Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 19 January 2026 – Friday 23 January 2026

Virtual Hearing

Name of Registrant:	Thresiamma Jaison
NMC PIN:	18L0182O
Part(s) of the register:	Nurses Part of the Register – Sub Part 1 RN1: Adult Nurse, Level 1 (12 December 2018)
Relevant Location:	Merseyside
Type of case:	Misconduct
Panel members:	Rachel Forster (Chair, Lay member) Harriet Fielder (Registrant member) Paul Barton (Lay member)
Legal Assessor:	Georgina Goring
Hearings Coordinator:	Aisha Charway
Nursing and Midwifery Council:	Represented by Ben Edwards, Case Presenter
Thresiamma Jaison:	Present and represented by Baiju Thittala, (Credence Law Group)
Facts proved by admission:	Charges 1, 2, 3i, 3ii 3iii, 3iv, 3v, 3vi, 3vii ,4, 5 and 6
Fitness to practise:	Impaired
Sanction:	**Suspension order (3 months)**

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

Details of charge

That you, a registered nurse:

1) On 23 March 2024, administered an overdose of Lorazepam medication to Resident A. **[PROVED BY WAY OF ADMISSION]**

2) On 24 March 2024, following Resident A's fall, used an inappropriate moving and handling technique when assisting Resident A. **[PROVED BY WAY OF ADMISSION]**

3) On 24 March 2024, failed in care planning and risk assessing in that, following Resident A's fall, you:

   a) Did not undertake observations for Resident A in that you:

      i) Did not undertake neurological observations adequately or at all. **[PROVED BY WAY OF ADMISSION]**
      ii) Did not undertake regular observations to monitor her condition, as required. **[PROVED BY WAY OF ADMISSION]**
      iii) Did not undertake blood pressure checks to monitor her condition. **[PROVED BY WAY OF ADMISSION]**
      iv) Did not undertake a full body check. **[PROVED BY WAY OF ADMISSION]**
      v) Did not complete a body map recording the injuries. **[PROVED BY WAY OF ADMISSION]**
      vi) Did not photograph the injuries. **[PROVED BY WAY OF ADMISSION]**
      vii) Did not commence the 24-hour post observation log. **[PROVED BY WAY OF ADMISSION]**

b) Did not call an ambulance. **[PROVED BY WAY OF ADMISSION]**

c) Did not undertake risk assessments for Resident A adequately or at all. **[PROVED BY WAY OF ADMISSION]**

d) Did not update Resident A's care plan and risk assessment documents, including failing to implement a wound care plan. **[PROVED BY WAY OF ADMISSION]**

4) On 24 March 2024, failed to follow safeguarding procedures in that you:

a) Did not complete an incident report following Resident A's fall adequately or at all, **[PROVED BY WAY OF ADMISSION]**

b) Signed off an incident form about an unwitnessed fall which was incorrect. **[PROVED BY WAY OF ADMISSION]**

5) On 24 March 2024 you were asleep on duty. **[PROVED BY WAY OF ADMISSION]**

6) On the night shift of 26-27 March 2024, you were asleep on duty. **[PROVED BY WAY OF ADMISSION]**

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

Background

The charges arose whilst you were employed as a registered nurse by Ainsdale Court Nursing Home ('The Home').

You were referred to the Nursing and Midwifery Council ('NMC') on 11 April 2024 by The Home where you had been employed as a registered nurse for approximately two months.

The Home raised concerns relating to allegations that you failed to take appropriate action after a resident ('Resident A') suffered a fall during a night shift on 23 March 2024. Resident A was a vulnerable end of life resident with dementia and cancer who was receiving pain medication as well as other medication to treat other health conditions. She was agitated and confused. The fall happened approximately three hours after you had administered a third dose of Lorazepam to Resident A, despite Resident A having already had her daily dose of Lorazepam administered to her that day.

After the fall, Resident A was helped back into bed but it is alleged that she was left for the rest of the night without further care being provided and without any escalation.

When Resident A was admitted to hospital the next day, it was discovered that as a result of the fall, Resident A had suffered a hip fracture, and an operation was required to pin the bone back in place.

The Home alleged that you:

- Failed to take clinical or neuro observations following the fall
- Failed to update care plans and risk assessments following the fall
- Failed to inform next of kin
- Failed to complete an incident form
- Failed to take photos of the wounds sustained
- Failed to implement wound care plans
- Made no thorough body checks or assessments following the fall
- Used incorrect moving and handling techniques to assist Resident A from the floor to the bed
- Did not implement the 24-hour post fall observation log
- Overdosed prescribed Lorazepam

The Home also raised concerns that you were allegedly sleeping while on shift on 24 March 2024 after Resident A had fallen, and that you were also found asleep while on shift on 26-27 March 2024.

You were dismissed from the Home on 2 April 2024 following an investigation and a disciplinary hearing.

Decision and reasons on facts

At the outset of the hearing, Mr Edwards presented the background of the case on behalf of the NMC and Mr Thittala on your behalf informed the panel that you made full admissions to all the charges.

The panel heard legal advice with regards to finding facts found proved by admission and took into account that you were legally represented and that the evidence before the panel supports the charges which you have admitted.

The panel therefore finds all charges proved in their entirety by way of your admissions.

In reaching its decision on the admitted charges, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Mr Edwards on behalf of the NMC and by Mr Thittala on your behalf.

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

- Witness 1: Manager of The Home at the time of the incident.

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 your 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 when determining whether the facts found proved amount to misconduct.

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, your fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct

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

Mr Edwards submitted that the facts found proved by way of admission amount to misconduct.

He referred the panel to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives 2018' (the Code) in making its decision.

He referred to Justice Collins judgement in the case of *Nandi v General Medical Council* [2004] EWHC 2317 (Admin)*:*

> *'That the adjective serious must be given its proper weight and in other contexts there has been reference to conduct which would be regarded as deplorable by fellow practitioners.'*

Mr Edwards identified the specific, relevant standards where your actions amounted to misconduct.

Mr Edwards submitted that the following codes had been breached:

> *'**1 Treat people as individuals and uphold their dignity***
> ***To achieve this, you must:***
> *1.2 make sure you deliver the fundamentals of care effectively*
>
> ***3 Make sure that people's physical, social and psychological needs are assessed and responded to***
> ***To achieve this, you must:***
> *3.3 act in partnership with those receiving care, helping them to access relevant health and social care, information and support when they need it*
>
> ***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*
>
> ***8 Work cooperatively***
> ***To achieve this, you must:***
> *8.1 respect the skills, expertise and contributions of your colleagues, referring matters to them when appropriate*

8.2 maintain effective communication with colleagues

8.3 keep colleagues informed when you are sharing the care of individuals with other health and care professionals and staff

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

8.6 share information to identify and reduce risk

10 Keep clear and accurate records relevant to your practice

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

13 Recognise and work within the limits of your competence

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

14 Be open and candid with all service users about all aspects of care and treatment, including when any mistakes or harm have taken place

To achieve this, you must:

14.1 act immediately to put right the situation if someone has suffered actual harm for any reason or an incident has happened which had the potential for harm

15 Always offer help if an emergency arises in your practice setting or anywhere else

To achieve this, you must:

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

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

To achieve this, you must:

18.1 prescribe, advise on, or provide medicines or treatment, including repeat prescriptions (only if you are suitably qualified) if you have enough knowledge of that person's health and are satisfied that the medicines or treatment serve that person's health needs

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

To achieve this, you must:

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

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

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

Mr Edwards submitted that code 6.1 is specifically relevant to Charge 3:

‘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;’

He stated that you had failed to undertake neurological observations adequately by not logging the injury in the 24-hour post observation log and not following The Home’s procedure when a resident has a fall.

Mr Edwards noted that in relation to Charges 3a, 3b, 3c and 3d you had not followed the requirements of codes 10.2 and 10.3:

‘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 and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements’

Mr Edwards informed the panel that code 15.2 was specifically relevant to charge 3b which he stated that you had admitted to not calling an ambulance following Resident A’s fall.

‘15.2 arrange, wherever possible, for emergency care to be accessed and provided promptly’

Mr Edwards highlighted code 18 which refers to the dispensing and administration of medication, and he noted that whilst part of this section of the code is not wholly relevant to you, it was relevant in relation to your conduct at Charge 1, in that you administered an overdose of Lorazepam.

Mr Edwards submitted that you have failed to uphold the standards and values set out in the code and invited the panel to find that the facts found proved amount to misconduct, and that your actions fell well below the standards expected of a registered nurse.

Mr Edwards further submitted that you had made a large number of mistakes and errors whilst caring for Resident A, and that, on 24 March 2024 and the night shift of the 26 - 27 March 2024, you admitted to falling asleep whilst on duty which put residents at risk by failing to carry out your duties and assess residents effectively and properly. He stated that members of the profession would find this admitted behaviour appalling as a registered nurse. He further stated that this conduct had not set a good standard for other members of the profession, and it had undermined public confidence in the profession.

Mr Thittala informed the panel on your behalf that you had made admissions to all the charges and also admitted that your conduct amounts to misconduct.

Submissions on impairment

Mr Edwards 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.

Mr Edwards referred to the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin) and submitted that limbs a, b and c of the *Grant* test are engaged and that limb d can be disregarded as there is no dishonesty in this case.

He referred the panel to paragraph 74 of *Grant* which states that a panel should 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 found.

Mr Edwards also referred to the case of *R (on the Application of Cohen) v. General Medical Council* [2008] EWHC 581 (Admin) which states that the panel must determine whether the conduct which led to the charge is remediable, has been remedied and whether there remains a risk of repetition.

Mr Edwards submitted that your conduct which resulted in these charges is remediable, but said that you have not currently remediated the concerns. He noted that you have undertaken some training but it is limited and no evidence has been provided by you as to how the training has strengthened your practice and what you have learnt from this training. He further noted that there is no other evidence to show that the conduct which led to the charges and referral to the NMC has been remediated appropriately.

Mr Edwards submitted that it is difficult to show whether this misconduct is highly unlikely to be repeated. He noted that your witness statement does not address your conduct and does not demonstrate insight into how your conduct impacted residents, colleagues and the profession. He further stated that this shows a lack of insight into your failings which presents a risk of repetition.

Mr Edwards invited the panel to consider your fitness to practise to be impaired on both public protection and public interest grounds. He submitted that this is needed to uphold proper professional standards and maintain public confidence in the profession.

Mr Thittala, on your behalf, submitted that you have admitted to all charges and that your fitness to practise is not currently impaired. He referred the panel to the notes of your disciplinary meeting with The Home and stated that, from an early stage, you have been honest about what went wrong, and have apologised for your misconduct. He read from your reflection:

'*I apologise for my medication error. Regarding the fall incident. I think I could have done a better job, documenting the incident. After hearing that the resident was admitted to hospital, I felt that with better training I could have done a better job.*

This incident happened due to my lack of concentration while on the job. I think this lack of concentration happened due to two factors. Mainly from the pressure of the job of having to do additional tasks which was[sic] not assigned in my job role and having to provide care for 23 residents in a shift with help of only two care staff. Also, the lack of training provided from the administration to my new role and atmosphere, and having to assume and exercise most of my job roles with my previous experience, which is with the NHS, who has a better and different setting, and no work colleagues were available during the time. Another factor was my personal circumstances at the time.

I could have been more thorough with my medication administration and documentations. There has been the first mistake in medication and documentation from me in my 6 years as a registered nurse in the UK and a further a [sic]total of 13 years as a nurse. I can assure you that I have learned from this mistake, and it would not happen again.

I would not let anything like this happen in the future from my side. I would check the medication record for any medications that should be administered and also I will be more vigilant and thorough in my practise. For the next week that I was working at that home, I seek more advise[sic] from my colleagues about the procedures to follow in the nursing home.

…

To practise effectively I should attend more training with the procedures and practises of nursing care home.'

He highlighted your challenging personal circumstances at the time of the incidents and what you had quoted in your NMC FtP reflective account form:

'… Sickness of my brother has had an impact on me for the time during which this incident occurred. After the incident along my personal circumstances has affected me and formed to take a stress leave from my workplace.'

Mr Thittala submitted that your reflection demonstrates that you have reflected and learned from your experience since the incidents. He said that your actions were neither attitudinal nor deliberate and that these incidents occurred due to your errors of judgment at a time when you were overwhelmed by personal circumstances, which he submitted were mitigating factors.

He further submitted that you have remedied the concerns by taking a number of steps to address them. He referred to the Ward Manager's report dated 20 August 2024 which stated:

'Thresiamma has completed her direct supervisory period and is able to take a team looking after 10 patients on her own…
Thresiamma has shown positive changes to her manner or [sic] working and she has taken the advice and directions and made some positive changes to how she is working.
Thresiamma is more attentive to patients and not so 'shy' and quiet when speaking to patients, but there is[sic] still some improvements that need to be made in communication.
Medication-medication is checked and spot checks are done to review and monitor if all medications are given according to the policy of the Trust. I have noticed Thresiamma picking up some discrepancies and highlighting these to the medical team, and that is a positive change as she is aware of the importance of correct medication policy procedures.
… Thresiamma has generally lost confidence in herself as a nurse, and she has said this to me in a discussion after the incident.
She has been encouraged to take this as a learning curve and improve her practice to proof [sic] *that she is the good nurse she is.*

Handover, and meetings are dealt with better by Thresiamma and the importance of effective handover is very important and she understands this…
She has got some serious financial pressures, and this is really affecting her as well, but we have offered Health work and well-being support.'

He referred to an earlier report dated 12 June 2024 by the same manager which details that you had highlighted a patient's needs during an emergency:

'She did action a patient who required an emergency call and attended and assisted the team till the task was completed. She did highlight a patient needs in the medical morning meeting and did escalate a concern without needing prompting.'

Mr Thittala referred the panel to a letter from your parish priest which spoke of your good character:

'I am aware that during the period relevant to the current NMC investigation Miss Jaison [PRIVATE]. *These were exceptional circumstances that placed her under considerable emotional strain and should be viewed as atypical of her usual conduct. Based on my knowledge of Miss Jaison, I believe she is a person of integrity and care, and I respectfully ask that her character and the context of her circumstances be given due consideration.'*

Mr Thittala informed the panel that you confirmed to him that you are a Christian, and you often go to church, and since this incident occurred you have sought comfort in attending church and speaking with your local parish priest.

Mr Thittala submitted that no further concerns have been raised by work colleagues and service users and the testimonies from current managers and work colleagues confirm that there were no concerns with your practice.

Mr Thittala further noted that the concerns raised have now been resolved through your training and current way of working. He submitted that you are no longer impaired on public protection grounds and informed the panel that this was the only incident that has occurred in your professional career.

Mr Thittala further submitted that it is highly unlikely that you would repeat this conduct and that these were isolated incidents. He said that you can practise kindly, safely and professionally and that there is no need for a finding of impairment on public interest grounds.

In response to panel questions Mr Thittala confirmed that you had worked around 30-40 shifts at The Home as an agency nurse prior to taking on full time employment with them.

In the response to panel questions, you told the panel that, when the incidents occurred, you were working independently as a nurse on that shift. You then told the panel that these were incidents that occurred in your professional life at a difficult time personally and that you regret them and have apologised. You stated that your personal circumstances had affected you greatly at the time. You further stated that you have learnt from this experience, and that now you will be more vigilant in the way that you work because you realise that you have a patient's life in your hands. You said that if you encounter a stressful situation in the future, you will take time off work, seek support and not bring family matters into work.

You told the panel that your practice is a lot better now, you have gained confidence, have a supportive manager and, as you are now working in an NHS trust, there are doctors and other professionals around you from whom you can seek help. You stated that whilst you were working in The Home, you could not seek help from senior nurses or doctors as no one was available.

Mr Thittala further submitted on your behalf that your financial responsibilities at the time of the incident were intense [PRIVATE].

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, *Cohen v General Medical Council* [2008] EWHC 581 (Admin) and *General Medical Council v Meadow* [2007] QB 462 (Admin).

Decision and reasons on misconduct

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

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

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

3 Make sure that people's physical, social and psychological needs are assessed and responded to
To achieve this, you must:
3.1 pay special attention to promoting wellbeing, preventing ill health and meeting the changing health and care needs of people during all life stages
3.3 act in partnership with those receiving care, helping them to access relevant health and social care, information and support when they need it

4 Act in the best interests of people at all times
To achieve this, you must:

4.1 balance the need to act in the best interests of people at all times with the requirement to respect a person's right to accept or refuse treatment

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 cooperatively

To achieve this, you must:

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

8.2 maintain effective communication with colleagues

8.3 keep colleagues informed when you are sharing the care of individuals with other health and care professionals and staff

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

8.6 share information to identify and reduce risk

10 Keep clear and accurate records relevant to your practice

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

13 Recognise and work within the limits of your competence

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

14 Be open and candid with all service users about all aspects of care and treatment, including when any mistakes or harm have taken place

To achieve this, you must:

14.1 act immediately to put right the situation if someone has suffered actual harm for any reason or an incident has happened which had the potential for harm

14.2 explain fully and promptly what has happened, including the likely effects, and apologise to the person affected and, where appropriate, their advocate, family or carers

14.3 document all these events formally and take further action (escalate) if appropriate so they can be dealt with quickly

15 Always offer help if an emergency arises in your practice setting or anywhere else

To achieve this, you must:

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

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

To achieve this, you must:

18.1 prescribe, advise on, or provide medicines or treatment, including repeat prescriptions (only if you are suitably qualified) if you have enough knowledge of that person's health and are satisfied that the medicines or treatment serve that person's health needs

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

To achieve this, you must:

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

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

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

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

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 determined that all the charges in your case amount to serious misconduct because you had not followed safeguarding procedures in The Home, you admitted to twice falling asleep on duty whilst being the only supervisory nurse on shift you failed to look after, take observations, monitor, record and update records and escalate appropriately for a particularly vulnerable resident who was on end-of-life care, and who had a fallen whilst you were on duty. Furthermore, your failings led to Resident A potentially being in pain for longer than necessary. The panel noted that you had also

made a medication error which resulted in a Lorazepam overdose which you had administered to Resident A, putting them at serious risk of harm.

The panel found that your actions were serious and fell far below the standards expected of a nurse and therefore amount to misconduct.

Decision and reasons on impairment

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

In coming to its decision, the panel had regard to the NMC Guidance on *'Impairment'* (Reference: DMA-1 Last Updated: 03/03/2025) in which the following is stated:

> *'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 be honest and open and act with integrity. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

In this regard the panel considered the judgment of Mrs Justice Cox in the case of *CHRE v NMC(1) and Grant(2)* (2011) EWHC 927 (Admin) in reaching its decision. In paragraph 74, she said:

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

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

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

The panel considered that the first three limbs of the Dame Janet Smith's test are engaged.

In relation to limb a), the panel determined that Resident A was put at unwarranted risk of harm as a result of your failings. It noted that Resident A was a vulnerable resident who suffered from a fracture following the fall which occurred when you were on duty.

The panel referred to the incident form which detailed Resident A's injury:

> *'**Diagnosis***
> *Right Neck Femur Fracture…*
> **Clinical Summary**
> *Resident A was admitted for correction of right sided femur fracture by intramedullary nail…'*

The panel considered that, as a result of your failure to escalate matters, Resident A's admission into hospital was unnecessarily delayed and had the potential to cause her unnecessary pain. The panel noted that Resident A's hospital admission was delayed for more than 12 hours.

The panel could not conclude that your medication error contributed to Resident A's fall. The panel agreed that your failure to undertake appropriate medication administration checks resulted in an overdose of Lorazepam, which was a further risk factor in terms of the potential harm to Resident A.

In relation to limbs b) and c), the panel determined that your misconduct had brought the profession into disrepute. The panel found breaches in all sections of the code, which signifies the level of seriousness of the misconduct and demonstrates that you have breached fundamental tenets of the code. The panel also considered that a well-informed member of the public upon learning about your behaviour as an experienced nurse would expect a finding of impairment.

Regarding insight, the panel considered your level of insight to be developing. The panel noted that there has been an improvement in your practice between the report provided by your manager in May 2024 and subsequent reports. The panel heard that your current manager, who had provided a reference dated 15 January 2026, was an interim manager who had been managing you for 2.5 months, but noted the significant improvement in your practice and confidence and that she has no concerns about your practice.

However, the panel determined that you have not provided sufficient evidence to demonstrate that your fitness to practise is no longer impaired.

The panel found that, although you have accepted that what you did was wrong, you have not sufficiently addressed the impact that your conduct had on residents, colleagues and the public. The panel had no recent written reflections and no evidence of how the learning and training that you have undertaken has been embedded in your practice since these incidents. You told the panel that you now realise that you were bringing the significant family issues for which you had responsibility into the workplace and that the level of pressure that you were under outside of your work significantly impacted your practice. You explained that now you would act differently if placed under similar circumstances and would take time off and use your leave entitlement. The panel acknowledges the beginnings of your developing insight but nevertheless determined that you need to provide deeper reflection into the wider impact of your misconduct and the changes that you would put in place for the future.

The panel was satisfied that the misconduct in this case is capable of being remediated. The panel carefully considered the evidence before it in determining whether or not you have taken sufficient steps to strengthen your practice. The panel took into account that you have completed in-person and online training, and that you have been working in a clinical environment for the last 18 months and you have complied with the interim order placed on your practice. The panel also noted the positive reference from your current manager.

However, the panel found that there is a risk of repetition based on your lack of reflection specifically on patient safety, medication management, poor practice and poor leadership. The panel further considered that there is limited up to date evidence of safe practice. The panel had regard to the reference from your current manger, and it noted that this did not address the concerns raised in the charges. The panel found that, in all the circumstances, there remains a risk of repetition of this misconduct.

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

The panel bore in mind that the overarching objective of the NMC is 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 recognises that there were some contextual, personal circumstances which contributed to your misconduct and it acknowledges that you have taken some steps in the intervene of two years to address your practice but given the number of serious failings and the breadth of them together with the fact that a very vulnerable resident suffered harm, a finding of impairment on the ground of public interest is necessary. The panel was of the view that a fully informed member of the public or the profession, who knew of the circumstances of this case, would be concerned if you were allowed to practise unrestricted as a nurse.

The panel determined that to not make a finding of impairment would significantly undermine the public’s trust and confidence in the nursing profession. It is also necessary to mark the seriousness of the misconduct and to uphold proper standards and conduct for members of the nursing profession.

Having regard to all of the above, the panel decided that your fitness to practise is also currently impaired on public interest grounds.

Sanction

The panel has considered this case very carefully and has decided to make a suspension order for a period of 3 months. The effect of this order is that the NMC register will show that your registration has been suspended.

Submissions on sanction

Mr Edwards, informed the panel that in the Notice of Hearing, dated 19 December 2025, the NMC had advised you that it would seek the imposition of a Suspension order of 3 to 6 months if your fitness to practise was found to be currently impaired.

Mr Edwards, submitted the following aggravating features the panel should consider:

- You delayed treatment and as a result of your failure to escalate matters Resident A was placed at a risk of harm
- Resident A was a vulnerable patient
- Repeated behaviour in that you fell asleep whilst on duty on two separate occasions
- Lack of insight and understanding but it was developing.

He then stated that the following mitigating factors should be considered:

- There have been no further concerns raised
- This was an isolated incident in that there have been no other previous regulatory concerns raised.
- The personal circumstances you were dealing with at the time.

Mr Edwards further submitted that due to the nature and seriousness of the charges admitted, a short suspension order with an opportunity to review this before its expiry will serve the public interest.

Mr Thittala asked the panel to consider a caution order as the most proportionate sanction. He submitted the following factors to be considered:

- You have not had any previous regulatory concerns
- This was not a position of trust issue
- You have full insight and accepted that there were issues with your misconduct and made early admissions during the disciplinary investigation
- You were experiencing difficult personal matters, and the panel should take this into consideration when considering what sanction to impose
- This is an isolated incident and there has not been a pattern of misconduct
- You have been subject to interim order of conditions which you have complied with where significant progress had been made resulting in a panel revoking those conditions

Mr Thittala stated that a sanction, should not be punitive as the purpose of the sanctions are to ensure how the nurse can learn from their mistakes. He further noted that you have demonstrated insight by understanding and taking the necessary steps.

He asked the panel to give sufficient weight to the cultural differences, explaining that English is not your first language and that this impacted how you expressed yourself throughout your reflection submitted. He stated your reflective statement would be different if English was your first language.

Mr Thittala stated that your line manager was on leave and so a shortened statement from the current manager was provided. He stated that had your line manager provided a more recent statement, it would have addressed the issues. He informed the panel that the line manager had returned to work this week.

Mr Thittala stated that should the panel impose a suspension order, you would lose your job. He stated that a conditions of practice order may result in your current employment being terminated. He submitted that your misconduct was at the lower end of the spectrum and the panel should also take this into consideration and impose a caution order.
In response to an objection by Mr Edwards regarding Mr Thittala's submissions on early admissions, Mr Thittala confirmed that you had been remorseful from the beginning of the investigation. He referred the panel to the investigatory meeting minutes conducted by Witness 1 which documented:

> *'TJ: Apologies for my mistakes. It was my personal matters, that why I didn't complete I am sorry…'*

Mr Thittala accepted however, that only charges 1 and 5 had been formally admitted by you to the NMC at an early stage.

In relation to this, the panel heard from Ms Goring who advised that this was a matter for the panel to consider based on the evidence it currently has.

In response to panel questions regarding your employment status following a conditions of practice order, Mr Thittala confirmed that you had informed him that you sensed you could potentially be dismissed or suspended from your current employment. You confirmed to the panel that you had tried to have a conversation with your manager regarding what your employment status would be following these proceedings but she had only returned from long term leave this week and had been unable to speak to you.

Decision and reasons on sanction

Having found your 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

sanction guidance (SG). The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features:

- You delayed treatment and as a result of your failure to escalate matters Resident A was put at a risk of harm
- Resident A was a vulnerable end of life resident with dementia and cancer
- You fell asleep whilst on duty on two separate occasions when you were the only nurse on duty
- You have not shown full insight and understanding of your actions.
- You were in a leadership role and did not demonstrate professional behaviour to colleagues.

The panel also took into account the following mitigating features:

- There have been no further concerns raised
- These incidents occurred over a short period of time, and no previous regulatory concerns have been raised.
- The significant personal circumstances you were dealing with at the time impacted your practice.
- You have continued to work as a Nurse in an NHS trust

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

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 your 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 your misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the issues identified and that you were impaired on public interest grounds. It also noted that you have not shown that you have fully remediated these concerns. 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 your registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. The panel took into account the SG, in particular:

- That you have currently shown developing insight
- There have been multiple breaches of the code
- There is still a continued risk as you have not reflected on your misconduct
- The panel considered the Ward Manager report dated 12 June 2024 of Manager 1 which had raised concerns about repeated behaviour regarding a medication error and insufficient detail in your report writing. This confirmed to the panel that there was a risk of repetition. The panel, in fairness to you, noted that in a subsequent report dated August 2024 by the same manager, there had been improvement in medication administration but there was still room for improvement with regards to care planning and documentation.
- The up-to-date reference provided was from a temporary manager and whilst positive, it was generic in nature and did not address the regulatory concerns.
- Your fitness to practise is impaired on both public protection and public interest grounds and as your conduct resulted in harm to a vulnerable person and multiple breaches of the code, a conditions of practice order would not sufficiently mark the seriousness of the findings or satisfy the public interest test.

The panel took into account NMC guidance Sanction SAN- 3c Conditions of practice it noted from the guidance:

> *'If a nurse, midwife or nursing associate's actions put people at risk of being harmed, this risk makes their case more serious.'*

Therefore, the panel concluded that the placing of conditions on your registration would not adequately address the seriousness of this case, would not protect the public and would not address the public interest.

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

- *A single instance of misconduct but where a lesser sanction is not sufficient.*
- *No evidence of repetition of behaviour since the incident.*
- *no evidence of harmful deep-seated personality or attitudinal problems*

The panel was satisfied that in this case, the misconduct was not fundamentally incompatible with remaining on the register.

Although this was not an isolated incident, the panel could see that a significant factor motivating your misconduct was the external stressful and significant personal issues which you were dealing with at the time and which you told the panel had overwhelmed you.

The panel could see from the improvement in the two reports submitted by your manager that you were addressing the concerns and that changes to your practice were being seen within a few months of the incidents. However, you have not demonstrated full insight in that you have not provided a reflection which details the wider impact of your misconduct

on patients, colleagues and the public, nor have you explained in sufficient detail that you have appreciated how serious the charges found proved are. You have also not explained sufficiently how you have improved your practice and how you will ensure that stressful periods of life will not impact on your practice and your care of patients. The panel found that currently you have developing insight.

Resident A suffered harm as a result of your failure to follow safeguarding procedures.

The panel was of the view that a short suspension order would allow you more time to reflect and undertake specific training to address the concerns. It acknowledged that English was not your first language but as part of your revalidation you are expected to complete five reflective pieces, and indeed you confirmed that you have done this in the last two years. Therefore, the panel was confident that you will be able to provide a full and deep reflection on your misconduct and the wider impact.

The panel found that your fitness to practise was also impaired on public interest grounds and considered that this period of suspension would sufficiently mark the seriousness of your conduct and satisfy the public and profession.

The panel went on to consider whether a striking-off order would be proportionate in your case but taking account of all the information before it, the panel concluded that it would be disproportionate and unduly punitive.

Balancing all of these factors the panel has concluded that a suspension order for a period of three months with a review was the appropriate and proportionate sanction in this case to mark the seriousness of the misconduct.

The panel noted the hardship such an order will inevitably cause you. 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:

- Your continued engagement, attendance and participation at the review hearing
- An up-to-date reference from your current manager which addresses the concerns in the charges.
- A refection which addresses each of the concerns raised in the charges and reflects on the wider impact on the patients, colleagues and the public and explains how you would act differently in the future.
- Undertake a course in documentation and record keeping and provide a reflection on what you have learnt from the course and how you will embed this in your practice

This will be confirmed to you 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 your own interests until the suspension sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Submissions on interim order

Mr Edwards submitted that given the seriousness of the charges found proved, an interim suspension order is necessary on the grounds of public protection and is also otherwise in the wider public interest.

The panel took account of the submissions made by Mr Edwards. He submitted that the NMC is seeking the imposition of an interim suspension order for a period of 18 months, to cover any potential appeal in the period until the substantive order takes effect and to cover the time that any such appeal may take.

Mr Edwards submitted that given the seriousness of the charges found proved, an interim suspension order is necessary on the grounds of public protection and is also otherwise in the wider public interest.

Mr Thittala made no submissions on the interim order.

Decision and reasons on interim order

The panel was satisfied that an interim order was necessary as you were impaired on public protection and public interest grounds. It concluded that it is in the public interest that this interim order is imposed to ensure the public is protected. The panel had regard to the seriousness of the facts found proved by way of your admissions 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 has taken into consideration that the substantive order only takes effect after 28 days. The panel therefore imposed an

interim suspension order for a period of 18 months to cover any potential appeal in the period until the substantive order takes effect and to cover the time that any such appeal may take.

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

The panel was satisfied that this period was proportionate in the circumstances of the case.

That concludes this determination.