Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Meeting

Tuesday 12 September 2023 - Thursday 14 September 2023

Virtual Meeting

Name of Registrant:	**Linda Maria Sullivan**
NMC PIN	88A2203E
Part(s) of the register:	RN3, Registered Nurse- Mental Health (April 1991)
Relevant Location:	Stockport
Type of case:	Misconduct
Panel members:	Anthony Mole (Chair, lay member) Jude Bayly (Registrant member) Gregory Hammond (Lay member)
Legal Assessor:	Charles Apthorp
Hearings Coordinator:	Yewande Oluwalana
Facts proved:	Charges 1a, 1b, 2b, 2c iii), 2c v), 2c vi), 2d, 2e i), 3 and 4
Facts not proved:	Charges 2a, 2c i), 2c ii), 2c iv), 2e ii), 2e iii)
Fitness to practise:	Impaired
Sanction:	**Striking-off order**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on service of Notice of Meeting

The panel was informed at the start of this meeting that that the Notice of Meeting had been sent to Ms Sullivan registered address by recorded delivery on 8 August 2023.

The panel had regard to the Royal Mail 'Track and trace' printout which showed the Notice of Hearing was delivered to Ms Sullivan's registered address on 9 August 2023. It was signed for against the printed name of 'SULLIVAN'.

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Meeting provided details of the allegation and the fact that the meeting would be held no earlier than 12 September 2023.

In the light of all of the information available, the panel was satisfied that Ms Sullivan has been served with notice of this meeting in accordance with the requirements of Rules 11A and 34 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Details of charge

That you, a registered nurse:

1) On 15 January 2022, in response to Patient A self-harming, said words to the effect of:

    a) *"you need to stop doing that, you're making an awful racket. Would you like me to get someone to put hands on?"* **[PROVED]**
    b) *"you really want to do the corner, not the middle of the wall. The corner makes more damage";* **[PROVED]**

2) Between 5 October 2019 and 6 October 2019:

    a) failed to assess Patient B; **[NOT PROVED]**

b) failed to undertake adequately, or at all, observations for Patient B and/or did not ensure that observations were undertaken by others; **[PROVED]**

c) Incorrectly recorded that you had conducted observations in Patient B's care records at the following times:
   i) 20:22 hours **[NOT PROVED]**
   ii) 22:05 hours **[NOT PROVED]**
   iii) 00:00 hours;**[PROVED]**
   iv) 02:25 hours **[NOT PROVED]**
   v) 04:00 hours;**[PROVED]**
   vi) 06:00 hours **[PROVED]**

d) Incorrectly recorded in Patient B's care records that a second nurse was present at the times recorded at charge 2(c) above; **[PROVED]**

e) failed to enter the seclusion area to conduct observations for Patient B at the following times:
   i) 20:22 hours **[PROVED]**
   ii) 22:05 hours **[NOT PROVED]**
   iii) 02:25 hours **[NOT PROVED]**

3) Your conduct at charge 2(c) was dishonest in that you intended to mislead any person reading Patient B's care records to believe that observations had been conducted when they had not; **[PROVED]**

4) Your conduct at charge 2(d) was dishonest as you intended to mislead any person reading Patient B's care records to believe that a second nurse was present when they were not; **[PROVED]**

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

Background

Ms Sullivan was referred to the Nursing and Midwifery Council ('NMC') on 14 April 2022 by the Priory Group Limited (Priory Group), in relation to her employment at the Priory Hospital Cheadle Royal (the Hospital). Ms Sullivan commenced employment with Priory Group on 14 December 2015 as a Registered Mental Health nurse, where she initially worked as a Deputy Ward Manager at Altrincham Priory before transferring to the Hospital in May 2017 where she worked as a Deputy Night Manager.

Ms Sullivan worked in the Orchard ward at the Hospital. The Orchard ward ('Orchard ward') is a 15 bed General Adolescent unit, which offers specialist service to treat young people between the ages 12 to 17 with a variety of mental health conditions including those with a risk of self-harm.

On 16 January 2022, Patient A [PRIVATE] reported that Ms Sullivan, the night manager, had verbally abused her during the night shift on 15 January 2022. This occurred on the Orchard ward at the Hospital.

The referral alleged that on 15 January 2022, while Ms Sullivan was working on a night shift, she displayed unprofessional conduct towards a young patient, causing them distress and upset. It is alleged that the patient told a member of staff at the Hospital that Ms Sullivan said that she should bang her head on the corner of the wall as it would do more damage. Ms Sullivan then closed the door and left the room.

It is alleged that initially Ms Sullivan denied verbally abusing the patient. However, upon reviewing the CCTV footage as part of the Priory Group's investigation into the incident, Ms Sullivan accepted in the investigation meeting, where she was shown the CCTV footage, that she made the comments to the patient. When the CCTV footage had been reviewed by Witness 2 it showed that Ms Sullivan was only present on the ward for one hour and twenty-two minutes throughout her night shift.

A disciplinary hearing was held on 7 April 2022 and the allegations were upheld. Ms Sullivan's employment was subsequently terminated on 8 April 2022, on the grounds of gross misconduct.

During the course of the NMC's investigation, a previous instance of Ms Sullivan allegedly neglecting another patient (Patient B) and failing to prioritise the patient's welfare needs, and falsifying the patient's nursing notes in October 2019. Witness 5 provided a witness statement in relation to the patient neglect incident as she investigated it. Witness 5 explained that Ms Sullivan worked a night shift on 5-6 October 2019 and was responsible for checking Patient B (who was then being kept in seclusion) every two hours along with a second nurse in attendance.

Ms Sullivan had documented that she had seen Patient B six times during the course of the night shift. However, based on CCTV footage, it transpired that she had only entered the seclusion suite to see Patient B on three occasions. It was not possible to conduct the observation from outside the seclusion suite or remotely from the CCTV.

Decision and reasons on facts

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

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

The panel had regard to the written statements of the following witnesses on behalf of the NMC:

- Witness 1: Safeguarding and Social Work Manager at the Hospital.

- Witness 2: Ward Manager at the Hospital, and the investigating officer for the disciplinary investigation.

- Witness 3: Ward Manager on Orchard ward at the Hospital.

- Witness 4: Healthcare Assistant on the Orchard Ward at the Hospital.

- Witness 5: Former Director of Clinical Services for the Priory Group at the time of the incident for Patient B.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor who referred it to the case of *Ivey v Genting Casinos* [2017] UKSC 67 with regard to the test for dishonesty. It considered the documentary evidence provided by the NMC and the CCTV footage for the incident on 15 January 2022.

The panel found that there were some discrepancies with the recorded time of *'02:25 hours'* as stated in the charges, against the time *'02:24'* which was contained in the documents for the Disciplinary hearing notes dated 20 December 2019. Further reference was given for *'02:24hrs'* in the CCTV evidence that Witness 5 reviewed at the time of the incident. The panel has borne this in mind when considering the charges.

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

Charge 1a and 1b

"That you, a registered nurse:

1) On 15 January 2022, in response to Patient A [PRIVATE], said words to the effect of:

a) *"you need to stop doing that, you're making an awful racket. Would you like me to get someone to put hands on?"*

b) *"you really want to do the corner, not the middle of the wall. The corner makes more damage";*

This charge is found proved.

In reaching this decision, the panel took into account that it had viewed the CCTV footage for the 15 January 2022. The panel determined that this was cogent evidence in which Ms Sullivan is clearly heard saying "*you need to stop doing that, you're making an awful racket. Would you like me to get someone to put hands on?"* and "*you really want to do the corner, not the middle of the wall. The corner makes more damage".*

The panel noted the staff rota was provided and it showed that Ms Sullivan was on shift. In the Investigation Meeting Notes dated 28 January 2022, Ms Sullivan initially accepts that she was the one entering the room, but she denied that she had verbally abused Patient A and maintained this position up to the point she was shown the CCTV footage. Ms Sullivan was then recorded to state the following:

'**[Witness 2]** *Why would you say hit your head on the corner you'll do more damage*

LS *I don't think I did say that, If I did, I don't remember saying it. Watching that has made me feel sick. I don't think I would say that to a patient*

…

[Witness 2] *If you saw or heard a member of staff saying comments like this what would you do?*

LS *I'd report them. It is abusive and not helpful in that situation. I'm not disputing I didn't say it, I heard it.'*

The panel considered all the information before it and found Charges 1a and 1b proved.

Charge 2a)

2) Between 5 October 2019 and 6 October 2019:

a) failed to assess Patient B;

This charge is found not proved.

In reaching this decision, the panel first examined whether the NMC had satisfied what Ms Sullivan's duty was and what she had to assess in respect of Patient B in relation to the above charge. The panel looked at the documentary evidence before it, namely Witness 5's statement, the Safeguarding Report/ Management Report Meeting minutes dated Wednesday 6 November 2019, and the Safeguarding Investigation Report into allegation of neglect of Patient B dated 6 October 2019.

The panel noted that within the Safeguarding Investigation Report, reference was made to the following:

> *Whilst in seclusion, a patient will be observed on a 1:1 basis and should be line of sight at all times. The observing nurse should document what they see every 15minutes.*
>
> *As per the MHA Code of Practice and Priory Policy H40 Seclusion, regular nursing reviews (with 2 nurses in attendance) should be undertaken at a maximum time interval of 2 hours.'*

However, the panel did not have sight of any policy documents or a definitive description of the duty that Ms Sullivan has allegedly failed to assess.

The panel determined that, due to the lack of evidence that has been provided by the NMC, it could not on the balance of probabilities find charge 2a proved. Therefore, this charge is found not proved.

Charge 2b)

b) failed to undertake adequately, or at all, observations for Patient B and/or did not ensure that observations were undertaken by others;

This charge is found proved.

In reaching this decision, the panel reviewed the documentary evidence of the Safeguarding Investigation report into allegation of neglect of Patient B (Safeguarding Investigation Report) dated 6 October 2019, the job description of a Night Manager as advertised by the Priory Group, and the Safeguarding Report/Management Report Meeting Minutes (Safeguarding Meeting) dated 6 and 7 November 2019.

The panel noted at the time of the alleged incident Ms Sullivan was an Acting Night Manager. It looked at the job description and what would have been required for her to do in her role which was as follows:

> '….
> *In this role you will be responsible for overseeing the hospital at night, providing leadership and support to the ward based* [sic] *nursing teams, and clinical supervision. You will ensure that a high standard of patient care is provided* [sic] *and that wards hospital comply with all quality standards and statutory requirements throughout the night shift.'*

The panel inferred from the job description provided that Ms Sullivan would have been responsible for overseeing the work and standards of her staff on the night shift. It noted from the Safeguarding Investigation Report that there was a litany of failings that other staff had committed whilst on shift, including the following:

> *'Observing staff at 0545 noted there was faeces on the seclusion room floor and report that they informed the nurse in charge of the ward of this.*
>
> *Observing staff at 0800hrs (on the day shift) states that it was not immediately obvious that the patient had smeared himself in faeces until the patient was observed doing this at 0815. However* [sic] *had the RMNs completed the reviews at 0600 as they have documented, an assessment of the patient would have been made. The CCTV evidence is that no nursing reviews took place after 0224hrs, therefore the RMNs are not in a position to comment on the patients* [sic] *situation as they have not seen him.*
> ….

RMN [XX] *has documented that she saw the patient in seclusion on 6 occasions during her night shift that commenced on 05/10/19 (2000, 2200, 0000, 0200, 0400 and 0600)*

…

From CCTV evidence, [XX] *is seen to enter the seclusion suite (and thus observe the patient) on 2 occasions, 2205hrs and 0021hrs. At no other time is* [XX] *seen in the seclusion suite.*

It would not have been possible for [XX] *to have observed the patient without entering the seclusion suite. Therefore, the seclusion entries documented at 2000, 0200, 0400 and 0600 cannot* [be] *a true reflection of what actually happened.*

…..

Between 0400 and 0500, Agency HCA … appears to fall asleep for most of this hour. He views the patient at 0400 and then again at 0500hrs.'

The panel considered that Patient B's notes contained information of numerous observations undertaken by Ms Sullivan and other nurses and Healthcare Assistants (HCAs). During the local investigation, Witness 5 reviewed CCTV footage from that night of October 2019, and in her witness statement was able to recall that there were many discrepancies between what was written in the notes and what was seen on CCTV. The panel noted that this footage is no longer available and did not have sight of it.

The Safeguarding Minutes dated 7 November 2019 included the following:

'LS	*LS reported that she came onto the ward at 06:00hrs. LS reported that she knows what has happened, she has gone onto the ward and taken the teams* [sic] *word that the patient was asleep and therefore not entered seclusion.*
[Witness 5]	[Witness 5] *reported that the difficulty with that it* [sic] *that staff member …has not observed patient.*

LS	*….. LS said that she holds her hands up and knows that at times she has not checked and taken the teams* [sic] *word that a patient is asleep. There is no justification and she apologies* [sic]. *LS assured* [Witness 5] *that it would never happen again.'*

Based on the evidence before it, the panel determined that Ms Sullivan had failed in her duties as an assistant night manager to undertake adequately, or at all, observations for Patient B and/or did not ensure that observations were undertaken by others. This charge is found proved.

Charge 2c

c) Incorrectly recorded that you had conducted observations in Patient B's care records at the following times:

i) 20:22 hours

This charge is found not proved.

The panel considered Witness 5's written statement, the Safeguarding Investigation Report, Disciplinary hearing notes dated 20 December 2019, the Disciplinary Hearing Decision letter dated 13 January 2020, Ms Sullivan's statement, Record of Nursing Reviews - Seclusion dated 5-6 October 2019, and Seclusion observation documentation dated 5-6 October 2019.

The panel noted that during the safeguarding investigation Witness 5 found discrepancies in the recorded times of observations undertaken for Patient B by Ms Sullivan. It was recorded that Ms Sullivan undertook observations on six separate occasions at the following times 20:00, 22:00, 00:00, 02:00, 04:00 and 06:00, and this is evidenced in the Record of Nursing Reviews - Seclusion. However, during Witness 5's review of the CCTV footage, it showed that Ms Sullivan had only attended to Patient B on three occasions at 20:22, 22:05 and 02:24.

Witness 5 in the Safeguarding Investigation report stated the following,

> *'From CCTV evidence, LS is seen to enter the seclusion suite (and thus observe the patient) on 3 occasions, 2022hrs, 2205hrs and 0224hrs. At no other time is LS seen in the seclusion suite.'*

The panel did not find that there was evidence Ms Sullivan completed any documentation for the time of 20:22 in the records provided, when CCTV showed she had actually visited Patient B. The panel determined that Ms Sullivan not completing the record when she should have done, does not satisfy the stem of the charge as Ms Sullivan has not recorded anything at the time stated in the charge. Therefore, the panel finds this charge not proved.

ii) 22:05 hours

This charge is found not proved.

For the same reasons stated under charge 2c i) above the panel determined that this charge is found not proved.

iii) 00:00 hours;

This charge is found proved.

The panel considered the same evidence as for charge 2c i) above and determined that this charge is found proved. There is contemporaneous evidence that shows Ms Sullivan completed an observation record for the time of 00:00 hours for Patient B, in that Witness 5 confirms she had viewed the CCTV footage that showed Ms Sullivan never attended to Patient B at the time she recorded the observations.

The charge is found proved that Ms Sullivan incorrectly recorded that she had conducted observations in Patient B's nursing notes.

iv) 02:25 hours

This charge is found not proved.

The panel note that there is a one-minute discrepancy between the time stated in the charge and the time recorded on CCTV footage which was 02:24 hours. The panel considered that this would not hinder its decision based on the evidence before it. However, it found that this charge is not proved for the same reasons stated in charge 2c i) above.

v) 04:00 hours;

This charge is found proved.

The panel noted that during the safeguarding investigation Witness 5 found discrepancies in the recorded times of observations undertaken for Patient B by Ms Sullivan. It was recorded that Ms Sullivan undertook observations on six separate occasions at the following times 20:00, 22:00, 00:00, 02:00, 04:00 and 06:00 and this is evidenced in the Record of Nursing Reviews - Seclusion. However, during Witness 5's review of the CCTV footage, it showed that Ms Sullivan had only attended to Patient B on three occasions at 20:22, 22:05 and 02:24.

In the local Disciplinary Hearing Decision Letter it stated:

> '*… The "04:00hrs" review you agreed with the evidence that you had not attended the seclusion suite but felt sure that you had been present on the ward around this time in order to complete the seclusion paperwork. You however confirmed that you had not personally assessed the patient to confirm he was asleep.*
>
> *You explained at the hearing that when you attended the ward to complete the "06:00hr" review you again did not enter the seclusion suite to review the patient and had been led by Nurse* [XX]*'s assessment that the patient was asleep.'*

The panel finds that Ms Sullivan did not attend to Patient B during at 04:00hrs when she stated she had. This charge is found proved that Ms Sullivan incorrectly recorded that she had conducted observations in Patient B's care records.

vi) 06:00 hours

This charge is found proved.

For the same reasons stated above in charge 2c v) the panel find that Ms Sullivan incorrectly recorded that she had conducted observations in Patient B's care records at 06:00hrs when she had not. This charge is found proved.

Charge 2d)

d) Incorrectly recorded in Patient B's care records that a second nurse was present at the times recorded at charge 2(c) above;

This charge is found proved.

The panel considered this charge in relation to charges 2c iii), v) and vi). The panel considered Witness 5's witness statement, the Record of Nursing Reviews - Seclusion and the Safeguarding Investigation Report. The panel found that Ms Sullivan's notes were entered as the second nurse and not the primary nurse undertaking the observations. Because it had already found that Ms Sullivan had not attended Patient B at the stated times, the panel found this charge proved.

Charge 2e)

e) failed to enter the seclusion area to conduct observations for Patient B at the following times:

i) 20:22 hours

This charge is found proved.

The panel considered Witness 5's witness statement at paragraph 13 which stated as follows:

> *'On CCTV, Ms Sullivan was seen opening the door to the seclusion suite at 20:22, 22:05 and 02:24. However she did not enter the seclusion area which was required to conduct the reviews. Additionally* [sic] *she is noted to be by herself and* [XX] *was not present. Ms Sullivan apologised and admitted that she often took the team's word for it that Patient B was well and did not check for herself.'*

The panel also considered the Disciplinary Hearing Decision letter which stated the following:

> *'At the "20:00hr" review you explained that prior to attending the ward you had had a telephone conversation with the nurse-in-charge* [XX] *during which it was decided that you would not enter the seclusion room to complete a full review. You explained that you had been guided by Nurse* [XX] *but agreed that you had made the final decision. You agreed that you made this decision without first seeing the patient and was* [sic] *therefore not in a position to make this assessment. You confirmed that when you attended the ward you entered the seclusion suite on your own and viewed the patient through the window alongside the observing Healthcare Assistant. You agreed with me that this act demonstrated the intent not to enter the seclusion room to fully assess the patient and provide them with their basic needs. You offered an explanation that the ward and hospital was busy but agreed that this was not an acceptable level of care'.*

Taking all the evidence into consideration the panel determined on the balance of probabilities that this charge is found proved.

ii) 22:05 hours

This charge is found not proved.

The panel noted Witness 5's witness statement, the Disciplinary Hearing notes and Disciplinary Hearing Decision Letter, the Safeguarding Investigation Report and

Safeguarding Meeting Minutes. It was recorded that Ms Sullivan had attended to Patient B and had carried out a full assessment, but this was not recorded in Patient B's care record notes.
The panel noted in the Disciplinary Hearing Decision Letter it stated the following:

> *'The evidence from CCTV showed that from the six reviews completed only the "22:00hrs" review was carried out in accordance to* [sic] *the Mental Health Act (1983) Code of Practise* [sic] *and Priory Policy H40: Seclusion.*
>
> *…*
>
> *It is noted that the seclusion room is entered at the "22:00hr" as per policy, with you and Nurse* [XX] *in attendance, during which time the patient's basic needs are addressed'.*

The evidence provided to the panel indicated Ms Sullivan entered the seclusion suite with another nurse at 22:05 and addressed Patient B's needs. The panel found based on this evidence the charge not proved.

iii) 02:25 hours

This charge is found not proved.

The panel had regard to Witness 5's witness statement paragraph 13 which stated as follows:

> *'On CCTV, Ms Sullivan was seen opening the door to the seclusion suite at 20:22, 22:05 and 02:24. However she did not enter the seclusion area which was required to conduct the reviews. Additionally* [sic] *she is noted to be by herself and* [XX] *was not present. Ms Sullivan apologised and admitted that she often took the team's word for it that Patient B was well and did not check for herself.'*

The panel also considered the Disciplinary Hearing Decision Letter dated 13 January 2020, which stated:

'It is evident that during the "02:00hr" and "04:00hr" reviews the observation records confirm the patient is asleep and therefore the care plan would be to not enter the seclusion room and disturb the patient but there is still a requirement for the two nurses to attend and assess the patient's physical wellbeing. You confirmed that during the "02:00hr" review you attended on your own. You explained that it was possible Nurse [XX] *was on her break at this period but you agreed that you should have either disturbed her or attended with the second night manager on duty with you. You were unable to explain why you had not done this.*

The panel noted the one-minute discrepancy between the time stated in the charge (02:25) and the time stated consistently in the evidence (02:24) and decided that this was not a material consideration. Taking all of the evidence into consideration the panel determined that Ms Sullivan did not enter the seclusion area, but a plausible reason was provided. It noted the reference to the care plan indicating that when a patient is asleep the checking staff should not enter the seclusion suite and disturb the patient. The panel therefore finds this charge is not proved.

Charge 3)

3) Your conduct at charge 2(c) was dishonest in that you intended to mislead any person reading Patient B's care records to believe that observations had been conducted when they had not;

This charge is found proved.

In reaching this decision, the panel considered its previous findings in charges 2c iii), v) and vi).

The panel moved on to the issue of whether Ms Sullivan's intent on recording observations for 00:00, 04:00 and 06:00 within Patient B's care record when she had not, was dishonest. The panel had regard to the test set out in *Ivey v Genting Casinos*, in particular*:*

- *What was the defendant's actual state of knowledge or belief at the time she made the entries;*
- *Whether that belief was genuinely held; and*
- *Was the conduct dishonest by the standards of ordinary decent people?*

The panel is satisfied that Ms Sullivan was dishonest in her actions. It noted that during the safeguarding investigation Ms Sullivan indicated that she took the word of another staff member when she completed the records, when she had not undertaken the observation of Patient B.

The Safeguarding Minutes dated 7 November 2019 stated the following:

'LS	*LS reported that she came onto the ward at 06:00hrs. LS reported that she knows what has happened, she has gone onto the ward and taken the teams word that the patient was asleep and therefore not entered seclusion.*
[Witness 5]	[Witness 5] *reported that the difficulty with that it* [sic] *that staff member …has not observed patient.*
LS	*… LS said that she holds her hands up and knows that at times she has not checked and taken the teams word that a patient is asleep. There is no justification and she apologies* [sic]. *LS assured* [Witness 5] *that it would never happen again.'*

The panel was of the view that, by completing Patient B's observations records at the various times, Ms Sullivan's intention was to mislead anyone reading the notes that the observations had occurred, *'as per the MHA Code of Practice and Priory Policy H40 Seclusion, regular nursing reviews (with 2 nurses in attendance) should be undertaken at a maximum time interval of 2 hours',* when they had not. It determined that an ordinary decent member of the public in these circumstances would consider this to be dishonest.

The panel therefore finds this charge proved.

Charge 4)

4) Your conduct at charge 2(d) was dishonest as you intended to mislead any person reading Patient B's care records to believe that a second nurse was present when they were not;

This charge is found proved.

The panel finds this charge proved by the same reasons established in charge 3 above. Ms Sullivan's action was dishonest as she intended to mislead any person reading Patient B's care records to believe that a second nurse was present when they were not.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider whether the facts found proved amount to misconduct and, if so, whether Ms 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 suitability to remain on the register unrestricted.

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

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

Representations on misconduct

The NMC referred to the case of *Roylance v GMC (No. 2)* [2000] 1 AC 311 which defines misconduct as a 'word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.' It also referred to comments of Jackson J in

Calheam v GMC [2007] EWHC 2606 (Admin) and Collins J in *Nandi v General Medical Council [2004] EWHC 2317 (Admin)*: '[Misconduct] connotes a serious breach which indicates that the doctor's (nurse's) fitness to practise is impaired'…'The adjective "serious" must be given its proper weight, and in other contexts there has been reference to conduct which would be regarded as deplorable by fellow practitioners'.

The NMC invited the panel to take the view that the facts found proved amount to misconduct. The NMC identified the specific relevant standards of *'The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates'* (the Code) which it submitted that Ms Sullivan had breached namely sections 1, 1.1, 1.2, 1.4, 3, 3.1, 3.3, 4, 8, 8.3, 8.5, 8.6, 10, 10.3, 17, 17.1, 20, 20.1, 20.2, 20.3, 20.5, 20.6, 20.8, 20.10, 25, 25.1.

The NMC submitted that the breaches of the Code that amount to misconduct are serious because Ms Sullivan's failings involved a serious departure from the standards expected of a registered professional. The failings are likely to cause a risk to patients in the future if they are not addressed and also undermine trust and confidence in the profession.

Representations on impairment

The NMC invited the panel to find Ms Sullivan's fitness to practise impaired.

The NMC requires the panel to bear in mind its overarching objective to protect the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. The NMC referred to the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin) and Silber J in the case of *R (on application of Cohen) v General Medical Council* [2008] EWHC 581 (Admin).

The NMC submitted that all four limbs of Dame Janet Smith's "test" as endorsed in the case of *CHRE v NMC and Grant,* can be answered in the affirmative in this case. It submitted that Ms Sullivan:

a) has in the past acted and/or is liable in the future to act as so 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 [nursing] profession into disrepute; and/or
c) has in the past committed a breach of one of the fundamental tenets of the [nursing] profession and/or is liable to do so in the future
d) has in the past acted dishonestly and/or is liable to act dishonestly in the future.

The NMC submitted the following:

a) *The failure to provide appropriate care to a vulnerable mental health Patient A* [PRIVATE] *raises an obvious risk of harm as does the failure to carry out adequate regular observations on another vulnerable mental health Patient B. Failing to ensure adequate standards of both patients' care and poor cooperation with colleagues to ensure that observations on Patient B were undertaken by others had the potential to put both vulnerable patients at risk of harm.*

b) *By making inappropriate comments to vulnerable mental health Patient A* [PRIVATE] *Ms Sullivan also put the patient at the risk of psychological and emotional harm by causing distress to the patient. In addition making such inappropriate comments to the patient was in breach of professional boundaries and therefore carried the risk to reputation of the nursing profession.*

c) *Equally the dishonesty in falsifying the clinical records to misleadingly present that the adequate regular observations had been carried out on Patient B and that the second nurse was present at those observations while both were not the case, also had the risk of reputational damage to the profession.*

d) *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. Nurses must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession. Ms Sullivan's failings relate to basic and fundamental nursing duties. As such her misconduct is liable to bring the profession into disrepute.

e) *The nursing profession is a caring profession. Ms Sullivan has breached the fundamental tenet of providing safe and effective care to patients. Further, the individual provisions of the professional Code, constitute fundamental tenets of the nursing profession. The conduct involved has engaged, and breached, the above provisions.*

The NMC submitted that in respect of the concerns being remediated, Ms Sullivan has not substantially engaged with the NMC about her case and has not provided a formal response to the regulatory concerns and charges. However, Ms Sullivan did provide written submissions regarding the incident involving Patient A at her Interim Order hearing on 5 May 2022, in which Ms Sullivan stated the following:

'…*I cannot express how awful I feel for having snapped at the young person that night in a career of over 30 years this has never happened before. I am more than remorseful and apologise for bringing my profession into disrepute…'*

The NMC submitted that Ms Sullivan accepts misconduct in relation to her clinical practice. In addition, it would appear that Ms Sullivan made admissions in respect of both incidents involving Patients A and B at a local level. Initially Ms Sullivan denied the allegations at the local investigations but finally admitted them after she had been shown the CCTV footage of the relevant shifts.

The NMC submitted that Ms Sullivan's misconduct of poor clinical care provided to Patient B took place in 2019 which was followed by another incident of equally poor clinical care provided to Patient A in 2022. This indicates a patten of repetition of misconduct carrying the risk of putting patients at unwarranted risk of harm in future.

Ms Sullivan has not engaged with the NMC investigation and has not provided formal responses to the charges. There is no evidence of Ms Sullivan's insight into the

dishonesty. It submitted that in the absence of a full reflection and relevant training and/or strengthened practice to cover all the concern raised, Ms Sullivan's insight is limited and requires greater development.

The NMC submitted that the concerns have not been remediated and there is a continuing risk to the public. Ms Sullivan has not practised in a clinical setting since May 2022 which, the NMC submits, when taken together with Ms Sullivan's lack of full insight, repetition of misconduct and the need to complete training and/or strengthen her practice in the areas of concern, leads to a risk of further repetition. Therefore, the NMC considers that there is a public protection requirement in a finding of impairment being made in this case to protect the public.

The NMC also considers that there is a public interest in a finding of impairment being made in this case to declare and uphold proper standards of conduct and behaviour. Ms Sullivan's conduct engages the public interest because it falls far below the proper professional standards required.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), *CHRE v NMC and Grant* and *Cohen v GMC* [2007] EWHC 581 (Admin).

Decision and reasons on misconduct

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

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

> *'**1 Treat people as individuals and uphold their dignity***
> *To achieve this, you must:*
> ***1.1** treat people with kindness, respect and compassion*

1.2 *make sure you deliver the fundamentals of care effectively*

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

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:

2.6 *recognise when people are anxious or in distress and respond compassionately and politely*

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

To achieve this, you must:

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

3.3 *act in partnership with those receiving care, helping them to access relevant health and social care, information and support when they need it*

4 Act in the best interests of people at all times

To achieve this, you must:

4.3 *keep to all relevant laws about mental capacity that apply in the country in which you are practising, and make sure that the rights and best interests of those who lack capacity are still at the centre of the decision-making process*

8 Work co-operatively

To achieve this, you must:

8.3 *keep colleagues informed when you are sharing the care of individuals with other health and care professionals and staff*

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

8.6 *share information to identify and reduce risk*

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:

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

17 Raise concerns immediately if you believe a person is vulnerable or at risk and needs extra support and protection

To achieve this, you must:

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

17.3 *have knowledge of and keep to the relevant laws and policies about protecting and caring for vulnerable people*

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*

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
25.2 *support any staff you may be responsible for to follow the Code at all times. They must have the knowledge, skills and competence for safe practice; and understand how to raise any concerns linked to any circumstances where the Code has, or could be, broken'*

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 actions fell seriously short of the conduct and standards expected of a registered nurse. It also considered that dishonesty is fundamentally at odds with the nursing profession.

The panel determined the charges found proved both individually and collectively amounted to serious misconduct.

The panel concluded that both an informed member of the public and a member of the nursing profession would find Ms Sullivan's behaviour to be deplorable and damaging to the public's trust in nurses, and to undermine professional standards.

Decision and reasons on impairment

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

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

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

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

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

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

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

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

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

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

The panel finds that all four limbs in Dame Janet's Smith's "test" are engaged. The panel determined that Ms Sullivan's actions put patients at significant risk of harm. It noted that actual harm was caused to Patient A. Ms Sullivan's comments caused Patient A's self harm to escalate by incorporating the advice from Ms Sullivan of how to achieve greater harm to herself by banging her head on the corners of the wall to cause greater damage. The panel considered this advice to be cruel. Regarding Patient B, if the patient had been

observed as part of Ms Sullivan's duty, they would not have been left in a degraded state smeared with faeces for such a long period. The panel determined that Patient A and Patient B were likely to be caused physical and emotional harm as a result of Ms Sullivan's misconduct.

Ms Sullivan's misconduct has breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. It was satisfied that confidence in the nursing profession would be undermined if its regulator did not find charges relating to her actions and to her dishonesty extremely serious.

The panel is aware that this is a forward-looking exercise and, accordingly, it went on to consider whether Ms Sullivan's misconduct was remediable and whether it had been remediated. The panel considered the factors set out in the case of *Cohen v GMC* [2007] EWHC 581 (Admin).

The panel noted that Ms Sullivan has had limited engagement with the NMC. Regarding insight, the panel considered the NMC's submission in respect of Ms Sullivan's reflection in relation to Patient A and her remarks acknowledging her misconduct. However, the panel considered that during the local investigation Ms Sullivan denied the allegations against her in relation to Patients A and B and only admitted them when she was shown incontrovertible evidence in the form of CCTV footage. The panel determined that Ms Sullivan has not engaged with these proceedings and has provided no evidence that she has reflected on the impact of her actions or shown genuine remorse or understanding of how her actions put patients at risk of harm or the impact they would have on her colleagues and the profession.

The panel considered that acts of dishonesty are hard to remediate. The panel was of the view that Ms Sullivan's actions were indicative of an attitudinal problem. The panel has not been provided with any evidence to show that Ms Sullivan has taken steps to strengthen her practice, address the concerns identified, her behaviour or her dishonesty.

The panel finds that Ms Sullivan's misconduct is attitudinal in nature, as the charges found proved show a pattern of poor practice over a period of time. The panel determined that the nature of the incidents is a reflection of Ms Sullivan's nursing practice which it deems

to be callous and appalling. It determined that there is a risk of repetition in this case, as Ms Sullivan does not appear to recognise the potential harm of her actions or their gravity and has not taken any steps to recognise and rectify her poor practice.

The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

The panel bore in mind 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 Ms Sullivan did not behave in a way that demonstrates that she practises kindly, safely and professionally. In addition, the panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case and therefore also finds Ms Sullivan's fitness to practise impaired on the grounds of public interest.

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

Representations on sanction

The panel noted that in the Notice of Meeting, dated 8 August 2023, the NMC had advised Ms Sullivan that it would seek the imposition of a striking-off order if Ms Sullivan's fitness to practise was found to be currently impaired.

The NMC submitted that taking no action and a caution order would not be appropriate in this case. The NMC Sanctions Guidance states that taking no action will be rare at the sanction stage and this would not be suitable where the nurse presents a continuing risk to patients. In this case, the seriousness of the alleged misconduct, of her failure to timeously and appropriately intervene to assist a distressed patient and to make adequate observations on a patient, and falsification of patient records means that taking no further action would not be appropriate. There is no evidence that Ms Sullivan has remedied these concerns or sufficiently reflected upon them. Therefore, taking no action would not provide the restriction on Ms Sullivan's practice that is required to protect the public.

It submitted that the NMC guidance makes clear that a caution order is the least restrictive sanction which will only be suitable where the nurse presents no risk to the public. Given the misconduct in this case and lack of remediation, there remains significant risk to the public.

The NMC submitted that a conditions of practice order would not be appropriate in this case. The misconduct, and the facts behind such conduct, indicate harmful deep-seated personality and attitudinal problems. Some of the misconduct covers clinical concerns which are serious. Whilst these can be more readily addressed by way of training, supervision and assessment, presence of other factors in this case, such as repetition of the misconduct, limited insight, dishonesty and attitudinal concerns, means that there are no practical conditions that could be put in place that would protect the public and maintain public confidence. There has been no evidence from Ms Sullivan of any learning from the concerns raised or any reflections detailing the impact of her action apart from the response submitted at the interim order hearing in May 2022 showing limited insight. There is no evidence of Ms Sullivan's safe practice since the allegations and, although it is accepted that she is subject to an interim suspension order and therefore unable to practise as a nurse, there is still no evidence from Ms Sullivan to explain why she behaved in the way she did and what she would do differently in the future. Therefore, it is submitted that a conditions of practise order is not appropriate in this case.

The NMC submitted that a suspension order would also be an insufficient sanction for this case. The misconduct was not a single, isolated incident as it covers more than one incident with serious failures in fundamental nursing care with the potential for serious harm to patients and damage to the reputation of the profession. The first incident involving Patient B resulted in Ms Sullivan receiving a formal warning, yet it would seem that this did not stop her in continuing with her uncaring, unprofessional behaviour towards vulnerable patients in her care as shown by the incident with Patient A. Additionally, there is evidence of harmful deep-seated personality or attitudinal problems. Ms Sullivan's encouragement of Patient A to continue with self-harming behaviour is something that is deplorable and not how a registered healthcare professional should behave. Given the issues identified and without full and developed evidence of insight, remorse and remediation, a suspension order would not be appropriate in this case.

The NMC submits that Ms Sullivan's actions in relation to her serious clinical failures and dishonesty as described above, insufficient insight and lack of strengthened practice are fundamentally incompatible with her remaining on the register. Therefore, it is submitted that a striking-off order is the only appropriate sanction in this case for public protection and in the public interest.

Decision and reasons on sanction

Having found Ms 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 SG. The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features:

- Harm caused to two patients
- Abuse of a position of trust
- Serious damage to the public confidence in the profession

- Lack of insight into failings
- Lack of meaningful engagement with the NMC
- A pattern of misconduct over a period of time.

The panel also considered the NMC's guidance regarding dishonesty and identified the following features of the case, namely:

- deliberately breaching the professional duty of candour by covering up when things have gone wrong, especially if it could cause harm to patients
- misuse of power
- vulnerable victims
- direct risk to patients

Although there was a single instance of dishonesty, these features put Ms Sullivan's misconduct in the upper half of the spectrum of seriousness.

The panel found no mitigating features in this case, but reflected on the following points:

- The panel noted Ms Sullivan's comments at the interim order hearing in May 2022, but the panel did not consider this to show insight as the words lacked depth and did not address the regulatory concerns raised.
- The panel also noted Ms Sullivan's admissions and remorse at the local investigation, but this was only provided after she was presented with CCTV footage that she could not dispute.
- It was clear to the panel that there were significant failures by other healthcare staff on Ms Sullivan's unit, but this does not mitigate her individual responsibility when working professionally as a nurse.

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

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict Ms 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 Ms 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 conditions of practice on Ms Sullivan's registration would be a sufficient and appropriate response. The panel was of the view that there are no practicable or workable conditions that could be formulated, given the nature of the charges in this case. The misconduct identified in this case was not something that can be addressed through retraining. The panel noted that Ms Sullivan was placed on an internal supervision plan in relation to Patient B in 2019, but this appears to not have altered her working practice as the other incident occurred with Patient A. There has been no meaningful engagement by Ms Sullivan with the NMC and therefore it would not be appropriate to consider conditions of practice. Furthermore, the panel concluded that the placing of conditions on Ms Sullivan's registration would not adequately address the seriousness of this case and would not protect the public.

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, midwife or nursing associate has insight and does not pose a significant risk of repeating behaviour*
- *…*

None of these factors is applicable in Ms Sullivan's case.

The conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. The panel considered that the serious breach of

the fundamental tenets of the profession evidenced by Ms Sullivan's actions is fundamentally incompatible with Ms Sullivan remaining on the register.

The panel therefore 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?*

Ms 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 Ms 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.

The panel also had regard to the NMC's guidance on *'Serious Concerns which are more difficult to put right (Reference: FTP-3a last updated 01/07/2022)'*

> *'We will need to do this where the evidence shows that the nurse, midwife or nursing associate is responsible for:*
>
> - *breaching the professional duty of candour to be open and honest when things go wrong, including covering up, falsifying records, obstructing, victimising or hindering a colleague or member of staff or patient who wants to raise a concern, encouraging others not to tell the truth, or otherwise contributing to a culture which suppresses openness about the safety of care*
>
> *….*

- *deliberately causing harm to patients'*

The panel found that Ms Sullivan's misconduct exhibited these features and would be difficult to put right.

Balancing all of these factors and after taking into account all the evidence before it during this case, the panel determined that the appropriate and proportionate sanction is that of a striking-off order. Having regard to the matters it identified, in particular the effect of Ms 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 a striking-off order would be sufficient in this case.

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

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

Representations on interim order

The panel took account of the written representations made by the NMC as follows:

> *'66. If a finding is made that Ms Sullivan's fitness to practise is impaired on a public protection basis and a restrictive sanction imposed, the NMC considers an interim order in the same terms as the substantive order*

should be imposed on the basis that it is necessary for the protection of the public and otherwise in the public interest.

67. If a finding is made that Ms Sullivan's fitness to practise is impaired on a public interest only basis and that their conduct was fundamentally incompatible with continued registration, the NMC considers an interim order of suspension should be imposed on the basis that it is otherwise in the public interest.'

Decision and reasons on interim order

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

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive order. The panel therefore imposed an interim suspension order for a period of 18 months in order to protect the public and the wider public interest to cover the 28-day appeal period and the duration of any appeal should Ms Sullivan decide to appeal the panel's decision.

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

That concludes this determination.