Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Order Review Hearing
Monday, 26 January 2026 & Tuesday 3 March 2026

Virtual Hearing

Name of Registrant:	Mrs Keshwaree Ramana
NMC PIN:	01I9597E
Part(s) of the register:	Mental Health Nursing 12 November 2004
Relevant Location:	Hampshire
Type of case:	Misconduct
Panel members:	Caroline Jones (Chair) Vinod Wagjiani (Lay member) Corinne Foy (Registrant member)
Legal Assessor:	Ashraf Khan (26 January 2026) John Bassett (3 March 2026)
Hearings Coordinator:	Andrew Ormsby
Nursing and Midwifery Council:	Represented by Shoba Aziz, Case Presenter (26 January 2026) and Iwona Boesche, Case Presenter (3 March 2026)
Mrs Ramana:	Present and represented by Priya Malhotra, instructed by Regulation Resolution Solicitors
Order being reviewed:	Suspension order (3 months)
Fitness to practise:	Not Impaired
Outcome:	**Order to lapse upon expiry in accordance with Article 30 (1), namely 4 March 2026**

Decision and reasons on review of the substantive order

The panel decided to let the current order lapse upon its expiry in accordance with Article 30(1) of the 'Nursing and Midwifery Order 2001' (as amended) (the Order) namely at the end of 4 March 2026.

This is the third review of a substantive suspension order originally imposed for a period of twelve months by a Fitness to Practise Committee panel on 3 May 2024. This was reviewed on 28 April 2025, and a further six-month suspension order was imposed by the reviewing panel. A second reviewing panel imposed a further three-month suspension on 27 October 2025.

The present hearing adjourned part-heard on 26 January 2026 and resumed on 3 March 2026.

The current order is due to expire at the end of 4 March 2026.

The panel is reviewing the order pursuant to Article 30(1) of the Order.

The charge found proved which resulted in the imposition of the substantive order was as follows:

'That you a Registered Nurse, while a Director at BSR London Limited, which owned and ran Chesterholme Lodge between August 2017 and 24 December 2019:

1. *Failed to adequately safeguard residents in that you did not ensure that:*

   a) There were sufficient numbers of suitably qualified staff to meet the service user's needs;
   b) Staff had received appropriate training;
   c) The Mental Capacity Act 2005 was understood and/or applied by staff;
   d) Residents' privacy and dignity was promoted;
   e) Residents were provided with a clean and hygienic environment;

f) Residents' nutritional needs were met;
g) Residents' care needs were assessed and/or met;
h) Effective systems was in place to ensure residents' health and safety;
i) Effective systems were in place to safeguard service users from abuse and/or improper treatment.'

The last reviewing panel determined the following with regard to impairment:

'In considering your insight and whether you have taken steps to strengthen your practice, the panel noted that you provided a reflective statement. However, it noted that this was not done using a recognised model and does not specifically address the sub-paragraphs of the charge. It added that whilst there is some development in your insight, your reflection was general and lacked specific examples and there is no detailed action plan of how you would do things differently in the future.

The panel took into account the evidence of your self-directed learning and acknowledged the recent training you undertook dating back to December 2024. It noted that some of the training undertaken since the last review does not specifically relate to the matters found proved. The panel added that during your oral evidence, you showed a developing insight into your failings and how the training you have undertaken will assist you in doing things differently in the future. It noted that you have not demonstrated this clearly in your reflective statement, and it has noted that the point you made in your oral evidence would be useful in your reflective statement. Much as the panel could see clear progress around the examples you provided and how they had begun to relate to the charges, they still felt you lacked a true depth of insight regarding your full responsibilities as a nurse who was a director in a care home. They determined your considerations were very operationally focussed, too immediate and lacked the necessary strategic vision which would guarantee the ongoing and long-term safety of patients in your care.

In particular the panel determined your commentary which intended to address the issue - 'to safeguard service users from abuse and/or improper treatment' – to be entirely reactive and superficial. You said you would immediately report any matters

of abuse to the CQC, NMC or police for investigation but were unable to say that you had any effective systems

in place to proactively identify the potential for and prevent ill treatment before it actually happened.

The panel could not be assured without this level of detail that there would be no repetition of your misconduct.

You provided the panel with testimonials and a written reflective statement. Whilst the testimonials speak to your character and personal qualities, they do not speak directly the matters found proved. While you recognise the importance of your duty of care, there remains a lack of insight into the potential impact of your misconduct on residents who were vulnerable, their families, and the impact on the profession and wider public confidence. In light of this, the panel considered that there was still a risk of repetition of your misconduct.

The last reviewing panel determined that you were liable to repeat matters of the kind found proved. Today's panel has received documentation and heard oral evidence from you. In light of this, this panel determined that you are liable to repeat matters of the kind found proved. The panel therefore decided that a finding of continuing impairment is necessary on the grounds of public protection.

The panel has borne in mind that its primary function is to protect patients and the wider public interest which includes maintaining confidence in the nursing profession and upholding proper standards of conduct and performance. The panel determined that, in this case, a finding of continuing impairment on public interest grounds is required.

For these reasons, the panel finds that your fitness to practise remains impaired.'

The last reviewing panel determined the following with regard to sanction:

‘The panel next considered whether 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 bore in mind the seriousness of the facts found proved, the nature of the misconduct and the nature of the shortcomings in your remediation. It concluded that a conditions of practice order could not be formulated which would be appropriate would adequately protect the public and satisfy the public interest.

The panel considered the NMC guidance, ‘Suspension Order’ (Ref SAN-3d), regarding the imposition of a further period of suspension. It found that due to the seriousness of the matters found proved, and in order to maintain public protection, that your temporary removal from the register remains necessary. Further, it was of the view that an extended period of suspension would allow you further time to remediate your misconduct.

The panel recognised that while you have taken some steps to strengthen your practice through some reflection and completing various training courses, you did not comply fully with the recommendations of the last reviewing panel which has left a gap in the remediation process.

The panel concluded that a further 3-month suspension order would be the appropriate and proportionate response and would afford you adequate time to further develop your insight and take steps to strengthen your practice. The panel noted that this will allow you sufficient time to directly address the sub-charges in your reflective statement.

The panel determined therefore that a suspension order is the appropriate sanction which would continue to both protect the public and satisfy the wider public interest. Accordingly, the panel determined to impose a suspension order for the period of 3 months would provide you with an opportunity to take further steps to articulate the level of insight you have achieved in your reflective statement. It considered this to be the most appropriate and proportionate sanction available.

This suspension order will take effect upon the expiry of the current suspension order, namely the end of 4 December 2025 in accordance with Article 30(1)

Before 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:

- *Continued engagement with, and attendance at the NMC review hearing.*
- *Reflection - A comprehensive reflection piece using a recognised model specifically addressing the sub-paragraphs of the charge. Using a model recognised within the nursing profession (such as Gibbs) might serve to steer your thinking and add depth to your reflection. In particular you may wish to consider more thoroughly the impact of your shortcomings on the residents and their families, and what actions you might take in future to prevent recurrence.*
- *Learning – you need to be able to articulate far more comprehensively firstly what training you have conducted, and secondly how that training cumulatively serves to develop your knowledge of safeguarding and addresses the charges. You might want to consider more specifically your involvement with developing safeguarding policy, implementing such policy and evaluating its effectiveness at a strategic and tactical level.*
- *Testimonials – your testimonials should wherever possible be relevant to your practice as a safeguarding senior leader and from independent observers. These might include from visiting district nurses, GPs or other health professionals. You might consider comment from individuals in your care or their families. Testimonials are likely to be more compelling if they directly comment on your shortcomings outlined in the charges.'*

Decision and reasons on current impairment

The panel has considered carefully whether your fitness to practise remains impaired. Whilst there is no statutory definition of fitness to practise, the NMC has defined fitness to

practise as a registrant's ability to practise kindly, safely and professionally. In considering this case, the panel has carried out a comprehensive review of the order in light of the current circumstances. Whilst it has noted the decision of the last panel, this panel has exercised its own judgement as to current impairment.

The panel has had regard to all of the documentation before it, including the NMC bundle and documentation provided on your behalf, as well as your oral evidence given at the hearing.

Ms Aziz, on behalf of the NMC, stated that the panel's role was to look at all the information that was provided and to see whether you are currently impaired or whether you had remediated.

Ms Aziz set out the background of this case and reminded the panel that the previous panel found that you did not have regard to the resident safety, or regard to safeguarding from abuse and improper treatment and emphasised that the previous panel found impairment on public interest grounds.

Ms Aziz stated that the previous panel found that your insight at the review remained limited and that you had not provided reflection on the courses you stated that you had learnt from or shown how you intended to apply what you had learnt. She stated that the previous panel found there was a lack of insight of the potential impact of misconduct on the residents.

Further, Ms Aziz stated that the previous panel found that it had received no information, as to how you understood what you had done wrong and how your actions had put the residents at harm and that there was a lack of information explaining what was learnt.

When this present hearing resumed, Ms Boesche, on behalf of the NMC, stated that the concerns relating to the matters found proved were serious and wide-ranging, but that the panel had now received reflections and evidence of actions taken. She submitted that if the panel was satisfied that the risk had decreased, then there were other options other than extending the current orders such as amending the order or allowing the order to lapse. She reiterated that there was no specific request from the NMC.

Ms Malhotra, on your behalf, submitted that the panel had received a significant body of material and evidence that supported the conclusion that your fitness to practise was no longer impaired. She stated that this had been demonstrated through the volume of material provided to the panel, which in terms of quality as well as quantity, demonstrated in favour of your returning to practice without restrictions.

Ms Malhotra stated that you had practised as a nurse since 2004 and that the index matters should be put in their proper context. She stated that you were extremely remorseful for your actions and did not wish to minimise them.

Ms Malhotra submitted that the panel was dealing with the present moment and you had told the panel that you had failed to oversee the safety of residents, staff, family and environment and that you had lost the trust of the public. She stated that this was the best evidence that the panel has of a registrant who fully accepted their wrongdoing.

Ms Malhotra stated that you had engaged with your regulator; provided a comprehensive reflection piece using a recognised model specifically addressing each subparagraph of the charge; provided evidence of, and articulated, learning in relation to safeguarding; and provided significant testimonials from general practitioners and other allied health care professionals relevant to your practice as a senior safeguarding leader who all spoke highly of you.

Ms Malhotra concluded by stating that a significant passage of time has elapsed since the index matters and asserted that the passage of time, as well as the significant evidence of remediation, supported the view that your fitness to practise was no longer impaired.

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

The panel considered whether your fitness to practise remains impaired.

In reaching its decision, the panel was mindful of the need to protect the public, maintain public confidence in the profession and to declare and uphold proper standards of conduct and performance.

The panel was also mindful of the fact that there was a persuasive burden on you to prove that you were no longer impaired. The panel also had regard to the case of *Abrahaem v GMC [2008] EWHC 183 (Admin)*, in which Blake J described the procedure as 'an ordered sequence of decision making'. The panel must first address whether fitness to practise is impaired before considering further sanction. In doing so:

> *'the review has to consider whether all the concerns raised in the original finding of impairment through misconduct have been sufficiently addressed to the Tribunal's satisfaction. In practical terms there is a persuasive burden on the practitioner at a review to demonstrate that he or she has fully acknowledged why past professional performance was deficient and through insight, application, education, supervision or other achievement sufficiently addressed the past impairments.'*

The panel had regard to all the evidence before it today. This included your detailed and extensive reflective statement, evidence of significant and targeted CPD you have undertaken, a number of testimonials attesting to your professionalism, and your oral evidence to the panel.

The panel noted the extent and depth of the reflections you have undertaken into the events which resulted in the substantive order. It considered that you have well-developed insight into what happened and why it happened. You have taken full responsibility for your actions and examined them closely to understand how they happened, and the steps you need to take to avoid them happening again. You have undertaken relevant training in relation to safeguarding. You have demonstrated reflection and insight into the lessons you have learned from those remedial steps and how to embed them into your clinical practice in future.

The panel considered that you had been candid in relation to your misconduct and your failures in relation to residents and staff. It also determined that you had provided significant evidence of continuous engagement with the regulatory process, reflections, learning and testimonials, as recommended by the previous reviewing panel.

The panel considered that you had provided extensive evidence to demonstrate that you have remedied the past concerns about your practice.

The panel bore in mind your extensive reflection, well-developed insight and considered that there was little risk of repetition. It also noted your commitment to continuing to develop, evolve and strengthen your nursing skills as you return to practice, and to seeking support in addressing any further issues you identify, and was satisfied that you now have the insight to do this. The panel was satisfied that you are unlikely to repeat failings of the kind involved in this case, and that you are now capable of safe, effective and kind nursing practice.

The panel concluded that your fitness to practise is not currently impaired on public protection grounds. It went on to consider whether a finding of impairment was required on wider public interest grounds, in order to uphold professional standards and maintain public confidence in the profession. In light of the steps you have taken to remedy the past issues of concern, the panel considered that a finding of impairment was no longer required in this case. It considered that the public interest considerations have been sufficiently addressed by the substantive order which has been in place since the substantive hearing.

The panel therefore concluded that your fitness to practise is no longer impaired.

The current order will be allowed to expire at its conclusion at the end of 4 March 2026, in accordance with Article 30(1).

This will be confirmed to you in writing.

That concludes this determination.