ambulance and/or GP were required to be called.

1.8 Failed to carry out an inquiry with the resident that pressed the emergency bell, and/or document in Resident A's medical notes: [PROVED]

1.8.1 What part of Resident A's body hit the floor.
1.8.2 Approximately how long Resident A was on the floor before the emergency bell was rung.

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

Decision and reasons on application to admit hearsay evidence

The panel heard an application made by Mr Rye under Rule 31 to allow the written statements of Sreehari Krishna (Ms Krishna) and Gift Ehiorobo (Ms Ehiorobo) to be adduced as evidence.

Mr Rye submitted that, despite numerous attempts, the NMC had not been able to obtain signed, written statements from Ms Krishna or from Ms Ehiorobo. The Case Officer was informed by Kingsthorpe Grange that neither Ms Krishna nor Ms Ehiorobo now work at the Home, and that no current contact details could be provided to the NMC. Mr Rye submitted that the evidence is highly relevant and though not provided during the course of the NMC's investigation, was produced for the purpose of the internal investigations.

Mr Rye submitted that both of these witnesses state that they were provided instructions by Ms Leonard to move Resident A from the floor, and they corroborate one another's evidence. He submitted that the evidence is neither sole nor decisive,

and submitted that it helps to assess Ms Leonard's actions or inactions in dealing with Resident A. Mr Rye submitted that, by adducing the evidence, the panel will be able to paint a fuller picture of Ms Leonard's actions.

Mr Rye submitted that there is no unfairness to Ms Leonard if this evidence were adduced, as there are other witnesses attending to give oral evidence, and Ms Leonard has provided her own account, both in an internal investigation and disciplinary hearing and to the NMC against which the hearsay evidence can be evaluated.

The panel accepted the advice of the legal assessor.

The panel determined to allow Ms Krishna and Ms Ehiorobo's evidence to be adduced as hearsay evidence.

In reaching this decision, the panel considered the principles set out in *Thorneycroft v Nursing and Midwifery Council* [2014] EWHC 1565 (Admin). The panel took into account that the NMC has made all reasonable efforts to secure the attendance of the witnesses. The witnesses have not engaged with the NMC and the NMC did not have, and was unable to obtain, their up-to-date contact information. It also took into account that the witnesses do not have a reasonable explanation for their non-attendance, as they have not engaged with the NMC's attempts to secure their statements.

The panel noted that Ms Krishna and Ms Ehiorobo were the only eyewitnesses to the incident. The panel determined that the evidence was relevant to the charges. The panel determined that the evidence is not decisive, as documentary evidence, Ms Leonard's responses to her employer and to the NMC and the oral evidence of other witnesses form the crux of many charges in this case.

The panel was of the view that there would be no unfairness or prejudice to Ms Leonard if this evidence were adduced as hearsay evidence. The evidence provided by Ms Krishna and Ms Ehiorobo is near contemporaneous and can be weighed carefully against both Ms Leonard's own explanations and the live witnesses who are due to give evidence at this hearing.

In these circumstances, the panel came to the view that it would be fair and relevant to accept into evidence the hearsay evidence of Ms Krishna and Ms Ehiorobo, but would give that evidence appropriate weight once it had heard and evaluated all the evidence provided by the NMC.

Decisions and reasons on facts

The panel was aware that the burden of proof rests on the NMC, and that the standard of proof is the civil standard, namely the balance of probabilities. This means that a fact will be proved if the 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:

- Samantha Titchner: Registered nurse and acting Home Manager of St Matthews Unit at the time of the incident
- Bewin Cyriac: Registered Nurse at Kingsthorpe Grange at the time of the incident
- Bianca Socol: Business Partner People at St Matthews Healthcare (which runs Kingsthorpe Grange)
- Lorraine Saunders: General manager at Hawthorne House at the time of the incident

Before making any findings on the facts, the panel heard closing submissions made by Mr Rye, on behalf of the NMC. The panel accepted the advice of the legal

assessor. The panel has drawn no adverse inference from the non-attendance of Ms Leonard.

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

Charge 1.1

> "1. On 7 October 2021, in relation to Resident A, who was vulnerable and had a fall: Failed to complete neuro-observations upon them."

This charge is found proved.

In reaching this decision, the panel took into account the witness statement and oral evidence provided by Samantha Titchner (Ms Titchner), the witness statement and oral evidence provided by Lorraine Saunders (Ms Saunders), Resident A's personalised care notes (the care notes), the witness statement and oral evidence provided by Bewin Cyriac (Mr Cyriac), the transcript of the interview between Ms Leonard and Ms Saunders (the interview transcript), and the email from Ms Leonard to Ms Titchner, dated 8 October 2021 (8 October email).

The panel first considered whether Ms Leonard was under a duty to complete the neuro-observations in relation to Resident A.

The panel took into account that Ms Titchner, Ms Saunders, and Mr Cyriac were clear in their oral evidence that neuro-observations would be required in the circumstances of the incident involving Resident A, irrespective of whether the fall was witnessed or unwitnessed. Ms Titchner and Ms Saunders, in their oral evidence, made it clear that there was not a neuro-chart recording any observations of Resident A. He may have sustained a head injury, which could be exacerbated because of his anti-coagulant medication, and was therefore a 'high-risk' resident. Resident A sustained a fall, which was to be treated as unwitnessed as the only possible witness was another resident whose account might not be reliable.

The hearsay evidence of Ms Krishna and Ms Ehiorobo and the oral evidence of Mr Cyriac, as well as the account of Ms Leonard, was that it was unclear whether

Resident A sustained an injury from this incident. Ms Titchner, Ms Saunders, and Mr Cyriac told the panel that Resident A was regarded as a high-risk patient with complex health needs, and was unable to articulate any pain or issues.

In her oral evidence, Ms Titchner informed the panel that Resident A was epileptic and was therefore at risk of having a seizure following his fall. In addition, he was on anti-coagulant medication which gave rise to an increased risk of internal bleeding after a fall.

The panel took into account Ms Titchner's NMC witness statement, stating:

> *'I had been at the St Matthews Unit for less than a month, when an incident arose with a male resident in the early hours of 7th October 2021. RESIDENT A was a fragile senior gentleman of over 70 years of age, with complex medical conditions including dementia of the Alzheimers type, he was partially sighted and had much reduced hearing. As a result of a car accident in his early teens, he had been left with brain damage, learning difficulties and dysphasia. He had suffered a heart attack and was on daily medication including anti-epileptic drugs and one to help prevent blood clots – so you can understand why I called him precious and fragile.*
>
> *Madeline went on to say that she gave him paracetamol because he had 'non-specific pain' but could stand, bend and stretch all his limbs, but there is NO mention of neurological observations ("neuros") being done. The plan does seem to have been amended by Madeline, just before 7 am on the morning of the accident.*
>
> *To NOT do neuros after a fall, especially where there was no witness to say a patient/resident did or did not hit his head is completely outside of a professional Nurse's training. Every Nurse is taught to undertake neuros where there is a possible head injury, plus, of course, the main reason you take them is to check for any decline/deterioration in the level of consciousness, which, if noted, should be treated as a matter of urgency. Furthermore, Resident A was documented as a sufferer of, and receiving daily medication for, […] medical issues such as depression and epilepsy and he*

was also taking anti-platelet clotting medication, again, daily, which would leave him more prone to bleeding. Perhaps he did fall… or perhaps he had an epileptic fit – I simply do not know…and Madeline would NOT have known, either.'

The panel accepted the evidence provided by Ms Titchner, Ms Saunders, and Mr Cyriac. The evidence was consistent, clear, and was not contradictory. While the witnesses did clarify that their recollection of the particular circumstances was not clear, they had very clear and specific recollection of the correct procedures expected of a registered nurse working with a vulnerable resident who experienced an unwitnessed fall.

The panel had regard to the care notes, which state that the planned outcomes for Resident A's care involved 'to ensure Resident A is safe all the time', 'to prevent falls and injuries from chair/bed', and 'to maintain Resident A comfort at all the time [sic]'. The care notes also highlighted the vulnerabilities and health concerns experienced by Resident A.

The panel was satisfied, in light of all the above, that Ms Leonard was under a duty to complete neuro-observations after Resident A's fall, given the nature of Resident A's health, vulnerabilities, his care plan, the nature of the unwitnessed fall itself, and the procedures expected of a registered nurse in these circumstances.

The panel next went on to consider whether Ms Leonard failed to carry out this duty.

The panel took into account Ms Titchner's NMC witness statement, stating:

'The fact that this was an unwitnessed fall made it even more important that his neuros were checked.'

The panel noted that there is no evidence before it to indicate that Ms Leonard had carried out any neurological observations following Resident A's fall. It took into account that nurses are expected to record any observations that are made, and according to Ms Titchner, there was no clear documentation recorded by Ms Leonard.

The panel also took into account the interview transcript, in which Ms Saunders asked Ms Leonard to walk her through the 'top to toe assessment' that Ms Leonard said that she had conducted on Resident A after his fall. When asked if vital signs observations and blood pressure was taken in the assessment, Ms Leonard responded that she omitted to do so because of disturbances in the background and loud, distracting behaviour from another resident. In the investigative interview conducted on 12 October 2021, when asked about the correct procedures that she should have carried out, Ms Leonard admitted that she had not conducted neuro-observations.

The investigative interview, dated 12 October 2021, states:

> *'[Ms Titchner]: As a nurse, if someone had an unwitnessed fall, that was reported by a resident, who's word we cannot rely on, what is one of the first things you should have done Maddie?*
>
> *[Ms Leonard]: I don't know.*
>
> *[Ms Titchner]: Neurological observations because you aren't sure if he has hit his head.*
>
> *[Ms Leonard]: Oh yeah, I didn't think about that.'*

The disciplinary hearing transcript stated:

> *'[Ms Saunders]: Let's talk about the top to toe again, any med vital signs checked?*
>
> *[Ms Leonard]: No, I have to admit that didn't happen. Admit mistake. Another resident was in the room.'*

The panel also took into account Ms Leonard's email, dated 14 July 2026, in which she states:

‘Only thing I forgot to do was observations i.e. pulse BP [sic]. All proper paperwork was done before I left work…’

Ms Leonard also asserted that equipment was not provided to make the proper assessments, such as pen torches. However, in her oral evidence, Ms Titchner was clear that there were pen torches at the nurses’ station and in the first-aid boxes.

In light of all the above, the panel determined that, on the balance of probabilities, it is more likely than not that Ms Leonard failed to complete neuro-observations upon Resident A, who was vulnerable and experienced a fall on 7 October 2021.

For these reasons, the panel found this charge proved.

Charge 1.2)

> “On 7 October 2021, in relation to Resident A, who was vulnerable and had a fall:
> Failed to consider their medications to assess the risks of possible internal bleeding.”

This charge is found proved.

In reaching this decision, the panel took into account the witness statement and oral evidence provided by Ms Titchner, the witness statement and oral evidence provided by Ms Saunders, the care notes), the interview transcript, the disciplinary hearing transcript, and Resident A’s medical notes. and the 8 October 2021 email.

The panel first considered whether Ms Leonard was under a duty to consider Resident A’s medications to assess the risks of possible internal bleeding.

The panel took into account Ms Saunders’s oral evidence, in which she made it clear that Ms Leonard should have had regard to Resident A’s health records, care plan, and MAR chart. Ms Titchner stated that Ms Leonard was under a duty to consider whether there was an internal injury particularly because Resident A was taking anticoagulant medication. This meant that, had Resident A sustained an internal

injury, this could lead to excessive or severe bleeding. For this reason, Ms Titchner's evidence was that Ms Leonard should have made clear in the patient notes and at handover that no further anticoagulant medication should be administered until it was established that Resident A had suffered no internal injury. The panel accepted this evidence.

Ms Titchner's NMC written statement states:

> *'Furthermore Resident A was documented as a sufferer of, and receiving daily medication for, amongst other medical issues such as depression and epilepsy and he was also taking anti-platelet clotting medication, again, daily, which would leave him more prone to bleeding. Perhaps he did fall… or perhaps he had an epileptic fit – I simply do not know… and Madeline would NOT have known, either.'*

The panel noted that it is recorded in Resident A's care plan that he is prone to bruising. In Ms Leonard's own risk assessment, as exhibited in Resident A's health records, she records that Resident A bruises easily and would have therefore been aware of this. Ms Leonard had also asserted that she had read Resident A's care plan many times.

The panel was satisfied that, in light of all the above, Ms Leonard was under a clear duty to consider Resident A's medications to assess the risk of possible internal bleeding. The panel also took into account that Ms Leonard was an experienced nurse and should have been aware of the importance of checking Resident A's care plan, nursing records, and MAR chart.

The panel next considered whether Ms Leonard failed in her duty to consider Resident A's medications to assess the risk of possible internal bleeding.

The panel also took into account that there is no evidence in any of the records of the findings and subsequent actions following Ms Leonard's 'top to toe' assessment. By not recording Resident A's vital signs, and comparing them to his 'known normals' or baselines, meant that changes could not be identified and specifically, signs of internal bleeding or raised intercranial pressure could be missed. The panel

took into account that in their oral evidence, Ms Saunders and Ms Titchner stressed that documentation of anything conducted and not conducted is very important for maintaining vigilance and sharing information with other staff to enable safe and effective care. Ms Leonard's explanation for this was that the practice was that only adverse matters were recorded after a 'top to toe' assessment conducted after a fall. The panel did not consider this to be likely or credible.

The panel also took into account that Ms Leonard contradicted herself in the interview transcript. She informed Ms Saunders that she was aware of Resident A's care plan but later wrongly told Ms Saunders that Resident A was not on any anti-coagulants. It was apparent to the panel, despite her assertions, that Ms Leonard had not familiarised herself with Patient A's care plan and MAR chart, and was in ignorance of the anti-coagulant medication he was taking (which was given during the day shift, she attending him on night shifts).

In light of all the above, the panel determined that, on the balance of probabilities, it is more likely than not that Ms Leonard failed to consider Resident A's medications to assess the risk of possible internal bleeding.

As such, this charge is found proved.

Charge 1.3)

> "On 7 October 2021, in relation to Resident A, who was vulnerable and had a fall: failed to carry out an assessment upon Resident A to ascertain what part of the body they were feeling pain prior to the administration of pain relief."

This charge is found proved.

In reaching this decision, the panel took into account the witness statement and oral evidence provided by Ms Titchner, the witness statement and oral evidence provided by Ms Saunders, the witness statement and oral evidence provided by Mr Cyriac, the care notes), the interview transcript, and the disciplinary hearing transcript), Resident A's medical notes, the 8 October 2021 email, and Ms Leonard's email dated 14 July 2026.

The panel first considered whether Ms Leonard was under a duty to assess Resident A to ascertain what part of the body he was feeling pain, prior to the administration of pain relief.

In her oral evidence, Ms Titchner told the panel that Ms Leonard was supposed to check whether Resident A was in pain, and if so from what area of the body. She also stated that there had to be a reason for administering pain relief, PRN. It also took into account Mr Cyriac's oral evidence, in which he said that even if a nurse did not see any signs of pain, they must assess the skin for bruises and swelling and check the parts of the body which may have been affected by the fall.

The panel accepted this oral evidence and determined that Ms Leonard was under a duty to carry out an assessment to ascertain whether Resident A was in pain and if so from which part of the body he was feeling pain, prior to the administration of pain relief. It then went on to consider whether she failed in this duty.

Ms Titchner expressed that she *"did not understand why [Ms Leonard] gave paracetamol"* if the notes made said that Resident A was not in pain. The panel also took into account that, if a nurse does not find out where the pain is coming from and administers pain relief, this *"dulls"* the pain and thereby masks where the pain is coming from.

In her statement, Ms Titchner stated:

> *'Madeline said she checked Resident A 'from top to toe' and then she asked if they would all then help him to his feet, before they sat him in a chair. As his named Nurse, Madeline ought to have been aware of the safety management section of Resident A's personalised Care Plan. Madeline went on to say that she gave him paracetamol because he had 'non-specific pain' but could stand, bend and stretch all his limbs, but there is NO mention of neurological observations ("neuros") being done. The plan does seem to have been amended by Madeline, just before 7 am on the morning of the accident.*

When Madeline told me he hadn't seemed to be in any pain, I asked why she had then given him paracetamol and she replied that 'he must've said he was in pain when he stood up'! I also asked her to explain why she had not started neuros on him or called an ambulance and she said she didn't feel he needed to see a doctor as she had examined him and everything seemed to be fine. I also asked why she and GE/SK lifted RESIDENT A off the floor into the chair and she was unable to answer me properly. She merely said 'she had forgotten and wouldn't do it again'

In the interview transcript, the panel took into account that Ms Leonard attested that she
conducted a top to toe assessment. She stated: *"found no injuries from top to toe. No concerns, no nerves [sic – Microsoft Teams automated transcript]. He was freely moving hips, knees, feet, arms, elbows, head, neck, all of it."* She explained that Resident A was able to bend his knees and twist his ankles. Ms Leonard explained that she gave a "general" pain relief in the form of paracetamol.

The investigation meeting transcript, dated 12 October 2021, states:

"[Ms Titchner]: Did you assess Resident A pain?
[Ms Leonard]: There was no pain.
[Ms Titchner]: but Maddie you gave paracetamol?
[Ms Leonard]: Yes he was in pain on standing.'

The panel noted the inconsistency in Ms Leonard's account, because in the interview with Ms Saunders on 21 October 2021 Ms Leonard said that Resident A was in pain when he stood up.

The panel also took into account the interview transcript with Ms Krishna, dated 12 October 2021. Ms Titchner inquired whether Resident A was in any pain when he was picked up by Ms Krishna, who responded in the affirmative. When asked by Ms Titchner how Resident A expressed this pain, Ms Krishna responded *"his facial expression indicated he was in discomfort and pain."* While this was hearsay evidence, it is a record made by Ms Titchner of a near contemporaneous interview with Ms Krishna and the panel accepted Ms Titchner's account of its accuracy and

saw no reason to doubt that Ms Krishna was both truthful and accurate in that interview.

The panel took into account Ms Titchner's written NMC statement, which stated:

> *'The GP came to visit Resident A, and after taking a history and examining him, felt Resident A should be X-rayed at A & E, as he thought he might have a fractured femur. An ambulance was therefore called (by BC) and Resident A was taken to hospital, where they X-rayed him and found he had fractured his hip. He was operated on the next day and had a 'hemiarthroplasty hip'.'*

In her email dated 21 July 2026, Ms Leonard mentioned that Resident A had a 'bump to his forearm', and so she had given him paracetamol. The panel noted that this was the first reference to Resident A having bumped his forearm.

The panel found that Ms Leonard's statements are contradictory as to whether or not Resident A was in pain, and therefore preferred the evidence provided by the NMC witnesses. The panel also noted that, despite Ms Leonard's assertions that Resident A was not in pain and was fine as per her top to toe assessment, he had sustained a hip fracture which required surgery.

In light of all the above, the panel determined that, on the balance of probabilities, it is more likely than not that Ms Leonard failed to carry out an assessment upon Resident A, who was in pain, to ascertain what part of the body he was feeling that pain prior to the administration of pain relief.

For these reasons, this charge is found proved.

Charge 1.4)

> "On 7 October 2021, in relation to Resident A, who was vulnerable and had a fall failed to escalate the incident by:
> 1.4.1 Calling for an Ambulance and/or
> 1.4.2 Calling for the GP"

This charge is found proved.

In reaching this decision, the panel took into account the witness statement and oral evidence provided by Ms Titchner, the witness statement and oral evidence provided by Ms Saunders, the witness statement and oral evidence provided by Mr Cyriac, the care notes, the interview transcript, the disciplinary hearing transcript, and Resident A's medical notes.

The panel first considered whether Ms Leonard was under a duty to escalate the incident. It took into account that it heard clear and reliable evidence from Mr Cyriac, Ms Saunders, and Ms Titchner around the policy at the care home. All three witnesses were very clear that, in relation to the 'falls procedure', a fall is considered unwitnessed unless witnessed by a member of staff. Where a fall is unwitnessed, and involves someone who has complex needs and/or is on anticoagulant medication, there is a clear duty to escalate. Ms Saunders informed the panel that the care home is focussed on comfort and told the panel that "*we are not doctors"* so that escalation was necessary. She was clear that paramedics are specifically trained to deal with trauma and have the necessary experience and equipment to deal with it. Ms Saunders told the panel that there were notices around the procedure at the nurses' station, the falls management wall, and the lift.

Ms Titchner informed the panel that, during the day staff are expected to call the GP, and 999 at night or out of hours so that paramedics could assess whether a resident who had sustained a fall needed to be taken to hospital. She said that, in the circumstances of Resident A's fall (before 6 am), the GP surgery would not have been open, and Ms Leonard should have called out of hours GP service or 999. In addition, there was an on-call manager available by telephone, and staff could have called the NHS 111 service for advice. Mr Cyriac said that it is better to err on the safe side and call the GP if it will be faster than 999.

The panel accepted this evidence and was satisfied that there was a duty to escalate, as set out in the charge.

The panel next considered whether Ms Leonard failed in her duty to escalate, by failing to call an ambulance and/or a general practitioner (GP).

The panel took into account that Ms Leonard does not dispute that she did not escalate the fall. In the investigation transcripts, she was asked by Ms Titchner: *"So did you not think at this point you should've called an ambulance and carried out clinical observations?",* to which Ms Leonard responded: *"No, I forgot. I have learned from my mistakes, I won't do it again, this is a good learning curve."*

In light of the above, the panel determined that, on the balance of probabilities, it is more likely than not that Ms Leonard failed to escalate the incident by calling for an ambulance and/or calling a GP.

As such, this charge is found proved.

Charge 1.5)

> "On 7 October 2021, in relation to Resident A, who was vulnerable and had a fall left them unattended, and/or ensure that they were not left unattended, after the fall."

This charge is found NOT proved.

In reaching this decision the panel took into account the witness statement and oral evidence provided by Ms Saunders, and an email to Ms Titchner dated 12 October 2021.

The email to Ms Titchner states:

> *"The NIC carried out the checks, after them she told us to help him sit on the chair. I and my colleagues including the nurses did help him to sit on the chair… the NIC then continued to attend to him."*

The policy of the home was that there should be 'general observation' of those in the lounge. This was undescribed, and the panel considered that it was intended to relate to day shifts when there was likely to be a member of staff in the lounge at all times. This was unlikely to be the case during the night shift.

Ms Saunders, in her oral evidence, stated that she was not able to say whether anyone was in the lounge at the time to conduct general observations, given the staffing levels.

Ms Krishna and Ms Ehiorobo had not been asked about this, and nor had Ms Leonard.

There was no CCTV of the incident.

The panel was of the view that there is a paucity of evidence around what occurred after Resident A was placed back in his chair. Ms The panel determined that, in the absence of any probative evidence, the NMC has not discharged the burden of proving this charge.

Accordingly, this charge is found not proved.

Charge 1.6)

> "On 7 October 2021, in relation to Resident A, who was vulnerable and had a fall failed to use and/or ensure a hoist was used when lifting / moving them from the floor."

This charge is found proved.

When considering this charge, the panel noted the wording of the charge referred to a "stand aid hoist". However, the panel accepted the evidence provided to it by witnesses and in the documentary evidence that a stand aid hoist would not be appropriate. The use of a standing aid would not accurately reflect the reality of the situation, as a stand aid hoist cannot be used for someone on the floor. The panel accepted the advice of the legal assessor and determined that there would be no injustice or prejudice to Ms Leonard or the NMC to amend this charge so that the wording "stand aid" would be omitted. The panel therefore decided, of its own volition, to amend the charge to omit the words 'stand aid'.

The mischief alleged was that Resident A had been manoeuvred by physical force and not in accordance with standard safe procedure, which was to use a hoist where someone was not able to rise from the floor unaided. The type of hoist is not germane to the charge, and it was not, in the panel's judgement, unfair to Ms Leonard to remove the incorrect reference in the charge to the type of hoist that should have been employed. Not to amend the charge would have resulted in a finding that the charge was not proved on a technicality.

In reaching its decision on this charge, the panel took into account the witness statement and oral evidence provided by Ms Titchner, the witness statement and oral evidence provided by Ms Saunders, the witness statement and oral evidence provided by Mr Cyriac, the care notes, the interview transcript, the disciplinary hearing transcript, Resident A's medical notes, and the 8 October 2021 email.

The panel first considered whether Ms Leonard was under a duty to use a hoist to lift Resident A. It took into account Resident A's care and medical records, which outlines that he needs support to stand and transfer to a wheelchair for mobilisation. It also noted that lifting Resident A by lifting him from the floor by holding him under the arms is described as an "illegal move" because of the risk of injury to the resident and to staff. Ms Saunders and Ms Titchner were both clear in their oral evidence that Resident A required a standard, or full body hoist to raise him from the floor. The panel accepted that there was a clear duty for Ms Leonard to use a hoist to lift Resident A after his fall.

In the disciplinary hearing transcript, Ms Titchner asked Ms Leonard how she lifted Resident A from up off the floor. The transcript states:

> *'[Ms Leonard]: *Maddie gestured an under-arm lift.**
>
> *[Ms Titchner]: Are you aware that this is an illegal move.*
>
> *[Ms Leonard]: Sorry.'*

The panel took into account Ms Krishna's hearsay evidence, in the form of the interview transcript, in which she was asked by Ms Titchner how she got Resident A up. Ms Krishna stated that it took three people, and when asked to physically demonstrate how he was lifted, Ms Krishna is described as going *"over to a chair*

and gesturing an under-arm technique." When Ms Titchner asked why she used this *"illegal technique",* Ms Krishna responded, *"the nurse said we could."*

The interview transcript states:

> *'[Ms Saunders]: …what happened when you guys said he's OK to move?*
>
> *[Ms Leonard]: Well, I'm not getting into that. That's dumb. They lifted him in a manner that was safe to do so.*
>
> *[Ms Saunders]: Can you describe to me how? What technique or what equipment they used to help him stand?*
>
> *[Ms Leonard]: That he doesn't use equipment you can normally have him sit on the edge of a chair and stand so he's not on hoist or [standing].'*

In the same interview, Ms Leonard was asked whether she had read Resident A's care notes, which specified that he required a standing hoist, two staff for transferring from sitting locations, and uses a wheelchair for mobility. She stated that, from what she remembered, the staff held Resident A's hands and helped him by placing their other hands around his back.

In light of all the above, the panel was satisfied that on the balance of probabilities that it is more likely than not that Ms Leonard failed to ensure a hoist was used when lifting / moving Resident A from the floor.

For these reasons this charge is found proved.

Charge 1.7)

> "On 7 October 2021, in relation to Resident A, who was vulnerable and had a fall failed to document in Resident A's medical notes the reasons why:
>
> 1.7.1 No neuro-observations were required.
>
> 1.7.2 No ambulance and/or GP were required to be called"

This charge is found proved.

In reaching this decision, the panel took into account the witness statement and oral evidence provided by Ms Titchner, the care notes, the interview transcript, the disciplinary hearing transcript, Resident A's medical notes, and Ms Leonard's 14 July 2026 email.

The panel first considered whether Ms Leonard was under a duty to document in Resident A's medical notes the reasons why no neuro-observations were required and why no ambulance and/or GP were required to be called.

The panel accepted Ms Titchner's oral evidence, in which she told the panel that it is expected of staff to record the exact reasons why things were not completed. She explained that there are clear expectations for staff to do this, and that making a record of everything completed or not completed, with reasons, is important for handover and continuity of care.

The panel took into account that in Resident A's nursing records, in the section titled "Daily Notes Print", it was clearly stated that *"if unable to complete, please state why".*

The panel also took into account that the Home's falls action plan clearly outlines the expectation of completing clear records:

§5.26 'Record Keeping Post Fall' states:

> *'The following records must be completed post fall in accordance with record keeping standards and as contemporaneously as possible.'*

The panel accepted Ms Titchner's oral evidence. It accepted that nurses are expected always to document their acts and omissions, and so found that Ms Leonard was under a clear duty to record why she had not taken such observations.

The panel next considered whether Ms Leonard failed in this duty.

The panel took into account Ms Leonard's email, dated 14 July 2026, in which she states:

> *'Only thing I forgot to do was observations i.e. pulse BP [sic]. All proper paperwork was done before I left work…'*

The panel also had regard to Resident A's nursing records, which did not contain reasons as to why no neuro-observations were recorded or no ambulance or GP were called.

In light of all the above, the panel was satisfied that on the balance of probabilities, it is more likely than not that Ms Leonard failed to document in Resident A's medical notes the reasons why no neuro-observations were required and why no ambulance and/or GP were required to be called.

For these reasons this charge is found proved in its entirety.

Charge 1.8)

> "On 7 October 2021, in relation to Resident A, who was vulnerable and had a fall failed to carry out an inquiry with the resident that pressed the emergency bell, and/or document in Resident A's medical notes:
> 1.8.1 What part of Resident A's body hit the floor.
>
> 1.8.2 Approximately how long Resident A was on the floor before the emergency bell was rung."

This charge is found proved.

In reaching this decision, the panel took into account the witness statement and oral evidence provided by Ms Titchner, the care notes, the interview transcript, the disciplinary hearing transcript, and Resident A's nursing records.

The panel first considered whether Ms Leonard was under a duty to carry out an inquiry with the resident who pressed the emergency bell and/or document in Resident A's notes what part of his body hit the floor, and approximately how long Resident A was on the floor before the emergency bell was rung.

Ms Titchner was very clear in her oral evidence that Resident B, who witnessed the fall, would be unlikely to remember the information if inquiries were made some time after the incident. Ms Titchner outlined that an inquiry straight away would have helped to paint the picture as to what happened, and where Resident A hit on his body when he fell. While the fall would still count as 'unwitnessed' as such an account might not be reliable, it could nevertheless be helpful, particularly in this

case as Resident A was non-verbal. Ms Titchner stated that this should have been done and recorded in Resident A's notes, and that this was an expectation. Ms Saunders also stated that there would be an expectation to ask any witness about how a resident was before a fall, and to know why and how they fell, as this would assist in a clinical assessment. The panel accepted this evidence and determined that Ms Leonard was under a duty to make enquiry of the resident who had pressed the emergency bell after Resident A's fall.

The panel next considered whether Ms Leonard failed in this duty. The panel took into account that, in the initial investigation, it was not put to Ms Leonard whether she failed to ask Resident B what occurred and whether he witnessed the fall. The panel also noted a near contemporaneous document, an email from Ms Leonard dated 8 October 2021 to Ms Titchner which states:

> *'[Resident B] was present and from enquiries only witness to slip, trip fall event.'*

The interview transcript stated:

> *'[Ms Saunders]: Has [Resident B] got capacity?*
>
> *[Ms Leonard]: He has enough capacity to say 'I saw him slide to the floor and fall' but didn't. I think he was also the chap who pressed the emergency bell.'*
>
> *'[Ms Leonard]: …but you know there was someone in the room who could say he slipped and he did this. He went stand up and this happened and that's what they sent* [sic – Microsoft Teams Automated Transcript].*'*

The panel determined that there is inadequate evidence before it to support that Ms Leonard did not ask Resident B what happened, as there are references to communication with Resident B throughout and it is unlikely that she failed to ask him what he witnessed. However, the panel took into account that there is no evidence that Ms Leonard recorded any of these inquiries. She did not document the inquiries made, and there were no records of any specific parts of Resident A's body that were observed to have been impacted during the fall incident. In her email, dated 14 July 2026, Ms Leonard made reference to a 'bump' on Resident A's forearm sustained from the fall, however, there were no records around this.

In her oral evidence, Ms Titchner was clear that no inquiries were documented. She told the panel that any inquiries should be in the care notes.

The panel therefore found that, although inquiries may have been made by Ms Leonard, on the balance of probabilities she failed to document in Resident A's notes what part of his body hit the floor, and how long Resident A was on the floor before the emergency bell was rung.

For these reasons this charge is found proved, to the extent that Ms Leonard did not record any enquiry made of Resident B.

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 Ms Leonard's fitness to practise is currently impaired. While there is no statutory definition of fitness to practise, the NMC defines fitness to practise as a registrant's ability to practise safely and effectively without restriction.

Submissions on misconduct

Mr Rye invited the panel to take the view that the facts found proved amount to misconduct. He referred the panel to the NMC code of professional conduct: standards for conduct, performance and ethics (the Code), and identified specific and relevant aspects of the Code which he submitted were breached to the extent that Ms Leonard's actions amounted to misconduct.

Mr Rye submitted that Ms Leonard's misconduct was very serious. He submitted that she breached fundamental tenets of the nursing profession when dealing with Resident A, as she failed to take proper observations and assess for any head injuries and internal bleeding, and failed to escalate Resident A to an ambulance or GP. Mr Rye submitted that this placed Resident A at an unwarranted risk of harm. He emphasised in his submissions that Resident A was very vulnerable and could not communicate his needs. It was only after Mr Cyriac, the nurse on the next shift, noticed that he was pain that the GP was called and Resident A was taken to hospital where he underwent an operation for his fractured hip.

Mr Rye submitted that Ms Leonard also failed to use safe and proper moving and handling techniques when moving Resident A from the floor, thereby exposing him to further risk of harm. Ms Leonard failed to complete necessary documentation, including recording her rationale as to why she felt no neuro and other observations were required. The panel had found that such observations were required. Mr Rye submitted that documentation is a cornerstone of the profession and helps to inform others when determining what actions are subsequently required for resident care. He submitted that Ms Leonard's failure to update documentation and records for Resident A exposed him to a further risk of harm because those caring for him subsequently would be unaware of what had happened, and Resident A was not able to communicate.

Mr Rye submitted that Ms Leonard's actions in the charges found proved are tantamount to neglect and so amounted to misconduct. He submitted that her care towards Resident A was seriously lacking.

Submissions on impairment

Mr Rye 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 of professional conduct, and to maintain public confidence in the profession and in the NMC as a regulatory body.

Mr Rye submitted that Ms Leonard's fitness to practice is currently impaired. He referred the panel to the legal test set out in the case of *CHRE v NMC and Grant* (the *Grant* test).

Mr Rye submitted that the misconduct relates to Ms Leonard's clinical practice and is therefore capable of being addressed. However, Ms Leonard had not engaged with the NMC or these proceedings in any meaningful way. She had not provided the panel with any evidence to enable it to conclude that she had remediated her misconduct. Accordingly, she had not demonstrated that she had strengthened her practice and remediated the concerns, and so the panel should find that her fitness to practise was currently impaired.

Mr Rye submitted that the first three limbs of the *Grant* test are engaged in this case. Mr Rye submitted that Ms Leonard put patients at unwarranted risk of harm in the past and is liable to put patients at unwarranted risk of harm in the future. He submitted that she had breached fundamental tenets of the nursing profession in the past and was liable to breach fundamental tenets of the nursing profession in the future. He submitted that she had brought the medical profession into disrepute in the past and was liable to do so in the future.

Decision and reasons on misconduct

The panel accepted the advice of the legal assessor, who referred it to various relevant cases and to the NMC guidance DMA-1 and FtP 2a.

The panel 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, Ms Leonard's fitness to practise is currently impaired as a result of that misconduct.

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.'*

The panel was of the view that Ms Leonard's actions fell significantly short of the standards expected of a registered nurse, and amounted to breaches of the Code of Conduct, specifically:

'1.1 Treat people with kindness, respect and compassion

1.2 Make sure you deliver the fundamentals of care effectively

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

3.4 Act as an advocate for the vulnerable, challenging poor practice […] and behaviour relating to their care.

6.2 Maintain the knowledge and skills you need for safe and effective practice.

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

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

10.3 Complete all records accurately […] taking immediate and appropriate action if you become aware that someone has not kept to these requirements

11.3 Confirm that the outcome of any task you have delegated to someone else meets the required standard

13.1 Accurately assess signs of normal or worsening physical and mental health in the person receiving care

13.2 Make a timely and appropriate referral to another practitioner when it is in the best interests of the individual needing any action, care or treatment

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

15.2 Arrange, wherever possible, for emergency care to be accessed and provided promptly,

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

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

25.1 Identify priorities, manage time, staff and resources effectively and deal with risk to make sure that the quality of

care or service you deliver is maintained and improved, putting the needs of those receiving care or services first'

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel decided that Ms Leonard's conduct in all of the charges found proved amounted to misconduct.

This was because Ms Leonard's conduct was very serious, involving an extremely vulnerable resident, who was unable to advocate for himself due to his long-standing brain injury and dementia. Resident A was entirely dependent on Ms Leonard, and she neglected to provide adequate care, or ensure his safety and wellbeing following his fall, and acted in a hasty manner without assessing the current situation and potential risks of harm that he faced.

Ms Leonard failed to conduct fundamental and important tasks, including:

- Conducting neurological observations and assessments (in case he had hit his head)
- Undertaking and recording frequent vital signs monitoring subsequent to his fall to identify changes or deterioration that might indicate blood loss and/or shock
- Considering recording that Resident A's anti-coagulant medication should be withheld in view of his fall and potential traumatic injuries, pending review
- Ascertaining the source of Resident A's pain prior to the administration of any pain killers
- Ensuring safe and correct manual handling with the use of a hoist
- Escalating the fall to an ambulance, GP, or out of hours service

The panel concluded that that these failures put Resident A at a real risk of significant harm. If Ms Leonard had correctly assessed Resident A, this would have mitigated the risk of harm to him. The panel was of the view that Ms Leonard's treatment of Resident A following his fall was seriously inadequate and was lacking in compassion, sensitivity, and care.

In the light of these factors, the panel determined that Ms Leonard's actions and inaction in all of the charges found proved were deplorable and 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, Ms Leonard's fitness to practise is currently impaired.

The panel had regard to the NMC Guidance on Impairment DMA-1 (28/01/2026):

> *'Being fit to practise is not defined in our legislation but for us it means that a professional on our register can practise as a nurse midwife or nursing associate safely and effectively without restriction.'*

The panel also had regard to the NMC Guidance notes FtP-16(a), (b), and (c).

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 make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

The panel considered the judgment of Mrs Justice Cox in the case of *CHRE v NMC and Grant* in reaching its decision. Paragraph 74 states:

> *'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 states:

'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 she/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;*

d) *...'*

When determining whether the Grant test is engaged in relation to the future, the panel considered whether the misconduct in this case is capable of being addressed and remediated. The panel took into account that the misconduct is largely related to Ms Leonard's clinical practice, including record keeping and falls management procedures. The panel concluded that the misconduct is capable of remediation.

The panel went on to consider whether Ms Leonard has addressed or remediated the misconduct so as to mitigate any risk of repetition in the future.

In this respect, the panel had no evidence before it to indicate that Ms Leonard has taken steps to strengthen her clinical practice and address the concerns in the misconduct. There is no evidence before it to show that Ms Leonard has any insight, has reflected on what happened, or has any remorse. Ms Leonard has not apologised or reflected on the impact that her misconduct had on Resident A,

Resident A's family, her colleagues, the Home, and on the reputation of the profession.

While Ms Leonard has made some slight admissions in the internal interviews and investigations, Ms Leonard does not appear remorseful, and her interview responses appear unconcerned and disinterested in the impact that her conduct has had on Resident A, her colleagues and the reputation of the profession.

In an email to the NMC dated 14 July 2026, Ms Leonard stated:

> *'Hello well I wont be there [PRIVATE]. I dont want that read out as i was fully trained in all of that and [PRIVATE] That was on my paperwork. So i was also careful when accidents happened. I still stand by my account of that mprni g and deny that i could have watched him as was completing an early morning Drug / Medication Round and adminisyering to those with specific mwdication when this occured.* [sic]
>
> *I attended and checked the gentleman TOP TO TOE ASSESSMENT and he indicated he bumped his left forearm so I gave him paracetamol. I found NO CAUSE FOR CINCERN OR INJURIES, JUST A BUMB TO HIS FOREARM ANDHIS HIPS WERE AS THEY SHOULD BE NO JUTTING OUT. ITS BEEN YEARSAND IVE FORGOTTEN PROPER TERMINOLOGY. NOF I THINK IS THE TERM TO USE. NO SHORTENING OF LEGS SO WE ASSISTED HIM BACK TO HIS CHAIR. ONLY THING I FORGOT TO DO WAS OBSERVATIONS IE PULSE BP. ALL PROPER PAPERWORK WAS DONE BEFORE I LEFT WORK AND FALLS PAPERWORK COMPLETED AS PER POLICY.* [sic]
>
> *THAT IS MY STATEMENT IN FULL. ALL MY TRAINING WAS COMPLETED WITHIN MY LIMITATIONS WHICH SMHC WAS FULLY AWARE OF ALSO. Thank you for the email.* [sic]
>
> *I sure hope my colleagues from back then are doing well and dont get involved also*. [sic]'

The investigative interview records the following exchanges between Ms Leonard and Ms Saunders:

> *'[Ms Saunders]: OK, and so what happened when you guys were you said he's OK to move? And how did the care staff and assistant assistant? (sic – Microsoft Teams automated transcript)*
>
> *[Ms Leonard]:* ***Well, I'm not getting into that. That's dumb****. They lifted him in a manner that was safe to do so.'*
>
> *…*
>
> *'[Ms Saunders]: Would you perhaps have dinner [sic – Microsoft Teams automated transcript – presumably "done a"] at the Abbey Pain Scale [before] you gave [paracetamol] tomorrow to assess [if] there is any kind of [pain there]?*
>
> *[Ms Leonard]: I find that pain scale really annoying and I think it needs reworking anywhere.'*
>
> *…*
>
> *'[Ms Leonard]: And one other thing falls management training. I'm quite content to redo all the malarkey and do everything that needs to be done, but I have do think these needs written up in this specific manner that she wants every single resident sending in hospital.'*

The panel noted that, throughout the interviews, Ms Leonard appeared deflective and refused to take accountability. She suggested that the relevant equipment was not available, that the excepted practice and procedure had not been communicated or had been changed, questioned the policies, and argued that sending residents, who appear fine following a fall, to the hospital every time will create 'false numbers'. The panel noted that Ms Leonard's statements and responses suggest an attitudinal concern.

In light of these concerns, as well as the absence of any remediation and insight, the panel determined that there is a risk of repetition of misconduct of the kind found proved. The first three limbs of the Grant test are therefore engaged in relation to the future.

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

The panel then considered whether any or all of the first three limbs of the *Grant* test also required a finding of current impairment by reason of what had been found proved.

Resident A was put at an unwarranted risk of harm by Ms Leonard's misconduct. He was unable to articulate his needs, including whether he was in pain, and Ms Leonard neglected to carry out proper and thorough assessments which were necessary to detect any life-threatening bleeding or complications suffered by Resident A following his unwitnessed fall. Ms Leonard did not use the correct and safe manual handling techniques, namely the use of a hoist, to lift Resident A from the ground, and instead used an 'illegal move' which put both Resident A and Ms Leonard's colleagues at risk of harm. She had administered pain killers which might have masked any subsequent deterioration. She had failed to make any records providing details of how the fall occurred, where or how Resident A was impacted, and what she had done to mitigate his risks of adverse consequences.

Ms Leonard's misconduct had breached fundamental tenets of the nursing profession and amounted to many serious breaches of the NMC Code of Conduct, and so brought its reputation into disrepute.

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

The panel accepted the advice of the legal assessor that the public interest is a high bar. Taking into account the evidence before it and its findings, the panel determined that a finding of impairment on public interest grounds is required.

The reasons why the panel considered that the high bar for a finding of current impairment was met were as follows: Resident A was an extremely vulnerable resident who was put at risk of significant unwarranted harm by the actions and inactions of Ms Leonard. He was not only extremely frail, but by reason of brain injury and dementia was not able to communicate effectively. He was totally reliant on Ms Leonard's nursing skills when he had the unwitnessed fall, and she failed him comprehensively. Her negligence and neglect resulted Resident A's fracture going undetected for a number of hours, and Resident A was consequently left in pain for some time, until another nurse noticed and escalated it to a GP. Resident A required surgery on his hip, which is an indication that he must have been in significant pain whilst under Ms Leonard's care. In addition, any other life-threatening injuries could have been missed by a lack of vigilance.

Ms Leonard has demonstrated no insight into her failings.

The panel concluded that public confidence in the nursing profession would be seriously undermined if a nurse who so neglected such a vulnerable patient and had not shown any remorse or insight was permitted to practise without a finding of current impairment.

Having regard to all of the above, the panel determined that Ms Leonard's fitness to practise is currently impaired.

Sanction

Having found Ms Leonard's fitness to practise currently impaired, the panel went on to consider what sanction, if any, it should impose. The panel bore in mind that any sanction imposed must be appropriate and proportionate and, although not intended to be punitive in its effect, may have such consequences. The decision on sanction is a matter for the panel independently exercising its own judgement.

In reaching this decision, the panel had regard to all the evidence that has been adduced in this case and to the NMC Guidance on the approach to sanctions and sanctions available, SAN-1 & 2 (28/01/2026), and to the NMC Guidance on conditions of practice, suspension, striking off, and on deciding between suspension and strike off (SAN-2b to e and SAN-3).

Submissions on sanction

Mr Rye informed the panel that in the Notice of Hearing, the NMC had advised Ms Leonard that it would seek the imposition of a suspension order if it found Ms Leonard's fitness to practise currently impaired.

Mr Rye invited the panel to impose a suspension order of 9 months, with a review.

Mr Rye submitted that the following aggravating factors are present:

- Ms Leonard's conduct was serious and put a resident at a risk of unwarranted harm.
- Ms Leonard's conduct breached fundamental tenets of the nursing profession.

Mr Rye submitted that the following mitigating factors are present:

- Ms Leonard made some admissions at local level.
- Isolated incident albeit with a pattern of misconduct.
- Ms Leonard joined the register in 2005 and has had an otherwise unblemished nursing career.

Mr Rye submitted that it would be neither appropriate nor proportionate to take no further action or impose a caution order in the circumstances of this case. He submitted that Ms Leonard's conduct was serious and put Resident A at a risk of unwarranted harm. He submitted that there are significant concerns around the public safety if Ms Leonard were to practise without restrictions.

Mr Rye submitted that, while the clinical concerns could potentially be addressed through conditions of practice, a conditions of practice order would not be appropriate in the circumstances of this case. He submitted that conditions of practice, according to the NMC guidance, is appropriate where there will be a

willingness to respond positively to any retraining. Mr Rye submitted that Ms Leonard has not provided any evidence or information to suggest that she is willing to engage with any retraining, and nor has she has provided any evidence of strengthened practice.

Mr Rye submitted that, looking at the particular circumstances of this case, this was an isolated incident which took place within an otherwise unblemished nursing career spanning 16 years. He submitted that, although Ms Leonard's misconduct is serious, it may not be fundamentally incompatible with her remaining on the NMC register as a nurse. He submitted that a suspension order of 9 months would be appropriate and proportionate, as this would allow Ms Leonard the time necessary to reflect and develop insight, while protecting the public and meeting the public interest.

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

Decision and reasons on sanction

The panel has decided to make a suspension order for a period of 9 months. The effect of this order is that the NMC register will show that Ms Leonard's registration has been suspended.

The panel considered the following aggravating factors in this case:

- Conduct which put an extremely vulnerable resident at unwarranted risk of harm
- Conduct which was tantamount to neglect and led to the delayed treatment of an extremely vulnerable resident, who was left in pain for longer than necessary as a result
- Failure to provide basic clinical care, despite being an experienced nurse
- Facilitated and abetted poor practice by Health Care Assistants, namely, poor manual handling which put a vulnerable resident at unwarranted risk of harm
- Ms Leonard's response to the internal investigation and to the NMC was defensive and deflective, and she did not take accountability
- Ms Leonard has taken no steps to strengthen her practice

- Lack of meaningful engagement with the NMC and these proceedings
- Lack of insight, reflection and remorse

The panel also considered the mitigating factors in this case:

- This was one course of action, primarily of omission, stemming from an inadequate assessment of a resident with whose circumstances and medication she had not made herself familiar
- One course of action on a single shift in an otherwise unblemished career since 2005

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

The panel next considered a caution order and had regard to the NMC Guidance on caution orders SAN-2b (28/01/2026), stating:

> *'A caution is only appropriate if the Committee has decided there's no risk to the public or to people using services that requires the professional's practice to be restricted. This means the case is at the lower end of the spectrum of impaired fitness to practise, but the Committee wants to mark that what happened was unacceptable and must not happen again.'*

The panel considered that Ms Leonard's actions were not at the lower end of the spectrum, and it found that there is a risk to patient and public safety which a caution order would not address. The panel therefore determined that a sanction that does not restrict Ms Leonard's practice would not protect the public. The panel also determined 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 Ms Leonard's registration would be appropriate. The panel is mindful that any conditions imposed must be relevant, proportionate, workable and measurable. The panel had regard to

the NMC Guidance on conditions of practice orders SAN-2c (28/01/2026) and had regard to the following factors:

- *'no evidence of deep-seated personality or attitudinal problems*
- *identifiable areas of the professional's practice in need of assessment and/or retraining*
- *potential and willingness to respond positively to retraining (this should be based on specific evidence provided by the professional)*
- *conditions can be created that can be monitored and assessed.'*

The panel acknowledged that the concerns and misconduct in this case are directly related to Ms Leonard's clinical practice and in principle, could be addressed by conditions of practice. However, in this case, it is not possible to formulate conditions of practice to address these concerns and enable Ms Leonard to practise safely as a registered nurse. This is because Ms Leonard has given no indication that she would be receptive to such an order.

The panel considered Ms Leonard's lack of engagement, and her responses to these proceedings and the charges against her generally. Ms Leonard appears to be deflective, defensive, and dismissive. Her communication with the NMC (excerpts from which appear in this determination) was unprofessional in tone and presentation. Ms Leonard has not shown any meaningful reflection or insight, and has not demonstrated strengthened practice through any retraining in areas relevant to the charges found proved, such as falls procedures. Her language in the interview transcripts shows that, while she may complete retraining as a "checklist exercise", it is currently unlikely that she would respond positively to a conditions of practice order. The panel also noted its finding at the impairment stage that there may be some indication of attitudinal concerns towards the charges.

In light of all the above, the panel was not satisfied that Ms Leonard would meaningfully and positively engage with conditions of practice at this time, and it would therefore not be the appropriate sanction in this case.

The panel went on to consider whether a suspension order is appropriate in this case. The panel had regard to the NMC Guidance on suspension orders SAN-2d

(28/01/2026), which sets out the following factors on when a suspension order may be appropriate:

- *'the impairment is very serious but not fundamentally incompatible with continuing to be a registered professional*
- *an outcome less severe than strike-off would still satisfy the over-arching objective.'*

The panel also had regard to the key considerations as set out in the NMC Guidance to weigh up before imposing a suspension, and the following list of circumstances that may make a suspension order an appropriate sanction:

- *'the charges found proved are at the most serious end of the spectrum and call into question the professional's suitability to continue practising, either currently or at all*
- *while it is possible that the professional could be fit to practise in future, only a period out of practice would be sufficient to allow them to fully strengthen their practice through reflection, the development of their professional skills and / or development of insight and remediation.'*

The panel was satisfied that in this case, while Ms Leonard's misconduct was serious, it was not so serious to be fundamentally incompatible with her remaining on the register.

The panel did go on to consider whether a striking off order would be the appropriate sanction. It took into account that, based on the evidence before it, this was a one-off incident, from which a series of clinical shortfalls flowed from Ms Leonard's failure to correctly assess and manage Resident A's care, following his unwitnessed fall. It noted that, at the time, Ms Leonard had an otherwise unblemished nursing career for over 15 years. The panel acknowledged that in his oral evidence, Mr Cyriac alluded to the workplace environment at the home being difficult, leading to him leaving the Home. This indicated that the working environment may have been sub-optimal.

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Had Ms Leonard engaged properly with the aftermath of the fall and with these proceedings and demonstrated insight remorse and strengthened practice the panel would not have considered a striking off order appropriate. The panel was concerned about Ms Leonard's lamentable attitude to the issues around Resident A and to these proceedings, and carefully considered whether this elevated the case to the level where a striking off order was required.

Ultimately, the panel decided that this would be disproportionate, and that, as the NMC suggested, a suspension order was the appropriate sanction.

The panel decided on a period of 9 months which both marks the seriousness of the matters found proved and Ms Leonard's response to them and gives her time to address the issues described in this determination.

The panel also took into account that Ms Leonard has been subject to NMC proceedings for some five years and concluded that a longer period of suspension would be disproportionate.

The panel acknowledged that a suspension order may have a punitive effect, but it determined that it would be unduly punitive in Ms Leonard's case to impose a striking-off order. The panel noted the hardship such an order will inevitably cause Ms Leonard. However, 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.

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.

Any future panel reviewing this case would be assisted by:

- An up-to-date reflective piece using a recognised reflection model, which includes and deals with:
    - The impact that Ms Leonard's misconduct had on Resident A, Resident A's family, her colleagues, the Home, and on the reputation of the nursing profession;
- Evidence of relevant training and any CPD undertaken, and how Ms Leonard will apply this learning and training to her practice;
- Up-to-date testimonials, including from health care settings;
- Meaningful engagement with the NMC; and
- Attendance at future NMC hearings.

The panel emphasised that the suspension order will be reviewed before it comes to an end. If Ms Leonard does not engage with the NMC a striking off order will be an option for that future reviewing panel.

The reviewing panel will be assisted if Ms Leonard engages with the issues set out in this determination and with the NMC. This could leave open the possibility of a conditions of practice order to replace it, or, exceptionally, the suspension order may be allowed to lapse.

This will be confirmed to Ms Leonard in writing.

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 Ms Leonard's own interests until the suspension sanction takes effect.

Submissions on interim order

Mr Rye submitted that, as the substantive suspension order will not take effect for 28 days from when the NMC decision letter is sent to Ms Leonard in writing, an interim suspension order would protect the public and meet the public interest during this

28-day period. Further, Mr Rye submitted that an interim suspension order of 18 months would protect the public and meet the public interest during any period of appeal.

The panel accepted the advice of the legal assessor.

Decision and reasons on interim order

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

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive order. The panel therefore imposed an interim suspension order for a period of 18 months in order to protect the public and meet the public interest during any period of appeal, including the during the mandatory 28-day appeal period.

If no appeal is made, then the interim suspension order will be replaced by the substantive suspension order 28 days after Ms Leonard is sent the decision letter for this hearing in writing.

That concludes this determination.