Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Order Review Meeting
Wednesday 4 November 2026

Virtual Meeting

Name of Registrant:	**Parveen Abbas Alishah**
NMC PIN:	97G1023O
Part(s) of the register:	Registered Nurse – Sub Part 1 Adult Nursing – (July 1997)
Relevant Location:	Surrey
Type of case:	Misconduct
Panel members:	Pamela Johal (Chair, Lay member) Richard Curtin (Registrant member) James Kellock (Lay member)
Legal Assessor:	Gillian Hawken
Hearings Coordinator:	Charis Benefo
Order being reviewed:	Suspension order (12 months)
Fitness to practise:	Impaired
Outcome:	**Striking-Off order to come into effect at the end of 30 December 2026 in accordance with Article 30(1)**

Decision and reasons on service of Notice of Meeting

The panel noted at the start of this meeting that the Notice of Meeting had been sent to Miss Alishah's registered email address by secure email on 1 October 2026.

The panel took into account that the Notice of Meeting provided details of the substantive order being reviewed, and that the review meeting would be held no sooner than 2 November 2026 and invited Miss Alishah to provide any written evidence seven days before this date.

The panel accepted the advice of the legal assessor.

In the light of all of the information available, the panel was satisfied that Miss Alishah 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 conducting this review in a meeting

The panel considered whether it would be appropriate for this case to be reviewed in a meeting rather than a hearing.

The panel noted that in the Notice of Meeting, sent to Miss Alishah on 1 October 2026, she was informed that this substantive review would be held in a meeting and she was invited to indicate if she would like a panel to consider it in a hearing instead. The panel did not have before it any response from Miss Alishah.

The panel had regard to the substantive order review meeting bundle before it and was satisfied that the substantive order in this case could be appropriately reviewed in a meeting, rather than a hearing.

Decision and reasons on review of the current order

The panel decided to replace the current suspension order with a striking-off order. This order will come into effect at the end of 30 December 2026 in accordance with Article 30(1) of the Nursing and Midwifery Order 2001 (as amended) (the Order).

This is the first review of a substantive suspension order originally imposed for a period of 12 months by a Fitness to Practise Committee panel on 26 November 2025.

The current order is due to expire at the end of 30 December 2026.

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

The charges found proved which resulted in the imposition of the substantive order were as follows:

> '*That you, a registered nurse, between 18 January 2021 & 2 December 2021, whilst employed as the registered manager of Church View Care Home (the Home)*
>
> *1) …*
>
> *2) …*
>
> *3) Did not adequately audit and/or review Resident B's care plan, in that, Resident B's background history had not been completed.*
>
> *4) …*
>
> *5) …*
>
> *6) Did not put a system in place which ensured that clinical staff undertook;*
>
> *a) …*
>
> *b) Annual competency assessments.*

7) *Did not put a system in place which ensured that staff were adequately trained to communicate with residents, in that on one or more occasions;*
   a) *Staff were unable to understand residents due to their lack of understanding English;*
   b) *Staff would talk in their own language in front of residents.*

8) *Did not monitor and/or supervise staff to ensure that care plans for one or more residents were adequately followed and/or up to date, in that*
   a) *In relation to Resident C, staff did not;*
      i) *Set Resident C's pressure mattress to their most recent weight measurement.*
      ii) *...*
   b) *In relation to Resident D;*
      i) *Did not ensure that Resident D had consented to a sensor mat being placed on their floor.*
      ii) *Allowed a sensor mat to be placed on Resident D's floor, despite Resident D having full capacity.*
      iii) *Did not ensure that staff recorded a valid reason for Resident D not having a shower seat.*

9) *Did not supervise and/or monitor and/or train staff to ensure that adequate care and/or personal care was provided to one or more residents, in that;*
   a) *Resident E's bathroom was not cleaned of urine.*
   b) *Resident E's bed bumper remained dirty.*
   c) *In relation to Resident F, did not ensure;*
      i) *...*
      ii) *That staff cleaned Resident F's bed bumper.*
      iii) *That Resident F was provided with an adequate wheelchair arm.*
      iv) *That Resident F was being showered and/or bathed as required by their care plan.*
      v) *That Resident F was having their teeth brushed regularly.*
      vi) *That Resident F shaved regularly*
   d) *Staff did not ensure that Resident H was provided with a wheelchair which allowed their feet to touch the floor.*

e) *Staff inappropriately allowed Resident I to use;*
    i) *Resident J's wheelchair.*
    ii) *Resident J's pressure cushion.*

10) *Did not ensure that all staff members were up to date with safeguarding training.*

11) *Did not put into place a system and/or training to ensure that all staff members understood how recognise and/or report;*
    a) *allegations of abuse.*
    b) *Safeguarding concerns.*

12) *On 2 December 2021;*
    a) *Did not wear appropriate Personal Protective Equipment, namely a face mask.*
    b) *Did not monitor and/or supervise staff adequately, in that;*
        i) *Resident B's catheter was not reviewed.*
        ii) *Personal care had not been provided to Resident B.*
    c) *...*
    d) *Inappropriately allowed staff to place one or more Residents in bed by 18:00.*
    e) *In regards to Resident I;*
        i) *Inappropriately allowed staff to leave them in bed with no clothes on their bottom half;*
        ii) *...*
        iii) *Did not ensure that Resident I's call bell was plugged in for them to use.*

13) *Between 2 December 2021 and 22 March 2022, failed to implement recommendations and/or improvements raised by the Care Quality Commission.*

14) *…*

15)…

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

The original panel determined the following with regard to impairment:

'*The panel next went on to decide if as a result of the misconduct, Ms Alishah's fitness to practise is currently 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. 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 her 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) ….'

In relation to limb a), the panel took into account that there was a risk of harm to a large number of residents, in particular vulnerable residents. The panel noted that Ms Alishah exposed those vulnerable residents to unacceptable risk of harm because she did not supervise or train staff as the care home manager as:

"staff did not always know people or take time to read their care plans to familiarise themselves with risks associated with people."

Furthermore:

"people were not always kept free from harm due to staff's lack of understanding and knowledge of people's care plans or potential risks."

The lack of supervision/monitoring and/or training in respect of providing care to vulnerable residents exposed these residents to unnecessary and unacceptable risk of harm both physically and psychologically.

In relation to limb b), the panel took into account that the misconduct has brought the nursing profession in disrepute by failing to ensure that the appropriate care was provided for vulnerable residents. This was a serious falling short of the standards expected of a registered nurse and a registered care home manager. The public would be shocked to know that a nurse failed in this manner and the reputation of nurses would be adversely affected, decreasing the public confidence in the profession.

In relation to limb c), the panel took into account that the conduct breached a number of fundamental tenets of the profession. Ms Alishah failed to prioritise the people she was ultimately responsible for by ensuring individualised care was provided and by not promoting their well-being. The panel considered that as Ms Alishah was the care home manager, it was her duty to provide this care to the residents at the home. The panel also took into account that there is no evidence of audits or feedback forms, other than the training that was provided at the 'Mini meetings' which meant she had no evidence regarding how residents were being cared for in practice. The panel considered that Ms Alishah did not act upon specific recommendations or take the necessary action to remedy the issues despite feedback provided by the CQC. The panel further took into account that Ms Alishah did not promote professionalism and trust by leading by example nor by ensuring that staff adhered to minimum standards of practice.

The panel decided that the first three limbs of Grant are engaged in the past.

The panel took into account that although Ms Alishah could potentially take steps to remediate her actions, there was no evidence before the panel in relation to insight and remediation. The panel had sight of an email communication between the NMC and Ms Alishah which stated:

> *"I don't remember anything about this case, due to [PRIVATE] I have not been able to response [sic] to your previous emails and I won't be able to attend the hearing in September.*
> *…*
> *Due to [PRIVATE] I have stopped working since 2022."*

The panel also considered that Ms Alishah has made some references to [PRIVATE], but no further information was put before the panel about this. The panel took into account that Ms Alishah has not taken any steps to address the concerns raised in the charges found proved.

The panel considered that the conduct would be highly likely to be repeated in the future, due to there being no evidence of learning, training and change, positive

testimonials, insight, or training since the time of the charges. The panel is of the view that there is a risk of repetition due to a lack of evidence on change, remediation or insight. 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 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 determined that, in this case, a finding of impairment on public interest grounds was required given the nature and extent of Ms Alishah's misconduct involving vulnerable residents. It determined that Ms Alishah's conduct has brought the profession into disrepute.

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

The original panel determined the following with regard to sanction:

'*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;*
- *In cases where the only issue relates to the nurse or midwife's health, there is a risk to patient safety if they were allowed to continue to practise even with conditions; and*

- *In cases where the only issue relates to the nurse or midwife's lack of competence, there is a risk to patient safety if they were allowed to continue to practise even with conditions.*

The panel was satisfied that in this case, whilst it was not a single instance of misconduct, on balance, the misconduct was not fundamentally incompatible with remaining on the register because the panel considered the conduct to be remediable. This provides Ms Alishah with further opportunity to demonstrate insight, remorse, and remediation.

It did go on to consider whether a striking-off order would be proportionate but, taking account of all the information before it, and knowing the details of the case, on balance 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 Ms Alishah's case to impose a striking-off order.

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 Ms Alishah. 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.

The panel determined that a suspension order for a period of up to one year was appropriate in this case to mark the seriousness of the misconduct.

At the end of the period of suspension, another panel will review the order. At the review hearing the panel may revoke the order, or it may confirm the order, or it may replace the order with another order.

Any future panel reviewing this case would be assisted by:

- *Evidence of a reflective piece showing insight and reflection on the impact on residents, the nursing profession as a whole, and the public confidence*
- *Testimonials attesting to her workplace practice and professionalism*
- *Evidence of training in the relevant areas including, but not limited to safeguarding, dignity, leadership, infection control, and pressure sore prevention*
- *Ms Alishah's engagement with the NMC*'.

Decision and reasons on current impairment

The panel has considered carefully whether Miss Alishah's fitness to practise remains impaired. Whilst there is no statutory definition of fitness to practise, the NMC has defined fitness to practise as the ability of a professional on our register to practise as a nurse, midwife or nursing associate safely and effectively without restriction. 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 had regard to all of the documentation before it, including the NMC bundle and a single email from Miss Alishah, dated 9 December 2025, which was sent in response to the NMC's request for her to complete a personal contact and employment details form. Miss Alishah's email stated:

'*I am not working since 2022 , I have [PRIVATE] for a long period due to [PRIVATE]*
I resigned from my previous job and have not been working since.
I am unable to fill out the attached form'

The panel accepted the advice of the legal assessor. She reminded the panel that the persuasive burden lies with Miss Alishah to demonstrate that her fitness to practise is no longer 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 considered whether Miss Alishah's fitness to practise remains impaired.

The panel had particular regard to the previous panel's decision regarding the seriousness of Miss Alishah's misconduct:

> '*The panel were of the view that the misconduct collectively was at the more serious end of the spectrum because of the risk of harm associated with Ms Alishah's misconduct. Ms Alishah was responsible for a large number of highly vulnerable residents many of whom were unable to advocate for themselves. Her failure to monitor, supervise or train staff adequately and to ensure that resident's care plans were met, alongside her disregard for simple infection control measures put these vulnerable residents at risk of harm. The panel considered the failure to implement the improvements and/or recommendations stipulated by the CQC particularly serious because the CQC highlighted specific issues and risks which were remediable. The failure to address these issues and risks unnecessarily exposed residents to ongoing risk for a prolonged period of time.*'

The panel noted that the original panel found that Miss Alishah had provided no evidence of insight. At this meeting, the panel noted that the last correspondence from Miss Alishah was in December 2025, when she indicated that she had [PRIVATE], that she had resigned from her previous job and that she had not been working since then. The panel considered that Miss Alishah has not engaged with the NMC or responded to any correspondence about her case since her email in December 2025. There was no documentary evidence before this panel regarding Miss Alishah's current circumstances and [PRIVATE]. There was also no new information to indicate that Miss Alishah has developed insight into the misconduct, that the serious concerns identified have been addressed or that she has taken steps to strengthen her practice.

The original panel determined that Miss Alishah was liable to repeat matters of the kind found proved. Today's panel had not received any new information or evidence from, or in

respect of, Miss Alishah to suggest that the risk of repetition has decreased. The panel had no evidence before it to suggest that Miss Alishah has engaged with the recommendations of the original panel. In light of this the panel determined that Miss Alishah is now still 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 also required due to the seriousness of the misconduct found and the absence of any remedial steps taken by Miss Alishah, as set out above.

For these reasons, the panel finds that Miss Alishah's fitness to practise remains impaired.

Decision and reasons on sanction

Having found Miss Alishah's fitness to practise currently impaired, the panel then considered what, if any, sanction it should impose in this case. The NMC made no submissions, nor did it make a sanction bid. The panel noted that its powers are set out in Article 30 of the Order. The panel has also taken into account the 'NMC's Sanctions Guidance' (SG) and has borne in mind that the purpose of a sanction is not to be punitive, though any sanction imposed may have a punitive effect.

The panel first considered whether to take no action, which would allow the current order to expire at the end of 30 December 2026, 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.

The panel 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 Miss Alishah'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, but the Committee wants to mark that what happened was unacceptable and must not happen again'. The panel considered that Miss Alishah's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the issues identified. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether a conditions of practice on Miss Alishah'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 noted the information that, as of December 2025, Miss Alishah had [PRIVATE], that she had resigned from her previous job and that she had not been working since. The panel did not have before it more recent information about Miss Alishah's current circumstances, employment, and [PRIVATE], however, in view of her last correspondence to the NMC and her lack of engagement with the proceedings, the panel considered that any conditions of practice order would not be workable and would serve no useful purpose since there is no indication that Miss Alishah has any insight, any desire to strengthen her practice or a willingness to abide by conditions of practice.

The panel also bore in mind the seriousness of the facts found proved at the original meeting and concluded that a conditions of practice order would not adequately protect the public or satisfy the public interest. The panel was not able to formulate conditions of practice that would adequately address the concerns relating to Miss Alishah's misconduct.

The panel next considered imposing a further suspension order. The panel was of the view that considerable evidence would be required to show that Miss Alishah no longer posed a risk to the public. The panel was cognisant of the brief reference to [PRIVATE] raised by Miss Alishah in her email dated 9 December 2025. It considered whether a further period of suspension would provide an opportunity for Miss Alishah to [PRIVATE], start engaging with this regulatory process, reflect on her misconduct, develop insight, take steps to strengthen her practice and assure a future panel that she can return to nursing safely. However, the panel had no information or evidence as to the nature and extent of

[PRIVATE], or of any potential intention to engage with the NMC and work towards safe and effective practice.

The panel had regard to the NMC guidance on '*Removal from the register when there is a substantive order in place*' (reference: REV-2h), which states:

'*This guidance is intended to help substantive order review panels decide what action to take where*

- *a professional hasn't addressed outstanding fitness to practise concerns, and*
- *the professional is unlikely to return to safe unrestricted practice within a reasonable period of time*'.

[PRIVATE]

The panel also paid very close attention to the NMC guidance on '*Striking-off order*' (reference SAN-2e), which states:

'*A striking-off order is the most serious sanction. It means removing the professional's name from the Register, which prevents them from working as a registered nurse, midwife or nursing associate.*

This sanction is likely to be appropriate if the professional's actions are fundamentally incompatible with being a registered professional. Before imposing this sanction, the Committee should consider:

- *Do the charges found proved raise fundamental questions about their professionalism?*
- *Can public confidence in the profession be maintained if the professional is not removed from the Register?*
- *Is there any amount of insight and reflection which could keep people receiving care and members of the public safe, maintain public confidence in the profession, and uphold professional standards?*

- *Is there a realistic prospect that, after suspension, the professional will have gained insight and strengthened their practice such that the risk they pose will have reduced?*

The Committee should refer to our guidance on sanctions for the highest risk cases. This highlights how the Committee should approach some types of cases where strike-off is most likely to be appropriate. This is because it may not be possible for the professional to put things right, or they will most seriously affect the public's trust and confidence in the professions.

The types of case that are most likely to result in a striking-off order are:

- *…*
- *Failing to engage with the fitness to practise process.*

This is not an exhaustive list.'

The panel was not satisfied that there is a realistic prospect that, after a further period of suspension, Miss Alishah will have gained insight and strengthened her practice such that the risk she poses will have reduced sufficiently. It also took account of Miss Alishah's ongoing lack of engagement with the fitness to practise process and noted that she has had a considerable period to engage with the regulatory process prior to and following the substantive meeting in November 2025, yet she has not.

Having considered all of the above matters, the panel determined that a further period of suspension would not serve any useful purpose in this case.

The panel recognised that a striking-off order is the most serious sanction and would prevent Miss Alishah from working as a registered nurse. The panel considered the requirements of the overarching objective, and the information before it. It considered that Miss Alishah's failure to engage with this regulatory process or provide any evidence of reflection, insight, or strengthening of her practice, cumulatively led the panel to conclude that this raised a fundamental concern about her professionalism and therefore continued retention on the register.

The panel determined, in light of all the matters outlined above, public confidence in nurses and the nursing profession could only be maintained if Miss Alishah was removed from the register.

Whilst the panel recognised that a period of suspension could still protect patients as it would prevent Miss Alishah from being able to work, it would not maintain the confidence of the public or the maintenance of professional standards given her lack of insight and reflection. The panel determined that it was necessary to take action to prevent Miss Alishah from practising in the future and concluded that the only appropriate sanction that would adequately protect the public and serve the public interest is a striking-off order.

The panel therefore decided to replace the current suspension order with a striking-off order.

This striking-off order will take effect upon the expiry of the current suspension order, namely the end of 30 December 2026 in accordance with Article 30(1).

This decision will be confirmed to Miss Alishah in writing.

That concludes this determination.