Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
27 October and 15 December 2017

Nursing and Midwifery Council, 61 Aldwych, London WC2B 4AE

Name of registrant:	Lea L Ledesma
NMC PIN:	01Y0047O
Part(s) of the register:	RN1 – Adult (Level 1) – August 2001
Area of Registered Address:	England
Type of Case:	Conviction
Panel Members:	David Bleiman (Chair, Lay member) Susan Field (Registrant member) John Vellacott (Lay member)
Legal Assessor:	Andrew Granville-Stafford
Panel Secretary:	Simran Saini (27 October 2017) Susan Curnow (15 December 2017)
Mrs Ledesma:	Present and represented by Nick Wayne, of Counsel
Nursing and Midwifery Council:	Represented by Tamsin Ryder, of Counsel, instructed by the NMC Regulatory Legal Team.
Facts proved:	All
Fitness to practise:	Impaired by reason of conviction
Sanction:	Striking-off order
Interim Order:	Interim suspension order, 18 months

Details of charge:

That you:

1. *On 14 December 2016, at the Crown Court sitting at Southwark, were convicted of:*

    a) *1 x Manslaughter*

and, in light of the above, your fitness to practise is impaired by reason of your conviction.

Background:

On 6 May 2014, a 75 year old male patient (Patient A) underwent surgery as part of a triple heart bypass procedure at The Heart Hospital. The surgery was successful and Patient A was placed in ITU. The nurse appointed to look after him was you. There was another man with a very similar name to Patient A on the same ward (Patient B).

On the evening of 6 May, Patient A was assessed as having low haemoglobin levels so required a blood transfusion. You administered this and no issues occurred.

At 7.30am on 7 May 2014, night duty staff administered a second bag of blood to Patient A and his condition continued to be monitored. You were part of the returning day shift and were asked at handover to continue with Patient A's care.

At 10.30am, Patient A was assessed by doctors as requiring another blood transfusion due to a significant amount of drainage from one of the chest drains.

At 10:39am, you went to the remote issue blood fridge named 'HaemoSafe'.You did not follow hospital protocol in relation to obtaining the unit of blood. You said that the paper patient notes, where a specific 'blood form' used for obtaining blood is kept, were missing. So in the absence of the patient notes, you noted down a patient hospital number from details being displayed on the bedside computer.

You maintain that the details of the patient being displayed on the computer were Patient B, although you did not realise this at the time.

The Trust policy was to compare the patient number with the medical notes and use medical notes for verification. It would also have been possible to print off a new copy of the blood form from the nurse's station computer but that would have taken a long time.

You therefore, without the notes, went to the blood fridge and dispensed the blood, obtaining blood for the wrong patient, which was of the wrong blood type.

You returned to the bed and checked the name on the blood bag against the patient's identity wrist band. It is said that you noted the name on the blood bag was different to the name on the patient's identity wrist band.

You then asked the patient for his date of birth. When the patient gave his date of birth, you checked this against the details written on his identity band and not against the details on the blood bag. You then re-checked the hospital number on the patient's wrist band against the blood bag and the numbers did not match.

You raised this with the nurse in charge, who told you to check the patient notes.

The medical notes were still not at the nurse's station so you re-checked the hospital number on the blood bag against details on the computer screen. You asserted that you genuinely did not know the patient details on the computer screen were not the patient's and therefore convinced yourself that the blood was cross matched for Patient A. You then administered this unit of blood.

At around 11.40am, Patient A's condition deteriorated. At first, doctors assessed there must have been a post-operative complication. During efforts to stabilise his condition, a further unit of blood was requested by doctors. Details from a sticker that accompanies the erroneous blood pack were used to obtain another unit of blood. The doctor noticed it was the wrong blood so sent it back.

You realised your mistake when you were approached by colleagues who had collected the second incorrect bag of blood. You informed the ward sister, who in turn ran to theatre to inform the surgeons.

Patient A subsequently died. The coroner's finding was that this was a suspected case of gross negligence manslaughter. The Home Office pathologist states that Patient A's condition was precipitated by the administration of an incompatible blood type – AB rather than O. The immunological reaction was a lowering of the blood pressure. In that condition, Patient A would have been vulnerable to the development of a fatal heart rhythm disturbance, particularly with an enlarged and fibrotic left ventricle and in spite of recent re-vascularisation.

You were interviewed by the police and you admitted that you did not follow the correct procedure for obtaining blood from the blood fridge and for carrying out correct patient identification checks.

The gross negligence in this case therefore was as follows:

- collection of a unit of blood from the 'HaemoSafe' not following the correct procedure, namely without medical notes or prescription pick up slip
- not carrying out sufficient patient identification checks prior to administration of the blood.

The matter proceeded to a trial on one count of manslaughter.

You were convicted after trial by jury on 14 December 2016.

The Judge in his sentencing remarks said as follows: "The jury by their verdict showed that they were sure that your errors and omissions that morning were so exceptionally bad and such a departure from the standards expected of a reasonably competent nurse, that they amounted to being criminal… the omissions and actions that led to Patient A's death essentially took place over the time of a quarter of an hour. I am not

going behind the jury's verdict in saying that it is still a mystery to me as to how and why you came to behave in the way you did."

The Judge in sentencing you took into account the numerous references from professional colleagues who supported you and letters received in personal mitigation, and he also said "you remain certain that the details of the other patient (that being Patient B) were shown on the deceased's monitor, and I cannot exclude that as a contributory factor. But the fact remains that your criminal negligence caused his death and a prison sentence must follow for what happened over that quarter of an hour period."

The sentence imposed was one of 18 months imprisonment, suspended for 2 years, together with a requirement to perform 300 hours unpaid work over a 12 month period.

The suspended sentence order is therefore due to expire on 9 February 2019.

Determination on potential conflict of interest:

Mrs Field, the Registrant Panel Member, informed the hearing that she had, at one time and in a different hospital, been the manager of a nurse, Ms 1, who had provided a witness statement which appeared in the hearing document bundle. Mrs Field had not had contact with Ms 1 for about 10 years.

Both parties, after considering the matter, confirmed that they saw no reason why Mrs Field should not continue to serve on the panel. This nurse's involvement in the matter was very minor and her credibility was not an issue.

After hearing legal advice, the panel deliberated and concluded that there was no conflict of interest, actual or apparent to a reasonable observer and that Mrs Field should continue to sit on this case.

Decision on the findings on facts and reasons:

The panel found Charge 1 proved by way of your conviction. The panel noted that the hearing document bundle presented to the panel today, contained a certificate of conviction. Mr Wayne also informed the panel that you admit the fact of the conviction. In accordance with Rule 24(5) of the Nursing and Midwifery Council (Fitness to Practise) Rules 2004 (as amended) ("the Rules"), the panel found this charge proved by virtue of your admission to the conviction.

Submissions on impairment:

The panel considered whether, firstly, your conviction goes to your fitness to practise, such that your fitness to practise is currently impaired. The NMC has defined fitness to practise as a registrant's suitability to remain on the register without restriction.

The panel heard submissions from Ms Ryder, on behalf of the NMC.

Ms Ryder referred the panel to the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant* [2011] EWHC 927 (Admin) (Grant). She referred the panel to the four limbs of Grant, although the last limb of dishonesty was not engaged in your case. Ms Ryder submitted that the limbs that were engaged in your case were that you:

a) Put patient(s) at an unwarranted risk of harm; and/or
b) Bring the profession into disrepute; and/or
c) Breach one of the fundamental tenets of the profession.

Ms Ryder submitted that limb (a) was engaged as you did not follow the required procedures and protocols put into place at the Heart Hospital when administering blood to Patient A. Furthermore, you failed to carry out the correct identity checks before you administered the blood to Patient A and as a result of this, you put Patient A at an unwarranted risk of harm and as a result of your actions, Patient A subsequently died.

Ms Ryder submitted that limb (b) was engaged as you did bring the profession into disrepute by not following the procedures and protocols at the Heart Hospital. She submitted your errors were a significant departure from safe nursing practice.

Ms Ryder then invited the panel to take the view that your actions amounted a breach of one of the fundamental tenets of *The Code: Standards of conduct, performance and ethics for nurses and midwives (2008)* ("the Code"). She directed the panel to the pre-amble to the Code which states: *"the people in your care must be able to trust you with their health and wellbeing."* Accordingly, she submitted that limb (c) was also engaged in your case.

She further addressed the panel on the need to have regard to the wider public interest. Ms Ryder referred the panel to Grant which makes it clear that the public interest must be considered and stated, "*it is essential, when deciding whether fitness to practise is impaired, not to lose sight of the fundamental considerations … namely, the need to protect the public and the need to declare and uphold proper standards of conduct and behaviour so as to maintain public confidence in the profession."*

Ms Ryder submitted that although you have demonstrated insight into your failings and the consequences of your actions on Patient A, his family and yourself, you have failed to recognise the implications of your actions on the wider public interest.

Ms Ryder then referred the panel to the case of *Cohen v General Medical Council [2008]* EWHC 581 (Admin) (Cohen). She outlined the test set out in Cohen. Ms Ryder informed the panel that this incident was an isolated incident in an otherwise unblemished career and that you are an individual who is highly regarded by colleagues. Ms Ryder directed the panel to have regard to the Judge's sentencing remarks which indicate that this incident was out of character and that you are generally a competent and professional nurse.

In respect of whether your failings can be remediated, Ms Ryder informed the panel that you have not worked in a clinical setting since the incidents occurred but you have been allowed to work in a non-clinical environment. Ms Ryder therefore submitted that due to

lack of patient interaction and cogent evidence of you working with patients, the risk of repetition cannot be wholly eliminated.

Accordingly, Ms Ryder invited the panel to find that a finding of current impairment is necessary on the grounds of public protection and the wider public interest.

Mr Wayne submitted that you were not currently impaired.

Mr Wayne, on your behalf referred the panel to the case of *Meadow v General Medical Council* [2006] EWHC 146 (Admin). He reminded the panel that in its consideration, the panel must be mindful that its duty is not to punish you but to protect the public and uphold and declare public confidence in the nursing profession and the NMC as its regulator.

In relation to the risk of repetition of an error giving rise to patient harm, Mr Wayne directed the panel to the numerous professional references commenting on your diligence and conscientiousness as a nurse. He referred the panel to the sentencing Judge's remark that your period of negligence was "wholly out of character". He further submitted that any risk to patients in the future was no more than any other nurse.

Mr Wayne invited the panel to consider whether the public would take the view that a nurse who had no deliberate intent of harming a patient and was trying to act in the patient's best interest, brought the profession into disrepute.

Mr Wayne questioned whether your failure to comply with the standards had reached the level of breaching fundamental tenets of the Code.

Mr Wayne referred the panel to the steps you have taken to remedy your actions, including your two reflective statements, one of which contained a comprehensive analysis of what went wrong on 7 May 2014 and your errors on that date. He drew the panel's attention to your remorse and recognition of the impact of your actions on Patient A and his family.

Mr Wayne said that you had been subject to an interim suspension order, which had limited your ability to address matters.

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

Panel's decision on impairment:

The panel then went on to consider, on the basis of the conviction whether your fitness to practise is currently impaired. The panel considered your insight and remorse. It considered whether your actions are capable of remedy, whether your actions have been remediated and if actions of such nature are likely to be repeated by you. It took account of the public interest, that is to say the need to protect patients, the maintenance of public confidence in the profession and the NMC as regulator, and the upholding and declaring of proper standards.

In reaching its conclusion, the panel took account of the guidance given by Dame Janet Smith in her Fifth Shipman Report, cited with approval by Mrs Justice Cox in the case of Grant. Accordingly, the panel considered whether you had in the past and/or were liable in the future to act in such a way as to:

a) Put patient(s) at an unwarranted risk of harm; and/or
b) Bring the profession into disrepute; and/or
c) Breach one of the fundamental tenets of the profession.

The panel considered that the above three limbs of *Grant* were engaged by way of your past actions. The panel was of the view that limb (a) was engaged as you had several opportunities during the incident to rectify your mistakes and ensure that an incident of such a nature did not occur. The panel took into account that there were policies and procedures put in place at The Heart Hospital which you failed to follow. The panel must rely on the fact of your conviction of manslaughter which the sentencing judge described as "manslaughter by gross negligence." The panel was therefore of the view that you did put patients at an unwarranted risk of harm.

The panel decided that your actions were of such a nature that they did bring the profession into disrepute. The panel took into consideration the submissions made by Mr Wayne in this regard. However, a member of the public would in the panel's view consider that your conviction for manslaughter brought the profession into disrepute. Accordingly, the panel found that limb (b) was engaged.

The panel then considered whether you had breached one of the fundamental tenets of the Code. The panel was of the view that in the past you had breached the requirements of the Code which state: *"the people in your care must be able to trust you with their health and wellbeing"* and also state: *"you must provide a high standard of practice and care at all times."* Further the Code requires that you must always act lawfully, whether those laws relate to your professional practice or personal life. Accordingly, the panel found that limb (c) was engaged.

The panel then went on to consider whether you are likely to put patients at an unwarranted risk of harm in the future. The panel took into account the positive references you have provided and the fact that you have reflected on your failings. Nonetheless, the panel was concerned if you were placed in a similar situation in the future there remains a real risk that an incident of such a nature may be repeated. The panel further decided that, given the seriousness of your errors, there remains a significant risk that you may bring the profession into disrepute in the future and that there is a risk that one of the fundamental tenets of the Code may be breached.

The panel considered whether your shortcomings are capable of remedy and whether they have been remediated. The panel was of the view that with adequate support and training, your failings are remediable. The panel bore in mind that to have adequately remediated your failings, you would need to have done so in a clinical setting. The panel acknowledged your reflection into the incidents and the steps you have taken in respect of extended reading. The panel was of the view that this indicates that you have started to remediate your errors however there remains a risk of repetition and inadequate remediation.

The panel considered the wider public interest in this case. The panel was of the view that this incident was so serious that a member of the public with full knowledge of the circumstances surrounding this case, would be concerned if no impairment was found.

The panel bore in mind that the overarching objectives of the NMC are to protect, promote and maintain the health, safety and well-being of the public and patients, and to uphold/protect the wider public interest, which includes promoting and maintaining public confidence in the nursing profession and upholding proper professional standards for nurses. The panel concluded that, given the nature of the conviction, a finding of impairment is necessary in this case on public interest grounds, in order to declare and uphold standards and maintain the reputation of the nursing profession.

Determination on Interim Order:

Ms Ryder submitted that an interim order should be made on the grounds that it is necessary for the protection of the public and is otherwise in the public interest. Ms Ryder submitted that as you have not practised for a period of three years, an interim conditions of practice order would not be workable. Mr Wayne did not oppose that an interim order should be made. However, Mr Wayne submitted that the most appropriate and proportionate order should be one of a conditions of practice.

The panel accepted the advice of the legal assessor.

The panel decided that an interim order is necessary for the protection of the public for the reasons set out in the panel's findings at the impairment stage. The panel decided that an interim order is also necessary on the grounds of public interest as the conviction of gross negligence manslaughter is of a serious nature.

The panel had regard to the seriousness of the charge and the panel has already found that the nature of the conviction gives rise to public protection concerns. Furthermore, the panel was of the view that the public would be concerned if you were allowed to practise without restriction during the interim period.

The panel determined that in a case of gross negligence manslaughter, where a nurse is still serving a suspended prison sentence, the most appropriate and proportionate order would be one of an interim suspension order. The panel was of the view that the high public interest in your case means that no other interim order would maintain public confidence in the profession.

The period of this order is for 18 months to allow for the possibility of an appeal to be made and determined, if necessary, following the sanction stage.

The panel was unable to conclude the case given the late hour and the need to consider an interim order. Dates were canvassed with the parties and was agreed to resume on 15th December 2017.

The hearing resumed on 15 December 2017.

Determination on sanction:

The panel then considered what sanction, if any, it should impose. In reaching its decision, the panel considered all the evidence before it, and heard submissions from Ms Ryder, on behalf of the NMC, and Mr Wayne, on your behalf.

The panel has considered this case very carefully and has decided to make a striking-off order. The effect of this order is that the NMC register will show that you have been struck-off the register.

Ms Ryder reminded the panel that you were convicted of manslaughter by gross negligence. She referred the panel to the case of *Council for the Regulation of Healthcare Professionals v (1) General Dental Council (2) Alexander Fleischmann [2005] EWHC 87 (Admin)* in which it was held that as a matter of general principle a registrant who had been convicted of a serious criminal offence should not be permitted to resume their practice until they had satisfactorily completed their sentence. She reminded the panel that you were sentenced to 18 months imprisonment suspended for 24 months, and that this sentence is not due to expire until 9 February 2019. The maximum period for which a suspension order can be imposed is 12 months.

She also referred the panel to the case of *General Pharmaceutical Council v Habib Khan [2016] UKSC 64.* Based on that case it would not be appropriate to impose a suspension order on the basis that the order could be reviewed and extended to cover the period until the suspended sentence expired.

She submitted that, in the light of the above cases, that the most appropriate sanction is that of a striking off order.

Mr Wayne submitted that it was a matter for panel's discretion as to what, if any sanction, should be imposed. He reminded the panel of the date your suspended sentence expires, and that were you to commit any further criminal offence, the Court would impose the custodial sentence which was currently suspended. He accepted that striking you from the register would send a clear message to the public in relation to

your act of gross negligence. However, he submitted that the question to be addressed by the panel is, given the particular circumstances of the conviction and understanding the full background of the case, whether the public would consider it proportionate to remove you from the register.

Mr Wayne referred the panel to the positive testimonials provided. He submitted that your departure from the standards expected of a nurse and resulted in grave consequences, but it was an act of negligence and not a deliberate or reckless act. It was an isolated incident in an otherwise exemplary career. Mr Wayne reminded the panel that there had been no dishonesty, and no challenge to your probity, integrity and trustworthiness. Other than on this occasion there have been no concerns regarding your fitness to practice and that there have been no previous disciplinary or NMC proceedings. Mr Wayne reminded the panel of your previous good history as a registered nurse.

Mr Wayne noted that the options for the panel were limited. He said that there was no dispute as to authorities and law in this area, but that the circumstances were exceptional in this case calling for a different response.

It was his submission that a conditions of practice order could be tailored to the particular circumstances of this case and would be sufficient to protect the public and satisfy the public interest. You accept that making your way back to being able to work as a nurse in a public facing role will take time. You recognise that, given this conviction, finding employment will be difficult, but a conditions of practice order would ensure that the profession does not lose a skilled and able nurse who has devoted her career to the NHS. Furthermore it would strike the appropriate balance between justice and maintaining confidence in the profession. He submitted that a striking-off sanction would not be proportionate and would have an adverse effect on you and your family.

When questioned by the panel as to the exceptional circumstances that might apply in this case, Mr Wayne submitted that often matters relating to a criminal conviction concern conduct outside a clinical setting. This was a set of tragic circumstances, a single act of clinical negligence, which led to a tragic death. There is no question as to

your integrity and there is nothing to suggest there will be a repetition of the conduct that led to your conviction. You accept that it was a severe failing to uphold the standards expected of a nurse, but this single incident is against a background of many years of good practice. He reminded the panel of the testimonials provided and your reflective statement.

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

In reaching this decision, the panel has had regard to all the evidence that has been adduced in this case. The panel had regard to both the public interest and your own interests, applying the principle of proportionality and weighing the interests of patients and the public with your interests. The panel bore in mind that the public interest includes the protection of patients, the maintenance of public confidence in the profession and the declaring and upholding of proper standards of conduct and behaviour.

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 Sanctions Guidance ("SG") published by the NMC. It recognised that the decision on sanction is a matter for the panel, exercising its own independent judgement.

The panel had regard to the aggravating and mitigating factors in this case.

The aggravating factors in this case include:-

- The conviction was of the utmost seriousness;
- The matters that led to your conviction took place within a clinical setting and resulted in the death of a patient.

The mitigating factors include:-

- There is no evidence before the panel of any prior regulatory or disciplinary proceedings in an otherwise unblemished career;

- The panel has had sight of several extremely positive professional and personal references and testimonials;
- You have demonstrated remorse;
- You have reflected on your failings;
- There is no evidence of harmful, deep seated attitudinal problems.

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 had expressed concern that there remained a risk of repetition if you were placed in a similar situation in the future, as you have not been in a position to remedy your clinical practice. The panel concluded that taking no action would be manifestly inappropriate in view of the serious nature of your failings and in respect of the panel's duty to protect the public and uphold proper standards of conduct and behaviour within the nursing profession. The panel decided that it would be neither proportionate nor in the public interest to take no further action.

Next, in considering whether a caution order would be appropriate in the circumstances, the panel took into account the SG, which 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 your failings were 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 your registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. The panel took into account the SG, and although it determined that conditions could be found that would allow you to address the clinical concerns relating to your failings, the public interest in this case would not be satisfied by a conditions of practice order. The panel took account of Mr Wayne's submissions that this was an exceptional case, however, a patient had died because of the actions of a registered nurse. The panel referred again to the sentencing

remarks of the judge dated 9 February 2017: *"the jury by their verdict showed that they were sure that your errors and omissions that morning were so exceptionally bad and such a departure from the standards expected of a reasonably competent nurse that they amounted to being criminal. … that was the definition that they were given, and they returned a verdict of guilty."*

The panel concluded that the placing of conditions on your registration would not adequately address the seriousness of this case and would not satisfy the wider public interest in declaring and upholding standards and protecting the reputation of the nursing profession.

The panel then went on to consider whether a suspension order would be an appropriate sanction. When considering the remaining sanctions the panel noted that both Ms Ryder and Mr Wayne were in agreement regarding the case law relevant to your conviction and current sentence and the difficulties in considering a suspension order. The panel found that imposing a suspension order was not a viable option, given that the length of the order it had the power to impose would not match the length of time remaining on your suspended criminal sentence. The panel did not find that the circumstances of your case were exceptional, in such a way as to justify distinguishing it from the relevant case law. The panel determined that a suspension order would not be an appropriate sanction and would not adequately address the seriousness of the case nor satisfy the wider public interest.

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

> *Is striking-off the only sanction which will be sufficient to protect the public interest?*
>
> *Is the seriousness of the case incompatible with ongoing registration?*
>
> *Can public confidence in the professions and the NMC be sustained if the nurse or midwife is not removed from the register?*

Serious departure from the relevant professional standards as set out in key standards, guidance and advice …

The panel bore in mind the remarks of Sir Thomas Bingham MR in the case of *Bolton v Law Society [1994] 1 W.L.R. 512* where it was stated that, "*the reputation of the profession is more important than the fortunes of any individual member. Membership of the profession brings many benefits, but that is part of the price."*

The panel also noted that the judge in your case in his sentencing remarks referred to the references and letters he had received from your colleagues: *"They all paint the same picture of a committed, hardworking dedicated nurse who has worked for many years in the pressurised atmosphere of the heart intensive unit . … you were committed to that unit. Everyone talks about how reliable you are, how competent, and how helpful. … I have rarely seen so many … [references that] are so measured and persuasive. So this period of negligence was about as out of character as can be."*

This was a tragic case with devastating consequences for the patient and his family.

The panel found that your failings were significant departures from the standards expected of a registered nurse and are fundamentally incompatible with you remaining on the register. The panel was of the view that the findings in this particular case demonstrate that your failings were so serious that to allow you to continue practising would undermine public confidence in the nursing profession.

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.

Determination on Interim Order

Pursuant to Article 29 (11) of the Nursing and Midwifery Order 2001, this panel's decision will not come into effect until after the 28 day appeal period, which commences

from the date that notice of the striking off order has been served. Article 31 of the Nursing and Midwifery Order 2001 outlines the criteria for the imposition of an interim order. The panel may only make an interim order if it is satisfied that it is necessary for the protection of the public, otherwise in the public interest or is in the registrant's own interest. The panel may make an interim order for a maximum of 18 months.

Ms Ryder invited the panel to consider the imposition of an interim suspension order for a period of 18 months. She submitted that an order is necessary for the protection of the public and is otherwise in the public interest.

Mr Wayne did not oppose the application.

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

The panel was satisfied that an interim suspension 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 suspension order. To do otherwise would be incompatible with its earlier findings.

The period of this order is for 18 months to allow for the possibility of an appeal to be made and determined.

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

That concludes this determination.