Northern Ireland Social Care Council

Determination of the Northern Ireland Social Care Council's Conduct Committee

REDACTED

Name: **Michelle Mary Carr**

SCR No: **2041168**

The Conduct Committee of the Northern Ireland Social Care Council, at its meeting on **04 August 2014, 15, 16, 17 and 30 April, 21 May, & 07 July 2015** made the following decision:

The Committee found the facts proved;

The Committee found that the Registrant has committed misconduct;

The Committee decided to admonish the Registrant and directed that a record of the admonishment should be placed on her entry in the Register for a period of five years.

Charge:

That, being registered under the Health and Personal Social Services Act (Northern Ireland) 2001 (as amended),

1. In a letter sent to the NISCC on 29th April 2011 you made the following statement,

   "While I did have my basic first aid training I was not qualified to detect a fractured hip and if I had of suspected this I would not have proceeded in assisting to move or clothe the lady. I was present when the senior on shift checked the lady for injuries and I can honestly say that I did not see any signs to indicate that her hip or leg area was injured. While I was present the lady did not indicate that while assisting in moving or clothing her I was causing any pain or distress in the leg or hip area and again I am certain that if she had have done I would not have proceeded in moving her as I would never intentionally cause additional pain or distress to any person that I was caring for."

   which was dishonest as you were aware that the service user in question was suffering from pain in her hip/leg area when the senior on shift checked the service user for injuries on 10th February 2008.

2. In evidence you gave to a Conduct Committee of the NISCC on 29th October 2012 you made the following statements,

   'Q. Did you detect an injury?
   A. The wrist, yes, but certainly just the wrist, at that stage there was nothing else that we had indicated

there was a problem with.

Q. Was the resident complaining of any pain?

A. No, no.

Q. Did she make any mention of pain in her hip?

A. No.

Q. Or her legs?

A. No, definitely not. So then we checked her over. The wrist was hurt so then we helped her up. She consented for us to do that there. We supported her to standing and then we supported over her to the bed.

Q. Okay. Well, when you helped her up off the floor did she complain of any pain in her hip?

A. No, just her wrist.

Q. Well was there any indication of pain in her hip while she was being dressed or having the protectors put on?

A. No, and she could move her legs. I mean, she could freely bend them so there definitely was nothing to suggest that there was an injury there.

Q. Did he carry out any examination of the resident while she was in the ambulance, while she was being transported?

A. ...He then asked her was she sore anywhere and she was very much no.

Q. All right. Is it the same regarding the severe pain in the left hip, that you don't remember that part of it really?

A. There was no severe pain in the left hip.

Q. ...there is evidence that shows that you and Mrs Thompson both were aware that this lady had a fractured hip or certainly a hip injury?

A. That evidence is incorrect.'

which were dishonest because you were aware that the service user in question was suffering from pain in her hip/leg area on 10th February 2008.

And your actions as set out above amount to Misconduct, such as to call into question your suitability to remain on the Social Care Register.

Preliminary Matters

Service

The Registrant was present and represented by Mr Brian McKee of Counsel, instructed by John McShane of McCartan, Turkington and Breen Solicitors. The Council's case was presented by Mr Alistair Wilson, Solicitor.

Background

The Registrant is currently registered on Part 1 of the Register as a qualified social worker and has been employed since August 2012 in the 16+ Services Team by the South Eastern Health and Social Care Trust. During the operative period in relation to this referral, the Registrant was employed as a support worker by Fold Housing Association at Spelga Mews, Banbridge. The index incident occurred on 10 February 2008 when the Registrant was working on a shift with Amanda Thompson, who was a senior support worker on shift at the time. The Registrant attended at the room in which a resident, Service User A, was residing. Upon hearing Service User A cry out, the Registrant attended almost immediately and was assisted by Amanda Thompson. They examined Service User A and a GP Out-of-Hours Service was called by Amanda Thompson. In turn, the doctor arranged for ambulance personnel to attend. Service User A was examined by ambulance personnel and taken to hospital where it was discovered, following x-ray, that she had sustained a fracture to the neck of her left femur and left wrist. Concerns were raised about the standard of care afforded to Service User A by Amanda Thompson and the Registrant. A referral was made to the Northern Ireland Social Care Council ('the Council'), and the Preliminary Proceedings Committee was convened to consider complaints against both Amanda Thompson and the Registrant. The Registrant wrote a letter to the PPC1 on 29 April 2011, in which she denied having any prior knowledge that Service User A had sustained a fracture to her left hip. The PPC1, in May 2011, decided to close the case and take no further action against the Registrant in respect of the referral to the Council. The complaint against Amanda Thompson was ultimately referred to the Conduct Committee. That Committee met in October 2012, and the Registrant gave evidence on behalf of Amanda Thompson at the fact finding stage. During the course of her evidence to the Committee, the Registrant again, on repeated occasions, denied having knowledge that Service User A had been complaining of hip pain when she attended at the scene.

Following a comprehensive review of the assertions made by the Registrant in her letter to the PPC1 in April 2011, and her evidence under oath to the Conduct Committee in October 2012, it was decided to refer fresh complaints against the Registrant to the Conduct Committee and to also allege that, in stating that she was unaware that Service User A was complaining of or suffering pain in her left hip / leg area, she was acting dishonestly.

Evidence

The Committee received in evidence a substantial bundle of documentation (Exhibit A) which comprised of the letter referred to above written by the Registrant, together with the transcripts of the evidence which she gave to the Conduct Committee in October 2012, and other documentary material containing witness statements and contemporaneous records, which documented Service User A's fall and her subsequent treatment at the Fold and at the relevant hospital. The Committee also admitted a document (Exhibit B) which detailed a pre-hearing review which was conducted in March 2014 before a Legal Adviser of the Council, at which the Registrant and her legal representatives were in attendance, together with a legal representative on behalf of the Council.

Decision to Hold Hearing in Private

The Committee heard a submission from Mr McKee, on behalf of the Registrant, that he wished to make an adjournment application on the basis of a fresh set of instructions which he had received at approximately 12.30 pm on the first day of the hearing. The Committee was advised by Mr McKee that the application to adjourn would centre upon matters relevant to the Registrant's health. Accordingly, he requested that the Committee hear the adjournment application in private, in accordance with Schedule 2 Paragraph 9 (2) of the NISCC (Conduct) Rules 2013 (the Rules). Mr Wilson, on behalf of the Council, did not oppose this application.

The Committee accepted the advice of the Legal Adviser in relation to the proper approach to be adopted on the issue of whether to hold the hearing in private. The Committee was satisfied that the health issues to be addressed outweighed the public interest in holding the hearing in public. The Committee was nonetheless mindful of the fact that it should only permit the hearing to be conducted in private for so long as was strictly necessary in order to fairly determine the case, having regard to the health issues raised by the Registrant. The Committee was resolved to revert to public session as soon as the health issue had been addressed.

Accordingly, the Committee decided to hear the adjournment application in private in accordance with Schedule 2 Paragraph 9 (2) (b).

Application for Adjournment

The Committee heard an application to adjourn the conduct proceedings from Mr McKee. He advised the Committee that after it had retired to consider the bundle of documents referred to as Exhibit A, he was told by a friend of the Registrant that the Registrant had been closely associated with an incident which occurred in February 2004. Mr McKee took detailed instructions in relation to this incident and its aftermath, and submitted that he required medical evidence to establish whether this event would have had an effect on the Registrant's memory, and would have affected her ability to recall accurately the traumatic events involving Service User A's fall and her recollection of whether she had a prior knowledge that the service user had sustained an injury to her left hip.

Specifically, Mr McKee indicated that he had been informed by Mr A, a friend of the Registrant, that his son had been killed along with three others in a road traffic accident in Belfast in February 2004. Mr A's son, at the time, was the Registrant's boyfriend. The driver of the car was prosecuted for causing death by dangerous driving and was tried in Court in 2006. The jury was unable to reach a verdict on this occasion and the driver was re-tried in May 2008 and convicted. Mr McKee submitted that this incident had a significant impact upon the Registrant.

Mr McKee argued that a just result in the circumstances of this case could only be arrived at by a proper exploration of the health condition raised, and whether any health condition could explain the inability of the Registrant to recall whether, at the material time, Service User A had sustained a fracture injury to her left hip.

Mr Wilson opposed the application to adjourn the proceedings. He criticised the lateness with which the application was made. He relied upon a number of previous opportunities at which the Registrant was offered the

chance to raise a health issue and chose not to. He laid particular emphasis on the pre-hearing review which was conducted in March 2014, at which the Registrant and her legal representatives were present. The Registrant specifically indicated (at (g)) that her health would not be raised at the substantive hearing as an issue. Mr Wilson also contrasted the Registrant's current argument that her health was now in play with her clear and confident evidence given during the conduct hearing concerning Amanda Thompson, that evidence demonstrating that both she and the Registrant had prior knowledge of the hip injury was 'incorrect'. Finally, Mr Wilson invited the Committee to find, on the basis on the evidence presented, that the Registrant's health was not properly in issue and therefore the proceedings, which have been convened at public expense, should continue.

The Committee heard and accepted the advice of the Legal Adviser, and was reminded of the factors to be taken into account when addressing the question of an adjournment application, which were derived from the decision in *CPS v Picton (2006) EWHC 1108.*

The Committee paid due regard to the submissions made by the Council, and noted that the application for an adjournment was raised on the first day of the substantive hearing. The health issue referred to by Mr McKee had never previously been raised in the long history of the Registrant's case in relation to the first, and subsequent, referral to the Council. The Committee was also mindful of the general need for expedition in the conduct of these proceedings, especially having regard to the fact that the subject incident occurred a significant period of time ago. The Committee was also aware of the public cost in convening the hearing, and also the pressing need to decide the facts when the memories of witnesses were fresh.

The Committee was satisfied that the submission made by Mr McKee, based upon his clear instructions, was sufficient to engage the test provided for by Paragraph 8 (2). It raised the possibility that the health condition referred to may have caused, or substantially contributed to, the misconduct alleged against the Registrant. The Committee was satisfied that if it refused to accede to the application to adjourn in these circumstances, the ability of the Registrant to have her case fairly decided would be fundamentally compromised, and that, while highly regrettable that things transpired in the way they did, fairness to the Registrant at this stage required for the adjournment application to be granted.

The Committee accepts that it has no jurisdiction to specify a date or dates upon which its hearings can resume. Nonetheless, the Committee notes that the events to which this referral relates occurred a significant time ago, and requested that the Council and the representatives of the Registrant act with all due vigour to ensure that the hearing is resumed at the first available opportunity.

For these reasons, and to ensure a fair hearing, the Committee has acceded to the application made by Mr McKee, and has adjourned the hearing for the health issue to be properly investigated under Schedule 2 Paragraph 13 (1) of the Rules.

Resumed Hearing

The Committee convened under the Health Procedure with the benefit of a Medical Adviser, in accordance with Schedule 2, Paragraph 28 of the Rules, and heard evidence at the fact finding stage on 15 and 16 April 2015. Specifically, the Committee heard evidence from two medical experts who had examined the Registrant and had consulted extracts from her GP notes and records. The Council engaged Dr A. The Registrant engaged Dr B. Both medical experts prepared reports (Exhibit C – Dr B; Exhibit D – Dr A). Following a further pre-hearing review at which the Parties' legal representatives were present, it was decided to ask the experts to answer a number of posed questions arising from their reports in an effort to isolate those areas where the experts agreed and disagreed. These joint statements were made available to the Committee (Exhibits E and F). In addition, the Registrant gave evidence under oath. The Committee retired on 16 April 2015 at the fact finding stage.

Expert Medical Evidence

The Committee heard extensively from Dr A and Dr B on the question of the Registrant's health. Both medical experts, in evidence, were agreed that the Registrant had a medical condition at the time of the index incident on 10 February 2008.

In his opinion, Dr B was of the view that, on the balance of probabilities, the Registrant had a medical condition on 10 February 2008, which could have impacted negatively on her ability to recognise Service User A's hip / leg pain. Dr B continued that the Registrant's difficulty with concentration arising from her health condition would have played a role in her inability to carry out her work duties to a satisfactory level, and would have impaired her ability to recognise Service User A's hip / leg pain.

In contrast, Dr A was of the opinion that the severity of the Registrant's health condition was not such as to impair the ability of the Registrant to recognise Service User A's hip / leg pain on the date in question. Dr A remarked in this regard that the Registrant had remained at work after the incident, and that there were no reports from any other source that any other aspect of her work had been compromised.

The evidence of both medical experts, whilst largely in agreement, was however divergent in the view taken by each of them as to whether the Registrant's health condition had an impact on her ability to recall and relate the hip / leg pain experienced by Service User A on 10 February 2008. The Committee was therefore required to examine this issue with great care. It derived considerable benefit from the medical reports (Exhibits C – F), and was greatly assisted by the clear and cogent evidence given by both Dr B and Dr A.

The Committee was told by Dr B, in support of his conclusion as set out above, that the Registrant had suffered from a number of traumatic and highly relevant life events prior to the index date. Her then boyfriend had been killed in a car crash in 2004 when the Registrant was still relatively young. A person was prosecuted over the death, which resulted in a three week trial in 2006. The Registrant attended the trial, during which traumatic and graphic evidence was given of the circumstances leading to the fatal collision. Unfortunately, the jury hearing the case was unable to reach a verdict and was discharged, following which a re-trial took place. The re-trial was due

to commence in May 2008, some three months after the index date. In addition, around the date in question, the anniversary of the Registrant's boyfriend's death was also imminent. [REDACTED]. This medical history, and the timing of the event in question which comprised the Charge against her, was significant in Dr B's estimation. At the time of the incident, the Registrant was [REDACTED]. She was the less experienced member of staff on duty, who discovered Service User A on the floor of her room and was involved in her care subsequently. Dr B confirmed to the Committee that, [REDACTED], would likely render her unable to register and retrieve the memory of Service User A's hip / leg injury. Dr B further confirmed that the blocking of memory can be a feature of a traumatic experience. On questioning, Dr B told the Committee that the trauma experienced by the Registrant did not relate to the actual fall itself, which might be considered a common occurrence in a setting such as Spelga Mews. Instead, it related to [REDACTED], owing to the fact that the Registrant had subsequently learned that she had failed to identify that Service User A had suffered a serious injury whilst in the Registrant's care.

Dr B accepted that the Registrant could have consciously lied about her ability to recall Service User A's hip / leg injury in order to avoid criticism or action against her by any third party in respect of her failure to properly treat and account for the hip / leg injury. Dr B, in his evidence, was of the view that the Registrant had been honest with him. He stated that he felt that the Registrant was not trying to 'misdirect' him or overstate her health condition, or use it as an excuse in order to avoid a finding being made against her.

For his part, Dr A gave evidence of the Registrant's relevant health background, and concentrated on two chronological reference points referred to above in April 2007 and April 2008. In particular, Dr A [REDACTED].

Both Dr B and Dr A were agreed that a patient who expressed extreme pain on a number of occasions in a localised area, or frequently complained of pain over a number of hours, would not have prevented a person with Ms Carr's medical condition from recognising hip / leg pain and being able to remember it.

Registrant's Evidence

The Registrant gave evidence to the Committee under oath. The Registrant confirmed that she went to Service User A's room on the morning of 10 February 2008 after hearing cries, and found Service User A lying on the floor. She immediately called for Amanda Thompson, who was her superior and who was also on duty, to assist her. Ms Thompson checked Service User A while she was on the floor. The Registrant confirmed that she noted that Service User A's wrist was swollen and bruised. After the check had been completed, Service User A was moved by Ms Thompson and the Registrant to her bed. The Registrant confirmed that she stayed in Service User A's room while Ms Thompson made phone calls at the other end of the building in respect of Service User A's fall. When Ms Thompson returned after a while, she brought breakfast to Service User A, and Service User A was then moved by Ms Thompson and the Registrant to a chair. The Registrant confirmed that Service User A sat on the chair for a while and did not eat her breakfast. The Registrant confirmed that Service User A had to go to hospital. Prior to the arrival of ambulance personnel, Ms Thompson and the Registrant changed Service User A's clothing, and recalled, in so doing, that Service User A's wrist was sore. She then told the Committee that

Service User A was moved back to her bed awaiting the arrival of ambulance personnel. The Registrant remained with Service User A until ambulance personnel arrived, at which point the Registrant left Service User A's room and got her coat. While she was out, Service User A was assessed by a paramedic. The Registrant told the Committee that she had accompanied Service User A to the hospital in the back of the ambulance.

The Registrant confirmed that a report of the accident was filled out by Ms Thompson, who signed the report and also requested and obtained the Registrant's signature on the report.

The Registrant indicated that she had no recollection of Service User A calling out in pain in relation to her hip or leg. She accepted that Service User A must have complained about pain in her leg while the Registrant was in the room, but that she had no recollection of Service User A making this complaint. The Registrant stated that, at the time, she was a junior member of staff and would have had no reason to tell lies to the Committee in respect of complaints made by Service User A concerning hip / leg pain.

The Registrant was questioned about her previous attendance as a witness on behalf of Ms Thompson, whose case appeared before a Conduct Committee in October 2012. She accepted that during this evidence (which formed part of the Charge against her at 2) she was more emphatic, and had denied that Service User A had complained of severe pain in her hip / leg. She stated to the Committee that she had relied on Ms Thompson's version of events when she gave her evidence in October 2012. A recording of the conversation between Ms Thompson and the GP Out-of-Hours Service (a transcript of which appeared in Exhibit A), during which Service User A's fall had been reported, clearly disclosed that Ms Thompson was aware that Service User A had suffered pain in her leg area. The Registrant denied that she had any knowledge of the content of this telephone conversation, and maintained in her evidence to the Committee in April 2015 that, despite being in Service User A's company from the point at which she discovered Service User A on the floor to Ms Thompson leaving Service User A's room to make the telephone call, she had no recollection of hip / leg pain being indicated to her by Service User A.

Approach of the Committee

The Committee reminded itself that where facts were disputed, the burden rested upon the Council to prove its case on the balance of probabilities. In this regard, the Committee accepted the advice of the Legal Adviser of the proper test to be applied, and accepted that it is a single and unvarying standard, and that neither the seriousness of the allegation faced by the Registrant, nor the seriousness of the consequences, should make any difference to the application of the standard of proof. The Committee also considered in detail the substantial volume of documentary material and medical reports. The Committee also paid particular regard to the evidence of the Registrant, and reminded itself that, on the question of whether she had acted dishonestly, she was entitled to be treated as a person of good character. Finally, the Committee was grateful for, and derived great assistance from, the careful and considered evidence given in written and oral form by Dr B and Dr A.

Finding of Facts

As set out above, the only factual matter which the Committee was required to address was whether, on two separate occasions as outlined in the Charge, the Registrant was acting dishonestly.

The Committee first considered the question of whether the Registrant could have missed, and failed to note, that Service User A had suffered an injury and was experiencing pain in her hip / leg area. In her evidence, the Registrant maintained that she had focused on Service User A's wrist, but accepted that she was in Service User A's company from the point in time at which she had found Service User A lying on the floor of her room until Ms Thompson had left the room to make a telephone call and, beyond that, until the arrival of ambulance personnel.

The Committee noted that in February 2008, the Registrant was a care assistant of four months' standing. It accepted her evidence that the Registrant had never witnessed a fall before, and that she was on duty with Ms Thompson who was in charge, and who had considerably more experience than the Registrant, at the material time. There was no evidence before the Committee as to what training the Registrant had received in the event of one of the residents of Spelga Mews falling and sustaining injury. The Committee noted, however, that at Ms Thompson's conduct hearing (Exhibit A, Page 96, Line 24), the Registrant accepted that, up to February 2008, she had received a one day training course in first aid.

The Committee carefully examined the Registrant's account of her movements in and about Service User A's room, and her close proximity to Service User A for a substantial period on the date in question. The Committee noted that the paramedic, who attended Spelga Mews and examined Service User A while the Registrant was out of the room, recorded that Service User A experienced 'extreme pain on movement' and that Service User A had complained of pain in her left hip and left wrist. This statement was based on a contemporaneous report (Exhibit A, Page 5b), which corroborated the paramedic's statement. The Registrant, in her evidence at the conduct hearing of Ms Thompson, indicated that she could not recollect being present whilst the NIAS Patient Report Form was being completed. The paramedic, in his statement, indicated that he had completed the NIAS Patient Report Form as soon as Service User A had been transferred to the ambulance. The Registrant accepted that she had accompanied Service User A in the back of the ambulance to the hospital for treatment for her injuries. The Committee was satisfied that Service User A, on the balance of probabilities, would have manifested pain on movement of her hip / leg, as documented by the paramedic. As a result, the Committee concluded on the balance of probabilities that the Registrant, even with a basic first aid knowledge, would have been aware of pain in the general area of Service User A's hip / leg. Accordingly, the Committee rejected the possibility that the injury to A's hip / leg may have been missed by the Registrant on 10 February 2008.

The Committee next turned to the contentious issue upon which Dr B and Dr A were disagreed; namely, whether the Registrant's health condition and the trauma of the event as set out above could have resulted in the Registrant blocking the memory of an injury to Service User A's hip / leg and, as a result, being unable to register and recall the memory in her letter to the PPC in April 2011 and while giving evidence at Ms Thompson's conduct hearing in October 2012.

The Committee undertook a detailed and careful assessment on this question of the oral and documentary evidence given by Dr B and Dr A. Dr B placed a significant degree of reliance on his view that the Registrant did not rely on her health condition as an excuse to cover her actions, and felt that she was being honest in her account as to why she did not have any recall at the time of Service User A's hip / leg injury. Dr A declined to comment on this issue and, in his evidence, deferred to the Committee's view of the Registrant's honesty after assessing all the available evidence. Dr B gave a clearly expressed opinion as to how the Registrant could have failed to have registered, remembered and retrieved the recollection that Service User A had sustained a hip / leg injury. He put the Registrant's failure to recollect the hip / leg injury squarely in the context of the Registrant's relevant medical history. Dr B laid particular emphasis on the trauma associated with the Registrant's recognition that she had missed the hip / leg injury as a mechanism for her blocking out and failing to recall the hip / leg injury as a memory. In contrast, Dr A did not lay as much emphasis on this as a mechanism, and instead gave a variety of reasons as to why a person might suppress a memory.

The Committee, after a careful analysis, decided to attach greater weight to the significance of the Registrant's health condition, and the associated trauma of the incident in February 2008, as a mechanism which could as a possibility explain the Registrant's failure to recollect the hip / leg injury suffered by Service User A, as described by Dr A.

Having addressed this issue, the Committee finally turned to assess the evidence given by Dr B and Dr A in relation to whether a person with Ms Carr's health condition, as suffered by the Registrant in February 2008, could have resulted in her failing to recollect Service User A's hip / leg injury in circumstances where Service User A complained of pain acutely in this area on a few occasions, or complained of pain more generally in this area over a longer period. Specifically, the Committee reminded itself of Dr B's evidence that the Registrant may have missed an expression of pain on one occasion that her hip was sore, but that the Registrant's condition could not explain a failure by her to recollect in a scenario where Service User A had complained about pain in that area either acutely on more than one occasion, or generally over a period of time.

The Committee was unable to avail of the evidence of Service User A, who is now deceased, and instead was required to rely upon the evidence given by the Registrant and the documentary evidence contained in Exhibit A. Service User A was discovered in her room by the Registrant, crying out and lying on the floor of her room at Spelga Mews. The Registrant accepted that, from this time, she was continually in the company of Service User A and was joined, shortly after finding Service User A on the floor, by Ms Thompson. At 9.04 am, Ms Thompson made a telephone call to the GP Out-of-Hours Service, in which she stated that Service User A had been 'complaining' and also 'shouting out in pain on her leg, her left upper thigh area' (Exhibit A, Page 18). The report by the GP Out-of-Hours Service (Exhibit A, Page 108) documented the call from Ms Thompson, and recorded that Service User A required an ambulance as she had 'persistent pain and difficulty bearing weight on [the] left leg'. Significantly, the records indicate a diagnosis as '?? hip fracture'. No reference is found in the notes from the GP Out-of-Hours Service to any injury to Service User A's wrist. A paramedic arrived at Spelga Mews at 10.15 am on the date in question, just short of two hours following Service User A's fall. His report (Exhibit A, Page 5b) was

also considered by the Committee. The paramedic recorded 'possible rotation' of Service User A's left leg, and that she had experienced 'extreme pain on movement'. In addition, the chief complaint recorded on this document was a possible fracture to the neck of the femur on Service User A's left side, together with a possible injury to her left wrist. In his statement, provided for the purpose of the Council's investigation into the Registrant's conduct, the paramedic confirmed that although Service User A had suffered from dementia, because of his recording in the 'History of Incident' section of his report, he was satisfied that Service User A was able, and did, communicate to him that she had pain in her left hip area. He also confirmed that pain was highlighted in Service User A's left hip and left wrist in the 'Examination' section of his report.

In addition, the Committee gave significant weight to the oral evidence of the Registrant before it, in which she confirmed that she was involved in moving Service User A, who was a frail 88 year old woman with dementia on the date in question, on at least three separate occasions from discovering her on the floor to placing her on a bed, pending the arrival of ambulance personnel. The Committee was careful to attach such weight as it considered appropriate to the documentary evidence referred to, and was mindful of the fact that the Council had not called the paramedic to give evidence at the hearing. Nonetheless, the Committee was persuaded that the paramedic's witness statement was consistent with other documentary evidence, in the form of the transcript and the Out-of-Hours record, to satisfy the Committee on the balance of probabilities that Service User A would have complained of pain in her hip / leg area when being moved. The Committee had no evidence to quantify the frequency of complaints made by Service User A in this regard, but inferred from the available documentary evidence that she would have complained to the Registrant and Amanda Thompson on being moved by them in a similar fashion to her expressions of pain as recorded by the paramedic when he moved Service User A during his assessment of Service User A in Spelga Mews prior to Service User A's transfer to hospital. The Committee laid emphasis on the fact that the documentary material identified was closely contemporaneous to Service User A's fall, and that the paramedic's statement, while prepared in July 2013, was based on a contemporaneous document.

The Committee also had regard to the statement of the Registrant, made on 11 September 2008 (Exhibit A, Pages 102 – 103), in which she denied that Service User A at any stage had complained about pain in her legs. Her account in that statement that Service User A had no difficulty weight-bearing was contradicted by the entry in the GP Out-of-Hours records, which confirmed that at 9.04 am on the date in question, Service User A had difficulty weight-bearing on the left leg. The Committee also had regard to the fact that the Registrant had made a further statement in relation to the incident in June 2009, in which she again denied that Service User A had exhibited any pain in her legs. The Committee was satisfied that both of these statements were made some significant time after February 2008, in circumstances where the conduct of the Registrant and Ms Thompson had been made the subject of a complaint by Service User A's family, and was under investigation by the Registrant's employers. For this reason, the Committee preferred to examine evidence which was as closely contemporaneous to the incident as possible in an effort to determine whether Service User A had complained, either to the Registrant directly or in the Registrant's presence and, if so, how frequently. The Committee also

noted that the Registrant accepted that she had applied hip protectors to Service User A while getting Service User A ready for transfer to the hospital. The Committee was satisfied that hip protectors were close-fitting, and that it would be more likely than not that pain would have been caused to Service User A during their application.

Finally, the Committee had regard to the Fold Housing Association's Accident Report Form, signed by Ms Thompson and the Registrant, and which documented the incident in question. The Committee noted that the form was signed by the Registrant and dated 10 February 2008. However, the Committee determined that there was no clear evidence presented which would assist in resolving the question of when, and in what circumstances, the document was filled in, as the Registrant disputed the timing of the completion of the form. Accordingly, it disregarded it in its assessment of the evidence on this issue.

On the basis of the transcript of the telephone conversation, the record of the conversation with the GP Out-of-Hours Service, and the contents of the NIAS Patient Report Form as detailed above, the Committee has inferred that it was more likely than not that Service User A complained of pain in the hip / leg area when being moved by the Registrant, or when she was moved by Ms Thompson in the Registrant's presence. As a result of this finding, and bearing in mind the evidence of Dr B and Dr A, the Committee has determined that the Registrant's health condition would not have prevented or blocked out a memory that Service User A had complained to the Registrant of pain in her hip / leg area, either acutely on more than one occasion or, more generally, over a period of time.

The Committee accepted the advice of the Legal Adviser on the proper test to be applied on the question of whether the Registrant, by her actions as alleged in the Charge, was acting dishonestly. The Committee was satisfied that, in acting as she did in relation to the letter written by her to the PPC, and giving of evidence by her in October 2012 that Service User A had not manifested pain in her hip / leg area when the Registrant knew that she had, she was acting dishonestly by the standards of ordinary and reasonable people. Furthermore, at the relevant time, the Registrant knew that she was acting dishonestly by those standards.

Accordingly, in all the circumstances and for the reasons set out above, the Committee finds as a fact, in relation to Particulars 1 and 2, that the Registrant was acting dishonestly.

Misconduct

The Committee heard a submission from Mr Wilson on behalf of the Council, and Mr McKee on behalf of the Registrant, on the question of misconduct. Mr Wilson submitted that the findings of fact made by the Committee were of the most serious kind and were far below the standard to be expected of a social care worker in the particular circumstances. Mr Wilson cited the applicable Codes of Practice which, in his submission, the Registrant's actions had breached by reason of the facts found proved against her. For his part, Mr McKee accepted that, in light of the Committee's findings on the facts, the Registrant had instructed him to admit misconduct on her behalf.

The Committee heard and accepted the advice of the Legal Adviser.

The Committee reminded itself that, notwithstanding the Registrant's admission, the burden of proving misconduct rested with the Council and the applicable standard of proof was the civil standard; namely, the balance of probabilities.

The Committee has found that on two dates, namely 29 April 2011 and 29 October 2012 as set out in the Charge, the Registrant acted in a dishonest manner. This involved her making an untruthful statement to her regulatory body, and giving dishonest evidence to a subsequent regulatory Committee of the NISCC which was enquiring into alleged misconduct on the part of her former work colleague. The Committee had no doubt that the Registrant's actions as found proved fell far below the standard to be expected of a social care worker in the Registrant's circumstances, and was serious. The Committee derived assistance from the Code of Practice for Social Care Workers, and was satisfied that the Registrant's actions breached the following provisions of the Code:

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

2.1 Being honest and trustworthy.

The public, work colleagues and vulnerable service users, in the estimation of the Committee, should expect social care workers to conduct themselves, both at work and outside it, to the highest professional standard. A fundamental requirement is placed upon a social care worker to act honestly and with integrity in relation to enquiries made of her by her professional regulatory body, and to give evidence honestly to a subsequent regulatory Committee. This Committee was entirely satisfied that the Registrant had failed in this regard and that her actions were serious and amounted to misconduct.

Both Mr Wilson and Mr McKee were agreed that the medical experts had both indicated that on the dates in question upon which the Registrant acted dishonestly, she was not experiencing any health issue. Accordingly, the Committee, having looked carefully at the evidence of the medical experts in this regard, was not satisfied that on those dates, as set out in the Charge, the Registrant's misconduct was caused or substantially contributed to by reason of her ill health.

Application to Revert to Conduct Procedure

The Committee heard an application by Mr Wilson, on behalf of the Council, following the Committee's finding on misconduct that the proceedings should revert to the conduct procedure. This application was opposed by Mr McKee on behalf of the Registrant. Mr Wilson referred the Committee to Paragraph 28 (6) of Schedule 2 of the Rules, which states as follows:

'If at any time during the hearing it appears to the Committee that the alleged Misconduct has not been caused, or substantially contributed to, by the Registrant's physical or mental ill health, the Committee may cease to consider the allegation following the Health Procedure and instead follow the Conduct Procedure.'

Mr Wilson submitted, in light of the Committee's finding referred to above, that this provision was engaged and required the Committee to revert to the conduct procedure. Mr McKee submitted that it would not be appropriate to adopt this course of action, and reminded the Committee that the subject incident occurred in April 2008 at a time when the Registrant was suffering from a significant health condition. In the alternative, Mr McKee argued that the Committee could rely upon Paragraph 9 (2) of Schedule 2 of the Rules, which permits a private hearing where the particular circumstances of the case outweigh the public interest in holding a public hearing.

The Committee considered this application very carefully, and heard and accepted the advice of the Legal Adviser on the proper approach to be adopted. In particular, the Committee had regard to the case cited by the Legal Adviser in relation to this matter – *Miller v GMC [2013] EWHC 1934 (Admin)*.

The Committee was satisfied that it had a discretion to continue to hear the case under the health procedure even in circumstances where, as here, the health issue has fallen away on a proper reading of Paragraph 28 (6). The Committee paid particular regard to Exhibit E, in which both medical experts were agreed that the Registrant was not experiencing health issues on the two dates which formed the factual basis of the Charge. Furthermore, neither medical expert was of the opinion that the Registrant was suffering presently from a health condition, but was suffering from stress associated with the regulatory proceedings being brought against her.

The Committee reminded itself that the default position in relation to regulatory proceedings was that the hearing should be conducted in public unless a compelling reason was apparent to continue to hold the case in private. At this stage, the Committee had no evidence before it which would persuade it not to adopt the default position, and it decided to exercise its discretion under Paragraph 28 (6) to follow the conduct procedure.

The Committee was mindful of the relevant and complicated medical evidence which it has considered in this case. The Committee determined that it would keep its decision under review. The Committee also reminded itself that it could revert to a private hearing, either wholly or substantially, at the mitigation and sanction stage following the conduct procedure under Paragraph 9 (2), or in circumstances where the test is met, to revert to the health procedure under Paragraph 8 (2).

Application to Adjourn

At the outset of the mitigation and sanction stage in open session, the Committee heard an application from Mr McKee on behalf of the Registrant to adjourn the proceedings. Mr Wilson on behalf of the Council adopted a neutral position on the question of the adjournment.

Mr McKee submitted that, in light of the findings of fact made against the Registrant, he wished to obtain updated references which would address the findings made by the Committee. He also indicated that he wished to obtain a medical report which touched upon the Registrant's health and any likelihood of recurrence of the conduct complained of.

The Committee accepted the advice of the Legal Adviser, and had regard to the proper approach to be adopted on the question of the adjournment in the case of *CPS v Picton [2006] EWHC 1108 (Admin)*. The Committee

decided to grant the request for an adjournment, and noted that the Committee and the Parties were next scheduled to consider the case on 07 and 08 July 2015. The Committee did not consider that this represented an undue delay, and determined that it was necessary and appropriate to obtain comprehensive and relevant documentary material in this case before deciding upon the appropriate sanction. The Committee was also mindful of the fact that while there was a general need for expedition in the conduct proceedings, it would be unfair to the Registrant to conduct the mitigation and sanction stage in the absence of the best available documentary material.

The Committee will consider any application for the hearing to be held wholly or substantially in private when it resumes the proceedings on 07 July, and will make no determination on an application for a private hearing in advance of 07 July.

Sanction

The Committee heard evidence from two witnesses called on behalf of the Registrant at the sanction stage. In addition, the Committee admitted into evidence a bundle (Exhibit G) of documents prepared by the Registrant, which comprised three character references and a further medical report from Dr B. It should be noted that two of the witnesses who gave oral evidence to the Committee also wrote the corresponding character references which were contained in Exhibit G. The Committee also comprehensively reconsidered the other available documentary evidence (Exhibits A to F) which was previously relied upon earlier in the hearing. The Committee also heard submissions on sanction from Mr Wilson on behalf of the Council and from Mr McKee on behalf of the Registrant.

The Committee heard and accepted the advice of the Legal Adviser, who reminded the Committee that the range of available sanctions was as follows:

- Admonishment for 5 years;
- A Suspension Order for up to two years;
- A Removal Order.

The Committee reminded itself that it should act proportionately, and that any measure taken to limit the Registrant's right to practise her profession should be no more than necessary in all the circumstances, and that the public interest should be at the forefront of the Committee's mind when addressing the most appropriate sanction to apply in this case.

The Committee first turned to the question of the misconduct found in this case, and reminded itself that it was satisfied that the Registrant's actions as found proved were serious. On two separate occasions, she acted dishonestly in the regulatory processes of the NISCC and, in so doing, undermined the confidence which the public should rightly have in the reputation of the social care workforce and the NISCC as a regulatory body.

In order to address the most appropriate sanction, the Committee was required to balance the public interest against the Registrant's interests, and consider carefully the aggravating and mitigating factors in this case.

The Committee first turned to the aggravating features of this case. The Committee was satisfied that the Registrant had engaged in two episodes of dishonesty which were linked, and which related to her participation in the regulatory process of the NISCC. The Committee took into account that the Registrant's dishonest actions related fundamentally to her involvement in an incident which occurred in 2008, but which did not form part of the Charge against her. The Registrant was not engaged in dishonesty on a broader level, and the Committee was satisfied that she did not embark on a pattern or course of dishonest behaviour. The Committee has found that the Registrant engaged in dishonest conduct, which is a most serious matter for any member of the social care workforce to have committed, and the Committee also heard that this conduct has had an adverse impact on the family of Service User A. The Committee also had no doubt that, in acting as she did, the Registrant engaged in pre-meditated activity and sought to conceal her wrong-doing by giving dishonest evidence and writing a letter which she knew was not a truthful account of the events in 2008 in relation to the standard of care given to Service User A. The Committee also had regard to the additional medical report prepared by Dr B, dated 11 June 2015, in which the Registrant related to him that she maintained her previously stated position in having no recollection of Service User A complaining of pain in the hip / leg area. Dr B, however, confirmed that the Registrant accepted the findings made against her on this issue, while maintaining that she may have blocked out a recognition of Service User A's hip / leg pain and her subsequent failure to report it at the time of the index incident. The Committee accepted that the Registrant has demonstrated some limited insight into her failings. In addition, by acting as she did, the Registrant has shown a serious disregard for the Code of Practice which requires social care workers to act honestly and openly.

The Committee then turned to address the mitigating factors which could be said to exist in this case. The Registrant has a previous good history and, until these proceedings in the regulatory proceedings of the NISCC, was a person of previous good character. The Registrant also, to her credit, co-operated at all stages with the NISCC investigation into her conduct. The Committee, from its previous reading of the agreed medical evidence in this case, accepted that the Registrant had been labouring under a health condition during the index incident in 2008, although she was not suffering from any health condition on the two occasions on which she has been found to have acted dishonestly. In addition to appropriate references submitted at the sanction stage, the Committee heard oral evidence from two witnesses who were well-acquainted with the Registrant on a personal and professional level. The Committee heard from the Registrant's current employer in this regard, who attested to the Registrant's good practice in her current employment, and also took account of the significant period of time which has elapsed since the Registrant acted dishonestly.

The Committee first turned to address the question of whether, in light of its findings of fact and in relation to misconduct, it would be appropriate to impose an admonishment in this case, which would remain on the Registrant's entry in the Register for five years. The Committee paid regard to the character references and oral evidence adduced on the Registrant's behalf.

The Committee paid particular attention to the explanation given of the Registrant's current employment. In this regard, the Registrant's senior manager told the Committee that the Registrant is currently the subject of an

extended period of AYE (Assessed Year in Employment). The usual one year period of close supervision under AYE has been extended well into the Registrant's second year of employment since her qualification. This witness confirmed to the Committee that this was due to the current NISCC proceedings against the Registrant, and that she was required to work under close supervision of her employer. The Committee was also advised that she is currently employed as a social worker in the 16+ team. The Registrant's senior manager confirmed that the Registrant was required to make presentations to panels in relation to support or care plans to meet the needs of young people who are in the care of the Trust. The reference prepared by the Registrant's senior manager was clear in asserting that the Registrant had 'demonstrated professional competence in the areas of assess, planning and review, which has contributed to the formulation of comprehensive support plans for a number of young people'. This issue was expanded upon when the Registrant's senior manager gave oral evidence to the Committee. He confirmed that he was fully aware of the Charge against the Registrant and the findings made against her by the Committee. He was clear in asserting that he had no concern in relation to the Registrant's honesty and integrity, and that she was regarded as a valued member of the social work team. Of particular significance, especially in light of the Charge which has led to these proceedings, was the Registrant's senior manager's confirmation in oral evidence that the Registrant has been entrusted with giving evidence when applying for secure orders. This evidence reinforced to the Committee the high regard in which the Registrant is held, and the trust placed in her in bringing applications to Court in a challenging and difficult arena of social work practice.

The Committee also considered a character reference and heard oral evidence from a person with detailed knowledge of the Registrant's personal circumstances. He told the Committee that she was dedicated to the young persons in her care. He expressed the view that the Registrant showed compassion, dedication and commitment in her current employment, and that she would be a loss to the social work profession if steps were taken to suspend or remove her registration.

The Committee was most impressed by these witnesses and their character references, which spoke highly of the Registrant's character and which confirmed that she is now acting in a challenging and difficult work environment and to a very high standard.

The Committee also paid due regard to the additional medical report of Dr B, dated 11 June 2015, and prepared in anticipation of the sanction hearing. He confirmed that the Registrant does not presently have any health condition which would compromise her ability to do her job, and that she would seek appropriate professional advice regarding the management of her health condition in the future if it deteriorated to ensure that her ability to fulfil her employment would not be compromised. Dr B continued that the Registrant had accepted that her failure to recognise and report Service User A's hip / leg pain was a 'significant failing' on her part, and that the likelihood of the Registrant acting dishonestly in the future in the manner found proved against her in the Charge was 'minimal'. Dr B concluded that, whilst the Registrant continued to maintain that she may have blocked out a recognition of Service User A's hip / leg pain and failed to report it, she accepted the findings against her by the Committee and accepted that such actions would be considered wrongful and dishonest.

The Committee had no direct evidence from the Registrant upon which to be satisfied that she accepted that the conduct proved against her was dishonest, nor did she give an undertaking either personally or through her representative that her dishonest conduct would not be repeated in the future. To her credit, however, the Committee was prepared to accept that the Registrant evidenced some degree of insight, albeit partial and limited, into her failings, and was prepared to infer from all the available evidence that she regretted her actions and may very well have acted differently had she had the opportunity to do so. The Committee was mindful of the fact that, at the time of the subject incident, the Registrant was a relatively inexperienced member of the social care workforce and was under the influence, to a significant degree, of a more experienced work colleague. There was also evidence before the Committee to suggest that the family of Service User A was rightly concerned that their elderly and vulnerable relative should receive the highest possible standard of care while in Spelga Mews, and had previously raised instances where, in their opinion, Service User A had not received care to this standard. The Committee was prepared to accept that the dishonest conduct in which the Registrant was involved was borne out of a particular and individual set of circumstances, and inferred that the Registrant was anxious to avoid a complaint being raised against her, or her more experienced work colleague, by Service User A's family in respect of the subject incident of 2008. The Committee accepted that during the subsequent NISCC investigation following a complaint by Service User A's family in relation to the subject incident, she engaged in two occasions of dishonest conduct, which was a serious breach of the Code of Practice. However, from its detailed consideration of the available documentary and oral evidence, the Committee was satisfied that the conduct which comprises the Charge did not amount to a broader pattern of dishonest behaviour. The Committee also attached significant weight to the report prepared by Dr B, and dated 11 June 2015, in which he opined that there was a minimum risk of the Registrant acting dishonestly in the future and giving dishonest evidence, either orally or in written form, to the NISCC in relation to her actions. The Committee accepted this assessment from Dr B, and was satisfied that there was a low risk of repetition in this case.

The Committee also derived assistance from Paragraph 3.16 of the Indicative Sanction Guidance document. The Committee has already concluded that the Registrant's conduct was borne out of a particular set of circumstances and has concluded that, for the reasons given, she is not fundamentally unsuitable for continued registration as a social worker. The Committee considered that the Registrant's character references, and the oral evidence which it heard, touching on her current professional competence, was impressive and demonstrated a credible commitment on the Registrant's part to maintain in the future the highest standards of practice, despite having engaged in a serious lapse of professional judgment which has resulted in a finding against her.

It should be clear to the Registrant that her behaviour was unacceptable and must not happen again. The Committee, however, is not satisfied that the Registrant will pose a risk in the future to the public and / or to vulnerable service users if she is permitted to continue in practice without restriction. The Committee, having carefully balanced the public interest together with the Registrant's interests, and reminding itself of its duty to act

proportionately, has decided, in the particular and wholly exceptional circumstances of this case, to admonish the Registrant for a period of five years.

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pp. Melissa Ou

Clerk to the Conduct Committee

17 July 2015

Date