Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 17 August 2026 – Friday, 21 August 2026

Nursing and Midwifery Council
10 George Street, Edinburgh, EH2 2PF

Name of Registrant:	**Lorna Fell**
NMC PIN:	13A1654E
Part(s) of the register:	Nurses part of the register Sub part 1 RNA, Registered Nurse – Adult (11 March 2013)
Relevant Location:	Somerset
Type of case:	Misconduct
Panel members:	Graham Gardner (Chair, Lay member) Colin Mark Allison (Lay member) Sophie Agolini (Registrant member)
Legal Assessor:	Graeme Dalglish
Hearings Coordinator:	John Kennedy
Nursing and Midwifery Council:	Represented by Alastair Kennedy, Case Presenter
Ms Fell:	Not present and unrepresented
Facts proved:	Charges 1a,1b,1c,1d,1e, 1f, 2, 3b, 3c, 3d, 3e, 3f, 3g, 4a, 4b, 5, and 6
Facts not proved:	Charges 3a
Fitness to practise:	Impaired
Sanction:	**Striking-off order**

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

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Ms Fell was not in attendance and that the Notice of Hearing letter had been sent to Ms Fell's registered address by recorded delivery and by first class post on 13 July 2026.

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

The panel accepted the advice of the legal assessor.

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

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

Decision and reasons on proceeding in the absence of Ms Fell

The panel next considered whether it should proceed in the absence of Ms Fell. It had regard to Rule 21 and heard the submissions of Mr Kennedy who invited the panel to continue in the absence of Ms Fell. He submitted that Ms Fell had voluntarily absented herself.

Mr Kennedy referred the panel to the documentation from Ms Fell which was most recently from February 2026 where she made an application to the NMC to be removed from the Register and stated that she had no intention of returning to nursing. Since then there has been no engagement from Ms Fell in respect of this hearing. He submitted that

there is no application from her to adjourn the hearing to a later date or indication that she will engage any further with the NMC.

The panel accepted the advice of the legal assessor.

The panel noted that its discretionary power to proceed in the absence of a registrant under the provisions of Rule 21 is not absolute.

The panel has decided to proceed in the absence of Ms Fell. In reaching this decision, the panel has considered the submissions of Mr Kennedy, and the advice of the legal assessor. It has had particular regard to the factors set out in the decision of *R v Jones (Anthony William)* (No.2) [2002] UKHL 5 and *General Medical Council v Adeogba* [2016] EWCA Civ 162 and had regard to the overall interests of justice and fairness to all parties. It noted that:

- No application for an adjournment has been made by Ms Fell;
- Ms Fell has not engaged with the NMC and has not responded to any of the letters sent to her about this hearing;
- Ms Fell has previously informed the NMC that she does not intend to return to nursing practice;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- Not proceeding may inconvenience the three witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- The charges relate to events that occurred in 2023 and 2024;
- Further delay may have an adverse effect on the ability of witnesses to accurately recall events; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Ms Fell in proceeding in her absence. The evidence upon which the NMC relies has been sent to her at her registered address. She will not be able

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

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

Details of charge

That you, a registered nurse:

1. On 19 October 2023:
    a. Failed to review Patient A's prescription prior to administering Oramorph
    b. Administered 20mg of Oramorph instead of 10mg as prescribed to Patient A
    c. Failed to record that a medication error occurred
    d. Did not inform Patient A that a medication error had occurred
    e. Asked Colleague A not to report the medication error
    f. Asked the resident doctor to change Patient A's prescription of Oramorph from 10mg to 20mg.

2. Your conduct at charges 1c and/or 1d and/or 1e and/or 1f was dishonest in that you intended to mislead others in believing that no medication error occurred.

3. On 12 March 2024:
    a. Removed Gabapentin from the controlled drug cupboard without a second checker

b. Left the prescribed Gabapentin next to Patient B
c. Did not observe Patient B consume Gabapentin
d. Incorrectly recorded Patient B consumed Gabapentin at 10pm
e. Failed to undertake regular observations of Patient B as directed
f. Failed to review Patient C's records prior to administering oral paracetamol
g. Incorrectly administered oral paracetamol to Patient C

4. On 13 March 2024:
    a. Removed Gabapentin from the controlled drug cupboard without a second checker
    b. Incorrectly recorded that Patient B missed their morning dose of Gabapentin

5. Your conduct at charge 3d was dishonest in that you intended to mislead others in believing that the evening dose had been consumed.

6. Your conduct at charge 4b was dishonest in that you intended to mislead others in believing that the morning dose was missed

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

Background

The charges arose whilst Ms Fell was employed as a registered nurse by Nuffield Health Hospital (the Hospital) since March 2015. In April 2024 Ms Fell was referred to the NMC by the Hospital over concerns relating to medication errors on two shifts in October 2023 and March 2024, including administration errors, poor record keeping, dishonesty, and following an internal local investigation by the Hospital.

Decision and reasons on facts

In reaching its decisions on the facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Mr Kennedy.

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

The panel was minded that albeit there were some admissions from Ms Fell throughout the documentation, they found on balance it would be safer and fairer to her, to hear the evidence in full.

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 heard live evidence from the following witnesses called on behalf of the NMC:

- Emma O'Sullivan: Clinical Governance Lead at the Hospital and ward sister at the time of the October 2023 incident, and who investigated the March 2024 incidents.

- Sharon Ingleston: Ward Manager at the Hospital, who investigated the October 2023 incident.

- Marinela Greanne Hemedes-Cabatay: Registered Nurse who worked the shift in October 2023 when the incident occurred.

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

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

Charge 1

1. On 19 October 2023:
    a. Failed to review Patient A's prescription prior to administering Oramorph
    b. Administered 20mg of Oramorph instead of 10mg as prescribed to Patient A
    c. Failed to record that a medication error occurred
    d. Did not inform Patient A that a medication error had occurred
    e. Asked Colleague A not to report the medication error
    f. Asked the resident doctor to change Patient A's prescription of Oramorph from 10mg to 20mg.

This charge is found proved

The panel addressed each sub-charge individually and decided to consider them as one in the determination as the evidence relates to the same course of conduct over the shift.

The panel had regard to the witness statement of Ms O'Sullivan which set out "*the five rights of drug administration*", and the procedures for drawing up any medication and the responsibilities of registered nurses as set out in the Medicines Management Policy v2.1 (5.23) which includes safe medication administration. This would apply to both controlled and non-controlled drugs. The panel found Ms O'Sullivan to be a reliable and credible witness.

The panel found that if Ms Fell had reviewed the prescription, as required by the policy, then she would have been aware of the correct dose to administer. Whilst there is no direct evidence that Ms Fell failed to review the prescription, the panel found that had she actually reviewed the prescription as required by policy, she would not have made the dosing error. The panel inferred from all the circumstances that Ms Fell failed to review the prescription.

The panel noted that consistently throughout Ms Fell's statements in the local investigations, and in her earlier statements to the NMC she admitted to having administered 20mg instead of the prescribed 10mg.

Ms Fell highlights in her own local statement that the patient told her that he had been given two syringes instead of the usual one: *'The patient [them]self-queried this with me stating [they] had only had one syringe prior and I reassured [them] at this point that it was correct'.*

The Hospital's policy was for the nurse to complete documentation immediately on a 'RADAR' (the system for reporting incidents) when a drug administration error came to light. The panel heard evidence from Ms Ingleston that the day after the incident she questioned Ms Fell about the Oramorph and why no RADAR had been completed. Ms Ingleston said that initially Ms Fell was reluctant to acknowledge her mistake and only when pressed, did she accept her error. The panel found Ms Ingleston to be a credible and reliable witness.

Ms Ingleston told the panel that Ms Fell responded to her that she had not completed any record of the incident and only did so after instruction from Ms Ingleston. Furthermore, no documentation of the medication error had been made by Ms Fell in the patient's notes.

The panel had sight of a written and signed statement from Ms Fell dated 13 July 2024 in her Agreed Removal Form (a voluntary application to be removed from the Register, which was refused):

> "*I have read the regulatory concerns. I am in agreement that id I did indeed give an incorrect dose of medication and did not witness the administration of a controlled drug.*
> *Whilst I somewhat agree that I did fail to comply with the duty of candour, in that I failed to report a medication administration error, failed to tell the patient that an*

error had been made and encouraged a colleague not to report the matter initially, I realised that this was not the correct behaviour.
I did indeed speak with the patient and reassured him that he would not come to any harm, however I did not actually tell him that an error had been made.
I also informed the RMO that an incorrect dose had been administered, in order for him to document that the actual dose given was documented.
I also discussed with my other colleagues what had happened as I was concerned. This was purely a knee jerk reaction to which I clearly regret. I was undergoing a great deal of stress ….In relation to the controlled drug incident, I admit I did not witness the patient taking it
or my colleague who did the check with me."

Further, the panel had sight of an undated reflective account of the incident written by Ms Fell, as part of the Hospital investigation report. In this she wrote:

'My initial reaction to this error was panic and asked my colleague if we could keep it amongst ourselves.

'I followed this through and informed the doctor on duty that I had given 20mg of oramorph instead of 10mg and asked him if he could prescribe a stat dose in order for the documentation to be correct. I assumed that he realised I had made an error despite me not actually using the phrase "I have made an error""

The panel found Ms Fell's explanation were partly corroborated by the evidence of Ms Hemedes-Cabatay. She told the panel that Ms Fell had asked her not to say anything about the incident to either nursing colleagues or the patient: "*Lorna asked me to keep quiet and said she would sort it out to cover both of our backs*".

Ms Hemedes-Cabatay further stated that she had heard Ms Fell ask the doctor to change the prescription stating '*[Ms Fell] told the doctor the patient was in pain'* and not that she had already administered an incorrect higher dose. The panel found Ms Fell had

deliberately set out to deceive the doctor into prescribing additional drugs to a vulnerable patient in an effort to conceal her earlier drug administration error. The panel found Ms Hemedes-Cabatay a reliable and credible witness

The panel therefore found charge 1a) to f) proved.

Charge 2

> Your conduct at charges 1c and/or 1d and/or 1e and/or 1f was dishonest in that you intended to mislead others in believing that no medication error occurred.

This charge is found proved

The panel applied the test for dishonesty as set out in the case of *Ivey v Genting Casinos* [2017] UKSC 67. It found that Ms Fell's actions constituted a sustained and deliberate course of conduct that all arose out of her intention to conceal her medication error.

The panel had regard to Ms Fell's local statements that she had not wanted the medication error to become common knowledge by her either admitting it to colleagues and/or the patient, documenting the error, or candidly advising the doctor why the request for a new prescription was required. The panel concluded that this demonstrated a lack of candour in Ms Fell's attitude at the time of the incident and her knowledge that what she was doing was a deliberate attempt to conceal her medication error.

The panel considered whether Ms Fell's actions might have been as a consequence of negligence, carelessness or the making of an honest mistake. The panel concluded that these alternative explanations, having considered the evidence in the round, were unlikely.

The panel then found that by the standards of ordinary decent people the act of concealing an error by not reporting it, not recording it, and giving misleading impressions to both the doctor and the patient was lacking in candour and was dishonest.

Therefore, the panel finds charge 2 in relation to 1c), d), e), and 1f) proved.

Charge 3a

On 12 March 2024:

a. Removed Gabapentin from the controlled drug cupboard without a second checker

This charge is found not proved

The NMC stated there was insufficient evidence in respect of charge 3a) and asked the panel to find it not proved.

In considering this charge the panel also considered the Gabapentin drug chart which shows that on the 12 March 2024 there were two members of staff who had signed for the drug.

Ms O'Sullivan confirmed in her evidence that there were two people at the controlled drug cupboard when Ms Fell removed the Gabapentin.

Therefore the panel found charge 3a not proved.

Charge 3b – e

On 12 March 2024:

b. Left the prescribed Gabapentin next to Patient B
c. Did not observe Patient B consume Gabapentin
d. Incorrectly recorded Patient B consumed Gabapentin at 10pm
e. Failed to undertake regular observations of Patient B as directed

This charge is found proved

The panel considered each sub charge individually, and decided to set them out as one in the determination as the evidence relates to the same course of conduct over the shift.

The panel noted that in a statement to the NMC dated 20 May 2024 Ms Fell stated:

> *'I agree I did not witness the patient take the medication'*
>
> *'The health care who undertook the observations was an experienced healthcare who notified me of her concerns.'*

The panel noted that Ms Fell said during the local investigation meeting on 26 March 2024: "*I gave this to her with a drink*." The panel also noted that Ms Fell admitted that Patient B had not consumed the medication. As a consequence of these admissions the panel found charges 3b) and 3c) proved.

The panel considered the evidence of Ms O'Sullivan and the local investigation report into this incident. The panel referred to the medication administration record which indicated consumption of Gabapentin at 2154 and concluded that this was an incorrect recording deliberately made by Ms Fell. Accordingly charge 3d) was found proved.

The patient notes stated that the required observations were *'neuro obs'* which should not have been completed by a healthcare assistant and needed to be completed by a registered nurse. Ms Fell had been instructed at the handover meeting to carry out regular, in this case initially 15-minute, observations, and she should have carried these out herself as the responsible nurse. In failing to do this Ms Fell did not follow the directions of senior medical colleagues to conduct observations of the patient.

The panel therefore found charge 3e) proved.

Charge 3f-g

On 12 March 2024:

f. Failed to review Patient C's records prior to administering oral paracetamol

g. Incorrectly administered oral paracetamol to Patient C

This charge is found proved

The panel considered each sub charge individually and decided to set them out as one in the determination as the evidence relates to the same course of conduct over the shift.

The panel reminded itself of the evidence heard at charge 1 in relation to the correct process for administering medication.

Ms O'Sullivan said in her evidence that the patient records stated that the paracetamol was administered intravenously and that for oral paracetamol a separate prescription is required. She stated that the drug chart had a clear warning not to administer two forms of paracetamol together.

The record stated that Ms Fell did administer oral paracetamol to Patient C when they had already received intravenous paracetamol.

The panel therefore inferred that Ms Fell had failed to review Patient C's record, thus making the error.

Therefore, the panel found that this charge is proved.

Charge 4

On 13 March 2024:

a. Removed Gabapentin from the controlled drug cupboard without a second checker
b. Incorrectly recorded that Patient B missed their morning dose of Gabapentin

This charge is found proved

The panel considered each sub charge individually, and decided to set them out as one in the determination as the evidence relates to the same course of conduct over the shift.

The panel had sight of the Controlled Drugs Book and noted that on 13 March 2024 there is an entry showing one Gabapentin capsule being removed with only Ms Fell's signature against it. The panel noted its earlier finding at charge 3a and found that it was a requirement for there to be a second checker and that Ms Fell was aware of this expectation in the Hospital medication management policy. The panel found that in the absence of this second checker signature that Ms Fell did not have a second signatory when she removed the Gabapentin.

The panel noted that the MAR (Medication Administration Record) chart indicated that the morning dose had not been administered. In actual fact at 0630 the patient themselves had taken that medication which had been improperly left with them at 2154 the previous evening by Ms Fell. This was revealed to Ms Fell by the patient during the mornings drug round. However, these events were not accurately reflected in the records made by Ms Fell. Ms O'Sullivan stated that this was noticed when the day shift checked the medication records and noticed there was a discrepancy.

The panel was mindful that Ms Fell also admits to this charge.

The panel therefore concluded that on the balance of probabilities the patient had not been given the morning dose of Gabapentin.

The panel therefore found this charge proved.

Charge 5 and 6

5. Your conduct at charge 3d was dishonest in that you intended to mislead others in believing that the evening dose had been consumed.

6. Your conduct at charge 4b was dishonest in that you intended to mislead others in believing that the morning dose was missed

These charges are found proved

The panel considered each charge individually, and decided to set them out its reasoning on both in the determination as the evidence essentially relates to the same course of conduct over the shift, involving Gabapentin.

The panel applied the test for dishonesty as set out in the case of *Ivey v Genting Casinos*. It found that Ms Fell's actions constituted a sustained and deliberate course of conduct that arose out of her desire to conceal her error in not observing the patient consume the drug and to mislead others.

Throughout the evidence the panel noted that Ms Fell was described by Ms O'Sullivan and Ms Ingleston as consistently lacking candour, evasive when confronted, defiant and dismissive of the concerns raised. Ms O'Sullivan said of Ms Fell that she would *"sweep it under the rug… we very much saw that pattern"*. Ms Ingleston also described Ms Fell as "*people who go out of their way to cover up…are dangerous practitioners*".

The panel found that Ms Fell accepted she had not observed the patient taking the evening dose of Gabapentin and that it had been left next to the patient's bed. Despite this she made a record in the medication chart that the evening dose had been administered properly, and consumed by the patient.

As a consequence of the error proven at 3d in relation to the evening medication, when Ms Fell attended the patient to administer the morning dose, the patient stated they had only just taken the dose. This dose that the patient consumed would very likely have been the previously untaken evening medication. These events should have been properly recorded by Ms Fell in the patient record. However, the panel saw in the records that Ms Fell had signed to say that the evening dose was administered and instead recorded that the morning dose was missed.

The panel considered whether Ms Fell's actions might have been as a consequence of negligence, carelessness or the making of an honest mistake. The panel concluded that these alternative explanations, having considered the evidence in the round, were unlikely.

The panel found an ordinary decent person would consider a course of action which concealed a number of errors, to be dishonest.

Therefore the panel found both charge 5 and charge 6 to be 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 Ms Fell'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 safely and effectively without restriction.

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

Submissions on misconduct

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

Mr Kennedy 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.

Mr Kennedy identified the specific, relevant standards where Ms Fell's actions amounted to misconduct. He submitted that Ms Fell's actions including dishonesty were directly linked to patient care and involved deceiving other healthcare professionals in order to conceal her errors. He submitted that this is serious and is a significant departure from the expected standards of a registered nurse amounting to misconduct.

Submissions on impairment

Mr Kennedy moved on to the issue of impairment and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. This included reference to the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin).

Mr Kennedy submitted that while the initial clinical and record keeping errors could be remediated Ms Fell's dishonesty is more difficult to address. While Ms Fell has submitted reflection pieces during the local investigation and as part of her agreed removal applications, they provide only limited insight into her behaviour and actions and offer less surrounding her dishonesty. He submitted that there is therefore a risk of repetition.

Mr Kennedy submitted that because of this risk of repetition there is a real risk of serious harm and a finding of impairment on public protection is required.

Mr Kennedy submitted that nurses are expected to act with integrity, candour, and honesty at all times and public confidence in the profession would be seriously undermined if a finding of impairment was not made in this case.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council*, and *Nandi v General Medical Council* [2004] EWHC 2317 (Admin).

Decision and reasons on misconduct

In reaching its decision on misconduct the panel had regard to the case law, and the NMC Guidance FtP-2a and FtP-2a-iii. The panel did not consider that the dishonesty in this case was '*one off*', and concluded that it was serious and sustained.

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

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

‘1.2 make sure you deliver the fundamentals of care effectively

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

2.2 recognise and respect the contribution that people can make to their own health and wellbeing

8.2 maintain effective communication with colleagues

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

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

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

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

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

16.1 raise and, if necessary, escalate any concerns you may have about patient or public safety, or the level of care people are receiving in your workplace or any other health and care setting and use the channels available to you in line with our guidance and your local working practices

16.4 acknowledge and act on all concerns raised to you, investigating, escalating or dealing with those concerns where it is appropriate for you to do so

17.1 take all reasonable steps to protect people who are vulnerable or at risk from harm, neglect or abuse

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

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

20.2 act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment

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

20.8 act as a role model of professional behaviour for students and newly qualified nurses, midwives and nursing associates to aspire to'

The specific aspects of Ms Fell's actions which the panel determined were serious are:

- Directly impacted the health of an extremely vulnerable patient. Ms Fell should have known her actions would likely leave this patient in considerable pain;
- Deliberating misleading a vulnerable patient in her care;

- Involved the mishandling and misrecording of dangerous and controlled drugs;
- Involved concerted efforts to deceive a senior medical staff member;
- Involved an effort to corrupt a junior staff member;
- Actions which took place, while subject to a final written warning, only months earlier, in October 2023, for similar behaviour, and took place in a professional capacity.

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel was of the view that Ms Fell's actions were part of a sustained and deliberate course of conduct to conceal the medication error through dishonesty. The panel considered that another registered nurse would highly likely consider these actions to be deplorable, as was reflected in the evidence of Ms Hermedes-Cabatay.

The panel found that Ms Fell'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, Ms Fell's fitness to practise is currently impaired.

In coming to its decision, the panel had regard to the NMC Guidance on *'Impairment'* (Reference: DMA-1 Last Updated:28/01/2026) in which the following is stated:

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

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional and to uphold the duty of candour and honesty. 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/ fitness to practise is impaired in the sense that S/He:*
>
> a) *has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*
>
> b) *has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*

c) *has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*

d) *has in the past acted dishonestly and/or is liable to act dishonestly in the future.'*

The panel finds that patients were put at risk of physical and emotional harm as a result of Ms Fell's misconduct. The panel considered that by administering more medication than required and leaving a controlled drug unattended by a patient's bed there is a real risk of serious harm to vulnerable patients who were dependent on the care of Ms Fell. This was compounded by Ms Fell embarking on a course of conduct involving a series of actions designed to cover up her mistake. This included falsifying records, coercing a junior colleague to ignore and not report the mistake, and deliberately deceiving the on duty doctor to erroneously prescribe additional and potentially dangerous drugs to an already unwell patient.

The panel decided that Ms Fell's misconduct had breached the fundamental tenets, namely honesty and integrity, of the nursing profession and therefore brought its reputation into disrepute. It was satisfied that confidence in the nursing profession would be undermined if its regulator did not find charges relating to dishonesty extremely serious.

Regarding insight, the panel considered that while Ms Fell has provided reflections at previous local investigations and to the NMC as part of the Agreed Removal Process she had not provided any specifically for this panel. In her earlier reflections the panel considered that her insight was extremely limited, focusing more on the medication errors, deflecting blame onto others, and continuing to attempt to conceal the full extent of her misconduct. This behaviour is corroborated by her colleagues who stated that Ms Fell does not take ownership of her drug errors, is defiant, dismissive, and a *'dangerous practitioner*'. The panel noted that there are no reflections on dishonesty and why a registered nurse needs to act with full candour and integrity. The panel also noted there is

no explanation of how Ms Fell would go about regaining the trust of her patients, colleagues, and the wider public.

The panel noted that Ms Fell has stated she is not practising as a registered nurse and that there is no information about any strengthening of practice, such as training courses or reflective learning discussions, that she might have done.

The panel further noted that the second incident occurred while Ms Fell was on a final written warning from the Hospital for similar actions in October 2023, as found proved in charge 1. Yet she made further similar clinical errors and again acted dishonestly in seeking to cover these up.

Therefore, the panel is of the view that there is a high risk of repetition and of serious harm to patients. 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 considered that it is a fundamental requirement of the nursing profession that in all areas, but especially clinical care, nurses act honestly displaying full integrity and candour towards patients and colleagues. The panel considered that public confidence in the nursing profession would be seriously undermined if a registered nurse who had repeatedly deceived colleagues and placed vulnerable patients at risk of harm and then failed to address these attitudinal behaviours was permitted to practice. Therefore the panel determined that a finding of impairment on public interest grounds is required.

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

Sanction

The panel has considered this case very carefully and has decided to make a striking-off order. It directs the Registrar to strike Ms Fell off the register. The effect of this order is that the NMC register will show that Ms Fell has been struck-off the register.

In reaching this decision, the panel has had regard to all the evidence that has been adduced in this case and had regard to the NMC Guidance on *'The sanctions available'* (Reference: SAN-2 Last Updated: 28/01/2026).

The panel accepted the advice of the legal assessor.

Submissions on sanction

Mr Kennedy informed the panel that in the Notice of Hearing, the NMC had advised Ms Fell that it would seek the imposition of a striking-off order if it found Ms Fell's fitness to practise currently impaired. He outlined a number of suggested aggravating and mitigating features of this case for the panel to consider. He submitted that given Ms Fell's repeated dishonesty which put vulnerable patients at risk of serious harm, and the failure to fully remediate and demonstrate strengthening of practice that only a striking-off order would protect the public and mark the seriousness of the misconduct.

Decision and reasons on sanction

Having found Ms Fell's fitness to practise currently impaired, the panel went on to consider what sanction, if any, it should impose. 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 decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features:

- Repeated dishonest acts
- Dishonesty in a clinical role
- No insight on dishonesty
- Failure to engage in the Fitness to Practise (FtP) process, without good reason
- No indication of having strengthened practice or any willingness to do so
- Vulnerability of the person receiving care
- Likelihood of actual harm caused to a patient
- Coercion of a junior member of staff
- Deceiving a doctor to improperly prescribe controlled and potentially dangerous drugs to a vulnerable patient
- Repeating her misconduct for which a final written warning had previously been issued by Ms Fell's employer

The panel also took into account the following mitigating features:

- Partial informal admission of the facts in the Agreed Removal Application
- Limited insight on clinical errors
- Some information of difficult personal circumstances

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.

The panel next considered a caution order and had regard to the NMC Guidance on *'Caution order'* (Reference: SAN-2b Last Updated: 28/01/2026) in which the following is stated:

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

The panel considered that Ms Fell’s actions were not at the lower end of the spectrum, and it found that there is a risk to patient and public safety. The panel therefore determined that a sanction that does not restrict Ms Fell’s practice would not protect the public. The panel also determined that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether to place a conditions of practice order on Ms Fell’s registration. In considering whether conditions of practice are appropriate, the panel had regard to the factors set out in the NMC Guidance on ‘Conditions of practice order’ (Reference: SAN-2c Last Updated: 28/01/2026).

The panel found that Ms Fell’s failings were serious, related to clinical practice and involved repeated dishonesty. The panel reminded itself of its earlier findings at the impairment stage that Ms Fell displayed an attitude of being dismissive of the concerns, was *‘defiant*’ and deflected blame, and had a tendency to ‘*sweep them under the rug’.* The panel found that this amounts to a serious attitudinal concern. It determined that a conditions of practice order would not be appropriate in the circumstances.

The panel considered that there are no relevant, proportionate, workable or measurable conditions that could be formulated to protect patients and to uphold professional standards. The panel further noted that Ms Fell has not engaged with the fitness to practice process and there is no indication that she would engage with any conditions imposed.

The panel went on to consider whether a suspension order is appropriate in this case. The panel had regard to the NMC Guidance on *'Suspension order'* (Reference: SAN-2d Last Updated: 28/01/2026) in which the following factors on when a suspension order may be appropriate are set out:

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

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

- *'the charges found proved are at the most serious end of the spectrum and call into question the professional's suitability to continue practising, either currently or at all*
- *while it is possible that the professional could be fit to practise in future, only a period out of practice would be sufficient to allow them to fully strengthen their practice through reflection, the development of their professional skills and / or development of insight and remediation*
- *there is a risk to the safety of people using services if the professional were allowed to continue to practise even with conditions*
- *what went wrong is so serious that public confidence in the profession and professional standards could not be maintained if the professional were able to continue practising without stopping for a period of time*
- *despite the seriousness of what happened, the professional has engaged in the proceedings and has shown at least some meaningful insight which evidences a realistic possibility that they will continue to develop this insight, address their concerns and return to practice.'*

Whilst the panel acknowledged that the risks identified could, under different circumstances be managed by Ms Fell being temporarily removed from the register, it

considered that approach would not be sufficient to uphold public confidence in the profession and maintain professional standards due to the seriousness and nature of the facts found proved. The panel took account of Ms Fell's lack of engagement with the fitness to practice process along with her failure to demonstrate insight into the multiple dishonesty charges found proved, her lack of remorse, the absence of any evidence of training and development, and the premeditated nature of her repeated dishonesty. It found that there is no realistic possibility that she would address the concerns to such a level where she could return to practise safely.

In this particular case, the panel determined that a suspension order would not be a sufficient, appropriate or proportionate sanction.

In considering a striking-off order, the panel had regard to the NMC Guidance on *'Sanctions for the highest risk cases'* (Reference SAN-4 Last Updated: 28/01/2026). The panel determined that this case falls within the definition of being a '*highest risk case'*. The panel considered the NMC Guidance SAN-4:

- *'deliberately breaching the professional duty of candour by covering up when things have gone wrong, especially if this could cause harm to people receiving care*
- *misuse of power*
- *personal or financial gain from a breach of trust*
- *direct risk to people receiving care*
- *premeditated, systematic or longstanding deception.'*

The panel found that all of these points are engaged in this case. Ms Fell's dishonesty was premeditated to conceal a medication error. This placed vulnerable patients at risk of harm, and was done in order to preserve her own employment particularly given the scrutiny she was under following earlier concerns. The panel considered that Ms Fell was dishonest to multiple people including the on duty doctor, her nursing colleagues, and especially the patient receiving care. This involved a premeditation of responses intended to mislead and deceive.

The panel had regard to the following considerations as set out in the NMC Guidance entitled *'Striking-off order'* (Reference: SAN-2e Last Updated; 28/01/2026):

- *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 panel found that given the high level of serious dishonesty which posed a risk of harm to vulnerable patients only a striking-off order would be appropriate in this case.

Ms Fell's actions and behaviours were significant departures from the standards expected of a registered nurse, and are fundamentally incompatible with her remaining on the register. The panel was of the view that the findings in this particular case demonstrate that Ms Fell's actions were so serious that to allow her to continue practising would not protect the public and would undermine public confidence in the profession and in the NMC as a regulatory body.

Balancing all of these factors and after taking into account all the evidence before it during this case, the panel determined that the appropriate and proportionate sanction is that of a striking-off order. Having regard to the effect of Ms Fell's actions in bringing the profession into disrepute by adversely affecting the public's view of how a registered nurse should conduct herself, the panel has concluded that nothing short of this would be sufficient in this case.

The panel considered that this order was 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.

This will be confirmed to Ms Fell in writing.

Interim order

As the striking-off order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order is required in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in Ms Fell's own interests until the striking-off sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Submissions on interim order

The panel took account of the submissions made by Mr Kennedy. He submitted that an interim suspension order is necessary for 18 months on the grounds of public protection and otherwise in the public interest to cover any potential appeal period.

The panel accepted the advice of the legal assessor.

Decision and reasons on interim order

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

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the striking-off order. The panel therefore imposed an interim suspension order for a period of 18 months as being necessary to protect the public and being otherwise in the public interest to cover any appeal period.

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

That concludes this determination.