2009/1PC & 2009/1PVA

IN THE CARE TRIBUNAL

MA

v.

DEPARTMENT OF HEALTH SOCIAL SERVICES AND PUBLIC SAFETY

Before:
J.A. Kenneth Irvine (Chairman)
James McCall
Mary O'Boyle

Hearing dates: 12th, 13th and 14th April 2010

Application

1. The Appellant appealed 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 were dated 28th October 2008.

Representation

2. The Appellant was represented by Brian Ferguson, Union Official of UNISON and the Respondent was represented by Denise McBride of Counsel (instructed by the Departmental Solicitor).

Preliminary matters

3. At the Directions Hearing held on 24th August 2009 the Tribunal made the following direction which was continued indefinitely at the conclusion of the hearing: 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.

4. a. The Appellant did not attend the Direction Hearing on 24th August 2009 nor was she represented. Directions as to exchange of documents were made at that hearing and hearing dates were arranged. The Appellant was duly notified of the Directions. She failed to comply with the Directions as to dates for exchange of documents and in consequence a further Directions Hearing

was held on 16th December 2009. The Appellant and her Representative were both present on that occasion. A fresh timetable for exchange and dates for hearing were arranged and were incorporated in a direction which was made by way of an Unless Order under Regulation 11.

b. The dates agreed for the hearing were 12th-14th April 2010. Tribunal duly sat on 12th April when Appellant's Representative was present but not the Appellant. The hearing was adjourned until the following day when she did attend and the hearing commenced.

The evidence

5. For the Respondent, Tribunal heard oral evidence from Marian Lawther, Fiona Rowan, Michael Halliday, Catherine Murray, Eddie Arthur, Andrea Wilson and Sharon Fleeton all of whom had lodged witness statements. It also had before it witness statements from Joanne Keys, Cynthia Crutchley, John McCart and Miriam Somerville. It heard oral evidence from the Appellant who had also lodged witness statements.

6. In addition, Tribunal had before it a substantial bundle of papers which included correspondence, minutes of meetings and other relevant material.

The law

DWVA list

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

8. 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

9. 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

10. 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

11. 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'.

12. 'Harm' in relation to children 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'. In relation to adults it is defined in Art. 48 (3) of the 2003 Order: (a) in relation to an adult who is not mentally handicapped it means ill-treatment or the impairment of health; (b) in relation to an adult who is mentally handicapped it means ill-treatment or impairment of health or development.

Burden of proof

13. The burden of proof is upon the Department.

Standard of proof

14. 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 and the evidence

15. **The Respondent's Evidence**

Tribunal had before it evidence in respect of five separate incidents:

i. CH – This complaint related to an incident on 15th/16th March 2007. Appellant had been employed as a Care Assistant at a residential unit which caters for about 14 adults with very complex needs. On the night in question she had been on 'waking night duty' which meant that she was the only member of staff awake during the night. Another, more senior, member of staff, a Residential Worker (EA) slept on the premises during the night.

One of the residents, CH, was a severely incapacitated adult who could only communicate by eye movements and non-verbal sounds. She was unable to feed herself and had to be given water and nourishment through tubes into the abdomen. The bottle of feed contained 950 ml. and she had to be given 400 ml. over one period and a further 400 ml. after a break.

On 15th March 2007 the Appellant was on waking night duty from 10 p.m. The senior member of staff on night duty was SF who gave evidence that when she came on duty at 7.30 a.m. the following morning she found that there were 550 ml. remaining in the bottle while there should only have been 150 ml.

ML, Manager of the unit, gave evidence that after the incident was reported to her she made numerous attempts by telephone and by letter to arrange a meeting with the Appellant to discuss the incident but it was not until 9th August 2007 that a meeting took place. At that meeting the Appellant said that she had not been trained in CH's feeding system. She also said that she had found the clip to be tight at 4/4.30 a.m. that morning and had then adjusted the clamp.

ii. PI – This resident required to use a urine bottle as he did not wear incontinence pads; he is paralysed down one side. On the morning of 16th March 2007 a Care Assistant, AW, came on duty and her evidence to Tribunal was that she then found that PI was lying in sheets stained with dried-in urine.

iii. BD – This resident did wear a continence pad. The evidence regarding this incident was contained in a memo from ZM, a Care Assistant who now resides abroad and was not available to give a witness statement or oral evidence to Tribunal. It was said that when ZM came on duty on 16th March 2007 she found BD's bed to be wet with urine and he also did not appear to have been cleaned properly as there was faecal matter around his buttocks.

iv. MM – The Appellant was then transferred to another residential unit which is a 24-hour supervised hostel for 12-14 adults with mental health problems.

MM is a resident of that unit who suffers from paranoid schizophrenia. On the night of 13th/14th May 2007 the Appellant was on waking night duty. MM suffered a psychotic episode during the night. He paced up and down the unit and picked his nose (a habit he has because he believes that he is trying to remove someone from inside his head) which gave rise to bleeding. Tribunal heard evidence from CM, a Residential Worker who is MM's key worker in the unit, from MH who was the Residential Worker on sleeping night duty and FR, the Manager of the Unit.

The evidence of MH was that he was not wakened by the Appellant during the night and that she only called him at 7 a.m. when he was already awake and preparing to go on to day duty. When he was wakened the

Appellant told him that MM had not slept at all that night and had been pacing the corridors for a few hours. MH then gave MM his medication (a little earlier than usual but within agreed parameters). CM's evidence was that when she was then getting MM into bed he told her and FR that his feet were stinging. They checked the feet and saw patches where the skin appeared to be lifting off and the feet were bleeding. Blood was then noticed on the carpets and on the walls and handrails. MM had to have pain relief and dressings applied by the treatment room nurse from his General Practitioner surgery who said that he had third degree burns to his feet. As well as pain relief he required daily dressings for a week.

v. Sleeping on duty - The following night, 14th/15th May 2007, Appellant was again on waking night duty. The Residential Worker on duty was JK. JK is now employed elsewhere and was not available to give evidence to the Tribunal. She did however complete a witness statement and there was also a memo made by her and dated 17th May 2007 included in the papers. Her statement was that she had emphasized to Appellant the importance of her duties especially in the light of the previous night's incident. JK then went on to sleeping night duty but because she was not confident that Appellant fully appreciated matters she got up at regular intervals during the night. She stated that she did not see Appellant at any time during the night. At around 4 a.m. she approached the sitting room and observed the Appellant sitting on the sofa with her eyes closed. When she entered the room Appellant opened her eyes.

16. **The Appellant's Evidence**

The Appellant had submitted three brief witness statements. She also gave direct oral evidence to the Tribunal. Essentially, that evidence consisted of a clear denial that she had done anything wrong and that she had at all times given to the residents the care which was required. She said that she would not leave a resident in a urine-stained bed, that CH had been given her appropriate nourishment, that she had been given induction training at the first unit but that at the second unit she had not been given any particular training regarding residents with mental health problems nor was she told to seek advice from the Residential Worker on sleeping night duty. As regards MM's damaged foot, she said that he had a pre-existing wound and that she had changed the dressing on it. She also maintained that she had documented all relevant actions in each case under consideration. She further denied that she had been sleeping as implied in JK's statement.

She was shown a memo of induction training dated 19th October 2006 and bearing her signature. She accepted that this was correct.

She was also referred to various other reports in the papers including various disciplinary matters and she denied that the records were correct. In a number of cases she said that she could not remember. She said that on 16th March she had dressed BD and other residents before going off duty and that the evidence of other witnesses that it was the day staff who did the dressing was incorrect.

The Appellant, in her evidence, accepted that she had been shown how to use the peg feed and that she had used it for nine months prior to the incident.

Regarding MM, she maintained that his behaviour was not 'serious' and for this reason she did not contact the Residential Worker.

The record of the disciplinary hearing indicated that she had accepted that she had made mistakes but she told Tribunal that she could not recall making any such acceptance.

17. **Assessment of the evidence**

Tribunal found the witnesses who gave evidence for the Respondent to be reliable. It had great problems with the Appellant's evidence which contained numerous manifest contradictions, particularly between what had been recorded in the notes of meetings attended by her (and such notes being signed by her) and that which she gave to the Tribunal.

Consequently, Tribunal finds in respect of the various alleged incidents as follows:

i. CH – The weight of the evidence makes it more likely than not that this happened as alleged and Tribunal finds the allegation proved. Appellant's failure to act constituted misconduct which led to risk to the health of the resident because it inevitably would cause her distress and could lead to an increased risk of her having a seizure (to which she was susceptible). Appellant had been operating the equipment for nine months and Tribunal cannot accept that she was not aware of how things worked and what CH's special needs were. She should also have been conscious of the need to seek help when the system was not working. Tribunal does not accept her statement that there was not a problem; she had previously accepted that there was one.

ii PI – Again, there was a conflict of evidence between what the Appellant told the Tribunal and what had been in her earlier statements. AW's evidence was clear and she had dealt directly with the resident. Tribunal finds this allegation proved. It accepts that to leave a disabled resident lying in urine-soaked sheets is degrading and that it amounts to 'ill-treatment' and accordingly constitutes 'harm' as defined in the Order.

iii. BD – In this case there was no direct evidence of the incident. ZM, the person who is said to have discovered the situation, is now abroad and was unable to supply a statement. Tribunal finds this allegation not proved.

iv. MM – Appellant had been instructed in this resident's needs and had been looking after him for around nine weeks and should therefore

have been aware of his special needs. There was a lack of clarity in the Appellant's evidence but Tribunal was satisfied that MM's behaviour during the night was sufficient to give rise to concern and should have led the Appellant to call the Residential Worker on sleeping night duty when it became clear that her efforts to calm MM had failed. Her failure to act appropriately had exacerbated the situation and made it harder for him to be calmed down when he was eventually medicated. Tribunal is satisfied that he suffered harm and was additionally placed at risk by the failure to act. It accepts that whether or not there was a pre-existing wound to his foot (as stated by her) her failure to attend to him in time resulted in greatly increased injury to the feet requiring treatment every day for a week.

v. Sleeping on duty – Tribunal did not have any oral evidence from JK and it is not at all clear from her statements that she is saying that the Appellant was actually sleeping. The only evidence was that her eyes were closed. It seemed from the evidence that use of the lounge while on night waking duty was acceptable. Tribunal finds this allegation not proved.

Suitability

18. Tribunal had to consider whether by her actions Appellant was rendered unsuitable to work with vulnerable adults or with children. It was thus necessary for it to consider the context in which the actions occurred including, among other things, Appellant's past conduct, the number of incidents, the nature and seriousness of the incidents, the training and support provided for her, and the risk of her repeating such conduct (which would include evidence of her recognition of the misconduct and its potentially harmful consequences).

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

a. 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.'

b. In *Selina Matswairo v Secretary of State for Health* [2007] 0937 PVA it said: '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.'

c. In *Gavin Rathbone v Secretary of State* [2007] 975 PVA it stated: 'In the Tribunal's view Mr. Rathbone's failure to take proper care despite the strong warnings, his inability to realise that he has gone wrong, to own up to it, to accept the responsibility and to do his best to put things right and to do better in future is a serious failing and one which, regrettably, casts very real doubt on his suitability to work with vulnerable adults or children. The Tribunal found much in [the Secretary of State's] submissions concerning a lack of insight and understanding and a cavalier and reckless indifference.'

d. In *Kathleen Jackson v Secretary of State* [2005] 623 PVA the Tribunal concluded its consideration: 'This leads us to consider the issue of suitability. We have considerable sympathy with the Appellant because she is a woman who has spent most of her working life in the care sector; she has gone to the trouble to get qualifications and she has achieved senior care status. However the very fact that she has had this training and was a senior carer and went on to behave the way she did raises questions about her suitability to work with vulnerable adults. In addition we note that originally when she was confronted with the allegations she did acknowledge that there might be some substance to them but when she came to the Tribunal she denied that anything at all had happened.'

20. The Appellant's reluctance to engage with her superiors following the CH incident, her failure to comply with the Tribunal's initial Directions and her failure to attend the first scheduled day of her hearing is evidence of her lack of appreciation of the seriousness of her situation and of her inability to try to understand her failings and to improve upon her performance. In her evidence to the Tribunal she showed a total failure to acknowledge that anything was wrong with her conduct. Tribunal also noted that her memory seemed to be selective in that she indicated an inability to remember certain crucial points but was very certain as to others.

Decision

21. It is the unanimous decision of the Tribunal that Appellant's appeals in respect of both lists be dismissed.

22. Tribunal feels compelled to express its concern about the fact that the Respondent was unable to produce the contemporaneous notes which were stated to have been made at the times of the incidents. It appreciates that typewritten memoranda were prepared and signed a few weeks later, before memories began to fade. None the less, it is imperative that records of any incidents be kept for a responsible period of time (say, six years) and that in the present case, where it was obvious that untoward incidents were under investigation a special effort should have been made to preserve all contemporaneous documentation.

Tribunal noted that it was told that this situation had now been rectified in the units involved in the present case but it wishes to draw attention to this issue for the benefit of other care providers.

Appeals dismissed.

J.A.Kenneth Irvine (Chairman)
James McCall
Mary O'Boyle
20th April 2010