Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Meeting
Tuesday, 24 February 2026 – Thursday, 26 February 2026

Virtual Meeting

Name of Registrant:	**Vanessa Wells**
NMC PIN:	82A2187E
Part(s) of the register:	Registered Nurse – Adult RN1; (29 March 2000)
Relevant Location:	Braintree
Type of case:	Misconduct
Panel members:	Patricia Richardson (Chair, Lay member) Alison Bielby (Registrant member) Kate Richards (Lay member)
Legal Assessor:	Alice Robertson Rickard
Hearings Coordinator:	Anya Sharma
Facts proved:	Charges 1 (in relation to 4,10,14 July 2023, 2, 5 September 2023 set out in Schedule 1), 2 (in relation to 4,10,14 July 2023, 2, 5 September 2023 set out in Schedule 1), 3 (in relation to 4,10,14 July 2023, 2, 5 September 2023 set out in Schedule 1), 4 (in relation to 22 August 2023 in relation to Schedule 2), 5 (in relation to 22 August 2023 in relation to Schedule 2), 6 (in relation to 22 August 2023 in relation to Schedule 2), 7a, 7b and 8
Facts not proved:	Charges 1 (in relation to 5, 11, 17, 23, 26 April 2023, 5, 17, 29 May 2023, 4, 7 June 2023, 22, 28 July 2023, 3, 12 August 2023 as set out in schedule 1), 2 (in relation to 5, 11, 17, 23, 26 April 2023, 5, 17, 29 May 2023, 4, 7 June 2023, 22, 28 July 2023, 3, 12 August 2023 as set out in schedule 1), 3 (in relation to 5, 11, 17, 23, 26 April 2023, 5, 17, 29 May 2023, 4, 7 June 2023, 22, 28 July 2023, 3, 12 August 2023 as set out in Schedule 1), 4 (in relation to 3 April 2023, 5 May

	2023 and 1 August 2023 in relation to Schedule 2), 5 (in relation to 3 April 2023, 5 May 2023 and 1 August 2023 in relation to Schedule 2), 6 (in relation to 3 April 2023, 5 May 2023 and 1 August 2023 in relation to Schedule 2)
Fitness to practise:	**Impaired**
Sanction:	**Striking-off order**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on service of Notice of Meeting

The panel noted that the Notice of Meeting had been sent to Mrs Wells' registered email address by secure email on 8 January 2026.

The panel accepted the advice of the legal assessor.

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

In light of all of the information available, the panel was satisfied that Miss Wells 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).

Details of charge

That you, a registered nurse:

1. Administered Fentanyl patches to Resident JL, without a witness signature, on one or more of the dates set out in Schedule 1.

2. Incorrectly entered a signature of another colleague as a witness for the administration of Fentanyl patches to Resident JL into the controlled drug book on one or more of the dates set out in Schedule 1.

3. Your actions at charge 2 were dishonest in that you sought to represent that another colleague had signed as having witnessed the administration of Fentanyl patches to Resident JL when you knew that they had not.

4. Received a quantity of Fentanyl, without a witness signature, on one or more dates set out in Schedule 2

5. Incorrectly entered a signature of another colleague as a witness for the receipt

of a quantity of Fentanyl on one or more dates set out in Schedule 2

6. Your actions at charge 5 were dishonest in that you sought to represent that another colleague had signed as having witnessed the receipt of the Fentanyl when you knew that they had not.

7. On 2 September 2023:
a) Disposed of controlled drugs without a witness signature;
b) Incorrectly entered a signature of another colleague as witnessing the disposal of controlled drugs.

8. Your actions at charge 7b were dishonest in that you sought to represent that another colleague had signed as having witnessed the disposal of the controlled drugs when you knew that they had not

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

Schedule 1

5 April 2023
11 April 2023
17 April 2023
23 April 2023
26 April 2023
5 May 2023
17 May 2023
29 May 2023
4 June 2023
7 June 2023
4 July 2023
10 July 2023
14 July 2023
22 July 2023
28 July 2023

3 August 2023
12 August 2023
2 September 2023
5 September 2023

Schedule 2
3 April 2023
5 May 2023
1 August 2023
22 August 2023

Background

Mrs Wells entered the register on 16 July 1984.

On 18 October 2012, she started working at Aspen Grange Care Home ("the Home") where she was a nurse and the clinical lead. On 6 September 2023, an anonymous letter was sent to the Home which stated "Clinical Lead forges signatures in controlled drugs book".

It is alleged that on one or more occasions, Mrs Wells administered controlled drugs namely Fentanyl patches without countersignature and fraudulently countersigned the controlled drug book using other members of staffs' signatures.

It is further alleged that Mrs Wells also received and disposed of controlled drugs without another witness's signature and fraudulently countersigned the controlled drug book using other members of staffs' signatures on one or more occasions, contrary to the Home's policy.

Decision and reasons on facts

In reaching its decisions on the disputed facts, the panel took into account all the documentary evidence in this case together with the representations made by the NMC and the response from Mrs Wells.

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

The panel had regard to the written statement of the following witness on behalf of the NMC:

- Witness 1: Regional Manager at Health Care Management Solutions

The panel also had regard to written representations from Mrs Wells received on 26 January 2026.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor, which included reference to the cases of *Enemuwe v NMC [2016] EWHC 1881 (Admin)* and *Ivey v Genting Casinos [2017] UKSC 67.*

It considered the documentary evidence provided by both the NMC and Mrs Wells.

The panel had particular regard to the following evidence:

As part of the local investigation, on 6 September 2023 staff confirmed in their interviews that some of the signatures purporting to be theirs were in fact not. During the investigation meeting the following staff members confirmed the following:

Colleague A confirmed that it was not their signature on 22 August 2023 with regards to receiving 10 Fentanyl patches for Resident JL. They also confirmed it was not their signature on 5 September 2023 entry which is in relation to administration of Fentanyl patches to Resident JL.

Colleague B confirmed that they do not always sign the controlled drug book although they watches Mrs Wells “administer the patch”. Colleague B confirmed they did

not witness Mrs Wells administer the patch on 2 September 2023. Colleague B also confirmed that they did not witness any medication being destroyed on 2 September 2023 and they did not sign the controlled drug book over the weekend 2/3 September.

Colleague C confirmed that they had only signed the controlled drug book on 26 May 2023. Colleague C confirmed that it was not their signature in relation to the entry on 4 July 2023.

Colleague D confirmed that they have never been asked to sign the controlled drug book and that it was not their signature in relation to the entry on 14 July.

The local Medicines management policy ('the policy') has clear guidance regarding the administration and witnessing of controlled drugs. It also provides clear guidance on disposal of medicines and on the receipt of controlled drugs. On 12 July 2022, Mrs Wells had completed eLearning for medication administration awareness, and on 13 March 2023 she had been assessed as competent having completed the annual medicines management assessment including controlled drugs.

During the local investigation interview on 7 September 2023, Mrs Wells was asked if she had ever forged a book. She responded by stating "I may have put one or two signatures yes". When asked why, she stated for "quickness and now I could lose my job". The panel noted that during the interview, Mrs Wells was not specifically questioned as to whether or not she was responsible for the signatures attributed to Colleagues A, B and C in relation to all of the dates listed in Schedule 1.

On 29 April 2024, Mrs Wells accepted the regulatory concerns of poor medication practice – in that she administered, checked in and disposed of controlled drugs without another competent individual witnessing this on several occasions, contrary to her employer's policy and dishonesty – in that she falsified medication records on several occasions.

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

Charge 1

1. Administered Fentanyl patches to Resident JL, without a witness signature, on one or more of the dates set out in Schedule 1.

This charge is found proved (in relation to 4 July 2023, 10 July 2023, 14 July 2023, 2 September 2023, 5 September 2023).

In reaching this decision, the panel took into account the controlled drug book entries for Resident JL. It also took into account the policy, which sets out the requirement for controlled drugs administration to be checked by a second person, who signs to confirm that they have witnessed the administration, namely:

> ***'3.26 Administration of Controlled Drugs***
>
> *3.26.2 Controlled drugs must be checked by a second person prior to administration. This person should normally also be competent in medication administration, however if the second person is not competent in medication administration their role is to witness the actions of the person administering the drugs – see paragraph 3.15. The second person will sign to confirm they have witnessed that:*
>
> *a) the correct controlled drug has been selected – the name of the drug matches the name of the drug on the MAR sheet,*
> *b) the person administering the CDs has checked the packaging for signs of interference or tampering,*
> *c) the name on the label attached to the controlled drug is the same as the person who is due to receive the drug and the MAR sheet,*
> *d) the dose on the MAR sheet matches the dose that has been prepared for administration,*
> *e) the identity of the person who is due to receive the drug matches the name and photograph on the MAR sheet,*
> *f) the administration is recorded in the CD register as well as signed on the medication chart.'*

The panel also took into account the following extract in relation to witnessing provisions:

> ***'3.16 Witnessing***
>
> *3.16.1 Administration of certain medicines such as controlled drugs require a witness to confirm the correct instructions have been followed and verify the remaining amount of medicines left.*
>
> *3.16.3 In the circumstances where there is no witness who is competent to administer medicines available, a member of staff that is not competent to administer medicines may act as witness. The member of staff administering the medicines must explain to the resident that they are witnessing the administration of the medicines. They do, however, need to understand that they are signing to verify that they have actually witnessed the administration of the medicine to the person named on the MAR sheet.*
>
> *3.16.4 Where a witness to administration of medicines is required, the onus is on the person administering the drugs to ensure that:*
>
> *a) The complete process is witnessed by another person.*
>
> *3.16.6 The person administering the medicines must check/count the amount of controlled drug remaining in the presence of, and being actively observed by, the witness to confirm the amount and enter this into the CD register. The witness signs to confirms this has been completed and the amount remaining tallies with that recorded on the register.*
> *3.16.7 A person acting as witness must not sign to confirm they have witnessed anything they have not actually observed.'*

The panel then considered the witness evidence before it in relation to this charge and the dates set out in Schedule 1. The panel noted that there is no direct evidence before it from Witness 1 that the witness signatures entered in the controlled drug book against some of

the dates specified in Schedule 1 were put to the colleagues who had purported to have witnessed the administration of the drugs by Mrs Wells on those dates.

Having considered the evidence provided by Colleagues A, B and C together with admissions made by Mrs Wells during interview, the panel was satisfied that there was sufficient evidence to prove that Mrs Wells administered Fentanyl patches to Resident JL without a genuine witness signature on the following dates set out in Schedule 1:

- 4 July 2023
- 10 July 2023
- 14 July 2023
- 2 September 2023
- 5 September 2023

The panel noted that although the administration of Fentanyl as recorded in the controlled drugs book for Resident JL contains an apparent witness signature for the above dates, the signature had in fact been entered by Mrs Wells. The panel considered the policy and noted that Mrs Wells could not witness her own administration of controlled drugs, and where Mrs Wells had written the second signature herself, the administration of that controlled drug for that date was effectively without a witness signature.

Taking all of this into account, the panel accordingly found charge 1 proved in respect of 4 July 2023, 10 July 2023, 14 July 2023, 2 September 2023, 5 September 2023 and not proved in respect of 5 April 2023, 11 April 2023, 17 April 2023, 23 April 2023, 26 April 2023, 5 May 2023, 17 May 2023, 29 May 2023, 4 June 2023, 7 June 2023, 22 July 2023, 28 July 2023, 3 August 2023 and 12 August 2023.

Charge 2)

2. Incorrectly entered a signature of another colleague as a witness for the administration of Fentanyl patches to Resident JL into the controlled drug book on one or more of the dates set out in Schedule 1.

This charge is found proved (in relation to 4 July 2023, 10 July 2023, 14 July 2023, 2 September 2023, 5 September 2023).

In reaching this decision, the panel took into account its findings in relation to charge 1, which factually also support charge 2, namely that Mrs Wells entered signatures purporting to be those of colleagues as witnesses when those colleagues had not witnessed the administrations of Fentanyl patches to Resident JL.

The panel therefore found charge 2 proved on the same dates as charge 1, namely:

- 4 July 2023
- 10 July 2023
- 14 July 2023
- 2 September 2023
- 5 September 2023

As per its findings in relation to charge 1, the panel found charge 2 not proved in relation to the remaining dates set out in Schedule 1 due to an absence of sufficient evidence before the panel.

The panel was satisfied that Mrs Wells had incorrectly entered a colleague's signature as if they had witnessed the administration when they had not, and this has been established for the dates 4 July 2023, 10 July 2023, 14 July 2023, 2 September 2023 and 5 September 2023.

Charge 3

3. Your actions at charge 2 were dishonest in that you sought to represent that another colleague had signed as having witnessed the administration of Fentanyl patches to Resident JL when you knew that they had not.

This charge is found proved.

In reaching its decision, the panel took into account its findings in relation to charge 2.

The panel was satisfied that when Mrs Wells fraudulently entered a colleague's signature in the witness column of the controlled drug book, she knew that her colleague had not witnessed the administration of Fentanyl patches to Resident JL. In reaching this decision, the panel had sight of the investigation meeting notes dated 7 September 2023, which includes Mrs Wells' admissions. During the interview, Mrs Wells had been asked *"Have you ever forged a book",* and Mrs Wells responded, *"I may have put one or two signatures in yes (The dates that were asked were 2/5 September 2023, 4,7,10,1431 July 2023 and 31 August 2023) but I haven't taken any CDs I promise…"*

The panel also had sight of Mrs Wells' reflective account dated 29 April 2024, where she had made admissions and in which she had described her actions as *'… dishonestly falsifying signatures on the medication records.'*

The panel noted that Mrs Wells had recent relevant medicines and controlled drugs training and therefore would have had a full understanding of the requirements for proper witnessing and signing. It also took into account that Mrs Wells is an experienced registered nurse who has continually worked from 1984 as set out in her written submissions. Taking all of this into account, the panel was of the view that Mrs Wells' conduct would be regarded as dishonest by the standards of ordinary decent people, as she had fraudulently signed the controlled drugs book in a way that falsely represented a second person had witnessed administration when they had not.

Accordingly, the panel found charge 3 proved in respect of the dates for which charge 1 and charge 2 are found proved, namely 4 July 2023, 10 July 2023, 14 July 2023, 2 September 2023 and 5 September 2023.

Charge 4

4. Received a quantity of Fentanyl, without a witness signature, on one or more dates set out in Schedule 2

This charge is found proved (in relation to 22 August 2023).

In reaching its decision, the panel had sight of the policy which details that receipt of controlled drugs must be checked and signed for by an authorised person and a witness as set out below:

> ***'3.23 Receipt of Controlled Drugs***
>
> *3.23.1 Receipt of controlled drugs must be recorded at the time of their arrival at the care home. The delivery must be checked and signed for by a person approved to administer medicines and a witness. Where possible one of these persons must be the Home Manager.'*

The panel then considered each of the dates set out in Schedule 2, and was of the view that for 3 April 2023, 5 May 2023 and 1 August 2023, there was insufficient evidence before it to prove that the witness signature was not genuine, as there is no witness evidence and no admissions from Mrs Wells for those dates.

The panel however found charge 4 proved in relation to 22 August 2023. In reaching this decision, the panel had sight of the investigation meeting notes dated 6 September 2023, in which the witness Colleague A had been shown *'the controlled drugs book and asked [them] if these signatures were [theirs] – 22nd August, which was the booking in of 10 Fentanyl patches for JL and [Colleague A] said no, [they have] never checked in controlled drugs'.* Taking this into account, the panel was satisfied that the entry related to Mrs Wells booking in/receiving the fentanyl and that the 'witness signature' was not genuine.

Accordingly, the panel found charge 4 proved in relation to 22 August 2023 and not proved for the remainder of the dates set out in Schedule 2, namely 3 April 2023, 5 May 2023 and 1 August 2023.

Charge 5

5. Incorrectly entered a signature of another colleague as a witness for the receipt of a quantity of Fentanyl on one or more dates set out in Schedule 2

This charge is found proved (in relation to 22 August 2023).

In reaching its decision, the panel took into account its findings in relation to charge 4 and found charge 5 proved in relation to 22 August 2023 only, based on Colleague A's response during questioning that they have never checked in controlled drugs. The panel was also satisfied that the witness signature had been incorrectly entered by Mrs Wells to represent witnessing which had not occurred.

Due to a lack of supporting evidence, the panel found charge 5 not proved in relation to 3 April 2023, 5 May 2023 and 1 August 2023.

Charge 6

6. Your actions at charge 5 were dishonest in that you sought to represent that another colleague had signed as having witnessed the receipt of the Fentanyl when you knew that they had not.

This charge is found proved.

In reaching its decision, the panel took into account its findings in relation to charge 3 and applied the same reasoning. The panel concluded that Mrs Wells knew that a witness was required for receipt of controlled drugs, and that entering a signature purporting to be that of another colleague who was not present was dishonest. Taking all of this into account, the panel was of the view that Mrs Wells' conduct would be regarded as dishonest by the standards of ordinary decent people.

Charge 7

7. On 2 September 2023:
a) Disposed of controlled drugs without a witness signature;
b) Incorrectly entered a signature of another colleague as witnessing the disposal of controlled drugs.

The panel found this charge proved (in its entirety).

In reaching its decision, the panel took into account the controlled drug book entries for 2 September 2023 showing controlled drugs recorded as *'destroyed/denatured'*, with '[Colleague B]' recorded as the witness.

The panel had sight of the further investigation meeting notes dated 6 September 2023, where Colleague B states that they did not witness any medication being destroyed on 2 September 2023:

> *'[Chairperson] – Did you go into the medication room on Saturday 2nd September*
>
> *[Colleague B] – No*
>
> *[Chairperson] – Did you witness any medication being destroyed on Saturday 2 September*
>
> *[Colleague B] – No*
>
> *[Chairperson] showed DJ the controlled medication book*
>
> *[Colleague B] – I signed the controlled book with […] the last time*
>
> *[Chairperson] – So this isn't your signature - (Chairperson showed [Colleague B] the signatures in the book)*
>
> *[Colleague B] – I didn't sign it*
>
> *[Chairperson] – So you didn't sign anything in the controlled book over the weekend 2/3rd September*
>
> *[Colleague B] - I haven't signed the book over the weekend*
>
> *Meeting ended'*

The panel considered the policy provisions indicating destruction/denaturing must be witnessed by an authorised person:

> *'3.27.5 In a home with nursing (except in Scotland), controlled drugs should be denatured using a denaturing kit following the manufacturer's instructions in preparation for collection by the Waste Disposal Company (See paragraph 3.28). The Home Manager or the Regional Manager is the authorised person to witness the denaturing of controlled drugs.'*

The panel took into account the investigation meeting notes dated 7 September 2023, which includes Mrs Wells' admissions. During the interview, Mrs Wells had been asked *"Have you ever forged a book",* and Mrs Wells responded, *"I may have put one or two signatures in yes (The dates that were asked were 2/5 September 2023, 4,7,10,1431 July 2023 and 31 August 2023) but I haven't taken any CDs I promise…".*

Taking all of this into account, the panel concluded that the disposal of controlled drugs was carried out without a genuine witness signature, and that Mrs Wells had entered another person's signature as though they had witnessed the disposal of controlled drugs, when they had not.

Charge 8

8. Your actions at charge 7b were dishonest in that you sought to represent that another colleague had signed as having witnessed the disposal of the controlled drugs when you knew that they had not

This charge is found proved.

In reaching its decision, the panel relied on the same dishonesty findings as set out in charges 3 and charge 6.

The panel was of the view that Mrs Wells knew that controlled drug witnessing and signing were important safeguards, and Mrs Wells had the relevant training, competencies and requirements expected of an experienced registered nurse. The panel noted that Mrs

Wells had made an admission to placing signatures as set out in her investigation meeting notes dated 7 September 2023 and later described her actions as dishonest/falsifying signatures in her reflective documentation. The panel concluded that ordinary decent people would consider it dishonest to sign to represent another person has witnessed the disposal of the controlled drugs when Mrs Wells knew that they had not.

Accordingly, the panel found charge 8 proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether Mrs Wells' 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, Mrs Wells' fitness to practise is currently impaired as a result of that misconduct.

Representations on misconduct and impairment

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

The panel had sight of the NMC's written submissions in relation to misconduct and impairment. The NMC invited the panel to take the view that the facts found proved amount to misconduct. The panel had regard to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015)' ("the Code") in making its decision. The NMC identified the specific, relevant standards where Mrs Well's actions amounted to misconduct.

The NMC requires the panel to bear in mind its overarching objective to protect the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. The panel has referred to the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant* [2011] EWHC 927 (Admin).

The panel also took into account the documentary evidence and written submissions from Mrs Wells.

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

Decision and reasons on misconduct

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

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

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

18.2 keep to appropriate guidelines when giving advice on using controlled drugs and recording the prescribing, supply, dispensing or administration of controlled drugs

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

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 Mrs Wells' actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

In reaching this conclusion, the panel noted that controlled drugs safeguards, including the requirement of a witness, exist to reduce the risk of human error and to protect patients by ensuring that medicines are administered, received and disposed of safely and properly. The panel was of the view that Mrs Wells' misconduct created a potential for harm as she did not follow the required checking and witnessing procedures and did so deliberately. The panel noted that Mrs Wells was an experienced registered nurse who understands policy and procedure, and despite this, chose not to follow the required process.

The panel was of the view that Mrs Wells' misconduct in this case was aggravated by her dishonesty, as she did not just omit witness signatures but falsified and forged signatures to give a false impression that the expected witnessing procedure had been followed.

The panel was therefore satisfied that Mrs Wells' conduct falls seriously short of the standards expected of a registered nurse and amounts to misconduct.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct, Mrs Wells' 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. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. To justify that trust, nurses must be honest and open and act with integrity. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

In this regard the panel considered the judgment of Mrs Justice Cox in the case of *CHRE v NMC and Grant* in reaching its decision. In paragraph 74, she said:

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

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

'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her/their fitness to practise is impaired in the sense that S/He/They:

a) *has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*

b) has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or

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

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

The panel was satisfied that Mrs Wells' misconduct placed patients at an unwarranted risk of harm, given that the requirement for a second checker/witness exists to prevent error and ensure that controlled drugs are handled safely. Mrs Wells' misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. It was satisfied that Mrs Wells had acted dishonestly.

Regarding insight, the panel considered that Mrs Wells' had demonstrated limited insight. It noted that whilst Mrs Wells had made some admissions at a local level, provided a reflective piece, written submissions and also provided extensive material in relation to workplace context and the associated pressures, Mrs Wells did not meaningfully address the safety rationale for witnessing the controlled drugs processes. The panel was also of the view that Mrs Wells did not demonstrate an understanding of the potential impact of her conduct on patients and the need for accurate controlled drug records. Further, Mrs Wells had not demonstrated an understanding of the potential impact on her colleagues in forging their signatures, which could have put them in difficulties and damaged trust within her team, the wider organisation and the reputation of the nursing profession. It also noted that Mrs Wells did not adequately demonstrate how she would handle a similar situation differently in the future and the importance of complying with policy.

The panel had sight of Mrs Wells' reflective material, in particular her reference to recognising that she should not have abused her position of trust and that she should have prioritised medicines management. The panel noted that Mrs Wells' reflective material also however repeatedly asserts that she "always administered the medicine correctly", which suggests that she does not fully understand that administering medicine correctly involves complying with controlled drugs procedures, which includes the use of witnesses and

proper record keeping. The panel considered that from her reflective material, Mrs Wells does not take full accountability and attempts to deflect, with references suggesting that others should have identified the concerns earlier.

The panel was satisfied that the misconduct in this case was more than just a single lapse of judgement and indicated behaviour that was attitudinal in nature. It acknowledged that it would therefore be difficult to address, particularly the charges of dishonesty that have been proved. Nevertheless, the panel carefully considered the evidence before it in determining whether or not Mrs Wells has taken steps to strengthen her practice. The panel took into account Mrs Wells' reflective piece, in which she includes some evidence of remorse and states that she felt devasted and ashamed and that she had let others down. The panel however noted that Mrs Wells' remarks were focused more on the consequences for her and did not address the impact of her conduct on patients and her colleagues and the wider impact on the nursing profession.

The panel was of the view that Mrs Wells had provided little evidence of remediation or strengthening of her practice. It considered that it has no evidence before it of any relevant training undertaken or any steps taken by Mrs Wells to address the regulatory concerns in this case. The panel noted that Mrs Wells no longer works as a nurse, and it is unclear whether her current employment involves use of her nursing registration.

The panel was of the view that Mrs Wells' conduct was repeated, deliberate and involved dishonesty and a complete disregard of the policy. The panel determined that Mrs Wells' had full knowledge and understanding of the requirements, given that she had not left entries blank and had provided a forged second signature. The panel considered that dishonesty is inherently difficult to remediate and Mrs Wells has not taken any meaningful steps in doing so. The panel was therefore satisfied that there is a risk of repetition and 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. Mrs Wells' actions had failed to uphold

standards and had brought the nursing profession into disrepute. The panel therefore determined that a finding of impairment on public interest grounds is required.

The panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case and therefore also finds Mrs Wells' fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that Mrs Wells' 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 Mrs Wells off the register. The effect of this order is that the NMC register will show that Mrs Wells 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.

Representations on sanction

The panel had sight of the NMC's written submissions in relation to sanction and that a striking-off order is the appropriate sanction in this case.

The panel also bore in mind Mrs Wells' written submissions in relation to sanction:

> *'I would like to say before you impose sanction, please would you take into consideration my length of service as a registered nurse (registered nurse – adult level 2 16/07/1984. Registered nurse – Adult 29/03/2000. I have continually worked from 1984 – present with an impeccable record until the incident.'*

Decision and reasons on sanction

Having found Mrs Wells' 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 panel had regard to the NMC Guidance on *'The sanctions available'* (Reference: SAN-2 Last Updated: 28/01/2026). The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features:

- Abuse of a position of trust
- Mrs Wells' conduct deliberately put service users at risk of suffering harm, in failing to obtain the required second check/witness for the controlled drugs
- Mrs Wells' deliberate breach of the policy, in that despite being trained and assessed as competent and understanding the procedure, she nonetheless chose not to follow it and falsified records to give the impression that witnessing had occurred.
- Mrs Wells' conduct was not a one-off event; there was a clear pattern of misconduct over a period of time, indicating deep-seated attitudinal concerns.
- Mrs Wells' dishonesty, involving the falsification and forgery of colleagues' signatures in controlled drug records.
- Mrs Wells' limited insight, as demonstrated in her reflective piece.

The panel also took into account the following mitigating features:

- Mrs Wells made early admissions at a local level
- Positive testimonials from Mrs Wells' current employer speaking highly of her professionalism, competence, kindness and compassion in her current role
- Mrs Wells' raised concerns of staffing pressure and workplace relationship concerns. The panel however found no direct link shown between the issues and the specific misconduct proved.

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 Mrs Wells' misconduct was 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 Mrs Wells' practise 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 conditions of practice on Mrs Wells' 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 the misconduct proved was attitudinal in nature and related to deliberate actions in forging signatures of her colleagues on numerous occasions with the aim of concealing the fact that she was in breach of the policy. Further, the panel noted that Mrs Wells misconduct had taken place within a short time of having been assessed as competent in relation to medication management, which included controlled drugs.

Having had regard to the nature and seriousness of Mrs Wells' conduct, the panel 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 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 be managed by Mrs Wells being temporarily removed from the Register, it considered that it 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. Given Mrs Wells' lack of meaningful engagement, limited insight (with her reflective piece showing signs of deflection and a focus on workplace context), together with no evidence of further training and development, the panel considered that there is no realistic possibility that she would address the concerns to such a level where she could return to practise safely.

The panel also considered that the dishonesty in this case is at the serious end of the spectrum, given that Mrs Wells had falsified/forged colleagues' signatures on controlled drugs records repeatedly, despite training and knowledge of the requirements. The panel was of the view that the misconduct was not isolated and involved a deliberate choice by Mrs Wells to bypass the required safeguards, and then conceal this through falsified records.

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 following considerations as set out in the NMC Guidance entitled *'Striking-off order'* (Reference: SAN-2e Last Updated; 28/01/2026) as set out below, and to the NMC Guidance on *'Sanctions for the highest risk cases'* (Reference SAN-4 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 Mrs Wells' actions, which involved dishonesty, were significant departures from the standards expected of a registered nurse, raised fundamental questions about her professionalism 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 Mrs Wells' actions were serious and to allow her to continue practising would undermine public confidence in the profession. Given Mrs Wells' lack of meaningful engagement, limited insight (with her reflective piece showing signs of deflection) together with no evidence of further training and development, the panel considered that there is no realistic possibility that she would address the concerns to such a level where she could return to practice safely.

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 matters it identified, in particular the effect of Mrs Wells' 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 Mrs Wells 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 Mrs Wells' own interests until the striking-off sanction takes effect.

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

Representations on interim order

The panel took account of the written representations made by the NMC inviting the panel to impose an interim order in the same terms as the substantive order on the basis that it is necessary for the protection of the public and otherwise in the public interest.

The panel heard and 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 substantive order. The panel therefore imposed an interim suspension order for a period of 18 months to cover any possible appeal period.

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

That concludes this determination.