Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Friday 9 – Wednesday 21 September 2022
Thursday 29 – Friday 30 September 2022
Friday 7 October 2022

Virtual Hearing

Name of registrant:	Gayle Squirrell
NMC PIN:	11C1140E
Part(s) of the register:	Registered Nurse – Sub part 1 Adult Nursing – March 2012
Relevant Location:	Lancashire and North Yorkshire
Type of case:	Misconduct
Panel members:	Philip Sayce (Chair, Registrant member) Patience McNay (Registrant member) David Hull (Lay member)
Legal Assessor:	Nigel Pascoe KC
Hearings Coordinator:	Sharmilla Nanan
Nursing and Midwifery Council:	Represented by Shekyena Marcelle-Brown, Case Presenter
Mrs Squirrell:	Not present and not represented at the hearing
Facts proved:	Charges 1, 2, 3, 4, 5, 6, 7, 8, 10, 11, 12, 13, 14, 15 and 16
Facts not proved:	Charges 9 and 17
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 Squirrell was not in attendance and that the Notice of Hearing letter had been sent on 11 August 2022, to an email address that was confirmed by Mrs Squirrell's former representatives at the Royal College of Nursing (RCN).

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

The panel accepted the advice of the legal assessor.

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

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

Decision and reasons on proceeding in the absence of Mrs Squirrell

The panel next considered whether it should proceed in the absence of Mrs Squirrell. It had regard to Rule 21 and heard the submissions of Ms Marcelle-Brown who invited the panel to continue in the absence of Mrs Squirrell. She submitted that Mrs Squirrell had voluntarily absented herself.

Ms Marcelle-Brown referred the panel to the email correspondence dated 6 September 2022 from Mrs Squirrell which states that she will not be attending the virtual hearing. She

submitted that there was no reason to believe that an adjournment would secure Mrs Squirrell's attendance on some future occasion. She noted that Mrs Squirrell has been invited to provide written submissions but declined to do so. Ms Marcelle-Brown submitted that it was fair, appropriate and proportionate to proceed in Mrs Squirrell's absence.

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'* as referred to in the case of *R* v *Jones (Anthony William)* (No.2) [2002] UKHL 5.

The panel has decided to proceed in the absence of Mrs Squirrell. In reaching this decision, the panel has considered the submissions of Ms Marcelle-Brown, the email correspondence from Mrs Squirrell, and the advice of the legal assessor. It has had particular regard to the factors set out in the decision of *R v Jones* and *General Medical Council v Adeogba* [2016] EWCA Civ 162 and had regard to the overall interests of justice and fairness to all parties. It noted that:

- No application for an adjournment has been made by Mrs Squirrell;
- Mrs Squirrell has indicated to the NMC that she has received the Notice of Hearing and is content for the hearing to proceed in her absence;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- Two witnesses are due to give live evidence today and others are due to attend;
- Not proceeding may inconvenience the witnesses, their employers and, for those involved in clinical practice, the clients who need their professional services;
- The charges relate to events that occurred between 2017 and 2019.

- Further delay may have an adverse effect on the ability of witnesses accurately to recall events; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Mrs Squirrell in proceeding in her absence. Although the evidence upon which the NMC relies will have been sent to her at her registered email address, she has made no response to the allegations. Mrs Squirrell will not be able to challenge the evidence relied upon by the NMC 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 Squirrell's decision to absent herself from the hearing, waive her rights to attend, and/or be represented, and to not provide evidence or make submissions on her own behalf.

In these circumstances, the panel has decided that it is fair, appropriate and proportionate to proceed in the absence of Mrs Squirrell. The panel will draw no adverse inference from Mrs Squirrell absence in its findings of fact.

Decision and reasons on application to amend the charge

The panel heard an application made by Ms Marcelle-Brown, on behalf of the NMC, to amend the wording of charge number 14.

The proposed amendment was to include the correct charge referred to in charge 14. It was submitted by Ms Marcelle-Brown that the proposed amendment would provide clarity and more accurately reflect the evidence. She submitted that this amendment does not affect the fairness or cause any injustice to Mrs Squirrell or the proceedings.

<u>Original charge:</u>

"That you, a registered nurse:

14) Your conduct in paragraph 12 above was dishonest in that you knew that you had not had one or more of the meetings as set out in that document and your actions were designed to mislead the NMC panel into believing that the entries in that document were genuine at the review hearing on 12 June 2019.

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

Proposed charge:

"That you, a registered nurse:

14) Your conduct in paragraph ~~12~~ **13** above was dishonest in that you knew that you had not had one or more of the meetings as set out in that document and your actions were designed to mislead the NMC panel into believing that the entries in that document were genuine at the review hearing on 12 June 2019.

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

The panel accepted the advice of the legal assessor and had regard to Rule 28 of the Rules.

The panel was of the view that such an amendment, as applied for, was in the interest of justice. The panel was satisfied that there would be no prejudice to Mrs Squirrell and no injustice would be caused to either party by the proposed amendment being allowed. It was therefore appropriate to allow the amendment, as applied for, to ensure clarity and accuracy.

Details of charge

That you, a registered nurse:

1) On an unknown date used an e-cigarette whilst on a ward

2) On 25 November 2017 administered IV medication to Patient A which was prescribed for a different patient.

3) On 25 November 2017 told Colleague 1 that you had almost administered the wrong IV medication to a patient and that the incident was a “near miss” or words to that effect.

4) Your conduct in Charge 3 above was dishonest in that you knew you had administered the wrong medication to Patient A when you spoke to Colleague 1 and your conduct was designed to conceal your error.

5) On the nightshift of 1-2 May 2018 in respect of Patient B:-

    a) Failed to administer their evening/bedtime dose of Ceftazidime;
    b) Signed the prescription chart to indicate that you had administered the aforesaid dose of Ceftazidime when you had not done so;
    c) Told Patient B that you had administered the aforesaid dose of Ceftazidime when you had not done so.

6) Your conduct in Charge 5(b) and/or 5 (c) above was dishonest in that you knew you had not administered the aforesaid dose and your conduct was designed to conceal this.

7) On 23 May 2018 in respect of Patient C:-

a) Failed to ensure that the patient's IV Furosemide infusion was recommenced promptly after his IV antibiotics infusion had finished;

b) Failed to administer Oramorph on one or more occasions during the shift;

c) Signed the prescription chart to indicate that you had administered Oromorph three times during the shift when you had not done so;

d) Failed to carry out observations every 2-4 hours during the shift.

8) Your conduct in Charge 7(c) was dishonest in that you knew you had not administered prescribed medication on one or more occasions during the shift.

9) On 23 May 2018 in respect of an unknown patient failed to carry out observations at the required intervals on one or more occasions.

10) On 19 March 2019 administered Midazolam to Patient D without being directly supervised in breach of an interim conditions of practice order dated 13 December 2018.

11) In or around 11 June 2019 caused or permitted your legal representatives to provide a document entitled "Staff Competency Assessment for the Management of Medicines" dated 23 December 2018 to the NMC on your behalf for the purposes of an interim order review hearing on 12th June 2019.

12) Your conduct in paragraph 11 above was dishonest in that you knew that the aforesaid Competency Assessment was inaccurate in that you had not completed the competencies set out therein by 23 December 2018 and your actions were designed to mislead the NMC panel into believing that the entries in that document were genuine at the review hearing on 12 June 2019.

13) In or around 10 June 2019 caused or permitted your legal representatives to provide a Personal Development Plan/Supervision Document to the NMC on your behalf for the purposes of an interim order review hearing on 12 June 2019.

14) Your conduct in paragraph 13 above was dishonest in that you knew that you had not had one or more of the meetings as set out in that document and your actions were designed to mislead the NMC panel into believing that the entries in that document were genuine at the review hearing on 12 June 2019.

15) On 14 June 2019 failed to administer, or alternatively failed to record the administration of, paracetamol to Patient E at 5pm.

16) On 22 June 2019 failed to administer, or alternatively failed to record the administration of, Hypromellose eye drops to Patient F at 12pm and/or 5pm.

17) On 22 June 2019 in respect of Patient G failed to administer, or alternatively failed to record the administration of:

a) Ramipril at 8am;
b) Ranitidine at 8am and/or 5pm.

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

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

At the outset of the hearing, Ms Marcelle-Brown made a request that parts of this case be held in private on the basis that proper exploration of Mrs Squirrell's case involves reference to the health of some of the NMC witnesses. The application was made pursuant to Rule 19 of the Rules.

The legal assessor reminded the panel that while Rule 19(1) provides, as a starting point, that hearings shall be conducted in public, Rule 19(3) 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 to go into private session when addressed on the health of the NMC witnesses in order to protect their right to privacy.

Decision and reasons on application to admit written NMC statement of Patient B

The panel heard an application made by Ms Marcelle-Brown under Rule 31 to allow the written NMC statement of Patient B into evidence. She referred to the principles outlined in *Thorneycroft v Nursing and Midwifery Council* [2014] EWHC 1565 (Admin) and applied them to this case. She submitted that Patient B was not present at this hearing and, whilst the NMC had made sufficient efforts to ensure that this witness was present, Patient B was unable to attend today [PRIVATE].

In the preparation of this hearing, the NMC had indicated to Mrs Squirrell that it was the NMC's intention for Patient B to provide live evidence to the panel. However, the NMC had been in contact with Patient B in the weeks preceding the hearing. [PRIVATE]. The NMC informed Mrs Squirrell by email on 26 August 2022 that it would make an application to admit Patient B's evidence as hearsay. On this basis Ms Marcelle-Brown advanced the argument that there was no lack of fairness to Mrs Squirrell in allowing Patient B's written NMC statement into evidence.

The panel gave the application in regard to Patient B's evidence serious consideration. The panel noted that Patient B's written NMC statement had been prepared in anticipation of being used in these proceedings and contained the paragraph, *'This statement … is true to the best of my information, knowledge and belief'* and had been signed by her.

The panel considered whether Mrs Squirrell would be disadvantaged by the change in the NMC's position of moving from reliance upon the live testimony of Patient B to that of a written statement.

The panel was of the view that Patient B's evidence was not the sole or decisive evidence in relation to the charges that she provided evidence for. It noted that Patient B's evidence had been corroborated by other witnesses.

[PRIVATE].

The panel considered that as Mrs Squirrell had been provided with a copy of Patient B's statement and, as the panel had already determined that Mrs Squirrell had chosen voluntarily to absent herself from these proceedings, she would not be in a position to cross-examine this witness in any case. It noted that Mrs Squirrell had been provided with prior notice that the NMC would make an application to admit Patient B's evidence as hearsay [PRIVATE]. The panel considered that the unfairness in this regard worked both ways in that the NMC was deprived, as was the panel, from reliance upon the live evidence of Patient B and the opportunity of questioning and probing that testimony. There was also public interest in the issues being explored fully which supported the admission of this evidence into the proceedings.

In all the circumstances, the panel came to the view that it would be fair and relevant to accept into evidence the written statement of Patient B, but would give what it deemed appropriate weight once the panel had heard and evaluated all the evidence before it.

Decision and reasons on application to amend the charge

The panel heard an application made by Ms Marcelle-Brown, on behalf of the NMC, to amend the wording of charge 7c.

The proposed amendment was to change the wording of the charge from *"three times"* to *"on one or more occasions".* It was submitted by Ms Marcelle-Brown that the proposed amendment would provide clarity and more accurately reflect the oral evidence as heard by the panel.

Original charge:

"That you, a registered nurse:

7) On 23 May 2018 in respect of Patient C:-

c) Signed the prescription chart to indicate that you had administered Oromorph three times during the shift when you had not done so"

Proposed amendment:

"That you, a registered nurse:

7) On 23 May 2018 in respect of Patient C:-

c) Signed the prescription chart to indicate that you had administered Oromorph ~~three times~~ **on one or more occasions** during the shift when you had not done so"

The panel accepted the advice of the legal assessor and had regard to Rule 28 of the Rules.

The panel of its own volition invited submissions from Ms Marcelle-Brown as to whether she had any views on changing the wording in charge 5b and 7c, from "*prescription chart*" to "*medication administration record chart*". Ms Marcelle-Brown indicated that she had no observations regarding the amendments outlined by the panel. The panel therefore

determined to amend the wording of charges 5b and 7c from "*prescription chart*" to "*medication administration record chart*.

With regard to the remaining amendment to charge 7c as outlined in the NMC's application, the panel was of the view that such an amendment, as applied for, was in the interest of justice. It noted that Mrs Squirrell had a copy of the NMC evidence bundle prior to the hearing taking place. The panel was satisfied that there would be no prejudice to Mrs Squirrell and no injustice would be caused to either party by the proposed amendment being allowed. It was therefore appropriate to allow the amendment, as applied for, to more accurately reflect the evidence.

Details of charge (as amended)

That you, a registered nurse:

1) On an unknown date used an e-cigarette whilst on a ward

2) On 25 November 2017 administered IV medication to Patient A which was prescribed for a different patient.

3) On 25 November 2017 told Colleague 1 that you had almost administered the wrong IV medication to a patient and that the incident was a "near miss" or words to that effect.

4) Your conduct in Charge 3 above was dishonest in that you knew you had administered the wrong medication to Patient A when you spoke to Colleague 1 and your conduct was designed to conceal your error.

5) On the nightshift of 1-2 May 2018 in respect of Patient B:-

    a) Failed to administer their evening/bedtime dose of Ceftazidime;

b) Signed the medication administration record (MAR) chart to indicate that you had administered the aforesaid dose of Ceftazidime when you had not done so;
c) Told Patient B that you had administered the aforesaid dose of Ceftazidime when you had not done so.

6) Your conduct in Charge 5(b) and/or 5 (c) above was dishonest in that you knew you had not administered the aforesaid dose and your conduct was designed to conceal this.

7) On 23 May 2018 in respect of Patient C:-

a. Failed to ensure that the patient's IV Furosemide infusion was recommenced promptly after his IV antibiotics infusion had finished;

b. Failed to administer Oramorph on one or more occasions during the shift;

c. Signed the MAR chart to indicate that you had administered Oromorph on one or more occasions during the shift when you had not done so;

d. Failed to carry out observations every 2-4 hours during the shift.

8) Your conduct in Charge 7(c) was dishonest in that you knew you had not administered prescribed medication on one or more occasions during the shift.

9) On 23 May 2018 in respect of an unknown patient failed to carry out observations at the required intervals on one or more occasions.

10) On 19 March 2019 administered Midazolam to Patient D without being directly supervised in breach of an interim conditions of practice order dated 13 December 2018.

11) In or around 11 June 2019 caused or permitted your legal representatives to provide a document entitled “Staff Competency Assessment for the Management of Medicines” dated 23 December 2018 to the NMC on your behalf for the purposes of an interim order review hearing on 12th June 2019.

12) Your conduct in paragraph 11 above was dishonest in that you knew that the aforesaid Competency Assessment was inaccurate in that you had not completed the competencies set out therein by 23 December 2018 and your actions were designed to mislead the NMC panel into believing that the entries in that document were genuine at the review hearing on 12 June 2019.

13) In or around 10 June 2019 caused or permitted your legal representatives to provide a Personal Development Plan/Supervision Document to the NMC on your behalf for the purposes of an interim order review hearing on 12 June 2019.

14) Your conduct in paragraph 13 above was dishonest in that you knew that you had not had one or more of the meetings as set out in that document and your actions were designed to mislead the NMC panel into believing that the entries in that document were genuine at the review hearing on 12 June 2019.

15) On 14 June 2019 failed to administer, or alternatively failed to record the administration of, paracetamol to Patient E at 5pm.

16) On 22 June 2019 failed to administer, or alternatively failed to record the administration of, Hypromellose eye drops to Patient F at 12pm and/or 5pm.

17) On 22 June 2019 in respect of Patient G failed to administer, or alternatively failed to record the administration of:

a) Ramipril at 8am;
b) Ranitidine at 8am and/or 5pm.

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

Decision and reasons on application to admit written NMC statement of Witness 8

The panel heard an application made by Ms Marcelle-Brown under Rule 31 to allow the written NMC statement of Witness 8 into evidence. She referred to the principles outlined in *Thorneycroft v Nursing and Midwifery Council* and applied them to this case. Witness 8 was not present at this hearing and, whilst the NMC had made sufficient efforts to ensure that this witness was present, she was unable to attend today [PRIVATE].

In the preparation of this hearing, the NMC had indicated to Mrs Squirrell that it was the NMC's intention for Witness 8 to provide live evidence to the panel. Despite knowledge of the nature of the evidence to be given by Witness 8, Mrs Squirrell made the decision not to attend this hearing. On this basis Ms Marcelle-Brown advanced the argument that there was no lack of fairness to Mrs Squirrell in allowing Witness 8's written NMC statement into evidence.

The panel gave the application in regard to Witness 8 serious consideration. The panel noted that Witness 8's statement had been prepared in anticipation of being used in these proceedings and contained the paragraph, *'This statement … is true to the best of my information, knowledge and belief'* and signed by her.

The panel considered whether Mrs Squirrell would be disadvantaged by the change in the NMC's position of moving from reliance upon the live testimony of Witness 8 to that of a written statement.

The panel considered that as Mrs Squirrell had been provided with a copy of Witness 8's statement and, as the panel had already determined that Mrs Squirrell had chosen voluntarily to absent herself from these proceedings, she would not be in a position to

cross-examine this witness in any case. There was also public interest in the issues being explored fully which supported the admission of this evidence into the proceedings.

The panel bore in mind that Witness 8 did not provide the sole and decisive evidence in this case. It noted that there were other witnesses who provided evidence to the charges that Witness 8 spoke to and the panel also had available to it, supporting contemporaneous documents.

The panel also considered that the unfairness in this regard worked both ways in that the NMC was deprived, as was the panel, from reliance upon the live evidence of Witness 8 and the opportunity of questioning and probing that testimony.

[PRIVATE]. It noted that Mrs Squirrell had been informed by email that the NMC would make an application to admit Witness 8's evidence as hearsay on 14 September 2022.

There was also public interest in the issues being explored fully which supported the admission of this evidence into the proceedings.

In these circumstances, the panel came to the view that it would be fair and relevant to accept into evidence the written NMC statement of Witness 8, but would give what it deemed appropriate weight once the panel had heard and evaluated all the evidence before it.

Decision and reasons on application to admit written NMC statement of Witness 9

The panel heard an application made by Ms Marcelle-Brown under Rule 31 to allow the written statement of Witness 9 into evidence. She referred to the principles outlined in *Thorneycroft v Nursing and Midwifery Council* and applied them to this case. Witness 9 was not present at this hearing and, whilst the NMC had made sufficient efforts to ensure that this witness was present, she was unable to attend [PRIVATE].

In the preparation of this hearing, the NMC had indicated to Mrs Squirrell that it was the NMC's intention for Witness 9 to provide live evidence to the panel. Despite knowledge of the nature of the evidence to be given by Witness 9, Mrs Squirrell made the decision not to attend this hearing. On this basis Ms Marcelle-Brown advanced the argument that there was no lack of fairness to Mrs Squirrell in allowing Witness 9's written statement into evidence.

The panel bore in mind that Witness 9's evidence was not the sole or decisive evidence. It also noted that other another witness also provided evidence in respect of charge 1, the charge that Witness 9 provided evidence for.

The panel was of the view that, although Mrs Squirrell had chosen not to attend this hearing, she was not aware at the time of making that decision, of this application to have Witness 9's statement read. The panel also took into consideration that neither it nor the NMC would have the opportunity to probe or test the evidence of Witness 9.

The panel noted that Mrs Squirrell was informed by the NMC on 15 September 2022, that it intended to make an application to admit Witness 9's statement as hearsay evidence. The panel determined that it was a basic principle of fairness that Mrs Squirrell has notice of Ms Marcelle-Brown's application and given the opportunity to factor this into any defence Mrs Squirrell chose to present to the panel.

The panel bore in mind that it did not have any supporting information [PRIVATE] as to why Witness 9 could not attend the hearing. The panel was of the view that the reason for Witness 9's non-attendance at the hearing was not supported by any independent information.

In these circumstances the panel refused the application.

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 together with the submissions made by Ms Marcelle-Brown on behalf of the NMC.

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

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 bore in mind that it heard live evidence from the following witnesses called on behalf of the NMC:

- Witness 1: Registered nurse who worked with Mrs Squirrell on Ward 37 at Royal Lancaster Hospital (the hospital).
- Colleague 1: Ward Sister who worked with Mrs Squirrell on Ward 37 at the Hospital.
- Witness 3: Registered nurse who worked with Mrs Squirrell on Ward 37 at the Hospital.
- Witness 4: Matron for Urgent and Emergency Care and Investigating Officer for the investigation carried out by University Hospitals Morecambe Bay NHS Foundation Trust (the Trust).

- Witness 5: Owner and Nominated Individual of Ingleborough Nursing Home (the Home).
- Witness 6: Clinical Site Manager at the Hospital.
- Witness 7: Band 6 Clinical Lead Nurse at the Hospital.

The panel had regard to the written and documentary evidence from the following witnesses:

- Patient B: A patient on Ward 37 at the Hospital who was under Mrs Squirrell's care.
- Witness 8: Registered nurse who worked with Mrs Squirrell at the Home.
- Witness 10 Registered nurse who worked with Mrs Squirrell at the Trust on Ward 37.
- Witness 11 Case officer at the NMC who was responsible at the relevant time of the allegations for the NMC's investigation into Mrs Squirrell's conduct and practise.

Ms Marcelle-Brown informed the panel that the evidence of Witness 10 and Witness 11 had been agreed prior to the hearing taking place. Consequently, Witness 10 and Witness 11 were not called to give live evidence.

Background

On 15 November 2018, the NMC received a referral from University Hospital Morecombe Bay NHS Foundation Trust (the Trust). Mrs Squirrell began working for the Trust as a Band 5 nurse in 2012.

At the time of the alleged incidents, in 2017, Mrs Squirrell was working as a Band 5 nurse on Ward 37 (the Ward) at Royal Lancaster Infirmary (the Hospital). The Ward caters for patients with serious respiratory conditions, and occasionally has patients from other departments with serious conditions that require high levels of nursing care when the Hospital has a limited bed capacity.

It was alleged that while working on the Ward in November 2017, Mrs Squirrell made a medication error by giving the wrong intravenous medication to a patient. In May 2018, Mrs Squirrell had reportedly completed her medication rounds and nursing tasks quicker than other staff and there were suspicions that she did not administer medication or complete patient care satisfactorily. It is also alleged that Mrs Squirrell had smoked an e-cigarette on the Ward.

Mrs Squirrell was suspended from her role on 22 June 2018 whilst the Trust completed an investigation.

As a result of the Trust's referral, Mrs Squirrell was placed on an Interim Conditions of Practice Order (ICOPO) on 13 December 2018. The interim order imposed stated "*You must not carry out medication administration unless directly supervised by another registered nurse, such supervision to consist of … Direct observation by another registered nurse deemed competent in medication administration*"

Mrs Squirrell was employed by Ingleborough Nursing Home (the Home) in December 2018. It is alleged that whilst employed at the Home, Mrs Squirrell administered

medication without being directly supervised in March 2019 in breach of the ICOPO which was in place at the time.

The ICOPO was reviewed by the NMC on 12 June 2019. Mrs Squirrell provided documents for the NMC's investigating committee to consider at this hearing, and the reviewing panel subsequently decided revoke the ICOPO. The Home was concerned that Mrs Squirrell provided misleading documentation to the NMC's investigating committee. It is alleged that Mrs Squirrell provided the NMC with a Medicine Management Assessment dated 23 December 2018 when this document had not yet been produced by the Home, and Mrs Squirrell provided a Personal Development Plan/Supervision Document. Mrs Squirrell later admitted on 6 June 2019 that she "*had no regular meetings with … (the Home Manager) and she had not undertaken any medication administration training*".

It is alleged that whilst working in the Home, Mrs Squirrell made further medication errors on 14 and 22 June 2019. These incidents are alleged to have happened at the Home after the ICOPO was revoked and the Registrant was able to practise independently on the two days that the Registrant was the sole nurse on duty at the Home.

The Home informed the NMC on 16 July 2019 and the ICOPO was reinstated on 10 September 2019.

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

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

Charge 1

"That you, a registered nurse:

1) On an unknown date used an e-cigarette whilst on a ward"

This charge is found PROVED.

In reaching this decision, the panel took into account the evidence of Colleague 1 and Witness 4. The panel also had regard to the Case Management Form provided to the NMC on Mrs Squirrell's behalf.

The panel next considered the evidence of Colleague 1. In her NMC witness statement she stated *"I have witnessed Ms Squirell use an e-cigarette whilst on Ward 37… Ward 37 is mainly for seriously ill respiratory patients… Ms Squirell and I were working on a night shift. When I walked into the bay Ms Squirrell was assigned, I could easily see the blue light of her e-cigarette. The lights were dimmed which made it easier to notice the light. Despite the windows being open, I could also smell the e-cigarette… I told Ms Squirrell that I had witnessed her using the e-cigarette on the bay. Ms Squirell denied everything. When I insisted I had clearly seen her use it she changed her mind and said that she must have done so by accident."* The panel took into consideration that Colleague 1 provided a detailed account of this incident and was honest with regard to not recalling the specific date of this incident in a further NMC witness statement.

The panel took into account the documentary evidence of Witness 4 which included an interview with Mrs Squirrell on 20 June 2018. In the interview Mrs Squirrell stated that she had used a e-cigarette on the ward *"By accident… I was on a night shift and reached into my pocket and put what I though[sic] was a pen in my mouth as I do not usually have my e-cigarette on me."* Mrs Squirrell reiterated this account in another interview with Witness 4 on 18 July 2018.

The panel bore in mind that the undated case management forms provided by the Royal College of Nursing (RCN) on Mrs Squirrell's behalf indicated that she accepted the facts of this charge. The panel acknowledged that the admission on the case management form had been provided whilst Mrs Squirrell had been legally represented in these proceedings.

The panel therefore found this charge proved on the balance of probabilities.

Charge 2

> "2) On 25 November 2017 administered IV medication to Patient A which was prescribed for a different patient."

This charge is found PROVED.

In reaching this decision, the panel took into account the evidence of Witness 10, Witness 6 and Witness 3.

The panel took into consideration the Investigation Meeting minutes dated 2 July 2018 with Witness 10 which states *"In November an incident occurred when we were really busy and she had finished her work and I had loads of IV's to give. She said she would help me with them and so I put them all out ready in the clinical room. Gayle asked me where one of them was for and it was for the patient in bed 21. When I approached the patient in bed 18 I realised that he already had his IV antibiotics in situ and not the patient in bed 21."* The panel also considered the NMC statement of Witness 10 which stated *"As Mrs Squirrell had finished her rounds before everyone ese, she offered to give me some assistance and between us we agreed that she would administer some of the IVs to my patients… I handed her a tray for patient in bed 21 and continued to prepare the medication for other patients… I was very clear in my handover… Mrs Squirrell returned to me and advised that the patient in bed 21 had been given his IV antibiotics etc, and only now required his IV paracetamol. I then proceeded to go to the patient in bed 18 and realised that his IV antibiotic was already hanging up and the tray was by his beside. Both patients in beds 18 and 21 were prescribed the same antibiotics but the patient in bed 21 also required Sodium Valproate, used in the management of Epilepsy."* The panel noted that the account that Witness 10 provided in their NMC statement was consistent with the account provided in the Investigation Meeting minutes dated 2 July 2018.

The panel considered the evidence of Colleague 1 who said in her NMC written statement *"I came onto the day shift and met Ms Squirrell who had been on the night shift, in the*

corridor. She was crying hysterically saying that she had almost administered the wrong IV to a patient… Ms Squirrell said that… it was a near miss… A few Months later I was informed that before speaking with me, Ms Squirrell had spoken with the night ward sister on duty as well as the on call doctor. They had attended the patient after she told them she had administered the incorrect medication." Further, the panel noted that in the Trust interview between Mrs Squirrell and Witness 4 dated 20 July 2018, she said that she told Colleague 1 that she *"made a boo boo"* and that she was *"not sure"* if she should raise a clinical incident.

The panel took into consideration the oral evidence of Witness 6 who was adamant that Mrs Squirrell had administered medication to the wrong patient. The panel also took into consideration the Professional Statement Proforma completed by Witness 6 on 27 June 2018. It noted that the Professional Statement Proforma included a detailed description of what transpired and that a clinical incident had not been submitted following the incident on the ward.

The panel bore in mind that the case management forms provided by RCN on Mrs Squirrell's behalf indicated that she accepted the facts of this charge. The panel acknowledged that the admission on the case management form had been provided whilst Mrs Squirrell had been legally represented in these proceedings.

The panel considered the evidence of Witness 3 and noted she did not provide any direct supporting evidence but was of the view that Mrs Squirrell was dishonest. The panel decided not to rely on the evidence of Witness 3's evidence in respect of this charge.

The panel considered all the evidence before it. It noted that when Mrs Squirrell was initially questioned by Witness 10 on the day of the incident, she asserted that she had given the medication meant for the patient in bed 21 to the patient in bed 18. The panel was of the view that this initial reaction from Mrs Squirrell demonstrated that it was more likely than not that the incident took place as alleged in the charge. The panel found this charge proved on the balance of probabilities.

Charge 3

> "3) On 25 November 2017 told Colleague 1 that you had almost administered the wrong IV medication to a patient and that the incident was a "near miss" or words to that effect."

This charge is found PROVED.

In reaching this decision, the panel considered the evidence outlined at charge 2.

The panel was of the view that Mrs Squirrell told Colleague 1 a different set of events that occurred on the shift to those that actually took place.

As outlined in the charge above, the panel noted that Mrs Squirrell admitted to this charge in the completed case management form submitted on her behalf, at a time when she was legally represented.

The panel therefore found this charge proved.

Charge 4

> "4) Your conduct in Charge 3 above was dishonest in that you knew you had administered the wrong medication to Patient A when you spoke to Colleague 1 and your conduct was designed to conceal your error."

This charge is found PROVED.

In reaching this decision, the panel took into account the evidence outlined at charge 2. It also bore in mind its decision in charges 2 and 3.

The panel noted that once Mrs Squirrell had administered the wrong IV medication, she initially admitted it and then subsequently had attempted to obfuscate those facts. The panel was of the view that Mrs Squirrell telling Colleague 1 that she had a *"near miss"* was part of her deception. The panel considered that there is no plausible, alternative explanation from the information available to explain her actions given the context of the incident and that ordinary decent people would find Mrs Squirrell's actions to be dishonest.

The panel found this charge proved on the balance of probabilities.

Charge 5a

"5) On the nightshift of 1-2 May 2018 in respect of Patient B:-

a) Failed to administer their evening/bedtime dose of Ceftazidime"

This charge is found PROVED.

In reaching this decision, the panel took into account the evidence of Patient B, Witness 1, Witness 3 and Witness 4.

The panel took into consideration the written NMC statement of Witness 1 who noted when Mrs Squirrell was asked about the administration of Patient B's medication she appeared *"flustered"* and that she asked for Patient B's name. Witness 1 commented to Mrs Squirrell that Ceftazdime *"required a second nurse to check it when it was put together"*. Witness 1 said that *"Ms Squirrell was insistent that she had given Patient B her medication whilst Patient B was asleep."* She noted that Patient B said, *"she did not fall asleep as she struggles to sleep in hospital and was only a light sleeper anyway".* Witness 1's noted that Patient B was insistent that she had not been given her medication.

The panel considered the written NMC statement of Patient B. It noted that she went to the nurse's office and spoke with a nurse she did not recognise, she told her that "*I did not believe that I had been given my night time dose of antibiotics". The panel also noted that*

Patient B said "I did not take the incident any further and did not speak to anyone else about it… I did not want Ms Squirrell to have her job impacted over this incident." The panel took into consideration Patient B's handwritten, contemporaneous, detailed statement to the Trust made at the time of the incident.

The panel considered the NMC written statement of Witness 3 who said that Patient B was "*fully compos mentis and independently mobile".* She noted that she was at the nurse's desk at the time when Patient B asked if she would be given her medication on this shift as she had not received it the night before, she said *"I spoke to her and said yes she would be receiving the medication."*

The panel took into account a Trust interview which took place on 20 June 2018, between Witness 4 and Mrs Squirrell. During this interview, Mrs Squirrell stated that she administered the medication to Patient B whilst she was asleep. However, during a Trust interview which took place on 18 July 2018 between Witness 4 and Mrs Squirrell stated that she assumed that the drugs had been checked and stated that she *"checked her wristband and her cannula"*.

The panel noted that a Lead Pharmacist at the Trust stated that Ceftazdime would always be supplied as a dry powder in an email dated 19 July 2018 within Witness 4's documentary evidence. The panel noted that Mrs Squirrell did not provide any details as to how to administer this medication in either of her interviews with the Trust.

The panel was of the view that Mrs Squirrell's account of this incident was inconsistent and continually developing as documented in the exhibits provided by Witness 4. It noted that at the Trust interview on 18 July 2018, Mrs Squirell provided more detail and that this was in contradiction to Patient B's recollection of events. For this reason, the panel preferred the evidence of Patient B which was corroborated by the evidence of Witness 1 and Witness 3. The panel therefore found this charge proved on the balance of probabilities.

Charge 5b

"5) On the nightshift of 1-2 May 2018 in respect of Patient B:-

b) Signed the medication administration record (MAR) chart to indicate that you had administered the aforesaid dose of Ceftazidime when you had not done so"

In reaching this decision, the panel took into consideration the evidence and findings outlined at charge 5a.

The panel bore in mind that it found that Mrs Squirrell had not administered Ceftazdime to Patient B. It considered the MAR chart for Patient B which contained Mrs Squirrell's signature.

The panel also took into consideration Witness 1's NMC witness statement which stated, *"Ms Squirrell showed both Patient B and I the signed prescription chart which indicated that she had been given the antibiotics."*

The panel took into the evidence outlined and found this charge proved.

Charge 5c

"5) On the nightshift of 1-2 May 2018 in respect of Patient B:-

c) Told Patient B that you had administered the aforesaid dose of Ceftazidime when you had not done so."

This charge is found PROVED.

In reaching this decision, the panel took into consideration the evidence outlined at charge 5a and 5b.

The panel was of the view that Patient B's contemporaneous statement made at the time of the incident was clear and detailed. It noted that it was corroborated by the written NMC witness statement of Witness 1. The panel decided to attach weight to Patient B's NMC statement and documentary evidence. The panel therefore found this charge proved on the balance of probabilities.

Charge 6

> "6) Your conduct in Charge 5(b) and/or 5 (c) above was dishonest in that you knew you had not administered the aforesaid dose and your conduct was designed to conceal this."

This charge is found PROVED.

In reaching this decision, the panel took into account the evidence outlined at charges 5a, 5b and 5c.

The panel considered the inconsistent and developing nature of Mrs Squirrell's account and her insistence to Patient B that she had administered the medication. The panel was of the view that the most plausible explanation for Mrs Squirrell's actions was so that she could hide her error. The panel was not of the view that Mrs Squirrell misremembered the events that took place and that there were no other alternative plausible explanations for Mrs Squirrell's conduct alleged in this charge. The panel was of the view that ordinary decent people would find Mrs Squirrell's conduct dishonest.

The panel considered the evidence and found it incredible that Mrs Squirrell did not remember the incident immediately after it occurred but was able to develop her account

sometime after. The panel was of the view that this was blatant dishonesty from Mrs Squirrell to hide her actions. The panel therefore found this charge proved.

Charge 7a

"7) On 23 May 2018 in respect of Patient C:-

a) Failed to ensure that the patient's IV Furosemide infusion was recommenced promptly after his IV antibiotics infusion had finished;"

This charge is found PROVED.

In reaching this decision, the panel took into account the evidence of Colleague 1, Witness 4 and Witness 7.

The panel considered the witness statement of Colleague 1 which outlined Patient C's medications and that two of his medications, antibiotics and Furosemide, could not be administered at the same time via the IV. It noted that Colleague 1 handed over to Mrs Squirrell that Patient C's syringe of Furosemide had been replenished for his 22:00 hours dose and that *"this would need reconnecting because Patient C currently had IV antibiotics going through the cannula which I had put up at around 0700am".* In her statement, she noted that *"Mrs Squirrell that she would have to arrange for another nurse to disconnect the antibiotics and reconnect the Furosemide as... she was restricted from administering IV medications".*

The panel noted that in Colleague 1's oral evidence she had asked all the other nurses who were on the day shift with Mrs Squirrell at the material time as to whether they were asked by Mrs Squirrell to assist her with the IV for Patient C, who all said no.

The panel considered the evidence of Witness 7 and noted that she was on the same day shift as Mrs Squirrell, she was not asked for any Furosemide assistance by Mrs Squirrell. The panel was of the view that this corroborated Colleague 1's evidence.

The panel also bore in mind Witness 4's evidence that Patient C's medication of Furosemide had not been run all day.

The panel was satisfied that as Patient C was Mrs Squirrell's patient, she had a responsibility to ensure that Patient C received all of his medications. The panel was not satisfied that she had taken any steps to ensure that she had completed her duty to the patient. The panel determined that on the balance of probabilities that Mrs Squirrell failed to ensure that Patient C's IV Furosemide infusion was recommenced promptly after his IV antibiotics infusion had finished.

Charge 7b

"7) On 23 May 2018 in respect of Patient C:-

b) Failed to administer Oramorph on one or more occasions during the shift;"

This charge is found PROVED.

In reaching this decision, the panel took into account the evidence outlined at charge 7a.

The panel was satisfied that it heard evidence that Patient C was under Mrs Squirrell's care and responsibility on this date.

The panel took into consideration the evidence of Colleague 1 who stated in her NMC witness statement that Patient C is prescribed Oramorph and that he *"he should have been given three or four doses of this during the day shift".* The panel noted that she *"replenished Patient C medication trolley as there was not enough Oramorph left in the*

medication bottle for the next shift… There is a prescription chart which you sign when you have administered a patient medication which had been signed by Ms Squirrell but there is not a record of the volume of medications used in the drug trolley which would indicate if medication have in fact been administered… in the medication trolley, the small amount of Oramorph in the bottle I measured on the previous shift was still there. The new bottle I placed on the medication trolley had not been opened. This indicated that there had been no Oramorph administered from that drugs trolley in the 13 hours of the shift Gayle was working. Despite there being signatures for administration of Oramorph."

The panel also considered the MAR chart for Patient C, exhibited by Colleague 1, and noted that it contained two signatures from Mrs Squirrell for the administration of Oramorph. The panel was of the view that this further indicates Mrs Squirrell's responsibility to administer Oramorph to Patient C.

The panel took into consideration the oral evidence of Witness 6 who it noted has worked on the Ward for a long time. It noted that she said that Oramorph was stored on the patient's medication trolley at the time of this incident but that this medication is now stored in a locked cupboard.

The panel did not have any alternative explanation as to how else the medication could have been administered to this patient except for Mrs Squirrell to take it from the patient's medication trolley nor did it have an explanation as to why the volume in the bottle had not changed. The panel found this charge proved on the balance of probabilities.

Charge 7c

"7) On 23 May 2018 in respect of Patient C:-

c) Signed the MAR chart to indicate that you had administered Oromorph on one or more occasions during the shift when you had not done so"

This charge is found PROVED.

In reaching this decision, the panel took into account the evidence of Colleague 1.

The panel considered Patient C's MAR chart and noted that it contained two of Mrs Squirrell's signatures. It took into account the oral evidence of Colleague 1 who identified Mrs Squirrell's signature on the MAR chart. The panel also bore in mind Colleague 1's NMC statement which stated "…*there had been no Oramorph administered from that drugs trolley in the 13 hours of the shift Gayle was working. Despite there being signatures for administration of Oramorph.*" The panel therefore found this charge proved.

Charge 7d

"7) On 23 May 2018 in respect of Patient C:-

d) Failed to carry out observations every 2-4 hours during the shift."

This charge is found PROVED.

In reaching this decision, the panel took into account evidence of Colleague 1.

The panel considered the MAR chart of Patient C. It noted that Mrs Squirrell had largely completed her observations of Patient C every two to four hours except on one occasion where she made an entry for her observations five hours after the last observation. The panel therefore found the charge proved.

Charge 8

"8) Your conduct in Charge 7(c) was dishonest in that you knew you had not administered prescribed medication on one or more occasions during the shift."

This charge is found PROVED.

In reaching this decision, the panel took into account the evidence and findings at charge 7c.

The panel was of the view that Mrs Squirrell would have known that she had not administered the medication to Patient C. It noted that she signed the MAR charts to indicate that she had administered the prescribed medication.

The panel took into consideration Colleague 1's NMC witness statement which said "*There is a prescription chart which you sign when you have administered a patient medication which had been signed by Ms Squirrell but there is not a record of the volume of medications used in the drug trolley which would indicate if medication have in fact been administered*". The panel was of the view that Mrs Squirrell may not have included this information on the MAR chart by accident or by negligence.

The panel considered that an ordinary person would find that Mrs Squirrell's actions in regard to this charge to be dishonest. The panel therefore found this charge proved.

Charge 9

> "9) On 23 May 2018 in respect of an unknown patient failed to carry out observations at the required intervals on one or more occasions."

This charge is found NOT PROVED.

In reaching this decision, the panel took into account evidence of Colleague 1.

The panel considered the NMC witness statement of Colleague 1, which stated *"… There was another patient that did not look well in the same bay of patients Ms Squirrell had been nursing that day… When I checked the observations records for that day all his*

blood pressure observations were all fine… the patient could have deteriorated quickly however it is unlikely that his blood pressure would have dropped so suddenly and therefore it is my clinical opinion that she had not carried out her observations of him".
The panel was of the view that there are instances where a patient's blood pressure can drastically change when being observed. The panel noted that the patient had a terminal health condition and was being treated on a respiratory patient ward where it is possible to see variations of a patient's health condition in short spaces of time.

The panel bore in mind that this patient was not identified nor did it have any patient records in the evidence provided to the panel. It had no supporting documentary evidence or corroborating accounts in relation to this charge.

The panel determined that in the absence no other corroborating or documentary evidence, it could not solely rely on the professional judgement of Colleague 1. The panel therefore found this charge not proved on the balance of probabilities.

Charge 10

> "10) On 19 March 2019 administered Midazolam to Patient D without being directly supervised in breach of an interim conditions of practice order dated 13 December 2018"

This charge is found PROVED.

In reaching this decision, the panel took into account the evidence of Witness 11, Witness 8 and Witness 5.

The panel took into consideration the documentary evidence of Witness 11 which included a letter dated 14 December 2018 which outlined the interim order which had been imposed at the hearing on 13 December 20218. The panel also took into consideration a telephone attendance note, dated 14 January 2019, recorded by Witness 11. The

telephone attendance note was of a call that took place between Witness 11 and Mrs Squirrell. It stated, *"The registrant had mentioned that her current employer has received the letter from the hearing team with the decision to impose and [sic] 18m ICOP on the registrant."*

The panel considered the hearsay NMC witness statement of Witness 8 which stated *"… on 19 March 2019…Ms Squirrell came to me an said that a resident called Patient D who was seriously ill required a drug which was Midazolam. Ms Squirrell told me that she was going to give this to him and she had the Midazolam with her. She then went upstairs to administer it to him… At no point during the shift did Ms Squirrell tell me that she needed to be observed. I signed the book retrospectively as the second signature when Ms Squirrell brought the book to me having already been told that Ms Squirrell had administered this… [Witness 5] then said to me that Ms Squirrell was subject to Interim Order Restrictions imposed by the NMC."*

The panel took into consideration NMC witness statement of Witness 5 which stated *"At some point on 19 March 2019, [Witness 8] and I were speaking and she told me that on the shift that same day (19 March) she had been working with Ms Squirrell and Ms Squirrell had administered a controlled drug called Medazolam on her own to a Resident … who was receiving end of life care. I was very concerned to hear that as I knew that her interim conditions did not permit her to administer medication independently… when I spoke to another nurse … she outlined the seriousness of what Ms Squirrell had done. She explained to me that it was not only that Ms Squirrell had breached her conditions of practice. She had also failed to follow correct procedure in that she had recorded the incorrect quantity of the medication in the controlled drug book and other nurses, as a result of this, had to spend time rectifying this mistake to ensure this was correct."* The panel noted that in Witness 5's oral evidence she was clear that she was not aware of the impact of the NMC's interim conditions.

The panel considered the evidence before it. It noted that Mrs Squirrell was aware of the interim conditions of practice order that had been imposed on her nursing practise given

her enquiries to the NMC. The panel was of the view that Witness 8's hearsay evidence had been corroborated by the evidence provided by Witness 5. The panel concluded that Mrs Squirrell had administered Midazolam to Patient D without being directly supervised and found this charge proved on the balance of probabilities.

Charge 11

> "11) In or around 11 June 2019 caused or permitted your legal representatives to provide a document entitled "Staff Competency Assessment for the Management of Medicines" dated 23 December 2018 to the NMC on your behalf for the purposes of an interim order review hearing on 12th June 2019."

This charge is found PROVED.

In reaching this decision, the panel took into account evidence of Witness 11.

The panel took into consideration the documentary evidence of Witness 11 which included an exhibited email dated 10 June 2019 with an enclosure called 'Gayle Squirrell PDP'. The panel bore in mind that this document was provided by the RCN on behalf of Mrs Squirrell for the interim order review hearing on 12 June 2019. The panel noted that this charge was also admitted by Mrs Squirrell on the completed Case Management Form. The panel found this charge proved.

Charge 12

> "12) Your conduct in paragraph 11 above was dishonest in that you knew that the aforesaid Competency Assessment was inaccurate in that you had not completed the competencies set out therein by 23 December 2018 and your actions were designed to mislead the NMC panel into believing that the entries in that document were genuine at the review hearing on 12 June 2019."

This charge is found PROVED.

In reaching this decision, the panel took into account the evidence of Witness 5.

The panel considered the evidence of Witness 5. In her witness statement she stated: *"I received a call from Ms Squirrell on 6 June 2019… neither of us were at the Home at the time of the call. She told me she had received a letter from the NMC stating that she had to attend an Interim Order Review Hearing on 12 June 2019. Her voice sounded to me as though she were really panicking. She said that she had not done anything that she needed to do to meet the conditions in her Interim Order. She said this was because she had not had regular meetings with [Ms 12] (Home Manager) and she had not undertaken any medication administration Training."*

Following the interim order review hearing on 12 June 2019, Witness 5 noted that Mrs Squirrell *"admitted to [her] that she had submitted documents to the NMC knowing they were not true."*

The panel bore in mind the CQC's request for an action plan following its visit in February 2019. The panel considered the Medicines Management Assessment (MMA) which was created on 29 March 2019.

The panel was of the view that Mrs Squirrell had provided documents to her RCN representative which she knew to be false and misled the NMC's Investigating Committee that considered the interim order that had been imposed on her nursing practise. The panel therefore found this charge proved on the balance of probabilities.

Charge 13

"13) In or around 10 June 2019 caused or permitted your legal representatives to provide a Personal Development Plan/Supervision Document to the NMC on your behalf for the purposes of an interim order review hearing on 12 June 2019."

This charge is found PROVED.

In reaching this decision, the panel took into account evidence of Witness 11.

The panel took into consideration the evidence of Witness 11 which exhibited an email dated 11 June 2019 with an enclosure called 'Various supporting documentation including testimonials and evidence of compliance with medication supervision'. The panel bore in mind that these documents were provided by the RCN on behalf of Mrs Squirrell for the interim order review hearing on 12 June 2019. The panel noted that Mrs Squirrell admitted this charge on the completed Case Management Form. The panel found this charge proved.

Charge 14

"14) Your conduct in paragraph 13 above was dishonest in that you knew that you had not had one or more of the meetings as set out in that document and your actions were designed to mislead the NMC panel into believing that the entries in that document were genuine at the review hearing on 12 June 2019."

This charge is found PROVED.

In reaching this decision, the panel took into account the evidence of Witness 5. It bore in mind the evidence outlined above at charge 12.

The panel considered the evidence of Witness 5. In her witness statement she stated: *"Ms Squirrell also said that she had only met with [Ms 12] in relation to the supervision meetings on a couple of occasions… Ms Squirrell said that the rest of the dates were*

falsified. She said that she had spent the few days before the Interim Order hearing putting together these documents."

Witness 5 stated: *"I checked the dates in the MMA against the fire book (which every person has to sign when they come on shift) and the holiday rota and found them [Ms 12] and Ms Squirrell could not have met. For example on 9 January 2019, … they could not have met for the meeting because Ms Squirrell was not on shift…* Also on *21 May 2019, they could not have met because [Ms 12] was on annual leave on that date*." The panel bore in mind the exhibited text message from Ms 12 to Witness 5 confirming that she was not working on 21 May 2019. The panel took into account that it had no other documentary evidence to support that the other dates which Ms 12 and Mrs Squirrell allegedly met.

The panel also considered evidence that this document had not in fact been created until the 7 June 2019, on Ms 12's computer, four days before Mrs Squirrell's RCN representatives contacted the NMC.

The panel was of the view that Mrs Squirrell had provided documents to her RCN representatives which she knew to be false and which misled the NMC's Investigations Committee considering the interim order that had been imposed on her nursing practise. The panel did not accept that Mrs Squirrell had misremembered the dates of meeting with Ms 12 and was of the view that Mrs Squirell knew that they did not take place. The panel concluded that there was no other plausible explanation for the events that transpired as outlined in the charge. The panel therefore found this charge proved on the balance of probabilities.

Charge 15

> "15) On 14 June 2019 failed to administer, or alternatively failed to record the administration of, paracetamol to Patient E at 5pm."

This charge is found PROVED.

In reaching this decision, the panel took into account the evidence of Witness 8.

The panel considered the evidence of Witness 8. It took into consideration the documentary evidence she exhibited including the copies of *"the fire book which is signed when staff members come in and out of the Home"* and noted that Mrs Squirrell entered the Home at 14:00 hours. The panel also considered the MAR chart of Patient E and noted the empty box for paracetamol for 14 June 2019 at 5pm.

The panel bore in mind the hearsay witness statement of Witness 8, which stated: *"On 14 June 2019, at the time of the missed medications / failure to record the administration of medications, Ms Squirrell would have been the nurse in charge. I was also in the building until 6pm completing additional duties which included catching up with my paperwork which meant that I was not on clinical duty or responsible for caring for the residents."*

The panel was satisfied that Mrs Squirrell had a responsibility to administer the medication to Patient E and failed to do so. The panel therefore found this charge proved on the balance of probabilities.

Charge 16

> "16) On 22 June 2019 failed to administer, or alternatively failed to record the administration of, Hypromellose eye drops to Patient F at 12pm and/or 5pm"

This charge is found PROVED (in respect of the 12pm administration only).

In reaching this decision, the panel took into account the evidence of Witness 5 and Witness 8.

The panel bore in mind that Witness 5 exhibited a documented called ‘Documents showing Ms Squirrell was the only nurse on shift on the relevant date’. The panel noted that on this document, on the date 22 June 2019 next to Mrs Squirrell’s name, “8.15 - 15.30” has been recorded.

The panel took into consideration that Witness 5 and Witness 8 in their respective NMC witness statements noted that Mrs Squirrell was the only nurse on shift and available to administer the Hypromellose eye drops to Patient F at the times outlined. Consequently, the panel found that there was a duty on Mrs Squirrell to administer the Hypromellose eye drops to Patient F.

The panel considered the MAR chart of Patient F and noted the empty boxes at 12pm and 5pm for the Hypromellose eye drops. The panel bore in mind that Ms Squirrell was not physically in the building at 5pm and would not have been able to administer the Hypromellose eye drops at 5pm to Patient E.

The panel therefore found that it was more likely than not that Ms Squirrell had failed to administer the Hypromellose eye drops to Patient F at 12pm based on the contemporaneous documentation made at the time. The panel therefore found this charge proved in respect of the administration of the Hypromellose eye drops to Patient F at 12pm and not 5pm.

Charge 17

> “17) On 22 June 2019 in respect of Patient G failed to administer, or alternatively failed to record the administration of:
>
> a) Ramipril at 8am;
> b) Ranitidine at 8am and/or 5pm”

These charges are found NOT PROVED.

The panel considered these charges together. In reaching this decision, the panel took into account the hearsay evidence of Witness 8 and the documentary evidence of Witness 5.

The panel bore in mind that Witness 5 exhibited a documented called 'Documents showing Ms Squirrell was the only nurse on shift on the relevant date'. The panel noted that on this document, on the date 22 June 2019 next to Mrs Squirrell's name, "8.15 - 15.30" has been recorded.

The panel considered the hearsay witness statement of Witness 8. It noted that she stated: *"On 22 June 2019, Ms Squirrell was the only nurse on shift."* The panel noted that Witness 8's statement did not clarify the times that Mrs Squirrell would have been expected to be in the building for her shift.

The panel bore in mind that it did not have the opportunity to hear live evidence from Witness 8 nor was it able to ask her questions, specifically if Mrs Squirrell arrived at the Home at 8.15am for her shift, would there still be an expectation that she was required to administer the medication to Patient G as outlined in the charge. The panel considered the fairness to Mrs Squirrell that it could not test Witness 8's evidence and determined to treat Witness 8's evidence with caution.

The panel considered the evidence before it and determined that it was not satisfied that Mrs Squirrell had a duty to administer Patient G's Ramipril at 8am and their Ranitidine at 8am and/or 5pm as she was not physically in the Home at those times. The panel therefore found both 17a and 17b of this charge not proved on the balance of probabilities.

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 Squirrell'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 suitability to remain on the register unrestricted.

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

Submissions on misconduct

Ms Marcelle-Brown referred the panel 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 Marcelle-Brown 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 Marcelle-Brown identified the specific, relevant standards where Mrs Squirrell's actions amounted to misconduct. She submitted that the misconduct must be serious. She noted that the charges are wide ranging and relate to medication administration, record keeping, honesty and integrity as well as general professionalism concerns. She reminded the panel of the charges found proved. She submitted that Mrs Squirrell's conduct has damaged the public's trust in the nursing profession, had caused a serious risk of harm to

patients and noted that she had not been candid about the mistakes that had taken place. She invited the panel to look at the relevant NMC fitness to practice guidance.

Submissions on impairment

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

Ms Marcelle-Brown submitted that there was a risk of repetition in this case, which presents a risk to public protection and invited to the panel to make a finding of impairment. She drew the panel's attention to Mrs Squirrell's lack of engagement, lack of insight and the absence of any evidence of strengthened practice or remediation. She submitted that Mrs Squirrell had not looked at the allegations objectively to understand what had gone wrong and what she could have done differently in the circumstances. She invited the panel to look at the relevant NMC fitness to practice guidance.

The panel accepted the advice of the legal assessor which included reference to the judgment of *CHRE v NMC and Grant.*

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 considered the misconduct of each charge found proved in turn.

The panel first considered charge 1. The panel took into consideration that Mrs Squirrell had been reported as smoking an e-cigarette on one occasion and this conduct had not been repeated. The determined that Mrs Squirrell's actions in charge 1 were a serious departure from the standards expected from registered nurses however the panel was of the view Mrs Squirrell's conduct in this charge, taken in isolation, did not amount to misconduct.

The panel next considered charge 2 and noted that there was no evidence that Mrs Squirrell had completed any basic checks to verify the patient prior to administering the IV medication. The panel noted that there was no evidence of actual harm caused to the patient in this instance but that there was a clear risk to the patient. The panel took into consideration that it heard no evidence of any extenuating circumstances. The panel was of the view Mrs Squirrell had a duty of care to ensure that she administered the IV medication to the correct patient. The panel was of the view that Mrs Squirrell's conduct was a serious departure from the standard expected of a registered nurse and was satisfied that Mrs Squirrell's actions in this charge amounted to serious misconduct.

The panel considered charges 3 and 4 together. It noted that there was a clear risk to the patient. The panel took into consideration its findings at the facts stage which included Mrs Squirrell's deliberate acts of dishonesty and determined she put her needs above that of her patient. The panel noted that Mrs Squirrell's colleagues were not provided with accurate information and therefore could not provide the appropriate treatment for the patient. The panel was of the view that Mrs Squirrell's behaviour in these charges was highly reprehensible and completely unacceptable. Consequently, the panel determined that Mrs Squirrell's actions fell far below the standards expected of a registered nurse and breached the fundamental tenets of nursing and amounted to serious misconduct.

The panel next considered charges 5 and 6. It noted that Mrs Squirrell had told Patient B that she had administered her medication when she had not. The panel found that Mrs Squirrell's dishonest behaviour in falsifying the patient records compounded her conduct as outlined in charges 5b and 5c. The panel was of the view that Mrs Squirrell's conduct

made Patient B feel uncertain and unsafe with the care that she had received, and that Mrs Squirrell had not carried out her duty of care to Patient B. The panel was of the view that Mrs Squirrell had a duty of candour to Patient B to be honest about the care she had received. The panel also took into consideration the impact of Mrs Squirrell's conduct on her colleagues and whether their confidence on the entries she made on patient records would be jeopardised. It also considered the impact that this would have on the reputation of the nursing profession. The panel determined that Mrs Squirrell's conduct in these charges fell below the standard expected of a registered nurse and amounted to serious misconduct.

With regard to charges 7 and 8, the panel considered that Mrs Squirrell had failed to practice within her limitations. The panel noted that it heard oral evidence from Colleague 1 that consequence of Mrs Squirrell's actions in charge 7 were likely to have had an adverse impact on the experience at the end of the patient's life. The panel also bore in mind the position Mrs Squirrell placed her colleagues in, by not seeking their assistance and completing MAR charts dishonestly. It also considered the impact that Mrs Squirrell's actions would have on the reputation of the nursing profession. The panel determined that Mrs Squirrell's conduct in these charges was a serious departure from the standards expected of a registered nurse and amounted to serious misconduct.

The panel next considered charge 10 and that Mrs Squirrell administered medication to a patient unsupervised, in beach of her ICOPO. The panel bore in mind that the interim ICOPO had been imposed to protect the public and that Mrs Squirrell had decided to ignore it. The panel was of the view that Mrs Squirrell's conduct in this charge was deplorable as she had deliberately subverted the protections instigated by her regulator. The panel was of the view that an informed member of the public would be appalled to learn of Mrs Squirrell's conduct and considered that it was a serious departure from the standards expected of a registered nurse and amounted to serious misconduct.

The panel took into consideration charges 11, 12, 13 and 14. It noted that Mrs Squirrell had provided falsified documents to her regulator and her legal representative. She had

consciously and deliberately crafted these documents to mislead her regulator. The panel determined that Mrs Squirrell had put her needs above the safety of her patients and the wider public. Consequently, the panel found that Mrs Squirrell's conduct in these charges were matters of the utmost seriousness and represented a grave departure from the standards expected of a registered nurse and amounted to very serious misconduct.

The panel considered charge 15 and was of the view that taken on its own, this represented a departure from the accepted standards of care. However, it did not meet the threshold of misconduct.

Finally, the panel considered charge 16 and was of the view that taken on its own, this represented a departure from the accepted standards of care. However, it did not meet the threshold of misconduct.

The panel went on to consider the failures within the charges found proved and noted that there were three identifiable areas of regulatory concern regarding Mrs Squirrell's nursing practice and conduct.

The panel noted that charges 2, 5, 6, 7a, 7b, 7c, 10, 15 and 16, all related to poor practice of administration of medication and collectively amounted to serious misconduct.

The panel noted that charges 3, 4, 6 and 8 related to dishonesty regarding the clinical care that she delivered to patients and found that collectively that these amounted to serious misconduct.

The panel noted that in charges 11, 12, 13 and 14, Mrs Squirrell failed to comply with the ICOPO and the associated dishonesty when dealing with her regulator. The panel was of the view that collectively these charges amounted to a grave departure from the acceptable standards of a registered nurse and amounted to serious misconduct. The panel was therefore of the view that Mrs Squirrell's actions did fall significantly short of the

standards expected of a registered nurse, and that Mrs Squirrell's actions amounted to a breach of the Code. Specifically:

*'**1 Treat people as individuals and uphold their dignity***

To achieve this, you must:

1.1 treat people with kindness, respect and compassion

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

3 Make sure that people's physical, social and psychological needs are assessed and responded to

To achieve this, you must:

3.1 pay special attention to promoting wellbeing, preventing ill health and meeting the changing health and care needs of people during all life stages

4 Act in best interests of people at all times

10 Keep clear and accurate records relevant to your practice

To achieve this, you must:

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

13 Recognise and work within the limits of your competence

To achieve this, you must:

13.1 accurately identify, observe and assess signs of normal or worsening physical and mental health in the person receiving care

13.3 ask for help from a suitably qualified and experienced professional to carry out any action or procedure that is beyond the limits of your competence

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:

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

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

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

18 Advise on, prescribe, supply, dispense or administer medicines within the limits of your training and competence, the law, our guidance and other relevant policies, guidance and regulations

19 Be aware of, and reduce as far as possible, any potential for harm associated with your practice

To achieve this, you must:

19.1 take measures to reduce as far as possible, the likelihood of mistakes, near misses, harm and the effect of harm if it takes place

20 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

20.4 keep to the laws of the country in which you are practising

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

23 Cooperate with all investigations and audits

To achieve this, you must:

23.1 cooperate with any audits of training records, registration records or other relevant audits that we may want to carry out to make sure you are still fit to practise'

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 Squirrell'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 Squirrell's fitness to practise is currently impaired.

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. To justify that trust, nurses must be honest 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 were satisfied that all four limbs of the Grant test were engaged. The panel finds that patients were both caused harm and put at risk of harm as a result of Mrs Squirrell's misconduct at different workplaces. Mrs Squirrell's misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. It was satisfied that confidence in the nursing profession would be undermined if its regulator did not find charges relating to the repeated instances of very serious dishonesty within which Mrs Squirrell subverted the instructions of her regulator.

Regarding insight, the panel considered that Mrs Squirrell had shown limited remorse. The panel bore in mind that where apologies had been offered they had been alongside dishonest conduct in which she attempted to deflect and deceive colleagues. It noted that she had not accepted all of the regulatory concerns and had stopped engaging with the NMC. Mrs Squirrell had provided no evidence or material to the panel regarding what happened, what she could do differently, how she would approach similar circumstances in the future and how her actions impacted on patients and her colleagues.

The panel carefully considered the evidence before it in determining whether or not Mrs Squirrell has taken steps to strengthen her practice. The panel took into account that it had no relevant training or the reflective piece addressing the concerns outlined in the charges.

The panel bore in mind that by falsifying documents and causing them to be provided to the NMC's Investigating Committee was a dishonesty which would be difficult to remediate. Subsequently, this panel had doubts as to whether Mrs Squirrell could be effectively regulated. The panel was of the view that an informed member of the public would be concerned to learn that a nurse who had not complied with restrictions imposed on their practice was not found to be impaired.

The panel is of the view that there is a risk of repetition based on Mrs Squirrell's lack of insight and lack of strengthened practice. The panel noted that here was nothing before it that indicated that the level of risk had reduced since the allegations had first come to light and was of the view that the conduct that was demonstrated in the past was likely to be repeated in the future. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

The panel bore in mind that the overarching objectives of the NMC; to protect, promote and maintain the health, safety, and well-being of the public and patients, and to uphold and protect the wider public interest. This includes promoting and maintaining public

confidence in the nursing and midwifery professions and upholding the proper professional standards for members of those professions.

The panel 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 Squirrell's fitness to practise impaired on the grounds of public interest.

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

Sanction

The panel has considered this case very carefully and has decided to make a striking-off order. It directs the registrar to strike Mrs Squirrell off the register. The effect of this order is that the NMC register will show that Mrs Squirrell 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 careful regard to the Sanctions Guidance (SG) published by the NMC. The panel accepted the advice of the legal assessor.

Submissions on sanction

Ms Marcelle-Brown informed the panel that in the Notice of Hearing, dated 11 August 2022, the NMC had advised Mrs Squirrell that it would seek the imposition of a striking off order if it found Mrs Squirrell's fitness to practise currently impaired. She provided aggravating and mitigating features of this case. Ms Marcelle-Brown took the panel through the other sanctions available to the panel and provided reasons as to why those were inappropriate.

Ms Marcelle-Brown submitted that a striking off order was appropriate in these circumstances as the facts found proved and Mrs Squirrell's disengagement demonstrated

a clear disregard from Mrs Squirrell for her regulator. She submitted that the charges concerning dishonesty are serious. Further, she submitted that an informed member of the public would be concerned to learn that a registrant, who practised in breach of their interim order and who had provided misleading information to a panel reviewing the interim order, was not removed from the NMC register. She submitted that the member of the public would be concerned not only in the standards of the regulator but also the wider nursing profession. She submitted that Mrs Squirrell's misconduct is extensive and deep rooted and as a consequence it should be marked with a strike off order. She invited the panel to consider the various NMC guidance regarding sanction and seriousness.

Decision and reasons on sanction

Having found Mrs Squirrell'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:

- Mrs Squirrell's dishonesty and misconduct which put patients at risk of harm.
- Mrs Squirrell demonstrated a pattern of conduct of putting patients at risk of harm over a period of time and across different employers.
- Mrs Squirrell put other registered nurses in difficulties by seeking to conceal her failings in patients care and by disregarding the restrictions on her practice.
- Mrs Squirrell's lack of insight.

The panel bore in mind that there were some indications of Mrs Squirrell's difficult personal circumstances. The panel was of the view that the information it had sight of had little effect on the mitigation with regard to the seriousness of the charges.

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 decided that taking no action would not protect the public.

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 Squirrell'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 Squirrell'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 Squirrell'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, which would manage the risk arising from many of the charges in this case. Not all the misconduct identified in this case was something that could be addressed through retraining. Furthermore, the panel concluded that the placing of conditions on Mrs Squirrell's registration would not adequately address the seriousness of this case and would not protect the public. It noted that public confidence would be undermined if a conditions of practice order was imposed given that an interim conditions of practice order has previously been imposed and Mrs Squirrell has not adhered to it, and as such, Mrs Squirrell has shown a disregard for the safety measures imposed by her regulator. It noted that Mrs Squirrell had acted in a way that was fundamentally inconsistent with what would be expected from a registered nurse. Further, the panel bore in mind that it had no assurances before it that Mrs Squirrell would adhere to conditions of practice in her future nursing career.

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; and*
- *The Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour.*

The misconduct in this case is very serious and was a significant departure from the standards expected of a registered nurse. The panel noted that there were multiple instances of dishonesty and, this indicated a deep-seated attitudinal problem. It noted that Mrs Squirrell's repeated her misconduct of medication administration errors at two different workplaces. The panel bore in mind that Mrs Squirrell has not engaged with the NMC hearing, and it therefore has no recent information regarding her insight. It concluded that Mrs Squirrell lacked insight. The panel noted that the serious breach of the fundamental tenets of the profession evidenced by Mrs Squirrell's actions is fundamentally incompatible with Mrs Squirrell 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?*

The panel also took into consideration SAN-2, the NMC guidance for "Considering sanctions for serious cases", and found that the following points were engaged in this case:

> *"In every case, the Fitness to Practise Committee must carefully consider the kind of dishonest conduct. Not all dishonesty is equally serious. Generally, the forms of dishonesty which are most likely to call into question whether a nurse, midwife or nursing associate should be allowed to remain on the register will involve:*
>
> - *deliberately breaching the professional duty of candour by covering up when things have gone wrong, especially if it could cause harm to patients*
> - *…*
> - *vulnerable victims*
> - *…*
> - *direct risk to patients*
> - *premeditated, systematic or longstanding deception"*

The panel determined that Mrs Squirrell's dishonesty was very serious. Mrs Squirrell'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 was of the view that the findings in this particular case demonstrate that Mrs Squirrell'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 Squirrell's actions in bringing the profession into disrepute by adversely affecting the public's view of how a registered nurse should conduct herself, the panel has concluded that nothing short of this would be sufficient in this case.

The panel considered that this order was necessary to mark the importance of maintaining public confidence in the profession, and to send to the public and the profession a clear message about the standard of behaviour required of a registered nurse.

This will be confirmed to Mrs Squirrell 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 Squirrell's own interest 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 Marcelle-Brown. She submitted that the panel should have regard to Rule 32(5) of the Rules. She submitted that an interim order was necessary to address the risk to public and to uphold the confidence in profession. She informed the panel that the sanction which it has imposed would not take effect for 28 days. She invited the panel to consider the NMC's SAN-5 guidance for

‘Interim orders after a sanction is imposed’. She submitted that an 18 month interim order would address the risks identified by the panel and cover any potential period of appeal.

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 due to period of appeal available to Mrs Squirrell.

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

That concludes this determination.