Northern Ireland
Social Care Council

Notice of Decision of the Northern Ireland Social Care Council's Fitness to Practise Committee

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Name: **Patricia Elizabeth Kearns**

SCR No: **6007632**

NOTICE IS HEREBY GIVEN THAT the Fitness to Practise Committee of the Northern Ireland Social Care Council, at its meeting on **09 and 10 April 2018**, made the following decision about your registration with the Northern Ireland Social Care Council:

The Committee found the facts proved;

The Committee found that your fitness to practise is impaired by reason of MISCONDUCT;

The Committee decided to make an Order for removal of your registration from the Register ('a Removal Order').

Particulars of the Allegation:

That, being registered under the Health and Personal Social Services Act (Northern Ireland) 2001 (as amended):	
1.	On or around 07 April 2014, whilst working as a Homecare Worker for the Northern Health and Social Care Trust, you failed to adhere to correct moving and handling procedures when assisting Service User N.
2.	On or around 08 April 2014, whilst working as a Homecare Worker for the Northern Health and Social Care Trust, you failed to adhere to correct moving and handling procedures when assisting Service User O.
3.	On or around 08 April 2014, whilst working as a Homecare Worker for the Northern Health and Social Care Trust, you used rough handling techniques when assisting Service User N.
4.	Between 12 October 2015 and 05 April 2016, whilst working as a Care Assistant at Ratheane Private Nursing Home, you failed to disclose your full employment history to Ratheane Private Nursing Home.
5.	Between 12 October 2015 and 05 April 2016, whilst working as a Care Assistant at Ratheane Private Nursing Home, you failed to disclose to Ratheane Private Nursing Home that you were under investigation by the Northern Ireland Social Care Council.
And your actions as set out above show that your fitness to practise is impaired by reason of your misconduct.	

Procedure:

The hearing was held under the fitness to practise procedure.

Preliminary Matters

The Registrant was neither present nor represented. The Council was represented by Ms Rachel Kelso, Solicitor, Directorate of Legal Services.

Service

The Committee heard a submission from Ms Kelso on the question of service of the proceedings. The Committee was told by Ms Kelso that the Notice of Hearing had been sent by the Council to the Registrant's registered address by Special Delivery post on 02 March 2018. The relevant Royal Mail Track and Trace documentation confirmed that the Notice had been signed for the following day, 03 March 2018. Ms Kelso invited the Committee to find that service of the Notice of Hearing had been effected in accordance with the Rules.

The Notice had been sent to the Registrant's registered address in excess of the 28 days required for service. The Notice had been signed for and there had been no other communication from the Registrant. The Committee was satisfied that service had been effected in accordance with Rule 3 and Paragraph 5 (2) of Schedule 2 of the NISCC Fitness to Practise Rules 2016 ('the Rules').

Proceeding in the Absence of the Registrant

The Committee heard a submission from Ms Kelso to proceed to hear and determine the case in the Registrant's absence. The Committee accepted the Legal Adviser's advice.

The Committee noted that the Registrant had failed, thus far, to engage with the regulatory proceedings brought against her by NISCC. She had not requested an adjournment in order to attend or be represented at a later date. The Committee had no reason to think that adjourning the hearing to a future date would secure the attendance of the Registrant or a representative on her behalf. The Committee noted that there would be some disadvantage if it decided to proceed in the Registrant's absence. The Committee considered, however, that the extent of this disadvantage could be mitigated somewhat by considering very carefully any written material provided by the Registrant on the question of the allegations faced by her. In addition, the Committee considered that there was a public interest in proceeding in her absence. The allegations were serious in nature and related, at the earliest, to events going back to 2014. In addition, NISCC had intended to call witnesses to give evidence. The Committee considered that it was important to proceed when the witnesses' memories about the events in question were as fresh as possible. The Committee also considered that it was fair and appropriate to proceed in the Registrant's absence in the public interest and that the public interest outweighed the Registrant's interests in all the circumstances.

Application to Admit Hearing Bundle

The Committee heard an application from Ms Kelso to admit a hearing bundle. The Committee acceded to the application on the grounds that the hearing bundle (Exhibit 1) was said to contain relevant evidence in connection with the allegations under consideration.

Background

The Registrant is registered on Part 2 of the Register as a Domiciliary Care Worker.

The matter was initially considered by NISCC when it received an Employer Referral Form from the Northern Health and Social Care Trust ('the Trust') on 02 June 2014. The Registrant was employed by the Trust as a Homecare Worker on an 'as and when' basis. She was suspended on a precautionary basis by the Trust, effective from 20 May 2014, following complaints received from fellow staff members about the Registrant's practice.

It was alleged by NISCC that the Registrant on 07 April 2014, while on shift with a Trust colleague, was assisting Service User N to the toilet with the use of a rolator. She witnessed the Registrant pulling the rolator forward which caused the service user to stumble and fall onto the witness who, in turn, fell into a reclining chair. The witness sustained an injury and was off work for four weeks as a result. It was further alleged that, on 08 April 2014, the Registrant was working with another Trust colleague and both were engaged in transferring Service User O using a hoist. The service user had constant pain in her legs which were sensitive to touch. It was alleged that during the transfer the witness saw the Registrant place her hand on the service user's legs while pushing her onto a reclining chair. As a result, Service User O called out in pain. When the witness told the Registrant not to touch the legs of the service user, it was alleged that the Registrant replied in response, '*well, she has to get onto the chair.*' It was NISCC's case that the Registrant's actions were contrary to the applicable moving and handling procedures adopted by the Trust.

It was further alleged that, on 08 April 2014, the Registrant was observed by a Trust witness rubbing the skin of Service User N very hard which caused the service user to call out in pain. Service User N suffered from haematomas and, as a result, her skin was very sensitive. The witness alleged that, rather than acknowledging the service user's pain, the Registrant instead continued to rub her skin. The witness also observed the Registrant pulling the service user's tripod in front of her when there was no need to do so. The Registrant's actions were alleged by NISCC, on this occasion, to amount to rough handling techniques which were contrary to the applicable Trust policy.

A Trust report was completed in respect of the Registrant's actions, as alleged, during a disciplinary process. The Registrant denied the allegations made in respect of her practice with Service Users N and O. On 25 January 2014, NISCC was informed that the Registrant had resigned from her post with the Trust and, as a result, no disciplinary hearing took place.

Subsequent to her employment with the Trust, the Registrant took up employment, on 12 October 2015, with Ratheane Private Nursing Home ('the Home'), operated by the Macklin Group, in a position as a domiciliary care

worker. NISCC alleged that the Registrant, in her application for employment at the Home, failed to disclose that she had previously been employed by the Trust. The Registrant was also alleged to have failed to disclose that, as a result of those matters reported in respect of Service Users N and O, she had been suspended from her previous position with the Trust pending an investigation. Instead, it was alleged that the Registrant documented that she had been employed previously with Riada Recruitment and had omitted any reference to her employment with the Trust in her application for employment with the Home. Further, it was alleged that the Registrant had not informed the Home that she had been referred to NISCC for investigation by the Trust.

As a result of further enquiries undertaken by the Home, on 12 April 2015, NISCC received a referral form in respect of the Registrant's employment with the Home.

Evidence

In addition to the hearing bundle, Exhibit 1, the Committee heard evidence from the following witnesses:

- Witness 1 – Homecare Worker employed by the Trust;
- Witness 2 – Homecare Worker employed by the Trust;
- Witness 3 – Nurse Manager at the Home; and
- Witness 4 – HR Manager at the Macklin Group.

Findings of Fact

The Committee carefully considered the documentary and oral evidence and accepted the Legal Adviser's advice. The general impression created by the evidence of the witnesses was that they gave their evidence in a straightforward manner. The witnesses were reliable and credible. The Committee had some difficulty with the quality of the recruitment process at the Home in general. The Committee was impressed that the staff employed at the Home by the Macklin Group fairly and appropriately conceded that there were some shortcomings in the process at the time, which have since been addressed.

Particular 1 - On or around 07 April 2014, whilst working as a Homecare Worker for the Northern Health and Social Care Trust, you failed to adhere to correct moving and handling procedures when assisting Service User N.

Witness 1 gave evidence to the Committee. She stated that she was an experienced care worker for the past 18 years and had worked with the Registrant on 07 / 08 April 2014. She did not work any other shifts with the Registrant. The witness gave evidence that she and the Registrant were assisting Service User N to the toilet with the aid of a rolator. The Registrant was in front of the service user and the witness was behind her. The witness observed the Registrant pulling the rolator forward. This caused the service user to stumble and fall onto the witness causing, in turn, the witness and the service user to fall onto a recliner chair. Although not injured, the witness described the service user as having been scared and frightened by the incident. The witness sustained an injury to her neck and arms which resulted in her being off work for four weeks. The witness described a conversation with the Registrant in the aftermath of the incident in which the Registrant belatedly

admitted to the witness that she might have pulled the service user causing her to stumble and fall. The Committee questioned the witness on how clear the incident was after the passage of time. The witness was clear in her evidence and stated that, because the incident was so uncommon, it was clearly impressed on her mind. The Committee also had regard to a witness statement provided by the witness to her employer on 20 May 2015. This statement was consistent with the account given by the witness in her evidence and in her NISCC statement contained in the hearing bundle. The Committee was therefore satisfied, on the balance of probabilities, that the incident giving rise to this Particular was proved.

Particular 2 - On or around 08 April 2014, whilst working as a Homecare Worker for the Northern Health and Social Care Trust, you failed to adhere to correct moving and handling procedures when assisting Service User O.

The Committee heard evidence from Witness 2, a Homecare Worker employed by the Trust, who described working with the Registrant on 08 April 2014. This was the only shift worked by the witness alongside the Registrant. The witness described attending with Service User O accompanied by the Registrant on a home visit on 08 April 2014. The witness stated that during the call to Service User O's home she and the Registrant were required to transfer the service user using a hoist. Service User O's condition meant that her legs were constantly sore. The witness had the remote of the hoist and was pulling the service user back onto the chair using straps at the back of the hoist at which point the Registrant put her hands onto Service User O's legs and pushed her onto the chair. The Registrant's actions caused the service user to cry out in pain. The witness told the Registrant not to touch the service user's legs to which the Registrant replied "*well she has to get onto the chair*". The Committee noted that the witness had provided a witness statement to her employer which was consistent with her evidence to the Committee and her NISCC statement. The Committee, therefore, found the facts giving rise to this Particular to be proved on the balance of probabilities.

The Committee further noted that Particulars 1 and 2 alleged that the Registrant had failed to adhere to correct moving and handling procedures when assisting Service Users N and O. The Committee in order to determine whether the Particulars were proved, needed to establish, on the evidence, whether the Registrant owed a duty to the service users in question and whether by her actions she had breached that duty.

The Committee noted the contents of the Registrant's employment contract with the Trust. The contract clearly required the Registrant to abide by all applicable Trust policies and procedures. The Registrant's job description also contained a relevant section in respect of the Trust's Manual Handling Policy, in which Trust employees were required to "always refer" to moving and handling risk assessments contained in the service user's care plan. The hearing bundle also disclosed that the Registrant had attended training in manual handling, provided by the Trust, on 12, 18, 19, 28 and 29 November 2013. These documents, to the Committee's mind, clearly established that the Registrant had a duty to provide care according to correct moving and handling procedures, and that she had breached that duty by her failure to adhere to those procedures.

Accordingly, the Committee found Particulars 1 and 2 proved in their entirety.

Particular 3 - On or around 08 April 2014, whilst working as a Homecare Worker for the Northern Health and Social Care Trust, you used rough handling techniques when assisting Service User N.

The Committee heard evidence from Witness 2 who attended a visit with the Registrant at Service User N's home. The witness' mother was Service User N.

The witness described Service User N's skin to be very fragile and that her arms were black. The Registrant proceeded to rub the service user's arms causing the service user to complain of pain. The Registrant did not acknowledge the pain caused and continued rubbing the service user's arms. The witness was shocked by the Registrant's actions and told the Committee that in the early hours of 09 April 2014, Service User N pressed her call button and told the witness that she was scared of the Registrant and did not want her to return to her home. In her evidence to the Committee, the witness was clear that Service User N's skin condition had been fully set out in her care plan and that a care worker would have been expected, in advance of the visit, to have familiarised herself with the care plan and how to care appropriately for the service user as a result. The Committee also noted that the witness had provided a statement, dated 20 May 2015, to her employer which was consistent with her evidence to the Committee and her NISCC statement. The Committee was mindful of the potential for bias in the witness' evidence given that Service User N was her mother. The Committee observed the witness carefully and considered that she gave a compelling account of the incident. The Committee also considered that there was independent support for the account of the incident having regard to the skin condition of Service User N contained in the care plan, and also the visual presentation of skin discolouration. The Committee was satisfied, on the balance of probabilities, that the facts giving rise to Particular 3 was proved.

The Committee noted that the Registrant's job description contained in the hearing bundle made clear that Trust employees were required to assist service users in such a manner as to maximise their physical comfort and to comply with relevant Trust policies and procedures. The Registrant, as set out above, attended a five day training event organised by the Trust in relation to proper manual handling techniques. The Committee noted that the fifth day contained specific training on tissue viability which, to the Committee's mind, would have encompassed the proper care to be given to vulnerable service users with skin conditions such as that experienced by Service User N. The Committee was therefore satisfied that the Registrant had not complied with applicable Trust policies and procedures and that she had used rough handling techniques when assisting with the care of Service User N.

Particular 4 - Between 12 October 2015 and 05 April 2016, whilst working as a Care Assistant at Ratheane Private Nursing Home, you failed to disclose your full employment history to Ratheane Private Nursing Home.

Particular 5 - Between 12 October 2015 and 05 April 2016, whilst working as a Care Assistant at Ratheane Private Nursing Home, you failed to disclose to Ratheane Private Nursing Home that you were under investigation by the Northern Ireland Social Care Council.

The Committee decided to take these Particulars together.

Witness 3 gave evidence to the Committee to confirm that the Registrant had failed to disclose her full employment history to the Home. The witness made a note of a conversation between herself and the Registrant in which the Registrant told the witness that she did not think that her previous employment with the Trust was relevant. In the same conversation, the Registrant stated that she had not disclosed the fact that she was under a NISCC investigation while working at the Home because she had considered that to be a confidential matter, she had not read the letters in connection with this and that, during the relevant time, she had been undergoing personal issues in her private life.

The Committee also heard evidence from Witness 4, the HR Manager with the Macklin Group. She provided the Committee with a note of a probation review meeting held with the Registrant on 11 April 2016. During this meeting, which was chaired by the witness, the Registrant indicated that she did not think that it was important to disclose her previous employment with the Trust and she said that she did not think it was relevant. The Registrant somewhat belatedly appeared to accept that she should have advised the Home of the NISCC investigation and that she had acted stupidly in that regard in not acting.

The Committee was satisfied, having heard from Witness 3 and Witness 4, that Particulars 4 and 5 were proved in their entirety on the balance of probabilities.

Fitness to Practise

The Committee heard a submission from Ms Kelso that the Registrant's actions seriously fell below the standards to be expected of a registered social care worker, and that it was necessary in the public interest for the Committee to make a finding of current impairment.

The Committee first addressed the question of whether, in light of the facts proved, the Registrant's actions amounted to misconduct. The Committee exercised its own independent judgement and accepted the Legal Adviser's advice.

The Committee had found on two occasions that the Registrant, in spite of her training, had breached Trust procedures to safeguard service users when they were being moved and handled. In addition, the Registrant had failed to adhere to correct procedures and had roughly handled a service user during a home visit. There was evidence that Service User N had been frightened as a result of the Registrant's actions and had asked Witness 2, her daughter, to ensure that the Registrant did not return to her home. Service User O was caused pain when the Registrant pushed her legs when transferring the service user by means of a hoist. In addition, the Committee heard evidence that Witness 1 was required to take four weeks off work as a result of the Registrant's actions when Service User N stumbled and fell onto the witness causing an injury to the witness' neck and arms. The Registrant's actions in failing to disclose, to her employer, her employment history and the fact that she was the subject of a NISCC investigation demonstrated a stark failing by the Registrant to act openly and transparently. The Committee was satisfied that the Registrant's actions had fallen far short of the standards to be expected of a competent member of the social care workforce and were serious.

In addition, the Committee considered that the Registrant, by her actions, had breached, at the material time, the following provisions of the NISCC Code of Practice for Social Care Workers:

Code 2: As a social care worker, you must strive to establish and maintain the trust and confidence of service users and carers. This includes:

2.1 Being honest and trustworthy.

Code 5: As a social care worker, you must uphold public trust and confidence in social care services. In particular you must not:

5.1 Abuse, neglect or harm service users, carers or colleagues.

Code 6: As a social care worker, you must be accountable for the quality of your work and take responsibility for maintaining and improving your knowledge and skills. This includes:

6.1 Meeting relevant standards of practice and working in a lawful, safe and effective way.

The Committee then turned to address the question of whether, in light of the Registrant's misconduct, her fitness to practise was currently impaired. The Committee was of the view that the behaviour underlying the allegations faced by the Registrant was capable of remedy. It was clear to the Committee that a practitioner such as the Registrant could benefit from undertaking training in the proper moving and handling of vulnerable service users and the importance of making full and true disclosures during the recruitment process. It was also clear to the Committee that there was no evidence that the Registrant had availed of any such training and had failed to engage in the regulatory process in any way. During the incidents covered by the allegations, the Registrant demonstrated little, if any, insight into her failings. For example, the Committee noted that she only belatedly accepted that she might have acted inappropriately in pushing Service User N's rolator in a conversation with Witness 1 afterwards. In addition, when confronted with her failure to be open with her employer, the Registrant asserted that she could not disclose a NISCC investigation for reasons of confidentiality. Having regard to the standards to be expected of a registered social care worker, this explanation was clearly implausible to the Committee's mind. As a result, the Committee concluded that the Registrant had demonstrated no insight into her failings and was at risk in the future of repeating the behaviour which had resulted in the regulatory proceedings against her.

The Committee also had regard to those factors identified by Dame Janet Smith in her fifth report to the Shipman Inquiry and concluded that the Registrant by her misconduct:

a) Had brought in the past and was liable in the future to bring the profession of social care into disrepute;

b) Had brought in the past and was liable in the future to breach a fundamental tenet of the social care profession;

c) Had brought in the past and was liable in the future to place vulnerable service users at unwarranted risk of harm.

For these reasons, the Committee determined that the Registrant's fitness to practise is currently impaired.

Sanction

The Committee heard a submission from Ms Kelso on the question of sanction. Ms Kelso confirmed that the Registrant had no previous findings of misconduct and had not acted in a premeditated manner. She stated that while no physical injury was caused to either service user, there was some evidence that one service user had some emotional reaction to the Registrant's actions. The Committee was told that the Registrant's registration had lapsed and that she was unable to practise in the social care field as a result. She submitted that the public interest required a Removal Order, in this case, to be applied to the Registrant.

The Committee had regard to the Indicative Sanctions Guidance document (June 2017) issued by NISCC and accepted the Legal Adviser's advice on the correct approach to be adopted when addressing the question of sanction.

Warning – with the exception of the Registrant's previous good history, the Committee considered that those factors that would justify a warning were largely absent in the circumstances of the Registrant's case. The Committee also noted that imposing a warning would allow the Registrant to work unrestricted in the social care field. This would be an inappropriate sanction to apply for that reason in light of the findings of fact and the serious nature of the allegations proved against the Registrant.

Conditions of Practice Order – the Registrant had failed to attend the hearing and had failed to engage at all in the regulatory proceedings brought against her by NISCC. The Registrant had not attended before the Committee to give evidence or make representations touching upon her insight or offering apology or remorse for what she had done. It was clear to the Committee that the Registrant had identifiable areas in her practice which would benefit from training and professional review. The Registrant had not engaged with the proceedings and had failed to confirm whether or not conditions were achievable or would adequately protect service users and the public at large. The Committee was satisfied, in any event, that a Conditions of Practice Order was inappropriate in light of the Registrant's failure to engage and the serious nature of the allegations found proved against her.

Suspension – while the Registrant was unable to practise because her registration had lapsed, the Committee noted that, nonetheless, the Registrant could reactivate her registration at any stage by complying with the registration requirements imposed by NISCC. The Registrant had failed to acknowledge her failings and while there was no evidence of repetition the Committee could not lose sight of the fact that the Registrant was unable to practise by reason of her lapsed registration. The Committee considered that the serious nature of the allegations combined with the Registrant's failure to engage with the process and her lack of insight rendered her behaviour as fundamentally incompatible with remaining on the Register.

Removal – the Committee, therefore, decided to impose a Removal Order. The Registrant had acted in an unprofessional manner in respect of two vulnerable service users and contrary to applicable Trust policies and procedures which were in place to safeguard those vulnerable individuals in her care. She had demonstrated a striking lack of candour in failing to disclose to her employer her previous employment history and the fact that she was the subject of a NISCC investigation into her conduct. It was obvious to the Committee that the

Registrant, with the benefit of a professional registration, should have been open and transparent in bringing those matters to the attention of her employer. She failed to do so, and subsequently offered a clearly implausible explanation for her actions. The Registrant had demonstrated no insight and no willingness to engage in the regulatory process. She presented a risk of repeating the behaviour which had led to the proceedings against her.

For the reasons given, the Committee considered that the public interest required no less a sanction and that the Registrant's behaviour was fundamentally incompatible with remaining on the Register.

Legal Advice Given

Service

I can advise you and your colleagues at this stage then on the question of whether service has been effected in accordance with the applicable Rules. As Ms Kelso has rightly indicated, service of the proceedings is governed by two provisions of the 2016 Rules, firstly, Rule 3 and Rule 3 makes clear that in relation to service of documents in a case of a Registrant any Notice of Hearing required to be served should be sent to the Registrant's home address, or the last known address if that differs from the address on the Register, and it appears likely to reach the Registrant better, then the last known address.

In this case, you have heard from Ms Kelso that the Notice of Hearing was sent to the Registrant's registered address on 02 March and in relation to that provision of Rule 3 it is clear that any such Notice shall be treated as having been served the day after it was posted.

Schedule 2 and Paragraph 5 specifically requires a Notice of Hearing to contain certain prescribed information, one such matter is the power of the Committee to proceed to hear the matter in the absence of a Registrant, but more pertinently for the purposes of service it requires that the Notice of Hearing should be sent to the Registrant not less than 28 days in advance of the hearing and that is by virtue of Paragraph 5 (2).

So, applying those provisions, namely Paragraph 5 of the said Schedule and Rule 3, it is my advice to you, at this stage at least, that it is safe to proceed and to determine that service has been effected in accordance with those two provisions. If, and only if, you are satisfied you must look separately at the question of whether you should proceed to exercise your discretion in the absence of the Registrant.

Proceeding in the Absence of the Registrant

Given the nature of Ms Kelso's submission to you, I don't intend to rehearse the factors identified by the Court of Appeal in the case of *Crown -v- Jones & Others*. It certainly appeared to me that being an experienced Committee you will be well familiar with those criteria and Ms Kelso has applied them insofar as the facts of this case are concerned.

The only more general observation I would make is that the House of Lords when considering the

circumstances of *Jones & Others* observed classically that the question of whether to proceed in the absence of a Registrant must only be conducted having exercised the utmost care and caution and other regulatory case law has also made plain that the discretion to proceed in absence is a severely constrained discretion.

Adeogba is also a relevant case in this arena. The Court of Appeal in that case sought to emphasize the distinction to be drawn between criminal and regulatory proceedings, whereas, for example, in the case of *Jones* there was an element of compulsion, a criminal court can compel a witness or defendant to appear before it, there is no such corresponding power with regard to a regulatory tribunal.

And the Court of Appeal also sought to emphasize the perhaps more subtle distinction to be drawn between a criminal court where the purpose of the proceedings potentially is to punish the defendant, whereas in proceedings such as this, the primary focus of your deliberations and that of your colleagues is focussed chiefly on the public interest and it is the public interest, which is to the fore in this particular case.

Findings of Fact

This is the first stage of the proceedings in relation to this Registrant Patricia Elizabeth Kearns. You must now determine, having regard to the allegations served in these proceedings, whether the facts, all or any of them, are found proved.

In relation to these regulatory proceedings, the Rules are very clear. The burden of proof in relation to the facts alleged rests upon the shoulders of Ms Kelso on behalf of the Council. You have previously decided that it was fair and appropriate to proceed and to determine this case in the Registrant's absence, but it is also clear that no adverse inference should be drawn at the fact finding stage against an absent Registrant. You should always remember that the burden of proof, even when the Registrant is absent, rests exclusively with the Council to prove its case.

So in that regard, what you must do is have regard to the available oral and documentary evidence. You obviously must look at the witnesses to assess their reliability and credibility and also the relevance of their evidence to the particulars set out in the allegations. But, you must go further than that. You must also probe the evidence and you must also give careful consideration where you identify any submission, or view, in written form at least, given by the Registrant in respect of the substance of the allegations which she faces.

It is also right to say that the standard of proof as set out in Paragraph 13 of the second Schedule to be applied to the facts is the balance of probabilities. The case law makes clear that the balance of probabilities means that an event is proved if a court, or a tribunal, in this case your Committee, is satisfied that, on the evidence, the occurrence of the event is more likely than not. It does not require you and your colleagues to be certain that the event occurred.

Other case law makes plain that there is only one civil standard of proof, the balance of probabilities, and neither the seriousness of the allegation, nor the seriousness of the consequences, should make any difference to the standard of proof to be applied, although it is recognised that in some cases a decider of fact,

in this case your Committee, may have to look at the facts more critically, or more anxiously than in others, before you can be satisfied to the requisite standard. However the standard is, it has been said, finite and unvarying.

Those are the matters at this stage that you must have regard to. It is also right to say that there is no general rule regarding the weighing of the strength of evidence presented to your Committee. It is a matter of common sense and logic based upon the particular circumstances of the case that you are dealing with.

Fitness to Practise

This is the second stage of the regulatory proceedings brought against Patricia Elizabeth Kearns and I am now required before you retire to provide you with some legal advice in relation to those matters, which you and your colleagues can properly take into account.

You have found the facts proved in this case. You must, however, now consider, in the light of those facts proved, whether the Registrant's fitness to practise is impaired by reason of her alleged misconduct. Unlike the first stage of the proceedings, at this stage of the proceedings you are required not to adhere to any particular standard of proof. You are required, in collaboration with your colleagues, to exercise your judgement in relation to both those matters.

The first issue which you must take into account is whether the proved allegations in this case amount to misconduct and Ms Kelso has rightly and usefully taken you to the definition provided in the speech of Lord Clyde in the case of the *GMC -v- Roylance*, a case from 2000 and although arising in the context of serious professional misconduct in the context of a doctor, this case has been held to have application across the entire range and scope of regulatory committees. Lord Clyde considered that the meaning of misconduct was a separate concept and he stated:

"Misconduct is a word of general effect involving some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be found by reference to the rules and standards ordinarily required to be followed by a practitioner in the particular circumstances."

Ms Kelso has also referred you to the applicable Standards governing the conduct of social care workers and although a finding that the Registrant to have breached these Standards is not determinative of misconduct, nonetheless, it provides a useful guide as to whether or not it can be said that the Registrant's actions have fallen below the standard to be followed by practitioners such as her in the social care sphere.

If, and only if, you are satisfied that the Registrant's actions amount to misconduct should you then consider whether, in light of that finding, the Registrant's fitness to practise is currently impaired. It is right to say the test is expressed in the present tense, fitness to practise is impaired. As the Court of Appeal noted in the case of the *GMC -v- Meadow*:

"The purpose of fitness to practise procedures is not to punish the practitioner for past misdoings, but is to protect the public against the acts and omissions of those who are not fit to practise. The panel thus looks

forward and not back. However, in order to form a view as to the fitness of that person to practice today, it is evident that it will have to take account of the way in which the person concerned has acted or has failed to act in the past."

Although, therefore, your task is not to punish her past misdoings, you must and you do need to take into account past acts, or omissions, in order to determine whether the Registrant's present fitness to practise is impaired.

The case of *Cohen -v- GMC* also reminds panels such as yours that you are concerned with the issue of whether, in light of any misconduct proved, the fitness of the Registrant to practise has been impaired taking account of the critically important public policy issues. Those issues which must be taken into account by panels such as yours were described by the Court in Cohen as:

"The need to protect the individual service user, the collective need to maintain confidence in the profession, as well as declaring and upholding proper standards of conduct and behaviour, which the public expect and that public interest includes amongst other things the protection of service users and the maintenance of public confidence in the profession."

Thus, in determining whether fitness to practise is impaired you must take into account a range of issues, which, in essence, comprise two components, first, that is to say, the personal component, the current competence, behaviour, et cetera, of the individual registrant. And second, the public component, that is to say the need to protect service users, declare and uphold proper standards of behaviour and maintain public confidence in the profession.

As the Court noted in Cohen, the sequential approach to considering allegations means that not every finding of misconduct will automatically result in a panel concluding that fitness to practise is impaired as there must always be situations in which a panel can properly conclude that the act was an isolated error on the part of the practitioner and that the chance of it being repeated in the future is so remote that his or her fitness to practise has not been impaired. The Court continued:

"It must be highly relevant in determining that fitness to practise is impaired. That first, the conduct which led to the charge is easily remediable. Second, that it has been remedied and third, that it is highly unlikely to be repeated."

It is important for panels such as yours to recognise the need to address the critically important public policy issues identified in Cohen, that is to say, *"to protect service users, to declare and uphold proper standards of behaviour and maintain public confidence in the profession"* means that you cannot adopt a simplistic view and conclude that fitness to practise is not impaired because since the allegation arose the Registrant has corrected matters, or has, *"learned his or her lesson."*

Ms Kelso has also provided you with the citation of the *CHRE -v- NMC and Grant* and contained within that judgment Mrs Justice Cox approved the formulation provided by Dame Janet Smith in her fifth report to the

Shipman Inquiry as a useful model in determining whether it can be said that fitness to practise of a practitioner is currently impaired. In that case, to paraphrase, Dame Janet posed a number of questions for panels to the effect that, arising from any misconduct proved is it right to say that the practitioner's conduct has in the past, or is liable in the future, to place vulnerable service users, or the public at large, at unwarranted risk of harm; whether the conduct renders the practitioner in the past, or liable in the future, to bring the profession of social care into disrepute and somebody, whether in the past has, or is liable in the future, to breach a fundamental tenet of the social care profession. That, again, has been put forward as a useful formulation in relation to the task which you now face.

That is my advice to you at this stage. It is, of course, a matter for your judgement in collaboration with your colleagues.

Sanction

This is now the third and final stage of the proceedings against Patricia Elizabeth Kearns. I am now required to provide you with some brief advice in relation to those matters, which you and your colleagues can properly take into account at this stage. Your powers are those as set for you at Paragraph 26 of the second Schedule of the Rules and that provision makes clear that you may apply one of the following sanctions, either to warn the Registrant for a specified period of up to five years. You may make a Conditions of Practice Order for a specified period not exceeding three years. You may order the suspension of the Registrant for a specified period not exceeding two years or, finally, you may make a Removal Order to remove the Registrant's registration from the Register.

In deciding what sanction is to be imposed, the Rules also make clear that you should take into account a number of matters, which include the seriousness of the particulars of the allegation, the degree to which the Registrant has fallen short of any expected standards, the protection of the public, the public interest and the degree of proportionality. Proportionality means that when you and your colleagues, in the exercise of your judgement identify the sanction which you consider adequately protects the public, you should not move any further to consider a more restrictive sanction, for to do so would be to punish a practitioner and being an experienced Committee you will no doubt be aware that the purpose of a sanction, whilst it may have a punitive effect, its intention is not to be punitive. It is, of course, to be applied for the upholding and protection of the public.

In that regard then, you should commence your deliberations by starting at the least restrictive sanction, that is to say start at a warning and if, and only if, you are not satisfied that such a sanction would be appropriate and would adequately protect the public should you then move to consider a more restrictive sanction in ascending order of severity.

It may be helpful for you and your colleagues in addressing the question of the appropriate sanction to have regard to the Indicative Sanctions Guidance document and to balance mitigating factors and aggravating factors, non-exhaustive lists of which are set out for you at Paragraphs 3.2 and 3.3 of the Indicative Sanctions

Guidance document. Once you, as it were, have calibrated the seriousness of the misconduct found in this case should you then move to consider the individual sanctions. The document also provides you with examples of what type of behaviour and misconduct might properly fit within the scope of each particular sanction.

Like the second stage of the proceedings, this part of the proceedings does not require you or your colleagues to adhere or apply any standard of proof. This is, of course, a matter for you and your colleagues in the exercise of your judgement as to what is appropriate, proportionate and what sanction adequately protects the public.

You have the right to appeal this decision to the Care Tribunal. Any appeal must be lodged in writing within 28 days from the date of this Notice of Decision.

You should note that the Fitness to Practise Committee's decision takes effect from the date upon which it was made.

The effect of this decision is that your entry in the Register has been removed.

You are prohibited from working as a social care worker in any of the following positions:

1. A member of care staff at a:
    a.) Children's home;
    b.) Residential care home;
    c.) Nursing home;
    d.) Day care setting;
    e.) Residential family centre.
2. A person who is supplied by a domiciliary care agency to provide personal care in their own homes for persons who by reason of illness, infirmity or disability are unable to provide it for themselves without assistance.
3. A manager of a:
    a.) Residential care home;
    b.) Day care setting;
    c.) Residential family care centre; or
    d.) Domiciliary care agency.

It is **compulsory** for the above social care workers to be registered with the Northern Ireland Social Care Council in order to work. This is pursuant to the Northern Ireland Social Care Council (Social Care Workers Prohibition) and Fitness of Workers Regulations (Northern Ireland) 2013 and the Northern Ireland Social Care Council (Social Care Workers Prohibition) and Fitness of Workers (Amendment) Regulations (Northern Ireland) 2017.

In accordance with Schedule 3, Paragraph 9 of the NISCC Fitness to Practise Rules, you may not apply to be restored to the Register within five years from the date of removal. This does not affect your right to appeal the Committee's decision to the Care Tribunal.

P.P M. Stewart

Committee Manager

16 April 2018

Date