Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Meeting
Monday, 19 January 2026 – Tuesday, 20 January 2026

Virtual Meeting

Name of Registrant:	**Anna Preyzner**
NMC PIN	15B0045C
Part(s) of the register:	Registered Nurse – Adult Nursing RNA – (2 February 2015)
Relevant Location:	Lancashire
Type of case:	Misconduct
Panel members:	Charlie Tye (Chair, Lay member) Richard Curtin (Registrant member) Kevin Connolly (Lay member)
Legal Assessor:	Emma Boothroyd
Hearings Coordinator:	Nicola Nicolaou
Facts proved:	Charges 1a, 1b, 1c, and 2
Fitness to practise:	Impaired
Sanction:	**Suspension order (6 months)**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on service of Notice of Meeting

The panel was informed at the start of this meeting that that the Notice of Meeting had been sent to Mrs Preyzner's registered email address by secure email on 8 December 2025.

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Meeting provided details of the allegation, the time, date and the fact that this meeting was heard virtually.

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

Decision and reasons on proceeding in the absence of Mrs Preyzner

The panel next considered whether it should proceed in the absence of Mrs Preyzner. It considered that there is sufficient evidence, which has not been challenged nor is there a material dispute as to the facts, before it to deal with this case at a meeting. Further, the panel acknowledged that the NMC decided that it was appropriate for this case to be heard at a meeting, rather than a hearing.

The panel accepted the advice of the legal assessor.

The panel considered that as there was sufficient evidence before it to deal with this matter at a meeting, rather than a hearing, it was fair to proceed with this matter as a meeting.

In reaching this decision, the panel noted that:

- No application for an adjournment has been made by Mrs Preyzner;
- The charges relate to events that occurred in 2021; and

- There is a strong public interest in the expeditious disposal of the case.

In these circumstances, the panel has decided that it is fair to proceed with this matter at a meeting.

Details of charge

That you, a registered nurse:

1) Between 27 and 28 March 2021:

    a) failed to accurately record one or more falls in relation to Resident A
    b) failed to adequately handover information to the day staff, in relation to Resident A's fall(s)
    c) inaccurately recorded temperature readings for one or more colleagues, during Covid-19 safety measures

2) Your conduct at 1c) above was dishonest, in that you knew you had neither taken, observed, nor been told their temperature readings.

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

Background

The NMC received a referral on 19 April 2021 from Lakeland View Care Centre ('the Care Centre') about Mrs Preyzner, who had been employed with them since July 2021 as a registered nurse.

The referral stated that Mrs Preyzner had allegedly falsely recorded temperatures for two staff members during the night shift of 27-28 March 2021. The Care Centre was following government protocols and required staff members to take and record their temperature twice during each shift, and to record the readings. It is alleged that there was no policy around who took or recorded the temperature readings.

The allegation in this instance arose because a member of staff went to take their own second reading of the shift and noticed that Mrs Preyzner had already filled out the sheet, despite the fact that they had yet to take the reading. The member of staff mentioned this to another colleague who then went to check the chart and saw that a reading had been recorded next to their name also, even though they had yet to take their reading.

The Care Centre also raised a concern regarding Mrs Preyzner's recording of an incident regarding a resident ('Resident A') during the same shift. It is alleged that Resident A had lost their balance and fallen. This was witnessed by at least one member of staff, who alerted Mrs Preyzner. Approximately 30 minutes later, it is alleged that Resident A fell a second time.

Mrs Preyzner allegedly recorded on Resident A's body map, and an incident form, that they were found sitting on the floor, when in fact they were lying on the floor. Mrs Preyzner also allegedly failed to record on the body map or incident form that Resident A had fallen on two occasions. It is the first occasion that Mrs Preyzner allegedly failed to record and failed to report the information accurately in Resident A's daily care notes, stating that Resident A had *'put themself on the floor'*.

Further, Mrs Preyzner was allegedly found to have failed to record the earlier fall at all and did not share with colleagues at the handover that Resident A had fallen twice and had subsequently needed a wheelchair.

Decision and reasons on facts

In reaching its decisions on the disputed facts, the panel took into account all the documentary evidence in this case together with the representations made by the NMC in their Statement of Case.

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

The panel had regard to the written statements of the following witnesses on behalf of the NMC:

- Witness 1: Provider Support/Company Secretary at North West Care Ltd at the time of the alleged incidents

- Witness 2: Registered nurse at the Care Centre at the time of the alleged incidents

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

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

Charge 1a

That you, a registered nurse:

1) Between 27 and 28 March 2021:

    a) failed to accurately record one or more falls in relation to Resident A

This charge is found proved.

In reaching this decision, the panel took into account Person 4's contemporaneous note dated 27 March 2021 which stated:

> *'I was working a night shift, whilst I was watching the main lounge I witnessed* [Resident A] *fall to the ground after he stood from a chair with his frame.* [Resident A] *fell straight back between 2 chairs.* […] *But then I noticed that Anna had put in her notes that* [Resident A] *had put himself to the floor. She lyed* [sic]*'*

The panel also took into account Person 4's local statement dated 29 March 2021 which stated:

> *'*[…] *She did not check over his body in the way that I always see other nurses check after a fall. A.P did not check* [Resident A's] *body at all.* […] *At no stage that night did I see* [Resident A] *put himself to the floor* [sic], *I saw that A.P had recorded that* [Resident A] *put himself to the floor. The fall I saw was a fall.* [Resident A] *did not put himself to the floor, I told AP that he had fallen backwards.'*

The panel also had sight of Person 7's local statement dated 30 March 2021 which stated:

> '[…] [Resident A] *stood up from his chair with his frame in front of him. He got up alright. Within seconds* [Resident A] *suddenly fell to the left towards the table. I heard a bang but I didn't see him bang his head* […]'

The panel considered that the evidence demonstrated that Resident A had two falls on the night in question. It considered that Mrs Preyzner was the sole nurse on the shift and had a duty to accurately record any falls that a resident has. The panel had sight of Resident A's care notes and determined that Mrs Preyzner only recorded one of Resident A's falls, and not the other.

The panel also had sight of Resident A's body map and noted that Mrs Preyzner had stated that Resident A was sat on the floor, when the evidence indicated that he was found to be laying on the floor. Therefore, the panel considered that the information recorded by Mrs Preyzner was inaccurate.

The panel determined that Mrs Preyzner failed to accurately record one or more falls in relation to Resident A. The panel found this charge proved on the balance of probabilities.

Charge 1b

1) Between 27 and 28 March 2021:

b) failed to adequately handover information to the day staff, in relation to Resident A's fall(s)

This charge is found proved.

In reaching this decision, the panel took into account Witness 2's witness statement which stated:

> *'Anna had told me* [Resident A] *experienced a fall at the start of the night shift. She described him going to sit down and missing the seat. He landed on his bottom, hard on the floor. Anna didn't mention any injuries.*
>
> […]
>
> [Person 5] *had asked me what Anna had told me about* [Resident A]. *I said Anna told me* [Resident A] *had a fall.* [Person 5] *told me* [Resident A] *actually had two falls and hadn't been able to walk since the second. He required to be moved in a wheelchair and couldn't get out of bed throughout the night.'*

The panel also took into account Person 3's local statement dated 29 March 2021 which stated:

> '[Witness 2] *had already explained to me that on handover A.P had stated that* [Resident A] *had lowered himself to the floor on one occasion that night but did not make reference to any fall.'*

The panel considered that Mrs Preyzner had a duty, as part of the fundamentals of the nursing profession, to communicate clearly and fully handover any information relevant to the care of a resident to the day staff. This would include information about the number and extent of Resident A's falls. The panel considered based on the evidence before it that Mrs Preyzner did not adequately handover information in relation to Resident A's falls to the day staff. The panel considered that the evidence of Witness 2 demonstrated that Mrs Preyzner had only mentioned one of the falls, did not mention that Resident A was unable to get out of bed, and so did not fully reflect what had happened. Therefore, the panel

concluded that the information provided at the handover was inadequate. The panel therefore found this charge proved on the balance of probabilities.

Charge 1c

1) Between 27 and 28 March 2021:

    c) inaccurately recorded temperature readings for one or more colleagues, during Covid-19 safety measures

This charge is found proved.

In reaching this decision, the panel took into account Witness 1's witness statement which sets out the Covid-19 procedures that were in place at the time. The witness statement stated:

> *'At the time, Covid temperature checks had to be undertaken twice during a shift. Each member of staff had to either have their temperature checked or check their own temperature and record it.'*

The panel also took into account the local statement of Person 5 which stated:

> *'I had recorded my own temperature when I arrived and I had not yet taken my second temperature. On the temperature sheet there was a reading of around 36° on my space for the second reading of the night. I did not record this. I had not yet taken my second temperature.'*

Similarly, Person 6's local statement dated 1 April 2021 stated:

> *'I went to complete my second temperature check of the shift, after midnight. I took my temperature which was fine. When I looked at the sheet, my temperature had already been recorded. It looked to me like it was A.P's writing* […]*'*

The panel took into account that both Person 5 and Person 6 stated that they did not make the second temperature entries on the sheet. The panel had sight of Mrs Preyzner's statement dated 6 April 2021 which stated:

> *'For both temperatures recorded on 27th and 28th March 21 under my name is 36.5 and 36.6. I have seen the record and this is my handwriting.* […] *I know it is not acceptable to record a temperature that I have not taken and just write a figure.* […]*'*

The panel considered that it appears that Mrs Preyzner made an admission to recording the temperatures for her colleagues, when she had not taken them, during the internal investigation. The panel took into account that the Care Centre had procedures in place due to the Covid-19 pandemic and that Mrs Preyzner had a duty to follow these procedures. The panel considered that the evidence demonstrated that Person 5 and Person 6 had not recorded their second temperature reading, and yet found that a record had been entered on their behalf. The panel concluded that this, taken with Mrs Preyzner's local admission that she made the records, meant it was more likely than not that Mrs Preyzner had recorded the temperatures of her colleagues. In addition, Mrs Preyzner admitted that she entered familiar temperatures for both members of staff. Therefore, the panel determined that it was more likely than not Mrs Preyzner did not know the temperatures of Person 5 and Person 6, and so inaccurately recorded them.

The panel determined that Mrs Preyzner inaccurately recorded the temperature readings for both colleagues and therefore found this charge proved on the balance of probabilities.

Charge 2

2) Your conduct at 1c) above was dishonest, in that you knew you had neither taken, observed, nor been told their temperature readings.

This charge is found proved.

In reaching this decision, the panel took into account Mrs Preyzner's statement dated 6 April 2021 which stated:

'*I know it is not acceptable to record a temperature that I have not taken and just write a figure.* […]'

The panel considered that Mrs Preyzner would have known that she did not take the temperatures of the two members of staff concerned, that she did not know what their temperatures were, and that she would have known that there was a need to record accurately. The panel considered that Mrs Preyzner would have been aware of the procedures in place at the time, and that she would have known her colleagues were not aware that she was recording their temperatures without having taken them. Moreover, in the statement she provided on 6 April 2021, Mrs Preyzner accepted that she knew this was not acceptable. Therefore, the panel found that Mrs Preyzner knowingly entered the temperatures for two members of staff, against the relevant policy, whilst fully aware that this was not appropriate.

The panel considered that knowingly entering false temperatures would be considered dishonest by the standard of ordinary decent people. Firstly, such an action would be a deliberate falsification. Secondly, this occurred during the time of a global pandemic where healthcare professionals were expected to maintain the safety of their patients and staff. The panel considered that intentionally recording false information to evade safety requirements during a global pandemic would be considered dishonest.

The panel therefore found this charge proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether Mrs Preyzner's fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's ability to practise kindly, safely and professionally.

The panel, in reaching its decision, has recognised its statutory duty to protect the public and maintain public confidence in the profession. Further, it bore in mind that there is no

burden or standard of proof at this stage and it has therefore exercised its own professional judgement.

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

Representations on misconduct and impairment

The NMC has provided an undated Statement of Case which sets out its position in relation to misconduct, impairment, sanction, and interim order. This will be summarised accordingly.

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

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

The NMC submitted the relevant standards where Mrs Preyzner's actions amounted to misconduct. The Statement of Case sets out that Mrs Preyzner's failings involved a serious departure from the standards expected of a registered nurse. The Statement of Case goes on to state that Mrs Preyzner's conduct included dishonest acts which were directly linked to her professional practice, occurring during a single weekend. The NMC state that residents of the Care Centre were put in direct risk of real harm as a result of Mrs Preyzner's conduct, and therefore amount to misconduct.

The NMC requires the panel to bear in mind its overarching objective to protect 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. The panel has referred to the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant* [2011] EWHC 927 (Admin).

The Statement of Case outlines that Mrs Preyzner's dishonest actions compromised patient safety and had the potential to cause serious harm to the patients in her care. The NMC also state that Mrs Preyzner breached fundamental tenets of the nursing profession and brought the profession into disrepute. Further, the Statement of Case outlines that Mrs Preyzner acted dishonestly in that she knew that the records she made in respect of her colleague's temperatures were inaccurate and had intended to create a misleading impression.

The Statement of Case further states that Mrs Preyzner has displayed limited insight into her misconduct, and that the dishonest conduct may be difficult to address, and calls into question Mrs Preyzner's integrity. The NMC state that there is a continuing risk to the public due to Mrs Preyzner's lack of insight and failure to demonstrate meaningful reflection in relation to her dishonest conduct. The NMC invited the panel to make a finding of current impairment on the ground of public protection.

In relation to public interest, the Statement of Case states:

> *'We consider there is a public interest in a finding of impairment being made in this case to declare and uphold proper standards of conduct and behaviour. Ms Preyzner's conduct engages the public interest and members of the public would be concerned to hear of a nurse failing to provide appropriate care and observations, and inaccurately and inadequately documenting and handing over an incident; and acting dishonestly in relation to falsifying records for infection control during the Covid-19 pandemic. Such conduct would severely damage and undermine public confidence in the nursing profession and the NMC, as the regulator.*
>
> […]
>
> *We therefore consider that there is a public interest in a finding of impairment being made in this case to declare and uphold proper standards of conduct and behaviour.'*

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

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 Mrs Preyzner's actions did fall significantly short of the standards expected of a registered nurse, and that Mrs Preyzner's actions amounted to a breach of the Code. Specifically:

> *'**8 Work cooperatively***
> *To achieve this, you must:*
> ***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*

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

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

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'*

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. In relation to charges 1a and 1b, the panel considered that Mrs Preyzner recorded only one of the two falls experienced by Resident A, accepted that Resident A was lying on the floor rather than sitting at the time, and handed over information in respect of only one of those falls to the day staff. The panel regarded these omissions as poor practice, reflecting a failure to fully and accurately record and communicate relevant information. However, the panel concluded that the shortcomings, taken in context, were not sufficiently serious to amount to misconduct.

Regarding charges 1c, and 2, the panel considered that Mrs Preyzner accepted in her statement dated 6 April 2021 that her actions were inappropriate. The panel considered that an act of dishonesty during the Covid-19 pandemic was particularly serious as it increased the risk of potential harm to residents and staff. The panel considered that Mrs Preyzner's actions at charges 1c and 2 were so serious that they amount to misconduct.

The panel found that Mrs Preyzner's actions did fall 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, Mrs Preyzner's fitness to practise is currently impaired.

In coming to its decision, the panel had regard to the Fitness to Practise Library, updated on 27 February 2024, which states:

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

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. To justify that trust, nurses must 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 and Grant* in reaching its decision. In paragraph 74, she said:

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

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

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

The panel considered that residents and staff were put at risk of harm as a result of Mrs Preyzner’s misconduct. It considered that during the Covid-19 pandemic, procedures were put in place to maintain safety of staff and residents, and that Mrs Preyzner attempted to frustrate these procedures by dishonestly recording false temperatures. The purpose of the procedure was to monitor staff to ensure they were not an infection risk. By recording a false temperature, staff and residents could have been put at risk because if one of the staff developed a temperature, and posed an infection risk, this may not have been noticed and properly addressed. The panel considered that both residents and members of staff would have been put at risk by an undetected, and unresolved, infection risk. While there is no evidence of actual harm, the panel nevertheless considered that the misconduct had the potential to jeopardise the safety of residents and staff.

The panel considered that Mrs Preyzner's misconduct had breached fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. Further, it was satisfied that confidence in the nursing profession would be undermined if its regulator did not find charges relating to dishonesty extremely serious.

The panel considered the factors set out in the case of *Ronald Jack Cohen v General Medical Council* [2008] EWHC 581 (Admin) when determining whether or not Ms Abogatal has taken steps to strengthen her practice. That is:

> *'Whether the misconduct is easily remediable;*
> *Whether it has in fact been remedied;*
> *Whether it is therefore highly unlikely to be repeated'*

In answer to whether the misconduct is easily remediable, the panel considered that the misconduct could be remedied. The panel acknowledged that in most cases, dishonesty can be more difficult to put right, but it considered that this was an isolated spontaneous incident, and there was no personal gain for Mrs Preyzner. The panel further considered that there was no evidence of a deep-seated attitudinal issue and so in all the circumstances the panel determined that this misconduct was capable of remediation.

In answer to whether the misconduct has been addressed and remedied, the panel took into account Mrs Preyzner's statement dated 6 April 2021 in which she acknowledged her wrongdoing and demonstrated a level of insight and remorse. However, the panel considered that there is no evidence before it to suggest that Mrs Preyzner has taken sufficient steps to address and remediate the misconduct in this case.

In answer whether the misconduct is highly unlikely to be repeated, the panel considered that there is a risk of repetition. The panel took into account that this was an isolated incident, and there is no evidence before it to suggest any repetition since the incidents occurred in 2021. However, the panel acknowledged that Mrs Preyzner has not been working as a registered nurse for the last five years. The panel noted Mrs Preyzner's remorse and insight, and also took into account the circumstances at the time, that this was during a global pandemic. However, the panel considered that as Mrs Preyzner has demonstrated limited insight, and has not demonstrated an understanding of the risk of

harm to vulnerable patients, and staff when working whilst possibly infectious. As the misconduct has not been fully remediated, and Mrs Preyzner's insight is still developing, the panel concluded that there is a risk of repetition of the misconduct in this case. Due to Mrs Preyzner acknowledging the wrongfulness of her actions at the local level, and the isolated nature of the incident, the panel did not consider this risk to be significantly high, but due to the still developing insight, the panel could not conclude that the misconduct was highly unlikely to be repeated. As some level of risk remains, the panel therefore determined that a finding of current impairment is necessary on the ground of public protection.

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 considered that honesty is essential to the nursing profession and critical for nurses to maintain the position of trust and confidence they occupy. Therefore, the panel considered a finding of impairment was necessary to signal to the public, and other registered professionals, that dishonesty within the nursing profession is intolerable. Moreover, the panel concluded that a fully informed member of the public would be deeply concerned if a nurse who dishonestly evaded safety procedures during a pandemic was permitted to practice without action being taken. As it would suggest that nurses are not obliged to act honestly at all times, and that procedures meant to maintain the safety of others could be dishonestly circumvented. Therefore, a finding of impairment is necessary to maintain public confidence in the profession and maintain professional standards.

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

Sanction

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

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

Representations on sanction

The Statement of Case sets out that a suspension order for a period of six months is an appropriate and proportionate sanction in this case.

The NMC state that taking no action or imposing a caution order would be disproportionate in this case and would not be sufficient to mitigate the risks, protect the public, or engage the public interest.

Regarding a conditions of practice order, the Statement of Case states that given the underlying attitudinal concerns, and the dishonesty element, a conditions of practice order would not be sufficient to address the misconduct in this case. The NMC state that there are no conditions which can adequately address the dishonesty, protect the public, or engage the public interest.

Regarding a suspension order, the Statement of Case states that a suspension order would be sufficient to protect the public and satisfy the public interest. Mrs Preyzner's dishonest conduct and lack of insight indicates a harmful deep-seated attitudinal concern. However, the Statement of Case states that there is no evidence of repetition of behaviour since the incidents occurred. The NMC state that a six-month suspension order with a review would be sufficient to protect the public and maintain confidence in the nursing profession.

The NMC state that a striking off order would be disproportionate in this case, as the dishonesty does not fall under the most serious category, and is less indicative of an attitudinal concern. This is because the dishonesty was not done to cover up any

wrongdoing, but rather was due to tiredness and generally poor decision making. The NMC say that there is a lesser sanction which can protect the public and maintain public confidence in the profession.

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- The context at the time, in that this was during the Covid-19 pandemic and the procedures that Mrs Preyzner circumvented were designed to maintain the safety of others

The panel also took into account the following mitigating features:

- An isolated incident of misconduct
- A previously unblemished career
- Early acceptance of the misconduct
- Admissions to the misconduct during the internal investigation
- Level of remorse and insight

The panel had regard to the NMC guidance on sanctions for particularly serious cases (ref: SAN-2), specifically, cases involving dishonesty. The guidance indicates that allegations of dishonesty will always be serious, and that the panel should carefully consider the conduct that has taken place. The panel noted that dishonesty which creates a direct risk to people receiving care should be treated as more serious. That the dishonesty in this case created a risk of harm was considered by the panel. This was balanced alongside the guidance indicating that isolated incidents of dishonesty, which are opportunistic or spontaneous, in

which there is no personal gain, can be treated as less serious. The panel considered that the seriousness of the dishonesty in this case was, on the whole, significantly lessened by it being opportunistic, isolated, and not done for personal gain. Therefore, the dishonesty was placed towards the lower end of the spectrum.

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

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict Mrs Preyzner's practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where '*the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that a caution order would be inappropriate in view of its findings that there remained a risk of harm to the public. Moreover, while the panel considered the dishonesty to be towards the lower end of the spectrum, that it created a risk of harm led the panel to conclude that the seriousness of the misconduct would not fully be captured by a caution order. 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 Mrs Preyzner's 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:

- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *Identifiable areas of the nurse or midwife's practice in need of assessment and/or retraining;*
- *No evidence of general incompetence;*
- *Potential and willingness to respond positively to retraining;*
- *…*

- *Patients will not be put in danger either directly or indirectly as a result of the conditions;*
- *The conditions will protect patients during the period they are in force; and*
- *Conditions can be created that can be monitored and assessed.*

The panel is of the view that there are no practical or workable conditions that could be formulated, given the nature of the charges in this case. The panel considered that the misconduct is not directly linked to Mrs Preyzner's clinical competence, but rather was concerned with dishonest decisions that she made during the course of her practice. The panel did not consider that there were any conditions that could address this. Furthermore, the panel noted the email from Mrs Preyzner in which she indicated that she had been out of the nursing profession for some time, and had no intention of returning to practice. Therefore, it is not clear that Mrs Preyzner would be able to respond positively to retraining. The misconduct identified in this case was not something that can be addressed through retraining.

Furthermore, the panel concluded that the placing of conditions on Mrs Preyzner's registration would not adequately address the seriousness of this case and would not protect the public, or meet 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 apparent:

- *A single instance of misconduct but where a lesser sanction is not sufficient;*
- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *No evidence of repetition of behaviour since the incident;*
- *The Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour;*
- *…*
- *…*

The panel was satisfied that in this case, the misconduct was not fundamentally incompatible with remaining on the register. The panel considered that this was a single instance of misconduct, and that there is no evidence of any harmful, deep-seated personality or attitudinal problems. The panel considered its previous findings and noted that there remains some risk of repetition due to developing insight, but did not consider that risk to be significant. In these circumstances the panel considered that a suspension order would mark the seriousness of the misconduct, protect the public, and meet the public interest.

The panel did go on to consider whether a striking-off order would be proportionate but, taking account of all the information before it, and of the mitigation provided, the panel concluded that it would be disproportionate. Whilst the panel acknowledges that a suspension may have a punitive effect, it would be unduly punitive in Mrs Preyzner's case to impose a striking-off order.

The panel had sight of an email sent by Mrs Preyzner to her NMC Case Officer dated 6 January 2026 in which she stated that she has not been working as a registered nurse for five years and does not intend to return to nursing practice. However, the panel considered that it would be inappropriate to impose a striking off order purely because Mrs Preyzner had indicated that she does not intend to return to nursing practice. If Mrs Preyzner does not wish to return to practice, then at a review hearing, the panel may allow the order to lapse with a finding of current impairment pursuant to the NMC guidance.

Balancing all of these factors the panel has concluded that a suspension order would be the appropriate and proportionate sanction.

The panel noted the hardship such an order will inevitably cause Mrs Preyzner. However, this is outweighed by the need to protect the public, and engage the public interest in this case.

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

The panel determined that a suspension order for a period of six months was appropriate in this case to mark the seriousness of the misconduct. Further, the panel considered that this period of suspension would allow Mrs Preyzner time to strengthen her practice and demonstrate further insight.

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:

- Testimonials from colleagues
- A reflective piece demonstrating further insight, whilst recognising the impact of falsifying staff temperatures when caring for vulnerable patients.

This will be confirmed to Mrs Preyzner 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 Mrs Preyzner's own interests until the suspension sanction takes effect.

Representations on interim order

The Statement of Case states:

> *'If a finding is made that the registrant's fitness to practise is impaired on a public protection basis and a restrictive sanction imposed we consider an interim order in the same terms as the substantive order should be imposed on the basis that it is necessary for the protection of the public and otherwise in the public interest.'*

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 noted its previous finding of a risk of repetition and consequent risk of harm to the public and therefore determined that an interim order is necessary on the ground of public protection. Further, the panel considered that an interim order is necessary to engage the public interest and maintain public confidence in the nursing profession and the NMC as the regulator.

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 to allow time for any possible appeal.

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

That concludes this determination.