Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Meeting
Wednesday, 22 May 2024 – Friday, 24 May 2024

Virtual Meeting

Name of Registrant:	**Jeffrey Saunderson**
NMC PIN:	00J0065S
Part(s) of the register:	Registered Nurse- Sub Part 1 RNA: Adult nurse, level 1 (29 September 2003)
Relevant Location:	East Lothian
Type of case:	Misconduct
Panel members:	Adrian Smith (Chair, Lay member) Helen Chrystal (Registrant member) Susan Ellerby (Lay member)
Legal Assessor:	Charles Conway
Hearings Coordinator:	Samantha Aguilar
Facts proved:	Charges 1, 2, 4, 5, 6, 7, 8 and 9
Facts not proved:	Charges 3 and 10
Fitness to practise:	Impaired
Sanction:	**Suspension order (12 months)**
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 the Notice of Meeting had been sent to Mr Saunderson's registered email address by secure email on 25 March 2024.

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Meeting provided details of the allegations, the time, dates and the fact that this meeting would be heard virtually.

In light of all of the information available, the panel was satisfied that Mr Saunderson 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 charges

That you, a registered nurse:

1. On 26 November 2011:
    a) Failed to accurately count and/or document Oxynorm when carrying out a controlled drugs check.
    b) Failed to sign the controlled drugs book to account for Oxynorm.

2. After its stop date of 29 March 2012, administered Co-amoxiclav to Patient A on 30 March 2012, and/or 31 March 2012.

3. On 12 November 2018 administered a nasal flu vaccination to Baby B after parental consent had been given for a flu vaccination by injection.

4. In April 2019, in relation to Colleague X, whilst demonstrating vaccination technique:
    a) grabbed her,
    b) pulled her on your lap,

c) pushed her legs apart.

5. On 26 June 2019, in relation to Baby C:
    a) Incorrectly administered the meningitis C, PCV (pneumoncoccal), MMR (measles, mumps and rubella) and meningitis B vaccination instead of the ‘6 in 1’ vaccination.
    b) Failed to notify Baby C’s parent that you had made a drug error in a timely manner.

6. On 8 October 2020 administered a nasal flu vaccination to Child D without Child D’s parental consent.

7. On 21 November 2021, in relation to Child E:
    a) Incorrectly indicated that parental consent had been given for Child E’s nasal flu vaccination.
    b) Failed to telephone Child E’s parent to confirm that consent had been given for a nasal flu vaccination.

8. On 21 January 2022, incorrectly referred to another patient’s consent form whilst administering a vaccination to Child F.

9. Worked on one or more of the following dates as a registered nurse in breach of an interim suspension order (“ISO”);
    a) 8 October 2022;
    b) 9 October 2022.
    c) 10 October 2022.

10. Your conduct in charge 9 showed a lack of integrity in that you knew there was an ISO hearing on 4 October 2022 where your registration could be restricted, and you did not inform yourself of the outcome

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

Background

Mr Saunderson was referred to the NMC on 7 September 2022 by the Deputy Nurse Director at NHS Lothian.

Mr Saunderson entered the NMC register on 29 September 2003 and began working for NHS Lothian. Over a period of 10 years, whilst Mr Saunderson was working in the Community Vaccination Team at NHS Lothian, seven incidents of poor medication practice were reported.

On 26 November 2011, it is alleged that the Mr Saunderson made an error in relation to counting and documenting Oxynorm (a controlled drug) during a drug check.

Between 30 and 31 March 2012, it is alleged that Mr Saunderson failed to follow the medicine administration policy. He allegedly administered antibiotics beyond their stop date of 29 March 2012.

On 12 November 2018, Mr Saunderson is alleged to have administered a vaccination nasally when the infant patient's parents had consented to administration via injection.

On 26 June 2019, Mr Saunderson allegedly administered a [PRIVATE] infant with immunisation for a one-year-old. There was an alleged delay in notifying the parents. The infant was taken to hospital after becoming unwell with a high fever. The infant was discharged the same day and there was no long-term harm caused.

On 8 October 2020, at [PRIVATE], Mr Saunderson allegedly administered a vaccination to a school pupil whose parents had not consented to them being vaccinated; there were two pupils with very similar names at the school and the other pupil's consent form was used.

On 21 November 2021, at [PRIVATE] vaccination day, Mr Saunderson allegedly administered a vaccination to a pupil whose parents had not consented by incorrectly marking on the form that consent had been given when triaging consent forms. Mr Saunderson then failed to follow operating procedure by contacting the parents regarding any confusion about the consent form.

On 21 January 2022, at [PRIVATE], Mr Saunderson allegedly administered a Human Papillomavirus (HPV) vaccination to the wrong pupil, as they had the same name as another pupil.

Following NHS Lothian's referral, an Interim Suspension Order (ISO) was imposed on 4 October 2022.

Mr Saunderson worked for Randolph Hill Nursing Home as a staff nurse from 21 June 2022 until 12 October 2022, when his employer discovered the ISO. It is alleged that Mr Saunderson worked as a nurse on 8, 9 and 10 October 2022 which was contrary to the ISO. Mr Saunderson did not engage with the ISO process or the NMC investigation.

During the NMC investigation, an incident where Mr Saunderson had behaved inappropriately towards a colleague was discovered. It is alleged that in April 2019, whilst demonstrating how to correctly hold an infant during vaccination, Mr Saunderson grabbed and pulled a colleague onto his lap and pushed their legs apart.

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 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: Clinical Nurse Manager at NHS Lothian.

- Witness 2: Team Lead at the time of the alleged incidents at NHS Lothian.
- Witness 3: Colleague X and [PRIVATE] April 2019 until January 2021 at NHS Lothian.
- Witness 4: Clinical Educator at NHS Lothian.
- Witness 5: Clinical Nurse Manager at NHS Lothian and Investigating Officer.
- Witness 6: Deputy Clinical Lead of the Community Vaccinations Team at NHS Lothian.
- Witness 7: Band 6 Nurse in the Community Vaccination Team at NHS Lothian.
- Witness 8: Deputy Manager at Fidra House, Randolph Hill Nursing Home.
- Witness 9: Case Officer at the NMC.

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

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

Charge 1

1. On 26 November 2011:
    a. Failed to accurately count and/or document Oxynorm when carrying out a controlled drugs check.
    b. Failed to sign the controlled drugs book to account for Oxynorm.

This charge is found proved in its entirety.

The panel took into account Witness 1's statement dated 10 March 2023, in which she stated, *'On 26 November 2011, Mr Saunderson made a drug error by failing to sign the controlled drugs book to account for a box of ampoules of Oxynorm.'* She then exhibited the contemporaneous statement from Mr Saunderson signed 1 December 2011, in which he said:

> *'*[…] *I neglected to sign for one of the patients boxes of ampoules in the controlled book.* […] *I did not sign for it due to a lapse in concentration only. I did not question the amount of stock* […]*'*

The panel had regard to the fact that this was an admission from Mr Saunderson. He appeared to accept that he did not sign the controlled drugs book to account for the Oxynorm, and nor did he accurately count and/or document Oxynorm when carrying out a controlled drugs check.

The panel determined that in light of the above evidence, this charge is found proved in its entirety.

Charge 2

> 2. After its stop date of 29 March 2012, administered Co-amoxiclav to Patient A on 30 March 2012, and/or 31 March 2012.

This charge is found proved.

The panel took into account Witness 1's statement to the NMC in which she stated:

> *'On or around 28 March 2012 to around 2 April 2012, Mr Saunderson incorrectly dispensed antibiotics that were past their stop date, which resulted in the patient taking the antibiotics for 3 days past the stop date.'*

The panel also had sight of the Datix record of the incident reported 2 April 2012. It stated, '*2 staff members have been spoken to so far re procedure and practice'* and further down the page, Mr Saunderson is listed as a '*perpetrator'*, amongst other staff members.

The panel noted Mr Saunderson's email response dated 26 April 2012. He stated:

> *'I was informed by yourself that I administered antibiotics to the patient for two days beyond the prescribed date on the kardex. Without evidence to the contrary, I accept this may have been the case and can only presume I failed to observe the correct stop date on the prescription. I accept that if culpable, this is an omission on my part, and further I appreciate the need for vigilance and best practice at all times in medicine administration.'*

The panel took the view that the above email was a partial admission by Mr Saunderson, in that he acknowledged that he may have made an error. This was further supported by the letter to Mr Saunderson dated 14 November 2012 from NHS Lothian which stated:

> *'You fully acknowledged this, following this error you have reflected on your practice and what went wrong and are much more focused and vigilant.*
> […]
> *Many thanks for you* [sic] *honestly* [sic] *in relation to this event'*

The panel therefore determined that given Mr Saunderson's partial admission when initially challenged about the incident and a subsequent apparent acknowledgement of the incident during the local level investigation by NHS Lothian, the panel found that on the balance of probabilities, that this charge is found proved.

Charge 3

> 3. On 12 November 2018 administered a nasal flu vaccination to Baby B after parental consent had been given for a flu vaccination by injection.

This charge is found NOT proved.

The panel took into account Witness 1's statement:

> *'On 12 November 2018, a child's consent form was incorrectly triaged by Mr Saunderson to be a nasal vaccine, as the completed form requested an injection instead. This incident was not included in the referral made to the NMC but came to my attention when I was dealing with* [the Investigating Firm's] *request for disclosure.'*

The panel next considered the Datix and noted that this incident was recorded on Datix by Mr Saunderson and that Witness 1 drew inference that it was Mr Saunderson who made the mistake.

However, the panel was not satisfied that there is evidence before it to confirm that it was Mr Saunderson who had made the error. It appeared that Mr Saunderson did in fact complete the Datix record, but the panel had not seen any clear evidence to prove that it was Mr Saunderson who made the error.

Accordingly, the panel determined that there was insufficient evidence from the NMC for this charge to be found proved.

Charge 4

4. In April 2019, in relation to Colleague X, whilst demonstrating vaccination technique:
   a. grabbed her,
   b. pulled her on your lap,
   c. pushed her legs apart.

This charge is found proved in its entirety.

The panel had regard to Witness 3/Colleague X's witness statement dated 6 March 2023:

> *'Mr Saunderson grabbed me and pulled me onto his lap, pushing my legs apart, so I was straddled across his lap facing him. I was absolutely mortified*

[…]*. This was completely Inappropriate* [sic]*, as you would never hold children in that way, or push or pull them. An appropriate way to demonstrate would be by gently touching someone's arm. There is no need to straddle a child across your lap when giving a vaccination. After this, I left the training session* [PRIVATE]*.*

[…] *I spoke to Mr Saunderson about this months later, when we knew each other better, and I told him that I found the incident inappropriate and* [PRIVATE]*. He said he was very sorry and we did not speak about it again.'*

The panel also had regard to Witness 4's statement to the NMC dated 6 February 2024:

'[…] *Mr Saunderson was explaining to the audience how a carer would hold their child, but despite him explaining, it still seemed unclear how the child would correctly be held. Mr Saunderson then turned around and invited* [Witness 3/Colleague X] *to come over to him; I believe she was the first person he saw.* [Witness 3/Colleague X] *walked over to Mr Saunderson and he beckoned her onto his lap; she was then in the position that a child would be held in, i.e. with her legs straddled over his thighs, her facing his chest.*

[…]

He said 'I didn't realise I would embarrass her… I didn't mean to do that…' I believed that he was being sincere.'

The panel took the view that there was sufficient evidence that this incident took place. Witness 3/Colleague X provided a first-hand account of the incident and recalled the [PRIVATE], so much so that she had to leave the room. Witness 4 was able to corroborate that the incident took place and later challenged Mr Saunderson about his inappropriate conduct in which he appeared to admit that his actions were not appropriate. The panel determined that with no other information to dispute the incident and taking into consideration Mr Saunderson's alleged response during the incident, the panel found this charge proved in its entirety.

Charge 5

5. On 26 June 2019, in relation to Baby C:
   a. Incorrectly administered the meningitis C, PCV (pneumoncoccal), MMR (measles, mumps and rubella) and meningitis B vaccination instead of the '6 in 1' vaccination.
   b. Failed to notify Baby C's parent that you had made a drug error in a timely manner.

This charge is found proved in its entirety.

The panel carefully considered each sub charge and established whether there is sufficient information before it to find the charge proved. The panel took into account the statement from Witness 2, in which she described the incident on 26 June 2019:

> *'In the afternoon I received a telephone call from Mr Saunderson saying he had given the wrong vaccinations to a baby. He told me that he was supposed to have administered the '6 in 1' vaccination (which vaccinates against diptheria, polio, tetanus, whooping cough, hepatitus* [sic] *B and HIB) and a meningitus* [sic] *B vaccination, which are standard vaccinations for* [PRIVATE]*. Mr Saunderson had administered meningtus* [sic], *PCV (pneumococcal), MMR (measles, mumps and rubella) and meningitus* [sic] *B by mistake.*[…]
>
> *On 27 June 2019, I was passed on a message from a nurse at NHS Lothian, who had received a telephone call to the main phone number from the baby's parents. The parents said that they had to take their baby to hospital as they had been quite unwell during the night with a high fever.* […] *the hospital staff asked if the baby had recently had any vaccinations and when the parents shared this, they realised there had been a mistake.*
>
> *There was no long-term harm caused to the baby* […] *The concern here is that Mr Saunderson made a drug error by administering the wrong vaccinations, which could have been dangerous and caused serious harm in*

another scenario. I do not know if Mr Saunderson followed the correct procedure for checking the baby's consent form, as I was not there on the day. […]

After I was passed the message from the parents, I told Mr Saunderson what had happened and asked if he got in touch with the parents, as I had asked him to the day before. He said he didn't get round to it the day before as he was too busy and would phone them that afternoon. I also asked Mr Saunderson to complete a DATIX.'

The panel next considered the Datix record as completed by Mr Saunderson the following day on 27 June 2019, following further information that Baby C was taken to the hospital overnight following a high fever. Mr Saunderson reported:

'I inadvertently administered the wrong vaccines to a patient during consultation. I realised my error when prepping for the next patient, but the family had left the premises by then. I phoned my line manager to raise an alert about this but did not have contact details for the family, and had the rest of the clinic list to manage.
It was agreed that I would contact them today to inform them of the mistake.

Overnight the child had took unwell with fever and presented at hospital'

The panel determined that in considering Charge 5a, it found that Witness 2's account very detailed and credible. It is supported by the Datix record which contained Mr Saunderson's admission that he *'administered the wrong'* vaccine. This incident may have led to Baby C's admission to the hospital with [PRIVATE]. Accordingly, the panel found Charge 5a proved.

The panel next considered Charge 5b. It took into account the response from Baby C's mother as noted in the Datix:

'[Baby C's mother] *would like to know why the nurse did not inform her of the mistake in a timely manner*'

The panel also considered Witness 2's response to Mr Saunderson about the incident:

> *'Mr Saunderson told me that he had realised his mistake straight away and gone out into the car park to try to catch the baby's parents, but they had already left. I advised Mr Saunderson to get in touch with the parents as soon as possible and let them know what happened; I presumed he would follow my instruction and do this'*

However, Mr Saunderson stated in the local investigation interview on 14 August 2019 that he managed to contact Witness 2 at around *'4.20pm on the day the incident took place.* [Mr Saunderson] *recollects that it was agreed that he would contact the parents first thing next morning'* Witness 2 challenged this and stated that this was not her recollection.

The panel determined that despite the inconsistency between Mr Saunderson's and Witness 2's account of the incident regarding when to contact the parents, the onus was on Mr Saunderson to immediately contact Baby C's parents. As such, it took the view that there was clear evidence to show that Mr Saunderson failed to notify Baby C's parents about the error. It therefore found that on the balance of probabilities, that Charge 5b is also proved.

Charge 6

> 6. On 8 October 2020 administered a nasal flu vaccination to Child D without Child D's parental consent.

This charge is found proved.

The panel took into account Witness 3's witness statement dated 6 March 2023. Witness 3 spoke about the school vaccination process; a student would be asked to confirm their name, date of birth and address, and the younger pupils would be asked the same questions, but also their house number and parents' names. When Witness 3 discussed the incident with Mr Saunderson, she recalled the following exchange in her statement to the NMC:

‘I asked Mr Saunderson for his account of what had happened, and he told me that he had followed the correct procedure of asking the child to confirm their details on their consent form and the child had answered all of the questions properly. I raised the fact that the child had told him his mother's name incorrectly and Mr Saunderson had supposedly told the child [PRIVATE]*, but he denied this conversation. Mr Saunderson seemed more concerned about himself than the pupil he had incorrectly vaccinated. If I had been in his position, I would have been mortified and spoken to the pupil's parents to apologise; I was surprised that Mr Saunderson did not have this reaction at all. He was adamant that the child was in the wrong, not him.’*

The panel also had regard to Witness 5’s statement to the NMC dated 23 January 2023:

‘I was approached by [Witness 1] *in October 2020 who told me that an incident had occurred with Mr Saunderson whilst he was administering nasal flu vaccines at* [PRIVATE]*.* [Witness 1] *told me that a child had been vaccinated in error when he did not have consent from his parents to be vaccinated. The error had occurred as the child had the same name as another child who did have consent, and this child's consent form was used in error, with the unconsented child's date of birth, CHI number and address written over the other child's. This consent form is exhibited* […]*. This is the only copy of the form that the CVT have been able to find. On the second page of the form the handwritten wording that isn't fully visible says 'no consent'. This was written by* [Witness 3] *when the parent telephoned the CVT to raise the error on 9 October 2020.*’

In the Datix record relating to the incident, Mr Saunderson wrote:

‘The child approached my desk and handed me the consent form he was holding.
I asked if the full name on the form was his and he confirmed it was.

I asked if the date of birth on the form was his and he confirmed it was, and I asked if he recognised the signature on his form and he said it was his mothers [sic] *signature.*
I then administered the vaccine to him and gave him the tear off slip.
The mother of another child […] *phoned the office later that day to enquire why her child had not been vaccinated. After investigation from the team it was discovered that the 1st child had presented with the wrong form and despite the checks above had falsely confirmed his identity and been vaccinated mistakenly'*

The panel also had sight of the Investigation Report dated and signed on 25 May 2021 by Witness 5. The panel considered the report to be clear and supported the account of Witness 3. Further, given Mr Saunderson's recollection of the event as in the Datix, the panel understood this to be an acceptance that he had made an error, although he later claimed during the investigation report that he could not remember.

Accordingly, taking into account the witness statements of Witnesses 3 and 5, and the Datix record, the panel found this charge proved.

Charge 7

7. On 21 November 2021, in relation to Child E:
    a. Incorrectly indicated that parental consent had been given for Child E's nasal flu vaccination.
    b. Failed to telephone Child E's parent to confirm that consent had been given for a nasal flu vaccination.

This charge is found proved in its entirety.

The panel considered the statement from Witness 6 dated 20 January 2023. She described in detail the consent form and attested to Mr Saunderson incorrectly triaging a child's consent form:

'I exhibit the consent form for the pupil concerned […]**.** *In the top*

right-hand corner, there is a 'Y' circled with Mr Saunderson's signature next to it and the date of 5 October 2021. This means that Mr Saunderson incorrectly wrote that the child had parental consent.

On the form, to the right of 'I consent to my child being immunised against flu', the tick box for 'yes' contains a cross and the 'no' tick box contains a tick.

Under the heading 'This consent section may be completed by secondary school pupil (tick box)', it says 'I understand about the immunisation and give my consent'. The 'no' tick box has been ticked and then crossed out and what appears to be 'in error' written underneath the tick box; this was written by the vaccination nurse on the day. This section did not apply to the pupil in question as they were a primary school pupil but the parent did complete it. It appears as though the parent could have been indicating that they did not consent to the immunisation.

If you are triaging a form like this, i.e. one where it is not clear whether the parents have consented to the child being vaccinated, you are supposed to telephone the parent to check whether they consented or not. […] *Mr Saunderson would have known this by virtue of internal training in the CVT. Mr Saunderson did not telephone the parents to check the consent when he triaged the form and the vaccination nurse on the day also did not telephone the parents to check.*

I was told by the CVT administration team that [PRIVATE] *telephoned to say he was unhappy that his child had been immunised.* [PRIVATE] *said that the* [PRIVATE] *had ticked the 'yes' box on the consent form and then later crossed it out, which was why there was an entry in both tick boxes on the consent form.'*

The panel next had regard to the Datix record completed by Witness 6, to report the incident and named Mr Saunderson as the staff member directly involved, along with another staff member.

The panel considered that the statement from Witness 6 was clear, and once she was made aware of the situation, she completed a Datix record. The panel therefore found that Mr Saunderson incorrectly indicated that parental consent was given for Child E's nasal flu vaccination and that he failed to contact Child E's parents upon checking the form to clarify whether consent was actually given. Accordingly, the panel found Charges 7a and 7b proved.

Charge 8

8. On 21 January 2022, incorrectly referred to another patient's consent form whilst administering a vaccination to Child F.

This charge is found proved.

The panel considered Witness 3's statement to the NMC regarding the incident on 21 January 2022:

'I was sat on the table next to Mr Saunderson when we were both administering vaccines. I wasn't with a pupil, so I looked over to Mr Saunderson and saw that he was [PRIVATE] *and packing up his things. I asked if he was ok and he responded saying 'I'm screwed, I've done it again, that's me, I'm done.' I asked him what had happened. He told me he checked the name, date of birth and parents name on the consent form before he vaccinated a pupil, saying he has been hyper-vigilant checking consent forms after the incident at* [PRIVATE]*. Mr Saunderson told me that the girl had said yes to all of his questions, then he had vaccinated her, then the girl went to report to a school teacher that her date of birth was incorrect on her consent form. I had not heard any of this happening as I was preoccupied vaccinating pupils myself. After he told me what had happened, Mr Saunderson left the school and went home.*

The next pupil I vaccinated was the correct girl from the consent form of Mr Saunderson's pupil; they had the same name. I went through the consent form with her and asked her why the other girl had confirmed the consent

form was her correct form when it wasn't. The pupil laughed and said 'she probably just went along with it.' I vaccinated her and then reported this to [Witness 7].*'*

Witness 7 provided the process in her statement dated 2 February 2023 and her account of the incident:

'[…] *The protocol is that the vaccinator should introduce themselves, then ask the pupil for their full name, date of birth, address and the name of the signatory on their consent form, to check that all of the details on the consent form are correct. Once they have confirmed that all the information is correct, the vaccinator should explain what they are going to do, administer the vaccine and then complete the bottom of the consent form, which tears off for the pupil to take home. This part of the consent form contains the pupil's name, date of birth, year group and has a tick box that you tick to confirm you have administered the vaccine. In this instance, the tear off slip had two tick boxes, and the vaccinator would indicate in each box which arm each of the two vaccines had been administered into.*

I firstly wanted to check that the first pupil who had been vaccinated with the incorrect form was eligible to be vaccinated; I checked her form and found that she had consent to be vaccinated, so there was no harm to this pupil. However, this was still of concern as vaccinating the incorrect person is a drug error. I then realised Mr Saunderson had signed her form to say he had administered the vaccinations. I took Mr Saunderson aside and made him aware of what had happened; he was really shocked and was adamant he had checked all of the pupil's information with her and vaccinated the correct pupil. If a vaccinator had checked all 4 pieces of information on the form, it would not be possible to vaccinate the wrong pupil. I told Mr Saunderson that he needed to go away and think about what had happened, write it down and reflect. I also felt that Mr Saunderson was not in a fit state to continue vaccinating, as he was [PRIVATE]*. When we had finished speaking, he went home.'*

The panel also noted the Datix record in which Mr Saunderson was named as the nurse involved.

The panel took the view that there is clear evidence that this incident took place. The accounts from Witnesses 3 and 7, and the admission from Mr Saunderson at the time of the incident provides sufficient evidence to find this charge proved. Accordingly, the panel found Charge 8 proved.

Charge 9

9. Worked on one or more of the following dates as a registered nurse in breach of an interim suspension order ("ISO");
   a) 8 October 2022;
   b) 9 October 2022.
   c) 10 October 2022.

This charge is found proved in its entirety.

In reaching this decision, the panel took into account the statement of Witness 8:

> *'Mr Saunderson worked the following shifts at the Home after 4 October 2022, i.e. after the interim suspension order took effect; 8 October 2022 from 07:45 to 20:45, 9 October 2022 from 07:45 to 20:45 and 10 October 2022 from 07:45 to 20:45. I exhibit the rotas from these days* […]'

The panel also had regard to the statement of Witness 9, who confirmed that all documentation was sent to Mr Saunderson's registered email address and exhibited the email correspondence between the NMC and Mr Saunderson. According to the emails, the interim suspension order decision letter was sent to Mr Saunderson's registered email address on 5 October 2022 at 12:51. Witness 9 further stated in his statement that Mr Saunderson answered a telephone call on 2 December 2022:

> *'I telephoned Mr Saunderson with the purpose of asking him whether he had received the communications referred to above and to check his contact details. Mr Saunderson told me that the contact details were correct, and he*

had received the emails from the NMC but he did not recall the contents of the emails or letters. Mr Saunderson then hung up the phone before I could ask any further questions. He told me he was disappointed in the NMC and his previous employer.'

The panel therefore determined that this charge is found proved on the facts. Mr Saunderson was made subject to an interim suspension order on 4 October 2022, and a copy of this was sent to him via email to his registered email address on 5 October 2022. The panel noted that it did not have sufficient evidence to confirm whether Mr Saunderson has read and understood the contents and if he was aware that he was subject to such an order when he worked the dated in question. However, given the handwritten rota as evidenced by Witness 8, Mr Saunderson did in fact work as a registered nurse during those dates, irrespective of whether he had knowledge of the outcome of his interim order hearing or not. Accordingly, the panel found Charge 9a, 9b and 9c proved.

Charge 10

10. Your conduct in charge 9 showed a lack of integrity in that you knew there was an ISO hearing on 4 October 2022 where your registration could be restricted and you did not inform yourself of the outcome

This charge is found NOT proved.

The panel took into account Witness 9's statement which confirmed that access was granted by an NMC Colleague to Mr Saunderson on 12 October 2022 via the Egress software. However, Witness 9 was unable to confirm whether Mr Saunderson did in fact access and read the outcome letter, prior to the date in question, namely 8, 9 and 10 October 2022. Nor is there sufficient evidence to prove that Mr Saunderson had opened any earlier emails which advised him of the forthcoming interim order hearing.

Accordingly, the panel took the view that there was insufficient evidence to prove that he knew that there was an Interim Order hearing on 4 October 2022 and that his practice could be restricted. In addition, there was insufficient evidence as to whether or not he informed himself of the outcome. The panel therefore found Charge 10 not proved.

Fitness to practise

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

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

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

Representations on misconduct and impairment

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

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 and midwives (2015)' ("the Code") and 'The Code: Professional standards of practice and behaviour for nurses and midwives (2018)' where Mr Saunderson's actions amounted to misconduct in respect of Charges 1 and 2. This included 10, 10.1, 10.2, 10.3, 10.4, 20 and 20.1. The NMC also submitted that the relevant code (in 2018) in respect of Charges 4 to 9 included 1, 1.2, 2, 2.5, 4, 4.2, 7, 7.4, 14, 14.1, 14.2, 14.3, 20, 20.1, 23 and 23.3.

The NMC submitted the following written submissions in relation to misconduct:

> *'24. It is submitted that the breaches of the Code amount to misconduct and are serious. Misconduct in any area of nursing practice puts patients at risk, whether that be by poor record keeping, which might mean other professionals do not have an accurate picture of care given or poor medication practice, which might mean patients do not receive the correct medication, resulting in a potential deterioration of their condition or unnecessary pain/ suffering.*
>
> *25. The misconduct in this case gives rise to public protection concerns as the Registrant placed patients, including babies, at a real risk of unwarranted harm. The Registrant's harassing behaviour towards Colleague X was unacceptable and embarrassing for Colleague X, who in her witness statement describes feeling absolutely* [PRIVATE]*.*
>
> *26. Working whilst subject to an ISO raises concerns about the Registrant's integrity as a registered nurse.*
>
> *27. The Registrant's behaviour, actions and lack of integrity fall so far below the standards expected of a nurse, that they amount to misconduct.*
>
> *28. The public interest is engaged as the Registrants misconduct and lack of integrity have the potential to damage public confidence in the profession.'*

The NMC invited the panel to bear in mind its overarching objective to protect the public and the wider public interest. This includes the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. The panel has referred to the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant* [2011] EWHC 927 (Admin).

In its written submissions, the NMC invited the panel to find Mr Saunderson's fitness to practise impaired. The NMC referred the panel to the questions outlined by Dame Janet Smith in the 5th Shipman Report as endorsed in the case of *CHRE and Grant v NMC*. The NMC submitted that limbs a, b and c are engaged and provided the following written submissions:

'[…]

i. *The Registrant's actions placed patients at risk of harm. Similar actions in the future could lead to a further risk of harm and distress if not addressed.*

ii. *Nurses occupy a position of privilege and trust and are expected to be professional at all times. Patients, their families and colleagues must be able to trust nurses who must make sure that their conduct justifies both their patients' and the public's trust in the profession, at all times. The Registrant's actions relate to basic and fundamental nursing duties and behaviour, such as counting/ documenting controlled drugs, checking relevant consent prior to administering vaccinations, etc. As such, the Registrant's actions are liable to bring the profession into disrepute.*

iii. *The Registrant has breached the fundamental tenets of the profession by not providing safe and effective care to patients and by behaving inappropriately towards a colleague. In addition, the Registrant worked whilst subject to an ISO.'*

The NMC outlined that in considering the approach of Silber J in the case of *R (on application of Cohen) v General Medical Council* [2008] EWHC 581 (Admin), Mr Saunderson has not engaged with the NMC investigation or taken any action to remediate his practice or demonstrate remorse or insight to allay the concerns that the conduct would not be repeated. Moreover, there has been no evidence put forward by Mr Saunderson to mitigate the risks identified in this case. Therefore, the concerns remain, particularly as the panel are left with limited information to assess Mr Saunderson's current impairment.

Additionally, it was the NMC's submissions that Mr Saunderson [PRIVATE] and therefore, a risk of repetition remains. Further, the risk of harm to the public remains, due to Mr Saunderson's lack of full insight and failure to undertake relevant training. He has not been able to demonstrate strengthened practice through work in a relevant area.

In addressing the public interest consideration, the NMC submitted:

> *'The NMC consider there is a public interest in a finding of impairment being made in this case to declare and uphold proper standards of conduct and behavior. The Registrant's conduct engages the public interest because the public would be shocked to hear of a registered professional making errors such as the Registrant has made and behaving in a harassing manner towards a colleague. The public rightly expects nurses to always perform their duties safely and behave in a professional manner. The absence of a finding of impairment risks undermining public confidence in the profession.'*

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant* and *R (on application of Cohen) v General Medical Council.*

Decision and reasons on misconduct

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

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

> *'**10 Keep clear and accurate records relevant to your practice***
> ***This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.***
> *To achieve this, you must:*

10.1 *Complete records at the time or as soon as possible after an event, recording if the notes are written some time after the event.*

10.2 *Identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need.*

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

10.4 *Attribute any entries you make in any paper or electronic records to yourself, making sure they are clearly written, dated and timed, and do not include unnecessary abbreviations, jargon or speculation.*

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'*

The above relates to charges 1 and 2. The paragraphs quoted above are from The Code: Professional standards of practice and behaviour for nurses and midwives (2015)'

'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*

1.5 *Respect and uphold people's human rights.*

2 Listen to people and respond to their preferences and concerns

To achieve this, you must:

2.5 Respect, support and document a person's right to accept or refuse care and treatment.

4 Act in the best interests of people at all times

To achieve this, you must:

4.2 make sure that you get properly informed consent and document it before carrying out any action

7 Communicate clearly

To achieve this, you must

7.4 Check people's understanding from time to time to keep misunderstanding or mistakes to a minimum.

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

To achieve this, you must:

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

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

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

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

To achieve this, you must:

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

19.4 *Take all reasonable personal precautions necessary to avoid any potential health risks to colleagues, people receiving care and the public.*

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.*

20.3 *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.'*

The above relates to charges 4 to 9. The paragraphs quoted above are from The Code: Professional standards of practice and behaviour for nurses and midwives (2018)'

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. The panel considered each, and individual Charge found proved and considered whether this amounted to misconduct.

The panel acknowledged that Charges 1 and 2 occurred in 2011 and 2012. It considered that individually, Mr Saunderson's actions at that time would not have amounted to misconduct. However, the panel noted that Mr Saunderson's actions in Charges 1 and 2 both reflect poor practice which continued in his career, namely his lack of attention to detail and failure to accept responsibility. Therefore, the panel considered that his actions at Charges 1 and 2 breached the Code (2015), specifically 10, 10.1, 10.2, 10.4, 20 and 20.1, and collectively amounted to serious misconduct.

In addressing Charge 4, the panel considered the serious nature of the Charge. It found that the behaviour displayed by Mr Saunderson demonstrated a serious disregard to Witness 3's personal boundaries and dignity, and breached the Code (2018), specifically 1.1, 1.2, and 1.5. At the time of the incident, Mr Saunderson was assisting in training how to immunise a child properly. The inappropriate behaviour took place in the presence of other colleagues and trainees. The incident caused Witness 3 [PRIVATE], and to such an

extent that she felt that she needed to leave the room. The panel therefore considered that Mr Saunderson's actions amounted to serious misconduct.

The panel found Mr Saunderson's actions in Charge 5 to 8 amounted to extremely serious misconduct and breached the Code (2018): 2.5, 4.2, 7, 14, 14.1, 14.2, 14.3, 19.1 and 19.4. Charges 5 to 8 relate Mr Saunderson's lack of attention to detail in relation to vaccination. In relation to Charge 5, Mr Saunderson gave the incorrect immunisation to a [PRIVATE] baby. The panel noted that Charge 6 in which Mr Saunderson used the incorrect consent form for the wrong child is particularly serious given that he failed to follow the protocol. The panel felt that this very clearly followed a pattern as in Charges 7 and 8, in that he failed to again follow procedure and clarify consent. The panel took the view that these charges are serious on their own and could have had more serious consequences.

In relation to Charge 9, the panel was unable to find sufficient evidence that Mr Saunderson knew that he was subject to an interim suspension order when he worked the shifts in October 2022. Therefore, in this context, the panel did not find this charge to have been so serious as to amount to misconduct. However, the panel was of the view that it would have amounted to very serious misconduct had he known that he was subject to an interim order and his practice restricted.

Panel's overall view

The panel determined that in looking at the Charges as a whole, the panel acknowledged that a single mistake would not necessarily mean serious misconduct in respect of the Charges found proved. However, in looking at the Charges cumulatively, the panel took the view that Mr Saunderson demonstrated a pattern of behaviour showing poor practice over a period of time, which placed patients at risk of harm. As such, the panel found that Mr Saunderson's actions did fall seriously short of the conduct and standards expected of a nurse and therefore amounted to misconduct.

Decision and reasons on impairment

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

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

> *'The question that will help decide whether a professional's fitness to practise is impaired is:*
> *"Can the nurse, midwife or nursing associate practise kindly, safely and professionally?"*
> *If the answer to this question is yes, then the likelihood is that the professional's fitness to practise is not impaired.'*

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

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

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

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

> *'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her/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)* […] *'*

The panel considered that limbs a, b and c are engaged. The panel found that patients were put at risk of physical and emotional harm as a result of Mr Saunderson's misconduct. Given the pattern in Mr Saunderson's behaviour, namely, lacking in attention to detail which led to incorrect vaccinations and the separate matter of inappropriate conduct with a colleague, the panel took the view that patients and or members of the public may be placed at unwarranted risk of harm.

Furthermore, the panel determined that Mr Saunderson's misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. Mr Saunderson's actions could undermine the trust of the public by failing to carry out the basic and fundamental nursing duties particularly towards infants and young children and acting in an inappropriate manner towards Witness 3.

The panel has not seen any evidence before it to demonstrate Mr Saunderson's insight. Mr Saunderson has chosen to disengage from his regulator and has not responded to the Charges as they were initially put to him. Therefore, the concerns remain, particularly as the panel are left with limited information to assess Mr Saunderson's current impairment.

The panel considered Mr Saunderson's remediation. The panel was satisfied that the misconduct in this case is capable of being addressed. The deficiencies in Mr Saunderson's practice can be addressed by re-training. However, given his lack of engagement, no evidence of strengthened practice and no reflective statement, there may be the presence of attitudinal concerns which could make the misconduct difficulty to correct unless Mr Saunderson was able to demonstrate a willingness to remediate.

The panel took the view that there is a risk of repetition. There is a lack of evidence to suggest any strengthened practice or any indication from Mr Saunderson that he recognised what went wrong, evidence of further training to mitigate the risks and how he would address the situation differently in the future. Without such information, the panel is unable to assess whether Mr Saunderson could return to practise as a safe, kind and professional practitioner. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

The panel bore in mind that the overarching objectives of the NMC; to protect, promote and maintain the health, safety, and well-being of the public and patients, and to uphold and protect the wider public interest. This includes promoting and maintaining public confidence in the nursing and midwifery professions and upholding the proper professional standards for members of those professions.

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 Mr Saunderson's fitness to practise impaired on the grounds of public interest.

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

Sanction

The panel has considered this case very carefully and has decided to make a suspension order for a period of 12 months. The effect of this order is that the NMC register will show that Mr Saunderson's registration has been suspended.

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 25 March 2024, the NMC had advised Mr Saunderson that it would seek the imposition of a 12-month suspension order (with review) if it found Mr Saunderson's fitness to practise currently impaired.

The NMC submitted the following aggravating factors:

- Lack of insight into failings.
- Pattern of misconduct over a period of time.
- Conduct which put patients at risk of harm.
- Vulnerable patients (babies and children)

No mitigating factors were put forward by the NMC.

The NMC provided the panel with a short summary of the sanctions available and submitted that a 12-month suspension order with review is the most appropriate sanction:

> *'A 12-month suspension order, with review, is the appropriate sanction in this case. The concerns are serious enough to require temporary removal from the register. The Registrant's actions were serious and placed patients at a real risk of harm. His behaviour towards his colleague was unacceptable as was the breach of the ISO. It is submitted that a suspension order would be the most appropriate sanction to impose in this case to manage the risk to*

the public. A 12-month suspension (with review) will mark the seriousness of the conduct and address the public interest.'

Decision and reasons on sanction

Having found Mr Saunderson'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 factors:

- Lack of insight into failings.
- Pattern of misconduct over a period of time.
- Abuse of position of trust.
- Conduct which put patients at risk of harm.
- Conduct involved vulnerable patients (babies and children)

The panel found no mitigating factors. Although, it noted that there appears to be no malice in Mr Saunderson's actions but rather a demonstration of his poor nursing practice during the period in question.

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 Mr Saunderson'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 Mr

Saunderson's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the issues identified. 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 Mr Saunderson's 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, in particular:

- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *Identifiable areas of the nurse or midwife's practice in need of assessment and/or retraining;*
- *No evidence of general incompetence;*
- *Potential and willingness to respond positively to retraining;*
- *Patients will not be put in danger either directly or indirectly as a result of the conditions;*
- *The conditions will protect patients during the period they are in force; and*
- *Conditions can be created that can be monitored and assessed.*

The panel is of the view that given Mr Saunderson's lack of engagement, there are no practical or workable conditions that could be formulated at present.

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. It gave careful consideration to the NMC Guidance at SAN-3d.

- *no evidence of repetition of behaviour since the incident.*

The panel was satisfied that in this case, the misconduct was not fundamentally incompatible with remaining on the register.

It did go on to consider whether a striking-off order would be proportionate but, taking account of all the information before it, the panel concluded that it would be disproportionate. Whilst the panel acknowledges that a suspension may have a punitive effect, it would be unduly punitive in Mr Saunderson's case to impose a striking-off order. Moreover, it concluded that it was not the only sanction available to protect patients or members of the public or maintain the professional standards.

Balancing all of these factors the panel has concluded that a suspension order would be the appropriate and proportionate sanction.

The panel noted the hardship such an order will inevitably cause Mr Saunderson. However, this is outweighed by the public protection concerns and by the public interest in this case.

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

The panel determined that a suspension order for a period of 12 months was appropriate in this case. The panel took the view that this would allow Mr Saunderson sufficient time to re-engage with the NMC should he wished to return to practise as a nurse.

At the end of the period of suspension, another panel will review the order. At the review hearing the panel may revoke the order, or it may confirm the order, or it may replace the order with another order.

Any future panel reviewing this case would be assisted by:

- Mr Saunderson's engagement with future proceedings.
- A reflective piece focusing on his insight into his failings in relation to the charges found proved and his general practice as a nurse.
- Testimonials from current employers.
- Further evidence of training which relates to the areas of concern, including (but not limited to) professional boundaries and competency in vaccination.

- An indication from Mr Saunderson of his future career plan for nursing, and/or whether he intends to return to nursing.

This will be confirmed to Mr Saunderson in writing.

Interim order

As the suspension 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 Mr Saunderson's own interests until the suspension sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Representations on interim order

The panel took account of the representations made by the NMC:

> *'If a finding is made that the Registrant's fitness to practise is impaired on a public protection basis and a restrictive sanction imposed, the NMC submit that an interim order in the same terms as the substantive order should be imposed for 18 months on the basis that it is necessary for the protection of the public and otherwise in the public interest.*
>
> *If a finding is made that the Registrant's fitness to practise is impaired on a public interest only basis and that their conduct was fundamentally incompatible with continued Registrant, an interim order of suspension for 18 months 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 on the grounds of public protection and that it is otherwise in the public interest.

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

That concludes this determination.