

IN THE CARE TRIBUNAL

KM

-v-

DEPARTMENT OF HEALTH, SOCIAL SERVICES AND PUBLIC SAFETY

Before:

J.A. Kenneth Irvine (Chairman)

Maureen Ferris

Lynda Eagleson

Hearing dates: 11th-13th February 2008

Application

1. The applicant appeals under Art.11(1)(a) of the Protection of Children and Vulnerable Adults (Northern Ireland) Order 2003, against the decision of the Department of Health Social Services and Public Safety to include her on the Disqualification from Working with Children (DWC) List, and under Art.42(1)(a) of the said Order, against the decision of the Department of Health Social Services and Public Safety to include her on the Disqualification from Working with Vulnerable Adults (DWVA list). Both these decisions are dated 29th June 2007.

Representation

2. The Applicant was represented by Mark McEvoy of Counsel (instructed by Mills Selig, Solicitors) and the Respondent was represented by Denise McBride of Counsel (instructed by the Departmental Solicitor).

Preliminary matters

3. Prior to the start of the hearing the Tribunal made the following direction: that there be Restricted Reporting Order under Regulation 19(1), prohibiting the publication (including by electronic means) in a written publication available to the public, or the inclusion in a relevant programme for reception in Northern Ireland, of any matter likely to lead members of the public to identify the applicant or any vulnerable adult. For this reason the names of all those referred to in this decision will be replaced by their initials.

The evidence

4. For the Respondent Tribunal heard oral evidence from ES and JY, both Care Workers at the HL Residential Home, IB, proprietor of said home, and

from Mrs. Eleanor Taggart, as an expert witness. Tribunal heard oral evidence from the Applicant, KM, and character evidence from HK.

5. Tribunal read written statements from KM, ES, JY and IB.

6. Tribunal was also provided with a considerable volume of associated documents relating to the HL home, the Applicant and the resident whose treatment gave rise to the listing.

7. At the outset of the hearing Miss McBride handed in a written submission and Mr. McEvoy indicated that he would be conceding the issues of misconduct and harm. Both of these steps considerably assisted the Tribunal and concentrated the issues upon which its Decision had to be made.

The law

DWVA list

8. Appeals against inclusion in the DWVA list are governed by Art.42 of the Protection of Children and Vulnerable Adults Order (Northern Ireland) 2003.

9. Art.42 (3) (a) provides that:

If on an appeal...under this Article the Tribunal is not satisfied of either of the following, namely -

(a) that the individual was guilty of misconduct (whether or not in the course of his employment) which harmed or placed at risk of harm a vulnerable adult; and

(b) that the individual is unsuitable to work with vulnerable adults the Tribunal shall allow the appeal....

DWC list

10. Article 11(3) of the Protection of Children and Vulnerable Adults Order (Northern Ireland) 2003 is in similar terms and governs appeals against inclusion in the DWC list.

Three stage test

11. Thus, in order to dismiss the appeal, the Tribunal must find:

(i) that there was misconduct,

(ii) that the misconduct harmed a vulnerable adult or child as the case may be, or placed a vulnerable adult or child at risk of harm and

(iii) that the individual is unsuitable to work with vulnerable adults or children.

Definition of Misconduct and harm or risk of harm

12. The Order does not define misconduct. However, in *Angella Mairs v*

Secretary of State [2004] 269.PC the Care Standards Tribunal in Great Britain observed that "misconduct could range from serious sexual abuse through to physical abuse (including inappropriate physical restraint) and/or poor child care practices in contravention of organisational codes of conduct". They referred to the case of *Doughty v. General Dental Council* [1987] where misconduct was said to be "a falling short, whether by omission or commission of the standards of conduct expected from members of [a] profession".

13. "Harm" is defined in Art.20 of the 2003 Order as having the same meaning as in Art.2(2) of the Children (Northern Ireland) Order 1995, that is "ill treatment or the impairment of health or development".

Burden of proof

14. The burden of proof is upon the Department.

Standard of proof

15. The standard of proof is the civil standard, that is, the balance of probability, as defined in *Re H* [1996] AC 563:

"The balance of probability standard means that a court is satisfied an event occurred if the court considers that, on the evidence, the occurrence of the event was more likely than not."

The facts

16. The basic facts which appeared to be accepted by all parties were:

- i. The Appellant KM was a Care Worker employed at the HL residential home and had worked there from 27th December 1997 to 18th April 2006.
- ii. HL is a residential home for residents with learning difficulties, the mentally ill and the frail elderly.
- iii. For about three years prior to the incident giving rise to the listing KM had been designated as Manager of the home although it did appear that this status was in name only.
- iv. On Saturday 15th April 2006 she was off duty but she received a number of telephone calls from the home requesting assistance in dealing with a difficulty which had arisen with a resident JB.
- v. The first and second calls related to the refusal of JB to move from the lounge where she was insisting in eating crisps in contravention of house rules. KM came to the home and managed to quieten JB down and persuaded her into the dining area where she remained calm while KM was there.
- vi. The third call came because JB had fallen in the dining area close to an Aga cooker and was refusing to get up. She would not co-operate with the staff then on duty.
- vii. KM returned to the home on receipt of this call. She spoke to JB

and then dragged her by her lower limbs away from the Aga, across the hallway and into her bedroom, a distance of approximately 28 feet.

17. It was accepted at the outset that KM's action did constitute misconduct and that it placed a vulnerable adult at risk of harm. From the evidence before it Tribunal has doubts as to whether any harm was actually occasioned to JB but she was certainly placed at risk of such harm. Indeed, the Department did not claim any actual harm. Tribunal therefore had to consider only whether by her actions KM was rendered unsuitable to work with vulnerable adults or with children. It was thus necessary for it to consider the context in which the action occurred including, among other things, the events surrounding the incident, the training and support provided for the Appellant, the physical environment in which the incident occurred and the risk of the Appellant repeating such conduct.

18. ES and JY, who were the two care assistants on duty at the time of the incident, gave their own descriptions of what happened on that evening. The incident occurred in the dining area where, inter alia, there are tables at which the residents eat, a sofa and a large Aga cooker which is used for cooking. The remaining residents, of which there appeared to have been eleven or twelve, were stated to have been in the lounge at the time. Tribunal had among its papers a number of photographs which showed the relation of the table to the Aga and the proximity of the dining area to JB's bedroom. At the time of the incident ES was sitting on the sofa doing paperwork while JY was sweeping the floor. JB got up from the table and for some reason for which no explanation was offered she raised her zimmer frame and threw it at JY who lifted her sweeping brush to defend herself. JB fell backwards as a result of throwing the zimmer frame and she landed beyond the table in proximity to the Aga. The consensus of the evidence seemed to be that she struck her back against the Aga and then moved away from it but neither witness seems to have actually seen her strike the cooker.

19. JB was said to have fallen with her feet pointing towards the door. JY said that she was lying facing the Aga. She was shouting and crying but did not appear to be in any danger. ES said that JB was not close enough to the Aga to be burnt. She and JY were concerned because it could take JB hours to calm down and they could not leave her where she had fallen. ES and JY both told Tribunal that JB was completely still when left alone but started lashing out as soon as either of them moved towards her.

20. It was clear that JB was a difficult person who exhibited challenging behaviour, she could shout and swear, kick out, throw things and generally seek attention. There was no record of her having thrown anything as substantial as a zimmer frame on any previous occasion.

21. When KM arrived the other two assistants seem to have continued their tasks rather than observed what KM was doing and accordingly neither of them appears to have seen what actually led KM to take the action which she did. Neither of them were asked to help nor did they offer to help nor did they

intervene. They later received written warnings from the home for their failure to intervene.

22. They followed KM into JB's room where they assisted in changing her for bed. She had wet herself during or after the incident and the floor was wet. When JB's top was removed ES noticed a 'red mark' on her back. She dressed it before the nightclothes were fitted. There was no satisfactory explanation as to what had caused this red mark. It seems to have been assumed that it was by striking the Aga or by lying too close to the hot surface. It seems to have been quite some time before the mark disappeared and ES told Tribunal that after some days it became a little 'pussy'. In any event, it was still being treated ten or more days later. No outside medical intervention was obtained. There was some suggestion that the mark might have been caused by the act of dragging JB across the floor. Tribunal saw nothing in the evidence to support this view.

23. KM, the Appellant, gave her version of what happened once she arrived. She told Tribunal that when she arrived she spoke first to JY who opened the door to her and then to ES who was doing paperwork on the sofa. Both explained what had happened. KM found JB with her back towards the Aga. There was not a great deal of space between the tables and chairs and the Aga (a fact verified by the photographs seen by Tribunal). KM estimated that JB was about an inch or an inch and a half from the Aga. JB told KM that she was not hurt. KM checked her over, talked to her, and quietened her down. JB had been hitting out when KM arrived but ceased when spoken to. KM accepted that it was wrong for her to have moved JB in the manner which she did. She stated that JB had her head up the whole time that she was being moved and that she was listening to KM. She asked JB if she was alright when being moved. JB did not respond. KM assumed that the red mark was a burn. She confirmed that it had not been there the previous day.

24. IB, owner of the home, told Tribunal that HL had in place Policies and Procedures. There were in the Tribunal papers numerous such policies but none were dated nor signed nor was there any review date stated. IB said that she had inherited these from the previous owner but had not up to the date of the incident reviewed them. KM, in her supplemental witness statement, said that the policies all post-dated the incident and were not in force when she was at HL. In the same statement she said that there was 'no specific policy' in HL on moving, handling or lifting nor on how staff should deal with situations such as that at issue and that she had not received training on these matters.

25. IB told Tribunal that she had found KM to be a good employee who had good relationships with the residents. Prior to this incident she had not had any problems with KM.

26. HK, owner of a nursing agency for which KM had worked gave character evidence, having known KM since 1998 and having had first-hand experience of her work and never having had any cause to criticise her work. She had indeed continued to employ KM after she had been placed provisionally on

the DWVA and DWC lists (having first checked with the Trust that it was in order to do so). She expressed the view that KM had realized 'well-on' that what she had done was wrong.

27. Mrs. Eleanor Taggart, a member of the Northern Ireland Social Care Council and with 37 years social care experience, gave her evaluation of the documentation produced by the home and by the Trust. This documentation was produced only once summonses had been issued by the Tribunal. Her initial evidence and the report which she submitted were directed towards the issue of misconduct rather than suitability and so, while her expertise is valued, it could not greatly affect the Tribunal's determinations. It did however assist in bringing to light certain documents which might otherwise not have been made available to the Tribunal. Mrs. Taggart was, rightly in Tribunal's view as that is its function, reluctant to express a view on the issue of KM's suitability.

Suitability

28. The Care Standards Tribunal in Great Britain has in a number of cases given guidance with regard to the issue of suitability.

In *CN v Secretary of State* [2004] 399 PVA it stated: 'When the Tribunal considers the question of unsuitability, it must look at the factual situation in the widest possible context. ... Each case will be decided on its own facts and context will be all important.'

In *Selina Matswairo v Secretary of State for Health* [2007] 0937 PVA it said: 'One incident of misconduct can suffice to give rise to a finding of unsuitability. But such a finding, as a matter of common sense, demands caution because no career is without its low points and few are wholly without any instances at all of human error. The gravity of the misconduct, the circumstances and, in particular, the probability of repetition are crucial factors.'

29. It was accepted that the question of suitability must be decided not as at the date of the incident but at the date of the hearing.

30. The context of the present case is that KM had a clear nine year record in the care profession. Both of her former employers, IB and HK, spoke glowingly of her standards of work and care. There had never been any previous incident

31. It is sometimes very difficult to categorise the degree of misconduct involved in a particular incident as no misconduct should ever be minimized. However, there are some acts which very clearly place a vulnerable person at serious risk and there are others which may pose comparatively slight risk. Most incidents will probably fall somewhere in between. Tribunal, without in any way downgrading what happened, would feel that the misconduct in this case would fall on the lower half of the scale.

32. Tribunal notes that at no stage was it suggested that KM had lost control or had lost her temper.

33. Tribunal must also ask if there were any extenuating circumstances particular to this case.

34. The timing of Appellant's recognition of wrongdoing is also an important factor in considering suitability. In her witness statement and in the letters incorporated into it she had repeatedly said that what she did was the lesser of evils and that she would do it again. She did before the Tribunal accept that what she had done was wrong and that she now so realized.

Decision

35. At the end of the day, Tribunal felt that having considered all of these factors, in particular the length of KM's clear record and the degree of the misconduct involved, the correct approach was to ask itself what was the likelihood of a repetition of any misconduct and also to ask whether public confidence would be adversely affected if the Applicant were to be permitted to continue in social care work. On balance, Tribunal formed the view that the likelihood of KM again committing such an act was slim and that the circumstances were not such as to impair public confidence.

36. It is the unanimous decision of the Tribunal that Applicant's appeal be allowed.

37. While Tribunal does not have any power to impose any condition upon KM it would suggest that it would be prudent (for her own benefit as much as for public protection) that she should work under supervision for a period of at least six months following her removal from the lists.

38. Tribunal feels compelled to express its concern about a number of issues which arose in the course of the hearing before it and which form part of the context for its Decision:

- i. There appear not to have been any written management strategies in place to deal with JB's challenging behaviour.
- ii. The staff had received only verbal support from the Behaviour Management Team. They had been verbally told that they could use reasonable force to move JB but there does not appear to have been any guidance given as to what was 'reasonable force' and in what circumstances it could be used.
- iii. Tribunal was concerned about the staff/resident ratio especially as it appeared from the evidence that staff were expected to clean and cook and do paperwork as well as care if so required. It was particularly concerned about the availability of staff to other residents if an incident or an emergency occurs.
- iv. The Trust had placed JB, a lady with challenging behaviour, in HL without having provided appropriate training to the home or its staff. The evidence from IB was that she had been refused such training.

- v. There does not appear to have been an annual review of JB until just after the incident.
- vi. Tribunal is concerned that proper procedures and policies should be implemented and reviewed not just in HL but throughout care homes generally.

Appeal allowed.

J.A.Kenneth Irvine (Chairman)
Maureen Ferris
Lynda Eagleson

15th February 2008