Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Tuesday, 27 August 2024 – Friday, 6 September 2024
Monday, 9 December 2024 - Friday, 13 December 2024

Nursing and Midwifery Council
2 Stratford Place, Montfichet Road, London, E20 1EJ

Name of Registrant:	**Kerry Ann Fell**
NMC PIN:	**04J0504E**
Part(s) of the register:	Nurses Part of the Register- Sub Part 1 RNA: Adult Nurse (Level 1) – 17 September 2005
Relevant Location:	Kent
Type of case:	Misconduct
Panel members:	Michelle McBreeze (Chair, Lay member) Richard Luck (Registrant member) Carson Black (Lay member)
Legal Assessor:	Attracta Wilson
Hearings Coordinator:	Jack Dickens (27 August 2024 – Friday, 6 September 2024) Samantha Aguilar (9 December 2024-13 December 2024)
Nursing and Midwifery Council:	Represented by Alex Radley, Case Presenter (27 August 2024 – Friday, 6 September 2024) Represented by Selena Jones, Case Presenter (9 December 2024-13 December 2024)
Mrs Fell:	Not present and not represented at this hearing
Facts proved:	Charges 12(b), 16, 17, 18 and 19

Facts not proved:	Charges 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12(a), 13 and 14
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 Mrs Fell was not in attendance and that the Notice of Hearing letter had been sent to her registered email address by secure email on 25 July 2024.

Mr Radley, 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 ('the Rules').

The panel heard and 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 Mrs 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 Mrs Fell has been served with the Notice of Hearing in accordance with the requirements of Rules 11 and 34 of the Rules.

Decision and reasons on proceeding in the absence of Mrs Fell

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

Mr Radley submitted that there had been minimal engagement by Mrs Fell with the NMC in relation to these proceedings. He drew the panel's attention to the bundle of correspondence from the NMC to Mrs Fell between 7 March 2024 and 21 August 2024.

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 and is one that should be exercised *'with the utmost care and caution'*.

The panel has decided to proceed in the absence of Mrs Fell. In reaching this decision, the panel has considered the submissions of Mr Radley 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:

- Mrs Fell has voluntarily absented herself.
- Mrs Fell has indicated that she will not be attending this hearing.
- Mrs Fell has not engaged with any further correspondence from the NMC about this hearing.
- There is no reason to presume that an adjournment would secure her attendance at a further hearing.
- The charges relate to events that occurred in 2018.
- A number of witnesses are scheduled to attend the hearing to give live evidence. To not proceed with the hearing may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services.
- Further delay may have an adverse effect on the ability of witnesses accurately to recall events.
- There is a strong public interest in the expeditious disposal of the case, and this outweighs the unfairness caused to Mrs Fell in proceeding.

There is some disadvantage to Mrs Fell in proceeding in her absence. Although the evidence upon which the NMC relies will have been sent to her via email, she has made no response to the allegations. 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 limited disadvantage is the consequence of Mrs Fell's decision to absent herself from the hearing, waive her right 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 Mrs Fell. The panel will draw no adverse inference from Mrs Fell's absence in its findings of fact.

Decision and reasons on application for hearing to be held in private

During the fact-finding stage, Mr Radley made an application for parts of this hearing to be held in private. The application was made pursuant to Rule 19 the Rules. He submitted that as there has been reference to [PRIVATE], it would be in their interests to hold those parts of the hearing in private.

The legal assessor reminded the panel that while Rule 19(1) of the Rules provides, as a starting point, that hearings shall be conducted in public, Rule 19(3) of the Rules states that the panel may hold hearings partly or wholly in private if it is satisfied that this is justified by the interests of any party or by the public interest.

The panel determined that it is justified by the interest of a third party to go into private session [PRIVATE]. To go into private session would protect their privacy.

Detail of Charges

That you, a registered nurse, while employed as the Manager of Hazeldene House Nursing Home:

1. When Resident A sustained injuries on 19 May 2018 and/or 4 June 2018, failed to:
    a. Notify CQC and/or Safeguarding;
    b. Investigate.

2. When Resident B sustained a skin tear in June 2018 failed to:
    a. Notify CQC and/or Safeguarding;
    b. Investigate.

3. When Resident C sustained injuries on 8 July 2018, failed to:
    a. Notify CQC and/or Safeguarding;
    b. Investigate.

4. When Resident C suffered a fractured femur on 14 September 2018, failed to:
    a. Notify Safeguarding and/or the police;
    b. Investigate.

5. When Resident D complained about being hit, failed to investigate.

6. When Resident E sustained bruising, failed to investigate.

7. When a report was made that Resident F had been hit by a carer, failed to investigate.

8. When a report was made that a carer abused Resident G on 17 June 2018, failed to:
    a. Notify Safeguarding;

b. Investigate.

9. When a report was made that Resident H had been abused by a carer, failed to:
    a. Notify Safeguarding;
    b. Investigate.

10. When Resident I sustained unexplained bruising, failed to investigate.

11. When Resident J sustained unexplained bruising on 15 September 2017 and/or 5 March 2018:
    a. Failed to investigate;
    b. Reinstated the carer involved without any, or any adequate, safeguarding precautions.

12. When Resident K sustained fractured ribs on 17 August 2018, failed to:
    a. Notify Safeguarding;
    b. Investigate.

13. Failed to refer Resident L for medical examination upon discovery of a breast lump, or alternatively failed to ensure appropriate reporting measures were in place.

14. When Resident M was reported to have been abused by a carer on or around 11 September 2018, failed to:
    a. Notify Safeguarding and/or the police;
    b. Conduct any, or any adequate, investigation.

15. Prior to 20 December 2018, failed to have in place any, or any adequate, medicines management.

That you, a registered nurse

16. On or after 20 November 2018 provided to the NMC a falsified reference purporting to be from Colleague A

17. Your actions at charge 16 above were dishonest in that:
    a. you knew that Colleague A had not provided you with a reference;
    b. you intended to deceive the NMC by use of the reference.

18. On or after 1 February 2019 provided to the NMC a falsified reference purporting to be from Colleague B.

19. Your actions at charge 18 above were dishonest in that:
    a. You knew that Colleague B had not provided you with a reference;
    b. You intended to deceive the NMC by use of the reference.

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

Background

Mrs Fell was referred to the NMC on 11 March 2021. The concerns arise out of Mrs Fell's employment at Hazeldene House Nursing Home (‘the Home’) between 27 March 2017 and 30 November 2018.

It is alleged that Mrs Fell failed to investigate reports of staff abusing residents. It is alleged that residents had unexplained injuries, including bruising, skin tears, and broken bones. It is also alleged that Mrs Fell did not have appropriate medicine management policies in place.

It is alleged that Mrs Fell did not refer the concerns to the appropriate third parties, such as the Care Quality Commission, safeguarding, or the police.

During the NMC's investigation Mrs Fell's registration had lapsed. It is alleged Mrs Fell knowingly and dishonestly submitted two false references in an intention to deceive the NMC.

Decision and reasons on facts

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

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

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:

- Witness 1 — Independent Crisis Manager commissioned by Panoramic Care Agency to undertake an investigation into the Home at the relevant time
- Witness 2 — Colleague B (in the Charges)
- Witness 3 — Deputy Manager of Hazeldene House Care Home, at the relevant time, and Colleague A (in the Charges)
- Witness 4 — Resident M's relative
- Witness 5 — Resident K's relative

In dealing with this case, the panel were at a distinct disadvantage due to the lack of documentary evidence. Witness 1 gave evidence of having completed an investigation report into the failings of the Home, which the panel considered was key evidence in relation to the Charges. She stated that her report contained rotas, investigation notes, safeguarding referrals, police investigations, meetings with staff, disciplinary records, body maps and photographs which related to incident reports but were not before the panel. Witness 1 explained that following completion of her investigation, she returned all documents in two files to the Home Owner and she did not keep a copy of her report for data protection reasons.

Witness 1 was relying on her recollection of events in 2018, and the panel noted that her witness statement was completed in August 2023, some five years later. This is not a criticism of Witness 1.

Throughout the hearing, the panel made numerous requests for documentation such as care notes, job description, medicine managements policy, the two files (referred to by Witness 1), safeguarding referrals, incident records, and the Case Presenter, through no fault of his own, was only able to produce one safeguarding referral.

The panel would have benefited from hearing from the Home Owner and the Compliance Manager.

The panel had sight of Mrs Fell’s police interview given under caution, however this contained significant redactions which prevented the panel being able to identify the residents mentioned in the Charges.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor.

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

Charge 1

That you, a registered nurse, while employed as the Manager of Hazeldene House Nursing Home:

1. When Resident A sustained injuries on 19 May 2018 and/or 4 June 2018, failed to:
    a. Notify CQC and/or Safeguarding;
    b. Investigate.

This charge is found NOT proved.

The panel determined that Mrs Fell had a general duty to notify Care Quality Commission ('CQC') and/or safeguarding. It also concluded that Mrs Fell had a duty to investigate any alleged concerns. In reaching its determination, the panel considered the evidence before it. The panel noted the police interview with Mrs Fell in which she accepted that as a manager, she had responsibility for the residents at the Home. The panel also noted the Safeguarding Adults and Prevention of Abuse Policy of the Home, dated 2017, which states:

'*At Hazeldene House, we work with many people who cannot always protect themselves from harm due to their care and support needs. We are committed to working along residents, staff, relatives and partner agencies to promote the wellbeing of our residents and to stop harm and neglect.'*

[…]

'Anyone having a concern about actual or possible adult abuse, generally, should talk urgently to the Manager or senior person on duty, making clear what they know or suspect.'

[…]

'If it appears that there are grounds to believe that adult abuse is or may be happening the Manager/senior person must ensure that a Safeguarding Adult's

Concern is actioned at the earliest possible opportunity and no later than at the end of the working day in question. IF the manager is uncertain that abuse has occurred or is indicated, then advice should be sought from one of the sources listed below.'

Witness 1 was contacted by Panoramic Care Agency to conduct an independent investigation on behalf of the owner after concerns were raised in relation to care at the Home. Witness 1 gave oral evidence that was consistent with their written statement. The panel noted Witness 1's professional background, qualifications, and experience, including as a manager. Witness 1 outlined the duties and responsibilities of a manager, which included notifying the CQC and/or safeguarding, and investigating, any alleged concerns.

The panel also noted that Mrs Fell said in a police interview under caution, in April 2019, that it was a judgment call whether to raise a safeguarding concern. Mrs Fell also stated in that interview that she does complete safeguarding forms when it was appropriate.

Considering all of this evidence, the panel found that as the manager, Mrs Fell did have a duty to notify CQC and/or safeguarding and investigate.

Having found that Mrs Fell had the required duty, the panel went on to consider whether Mrs Fell had failed to fulfil this duty in relation to Resident A.

Witness 1 in her written statement and oral evidence, stated that she found no evidence that Mrs Fell had taken any action in response to the reported injuries sustained by Resident A and that she had not made the required referrals to safeguarding,

Witness 1 was approached to carry out an independent inspection of the Home and her time at the Home overlapped with Mrs Fell for 3 days. She was independent of the Homeowner and of Mrs Fell. Following her investigation, she prepared a report which she provided to the Home, but this was not before the panel. The panel did not have sight of any of the documents or records relied upon by Witness 1 to support her findings. Witness 1 referred to interviews with staff members, but those staff members were not

identified and there were no interview notes or records of those interviews to assist the panel.

Witness 1 produced documentation. She referred to her witness statement and oral evidence to Exhibit SB1. The panel considered Exhibit SB1. Exhibit SB1 is a document prepared by the Home's Compliance Manager who compiled this from Witness 1's logs (file 1 and 2 which were not before the panel). The panel have not heard from the Home's Compliance Manager and have not had sight of the files referred to. Exhibit SB1 records that there was no referral to safeguarding and that Mrs Fell took no action in relation to the incidents charged. However, in the absence of any detail of how those conclusions were reached or any supporting evidence the panel find that evidence of little assistance.

The panel also had sight of Witness 1's police witness statement given under caution. However, the panel was unable to identify any evidence relative to Resident A in that statement. The panel considered Exhibit SB4. Exhibit SB4 is a list of responses and information gathered by the Home. This document is not signed or dated, and the author is not identified, the information relied upon in completing Exhibit SB4 is not explained and there is no supporting documentation provided to the panel. Furthermore, it makes no reference to Resident A and is of no assistance to the panel.

The panel considered a transcript of a police interview with Mrs Fell given under caution. This interview took place on 14 April 2019 which is relatively close to the time of the incidents charged. In that transcript, Mrs Fell provided details of her approach to safeguarding incidents and records were put to her during the interview which was not before the panel. However, the panel noted that in her police interview, Mrs Fell referred to the exercise of her discretion in relation to safeguarding referrals.

The panel considered the evidence in the round. It also noted that there was no indication of a methodology of how the information was sourced or compiled in Exhibit SB1 (table of incidents investigated at the Home), Exhibit SB3 (Summary of disciplinary action taken against staff at the Home) and Exhibit SB4 (List of responses and information gathered by

the Home). Nor was there any information before the panel that was relied upon in reaching the conclusion in these documents. For example, no patient notes, no care notes, no care plans, no incident records, no safeguarding forms, or the photographic evidence referred to, were before the panel. The panel also heard evidence of how the anonymisation of some residents in this table was incorrect.

Witness 1 provided evidence that there was no referral to the CQC and/or safeguarding but there is nothing by way of corroboration to support this finding. There is a spreadsheet of safeguarding concerns at the Home known to CQC at Exhibit JW2. However, this spreadsheet does not cover May or June 2018.

In all of the circumstances the panel is not satisfied on the balance of probabilities that Mrs Fell failed to notify CQC and/or safeguarding when Resident A sustained injuries on the 19 May 2018 and/or 4 June 2018. For the same reasons the panel cannot be satisfied that Mrs Fell failed to investigate as charged.

Accordingly, the panel found Charge 1 not proved.

Charge 2

That you, a registered nurse, while employed as the Manager of Hazeldene House Nursing Home:

2. When Resident B sustained a skin tear in June 2018 failed to:
    a. Notify CQC and/or Safeguarding;
    b. Investigate.

This charge is found NOT proved.

For the same reasons as given at Charge 1, the panel found that as the manager, Mrs Fell did have a duty to notify CQC and/or safeguarding and investigate concerns.

The panel was of the view that the evidence in relation to this charge is the same as that relied upon in Charge 1 (Exhibits SB1 which is a table of incidents investigated at the Home, SB3 which is a summary of disciplinary action taken against staff at the Home and SB4 which is a list of responses and information gathered by the Home), and for reasons already given, it has placed limited weight on this evidence. It noted the [PRIVATE] of Resident B are said to have reported the concern to safeguarding, but there is no evidence before the panel to this effect. Further, the panel heard evidence of photographs having been taken of the skin tear sustained by Resident B but that was not before the panel either.

Considering the evidence in relation to this charge in its totality, the panel was of the view that the evidence before it was vague, weak and unsupported.

In the absence of any supporting evidence such as care notes, photographs referred to by Witness 1, incident forms, the complaints record referred to by Witness 1 in her oral evidence, and safeguarding referral reportedly made by a relative, the panel could not be satisfied on the balance of probabilities that Mrs Fell had failed to fulfil her duties to notify CQC and safeguarding when Resident B sustained a skin tear. Furthermore, having considered the evidence in the round, the panel could not be satisfied that it was more likely than not that Mrs Fell had knowledge of the injury sustained and if she did not have knowledge of these injuries, her duty to notify and investigate would not be engaged.

The panel took into account that Witness 1's evidence was hearsay, and because she had returned all documentation to the Home, she was unable to provide corroborative documentary evidence.

For these reasons, the panel was not satisfied that the NMC has discharged its evidential burden in relation to this charge and find Charge 2 not proved.

Charge 3

That you, a registered nurse, while employed as the Manager of Hazeldene House Nursing Home:

3. When Resident C sustained injuries on 8 July 2018, failed to:
    a. Notify CQC and/or Safeguarding;
    b. Investigate.

This charge is found NOT proved.

For the same reasons as given at Charge 1, the panel found that Mrs Fell had a duty to notify CQC and/or safeguarding and to investigate when Resident C sustained injuries on 8 July 2018.

The panel were of the view that the evidence in relation to this charge is the same as that at Charge 1 (Exhibits SB1 which is a table of incidents investigated at the Home, SB3 which is a summary of disciplinary action taken against staff at the Home and SB4 which is a list of responses and information gathered by the Home), and it has placed limited weight on this evidence for reasons already given.

In the absence of any supporting evidence such as care notes, photographs referred to by Witness 1, incident forms and the complaints record referred to by Witness 1 in her oral evidence, the panel could not be satisfied on the balance of probabilities that Mrs Fell had failed to fulfil her duties in relation to Resident C. Furthermore, having considered the evidence in the round, the panel could not be satisfied that it was more likely than not that Mrs Fell had knowledge of the injury sustained and if she did not have knowledge of these injuries, her duty to notify and investigate would not be engaged. The panel took into account that Witness 1's evidence was hearsay, and through no fault of her own, she was unable to provide corroborative documentary evidence.

For these reasons, the panel was not satisfied that the NMC has discharged its evidential burden in relation to this charge and find Charge 3 not proved.

Charge 4

That you, a registered nurse, while employed as the Manager of Hazeldene House Nursing Home:

4. When Resident C suffered a fractured femur on 14 September 2018, failed to:
    a. Notify Safeguarding and/or the police;
    b. investigate

This charge is found NOT proved.

For the same reasons as given at Charge 1, the panel found that as the manager, Mrs Fell did have a duty to notify CQC and/or safeguarding and investigate concerns.

The panel had two further pieces of evidence beyond that which had already been considered by the panel in relation to previous Charges.

One of the documents before the panel was titled *'police witness statement and exhibits'* of Witness 1. This document was exhibited by Witness 1. The information contained within this document was similar in nature to the evidence in the document that had already been considered which had redactions applied. The panel was of the view that the redactions made to this document, without corresponding anonymisation, made it difficult to identify which resident was being discussed. As such, the panel could not be satisfied that it was more likely than not that the document was discussing Resident C. In light of these reasons, the panel were of the view that this document carries little weight.

Another document that the panel had sight of was titled *'Email from Kent County Council safeguarding team, dated 20 September 2019, and enclosed referral form'*. This document was exhibited by a witness whom the NMC did not call to give oral evidence and was therefore admitted through operation of the Rules. The safeguarding referral form does not

state who the author is. The safeguarding referral form states the nature of the injuries to the resident. It also states that an internal investigation was being carried out and that 999 was called. As the dates and injuries match those alleged in the Charges the panel was satisfied on the balance of probabilities that this safeguarding referral form related to Resident C.

The panel considered that the referral was not signed, and therefore it could not be satisfied that Mrs Fell did not raise it. Likewise, as the form states that an internal investigation was being carried out, it could not be satisfied that Mrs Fell failed to investigate.

In light of these findings, it could not be satisfied, on the balance of probabilities that Mrs Fell failed to notify safeguarding and/or inform the police when Resident C suffered a fractured femur on 14 September 2018. It could also not be satisfied that she failed to investigate.

Accordingly, the panel found Charge 4 not proved.

Charge 5

That you, a registered nurse, while employed as the Manager of Hazeldene House Nursing Home:

5. When Resident D complained about being hit, failed to investigate.

This charge is found NOT proved.

For the same reasons as given at Charge 1, the panel found that as the manager, Mrs Fell did have a duty to investigate concerns. The panel noted that no date was provided in relation to the allegation that Mrs Fell failed to investigate a complaint by Resident D that they had been hit. Further, the panel had no direct evidence of the alleged incident.

The panel were referred to two specific pieces of evidence related to this charge, titled *'Summary of disciplinary action against staff'* and *'List of information and responses gathered by home'.* This was exhibited by Witness 1. These contained a list of staff members involved in incidents at the Home and the action taken against them. Although, it makes reference to a Resident D and allegation that they were hit, it does not identify the author. The panel were satisfied on Witness 1's own evidence that it was not written by her. In addition, the document does not state when it was compiled, what information was used in compiling this document, or for what purpose the document was created. Further, there was significant confusion around the anonymisation which the witness had not applied and thus found confusing. The panel therefore could not be satisfied on the balance of probabilities that Resident D could be correctly identified. Therefore, the panel could only place limited weight on these documents when reaching findings of fact.

There was no direct evidence to support Charge 5. Further, there was no corroborating evidence beyond the documents titled, *'Summary of disciplinary actions against staff'* and *'List of information and responses gathered by home'* to support the allegation that Mrs Fell failed to investigate the complaints of Resident D. Considering the evidence in its totality, the panel was of the view that the evidence before it was unreliable and very weak.

Therefore, the panel was not satisfied that on the balance of probabilities that Mrs Fell failed to investigate Resident D's complaints of being hit.

Charge 6

That you, a registered nurse, while employed as the Manager of Hazeldene House Nursing Home:

6. When Resident E sustained bruising, failed to investigate.

This charge is found NOT proved.

The panel found that as the manager of the Home, Mrs Fell did have a duty to investigate when Resident A sustained bruising.

The panel were of the view that the evidence in relation to this Charge is the same as that which the panel have already determined as having limited weight.

Considering the evidence in relation to this Charge in its totality, the panel was of the view that the evidence before it was vague, weak and unsupported.

In the absence of any further supporting evidence, such as care notes, the panel could not be satisfied on the balance of probabilities that Mrs Fell had failed to fulfil her duty to investigate in relation to the bruising sustained by Resident E. The panel noted Exhibits SB3 and SB4 and found that there is no reference to Resident E within this evidence. There is reference by Witness 1 to photographs, but no photographs have been produced to the panel. The panel noted that there is no date provided in Charge 6 alleging that Mrs Fell failed to investigate when Resident E sustained bruising. There is no direct evidence at all in relation to this charge. The panel noted from paragraph 34 of Witness 1's statement that Mrs Fell was made aware of the injuries and that she made a safeguarding referral but could find no evidence of an internal investigation.

The only evidence the panel has in relation to the Charge is the written statement of Witness 1 and her oral evidence. In her written statement, Witness 1 stated that she saw no evidence of an investigation by Mrs Fell. The panel have not had sight of the documents that Witness 1 relied upon her investigation, nor has sight of her investigation report. The panel took into account that Witness 1's written statement was completed on 4 August 2023 and although there is no date stated in the charge, the incident occurred whilst Mrs Fell was in employment in 2018. That is some six years ago, and in the circumstances, where Witness 1 speaks from her recollection some years later, the panel

cannot be satisfied on the balance of probabilities without further evidence that Mrs Fell failed to investigate when Resident E sustained bruising.

For these reasons, the panel was not satisfied that the NMC has discharged its evidential burden in relation to this charge and find Charge 6 not proved.

Charge 7

That you, a registered nurse, while employed as the Manager of Hazeldene House Nursing Home:

> 7. When a report was made that Resident F had been hit by a carer, failed to investigate.

This charge is found NOT proved.

The panel found that as the manager, Mrs Fell did have a duty to investigate concerns.

The panel considered the evidence of Witness 1 where in her written statement at paragraph 38, she explained *'I found no evidence of any internal investigation'.* The panel took into account that Witness 1 did not directly witness the incident neither did she speak to Mrs Fell to obtain her version of events. The panel did not have any of the documentation relied upon by Witness 1 for the purposes of her investigation, neither did it have a copy of her investigation report. The panel took into account that Witness 1 was speaking from recollection some years after the event.

In relation to Exhibit SB4, Witness 1 in her oral evidence suggested that the information relating to Resident F was incorrect as she recollected it was another resident. The responses by Witness 1 in her oral evidence further confirms the confusion in identifying the issues relating to "*Resident F"*.

"[Witness 1] *Right. But Resident I on SB1 is not Resident I in SB4.*
[Case Presenter] *Okay.*
[Witness 1] *Completely different.*
[Case Presenter] *Okay. So Resident I on SB4 should be whom?*
[Witness 1] *Oh my goodness, I had this a moment ago. So this was hitting the resident over the ear and it was* […] *that did that. So that was* [...]
[Case Presenter] *Okay. And that's Resident F.*
[Witness 1] *Yes – no. No, no. That's – I'm getting lost as well now. So Resident J was the bruising on the resident but… The husband had brought that to my attention."*

The panel noted that there was confusion in Witness 1's mind as to which resident this Charge relates to. Given this fact, and the fact that the evidence overall in relation to this charge is tenuous, unreliable and lacking clarity, the panel cannot be satisfied on the balance of probabilities that Mrs Fell failed to investigate when a report was made that Resident F had been hit by a carer.

For these reasons, the panel find Charge 7 not proved.

Charge 8

That you, a registered nurse, while employed as the Manager of Hazeldene House Nursing Home:

8. When a report was made that a carer abused Resident G on 17 June 2018, failed to:
    a. Notify Safeguarding;
    b. Investigate.

This charge is found NOT proved.

For the same reasons as given at Charge 1, the panel found that as the manager, Mrs Fell did have a duty to investigate concerns.

The panel had no direct evidence in relation to this charge. It is alleged that the incident was witnessed and reported by the relative of another resident. Neither the other resident nor their relative are identified and there was no documentary evidence to support their reports.

It is alleged that a nurse raised concerns with Mrs Fell in relation to this incident. However, the nurse is not identified and there is no documentary evidence to support the report having been made. The panel had not been provided with any corroborating evidence in relation to this incident.

The panel were of the view that the evidence in relation to this charge is tenuous and unreliable.

In the absence of any supporting evidence, such as patient records in which you would expect to find references to any investigation carried out, the panel could not be satisfied on the balance of probabilities that Mrs Fell had failed to fulfil her duty to investigate in relation to the bruising sustained by Resident G.

For these reasons, the panel was not satisfied that the NMC has discharged its evidential burden in relation to this charge and find Charge 8 not proved.

Charge 9

That you, a registered nurse, while employed as the Manager of Hazeldene House Nursing Home:

9. When a report was made that Resident H had been abused by a carer, failed to:
    a. Notify Safeguarding;

b. Investigate.

This charge is found NOT proved.

In considering Charge 9a, the panel considered a witness statement completed by the CQC Inspection Manager. This statement was admitted by the panel under Rule 31, the panel having been satisfied that the evidence was relevant to the Charges and that it would be fair to admit it. The panel had taken into account that the statement was made by a CQC Inspection Manager who would have had no reason to fabricate or embellish evidence. Further, the panel noted that this statement was supported by documentary evidence created following a review of the documentation held by the CQC and within the knowledge of the witness.

The CQC Inspection Manager, who provided a statement, had no involvement in the inspection of the Home. They provided their statement based upon a review of the documentation held by the CQC. The witness also confirmed that they had never met Mrs Fell. The exhibits that the witness produced were documents that were within their own knowledge. The panel determined that this witness, their statement and exhibits were credible and reliable. It had no reason to believe that the evidence given was fabricated or embellished in any way.

The witness also produced an exhibit titled *'Safeguarding referral for Resident H'.* The panel determined that, based on the information contained within the safeguarding referral, the form was completed by a relative of Resident H. Therefore, as this was the case as indicated in the safeguarding referral, the panel was satisfied that Mrs Fell did not need to notify safeguarding as this had already been done.

Accordingly, the panel found Charge 9a not proved.

In relation to Charge 9b, the panel considered the evidence of Witness 1. Witness 1's evidence outlined that a relative of Resident H had reported a concern. Their statement

also outlined that the relative of Resident H had complained to Mrs Fell but that they had not heard a response beyond Mrs Fell allegedly saying, '*you do realise* [Resident H] *has dementia don't you?'*. Therefore, the panel were satisfied that it was more likely than not Mrs Fell had knowledge of the allegations of Resident H being abused by a carer. Witness 1 and the CQC Inspector say there was no further update received by the relative who made the complaint to the Home.

In Witness 1's written statement, she refers to an internal investigation that she found no evidence that Mrs Fell had taken any action to the concerns. The panel do not have the internal investigation completed by Witness 1 and have no information in relation to the methodology used by Witness 1 when investigating or what she took into account when reaching her conclusion that Mrs Fell failed to investigate. The panel noted the written statements produced by the CQC Inspector.

The panel also considered the evidence given by Mrs Fell under police caution in relation to this incident. In her police interview, Mrs Fell described steps taken by her following the incident. When asked if she carried out an internal investigation, she stated that she spoke with the carer but could not recall if she had documented this in the care notes. She did indicate that she did not expressly record on the care notes that she was investigating it, however, she described writing in this care plan that Resident H was not to be looked after by male carers.

The panel cannot be satisfied that on the balance of probabilities Mrs Fell did not carry out any investigation. In reaching this conclusion, the panel took into account that Mrs Fell spoke to the carer in question and ensured he was no longer involved in the care of Resident H. The panel considered that this indicated that Mrs Fell undertook some type of investigation.

Accordingly, the panel found Charge 9b not proved.

Charge 10

That you, a registered nurse, while employed as the Manager of Hazeldene House Nursing Home:

10. When Resident I sustained unexplained bruising, failed to investigate.

This charge is found NOT proved.

The panel noted the documentary evidence, Exhibits SB1 (Table of incidents investigated at the Home) and SB4 (List of information and responses gathered by the Home), which the panel have already determined as having limited weight. Furthermore, in relation to Exhibit SB4, Witness 1 in her oral evidence suggested that the information relating to Resident I was incorrect as she recollected it was another resident. Therefore, the panel could not give to any weight to this documentary evidence. Witness 1 refers to Resident I in her written statements, however, the panel found that the information related to another resident. The responses by Witness 1 in her oral evidence further confirms the confusion in identifying the issues relating to "*Resident I"*.

> *"*[Witness 1] *Right. But Resident I on SB1 is not Resident I in SB4.*
> [Case Presenter] *Okay.*
> [Witness 1] *Completely different.*
> [Case Presenter] *Okay. So Resident I on SB4 should be whom?*
> [Witness 1] *Oh my goodness, I had this a moment ago. So this was hitting the resident over the ear and it was* […] *that did that. So that was* [...]
> [Case Presenter] *Okay. And that's Resident F.*
> [Witness 1] *Yes – no. No, no. That's – I'm getting lost as well now. So Resident J was the bruising on the resident but… The husband had brought that to my attention."*

The panel was of the view that the evidence in relation to this charge lacked clarity and is unreliable.

For these reasons, the panel was not satisfied that the NMC has discharged its evidential burden in relation to this charge and find Charge 10 not proved.

Charge 11

That you, a registered nurse, while employed as the Manager of Hazeldene House Nursing Home:

11. When Resident J sustained unexplained bruising on 15 September 2017 and/or 5 March 2018:
    a. Failed to investigate;
    b. Reinstated the carer involved without any, or any adequate, safeguarding precautions.

This charge is found NOT proved.

In relation to Charge 11a, the panel considered Exhibit SB4 (list of information and responses gathered by the Home), where Witness 1 states that Resident J's husband had raised the concerns and reported it to the police. In the same document, it is said that Mrs Fell suspended the carer pending the outcome of safeguarding and police investigation. The panel had no direct evidence from Resident J's husband or contemporaneous notes, neither did the panel have sight of the police report in relation to this incident.

During the course of Witness 1's oral evidence, Witness 1 was asked for clarity around corroborative evidence to assist the panel. However, despite time being given to the NMC to enquire whether documentation was available and if so, to produce that documentation, no documentation could be located in relation to this charge, and none was provided. This is not a criticism of Witness 1 or the Case Presenter. Such was the lack of documentation, the panel could not be satisfied that Mrs Fell failed to investigate, accordingly, Charge 11a is found not proved.

In relation to Charge 11b, the panel were presented with Exhibit SB4 (list of information and responses gathered by the Home), which states that Mrs Fell suspended the carer pending the outcome of the safeguarding and police investigation and that Mrs Fell reinstated the carer when the police investigation and safeguarding investigation closed due to insufficient evidence. However, the panel did not have sight of a safeguarding referral or any other supporting documentation surrounding the carer or any Human Resources ('HR') record relating to this carer. Therefore, the panel could not be satisfied on the balance of probabilities that Mrs Fell had reinstated the carer involved without any, or any adequate safeguarding precautions.

Accordingly, the panel found Charge 11b not proved.

Charge 12(a)

That you, a registered nurse, while employed as the Manager of Hazeldene House Nursing Home:

12. When Resident K sustained fractured ribs on 17 August 2018, failed to:
    a. Notify Safeguarding;

This charge is found NOT proved.

For the same reasons as given at Charge 1, the panel found that as manager of the Home, Mrs Fell did have a duty to investigate concerns.

The panel note that there was a discrepancy regarding the dates of this incident. Some of the document state that it occurred on 17 August 2018, whilst Witness 5 stated that it occurred on 18 August 2018. The legal assessor advised the panel that they should not let a case fall on a technicality (*The Professional Standards Authority for Health and Social Care v The Nursing and Midwifery Council, Ms Winifred Nompumelelo Jozi* [2015] EWHC

764 (Admin)). The legal assessor reminded the panel of its duty in protecting the public and upholding the public interest. The panel was of the view that the mischief to be addressed in this case was Mrs Fell's failure to notify safeguarding. Based on the information before it, the panel were satisfied that no injustice or unfairness would be caused by interpreting the charge to read on or around 17 August 2018.

The panel had further evidence beyond that which already been discussed in support of this charge.

The panel heard oral evidence of the Resident K's relative, Witness 5. It considered Witness 5's oral evidence to be consistent with their written statement and Witness 5's exhibit was titled *'Police Witness Statement'* and dated 22 February 2020. It was of the view that Witness 5 is a credible witness. Their oral evidence was corroborated by their police statement, for that reason, the panel found the evidence of Witness 5 reliable.

Witness 5 explained to the panel that a Nurse at the Home called an ambulance for Resident K as they were complaining of chest pain and the staff suspected that Resident K was having a heart attack. At the hospital, they concluded that it was not a heart attack but broken ribs. Upon discovering this, the hospital then completed a safeguarding referral.

The panel was satisfied that Mrs Fell did not complete the safeguarding referral as the hospital had already notified safeguarding when the finding of Resident K's broken ribs came to light.

In light of this, the panel did not find that Mrs Fell failed to notify safeguarding when Resident K sustained fractured ribs.

Accordingly, the panel found Charge 12a not proved.

Charge 12(b)

That you, a registered nurse, while employed as the Manager of Hazeldene House Nursing Home:

12. When Resident K sustained fractured ribs on 17 August 2018, failed to:
    b. Investigate.

This charge is found proved.

For the same reasons as given at Charge 1, the panel found that as the manager, Mrs Fell did have a duty to investigate concerns.

The panel considered all the evidence it considered in Charge 12(a). This included Witness 5's oral evidence which was consistent with their written statement and exhibits. Witness 5's exhibit was titled *'Police Witness Statement'* and was dated 22 February 2020.

In Witness 5's *'Police Witness Statement'* the stated that:

> *'there was no investigation carried out by the Home it was left as an unwitnessed fall'.*
> […]
> *'I raised so many concern with Kerry but she ignored them all.* […] *She never investigated any of my complaint's or concerns and if she did she never once gave me any acknowledgement or feedback.'*
> […]
> *'My complaints were always in person but it seemed they were ignored.'*

Witness 5 stated in oral evidence that Mrs Fell was dismissive of concerns. They said that Mrs Fell doubted the concerns and said a standard response was that *"they will never know what happened"*.

Based on the evidence before the panel and in particular, the direct evidence of Witness 5, the panel determined on balance of probabilities, it was more likely than not that Mrs Fell did not investigate this concern. The panel therefore find this charge proved.

Charge 13

That you, a registered nurse, while employed as the Manager of Hazeldene House Nursing Home:

> 13. Failed to refer Resident L for medical examination upon discovery of a breast lump, or alternatively failed to ensure appropriate reporting measures were in place.

This charge is found NOT proved.

The panel considered the witness statement of Witness 1 which stated that a nurse was informed that Resident L had a breast lump but had not taken any further action. In Witness 1's oral evidence, she stated that the nurse had informed Mrs Fell that there was a lump in the resident's breast and therefore the panel considered that the nurse had taken action. When asked a question in oral evidence as to whose responsibility it would be to make a General Practitioner ('GP') referral, Witness 1 replied, *"it would be the nurse".* There is inconsistency between Witness 1's written and oral evidence. The panel did not have a job description setting out Mrs Fell's roles and responsibilities neither did it have a job description for a care home nurse. There is no direct evidence before the panel in relation to this charge, all evidence is hearsay and there is no contemporaneous notes or documents to corroborate the hearsay evidence.

The panel had not been furnished with any policy or procedure of when a resident would be referred to a GP and by whom.

The panel considered whether as manager of the Home, Mrs Fell had a duty ensure appropriate reporting measure were in place. The panel noted that whilst Mrs Fell was the Home Manager, in the absence of a job description, the panel could not be satisfied that the responsibility fell on her. Therefore, the panel could not be satisfied on the balance of probabilities that Mrs Fell had appropriate reporting measures in place.

Accordingly, the panel found Charge 13 not proved.

Charge 14

That you, a registered nurse, while employed as the Manager of Hazeldene House Nursing Home:

14. When Resident M was reported to have been abused by a carer on or around 11 September 2018, failed to:
    a. Notify Safeguarding and/or the police;
    b. Conduct any, or any adequate, investigation.

This charge is found NOT proved.

For the same reasons as given at Charge 1, the panel found that as the manager of the Home, Mrs Fell did have a duty to investigate concerns.

It noted that in relation to limb (a) of this charge that Case Presenter conceded that at the time of this incident, Mrs Fell was on holiday and action in relation to notifying safeguarding and/or the police had already been taken.

Regarding limb (b) of this charge the panel noted that there was further evidence beyond that already discussed in this determination. The further evidence was that of Witness 3 (the Deputy Manager of the Home) and Witness 4 (relative of Resident M).

In relation to Witness 3, the panel considered Witness 3's oral evidence to be, in the round, consistent with their written statement and exhibits. It was of the view that, overall, Witness 3's evidence is a credible and reliable. Resident M had a diagnosis of Lewy Body dementia, Witness 4 visited on a regular basis and in their written statement described injuries in the form of bruises and skin tears, and on one occasion saw his toes were *'completely black with a bruise',* along with bruises on Resident M's back. Witness 4 was so concerned that he installed a camera in Resident M's room which captured footage of a care worker physically assaulting Resident M.

Subsequently, Witness 4 rang the Home to report the incident. However, Mrs Fell was on holiday and Witness 4 was advised to ring the Home which he did, and he reported it to the Deputy Manager, Witness 3. In Witness 3's oral evidence, she stated that she referred the matter to safeguarding and produced the safeguarding referral form for the panel's consideration. Therefore, the panel could not be satisfied that in circumstances where a referral had already been made, it was the responsibility of Mrs Fell to make a further safeguarding referral. In relation to the charge, Witness 4 had already informed the police, and the panel had sight of his witness statement to the police. The panel considered that as Witness 4 had already informed the police, it would not have been necessary for Mrs Fell to do so.

Accordingly, the panel found Charge 14a not proved.

In considering Charge 14b, when asked in oral evidence about the investigation, Witness 4 had stated he had been informed about an internal investigation but have not been given any outcomes by Mrs Fell. In the absence of any evidence as to the nature and scope of the investigation that took place, it could not determine whether this investigation was adequate.

Accordingly, the panel found Charge 14b not proved.

Charge 15

That you, a registered nurse, while employed as the Manager of Hazeldene House Nursing Home:

15. Prior to 20 December 2018, failed to have in place any, or any adequate, medicines management.

This charge is found NOT proved.

The panel was satisfied on the balance of probabilities that Mrs Fell had an overall responsibility for adequate medicines management in her role as manager, and this would have fallen within the remit of the duties of the manager.

This Charge arises out of a resident found to be storing their medication in their handbag with a view to taking their own life. Witness 1 stated in their oral evidence that there was a medicines management in place when they started working at the Home in August 2018. This was the only evidence before the panel in relation to medicine management. The panel could not be satisfied that prior to 20 December 2018 that Mrs Fell failed to have in place any or adequate medicine management given that Witness 1 stated that there had been one in place in August 2018. The panel were unclear as to when Mrs Fell went on gardening leave prior to her dismissal on 30 November 2018. Witness 1 informed the panel that Mrs Fell was placed on gardening leave but could not give any dates.

Considering the evidence in relation to this charge in its totality, the panel was of the view that the evidence before it was vague, weak and unsupported.

For these reasons, the panel was not satisfied that the NMC has discharged its evidential burden in relation to this charge and find Charge 15 not proved.

Charge 16

That you, a registered nurse

16. On or after 20 November 2018 provided to the NMC a falsified reference purporting to be from Colleague A

This charge is found proved.

Colleague A was called to give live evidence. Colleague A also gave evidence in relation to other Charges and as such has been anonymised as Witness 3 in this determination.

The panel had regard to the following contemporaneous documentation exhibited by Witness 3:

- Witness 3's witness statement
- Witness 3's oral evidence
- Witness 3's exhibit titled *'Character reference 20 November 2018'*
- Witness 3's exhibit titled *'Handwriting sample'*
- Witness 3's exhibit titled *'Further handwriting sample'*
- The witness statement of the Senior Registration and Revalidation Officer in the UK Registrations Team at the NMC. This witness exhibited the following in support of this charge:
    - An exhibit titled *'Character reference (reference form 3) signed in the name of* [Witness 3], *dated 20 November 2018'*
    - An exhibit titled *'Screen shot of the NMC system regarding reference form 3 signed by* [Witness 3]'

In relation to the Senior Registration and Revalidation Officer's statement, the panel took into account that this witness did not give oral evidence. However, they exhibited contemporaneous documentary evidence extracted from the NMC's official records. The panel had no reason to dispute the accuracy or veracity of these documents.

The panel considered the written statements and oral evidence of Witness 3. Witness 3 confirmed that the signature on the reference which Mrs Fell relied upon was not theirs (Witness 3's signature).

The panel received consistent and credible evidence in relation to this charge. Witness 3 stated that they were asked by Mrs Fell to provide a reference but refused. Witness 3 was clear in their evidence that they did not provide a reference for Mrs Fell. The panel accepted this evidence. The panel also heard that when Witness 3 refused, Mrs Fell responded by saying *"Thank you. I am very disappointed in you".* The panel also took into account Witness 3's evidence that the signature on the reference provided to the panel was not hers.

Therefore, on the balance of probabilities, the panel determined it is more likely than not that the reference provided in Colleague A's name was falsified by Mrs Fell.

Accordingly, the panel found Charge 16 proved.

Charge 17

That you, a registered nurse

17. Your actions at charge 16 above were dishonest in that:
    a. you knew that Colleague A had not provided you with a reference;
    b. you intended to deceive the NMC by use of the reference.

This charge is found proved.

The panel considered all the evidence outlined at Charge 16. It also considered the test as set out in *Ivey v Genting Casinos Ltd t/a Crockfords* [2017] UKSC 67.

At the time, Witness 3/Colleague A sent a message to Mrs Fell stating that she would not provide a reference and Mrs Fell responded, *'Thank you. I am very disappointed in you'.* It was the panel's view that Mrs Fell knew that the reference had not been provided.

The panel next considered whether Mrs Fell's conduct was dishonest and took into account the *'Ivey'* test. The panel was satisfied that Mrs Fell's knew that her behaviour in submitting a falsified reference to the NMC was dishonest, and that in doing so, she was intending to deceive the NMC. The panel was satisfied that according to the objective standards of ordinary decent people, Mrs Fell's conduct would be considered dishonest. The panel concluded that no reasonable person would find this behaviour honest. It was of the view that Mrs Fell's intention was clearly to deceive the NMC by use of the reference.

Accordingly, the panel found Charge 17 proved in its entirety.

Charge 18

That you, a registered nurse

> 18. On or after 1 February 2019 provided to the NMC a falsified reference purporting to be from Colleague B.

This charge is found proved.

Colleague B/Witness 2 was called to give live evidence. Colleague B also gave evidence in relation to other Charges and as such has been anonymised as Witness 2 in this determination.

The panel had regard to the following evidence in reaching its determination on this charge:

- Witness 2's witness statement
- Witness 2's oral evidence

- Witness 2's exhibit titled *'Email from the NMC dated 16 July 2024'*
- Witness 2's exhibit titled '*Copy of reference received from the NMC'*
- The witness statement of the Senior Registration and Revalidation Officer in the UK Registrations Team at the NMC. This witness exhibited the following in support of this charge:
    - An exhibit titled *'Screen shot of the NMC system with* [Witness 2]'s *reference'*

In relation to Witness 2, the panel considered that their oral evidence was consistent with their written statement and corroborated by the documentary evidence exhibited by them. It considered Witness 2's evidence to be reliable.

In Witness 2's witness statement, they confirmed that they had been approached by Mrs Fell to provide her with a reference and they refused. Witness 2 explained in his oral evidence that they had refused on the basis that they were not working with Mrs Fell as a nurse, only as a manager, and therefore they could not comment on Mrs Fell's nursing skills:

> *"I don't know what skills she has* […] *I never worked with her"*

Witness 2 further added:

> *"'No, I can't do this, because I don't know you'. I 17 don't know her skills. I don't know her knowledges. I don't know her like a 18 nurse. I not work with her like a nurse."*

The panel received consistent and credible evidence in relation to this Charge. Witness 2 stated that they refused to write a reference for Mrs Fell. They stated that they could not provide the reference as they had not worked with Mrs Fell in a nursing capacity. Witness 2 was clear, consistent, and persuasive in stating that they never provided a reference for Mrs Fell.

The panel considered the reference that Mrs Fell provided to the NMC which relates to this charge. In considering Witness 2's oral evidence, the panel noted that he said:

> *"From NMC, I received from your colleague a form with my name incomplete. My name, with the wrong PIN number, with a different handwriting, with a different signature, and I done my statement. It's not my name complete. It's not my handwriting. It's not my PIN, and probably you know. It's not my signature, and I've never done something similar in my life."*

The panel took into account that Witness 2's evidence was corroborated by the document provided by Mrs Fell to the NMC which she purported to be a reference completed by Witness 2.

Therefore, on the balance of probabilities, the panel determined it is more likely than not that the reference provided in Colleague B's name was falsified by Mrs Fell.

Accordingly, the panel found Charge 18 proved.

Charge 19

That you, a registered nurse

19. Your actions at charge 18 above were dishonest in that:
    a. You knew that Colleague B had not provided you with a reference;
    b. You intended to deceive the NMC by use of the reference.

This charge is found proved.

The panel considered all the evidence outlined at Charge 18. It also considered the test as set out in *Ivey*.

Based on the evidence before it, the panel concluded that Mrs Fell did know that Colleague B did not provide a reference for Mrs Fell.

The panel next considered whether Mrs Fell's conduct was dishonest and took into account the *Ivey* test. The panel was satisfied that Mrs Fell's knew that her behaviour in submitting a falsified reference to the NMC was dishonest, and that in doing so, she was intending to deceive the NMC. The panel was satisfied that according to the objective standards of ordinary decent people, Mrs Fell's conduct would be considered dishonest. The panel concluded that no reasonable person would find this behaviour honest. It was of the view that Mrs Fell's intention was clearly to deceive the NMC by use of the reference.

Accordingly, the panel found Charge 19 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 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 kindly, safely and professionally.

The panel, in reaching its decision, has recognised its statutory duty to protect the public and maintain public confidence in the profession. Further, it bore in mind that there is no burden or standard of proof at this stage, and it has therefore exercised its own professional judgement.

The panel adopted a two-stage process in its consideration. First, the panel must determine whether the facts found proved amount to misconduct. Secondly, only if the facts found proved amount to misconduct, the panel must decide whether, in all the

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

Submissions on misconduct

In coming to its decision, the panel had 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.'*

Ms Jones, on behalf of 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.

Ms Jones identified the specific, relevant standards where Mrs Fell's actions amounted to misconduct. This included sections 20 and 21. Ms Jones submitted that given the panel's findings on fact, she invited the panel to find that Mrs Fell's actions amounted to serious misconduct.

Submissions on impairment

Ms Jones 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.

Ms Jones submitted that many of the actions taken by Mrs Fell are attitudinal in nature and therefore harder to remediate. She referred the panel to the relevant NMC Guidance when considering impairment, which is a forward-thinking exercise. In addressing the current evidence before the panel, Ms Jones submitted that there are no courses or

testimonials to demonstrate any strengthening of practice, and therefore, invited the panel to find that Mrs Fell's practice remained impaired.

The panel asked Ms Jones the state of Mrs Fell's registration. Ms Jones was granted time to seek instructions from the NMC. Ms Jones informed the panel that Mrs Fell remains on the register as a result of these NMC proceedings.

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* (No 2) [2000] 1 A.C. 311, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin) and *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin).

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

> ***'10 Keep clear and accurate records relevant to your practice***
> *To achieve this, you must:*
>
> *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.*

14 Be open and candid with all service users about all aspects of care and treatment, including when any mistakes or harm have taken place

To achieve this, you must:

14.2 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 Act without delay if you believe that there is a risk to patient safety or public protection

To achieve this, you must:

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.

20 Uphold the reputation of your profession at all times

To achieve this, you must:

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

20.2 Act with honesty and integrity at all times, […]

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 […]'

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 the Charges found proved were

extremely serious. In respect of Charge 12b, the panel found that Mrs Fell's action amounted to serious misconduct given that she was the manager of Hazeldene House and bore a level of responsibility in her capacity as the manager and a registered nurse to investigate serious events, such as the fractured ribs of Resident K. By failing to do so, Mrs Fell breached the Code by failing to take appropriate action in investigating and dealing with the concerns.

In relation to dishonesty (Charges 16, 17, 18 and 19), the panel considered that the charges relating to dishonesty are exceptionally serious. Mrs Fell knew that Colleagues A and B had clearly refused to provide her reference for readmission to the NMC register but proceeded to use their details and falsified references. This was in full acknowledgement that in doing so, she was deceiving future employers and her own regulator that she has met the appropriate requirements to remain on the register. The panel found that deliberately deceiving her own regulator was a serious breach of the fundamental tenets of the nursing profession, and therefore amounted to serious misconduct.

In conclusion, the panel found that Mrs 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, Mrs Fell's fitness to practise is currently impaired.

In coming to its decision, the panel had regard to the Fitness to Practise Library, updated on 27 March 2023, which states:

> *'The question that will help decide whether a professional's fitness to practise is impaired is:*
> *"Can the nurse, midwife or nursing associate practise kindly, safely and professionally?"*

If the answer to this question is yes, then the likelihood is that the professional's fitness to practise is not impaired.'

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. To justify that trust, nurses must be honest and open and act with integrity. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

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

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

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

'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her/ 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 found limbs a), b), c) and d) of *Grant* engaged. In addressing limb a), patients (in particular, Resident K) were placed at risk of harm in that Mrs Fell failed to investigate the incident and in the absence of any current information about the state of Mrs Fell's practice, the panel took the view that her misconduct is liable in the future to place patients at unwarranted risk of harm. In addressing limb b), Mrs Fell's misconduct in the past breached, and is liable in the future to bring the nursing profession into disrepute given that she was a manager and a nurse, bound by the Code, to act in the best interest of patients and to care for vulnerable elderly patients. In addressing limb c), the panel took the view that Mrs Fell's misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute and is liable to do so in the future. It was satisfied that confidence in the nursing profession would be undermined if its regulator did not find Charges relating to dishonesty extremely serious.

The panel acknowledged that in Mrs Fell's absence, the information before the panel is limited given that the panel has no evidence before it to establish insight, remorse, strengthening of practice and remediation.

In the absence of such information, the panel took into account Mrs Fell's police interview dated 14 April 2019. The panel recognised that it is determining current impairment as opposed to impairment at the time of the incidents. However, the panel considered that evidence of remorse or insight in 2019 when interviewed by the police would have been of some assistance to the panel in determining her response to Charge 12b. It closely

examined whether there was any evidence of insight or remorse. The panel went onto find no evidence to demonstrate Mrs Fell's insight or remorse based on the evidence it has before it. In particular, there is nothing to suggest Mrs Fell's understanding of how her actions placed patients, in particular, Patient K, at risk of harm, why her actions were wrong and how this impacted negatively on the reputation of the nursing profession.

The panel was satisfied that the misconduct identified in Charge 12b is capable of being addressed by way of further training and remorse and sufficient reflection of the incidents that occurred. However, the panel has not received any written reflective piece, testimonies or training certificates to demonstrate any strengthening of practice.

In addressing the dishonesty Charges found proved (Charges 16, 17, 18 and 19), the panel took into account the nature and level of dishonesty demonstrated by Mrs Fell. It found that there appeared to be deep-seated attitudinal concerns, which was sustained over a significant period. It considered that Mrs Fell's actions were calculated in that she knowingly used the details of Colleagues A and B after they had very clearly informed her that they were refusing to provide a reference. The panel noted that dishonesty is considered within the NMC guidance as a serious concern and is more difficult to put right. However, in the absence of any insight or meaningful reflection from Mrs Fell, the panel cannot be assured that such behaviour is capable of being addressed. Accordingly, the panel is of the view that there remains a risk of repetition which carries an inherent risk of harm to the public. 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.

Having regard to all of the above, the panel was satisfied that Mrs Fell's fitness to practise is currently impaired on the grounds of both public protection and public interest.

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 Fell off the register. The effect of this order is that the NMC register will show that Mrs Fell has been struck-off the register.

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

Submissions on sanction

Ms Jones informed the panel that in the Notice of Hearing, dated 25 July 2024, the NMC had advised Mrs Fell that it would seek the imposition of a striking off order if it found Mrs Fell's fitness to practise currently impaired.

Ms Jones submitted that taking no action would be inappropriate given the seriousness of the case. She submitted that it would be neither proportionate nor in the public interest to take no further action. She further submitted that the imposition of a caution order would not be appropriate in these circumstances.

In relation to a substantive conditions of practice order, Ms Jones submitted that Mrs Fell has not provided any written reflection piece, training certificates or demonstrated any engagement in these proceedings. As such, Ms Jones submitted that the panel may take a view that a conditions of practice order would not be appropriate.

Ms Jones submitted that the most appropriate order in this case is a striking off order based on the nature and seriousness of the Charges found proved. Ms Jones submitted

that the only proportionate order in this case which would protect the public and satisfy the public interest considerations is a striking off order.

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- Dismissive of concerns when raised by Resident K's relatives.
- Abuse of a position of trust.
- No evidence of insight.
- Dishonesty took place on two occasions in a period of over three months.
- The case involved acts of dishonesty including forgery of signatures in order to deceive the NMC.
- Conduct which put patients at risk of suffering harm in Mrs Fell's failure to investigate and her dishonest conduct.

The panel found no mitigating features.

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

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not

restrict Mrs Fell's practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that Mrs Fell's misconduct was not at the lower end of the spectrum and that a caution order 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 impose a caution order.

The panel next considered whether placing conditions of practice on Mrs Fell's registration would be a sufficient and appropriate response. The panel is of the view that there are no practical or workable conditions that could be formulated to address the findings of dishonesty. The misconduct identified in this case also suggests attitudinal concerns. The panel has taken into account that Mrs Fell has not been able to demonstrate any meaningful engagement with these proceedings and therefore concluded that it would be unlikely that she would engage with any conditions imposed on her practice.

The panel then went on to consider whether a suspension order would be an appropriate sanction. The SG states that suspension order may be appropriate where some of the following factors are apparent:

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

The conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. The panel noted that the serious breach of the fundamental tenets of the profession evidenced by Mrs Fell's actions is fundamentally incompatible with Mrs Fell remaining on the register.

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

Finally, in looking at a striking-off order, the panel took note of the following paragraphs of the SG:

- *Do the regulatory concerns about the nurse or midwife raise fundamental questions about their professionalism?*
- *Can public confidence in nurses and midwives be maintained if the nurse or midwife is not removed from the register?*
- *Is striking-off the only sanction which will be sufficient to protect patients, members of the public, or maintain professional standards?*

Mrs Fell's actions were significant departures from the standards expected of a registered nurse and are fundamentally incompatible with her remaining on the register. The panel took into account that Mrs Fell sought to falsify references for the purposes of revalidation/re-registration and in doing so, showed scant regard for the integrity of the register or its purpose in keeping patients safe and maintaining confidence in the profession.

The panel was of the view that the findings in this particular case demonstrate that Mrs Fell's actions were serious and to allow her to continue practising 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 Mrs 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 to protect the public and to maintain public trust and confidence in the nursing profession and in the NMC as regulator.

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 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 Mrs 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 Ms Jones. She invited the panel to impose an interim suspension order to reflect the panel's decision on sanction. Ms Jones submitted that this would satisfy the grounds of public protection and the wider public interest.

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 the appeal period.

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

That concludes this determination.