Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 5 January 2026 – Friday, 9 January 2026;
Monday, 12 January 2026 – Friday, 16 January 2026
Tuesday, 07 April 2026-Friday, 10 April 2026

Virtual Hearing

Name of Registrant:	**Kate Sullivan**
NMC PIN	16G0174W
Part(s) of the register:	Nursing Sub Part 1 RNMH - Registered Nurse - Mental Health - 2 September 2016
Relevant Location:	Neath Port Talbot
Type of case:	Misconduct
Panel members:	Alisa Newman (Chair, Lay member) Angela Horsley (Registrant member) Lorraine Chalk (Lay member)
Legal Assessor:	Lucia Whittle-Martin
Hearings Coordinator:	Sabrina Khan (5 – 9 January 2026) Emily Mae Christie (12 January 2026) Fabbiha Ahmed (13 – 14 January 2026) Sabrina Khan (15-16 January 2026) Sabrina Khan (7 April 2026-10 April 2026)
Nursing and Midwifery Council:	Represented by Pamela Muniya, Case Presenter
Miss Sullivan:	Not present and not represented at this hearing
No evidence offered:	Charge 9d
Facts proved:	1a, 1b, 2a, 2b, 2c, 3a, 3b, 3c, 4a, 4b, 5, 6, 8a, 8c, 8f, 9a, 9b, 9c, 10a, 10b, and 10d.
Facts not proved:	7, 8b, 8d, 8e and 10c.
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 Miss Sullivan was not in attendance and that the Notice of Hearing letter had been sent to Miss Sullivan's registered email address by secure email on 27 November 2025.

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

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Hearing provided details of the allegation, the time, dates and that the hearing was to be held virtually, including instructions on how to join and, amongst other things, information about Miss Sullivan's right to attend, be represented and 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 Miss Sullivan has been served with the Notice of Hearing in accordance with the requirements of Rules 11 and 34.

Decision and reasons on application for the proceeding in absence application to be held in private

Ms Muniya made a request that the proceeding in absence application be held in private on the basis that details of the application would involve references to Miss Sullivan's [PRIVATE]. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (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 decided to hear the proceeding in absence application in private as it required a consideration of Miss Sullivan's [PRIVATE], which forms part of her private life and outweighs the public interest in hearing the application in public.

Decision and reasons on proceeding in the absence of Miss Sullivan

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

Ms Muniya referred the panel to an email dated 9 October 2025 sent to the NMC by Miss Sullivan's former legal representative at the Royal College of Nursing (RCN), attaching a letter from Miss Sullivan in which she explained that she did not wish to be contacted further, nor did she wish to engage with the process, due to ongoing [PRIVATE].

The panel accepted the advice of the legal assessor.

The panel noted that its discretionary power to proceed in the absence of a registrant under the provisions of Rule 21 is not absolute and is one that should be exercised *'with the utmost care and caution"*.

The panel decided to proceed in the absence of Miss Sullivan. In reaching this decision, the panel has considered the submissions of Ms Muniya and the advice of the legal assessor. It had particular regard to the factors set out in the decision *General Medical Council v Adeogba* [2016] EWCA Civ 162 and had regard to the overall interests of justice and fairness to all parties. It decided that:

- No application for an adjournment has been made by Miss Sullivan;

- Miss Sullivan has informed the NMC through her RCN representative, that she wishes all contact from the NMC with regards to this case to cease and that she will not be attending this hearing;
- There is no reason to suppose that adjourning would secure Miss Sullivan's attendance at some future date;
- Four witnesses have been scheduled to give live evidence for this hearing;
- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- The charges relate to events that occurred in October 2020-May 2022;
- 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.

The panel was mindful that there will likely be some disadvantage to Miss Sullivan in proceeding in her absence. Miss Sullivan will not be able to challenge the evidence relied upon by the NMC in person and is not here to give evidence on her own behalf albeit she has provided some written representation.

However, the panel decided that this disadvantage is outweighed by the other factors set out in bullet points above.

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

Details of charge

That you, a registered nurse:

1. On or after October 2020,
    a. were in a personal relationship with Colleague A.
    b. failed to disclose your relationship with Colleague A to your employer.

2. Engaged in sexual intercourse with Colleague A in the workplace, on
    a. 4 March 2021.
    b. 8 January 2022.
    c. 17 January 2022.

3. On or more occasions breached professional boundaries, in that you
    a. permitted Patient B to be in your office with you, without 2:1 supervision.
    b. hugged Patient B.
    c. permitted Patient B to call you '*babe*'.

4. On 22 March 2022 with Colleague A took Patient B for bloods leaving the ward without,
    a. sufficient male staffing numbers.
    b. managerial support.

5. On 2 May 2022 refused to examine Patient A.

6. Between 6 and 9 May 2022 refused tobacco or tobacco alternatives to Patient A.

7. On 21 May 2022 refused Patient C community leave without clinical justification.

8. On one or more occasions demonstrated poor leadership in that you,
    a. manipulated the rota and/or levels to work with Colleague A.
    b. went on breaks with Colleague A.

c. left the ward short-staffed by going to see Colleague A on their breaks.
d. gave Colleague A access to overtime shifts before others.
e. refused female colleagues time off in preference to male colleagues.
f. worked on 17 April 2022 when you were not required.

9. On one of more occasions failed to complete a Datix report and/or escalate incidents:
   a. when Patient B grabbed Colleague B from behind, and grinded against them for sexual gratification on 10 December 2021.
   b. when Patient A poked your thigh on 13 April 2022.
   c. when Patient B touched Colleague B's buttocks on 17 April 2022.
   d. when Patient D was calling Colleague C '*fat*', or words to that effect in April 2022.

10. On, one or more occasions behaved unprofessionally, in that you,
    a. criticised Colleague E's paperwork in front of others
    b. stated Colleague D was '*a lazy cunt, she's [Colleague D] left me to do this all alone',* or words to that effect
    c. stated '*I'm going to put her [Colleague F] with him, because she looks like a man and he won't fancy her'*, or words to that effect.
    d. breached colleagues' confidentiality by disclosing their sickness absence reasons.

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

Decision and reasons on application to offer no evidence in relation to charge 9d.

The panel heard an application made by Ms Muniya to offer no evidence in relation to charge 9d.

Ms Muniya submitted that by way of background, charge 9 concerns a series of alleged incidents in which Miss Sullivan is said to have failed to complete Datix

reports and/or to escalate incidents appropriately. Charge 9d relates to an alleged incident in April 2022 involving Patient D, who was said to have been calling Colleague C *'fat'* and that Miss Sullivan failed to complete a Datix report or escalate that incident.

Ms Muniya submitted that there is no direct witness statement from Colleague C. The NMC's case therefore relies on interview notes contained within Appendix 19 of the exhibit bundle, comprising notes of an interview conducted by Witness 4, the local investigating officer, when the concerns were reported following the ward manager's return to work.

Ms Muniya drew the panel's attention in particular to question 11 of that interview; In response, Colleague C stated that Patient D would constantly call her names, insult her and target her throughout the shift. She further stated that she told Miss Sullivan that Patient D was still targeting her and constantly calling her names. Colleague C said that she could not remember the exact words used by Miss Sullivan but recalled that Miss Sullivan brushed it off as nothing and did not offer any support. Colleague C went on to state that when the ward manager, returned to work from a period of absence, the issue was addressed on 25 May in a meeting involving Patient D and Miss Sullivan, and that Miss Sullivan had then suggested that she had not previously been made aware of Patient D's behaviour.

Ms Muniya further referred to Appendix 20, which contains interview notes between Witness 4 and Colleague D. At question 22, Colleague D stated that Colleague C had a really difficult patient at the time and had approached Miss Sullivan on a few occasions for supervision, and that Miss Sullivan had been quite dismissive of her.

Ms Muniya submitted that this represents the full extent of the evidence from these two individuals, neither of whom will be called as live witnesses in these proceedings.

Ms Muniya then referred the panel to the witness statement of Colleague B. Colleague B stated that Patient E, was bullying a student by calling her fat and making comments about the weight of members of staff. Colleague B did not name

the student concerned and expressly stated that she could not remember who the comments were directed towards, noting that there were many students on the ward at the relevant time.

Ms Muniya submitted that Colleague C is not a live witness in these proceedings and, as such, the NMC is unable to clarify what specific comments were allegedly made by Patient D. The panel will have noted that in her interview response to question 11, Colleague C made no specific reference to the word "*fat*" or to any particular terminology used by the patient.

Against that evidential background, Ms Muniya submitted that the NMC seeks to offer no evidence in relation to charge 9d because it does not materially add to the seriousness of the case in respect of Miss Sullivan's alleged failures to complete Datix reports or to escalate incidents. She submitted that the evidence of Colleague B's witness statement is vague and could relate to any member of staff, and that to treat it as corroborative of Colleague C's account would require the panel to engage in speculation. In effect, the NMC would be inviting the panel to assume that Colleague B was referring to the same incident involving Colleague C, which, in the circumstances, may be unfair.

Ms Muniya further submitted that the incident alleged at charge 9d was not specifically considered by the Case Examiners when they determined the concerns on 6 August 2024 in relation to poor leadership and/or management, including alleged failures in line and staff management and the use of derogatory or offensive language. Accordingly, charge 9d was not one of the specific allegations underpinning the Case Examiners' decision.

Finally, Ms Muniya submitted that the remaining charges, namely charges 9a to 9c, properly reflect the extent of the NMC's concerns regarding Miss Sullivan's alleged failure to report or escalate incidents. Those charges adequately capture the alleged risk of harm to patients and the wider public interest considerations, including public confidence in the nursing profession, which the panel will consider at the appropriate stage.

For all of those reasons, Ms Muniya submitted that the NMC applies to offer no evidence in relation to charge 9d only.

The panel accepted the advice of the legal assessor.

The panel considered the application by the NMC to offer no evidence in relation to charge 9d.

The panel reminded itself that the burden of proof rests on the NMC and that it must be satisfied that there is a realistic prospect of the charge being proved on the evidence available.

In considering the evidence relevant to charge 9d, the panel noted that it is not clear from the witness statements who the alleged comment was directed towards. In particular, the evidence does not clearly establish to whom the comment was made. The panel also noted that the precise wording of the alleged comment is uncertain. Whilst reference is made to words "*to that effect*", there is no clear evidence that the specific word "*fat*" was used, or in what context.

The panel observed that there is no direct witness statement addressing charge 9d and no live witness evidence capable of clarifying the allegation. The written evidence that is available does not specify to whom the comment was made and is vague in nature. As such, the panel concluded that the evidence lacks the clarity and specificity required to establish the allegation to the requisite standard.

The panel further agreed that charge 9d does not add materially to the overall seriousness of the charges it has been asked to consider. The remaining allegations adequately reflect the nature and extent of the concerns raised by the NMC. In those circumstances, the continuation of charge 9d would not assist the panel and would risk unfairness to Miss Sullivan.

The panel also noted the practical difficulties encountered when reviewing the documentary evidence and accepted that, even with careful scrutiny, the evidential basis for charge 9d could not be clearly identified or substantiated.

Having taken all these matters into account, the panel determined that there is no realistic prospect of charge 9d being proved. The panel therefore accepted the NMC's application to offer no evidence in relation to charge 9d.

Decision and reasons on application to admit hearsay evidence

The panel heard an application made by Ms Muniya under Rule 31 to allow the following written statements and local investigation interview notes into evidence:

- Colleague G's local statement, dated 9 June 2022;
- Local investigation interview notes with Colleague G, dated 18 October 2022;
- Colleague E's local statement;
- Local investigation interview notes with Colleague E, dated 25 October 2022;
- Colleague F's local statement;
- Local investigation interview notes with Colleague F, dated 19 October 2022;
- Local investigation interview notes with Ms 1, dated 6 October 2022;
- Local investigation interview notes with Colleague D, dated 22 November 2022; and
- Local investigation interview notes with Colleague C, dated 21 November 2022.

Ms Muniya provided the panel with written submissions and supplemented these with oral submissions. She referred the panel to the case of *Thorneycroft v NMC* [2014] EWHC 1565.

Ms Muniya submitted that no statement had been sought from any of these individuals on behalf of the NMC. She submitted that it would not be practical or proportionate to require these individuals to attend and give evidence in these proceedings, as they are medical professionals working within the same ward, meaning their absence from clinical duties to give oral evidence before the panel would cause unnecessary disruption to patient care. Additionally, she submitted that their accounts largely replicate evidence already before the panel, either through live

evidence or in documentary records. In light of this, Ms Muniya submitted that admitting the hearsay evidence was necessary and fair.

In relation to the nature and extent of any challenge to the statements, Ms Muniya submitted that these are serious allegations; however, Miss Sullivan has made little to no challenge to the nature of the concerns. Ms Muniya submitted that there is no evidence before the panel to suggest that any of the statements or interview notes are fabricated, and there is no plausible reason for these individuals to lie.

Ms Muniya went on to address the panel in respect of the evidence of each charge.

Charges 1a and 1b

Ms Muniya submitted that Colleague D and Ms 1's evidence is relevant in relation to charges 1a and 1b as it deals with the issue regarding whether they had knowledge of or received disclosure of the personal relationship between Miss Sullivan and Colleague A. She submitted that whilst this evidence is relevant to charges 1a and 1b, it is not the sole or decisive evidence of either charge, as the panel has heard live evidence from Witnesses 1, 2, and 3, and it has access to the text messages, the *'Personal Relationships at Work'* policy and Appendix 47.

Charge 5

Ms Muniya submitted that Colleague E's evidence is relevant to charge 5 as it relates to the argument that Miss Sullivan asked two nurses, including Colleague E to attend to Patient A. She submitted that Colleague E's evidence corroborates the live evidence of Witness 3 and is therefore not the sole or decisive evidence to charge 5.

Charge 6

Ms Muniya submitted that Colleague F's evidence is relevant in relation to charge 6 and supports the evidence of Witness 3 as well as Patient A's notes during 6th May to 9th May 2022, and the account given by Colleague B. She submitted that whilst

this evidence is relevant to charge 6, it is not the sole or decisive evidence of either charge, as the panel has heard live evidence from Colleague B and 3, as well as Patient A's clinical notes.

Charge 7

Ms Muniya submitted that Colleague F's evidence is relevant in relation to charge 7 and is the sole and decisive evidence of this charge. She submitted that Colleague F's statement provides the only detailed, contemporaneous account of the incident and describes how Colleague A was allocated to escort Patient C on planned community leave, but Miss Sullivan refused this leave without any clinical justification. Although this is the only direct account for this charge, it is corroborated by Patient C's paperwork.

In relation to this charge, Ms Muniya submitted that admitting Colleague F's evidence as hearsay is both necessary and fair. She submitted that this allegation is only disputed in a limited way, and the fact of refusal is accepted. Furthermore, she submitted that Colleague F's account is highly relevant and goes to the heart of whether Miss Sullivan acted without clinical justification. Ms Muniya submitted that there would be no unfairness in admitting this hearsay because the panel are invited to weigh it alongside Miss Sullivan's own interview responses and the investigation evidence provided by Witness 4. She submitted that without Colleague F's statement, the panel would lack the only detailed narrative of the incident, making it unlikely that Charge 7 could be properly proved.

Charges 8(a), 8(b), 8(c), 8(d), 8(e) and 8(f)

Ms Muniya submitted that the evidence of Colleague G is relevant to charges 8(a), 8(b), 8(c), 8(d), 8(e) and 8(f), and referred the panel to a number of sections of his statement which refer to concerns about rota manipulation; going on breaks with Colleague A and leaving wards short-staffed; preferential treatment and derogatory comments. Further, she submitted that the evidence of Colleague E is also relevant to these charges, and she referred the panel to relevant sections of her statement. Ms Muniya submitted that the evidence of Colleague G and Colleague E is not the

sole or decisive evidence for these charges, as the panel have already heard live evidence from Witnesses 1, 2, and 3.

Charges 9(a), 9(b), and 9(c)

Ms Muniya submitted that the evidence of Ms 1 is relevant in relation to charges 9(a), 9(b), and 9(c) as it details her perspective regarding incident reporting as the ward manager. Additionally, she submitted that the evidence of Colleague E is relevant in relation to charge 9b as she was an eyewitness to the incident where Patient A poked Miss Sullivan on the thigh on 13 April 2022. She submitted that the evidence of both Ms 1 and Colleague E is not the sole or decisive evidence of these charges, as the panel has heard live evidence from Colleague B, as well as having access to Patient A's clinical notes.

Charge 10(b)

Ms Muniya submitted that the evidence of Colleague G is relevant to charge 10(b) as he directly addresses the concern in his evidence. She submitted that Colleague G's evidence is not the sole or decisive evidence of this charge as the panel have already heard live evidence from Colleague B, who provided it with direct evidence.

Charge 10(d)

Ms Muniya submitted that the evidence of Colleague G is relevant to charge 10(d) as he addresses the concerns within the charge. Additionally, she submitted that the evidence of Colleague F is also relevant, as she explained that she witnessed Miss Sullivan speaking about colleagues' confidential information, including reasons why people are off sick.

Ms Muniya submitted that the hearsay evidence of Colleague G and Colleague F should be balanced alongside Miss Sullivan's responses, where she has openly admitted to it. Ms Muniya submitted that there is no unfairness in admitting this evidence as hearsay in respect of charge 10(d) as the panel can weigh it alongside Miss Sullivan's own responses.

Evidence of Colleague C

Colleague C was a band 5 mental health nurse who worked on the ward with Miss Sullivan. Although her evidence is no longer relevant to a specific charge, it is highly relevant to the panel's consideration of Miss Sullivan's conduct towards staff and, in particular, her treatment towards newly qualified staff and those she mentored.

Ms Muniya submitted that if the panel were to admit this evidence as hearsay, it would not create any prejudice to Miss Sullivan, as she has had a fair opportunity during the local investigation to respond to the allegations. Although this evidence cannot be tested through cross-examination, Ms Muniya submitted that Miss Sullivan has voluntarily absented herself from the proceedings and withdrawn her representation, meaning that she would not have cross-examined these individuals in any circumstance. Ms Muniya submitted that any concerns can be mitigated by the panel's ability to determine the appropriate weight to attach to the hearsay evidence after admission.

In conclusion, Ms Muniya invited the panel to admit all the evidence listed above as hearsay.

The panel heard and accepted the legal assessor's advice on the issues it should take into consideration in respect of this application. The legal assessor drew the panels attention to the following authorities: *NMC v. Ogbonna* [2010] EWCA Civ 1216, *R (Bonhoffer) v GMC* [2012] IRLR 37, *Thorneycroft v. Nursing and Midwifery Council* [2014] EWHC 1565 (Admin), The legal assessor referred to Rule 31 which provides that, so far as it is 'fair and relevant', a panel may accept evidence in a range of forms and circumstances, whether or not it is admissible in civil proceedings. The panel also had regard to NMC Guidance 'DMA-6' Evidence as well as the guidance set out in *Thorneycroft,* which sets out that the admission of hearsay is not a routine matter and identifies a number of factors to be considered, including:

- *Whether the statement is the sole and decisive evidence in support of the charges;*

- *The nature and extent of the challenge to the contents of the statement;*
- *Whether there was any suggestion that the witness had reason to fabricate their allegation;*
- *The seriousness of the charge, taking into account the impact which adverse findings might have on the registrant's career;*
- *Whether there was a good reason for the non-attendance of the witness;*
- *Whether the regulator had taken reasonable steps to secure the witness's attendance; and*
- *Whether the registrant did not have prior notice that the witness statement would be read.*

The panel then considered each witness, applying the factors set out in Thorneycroft and the tests of relevance and fairness under Rule 31.

Colleague G

The panel considered that Colleague G's evidence arises from a local statement and local investigation. It noted that his account is relevant to its consideration to Charges 1(a), 8 (a),8(b),8(c),8(d)8(e),8(f),10(b) and 10(d). It also noted that Colleague G's account is broadly consistent with other material before it.

The panel took into account that Colleague G is not the sole witness to the events in relation to the Charges 1(a), 8 (a),8(b),8(c),8(d)8(e),8(f),10(b) and 10(d). It considered that there is other evidence, including the written and oral evidence from Witness 1, 2 and 3. The panel concluded that Colleague G's evidence is therefore not sole or decisive.

The panel noted that certain aspects of Colleague G's account appears not to be disputed by Miss Sullivan in relation to Charge 1(a) and partially to Charge 8(a). The panel noted that Miss Sullivan does deny the other charges that this witness speaks to. However, the panel considered that Miss Sullivan had been provided with Colleague G's account in advance and had not brought any specific challenge to the

accuracy of Colleague G's statement. In addition, no complaint has been raised about the manner in which it was obtained, and there is no suggestion of fabrication.

The panel noted that no active steps were taken by the NMC to secure Colleague G's attendance, on the basis that it was not anticipated or intended to call on this witness, as it was supported by other primary materials. The panel accepted that, in circumstances where Colleague G's evidence is not sole or decisive and is merely supportive of other evidence.

The panel recognised that the charges that Colleague G's evidence speaks to are serious and can carry potentially serious consequences for Miss Sullivan's career if found proved. It was of the view that to admit Colleague G's account into evidence would not unfairly prejudice Miss Sullivan, given that the evidence is not sole or decisive, is partly supported by Miss Sullivans account, and is corroborated by independent material. The panel noted that the limitations in Colleague G's not attending the hearing to give live oral evidence can be adequately balanced and reflected in the weight the panel attaches to his statement.

Taking all the above into account, the panel determined that Colleague G's hearsay evidence is relevant and that it is fair to admit under Rule 31.

Colleague E

The panel considered that Colleague E's hearsay evidence relates to Charges 4, 5 9(b) and 10(d). It took into account that Colleague E provides further detail as to what occurred and the context around these Charges and supports the live evidence of Colleague B and 3. The panel took into account that Colleague E provides further details as to what occurred and was satisfied that Colleague E's evidence is relevant.

The panel noted that Colleague E's account is not the only evidence before it, and that it has the benefit of other witness accounts and documentary records of patient notes in relation to the same events. The panel concluded that Colleague E's evidence is therefore not sole or decisive in nature.

The panel noted that although Miss Sullivan provides an alternative account for her actions in respect to Charges 4, 5 and 9(b) she has not disputed the underlying events.

The panel noted that Colleague E's account appears not to be contested by Miss Sullivan and that an explanation was provided by her in relation to Colleague E's evidence. The panel considered that Miss Sullivan has been provided with Colleague E's account in advance. No specific challenge has been made to Colleague E's account, and there is no material before the panel suggesting that Colleague E had any motive to fabricate her account.

The panel accepted the NMC's position which mirrors their position in relation to Colleague G, in that no attempts were made to secure Colleague E's attendance, given that the evidence was not anticipated to be disputed and was supported by other material. The panel accepted this explanation.

The panel noted that the charges that Colleague E speaks to are serious and carry potentially serious consequences for Miss Sullivan's career if found proved. It was of the view that, to admit Colleague E's account into evidence would not unfairly prejudice Miss Sullivan, given that the evidence is not sole or decisive, is not contested by her and is corroborated by live evidence. The panel noted that the limitations of Colleague E not being called to give live oral evidence can be balanced against the other evidence before it.

Taking all the above into account, the panel determined that Colleague E's hearsay evidence is relevant and that it is fair to admit under Rule 31.

Colleague F

The panel considered that Colleague F provides a contemporaneous account of events within her local statement and is relevant to Charge 7, including the context and reasoning of what occurred.

The panel took into account that it is accepted on behalf of the NMC that Colleague F's evidence is the sole evidence in relation to this charge. Whilst the panel note that it is not disputed that Patient C's community leave was cancelled the reasons Miss Sullivan noted for cancelling it is at odds with Colleague F's account. The panel recognised that the charge that Colleague F's evidence speaks to is serious and can carry potentially consequences for Miss Sullivan's reputation and career if found proved.

The panel noted the submissions put forward on behalf of the NMC, that no active steps were taken by the NMC to secure Colleague F's attendance, on the basis that it would absent her from clinical duties, cause unnecessary disruption to patient care and place an undue burden on health care resources. However, it noted that there was no evidence before it to support the suggestion that Colleague F is currently working on the same ward, some three and a half years later, and that the consequences relied on would necessarily result from a day's absence on her part. It also noted that there is no evidence before it to suggest that Colleague F was not willing to give a statement to the NMC and attend this hearing to give live evidence. Notwithstanding Miss Sullivan's absence at this hearing the non-attendance of Colleague F, who provides the sole evidence of this charge, means that the disputed evidence cannot be tested in live testimony.

Taking all the above into account, the panel considered that give the seriousness of the charge, the nature of the evidence that this witness provides and the extent to which it is disputed, the reasons provided by the NMC for Colleague F's non-attendance is not acceptable. It determined that it would be entirely unfair and prejudicial to Miss Sullivan to allow this evidence in as hearsay.

The application in respect of Colleague F is therefore refused, and Colleague F's evidence will not be admitted as hearsay.

Ms 1

The panel considered that Ms 1's hearsay evidence speaks in general terms to the policy at the Trust and relates to Charges 1(a) and 6. The panel also noted that this

Witness speaks to the process around Datix reports and her expectations as the ward manager. The panel was therefore satisfied that Ms 1's evidence is relevant.

The panel noted that Ms 1's evidence in not the only evidence before it, and that it has had the benefit of hearing live evidence from Witnesses 1, 2 and 3 in relation to the events. The panel concluded that Ms 1's evidence is therefore not sole or decisive in nature.

The panel also noted that Ms 1's statement had been served on Miss Sullivan in advance and that she has not raised a specific challenge to Ms 1's interview notes. It had no material evidence before it to suggest that the evidence she provided is fabricated.

The panel took into account that the NMC did not take steps to secure Ms 1's attendance, relying on the fact that this evidence is supported by other material/witnesses. The panel considered that although it would have benefited from hearing from Ms 1 in relation to her responsibilities as the ward manager, it considered it proportionate not to call on her as a witness at this time.

The panel noted the serious nature of the charges that are being considered. However, given its considerations above it determined that it was fair to admit the evidence of Ms 1.

The panel therefore determined that Ms 1's evidence is relevant, and it is fair to admit it as hearsay.

Colleague D

The panel considered that Colleague D's hearsay evidence does not relate directly to any of the charges before it. Colleague D's evidence speaks more to some of her duties as ward manager and to some workplace dynamics that she did not witness. The panel also noted that Colleague D is not Miss Sullivan's manager and that she rarely worked with her.

The panel determined that it would be unfair to admit the account as there is little to no relevancy between Colleague D's evidence and the charges. The application in respect of Colleague D is therefore refused, and her statement will not be admitted in evidence.

Colleague C

The panel considered that Colleague C hearsay evidence does not relate to any of the charges before it. It noted that Colleague C's evidence speaks to Charge 9(d) in which the NMC offered no evidence on and that Colleague C's evidence speaks generally to newly qualified staff and that there are no charges specific to newly qualified staff.

The panel determined that Colleague C's account is of very little relevance to the remaining charges as submitted by the NMC and therefore decided not to admit the account.

The application in respect of Colleague C is therefore refused, and Colleague C's evidence will not be admitted as hearsay.

Background

Miss Kate Sullivan was referred to the NMC on 8 August 2023. Miss Sullivan was employed by Swansea Bay University Health Board ("the Health Board") on Rowan Ward ("the Ward"), as a Band 6 staff nurse.

Miss Sullivan was employed by the Health Board from 2016 as a Band 5 staff nurse, until their promotion to a Band 6 in September 2021. Miss Sullivan also acted up as a Band 7 Ward Manager from December 2021 to May 2022 as part of a job share with Colleague D. Following a number of concerns relating to both Miss Sullivan's clinical and non-clinical practice, a disciplinary hearing was held on 18 and 26 July 2023, following which Miss Sullivan was dismissed on the grounds of gross misconduct.

The Ward is a Low Secure Rehabilitation all-male Unit based in Glanrhyd Hospital, with a high number of the admissions from prison.

Clinical concerns included allegations that Miss Sullivan: (i) refused to examine a patient suffering from a rash on their groin; (ii) failed to appropriately manage a patient's nicotine addiction; (iii) allowed a patient into her office without appropriate supervision; and (iv) failed to submit Datix reports to record relevant incidents. Non-clinical concerns included allegations that Miss Sullivan had: (i) engaged in sexual activity on the Ward whilst on duty/not disclosed an intimate relationship to management; (ii) left the Ward short staffed whilst accompanying a patient to a hospital appointment, failing to return for a protracted period of time; and (iii) breached professional boundaries with a patient.

Miss Sullivan is also alleged to have (i) made derogatory comments about a HCSW to another member of staff; (ii) been openly negative to colleagues about other colleagues' work, such as the quality of their record keeping; (iii) used offensive language whilst on the Ward; (iv) failed to ensure that members of staff in the team behaved in a professional manner.

A referral was made to Bridgend Multi Agency Safeguarding Hub ("MASH") on the Health Board becoming aware of the concerns. A professional concern strategy meeting agreed that the threshold for criminality was not met and that the Health Board was to proceed with their disciplinary investigation. The matter was continued by Safeguarding on conclusion of the Health Board's disciplinary hearing and a reconvened professional concern strategy meeting took place on 8 August 2023, following which the allegation was found substantiated.

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 written and oral submissions made by Ms Muniya.

The panel has drawn no adverse inference from the non-attendance of Miss Sullivan.

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

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

- Witness 1: Clinical Lead on the Rowan Ward
- Colleague B: Health Care Support Worker at Swansea Bay University Health Board.
- Witness 3: Health Care Support Worker at Swansea Bay University Health Board.
- Witness 4: Workforce Investigator at Swansea Bay University Health Board.

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 both the NMC and Miss Sullivan.

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

Charge 1a)

That you, a registered nurse:

1. On or after October 2020,

a. were in a personal relationship with Colleague A.

This charge is found proved.

The panel noted that Miss Sullivan accepted that she was in a relationship with Colleague A from October 2020 until summer 2021. In her reflective piece, she said,

> *"I engaged in a casual relationship with a fellow colleague and he was working as a Band 2 on the ward at that time."*

Miss Sullivan also accepted that she had told Witness 1 and Colleague B about this relationship. The panel heard evidence from Witness 1, Colleague B and Witness 3, all of whom independently confirmed that Miss Sullivan was in a personal and intimate relationship with Colleague A. Their evidence was consistent and mutually supportive.

The panel was also provided with a number of text messages between Miss Sullivan and Colleague A.

Although Miss Sullivan described the relationship as casual, the panel concluded that the frequency, content and tone of the communications demonstrated a personal relationship within the meaning of the Trust policy.

The panel was therefore satisfied on the balance of probabilities that Miss Sullivan was in a personal relationship with Colleague A during the relevant period.

Charge 1a is found proved.

Charge 1b)

That you, a registered nurse:

1. On or after October 2020,
b. failed to disclose your relationship with Colleague A to your employer.

This charge is found proved.

Miss Sullivan admitted during her local interview that she had not disclosed the relationship and that, in hindsight she should have done so.

The panel acknowledged that the Trust's Personal Relationships at Work Policy required staff to disclose romantic relationships to avoid conflicts of interest and protect patients and staff. The panel noted that Miss Sullivan had previously been spoken to in 2018 regarding another workplace relationship, as a result of which the male colleague was moved to another ward. This demonstrated that Miss Sullivan was aware of the policy requirements.

The panel accepted evidence that Miss Sullivan did not complete the required disclosure forms and that management were unaware of the relationship.

The panel therefore concluded that on the balance of probabilities that Miss Sullivan failed to disclose a relationship she was required to declare and found charge 1b proved.

Charge 2a)

That you, a registered nurse:

2. Engaged in sexual intercourse with Colleague A in the workplace, on

a. 4 March 2021.

This charge is found proved.

The panel had regard to the evidence of Colleague B, who gave detailed evidence that during a night shift on 4 March 2021, Miss Sullivan and Colleague A were discussing by means of text messages that they wanted her to go into the next room. Miss Sullivan took Colleague B to the hub shop and showed her these messages. Colleague B vacated to the adjacent room leaving Colleague A and Miss Sullivan alone. Colleague B said that she then heard sounds consistent with sexual intercourse coming from the adjacent room.

> *"I could hear the desk was banging against the wall, and I could hear them both making noises. There was no one else around, and all of the patients were asleep, so I was certain the noise I heard came from them next door. The sex did not last very long, the noises went on for about two to five minutes."*

Colleague B stated that she was confident about what she heard and later confronted Miss Sullivan during handover. The panel did note that Colleague B in their local statement said that they had been made to feel very uncomfortable by Miss Sullivan's and Colleague A's behaviour.

It appeared from the details of the investigation that Miss Sullivan denied this allegation.

The panel considered all the evidence before it including text exchanges between Miss Sullivan and Colleague B regarding sexual activity in the workplace. The panel found Colleague B's explanations in live evidence to be consistent with the evidence she provided in her NMC witness statement and the evidence she provided during the internal investigation. The slight exception to this was that at the time of the investigation, Colleague B did not say that she heard them having sex. However, she subsequently clarified that this was because she did not have "*material evidence*", as

she had deleted an apology that Miss Sullivan had sent her by text after she had been confronted.

In those circumstances, the panel found Colleague B to be a credible and reliable witness.

Therefore, on the balance of probabilities charge 2a was found proved.

Charge 2b)

That you, a registered nurse:

2. Engaged in sexual intercourse with Colleague A in the workplace, on
b. 8 January 2022.

This charge is found proved.

The panel considered the text messages sent by Miss Sullivan to Colleague B on 8 January 2022 between 16:38 and 16:40. These messages refer to Miss Sullivan telling Colleague B that she had engaged in sexual activity with Colleague A in a room at work, which Colleague B clarified in her evidence was the recharge room. The messages were contemporaneous and aligned with the shift patterns of both staff members at the relevant time and date.

The panel noted Miss Sullivan's claim that she would, *"…fabricate stories to keep them (Witness 1 and Colleague B) interested in talking to her."*

However, the panel found it inherently unlikely that Miss Sullivan would have invented a story that she and Colleague A had sex in the workplace.

On the balance of probabilities, the panel found that sexual intercourse occurred in the workplace on this occasion.

Charge 2b is found proved.

Charge 2c)

That you, a registered nurse:

2. Engaged in sexual intercourse with Colleague A in the workplace, on
c. 17 January 2022.

This charge is found proved.

The panel had regard to the text messages dated 17 January 2022 at 1:26 am, that Miss Sullivan had sent to Colleague B stating:

"haha (Colleague A) just had sex with me."

E-rosters confirmed that Miss Sullivan and Colleague A were both on a night shift at that time. Further messages included references to other colleagues who were confirmed to be on duty at the same time.

The panel again rejected Miss Sullivan's account that she fabricated stories to keep colleagues interested in talking to her.

The panel was satisfied that these messages were genuine and reflected real events. Therefore, on the balance of probabilities, the panel found charge 2c proved.

Charge 3a)

That you, a registered nurse:

3. On one or more occasions breached professional boundaries, in that you
a. permitted Patient B to be in your office with you, without 2:1 supervision.

This charge is found proved.

In her local interview Miss Sullivan admitted that she has often:

"…allowed him (Patient B) to sit in the office while she works."

The panel noted that Patient B was subject to a care plan requiring 2:1 supervision. Miss Sullivan, as his primary nurse, was aware of this and that he was an incredibly complex patient. Witness 1, Colleague B and Witness 3 all gave compelling evidence as to his vulnerabilities and that he was very unwell, unstable and unpredictable.

Witness 3 gave evidence that she observed Patient B alone with Miss Sullivan in her office with the door closed and blinds down for approximately 20 minutes. Colleague B also described seeing Patient B alone in the office with Miss Sullivan on numerous occasions. Witness 4's evidence confirmed that Miss Sullivan admitted allowing Patient B into her office alone.

The panel concluded that Miss Sullivan knowingly breached professional boundaries by allowing Patient B into the office contrary to his care and ward safety plans/supervision levels. Therefore, on the balance of probabilities charge 3a was found proved.

Charge 3b)

That you, a registered nurse:

3. On or more occasions breached professional boundaries, in that you
b. hugged Patient B.

This charge is found proved.

The panel had regard to the evidence of Witness 1, who gave detailed evidence that Miss Sullivan told her she had hugged Patient B in the HRS room following an aggressive incident. Witness 1 stated that this was not permitted under the Trust's Therapeutic Touch Policy. Witness 3 also gave evidence that she had observed Miss Sullivan hugging Patient B on multiple occasions, sometimes when no other staff were present. Witness 3 recalled that Miss Sullivan stated that she "*knows you're not*

supposed to", in reference to hugging Patient B, confirming that Miss Sullivan was aware of the fact that the hugging was not permitted or appropriate.

In the registrant's response bundle, Miss Sullivan admitted hugging Patient B in the presence of Witness 1 and also on an occasion when he was stressed and upset. The panel considered the evidence of Witness 1 and Witness 3 and found that the physical contact went beyond what was permitted, for example- a pat on the back, fist bump and handshake and was especially inappropriate given Patient B's sexualised behaviour and difficulties in understanding boundaries.

Therefore, on the balance of probabilities the panel found charge 3b as proved.

Charge 3c)

That you, a registered nurse:

3. On or more occasions breached professional boundaries, in that you
    c. permitted Patient B to call you 'babe'.

This charge is found proved.

The panel considered the evidence of Colleague B, who gave evidence that Patient B repeatedly called Miss Sullivan "babe" and that Miss Sullivan often laughed this off and failed to challenge Patient B calling her babe, except selectively when management were present. Colleague B explained that this undermined professional boundaries for a complex patient such as Patient B and affected how Patient B related and responded to other staff when they correctly challenged his behaviour.

The panel accepted Colleague B's evidence and concluded that Miss Sullivan failed to maintain appropriate professional boundaries. Therefore, on the balance of probabilities, it found charge 3c proved.

Charge 4a)

That you, a registered nurse:

4. On 22 March 2022 with Colleague A took Patient B for bloods leaving the ward without,

a. sufficient male staffing numbers.

This charge is found proved.

The panel considered the evidence of Witness 1 and accepted her account regarding the importance of maintaining balanced staffing on the ward. The panel acknowledged that the rota was designed to ensure an appropriate balance of male and female staff wherever possible, and that where staffing fell below safe levels, support could be sought from Cedar Ward. The panel accepted evidence that on 22 March 2022, the only male staff members on shift were Colleague A and one agency worker. The panel further accepted Witness 4's evidence that the agency worker on duty was male, as confirmed in her report.

The panel also accepted the evidence of Witness 3, who described the ward as demanding and confirmed that several patients, including Patient A, required high-level observations on that day. The panel accepted Witness 1's oral evidence that, in hindsight, Witness 3 would have been a more appropriate choice to escort the patient for blood tests, which was consistent with what Witness 1 had previously stated during her interview in 2022. The panel also accepted Witness 1's explanation that both she and Miss Sullivan did not have the necessary vehicle insurance cover and that Witness 1 had suggested that Witness 3 accompany the patient because male staff were needed on the ward to manage patients requiring 2:1 or 3:1 observations, who were considered high risk to female staff. The panel further accepted Witness 1's evidence that Patient B had a particularly difficult relationship with Colleague A, which made the decision to remove him from the ward even less appropriate.

The panel was satisfied that it was Miss Sullivan's decision to leave the ward with Colleague A on that day. The panel accepted Witness 1's evidence that if Colleague A had remained on the ward alongside another male staff member, staffing levels

would have been manageable, but that removing one of only two male staff members left the ward insufficiently staffed. The panel also accepted Witness 3's evidence that if the remaining agency worker was male, he would have been required to remain on high-level observations, which would further restrict patient leave and reduce flexibility in managing patient risk.

Having considered this evidence, which the panel found to be credible and reliable, the panel was satisfied that Miss Sullivan's decision to leave the ward with Colleague A resulted in insufficient male staffing and had a significant adverse impact on the safe management of the ward.

Therefore, on the balance of probabilities, the panel found charge 4a proved.

Charge 4b)

That you, a registered nurse:

4. On 22 March 2022 with Colleague A took Patient B for bloods leaving the ward without,
b. managerial support.

This charge is found proved.

The panel accepted evidence of Witness 4, who confirmed from Trust records that Colleague D was on a management day and therefore not present on the ward on this occasion. The panel also accepted the evidence of Witness 3, who stated that Band 5 nurses do not provide managerial cover and are not trained to undertake managerial responsibilities on the ward.

The panel further considered the E-rostering records, together with the evidence of Witness 1, who stated that Miss Sullivan was the most senior member of staff on duty that day. The panel therefore found that Miss Sullivan held managerial responsibility for the ward during this shift.

The panel accepted the evidence from the car log, which showed that Miss Sullivan left the ward with Colleague A at approximately 2.45pm and did not return until around 7.15pm. During this period, the ward was left without managerial oversight and with reduced male staffing levels.

In light of the nature of the low secure male ward and the risks associated with the patient group, the panel concluded that staffing resilience and managerial cover were compromised during Miss Sullivan's absence. The panel found that Miss Sullivan's decision to leave the ward in these circumstances was not consistent with safe and effective ward management.

The panel concluded that Miss Sullivan's absence removed managerial supervision during a high-risk period.

Therefore, on the balance of probabilities, charge 4b is found proved.

Charge 5

That you, a registered nurse:

5. On 2 May 2022 refused to examine Patient A.

This charge is found proved.

The panel accepted the evidence of Witness 3 and found her to be a credible and reliable witness. The panel noted that Witness 3 was sufficiently concerned about Patient A's medical condition that she contacted the ward manager's office to report her concerns. The panel accepted Witness 3's oral evidence that, even before Patient A showed her his leg, she could detect a strong odour which she associated with a fungal infection, and that she requested that a nurse assess the patient as a matter of concern.

The panel accepted Witness 3's evidence that shortly afterwards Colleague A attended the ward and informed her that Miss Sullivan had refused to assess Patient

A because she did not feel comfortable following previous incidents involving the patient. The panel noted that Miss Sullivan accepted that she did not assess Patient A but sought to justify this on safety grounds and stated that two other nurses had also refused to assess him.

The panel considered the evidence of Colleague E, whose account directly contradicted Miss Sullivan's explanation. Colleague E stated that she was not asked by Miss Sullivant to assess Patient A and that, had she been asked, she would have done so. The panel found Colleague E's evidence to be credible and consistent.

The panel also noted that during the investigation Miss Sullivan initially stated that her refusal was in "*retaliation*" for earlier incidents, later seeking to reframe this as "*risk minimisation".* The panel considered this change in explanation to undermine Miss Sullivan's credibility. The panel found that Colleague A's explanation to Witness 3 at the time, that Miss Sullivan had refused due to what Patient A had previously done, supported the conclusion that the refusal was reactive rather than clinically based.

The panel accepted Witness 3's evidence that Patient A's condition had clinically improved since earlier incidents and that there was no clinical justification for refusing to assess him. This was supported by the clinical records, which showed that Witness 3 had referred her concerns to Miss Sullivan, but there was no subsequent nursing entry by Miss Sullivan documenting an assessment, any clinical reasoning for declining to assess, or any referral to another nurse.

The panel also took into account evidence that Miss Sullivan had previously stated that she felt safe assessing challenging patients when accompanied by Colleague A, who was on shift at the relevant time. Despite this, Miss Sullivan still refused to assess Patient A. The panel considered this further undermined the credibility of Miss Sullivan's safety justification.

Having considered all of the evidence, the panel concluded that Miss Sullivan's refusal to assess Patient A was not clinically justified.

On the balance of probabilities, the panel therefore found charge 5 as proved.

Charge 6

That you, a registered nurse:

6. Between 6 and 9 May 2022 refused tobacco or tobacco alternatives to Patient A

This charge is found proved.

The panel found the written and oral evidence of Witness 3 to be credible and compelling in relation to this matter. The panel accepted that Patient A lacked capacity to manage his finances and nicotine use and that, in accordance with his formal care plan, staff were required to purchase and prepare tobacco for him. The panel accepted Witness 3's evidence that appropriate management of Patient A's nicotine use was important in reducing his distress and supporting his engagement with treatment.

The panel was satisfied that, through no fault of his own, Patient A ran out of tobacco between 6 and 9 May 2022 and did not have funds to obtain more. In those circumstances, the panel accepted that two reasonable options were available to staff.

First, the panel accepted evidence that it was established practice on the ward for the ward manager to lend money from petty cash when patients ran out of tobacco, to be reimbursed once benefits were received. The panel accepted Colleague B's evidence that Miss Sullivan stated that money would no longer be lent, indicating that "*Jo has said we're not to lend money."* The panel also accepted the consistent evidence of Colleague B and Witness 3 that lending money in this way was commonly known and previously used practice on the ward. Further, the panel placed weight on the email from Ms 1 confirming that lending had been used previously and that she would not have allowed Patient A to go without tobacco. The panel noted that Colleague D was off sick during this period and that Miss Sullivan was acting ward manager, meaning that only Miss Sullivan was able to authorise any petty cash loan. The panel therefore concluded that Miss Sullivan had the authority to lend money but chose not to do so.

Second, the panel accepted evidence that nicotine replacement therapy could have been arranged as an alternative. The panel accepted Witness 1's evidence that

patients could be referred for nicotine replacement therapy and that this could be provided by way of patches, gum, or inhalers on prescription. The panel also accepted the evidence of Colleague B and Witness 3 that no such arrangements were made for Patient A during this period.

The panel considered the patient records and staff observations, which demonstrated that Patient A became increasingly distressed, was distracted from therapeutic activities, made repeated requests for cigarettes, and was observed picking up cigarette remnants from the floor, placing him at risk of physical harm. The panel concluded that, as nurse in charge, Miss Sullivan failed to implement either of the available options to manage Patient A's nicotine dependence and therefore failed to provide appropriate care during this period.

The panel therefore found, on the balance of probabilities, charge 6 is proved.

Charge 7

That you, a registered nurse:
7. On 21 May 2022 refused Patient C community leave without clinical justification.

This charge is found not proved.

In her investigation interview Miss Sullivan said that she had refused Patient C's community leave. Miss Sullivan claimed that her decision had been based on a staff shortage at the time. At the commencement of the hearing, the NMC had sought to rely on the evidence provided by Colleague F to prove that Miss Sullivan's act had lacked clinical justification. However, Colleague F's evidence had been ruled inadmissible by the panel. The panel was now asked to find charge 7 proved on the basis that as Miss Sullivan appeared to have admitted refusing leave, the panel could and should infer that the refusal had lacked clinical justification. However, the panel did not accept that stance and concluded that without any further evidence from the NMC, there was nothing to prove that the refusal had lacked clinical justification.

The panel found, on the balance of probabilities, charge 7 as not proved.

Charge 8a)

That you, a registered nurse:

8. On one or more occasions demonstrated poor leadership in that you,
a. manipulated the rota and/or levels to work with Colleague A.

This charge is found proved.

The panel carefully considered the evidence relating to allegations that Miss Sullivan manipulated staffing arrangements in order to work with Colleague A. The panel first considered whether Miss Sullivan manipulated the formal rota. While several witnesses expressed concerns and perceptions that the rota had been manipulated, the panel was not satisfied on the balance of probabilities that Miss Sullivan was responsible for, or had sufficient control over, the formal rota. The panel accepted evidence that responsibility for completing the rota was shared and that Miss Sullivan was not always the person responsible for compiling or authorising it. Accordingly, the panel was not satisfied that manipulation of the rota itself was proved.

However, the panel reached a different conclusion in relation to the allocation of "*observation levels duties"* during shifts. The panel accepted the evidence of Witness 3, who stated in her witness statement and oral evidence that Miss Sullivan regularly allocated herself to work on 2:1 observations with Colleague A, despite being a Band 6 nurse and despite there being sufficient other staff available to undertake those duties. Witness 3 told the panel that she personally observed Miss Sullivan altering the observation board, including wiping off or changing names, in order to ensure that she was paired with Colleague A. Witness 3 stated that this occurred frequently and described it as happening on a weekly basis.

The panel also accepted the evidence of Colleague B, who stated that from around March 2021 she noticed that Miss Sullivan regularly allocated herself and Colleague A to work together on observation levels, particularly on night shifts. In her oral evidence, Colleague B explained that Miss Sullivan was in charge of the shift and

was responsible for delegating staff to observation duties, and that she routinely delegated herself to work alongside Colleague A.

The panel further considered documentary evidence, including an observation level sheet and a screenshot provided during the investigation, which demonstrated that Miss Sullivan and Colleague A were repeatedly paired together for prolonged periods, while all other staff pairings changed. The panel noted that this documentary evidence corroborated the accounts of Colleague B and Witness 3.

The panel also considered Miss Sullivan's own admissions during her interview, in which she accepted that she had frequently worked observation levels with Colleague A. Miss Sullivan stated that this was because she felt safe working with him and that it was easier to keep the same pairings rather than swapping staff around. However, the panel did not accept this explanation. The observation sheet demonstrated that other staff were regularly rotated, whereas Miss Sullivan and Colleague A were not. The panel therefore rejected Miss Sullivan's assertion that pairings remained unchanged for convenience or safety reasons.

Although the panel noted evidence that overall shift overlap between Miss Sullivan and Colleague A was not markedly higher than between other staff members, the panel placed greater weight on the specific evidence concerning allocation of observation levels within shifts. The panel was satisfied that Miss Sullivan exercised control over these allocations when she was in charge of the shift and that she used this control to ensure that she worked with Colleague A.

Taking all of this evidence together, the panel concluded that while manipulation of the formal rota was not proved, Miss Sullivan did manipulate the allocation of observation levels in order to work with Colleague A.

Accordingly, the panel finds Charge 8a proved on the basis of manipulation of levels, but not on the basis of manipulation of the rota.

Charge 8b)

That you, a registered nurse:

8. On one or more occasions demonstrated poor leadership in that you,
b. went on breaks with Colleague A.

This charge is found not proved.

In reaching its decision the panel had regard to the evidence of Witness 3, who informed the panel that Miss Sullivan did not actually take formal breaks, which supported what Miss Sullivan said in her local interview.

Although evidence showed Miss Sullivan left the ward when Colleague A went on break, the panel was not satisfied that this amounted to formally taking breaks together as alleged.

The panel therefore found that charge 8b is not proved on the balance of probabilities.

Charge 8c)

That you, a registered nurse:

8. On one or more occasions demonstrated poor leadership in that you,
c. left the ward short-staffed by going to see Colleague A on their break.

This charge is found proved.

The panel considered the evidence of Witness 3 and found her to be a credible and reliable witness. In her interview, Witness 3 stated that Miss Sullivan would not inform colleagues when she was leaving the ward, which resulted in the ward being left short staffed and at risk. In her oral evidence, Witness 3 explained that on several occasions during Colleague A's one-hour breaks, when he would go to the gym, Miss Sullivan would also leave the ward without informing colleagues and could not be located. Witness 3 described the ward as becoming unsettled during these periods. She told the panel that although Miss Sullivan did not usually take formal

breaks, she would nonetheless leave the ward when Colleague A left, going wherever he went, including to the gym, down corridors, or to where he was undertaking observations. Witness 3 was clear that Miss Sullivan would not notify staff that she was leaving, and she described this as creating risk, particularly given that staffing levels were often already low. Witness 3 further recalled seeing Miss Sullivan and Colleague A together in the staff room on breaks and stated that when she indicated her concern to Miss Sullivan, she would simply smile and walk away.

The panel also accepted the evidence of Colleague B, who stated that Colleague A regularly went to the gym during his breaks and that on multiple occasions Miss Sullivan would leave the ward to find him there. Colleague B described this as a very regular occurrence. She told the panel that Miss Sullivan would sometimes do this when she herself was not on a break. Colleague B further stated that she believed Miss Sullivan would sometimes leave to meet Colleague A in the shower area. She explained that this behaviour became more frequent when Miss Sullivan was in a managerial position, although it had also occurred previously when the ward manager finished after 5pm.

The panel also took into account the oral evidence of Witness 1, who stated that she recalled an occasion when Miss Sullivan appeared to schedule her break around that of Colleague A. Witness 1 told the panel that she challenged Miss Sullivan about this and told her that she could not take her break because there were insufficient staff on the ward.

In addition, the panel considered the hearsay evidence of Colleague G, who reported that staff felt uncomfortable working with Miss Sullivan and Colleague A because Miss Sullivan would follow Colleague A around the ward and would sometimes leave the ward when he went on breaks, resulting in the ward being left short staffed and causing staff to feel unsafe.

Having considered all of this evidence together, the panel was satisfied that Miss Sullivan’s conduct formed a sustained and intentional pattern of leaving the ward to follow or meet Colleague A during his breaks, including when Miss Sullivan herself was not on a scheduled break, and without ensuring adequate staffing cover. The

panel concluded that this behaviour occurred despite known staffing pressures and created risks to both patients and staff.
On the balance of probabilities, charge 8c is found proved.

Charge 8d)

That you, a registered nurse:

8. On one or more occasions demonstrated poor leadership in that you,
d. gave Colleague A access to overtime shifts before others.

This charge is found not proved.

The panel carefully considered the submissions of Ms Muniya and the oral and documentary evidence relating to the allocation of overtime shifts.

The panel noted the evidence of Witness 3, who stated that surplus shifts were ordinarily offered on a first-come-first-served basis through WhatsApp, online systems or a physical book, and that Colleague A appeared to be aware of shifts becoming available before they were publicly advertised. Witness 3 gave an example in which she believed that Colleague A must have been informed of a colleague's sickness absence by management, as he appeared to secure shifts without responding to group messages.

The panel further noted that Ms 1 confirmed that responsibility for the off-duty rota rested with Miss Sullivan during periods when Colleague D was absent, and that Miss Sullivan accepted she was involved in managing shift changes and requests.

However, the panel was not satisfied that the evidence established, on the balance of probabilities, that Miss Sullivan personally allocated overtime shifts to Colleague A ahead of others. The evidence before the panel demonstrated that there were multiple routes by which staff could become aware of and request overtime shifts, including informal awareness of staffing shortages, checking rotas in advance, and submitting requests through different systems. While the panel accepted that

Colleague A appeared proactive in securing shifts and may have had greater awareness of opportunities, this did not, in itself, establish that Miss Sullivan was providing him with preferential access.

The panel also noted that much of the evidence in support of this allegation was based on inference rather than direct observation of Miss Sullivan allocating shifts preferentially to Colleague A. No documentary evidence demonstrated that Colleague A was formally allocated overtime shifts ahead of others who had requested them, and no specific incident was identified where the panel could be satisfied that Miss Sullivan had denied another staff member an overtime shift in favour of Colleague A.

While the panel accepted that Miss Sullivan acknowledged taking Colleague A's childcare needs into account when responding to requests, the panel did not consider that this amounted to proof that overtime was systematically or improperly allocated to him ahead of others.

Accordingly, the panel found that there was insufficient direct evidence that Miss Sullivan personally allocated overtime shifts to Colleague A ahead of other staff.

On the balance of probabilities, charge 8d is found not proved.

Charge 8e)

That you, a registered nurse:

8. On one or more occasions demonstrated poor leadership in that you,
e. refused female colleagues time off in preference to male colleagues.

This charge is found not proved.

The panel considered the evidence of Witness 3, who stated that she had previously been refused leave by Colleague D on the basis that the rota had already been finalised, but that subsequently two male colleagues, including Colleague A and

Colleague H, were granted leave for the same date by Miss Sullivan when Colleague D was absent. Witness 3 stated that she believed Miss Sullivan had personally approved that leave and that this amounted to preferential treatment of male colleagues.

The panel also considered Witness 3's local statement, in which she referred to leave being granted to Colleague A and another Colleague H on 30 April 2022 by Miss Sullivan, and Miss Sullivan's own evidence in interview, in which she accepted that she agreed to requests for leave from both men, explaining that Colleague H was persistent and that Colleague A cited childcare reasons.

The panel accepted that Miss Sullivan approved leave for the two male colleagues on that date and that Witness 3 had previously been refused leave by another manager. However, the panel was not satisfied that the evidence established that Miss Sullivan personally refused leave to female colleagues while granting it to male colleagues.

In particular, the panel noted that Witness 3's leave request had been refused by Colleague D, not by Miss Sullivan, and that there was no evidence that Miss Sullivan reviewed, overturned, or was aware of the earlier refusal when she later approved leave for Colleague A and Colleague H. The panel also noted that the charge alleged refusal of time off to female colleagues in the plural, whereas the evidence related to a single individual and a single episode.

While the panel had concerns about the fairness and consistency of leave management during this period, it was not satisfied that the evidence demonstrated that Miss Sullivan herself refused leave to female staff members in preference to granting it to male staff members, as alleged in the charge.

The panel therefore concluded that, although the situation may have given rise to perceptions of unfairness, there was insufficient evidence that Miss Sullivan personally refused leave to female colleagues while granting leave to male colleagues. Therefore, charge 8e is not proved on the balance of probabilities.

Charge 8f)

That you, a registered nurse:

8. On one or more occasions demonstrated poor leadership in that you,
f. worked on 17 April 2022 when you were not required.

This charge is found proved.

The panel considered the e-rostering evidence reviewed by Witness 4, which showed that there were seven staff rostered on duty for the shift on 17 April 2022. The panel accepted the evidence of Colleague B and Colleague G, both of whom stated that Miss Sullivan was an additional eighth member of staff on that shift and was not required for staffing cover. The panel also accepted Colleague B's evidence that Miss Sullivan was not needed operationally and that she believed Miss Sullivan worked the shift because Colleague A was also working that day.

The panel considered Miss Sullivan's explanation that she attended work because staffing levels required her presence and because she was experiencing financial difficulties. However, the panel found this explanation to be undermined by Witness 4's evidence that she compared the staffing levels on 17 April 2022 with another date of similar patient occupancy and acuity, where only six staff were rostered, indicating that the staffing level on 17 April 2022 was already sufficient without Miss Sullivan's additional attendance.

The panel also considered that, if additional cover had genuinely been required, Miss Sullivan could have rostered herself in her substantive managerial role and at her usual banding, rather than working as an additional healthcare support worker. The panel therefore concluded that there was no clinical or operational necessity for Miss Sullivan to work on that shift. On the balance of probabilities, the panel found that the most likely explanation for Miss Sullivan's decision to work that shift was personal, namely that Colleague A was also working on that date.

Therefore, charge 8f is proved on the balance of probabilities.

Charge 9a)

That you, a registered nurse:

9. On one of more occasions failed to complete a Datix report and/or escalate incidents:
a. When Patient B grabbed Colleague B from behind, and grinded against them for sexual gratification on 10 December 2021.

This charge is found proved.

The panel considered Miss Sullivan's interview with Witness 4 in which Miss Sullivan accepted that no incident report had been completed in relation to this incident and was unable to explain why this had not occurred. Miss Sullivan stated that incident reports could be completed retrospectively depending on workload and acuity. The panel noted this explanation but found that it did not account for the complete absence of any incident report in this case.

The panel accepted the evidence of Colleague B, whom it found to be a clear, consistent and credible witness. Colleague B told the panel that she reported the incident to Miss Sullivan promptly and in detail, and that Miss Sullivan told her she would complete a Datix report. The panel accepted Colleague B's evidence that she provided full details within a short period after the incident and that there was no subsequent follow-up by Miss Sullivan to obtain further information or to complete the report with her.

The panel further noted that several months later, when the patient was transferred to another hospital, the receiving hospital queried the absence of a safeguarding or incident report, despite the incident having been recorded in the patient's care notes by Colleague F. The panel reviewed the clinical entry dated 10 December 2021, which recorded the incident, and accepted that no corresponding Datix reference was present.

The panel also accepted the oral evidence of Witness 4, who confirmed that she reviewed the records for that date and found no evidence that any Datix incident report had been completed. Taken together, the panel was satisfied that no Datix report was made in relation to this incident, despite Miss Sullivan having been informed of the incident and having indicated that she would complete the report.

In her investigation interview, Ms 1 said that Miss Sullivan's duties included filling in Datix reports and escalating incidents to the multi-disciplinary team.

On the basis of the evidence it accepted, the panel concluded that Miss Sullivan failed to complete a Datix report and failed to appropriately escalate the incident.

Therefore, on the balance of probabilities, charge 9a is found proved.

Charge 9b)

That you, a registered nurse:

9. On one of more occasions failed to complete a Datix report and/or escalate incidents:
b. when Patient A poked your thigh on 13 April 2022.

This charge is found proved.

The panel noted that Colleague B and Colleague E were both on levels at the time of the incident. The panel considered the contemporaneous nursing notes made by Colleague E in the patient's records and found that these aligned with Colleague B's account of events and were inconsistent with Miss Sullivan's description of what had occurred. The panel placed significant weight on these contemporaneous clinical records as reliable evidence of what took place.

The panel also accepted the evidence of Witness 4, who confirmed that no Datix incident report had been filed in relation to this incident. Witness 4 explained in her oral evidence that the usual process is for an incident to be recorded in the patient

notes with a corresponding Datix reference number, which then allows the incident report to be traced and reviewed. She stated that where there is no reference number recorded, this indicates that no Datix report was completed. The panel accepted this explanation and found it to be clear and logical.

In her investigation interview, Ms 1 said that Miss Sullivan's duties included filling in Datix reports and escalating incidents to the multi-disciplinary team.

The panel further noted that Miss Sullivan admitted that no Datix report had been submitted. Taking all of this evidence together, the panel was satisfied that the incident had not been reported through the Datix system and that Miss Sullivan had failed to escalate the matter appropriately.

Therefore, on the balance of probabilities, charge 9b is proved.

Charge 9c)

That you, a registered nurse:

9. On one of more occasions failed to complete a Datix report and/or escalate incidents:
c. when Patient B touched Colleague B's buttocks on 17 April 2022.

This charge is found proved.

In relation to the incident on 17 April 2022, the panel considered the evidence of Colleague B and accepted her account as credible and reliable. In her local statement, Colleague B described that Patient B touched her on the buttocks while she was on duty. The panel also accepted Colleague B's evidence that shortly after this incident, she heard Miss Sullivan state in the office, in the presence of other staff members, words to the effect that "*Patient B only touched her bum*". The panel noted that Miss Sullivan stated that she had no recollection of making this comment and denied being dismissive.

However, the panel also considered the clinical notes drafted by Witness 1 on 17 April 2022, which referred to incidents involving Patient B on that date. The panel noted that an incident reference number appeared alongside one description of inappropriate behaviour towards a member of staff, but that this reference number was positioned in a way which indicated that it related to a different incident involving Patient B, and not to the assault on Colleague B. The panel accepted the evidence of Witness 4, who concluded during her investigation that the reference number did not relate to the incident involving Colleague B. Although Witness 1 stated that it may have related to both incidents, she was unable to confirm this, and the panel was not satisfied that a Datix report had been completed in respect of the assault on Colleague B.

The panel considered Miss Sullivan's evidence that she was informed of the incident during handover, that she spoke to Patient B, and that she later checked on Colleague B's wellbeing when she was acting as ward manager. The panel also considered Miss Sullivan's explanation that responsibility for completing incident reports lay with the nurse in charge on the shift when the incident occurred, and that she was not the nurse in charge on that day. However, the panel noted that Miss Sullivan accepted she could not explain why an incident report had not been completed in relation to this assault.

The panel took into account the wider context of Miss Sullivan's prior minimisation of concerns raised by Colleague B and Miss Sullivan's inappropriate professional boundaries with Patient B. The panel considered that this context was relevant when assessing Miss Sullivan's approach to reporting and escalating serious incidents involving Patient B.

In addition, the panel considered Miss Sullivan's admissions during interview that, in hindsight, incident reports should have been completed, and that incidents were not always formally recorded on the ward. The panel found that this supported the conclusion that appropriate reporting procedures were not followed in this case.

In her investigation interview, Ms 1 said that Miss Sullivan's duties included filling in Datix reports and escalating incidents to the multi-disciplinary team.

Having considered all of the evidence, the panel was satisfied on the balance of probabilities that no Datix report was completed in relation to the assault on Colleague B on 17 April 2022 and that the incident was not appropriately escalated.

Therefore, on the balance of probabilities, charge 9c is found proved.

Charge 10a)

That you, a registered nurse:

10. On, one or more occasions behaved unprofessionally, in that you,
a. criticised Colleague E's paperwork in front of others

This charge is found proved.

The panel considered the evidence of Witness 1 and found her to be a credible and reliable witness. Witness 1 and Colleague E were peers of Band 5 grading. In her written statement where, Witness 1 stated that Miss Sullivan had said that Colleague E's paperwork was "*not good enough*". In her oral evidence, Witness 1 explained that Miss Sullivan had said she was having to "*pick up*" due to a lack of detail in Colleague E's documentation, specifically in relation to care and treatment plans. The panel accepted Witness 1's evidence in this regard.

The panel concluded that, by making these comments openly to colleagues, Miss Sullivan criticised a colleague's professional work in an inappropriate manner, rather than addressing any concerns through appropriate professional channels or privately and constructively. The panel found that this amounted to unprofessional behaviour, as it undermined a colleague and failed to demonstrate the standards of professionalism and leadership expected of a registered nurse.

Therefore, on the balance of probabilities, charge 10a is found proved.

Charge 10b)

That you, a registered nurse:

10. On, one or more occasions behaved unprofessionally, in that you,
b. stated Colleague D was ‘a lazy cunt, she’s [Colleague D] left me to do this all alone’, or words to that effect

This charge is found proved.

The panel considered the evidence relating to Miss Sullivan’s comments about Colleague D and found this aspect of the charge proved. The panel accepted the evidence of Colleague B, who stated that she personally heard Miss Sullivan refer to Colleague D in highly derogatory terms, describing her as “*a lazy cunt*” and stating that Colleague D had left her to “do this alone.”

The panel noted that Miss Sullivan admitted referring to Colleague D as “*lazy*,” although she maintained that this comment was made only to Witness 1 and not in front of others. However, Colleague B, stated that these comments were made in the presence of others. The panel found Colleague B’s evidence to be clear, consistent and credible. The panel also took into account hearsay evidence from Colleague G, which supported the account that Miss Sullivan regularly made similar disparaging comments about managers, referring to them as “*lazy*” and suggesting that they left all responsibility to her.

The panel considered that Miss Sullivan’s own admissions lent further weight to this evidence, particularly where she stated in her interview that she felt she was “*doing everything*” in relation to sharing the ward manager role with Colleague D. The panel considered this consistent with the complaints she was heard to make about Colleague D and other managers.

The panel was satisfied that this was not an isolated or momentary lapse in judgment, but part of a pattern of habitually making disparaging remarks about colleagues, in an unprofessional and inappropriate manner.

Therefore, on the balance of probabilities, charge 10b is found proved.

Charge 10c)

That you, a registered nurse:

10. On, one or more occasions behaved unprofessionally, in that you,
c. stated ‘I’m going to put her [Colleague F] with him, because she looks like a man and he won’t fancy her’, or words to that effect.

This charge is found not proved.

No local statement was taken from the Colleague that witnessed the alleged comments made by Miss Sullivan about Colleague F. They were not interviewed as part of the investigation.

The panel was asked to rely on evidence from Colleague B, that was third-hand. Whilst the panel considered Colleague B to be a credible and reliable witness, she was reliant on the credibility and reliability of those who had reported the alleged comments to her. There was no direct evidence from the witnesses who are said to have heard the comments to support this charge.

For that reason, on the balance of probabilities, charge 10c is found not proved.

Charge 10d)

That you, a registered nurse:

10. On, one or more occasions behaved unprofessionally, in that you,
d. breached colleagues’ confidentiality by disclosing their sickness absence reasons.

This charge is found proved.

The panel considered the hearsay evidence of Colleague G, which recorded that Miss Sullivan had discussed confidential staff information, including details of colleagues’

sickness absence and other personal matters communicated by email, with other members of the team. The panel was satisfied that this evidence was consistent with other material before it and gave it appropriate weight.

The panel also considered the supplementary report of Witness 4, in which this issue was explored with Miss Sullivan. In particular, Miss Sullivan stated that sharing personal information about colleagues was regarded as an "*open conversation within the team as to why someone is off*". The panel regarded this admission as significant and accepted that it demonstrated a casual and inappropriate approach to confidential information.

The panel concluded that discussing colleagues' sickness absence and personal circumstances in this way constituted a breach of confidentiality and a failure to uphold professional standards. The panel was satisfied that such behaviour would undermine trust between colleagues and was inconsistent with Miss Sullivan's professional obligations.

Therefore, on the balance of probabilities, charge 10d is found proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether Miss Sullivan's fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's ability to practise kindly, safely and professionally.

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

The panel adopted a two-stage process in its consideration. First, the panel must determine whether the facts found proved amount to misconduct. Secondly, only if the facts found proved amount to misconduct, the panel must decide whether, in all the circumstances, Miss Sullivan's fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct

Ms Muniya submitted that the panel, having found Charges 1a, 1b, 2a, 2b, 2c, 3a, 3b, 3c, 4a, 4b, 5, 6, 8a, 8c, 8f, 9a, 9b, 9c, 10a, 10b and 10d proved, is now invited to determine whether those facts amount to misconduct. Ms Muniya submitted that, applying the authorities of *Roylance v General Medical Council (No. 2) [2000] 1 AC 311* and *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), misconduct involves conduct which falls seriously short of the standards expected of a registered professional, judged against the standards of the profession. She submitted that the NMC Code is the appropriate benchmark and that Miss Sullivan's conduct represents multiple, serious and sustained departures from fundamental tenets of nursing practice.

Ms Muniya submitted that in respect of Charges 1a and 1b, Miss Sullivan deliberately failed to disclose a personal romantic relationship with a colleague

despite clear policy requirements and prior management intervention. This, she submitted, was a knowing concealment which created conflicts of interest, risks of bias, and undermined trust. It breached core duties of honesty, integrity and transparency under the Code, and constituted a serious departure expected of a senior nurse.

Turning to Charges 2a, 2b and 2c, Ms Muniya submitted that Miss Sullivan engaged in sexual activity with a colleague within clinical areas during working shifts. This, she submitted, was a profound breach of professional boundaries, a misuse of clinical space, and a neglect of duty which risked patient safety and brought the profession into disrepute. Such conduct, she submitted, is inherently serious and wholly incompatible with safe and effective professional practice.

In relation to Charges 3a, 3b and 3c, Ms Muniya submitted that Miss Sullivan breached professional boundaries with a vulnerable patient by permitting unsupervised access, engaging in inappropriate physical contact, and failing to challenge inappropriate familiarity. This conduct, she submitted, exposed the patient and others to risk, undermined safeguarding measures, and demonstrated a failure to model appropriate professional behaviour. It was not an isolated lapse but repeated and deliberate conduct.

Addressing Charges 4a, 4b, 5 and 6, Ms Muniya submitted that Miss Sullivan failed in her responsibilities as nurse in charge by leaving the ward inadequately staffed, refusing to assess a patient due to personal feelings, and failing to manage a patient’s clinical needs appropriately. These, she submitted, were serious failures of leadership, accountability and patient-centred care, creating risk of harm and demonstrating disregard for safe practice.

In respect of Charges 8a, 8c and 8f, Ms Muniya submitted that Miss Sullivan manipulated staffing arrangements to facilitate her relationship, including altering rotas and pairing herself with a colleague. This, she submitted, was an abuse of position, undermined fairness, destabilised staffing, and placed patient safety at risk. The repetition of such conduct aggravated its seriousness.

Turning to Charges 9a, 9b and 9c, Ms Muniya submitted that Miss Sullivan repeatedly failed to report significant incidents, including assaults and inappropriate conduct. She submitted that incident reporting is a fundamental safeguard mechanism and that repeated failures, particularly after assurances, represent serious neglect of duty and undermine clinical governance and public protection.

Finally, in relation to Charges 10a, 10b and 10d, Ms Muniya submitted that Miss Sullivan behaved unprofessionally towards colleagues by using derogatory language and breaching confidentiality. This conduct, she submitted, was inappropriate, potentially bullying in nature, and damaging to team cohesion and safe service delivery.

Drawing these matters together, Ms Muniya submitted that Miss Sullivan's conduct was not isolated but formed a pattern of repeated, deliberate and serious misconduct involving dishonesty, boundary violations, abuse of position, failures of leadership and disregard for patient safety. She submitted that the cumulative effect of these findings clearly meets the threshold of serious professional misconduct, and the panel is invited to so find.

Submissions on impairment

Ms Muniya moved on to the issue of impairment and submitted that the question of impairment is forward-looking and concerned with public protection and the wider public interest, in line with the guidance in *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin). She submitted that the panel must consider whether Miss Sullivan's fitness to practise is currently impaired, having regard to risk of harm, public confidence, and professional standards.

Applying the *Grant* test, Ms Muniya submitted that multiple limbs are engaged. First, she submitted that Miss Sullivan has in the past put patients at unwarranted risk of harm through boundary breaches, unsafe staffing decisions, failure to assess patients, poor leadership and failure to report incidents. Secondly, she submitted that Miss Sullivan has brought the profession into disrepute through sexual activity in the

workplace, inappropriate conduct towards colleagues and manipulation of systems for personal benefit. Thirdly, she submitted that Miss Sullivan has breached fundamental tenets of the profession, including honesty, integrity, safeguarding and professionalism.

Ms Muniya submitted that Miss Sullivan's insight is significantly lacking. She submitted that Miss Sullivan denied key aspects of the misconduct despite the panel's findings and, relying on *Sawati v GMC* [2022] EWHC 283 (Admin), submitted that such denials, particularly where implausible and contrary to the evidence, demonstrate an unwillingness to accept wrongdoing. She submitted that Miss Sullivan has minimised her conduct, sought to justify inappropriate behaviour, and failed to acknowledge the seriousness of her actions.

Ms Muniya further submitted that there is no evidence before the panel of meaningful remediation. There has been no demonstration of reflection, no evidence of steps taken to address boundary issues, leadership failings or attitudinal concerns, and no indication that Miss Sullivan has developed insight into the impact of her conduct. In those circumstances, Ms Muniya submitted that the risk of repetition remains real and ongoing.

On public protection grounds, Ms Muniya submitted that Miss Sullivan poses a continuing risk to patients, colleagues and the wider public, given the nature of the misconduct and the absence of insight and remediation. Accordingly, a finding of current impairment is necessary to protect the public.

On public interest grounds, Ms Muniya submitted that a finding of impairment is required to uphold proper professional standards and maintain public confidence in the profession. She submitted that the misconduct in this case, particularly sexual activity in the workplace, breaches involving vulnerable patients, misuse of authority, dishonesty and repeated failures of professionalism, is of such seriousness that a failure to find impairment would undermine public confidence in the regulatory process and the profession as a whole.

In conclusion, Ms Muniya submitted that Miss Sullivan's fitness to practise is currently impaired on both public protection and public interest grounds and invited the panel to make such a finding.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311, *CHRE v NMC and Grant* and *Ronald Jack Cohen v General Medical Council [2008] EWHC 581 (Admin).*

Decision and reasons on misconduct

The panel has considered whether the facts found proved amount to misconduct. In doing so, the panel has borne in mind that misconduct is not defined in the Nursing and Midwifery Council rules but is a matter of judgment. The panel has applied the guidance in *Roylance v General Medical Council* and *Nandi v General Medical Council,* namely that misconduct is conduct which falls short of the standards expected of a registered professional and that such a falling short must be serious. The panel has assessed Ms Sullivan's conduct by reference to the standards set out in the NMC Code.

The panel has considered the charges both individually and cumulatively.

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

Charges 1a and 1b

The panel determined that Ms Sullivan's personal relationship with Colleague A and failure to disclose that personal relationship with Colleague A, despite being aware of the relevant policy and prior management intervention in relation to a previous workplace relationship, amounted to misconduct. The panel found that this was a deliberate concealment and not an oversight.

The panel considered that this conduct created conflicts of interest and had a detrimental impact on team dynamics, particularly as she progressed to Band 6-acting ward manager. It placed colleagues with whom she shared details about the relationship in a compromised position and contributed to a toxic working environment. The panel also found that Ms Sullivan, as a nurse and subsequently in a position of seniority, was expected to act as a role model and uphold professional standards, and failed to do so.

The panel concluded that this conduct breached fundamental tenets of promoting professionalism and trust, in particular Code paragraphs 20.1, 20.2 and 20.3.

> *'**20 Uphold the reputation of your profession at all times***
> ***To achieve this, you must:***
> *20.1 keep to and uphold the standards and values set out in the Code*
> *20.2 act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment*
> *20.3 be aware at all times of how your behaviour can affect and influence the behaviour of other people.*
> *20.8 act as a role model of professional behaviour for students and newly qualified nurses, midwives and nursing associates to aspire to'*

Charges 2a, 2b and 2c

The panel found that Ms Sullivan engaged in sexual activity with a colleague on three occasions whilst on duty and within clinical areas, the intimate details of which she shared with two colleagues. At this time, she was variously working as a Band 5, Band 6 or acting ward manager.

The panel determined that this conduct constituted a profound breach of professional boundaries and a neglect of duty. It found that Ms Sullivan prioritised her personal interests and pursuit of a sexual relationship over her professional responsibilities,

leaving the ward potentially unsafe and colleagues unsupported. Engaging in sexual activity, whilst on duty rendered her unable to perform her nursing duties. The panel considered that such conduct exposed patients, who were vulnerable and unpredictable, to risk of harm.

The panel also found that this behaviour would be regarded as deplorable by members of the nursing profession and amounted to serious misconduct. It breached multiple provisions of the Code, including 20.1, 20.2, 20.3, and 20.8.

> ***'20 Uphold the reputation of your profession at all times***
> ***To achieve this, you must:***
> *20.1 keep to and uphold the standards and values set out in the Code*
> *20.2 act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment*
> *20.3 be aware at all times of how your behaviour can affect and influence the behaviour of other people.*
> *20.8 act as a role model of professional behaviour for students and newly qualified nurses, midwives and nursing associates to aspire to'*

Charges 3a and 3b

The panel determined that Ms Sullivan's conduct in allowing Patient B into her office without appropriate supervision and engaging in inappropriate physical contact constituted serious misconduct.

The panel found that Patient B was highly vulnerable, displayed sexualised behaviour, and required strict professional boundaries. Ms Sullivan's conduct blurred those boundaries, increased risk to the patient, herself, and other staff, and undermined established care and safety plans. The panel also noted that Ms Sullivan failed to respond appropriately when concerns were raised and did not take the matter seriously.

The panel concluded that this conduct breached Code provisions relating to maintaining professional boundaries and preserving safety, including 13.4, 16.4, 20.5, 20.6 and 20.8. The panel was satisfied that this represented serious misconduct.

> ***'13 Recognise and work within the limits of your competence***
> ***To achieve this, you must, as appropriate:***
> *13.4 take account of your own personal safety as well as the safety of people in your care'*
>
> ***'16 Act without delay if you believe that there is a risk to patient safety or public protection***
> ***To achieve this, you must:***
> *16.4 acknowledge and act on all concerns raised to you, investigating, escalating or dealing with those concerns where it is appropriate for you to do so.'*
>
> ***'20 Uphold the reputation of your profession at all times***
> ***To achieve this, you must:***
> *20.5 treat people in a way that does not take advantage of their vulnerability or cause them upset or distress*
> *20.6 stay objective and have clear professional boundaries at all times with people in your care (including those who have been in your care in the past), their families and carers*
> *20.8 act as a role model of professional behaviour for students and newly qualified nurses, midwives and nursing associates to aspire to'*

Charge 3c

In relation to Charge 3c, the panel determined that Ms Sullivan's conduct fell below the standards expected of a registered professional. However, when considered in isolation, the panel did not consider that this particular conduct reached the threshold of serious misconduct.

The panel found that, whilst inappropriate and indicative of blurred boundaries, this behaviour was of a lower level of seriousness when compared to the other boundary breaches. Accordingly, the panel determined that this charge amounts to misconduct, but not serious misconduct.

Charges 4a and 4b

The panel determined that Ms Sullivan's decision to leave the ward without sufficient staffing or managerial oversight amounted to serious misconduct.

The panel found that Ms Sullivan was in a position of responsibility and that her actions left vulnerable patients and colleagues at risk. The panel considered that she failed to manage resources appropriately and demonstrated unsafe managerial practice.

The panel concluded that this conduct breached Code provisions including 11.2, 13.4, 15.3, 20.3 and 25.1.

> ***'11 Be accountable for your decisions to delegate tasks and duties to other people***
> ***To achieve this, you must:***
> *11.2 make sure that everyone you delegate tasks to is adequately supervised and supported so they can provide safe and compassionate care'*
>
> ***'13 Recognise and work within the limits of your competence***
> ***To achieve this, you must, as appropriate:***
> *13.4 take account of your own personal safety as well as the safety of people in your care'*
>
> ***'15 Always offer help if an emergency arises in your practice setting or anywhere else***
> ***To achieve this, you must:***

15.3 take account of your own safety, the safety of others and the availability of other options for providing care'

'20 Uphold the reputation of your profession at all times
To achieve this, you must:
20.3 be aware at all times of how your behaviour can affect and influence the behaviour of other people'

'25 Provide leadership to make sure people's wellbeing is protected and to improve their experiences of the health and care system
To achieve this, you must:
25.1 identify priorities, manage time, staff and resources effectively and deal with risk to make sure that the quality of care or service you deliver is maintained and improved, putting the needs of those receiving care or services first.'

Charges 5 and 6

The panel determined that Ms Sullivan's refusal to examine Patient A and her failure to appropriately manage Patient A's clinical needs amounted to serious misconduct.

The panel found that Ms Sullivan failed to act in the best interests of a vulnerable patient, resulting in unnecessary suffering and distress. The panel also found that her decisions appeared to be influenced by personal feelings rather than clinical judgment. In relation to the management of tobacco dependency, the panel found that Ms Sullivan failed to take appropriate steps, leading to degrading and unsafe outcomes for the patient.

The panel concluded that this conduct demonstrated a fundamental failure in patient care and breached numerous provisions of the Code, including those relating to prioritising people, preserving safety, and acting with compassion and professionalism. The panel was satisfied that this conduct amounted to serious misconduct.

'1 Treat people as individuals and uphold their dignity

To achieve this, you must:

1.1 treat people with kindness, respect and compassion

1.2 make sure you deliver the fundamentals of care effectively1

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

1.5 respect and uphold people's human rights'

'2 Listen to people and respond to their preferences and concerns

To achieve this, you must:

2.1 work in partnership with people to make sure you deliver care effectively'

'13 Recognise and work within the limits of your competence

To achieve this, you must, as appropriate:

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

13.2 make a timely referral to another practitioner when any action, care or treatment is required

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

13.4 take account of your own personal safety as well as the safety of people in your care'

'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

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

‘15 Always offer help if an emergency arises in your practice setting or anywhere else

To achieve this, you must:

15.2 arrange, wherever possible, for emergency care to be accessed and provided promptly’

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

To achieve this, you must:

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

‘20 Uphold the reputation of your profession at all times

To achieve this, you must*:*

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

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

Charges 8a, 8c and 8f

The panel determined that Ms Sullivan’s manipulation of staffing arrangements and altering observation level pairing to ensure that she was paired with Colleague A, with whom she was in a relationship, to facilitate her relationship amounted to serious misconduct.

The panel found that Ms Sullivan abused her position of authority, destabilised the working environment, and placed patients and colleagues at risk. Additionally, placing herself on a bank holiday duty when not required created an avoidable financial cost for the Trust. The panel also found that her conduct contributed to a toxic workplace culture and undermined trust and morale.

The panel concluded that this behaviour breached Code provisions relating to leadership, professionalism and trust, including 8.2, 8.5, 8.6, 20.1, 20.2, 20.3, 20.8 and 25.1.

> ***'8 Work co-operatively***
> ***To achieve this, you must:***
> *8.2 maintain effective communication with colleagues*
> *8.5 work with colleagues to preserve the safety of those receiving care*
> *8.6 share information to identify and reduce risk'*
>
> ***'20 Uphold the reputation of your profession at all times***
> ***To achieve this, you must:***
> *20.1 keep to and uphold the standards and values set out in the Code*
> *20.2 act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment*
> *20.3 be aware at all times of how your behaviour can*
> *20.8 act as a role model of professional behaviour for students and newly qualified nurses, midwives and nursing associates to aspire to'*
>
> ***'25 Provide leadership to make sure people's wellbeing is protected and to improve their experiences of the health and care system***
> ***To achieve this, you must:***
> *25.1 identify priorities, manage time, staff and resources effectively and deal with risk to make sure that the quality of care or service you deliver is maintained and improved, putting the needs of those receiving care or services first'*

Charges 9a, 9b and 9c

The panel determined that Ms Sullivan's repeated failure to report significant incidents amounted to serious misconduct.

The panel found that incident reporting is a fundamental aspect of clinical governance and patient safety. Ms Sullivan's failure to report serious incidents, including assaults, undermined safeguarding processes, prevented learning, and exposed patients and staff to ongoing risk. The panel also found that her actions minimised the experiences of colleagues and eroded trust.

The panel concluded that this conduct breached Code provisions relating to record-keeping, raising concerns, and safeguarding, including sections 10.1, 10.2, 10.3, 10.4, 14.1, 14.2, 14.3, 16.1, 16.4, 16.5, 16.6, 19.1, 20.1 and 20.8. The panel was satisfied that this conduct amounted to serious misconduct.

> ***'10 Keep clear and accurate records relevant to your practice***
> ***This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.***
> ***To achieve this, you must:***
> *10.1 complete records at the time or as soon as possible after an event, recording if the notes are written some time after the event*
> *10.2 identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need*
> *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*
> *10.4 attribute any entries you make in any paper or electronic records to yourself, making sure they are clearly written, dated and timed, and do not include unnecessary abbreviations, jargon*

or speculation'

'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'

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

To achieve this, you must:

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

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

16.5 not obstruct, intimidate, victimise or in any way hinder a colleague, member of staff, person you care for or member of the public who wants to raise a concern

16.6 protect anyone you have management responsibility for from any harm, detriment, victimisation or unwarranted treatment after a concern is raised'

'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

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

Charges 10a, 10b and 10d

The panel determined that Ms Sullivan's use of derogatory language, inappropriate criticism of colleagues, and breach of confidentiality amounted to serious misconduct.

The panel found that Ms Sullivan failed to treat colleagues with respect, acted in a manner that was incompatible with her position as a leader and role model, and breached fundamental principles of confidentiality. The panel also found that her conduct contributed to a toxic working environment and undermined professional relationships and team cohesion.

The panel concluded that this behaviour breached Code provisions relating to communication, respect, professionalism and confidentiality, including sections 1.1, 8.1, 8.2, 8.7, 9.1, 9.4, 20.1, 20.2, 20.3, 20.5, 20.8 and 20.10. The panel was satisfied that this conduct amounted to serious misconduct.

'1 Treat people as individuals and uphold their dignity

To achieve this, you must:

1.1 treat people with kindness, respect
and compassion'

'8 Work co-operatively

To achieve this, you must:

8.1 respect the skills, expertise and contributions
of your colleagues, referring matters to them
when appropriate
8.2 maintain effective communication with colleagues
8.7 be supportive of colleagues who are encountering
health or performance problems. However, this
support must never compromise or be at the
expense of patient or public safety'

'9 Share your skills, knowledge and experience for the benefit of people receiving care and your colleagues

To achieve this, you must:

9.1 provide honest, accurate and constructive feedback to colleagues 9.4
support students' and colleagues' learning to help them develop their
professional competence and confidence'

'20 Uphold the reputation of your profession at all times

To achieve this, you must:

20.1 keep to and uphold the standards and values set
out in the Code
20.2 act with honesty and integrity at all times,
treating people fairly and without discrimination,
bullying or harassment
20.3 be aware at all times of how your behaviour can
affect and influence the behaviour of other people
20.5 treat people in a way that does not take
advantage of their vulnerability or cause them

upset or distress
20.8 act as a role model of professional behaviour for students and newly qualified nurses, midwives and nursing associates to aspire to
20.10 use all forms of spoken, written and digital communication (including social media and networking sites) responsibly, respecting the right to privacy of others at all times'

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel was of the view that Ms Sullivan's conduct demonstrates repeated, deliberate and serious departures from the standards expected of a registered nurse, including breaches of trust, professional boundaries, patient care, leadership and safeguarding responsibilities.

Accordingly, the panel finds that Ms Sullivan's actions amount to misconduct.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct, Miss Sullivan's fitness to practise is currently impaired.

In coming to its decision, the panel had regard to the NMC's guidance on the issue of impairment dated 28 January 2026.

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional and to maintain professional boundaries. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. To justify that trust, 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 she/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.'*

It was not suggested on behalf of the NMC that this was a dishonesty case and the panel agreed that the fourth limb was not engaged in the circumstances of this hearing.

The panel was satisfied that Miss Sullivan's misconduct placed patients at unwarranted risk of harm.

The panel found that Miss Sullivan repeatedly left the ward understaffed in order to pursue an undisclosed sexual relationship with a colleague. This conduct compromised staffing levels and meant that appropriate supervision ratios for vulnerable patients were not maintained. On one occasion, she left the ward with Colleague A to accompany a patient to hospital with that colleague further exacerbating staffing deficiencies due to their absence.

The panel also found that Miss Sullivan refused to examine a patient presenting with an infection and, on a separate occasion, failed to provide the same patient nicotine replacement therapy without clinical justification. These actions exposed patients to unnecessary distress and potential harm.

Further, the panel noted that Miss Sullivan breached professional boundaries with a highly vulnerable patient, including permitting unsupervised access and engaging in inappropriate physical contact. The panel determined that such conduct posed a clear safeguarding risk.

Additionally, the panel noted that on several occasions Miss Sullivan failed to complete the required incident reports (Datix) following serious incidents where staff had been sexually assaulted by patients. This resulted in inadequate risk assessments and the potential for patient harm on that ward or in other clinical settings.

Taken cumulatively, the panel determined that Miss Sullivan's conduct demonstrated a pattern of behaviour that repeatedly placed patients at unwarranted risk of harm.

The panel determined that Miss Sullivan's conduct brought the nursing profession into disrepute.

The panel considered that members of the public would be appalled to learn that a senior nurse engaged in sexual activity in the workplace whilst on duty, failed to

prioritise patient care, and repeatedly abandoned her clinical responsibilities to pursue a personal relationship.

Further, the panel noted that Miss Sullivan concealed that relationship from management, manipulated staffing arrangements, and failed to adhere to Trust policies and clinical management plans. It also noted that Miss Sullivan made derogatory comments about colleagues and failed to complete essential clinical duties.

The panel considered that such behaviour represents a serious departure from the standards expected of a registered nurse. The panel was of the view that the cumulative effect of these actions would significantly undermine public trust and confidence in the profession.

The panel was satisfied that Miss Sullivan's misconduct constituted serious and wide-ranging breaches of the fundamental tenets of the nursing profession. The panel was of the view that Miss Sullivan failed in her duty of care, did not act with candour, and did not uphold professional accountability. The panel noted a lack of compassion in her refusal to provide care and a failure to prioritise patient needs. Miss Sullivan breached confidentiality with regard to the reasons for staff sickness and used highly offensive derogatory language about a colleague.

The panel determined that Miss Sullivan abused her position of seniority, prioritising her personal relationship over patient safety and staff welfare. Her leadership was self-serving and ineffective, and her behaviour fell far short of what is expected of a nurse, particularly one in a supervisory or managerial role.

The panel concluded that the breaches were serious, repeated, and extended over a period of time, rather than being isolated incidents.

The panel carefully considered whether Miss Sullivan's misconduct is capable of remediation. While some aspects, such as record keeping, adherence to policy, and clinical decision-making are theoretically remediable, the panel was not satisfied that Miss Sullivan has demonstrated meaningful remediation.

The panel determined that Miss Sullivan's reflective piece showed very limited insight. She minimised the nature and extent of her relationship, denied key aspects of the misconduct (including sexual activity at work). [PRIVATE]. In her reflective statement she stated:

'[PRIVATE]'

Miss Sullivan failed to accept full responsibility for the impact of her actions and inactions and her contribution to the workplace culture that was described as toxic.

The panel was particularly concerned that Miss Sullivan did not accept that her clinical decisions were inappropriate, despite clear findings to the contrary. In her reflective piece she said:

'[PRIVATE]'

This lack of insight significantly increases the risk of repetition.

The panel acknowledged that Miss Sullivan was newly promoted and in her reflective piece she said that she had not had any, *"formal or informal training"* for the Band 6 or 7 roles. She stated that she, *"underestimated the difficulties that would arise*". [PRIVATE]

The panel also noted that Miss Sullivan has not been practising in a healthcare setting and has not provided evidence of strengthened practice, remediation, or relevant training. Her reflections were largely focused on the impact on herself and on her own circumstances rather than the impact of her actions on patients and colleagues.

Accordingly, the panel found that there is a real risk that Miss Sullivan would repeat similar misconduct 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 determined that a finding of impairment on public interest grounds is required because the seriousness and breadth of the misconduct, encompassing clinical failures, boundary violations, dishonesty by omission, and poor leadership. The panel concluded that public confidence in the profession would be undermined and professional standards would not be maintained, if a finding of impairment were not made in this case and therefore also finds Miss Sullivan's fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that Miss Sullivan'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 Miss Sullivan off the register. The effect of this order is that the NMC register will show that Miss Sullivan 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 Muniya submitted that the panel has now found substantive facts proved against Miss Sullivan, that those facts amount to misconduct, and that Miss Sullivan's fitness to practise is currently impaired on the grounds of both public protection and the wider public interest. In those circumstances, the panel is now required to determine

the appropriate and proportionate sanction. Ms Muniya submitted that the appropriate and necessary sanction in this case is a striking-off order.

Ms Muniya submitted that, in approaching sanction, the panel should be guided by the overarching objective of protecting the public, maintaining public confidence in the profession, and declaring and upholding proper professional standards. She submitted that professional disciplinary proceedings are not solely concerned with the individual practitioner, but with the reputation of the profession as a whole and the need to ensure that those admitted to practise are worthy of trust. The question for the panel, she submitted, is whether, having regard to the seriousness of the findings, the risk identified, and the wider public interest, Miss Sullivan is fit to remain in unrestricted practice. The NMC's position is that she is not.

Ms Muniya submitted that the panel should first consider, and rule out, the lesser sanctions in ascending order before arriving at the sanction that properly addresses the gravity of the case. She submitted, firstly, that taking no further action would be wholly inappropriate. This is an exceptional disposal and is plainly not sufficient in a case where the panel has already found current impairment on the grounds of public protection and public interest. Ms Muniya submitted that there remains a continuing risk arising from Miss Sullivan's conduct, and that it would seriously undermine public confidence if a nurse who has placed both patients and colleagues at risk of significant harm, and who has demonstrated only limited or absent insight, were to face no sanction at all. In those circumstances, taking no action would neither protect the public nor satisfy the public interest.

Turning to a caution order, Ms Muniya submitted that this is also not an appropriate or sufficient disposal. A caution order is the least restrictive sanction and is generally reserved for cases at the lower end of the spectrum where the risk of repetition is low, where the registrant has demonstrated significant insight, and where there is evidence of retraining, remediation or strengthened practice. Ms Muniya submitted that none of those features are present here**.** There has been no significant evidence of retraining or remediation. There has been no significant insight on the part of Miss Sullivan. Further, the panel could not safely conclude that Miss Sullivan is able to practise safely and unrestricted. Ms Muniya submitted that this is not a case

involving isolated or minor failings. Rather, she submitted, that it concerns serious misconduct spanning professional boundaries, clinical decision-making, leadership, record-keeping, colleague safety and patient welfare. Ms Muniya submitted that a caution order would not protect the public, would not maintain public confidence, and would be wholly insufficient to mark the seriousness of the misconduct found proved.

Ms Muniya next addressed a conditions of practice order and submitted that this option should likewise be ruled out. She submitted that conditions of practice are generally appropriate where the concerns are clinical in nature, capable of remediation, and where workable, realistic and verifiable conditions can be formulated. However, the gravamen of this case does not lie merely in remediable clinical shortcomings. Rather, the concerns relate fundamentally to Miss Sullivan's professionalism, attitude, judgement, priorities and behaviour towards both patients and colleagues. Ms Muniya submitted that these are attitudinal concerns of a much more serious and entrenched nature, which are not readily addressed through conditions.

Ms Muniya further submitted that there are no relevant, workable or measurable conditions that could adequately address the breadth of the concerns in this case whilst also protecting the public. She submitted that the panel has found misconduct involving sexual activity in the workplace, prioritisation of a personal relationship over patient care and staffing safety, failure to report serious incidents, refusal of clinical care, inappropriate conduct towards vulnerable patients, and offensive and derogatory behaviour towards colleagues. Ms Muniya submitted that such conduct speaks not simply to competence, but to deep concerns regarding judgment, integrity, professionalism and trustworthiness. In addition, she submitted that there is no evidence before the panel that Miss Sullivan would be willing to engage positively with any conditions, retraining or supervision. On the contrary, Ms Muniya submitted that the panel has seen from Miss Sullivan's correspondence and lack of participation in these proceedings that she has made it clear that she does not wish to engage with the fitness to practise process. In those circumstances, she submitted, the panel can have no confidence that she would comply with conditions over time. Therefore, Ms Muniya submitted that a conditions of practice order would not be appropriate, realistic or sufficient.

Ms Muniya then turned to suspension and submitted that this sanction also falls short of what is required in this case. She submitted that a suspension order is not sufficient to address the seriousness of the misconduct or to protect the public adequately. She submitted that the concerns identified by the panel are not limited to a discrete lapse or a single episode of poor judgment. Rather, she submitted, they are serious, repeated, and indicative of harmful, deep-seated attitudinal and behavioural problems over a sustained period. Ms Muniya submitted that the findings show that Miss Sullivan repeatedly placed her own interests above those of vulnerable patients, colleagues and the safe running of the ward. She submitted that the misconduct affected not only patients receiving care, but colleagues who were left unsupported and exposed to risk.

Ms Muniya submitted that there has been no real insight demonstrated by Miss Sullivan into either her actions or the impact those actions had, or could have had, on patients and colleagues. She submitted that there has been no meaningful acceptance of wrongdoing of the kind that would give the panel confidence that a period of suspension would lead to genuine remediation. As such, she submitted, a suspension order would not sufficiently protect the public, nor would it satisfy the wider public interest in maintaining confidence in the profession and upholding standards.

Ms Muniya further submitted that, in assessing proportionality, the panel should take into account the fact that Miss Sullivan has already been subject to an interim suspension order since 4 July 2025, which was due to expire on 3 July 2026. She submitted that this is a relevant factor which the panel is entitled to consider at the sanction stage. In support of that proposition, she relied on the authority of *Kamberova v NMC*, which confirms that a panel may properly take into account the existence and duration of any interim order when assessing the proportionality of a final sanction.

However, Ms Muniya submitted that, whilst this is a relevant consideration, it does not reduce the seriousness of the misconduct nor diminish the need for a sanction that properly protects the public and upholds the public interest. The period of interim

suspension does not negate the need for a substantive sanction commensurate with the gravity of the findings.

Ms Muniya submitted that the panel should therefore conclude that the only appropriate sanction remaining is a striking-off order. She submitted that Miss Sullivan's actions are fundamentally incompatible with continued registration. She submitted that the misconduct found proved is exceptionally serious. Miss Sullivan engaged in a relationship with a colleague which extended to sexual intercourse at work. She then made decisions to spend time with that colleague to the detriment of patients, colleagues, staffing levels and ward safety. She prioritised her own personal interests over her professional obligations. That conduct, Ms Muniya submitted, directly called into question her professionalism and placed both patients and colleagues at real and significant risk of harm.

Ms Muniya further submitted that, clinically, Miss Sullivan failed to report assaults and incidents properly, thereby leaving colleagues vulnerable to further risk and depriving the organisation of the opportunity to respond appropriately through incident reporting, review and care planning. She submitted that this failure had wider implications, because it risked fostering a closed culture in which serious incidents are not recorded, escalated or learned from. That is a matter of grave regulatory concern.

Ms Muniya also submitted that Miss Sullivan refused to provide basic clinical care to patients, leaving them in discomfort and distress. Whether one considers the refusal to examine a patient with a rash or the refusal to provide nicotine replacement therapy to a patient in need of it, those matters go to the fundamentals of nursing care. They are not peripheral concerns. They represent serious departures from the standards expected of a registered nurse. In addition, she submitted that Miss Sullivan's use of offensive and derogatory language towards colleagues, together with breaches of confidentiality, undermined professional relationships and created a culture capable of negatively affecting patient safety.

On that basis, Ms Muniya submitted that only a striking-off order can properly protect the public and meet the wider public interest. She submitted that Miss Sullivan has

abused her position of trust, lacks insight into her failings, and has displayed a pattern of misconduct over a period of time. These are substantial aggravating features which strongly support removal from the register.

Ms Muniya invited the panel, when considering whether to impose suspension or strike off, to have regard to the further guidance concerning that distinction. She submitted that the aggravating features in this case are numerous and serious. First, Miss Sullivan abused a position of trust. Secondly, she has shown a lack of insight into her failings. Thirdly, the misconduct formed a pattern over a sustained period and was not an isolated event. Fourthly, her conduct put people receiving care at risk of harm. Fifthly, her conduct also placed colleagues at risk. Ms Muniya submitted that these aggravating features overwhelmingly outweigh anything that could properly be regarded as mitigation.

Ms Muniya further submitted that there is no substantive mitigation before the panel. Miss Sullivan has not attended the hearing, is not represented, and has not provided evidence demonstrating remediation, training, reflection, strengthened practice or a developed understanding of the seriousness of her misconduct. In those circumstances, she submitted that the balance plainly falls in favour of strike off rather than suspension.

Ms Muniya also submitted that, if the panel were to consider suspension, it should ask itself whether public confidence would truly be maintained if Miss Sullivan were to return to practice after a period of suspension, whether one year or at all. The NMC’s submission is that it would not. Given the breadth and seriousness of the misconduct, the lack of insight, the absence of engagement, and the serious concerns identified by the panel, public confidence would not be protected by allowing for a future return to unrestricted practice. Ms Muniya submitted that the public would rightly expect that conduct of this nature, involving repeated disregard for patient welfare, colleague safety and professional standards, should result in removal from the register.

Ms Muniya also invited the panel to consider whether it is realistically possible that Miss Sullivan’s insight and attitude would change positively during any period of

suspension. On the evidence before the panel, she submitted that there is no basis for such optimism. There has been no meaningful engagement by Miss Sullivan in these proceedings and no evidence that she intends to address the concerns identified. In those circumstances, suspension would serve only as an ineffective holding measure, rather than a proportionate and purposeful sanction.

Further, Ms Muniya submitted that professionals are under an obligation to cooperate with their regulator, and where a registrant has failed to engage with the fitness to practise process, it will not usually be appropriate to use suspension as a means of giving them a last opportunity to reflect or demonstrate insight. Miss Sullivan has had that opportunity already. She has not taken it. The absence of engagement therefore points strongly away from suspension and in favour of strike off.

Finally, Ms Muniya submitted that sanction must also serve the purpose of preventing repetition and maintaining the reputation of the profession. A striking-off order would ensure that Miss Sullivan does not have the opportunity to repeat this misconduct in the future. More fundamentally, it would send a clear and necessary signal to the public, the profession and fellow registrants that conduct of this nature is wholly incompatible with continued registration as a nurse.

Accordingly, Ms Muniya submitted that, when all of the panel's findings are viewed cumulatively, and when the aggravating features, absence of mitigation, lack of insight, lack of remediation, lack of engagement, risk of repetition, risk to patients and colleagues, and the wider public interest are properly weighed, the only appropriate, proportionate and sufficient sanction is a striking-off order.

Decision and reasons on sanction

Having found Miss Sullivan'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 Sanction Guidance 2026 (SG). The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel also considered the section of the guidance dealing with sanctions for the highest risk cases, including the section entitled cases involving sexual misconduct. However, the panel concluded that the nature of the conduct found proved in relation to the sexual activity did not fall neatly within the type of case envisaged by that section of the guidance. The panel therefore did not regard this case as one of sexual misconduct as specifically identified in that part of the guidance. Nevertheless, the panel considered that the sexual activity in the workplace remained a highly serious feature of the misconduct and formed part of the overall assessment of sanction.

The panel took into account the following aggravating features:

- Abuse of a position of trust.
- Very limited insight into failings.
- A pattern of misconduct over a period of time.
- Conduct which put vulnerable patients at risk of suffering harm.
- Conduct which put colleagues at risk of harm.
- Manipulated circumstances and staffing arrangements in order to pursue her own objectives.

The panel also took into account the following mitigating features:

- Previous good character or history

[PRIVATE]. However, the panel did not regard those matters as carrying material mitigating weight in the circumstances. There was no sufficient independent evidence before the panel to establish any causal link that would meaningfully reduce Miss Sullivan's responsibility for the misconduct. In any event, the panel was satisfied that such matters could not explain or excuse the breadth and seriousness of the misconduct found proved.

Balancing all of these matters, the panel concluded that the aggravating features overwhelmingly outweighed the limited mitigation.

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

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict Miss Sullivan'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 Miss Sullivan'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 a conditions of practice order on Miss Sullivan's registration would be a sufficient and appropriate response. The panel concluded that such an order would not be appropriate, workable, or sufficient to meet the overarching objectives. While some limited aspects of the misconduct, viewed in isolation, might theoretically be capable of remediation, the panel was satisfied that the core concerns in this case are not simply matters of clinical competence. Rather, they concern Miss Sullivan's professionalism, judgement,

attitude, and behaviour. The panel found those concerns to be deep-seated and attitudinal in nature.

The panel was not able to formulate any practical or workable conditions that would adequately address the breadth and seriousness of the concerns identified. In particular, the panel considered that conditions could not sufficiently address Miss Sullivan's repeated prioritisation of her own personal interests over patient care and staff safety, her minimisation of serious matters, her poor leadership, her retaliatory refusal of care, and her failure to recognise the seriousness of her conduct. The panel also took into account Miss Sullivan's lack of engagement with the proceedings and the evidence that she no longer wishes to return to practice. In those circumstances, the panel had no confidence that she would engage with, comply with, or benefit from a conditions of practice order. The panel therefore rejected that sanction.

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

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

However, having considered all of the circumstances of this case, the panel concluded that a suspension order would not be sufficient.

The panel was particularly concerned by the scale and duration of the misconduct, the number of breaches proved, and the extent to which Miss Sullivan's conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. The misconduct was not isolated or momentary. It

was repeated over time and affected multiple areas of professional practice, including patient care, patient safety, staff safety, professional boundaries, leadership, incident reporting, and professional behaviour towards colleagues.

The panel also attached significant weight to Miss Sullivan's very limited insight. It found that she has failed to demonstrate a genuine understanding of the seriousness of her misconduct or of the impact of her actions on patients, colleagues, the profession, or the public. There is no evidence of strengthened practice, no persuasive evidence of remediation, and no evidence that a period of suspension would lead to meaningful change. The panel considered that Miss Sullivan has not shown any real recognition of the gravity of what occurred.

The panel was further concerned that a suspension order, which can only be imposed for a limited period, would not sufficiently address the public interest in this case. The panel considered that public confidence in the profession, and confidence in the regulator, would be seriously undermined if Miss Sullivan were permitted to return to practice after a period of suspension in light of the seriousness of the findings in this case. The panel therefore concluded that suspension would be insufficient to protect the public, uphold standards, and maintain confidence in the profession.

The panel further noted that the serious breach of the fundamental tenets of the profession evidenced by Miss Sullivan's actions is fundamentally incompatible with Miss Sullivan 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?*

Miss Sullivan'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 Miss Sullivan'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 Miss Sullivan'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 has also considered the proportionality of sanction in light of the previous interim order of suspension that has been in place. The panel took into account the existence and effect of that interim order when assessing what sanction is now necessary and proportionate. Having done so, the panel remained satisfied that, notwithstanding the period for which Miss Sullivan has already been subject to interim restriction, a striking-off order is the only sanction sufficient to protect the public, maintain public confidence in the profession and in the regulator, and uphold proper professional standards. It was also the order which is necessary to mark the importance of maintaining public confidence in the profession, and to send to the public and the profession a clear message about the standard of behaviour required of a registered nurse.

Accordingly, the panel has decided to impose a striking-off order.

This will be confirmed to Miss Sullivan 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 Miss Sullivan's own interests until the striking-off sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Submissions on interim order

The panel took account of the submissions made by Ms Muniya. She submitted that following the panel's decision to impose a striking-off order, the panel must now consider whether it is necessary to impose an interim order to cover the period before that substantive sanction takes effect.

Ms Muniya submitted that, as the panel is aware, a striking-off order does not take effect immediately. She submitted that there is a statutory appeal period of 28 days, and in the event that Miss Sullivan exercises her right of appeal, the substantive order will not take effect until the appeal is concluded. In those circumstances, absent an interim order, Miss Sullivan would be free to practise without restriction during that period. She submitted that the NMC therefore applies for an interim suspension order for a period of 18 months.

Ms Muniya submitted that such an order is necessary on the grounds of both public protection and the public interest.

Ms Muniya submitted that the panel has already determined, at the impairment stage, that Miss Sullivan poses a current risk to patients, colleagues and the wider public. Further, the panel has imposed a striking-off order precisely because of the seriousness of that risk and the incompatibility of Miss Sullivan's conduct with continued registration. She submitted that those findings strongly support the

imposition of an interim order. She submitted that this is not a case where an interim order would merely be desirable; rather, it is necessary to protect the public whilst the substantive sanction awaits implementation.

Ms Muniya invited the panel to have regard to its own findings of fact and the risks identified within them. She submitted that those findings demonstrate both actual harm and a real risk of harm. By way of example, she reminded the panel that:

- Miss Sullivan engaged in boundary breaches with a vulnerable patient, contrary to care plans and ward safety requirements, exposing that patient, herself and colleagues to risk;
- Miss Sullivan left the ward understaffed, including in relation to charges where insufficient staffing levels and management oversight placed vulnerable patients and colleagues at risk;
- Miss Sullivan manipulated staffing arrangements and observation levels in order to spend time with a colleague, again leaving the ward inadequately staffed and exposing both patients and colleagues to risk;
- Miss Sullivan failed to report serious incidents, thereby exposing both patients and staff to ongoing and unmanaged risks.

Ms Muniya submitted that these findings demonstrate a clear pattern of behaviour that repeatedly placed patients and colleagues at unwarranted risk of harm. She submitted that the panel has already concluded that there is no confidence that Miss Sullivan can practise safely and effectively. In those circumstances, she submitted that there remains a continuing and real risk to the public.

Ms Muniya further submitted that the previous interim suspension order has now lapsed following the panel's substantive decision. As such, without the imposition of a new interim order, Miss Sullivan would be at liberty to practise unrestricted during the appeal period. She submitted that this would be wholly inconsistent with the panel's findings and would expose the public to unacceptable risk.

Accordingly, she submitted that an interim suspension order is required to ensure continued protection of the public pending the implementation of the striking-off order.

Ms Muniya further submitted that an interim order is also necessary on public interest grounds. She reminded the panel that it has already found impairment on public interest grounds, and that those findings remain highly relevant at this stage. She submitted that an informed member of the public would be seriously concerned, and indeed shocked, if a nurse who has been found to have committed serious misconduct and who is subject to a striking-off order were permitted to continue practising without restriction during the appeal period.

Ms Muniya submitted that the panel has found serious and wide-ranging misconduct, including:

- engaging in sexual activity in the workplace whilst on duty;
- failing to prioritise patient care, thereby exposing vulnerable patients to risk;
- misusing a position of authority and failing to adhere to Trust policies and clinical management plans;
- demonstrating a lack of integrity, including concealment of relevant matters;
- behaving in a manner that disrespected colleagues and undermined professional standards.

Ms Muniya submitted that these findings go to the heart of the trust placed in registered nurses by the public. Allowing Miss Sullivan to practise unrestricted in the face of such findings would significantly undermine public confidence in the profession and in the regulatory process.

Ms Muniya submitted that the need to maintain confidence in the profession and to uphold proper standards clearly outweighs Miss Sullivan’s personal interest in being able to practise during the interim period.

Ms Muniya submitted that an interim suspension order is the appropriate and proportionate form of restriction. She submitted that interim conditions of practice would not be suitable in this case. The concerns identified by the panel are not limited to remediable clinical deficiencies but relate to deep-seated attitudinal and behavioural issues, including professionalism, integrity, judgement and prioritisation of patient care. In addition, the panel has already found a lack of engagement on the part of Miss Sullivan, and there is no evidence that she would comply with or respond positively to any conditions imposed.

Ms Muniya submitted that conditions would not be workable or sufficient to manage the risks identified. She submitted that a suspension order, by contrast, is consistent with the seriousness of the findings and aligns with the panel's decision to impose a striking-off order.

Ms Muniya submitted that the NMC seeks an interim suspension order for a period of 18 months. She submitted that this period is appropriate and proportionate in light of the current backlog of cases and the potential duration of any appeal proceedings. This would ensure that the public remains protected for the full duration of the appeal process, should one be pursued.

Ms Muniya reminded the panel that, if Miss Sullivan does not appeal, or if any appeal is concluded sooner, the interim order will fall away and the substantive striking-off order will take effect.

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 the fact that the risk identified at the impairment stage remains current and ongoing. Miss Sullivan's conduct demonstrated a pattern of behaviour that placed patients and colleagues at risk of harm, and the panel has found that there is no sufficient insight or remediation to mitigate that risk at this stage.

The panel determined that an interim order is necessary on both public protection and public interest grounds.

In relation to public protection, the panel was satisfied that there remains a real and continuing risk of harm to patients and colleagues if Miss Sullivan were permitted to practise without restriction. The seriousness of the misconduct, the lack of insight, and the absence of remediation all contribute to that ongoing risk.

In relation to the public interest, the panel considered that public confidence in the nursing profession and in the regulatory process would be seriously undermined if a registrant who has been found to have committed serious misconduct, and who is subject to a striking-off order, were allowed to continue practising unrestricted during the appeal period. The panel considered that an informed member of the public would find such a situation incongruous and unacceptable.

The panel considered whether an interim conditions of practice order would be sufficient. For the same reasons identified at the substantive sanction stage, the panel concluded that conditions would not be appropriate, workable, or sufficient to address the risks identified. The concerns in this case are not limited to remediable clinical deficiencies but relate to serious attitudinal and behavioural issues. The panel also had no confidence that Miss Sullivan would engage with or comply with any conditions.

The panel therefore concluded that an interim suspension order is the only appropriate and proportionate form of restriction.

The panel considered the appropriate length of the interim order. It determined that a period of 18 months is necessary and proportionate. This period allows for the 28-day appeal window and any potential appeal process to be concluded, ensuring that the public remains protected throughout.

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

That concludes this determination.