

**Outcome of Fitness to Practise Panel impairment hearing held on Monday 7, Tuesday 8, Wednesday 9, Thursday 10 and Tuesday 15 December 2020.**

<b>Name</b>	Jennifer Geddes Conner
<b>Registration number</b>	3054055
<b>Part of Register</b>	Support Workers in a Care Home Service for Adults
<b>Current or most recent town of employment</b>	Leven
<b>Sanction</b>	Removal
<b>Date of effect</b>	5 January 2021

The decision of the Fitness to Practise Panel is below followed by the allegation.

The following allegation and decision may refer to the Scottish Social Services Council as 'the Council' or 'the SSSC'.

### **Decision**

This is a Notice of the decision made by the Fitness to Practise Panel (the Panel) of the Scottish Social Services Council (the SSSC) which met on Monday 7, Tuesday 8, Wednesday 9, Thursday 10 and Tuesday 15 December 2020 by videoconference.

At the hearing, the Panel decided that some of the allegations against you were proved, that your fitness to practise is impaired, and made the decision to impose a Removal Order on your Registration in the part of the Register for Support Workers in a Care Home Service for Adults.

### **Matters taken into account**

In coming to its decision, the Panel had regard to these documents:

- the Act
- the Code of Practice for Social Services Workers Revised 2016 (the Code)
- the Scottish Social Services Council (Fitness to Practise) Rules 2016 as amended (the Rules)
- Decisions Guidance for Fitness to Practise Panels and Scottish Social Services Council staff dated December 2017 (the Decisions Guidance).

### **Allegations**

The allegations against you at the hearing were that:

While employed as a Care Assistant at Forth View Care Centre and during the course of that employment you did:

1. on an occasion in or around June 2017
  - a. refer to resident AA as "a fucking old c\*\*t words to that effect
  - b. on the same date, while providing personal care to AA, act in an aggressive manner by leaning forward and placing your face close to AA's face
  - c. state "what are you going to do?", or words to that effect, to AA in an aggressive manner
  - d. and your actions in b. and c. above did cause or materially contribute to AA kicking your colleague ZZ in the stomach
2. on one occasion in or around a date in January 2017, state to resident BB "shut your pus BB" or words to that effect
3. on an occasion in or around January 2017, transfer resident CC to bed alone, contrary to CC's care plan that she required the assistance of two staff for transfers
4. on or around 26 June 2017, state "fucking hell DD", or words to that effect, when providing personal care to resident DD

and in light of the above your fitness to practise is impaired because of your misconduct as set out in allegations 1.-4.

After hearing evidence and before making its findings of fact, the Panel allowed allegation 2. above to be amended by deletion of the words "a date in." See paragraphs 26 and 27 below. Allegation 2. now reads:

on one occasion in or around January 2017, state to resident BB "shut your pus BB" or words to that effect.

### **Findings of Fact**

1. The Panel found allegations 1.a., 1.b., 1.c., 2. (as amended) and 4. to be proved.

### Evidence

2. The Presenter led evidence from the following witnesses, all of whom had worked as care assistants at Forth View Care Centre at the time of the allegations:
3. YY spoke to working with you and to witnessing the events giving rise to allegations 1.a. and 3. She was referred in her evidence to the following documents:
  - Her handwritten statement at page 34.
  - Excerpt from care plan at page 57.
  - Excerpt from care plan at page 54.
  - Excerpt from care plan at page 56.
  - Her statement to the SSSC at pages 71-72.
4. ZZ spoke to working with you and to witnessing the events giving rise of allegations 1.a., 1.b., 1.c., and 1.d. she was referred in her evidence to the following documents:
  - Excerpt from care plan at page 56.
  - Her handwritten statement at pages 32-33.
  - Her statement to the SSSC at pages 73-74.
5. XX spoke to working with you and witnessing the events giving rise to allegations 2. and 3. During the course of her evidence she was referred to the following documents:
  - Excerpt from care plan at page 57.
  - Her handwritten statement at page 35.
  - Investigatory meeting minute at pages 40-41.
  - Her SSSC statement at pages 75-76.
6. WW spoke to working with you and witnessing the events giving rise to allegation 4. During the course of her evidence she was referred to the following documents:
  - Investigatory meeting minute at page 43.
  - Excerpt from care plan at page 54.
  - Her SSSC statement at page 83.

#### Presenter's submissions on Findings of Fact

7. The Presenter submitted that all of the allegations should be found to be proved on the basis of the evidence heard. He summarised the evidence on which he founded in respect of the of the allegations. He founded on the oral evidence of the witnesses referred to in paragraphs 15 - 18 above, as supplemented by their written statements and minutes from investigatory meetings.

8. The Presenter submitted that each of the witnesses was credible and reliable. Not all could remember dates clearly, but their recollection of events was clear. All of the witnesses had had concerns about the language you had used around residents. He suggested that the accounts they gave were plausible. The evidence in relation to allegation 1.d. was more tenuous than the evidence in relation to the other allegations, insofar as it required the Panel to draw an inference. In all the circumstances, the Panel should find all of the allegations proved.

#### Your position

9. Because of your failure to engage with proceedings, the Panel had limited information on your position. The hearing papers included minutes of investigatory meetings with you (pages 46-49), minutes of a disciplinary meeting (pages 50-51) and your letter of dismissal (pages 52-53). However, no witnesses were produced to speak to these and the evidence was therefore hearsay only. The Panel proceeded on the basis that you did not admit the allegations and it was therefore for the SSSC to prove them on balance of probabilities.

#### Reasons for the Panel's decision on Findings of Facts

10. The Panel found each of the witnesses to be credible and reliable. The Panel did not consider there to have been any collusion between or among them. It formed the impression that each was telling the truth about their recollection of events. Whilst witnesses (with the exception of WW) could not always be certain of precise dates during the course of their oral evidence, this was resolved by them being referred to the documentary evidence. Given the passage of time between the events giving rise to the allegation and the date of the present hearing, that was not a matter which troubled the Panel.
11. The Panel found allegation 1.a. proved on the basis of the evidence of YY and ZZ. YY said she was talking to resident AA in the corridor one evening and that you had walked past and called him a "fucking old c\*\*t." She had "pulled you up" about it. ZZ said that she had heard you say "Don't speak to him, he's an old c\*\*t." The allegation was dated to around June 2017 by ZZ referring to paragraph 4 of her witness statement at page 71.
12. The Panel found allegations 1.b. and 1.c. proved by reference to the evidence of ZZ. She spoke to you not liking resident AA very much and to raising your voice and shouting around him. She was referred to handwritten witness statement at pages 32-33, which she said was accurate. In that statement she said that you had "got in to AA's face" and that you had said to him "what are you going to do." She confirmed in that statement that the date was the same date as the events giving rise to allegation 1.a.

13. The Panel did not find allegation 1.d. to be proved. ZZ spoke to being kicked in the stomach by resident AA but she said that she did not think that AA meant to do it and could not be sure that it had been caused by your actions. Whilst the Panel was satisfied that resident AA did indeed kick ZZ in the stomach, it was not persuaded that there was sufficient evidence to draw the inference that it was your actions which caused or materially contributed to that occurrence. It was a possibility, but no more than that.
14. The Panel found allegation 2., as amended, to be proved on the basis of the evidence of XX. Before making findings of fact, the Panel reconvened to ask the Presenter to clarify where the evidence was which justified the allegation being framed as having occurred "in or around a date in January 2017." The Presenter confirmed that the evidence of XX amounted to having said that the events occurred in winter at the start of 2017. She could not be more precise. He referred the Panel to Rules 17.2. and 17.3. and moved the Panel to delete the words "a date in." That would bring the allegation into line with the evidence.
15. The Panel was satisfied that no prejudice was caused by amending the allegation to bring it into line with the evidence. It therefore amended allegation 2. by deletion of the words "a date in" so that allegation 2. now reads:

"on one occasion in or around January 2017, state to resident BB "shut your pus BB" or words to that effect"
16. XX had a clear recollection of BB being confused and thinking that she was a friend of his called [information redacted]. She said that she had gone along with this to diffuse the situation. You had gone by and said "Shut your pus, BB."
17. The Panel did not find allegation 3. to be proved. The allegation was spoken to by both YY and XX and the Panel accepted their evidence that you had transferred resident CC to bed alone. However, the Panel considered that for the allegation to be proved, it was necessary for it to be satisfied that this was contrary to the care plan in force for resident CC in January 2017. A document called an "Outcome" was produced at page 57 and spoken to XX. The Panel was told that it was an excerpt from resident CC's care plan. However, the document was undated. No witness was able to say that this was an excerpt from the care plan current in January 2017. For that reason, the Panel did not find allegation 3. to be proved.
18. The Panel found allegation 4. to be proved on the basis of the evidence of WW. She spoke to the date of the allegation and to having only worked with you on two shifts. She told the Panel that you and she had gone into resident DD's room. He suffered from [information redacted] and was hard to move. You had dragged him by the arms, saying "fucking hell, DD."

## **Impairment**

19. The Panel has decided that your fitness to practise is impaired by reason of your misconduct.

### Presenter's submissions on Impairment

20. The Presenter advised the Panel that he did not intend to lead witnesses at this stage, nor were any further papers to be lodged. He would make submissions on impairment based on the evidence before the Panel. He advised the Panel that no admission of impairment had been made by you or on your behalf.
21. The Presenter referred the Panel to Rule 2.1. and Rule 2.2. He submitted that the allegations found proved showed an attitudinal problem. They amounted, he said, to breaches of the following parts of the Code: 1.2, 1.4, 2.2, 3.10, 5.1, 5.7, 5.8, 6.5 and 6.10. He advanced the proposition that they amounted to misconduct and referred the Panel to the definition of misconduct contained in *Roylance v General Medical Council* [2000] 1 AC 1.
22. The Presenter advised the Panel that SSSC records showed that you had not been in registrable employment since 30 January 2018. He suggested that a Worker's fitness to practise was impaired if his or her ability to comply with the Code was reduced in some way. He said that *R (on the application of Cohen) v General Medical Council* was a useful case which dealt with the matter of impairment of fitness to practise. It showed that protection of the public and maintenance of confidence in the profession was paramount. It acknowledged that not every case of misconduct would result in a finding of impairment of fitness to practise.
23. The Presenter said that the allegations found proved demonstrated a pattern of behaviour over a period of time. Your career in registrable employment dated back only to 2015, so it was not so long as to constitute an unblemished career. However, you ought to have been experienced enough to realise that your conduct was not appropriate. Looking at the guidance given in *R (on the application of Cohen) v General Medical Council* [2008] EWCH 581 Admin, one could not say that your conduct was highly unlikely to be repeated because there had been four separate incidents. You had not shown insight, regret or apology. You had not returned your personal statement form. Your conduct, the Presenter said, amounted to misconduct and to impairment of fitness to practise.

### Your position

24. The Panel had no indication of your position on impairment apart from the fact that you had made no admission.

### Reasons for the Panel's decision on Impairment

25. The Panel reminded itself that it was necessary first of all to consider the question of misconduct: without misconduct there could be no impairment of fitness to practise. The Panel therefore considered the allegations found proved against the provisions of the Code.

- Part 1.4 imposes a duty to respect and maintain the dignity and privacy of people who use services. The allegations found proved relate largely to the use of foul language to, or in the presence of, vulnerable service users. In the case of allegation 1.b., you acted in an aggressive manner to a service user. These were clear failures to respect their dignity.
- Part 2.2 requires Workers to communicate in an appropriate, open, accurate and straightforward way. Your use of language in your communication with residents AA, BB and CC was far from appropriate.
- Part 3.10 imposes a duty to recognise and use responsibly the power and authority you had when working with service users. Your conduct showed that you failed in that duty.
- Part 5.1 requires Workers not to abuse, neglect or harm service users. All of the allegations found proved amounted to abuse and were capable of causing emotional harm.
- Part 5.7 imposes a duty on Workers not to put themselves or other people at unnecessary risk. Your actions placed service users at the risk of emotional harm. In particular, your actions in allegation 1.b. and 1.c. were capable of causing a vulnerable service user to fear that he was at risk of physical harm.
- Part 5.8 imposes a duty on Workers not to behave in a way which would bring into question their suitability to work in social services. The Panel was satisfied, as a matter of common sense, that your behaviour to and the in the presence of vulnerable service users was behaviour which calls into question your suitability to work in the profession.
- Part 6.10 imposes a duty on Workers to listen to feedback from people who use services, carers and other relevant people. The Panel heard evidence that colleagues had spoken to you about the foul language you used in front of service users. In spite of that, you continued to use such language. The Panel considered it to be a reasonable inference that you did not use that feedback to improve your practise.



26. The Panel did not consider that parts 1.2 or 6.5 of the Code applied to the allegations it found proved.
27. The Panel had regard to the breaches of the Code specified in paragraph 37 above. It had regard to the definition of misconduct in the case of *Roylance*. It had no difficulty in concluding that your conduct on the occasions specified fell short of what was proper in the circumstances. Your behaviour was sufficiently serious to amount to misconduct.
28. The Panel went on to consider whether or not your misconduct amounted to current impairment of fitness to practise. As encouraged to do by the Decisions Guidance, it weighed up the mitigating and aggravating factors and identified those factors which were absent or neutral.
29. The mitigating factor was this:
  - You had no disciplinary history with your employers prior to the allegations.
30. The aggravating factors were these:
  - your behaviour took place at work;
  - you have failed to engage with the SSSC: whilst any Worker is entitled to deny allegations, it is possible to co-operate with a SSSC enquiry without making admissions. You have not engaged at all;
  - the allegations found proved involved three separate service users on three distinct occasions, with each occasion involving the use of foul language. There was therefore a pattern of behaviour;
  - your behaviour was capable of causing emotional harm to service users and certainly caused upset to your colleagues; and
  - your behaviour constituted an abuse of trust, insofar as vulnerable, elderly service users are entitled to be treated with dignity and respect. Your behaviour towards them, or in their presence, was a failure to treat them in the manner they, their families and the public were entitled to expect.
31. The neutral or absent factors were these:
  - insight, regret or apology: whilst you apparently told your employers that you would accept training or counselling, there was insufficient evidence to show the Panel that you appreciated the consequences of your wrongdoing and were sorry for it;



- the circumstances leading up to the incident: there was no information before the Panel about any circumstances either at work or in your personal life in the lead-up to the allegations;
  - the length of time since the incident and subsequent practise: the Panel had no information on what work you have done since January 2018, except insofar as there is no record of you working in social services;
  - duress: there was no evidence that you acted under duress; and
  - concealing wrongdoing: there was no evidence that you concealed your behaviour.
32. The Panel had regard to the test for impairment suggested in the case of *Grant*. It asked itself if its findings of fact showed that your fitness to practise is impaired in the sense that you have:
- (a) in the past acted and/or are liable in the future to act so as to put a service user at unwarranted risk of harm; and/or
  - (b) in the past brought and/or are liable in the future to bring the profession into disrepute; and/or
  - (c) in the past breached and/or are liable in the future to breach one of the fundamental tenets of the profession.
33. The Panel found that the answer to each of those questions was “yes.” Your actions put service users at the risk of emotional harm; they brought the profession into disrepute; and in failing to respect and uphold the dignity of service users, you breached a fundamental tenet of the profession.
34. The Panel then considered the issue of remediation, as encouraged to do in the case of *Cohen*. First, it asked itself if the conduct it has found proved is easily remediable. The Panel considered that such conduct is attitudinal in nature and, whilst at least potentially remediable, is not easily remediable. Secondly, the Panel asked itself if the conduct has, in fact, been remediated. Unfortunately, your lack of engagement with the SSSC meant that the Panel had no evidence whatsoever that you have done anything to remediate your conduct. The Panel therefore considered that the answer to this question had to be “no.” Thirdly, the Panel asked itself if it was highly unlikely that your conduct would be repeated. Once again, your lack of engagement with the SSSC meant that the Panel simply had no evidence which would allow it to reach that conclusion. The Panel could not therefore be satisfied that it was highly unlikely that your conduct would be repeated.
35. In terms of public protection, the Panel considered that a finding of impairment of fitness to practise was necessary: service users require to be

protected against conduct on the part of Workers which is capable of causing them emotional harm. Looking at the broader public interest, it is also necessary for the public to have confidence in the social service workforce and in the SSSC as the regulatory body. The Panel considered that, if no finding of impairment were made, public confidence in the social services profession and in the SSSC as regulator could well be undermined.

36. Accordingly, it was the Panel's decision that your fitness to practise is currently impaired by reason of your misconduct.

### **Sanction**

37. The Panel decided to impose a Removal Order.

#### Presenter's submissions on Sanction

38. The Presenter referred the Panel to Rule 20.9. in relation to considering what sanction, if any, to impose. He reminded the Panel that any sanction had to be proportionate and submitted that the proportionate sanction was a Removal Order. Regard should be had to the Decisions Guidance in terms of Rule 36.1.
39. The Presenter then considered each of the available outcomes. He suggested that to take no action was simply not appropriate. He then rehearsed the relevant factors in respect of each of the disposals open to the Panel.
40. The Presenter said that the least restrictive sanction was a warning. This might be appropriate where a Worker's behaviour was at the lower end of the scale; where there was no risk to the public; where insight had been shown; and where the Worker's conduct had been corrected. He submitted that these factors did not apply in your case. In particular, there had been no insight, apology or remediation. The importance of this was shown in *Kimmance v General Medical Council* [2016] EWHC 1808 (Admin).
41. Since a warning was not appropriate, the Presenter submitted that the Panel ought to go on to consider imposing conditions on your Registration. Conditions might have been appropriate, he said, had you engaged with the SSSC and had you shown insight. Section 15.1 of the Decisions Guidance indicated where conditions might be appropriate. The situations were listed under the heading "Conditions may also be appropriate the following factors are present." None of these applied in your case and so conditions were not appropriate.
42. A warning combined with conditions was not appropriate for the same reasons that a warning individually was not appropriate and conditions individually were not appropriate.

43. The Presenter then addressed the Panel on the option of a Suspension Order. He argued that this might be appropriate in cases where there were serious failings on the part of a Worker but the failings were such as were realistically capable of being remedied during the period of suspension. He submitted that a Suspension Order was only appropriate where there were no underlying issues about values and where there was a significant and developed sense of insight.
44. The Presenter submitted that a Suspension Order combined with a Conditions Order was not appropriate for the same reasons as conditions and suspension were individually inappropriate.
45. That left a Removal Order, which the Presenter submitted was the only appropriate sanction. He said that a Removal Order was appropriate where there was no other way to protect the public or to maintain confidence in the profession.
46. In response to questioning from the Panel, the Presenter provided information on the apparent delays in bringing this case to a conclusion. He advised that the SSSC had received the referral from your employers on 14 February 2018. A Temporary Suspension Order (TSO) had been imposed on 18 April 2018. It was renewed in October 2018 for four months and then allowed to lapse. The SSSC had written to you on 3 June 2020 to advise of a change of caseholder. The next letter to you had been on 8 November 2019. The decision to refer matters to an Impairment hearing had not been taken until 20 August 2020. There had been two changes of caseholder and an unfortunate delay in taking a decision to refer your case to a hearing. He submitted, however, that any tardiness on the part of the SSSC should not affect the sanction.

#### Your position on Sanction

47. You did not provide the Panel with your views on sanction.

#### Reasons for the Panel's decision on Sanction

48. The Panel reminded itself that the purpose of sanction is not punitive, though sanctions may have punitive effect. Rather, the purpose of sanction is primarily to protect the public and to satisfy the public interest by protecting the reputation of the profession and providing confidence in the regulatory process.
49. The Panel considered that this case ought to have been dealt with rather more expeditiously than it has been: a period of 34 months between matters being referred to the SSSC and the conclusion of an Impairment hearing is far from impressive. That is particularly so when no real reason apart from changes in caseworkers has been advanced for the delay. Such

a tardy way in dealing with a serious case does the SSSC no credit; and the Panel trusts that lessons have been learnt. However, since the purpose of sanction is public protection and safeguarding the public interest, delay has no automatic effect on sanction except, perhaps, when a Panel decides to impose a Suspension Order. In that eventuality, any period a Worker has already spent subject to a TSO may be highly relevant to the length of any final Suspension Order.

50. The Panel had regard to the aggravating, mitigating and neutral factors of this case. Since no further evidence was led at the sanction stage, the aggravating, mitigating and neutral factors are those identified in the Panel's decision on impairment and set out in paragraphs 41, 42 and 43 above.
51. The Panel had regard to the Decisions Guidance. Because of the aggravating factors set out in the Panel's decision on impairment, the Panel found this to be a case in which a sanction was required. The Panel considered that there would be a reasonable public expectation that a sanction would be imposed on you, given its findings on impairment. It therefore did not consider that yours was a case where it was possible to decide to impose no sanction.
52. The Panel went on to consider a warning, as being the least restrictive sanction. It decided that a warning would not address adequately the impairment of your fitness to practise, given the nature of your conduct and the lack of evidence of apology, insight or remediation. A warning would not protect the public nor would it address the public interest in having confidence in the profession and in the SSSC as regulator.
53. The Panel next considered whether matters could be dealt with by imposing conditions on your Registration. The Panel had regard to section 15 of the Decision Guidance to assist it in informing itself as to when conditions might be appropriate. The Panel had no evidence of you showing insight into your failings. There was nothing to suggest that training or supervision would address these failings. The Panel had no information which would allow it to conclude that you had the potential to respond to remediation, training or supervision. The Panel had no information about your current employment status such as would allow it to consider what conditions could be measurable, workable or enforceable. Even if it did have such information, the Panel was of the view that your conduct demonstrated a fundamental attitudinal problem which would be difficult to address by conditions. Your lack of engagement with the SSSC meant that the Panel had no indication that you would comply with conditions in any event. The Panel therefore decided that conditions would not be appropriate.
54. A warning combined with conditions would not be appropriate for the same reasons that a warning alone would not be appropriate and conditions alone would not be appropriate.

55. The Panel then considered whether or not to impose a Suspension Order. The Panel considered that your impairment of fitness to practise is such the public interest would not be served by a period of suspension. There is no evidence that a period of suspension would allow you to remedy the cause of the impairment of your fitness to practise. A Suspension Order may be appropriate where there are no underlying issues about a Worker's values and where she has shown a significant and developed sense of insight. In your case, there are underlying values issues and no evidence of insight.
56. A Suspension Order plus conditions would not be appropriate for the same reasons that a Suspension Order alone would not be appropriate and conditions alone would not be appropriate.
57. The Panel then went on to consider a Removal Order. It decided that such an order was the most appropriate sanction, as being necessary both to maintain the continuing trust in the profession and in the SSSC as regulator. The Panel considered your behavior to be fundamentally incompatible with professional Registration in terms of section 10.6 of the Decisions Guidance. Such a conduct places service users at risk, breaches public trust and undermines confidence in the profession. In all the circumstances, the Panel considered the only proper sanction in your case to be a Removal Order. Such an order will allow the public to continue to have confidence in the social services profession and in the SSSC as regulator.
58. The case of *Kimmance* referred to in paragraph 52 above emphasised the importance of a Worker's participation in regulatory proceedings. The judge put matters in a straightforward way at paragraph 66 of his judgement:

*"There was indeed no evidence of insight and remediation ... .. a professional who has done wrong has to look at his or her conduct with a self-critical eye, acknowledge fault, say sorry and convince a Panel that there is real reason to believe that he or she has learnt a lesson."*

Unfortunately, you chose to do none of these things.

59. In making a Removal Order, the Panel acknowledged that this may have financial and reputational consequences for you, as it may for any Worker. The Panel was of the view that any such consequences for you (and you have not provided the Panel with any information as to what they may be) are outweighed by the need to protect the public, to serve the wider public interest, to protect the reputation of the profession and to maintain confidence in the SSSC as regulator. In all the circumstances, the Panel considered a Removal Order to be both fair and proportionate.