Outcome of Fitness to Practise Panel impairment hearing held on Monday 13, Tuesday 14, Friday 17 and Tuesday 21 May 2019

Name	David Chambers
Registration number	3032928
Part of Register	Support Workers in a Care Home Service for Adults
Current or most recent town of employment	Wishaw
Sanction	Removal Order
Date of effect	13 June 2019

The Scottish Social Services Council (SSSC) Fitness to Practise Panel held on Monday 13, Tuesday 14, Friday 17 and Tuesday 21 May 2019.

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 13, Tuesday 14, Friday 17 and Tuesday 21 May 2019 at Compass House, 11 Riverside Drive, Dundee, DD1 4NY.

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 November 2016 (the Decisions Guidance).

Allegations

The allegations against you were that between 25 July 2014 and 11 August 2017, while employed as a Care Assistant by Tower Bridge Homes Care Limited, at Beechwood Care Home in Wishaw, and during the course of that employment, you did:

1. with regard to resident AA, a female [age] living with a cognitive impairment:

    a. on or around 11 August 2017 walk behind AA with your hands on AA's shoulders, forcing her down the corridor

    b. between on or around 7 August 2017 and on or around 11 August 2017 grab AA's wrist or wrists and move her by the wrist

    c. prior to 11 August 2017 put your hands on or around AA's waist and walk at a faster pace than was manageable for AA

    d. between on or around 1 June 2017 and on or around 11 August 2017:

        i. grab AA by the armpit rushing her along causing AA to walk on her tiptoes

        ii. say to AA "come on" or words to that effect

    e. prior to 11 August 2017, on more than one occasion, push AA to her room holding her elbow against her will

    f. between on or around 1 April 2017 and on or around 31 May 2017:

        i. say to AA "you will need to come with me" or words to that effect

        ii. pull AA

        iii. by your actions in 1(f)(ii) above, cause AA to nearly fall

    g. between on or around 1 June 2017 and on or around 31 July 2017 tie a knot in AA's dressing gown so tight that she could not untie it

2. prior to 11 August 2017 refuse to allow resident BB to go to bed when she wanted to

3. between on or around 1 June 2017 and on or around 31 July 2017, shout at resident CC "go to your room to watch TV" or words to that effect

4. between on or around 1 June 2017 and on or around 11 August 2017 transfer resident DD by lifting DD under her arms rather than using a full body hoist and full body sling as is stated in DD's moving and handling assessment

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

Preliminary matters

Amending the allegations

The Presenter moved the Panel to amend the allegations to delete "or wrists" from allegation 1.b.; and to substitute "Standaid" for "full body hoist and full body sling" in allegation 4. He drew the Panel's attention to the letter sent to your registered address on 12 April 2019 advising, amongst other things, of the SSSC's intention to make such an application.

The Panel was satisfied that amendment was fair, in that it deleted part of the allegation and otherwise did not represent a material change in the alleged conduct from that previously alleged.

Findings of fact

Background

The allegations that led to the hearing arose from your employment as a Support Worker in a Care Home Service for Adults, with Tower Bridge Homes Care Limited at Beechwood Care Home in Wishaw.

Evidence

The Panel heard evidence on behalf of the SSSC from the following witnesses:

- ZZ, Registered Staff Nurse
- YY, Care Assistant
- XX, Housekeeper
- WW, Care Home Manager.

The Panel also had regard to the documentary evidence provided within the hearing bundle.

The Panel's approach

In reaching its decision on the facts, the Panel has borne in mind the advice it received from the Chair. That advice was that the burden of proof lies on the SSSC and it is for the SSSC to prove the allegations. You did not need to prove anything. The standard of proof applied was that applicable in civil proceedings,

namely the balance of probabilities, i.e. whether it was more likely than not that the events occurred. The Panel was entitled to draw reasonable inferences but was not to speculate. The Panel was to consider the evidence in the round and not compartmentalise the evidence in respect of each aspect of the allegations.

The Panel's analysis of the evidence

The Panel found all of the witnesses lead by the SSSC to be credible and reliable. They all gave their evidence in a straightforward and measured manner. In respect of ZZ, YY and XX, their evidence was, on material matters, consistent with records of interviews conducted with them by WW at or around the time of the incidents alleged. Their evidence was also consistent, on material matters, with the contents of their written statements within the hearing bundle. Furthermore, their recollections of events demonstrated a broadly similar pattern of behaviour on your part towards residents, which the Panel considered was relevant in adding to their credibility and reliability.

ZZ, YY and XX were asked to comment on the observations in your Personal Statement Form as to how you say you guided resident AA. All three disputed that your recollection as to how you "guided" resident AA was an accurate reflection of what had occurred when you had been observed by them in respect of the particular allegations each spoke to. In light of the view the Panel takes of the evidence of those witnesses, where your recollection, as stated in your Personal Statement Form, contradicted their evidence, the Panel preferred their evidence.

Where the allegations were not spoken to by any of those three witnesses, the Panel accepted the evidence of WW that she had interviewed other members of staff regarding your behaviour and that the records of interview with other members of staff were accurate records of their statements to her as regards your observed conduct. Whilst that evidence was hearsay, that was not a ground upon which to exclude the evidence. The Panel recognised that hearsay evidence, whilst admissible, must be weighted cautiously, but noted that it was generally consistent with the witness statements of the individuals who had been interviewed. The Panel determined that those witness statements were admissible in terms of Rule 32.4 of the Rules, albeit that the weight to be attached to the same, in the absence of oral evidence from those witnesses, had to be carefully considered. However, where the narrative in the record of interview broadly accorded with the narrative in the witness statement, the Panel considered that material weight could be placed on both. Where there was not a broad consistency or where the Panel was not satisfied that the incidents referred to could be distinctively identified as relating to a specific limb of the allegations, the Panel did not accord the evidence such weight.

Panel's Decision

The Panel having considered the evidence finds the following:

that between 25 July 2014 and 11 August 2017, while employed as a Care Assistant by Tower Bridge Homes Care Limited, at Beechwood Care Home in Wishaw, and during the course of that employment, you did:

1. with regard to resident AA, a female [age] living with a cognitive impairment:

    a. on or around 11 August 2017 walk behind AA with your hands on AA's shoulders, forcing her down the corridor.

Determined and found Not Proved

This incident was said to be referred to in both the interview with, and statement of, VV. The Panel noted an inconsistency in the narrative between those two pieces of evidence as to where it was said resident AA had been touched. In light of that and the possibility that the incident spoken to could relate to the incident at allegation 1.c., the Panel was not satisfied on the balance of probabilities that the incident referred to in that evidence was distinct from that referred to at 1.c. and therefore was not satisfied that it had been proved as a distinct matter on the balance of probabilities.

b. between on or around 7 August 2017 and on or around 11 August 2017 grab AA's wrist and move her by the wrist.

Determined and found Proved

This incident was referred to in the interview with UU and in her witness statement. The Panel was satisfied on the balance of probabilities that in light of the consistency, and the credibility and reliability it attached to the evidence of WW, that the interview record was an accurate statement of events.

c. prior to 11 August 2017 put your hands on or around AA's waist and walk at a faster pace than was manageable for AA.

Determined and found Proved

This incident was referred to in the interview with TT and in her witness statement. The Panel was satisfied on the balance of probabilities that in light of the consistency, and the credibility and reliability it attached to the evidence of WW, that the interview record was an accurate statement of events.

The Panel had regard to the Duty Rota kept in respect of your employment and noted that you did not return to work after 11 August 2017 and therefore concluded on the balance of probabilities that the incident occurred before that date.

In light of that finding in fact the Panel refused a motion made by the Presenter to amend the allegation to extend the period in the allegation to 14 August 2018.

d. between on or around 1 June 2017 and on or around 11 August 2017:

i. grab AA by the armpit rushing her along causing AA to walk on her tiptoes

ii. say to AA “come on” or words to that effect.

Determined and found Proved

This incident was spoken to by ZZ. The Panel accepts her evidence for the reasons already given.

e. prior to 11 August 2017, on more than one occasion, push AA to her room holding her elbow against her will.

Determined and found Proved

This incident was spoken to by YY. The Panel accepts her evidence for the reasons already given.

f. between on or around 1 April 2017 and on or around 31 May 2017:

i. say to AA “you will need to come with me” or words to that effect

ii. pull AA

iii. by your actions in 1.f.ii. above, cause AA to nearly fall.

Determined and found Proved

This incident was spoken to by XX. The Panel accepts her evidence for the reasons already given.

g. between on or around 1 June 2017 and on or around 31 July 2017 tie a knot in AA’s dressing gown so tight that she could not untie it.

Determined and found Proved

This incident was spoken to by ZZ. The Panel accepts her evidence for the reasons already given.

2. prior to 11 August 2017 refuse to allow resident BB to go to bed when she wanted to.

Determined and found Proved

This incident was spoken to by YY. The Panel accepts her evidence for the reasons already given.

The Panel had regard to the Duty Rota kept in respect of your employment and noted that you did not return to work after 11 August 2017 and therefore concluded on the balance of probabilities that the incident occurred before that date.

3. between on or around 1 June 2017 and on or around 31 July 2017, shout at resident CC "go to your room to watch TV" or words to that effect.

Determined and found Proved

This incident was spoken to by ZZ. The Panel accepts her evidence for the reasons already given.

4. between on or around 1 June 2017 and on or around 11 August 2017 transfer resident DD by lifting DD under her arms rather than using a full body hoist and full body sling as is stated in DD's moving and handling assessment.

Determined and found Proved

This incident was spoken to by ZZ. The Panel accepts her evidence for the reasons already given.

Impairment

The Panel next considered, in accordance with Rule 18 of the Rules whether, on the basis of the facts found proved, your fitness to practice is impaired by reason of misconduct.

The evidence

The Panel took into account all of the evidence received during the Finding of Facts stage of the hearing, both oral and documentary. No further evidence was presented.

Submissions

The Presenter submitted that your fitness to practise was impaired by reason of misconduct. He submitted that your conduct demonstrated a failure to treat residents as individuals and a failure to respect their wishes and dignity. He submitted that your oral communication with residents, as found proved, was inappropriate. Further, your conduct demonstrated a misuse of the power and

authority you had when working with residents. By encouraging resident AA to walk at speed and by grabbing and pulling her, you adopted techniques that gave rise to a risk of potential harm. By refusing to allow resident BB to go to bed you failed to respect her wishes. By shouting at resident CC you failed to communicate to that resident in an appropriate manner. By lifting resident DD without a standaid you placed her at risk of harm also.

Under reference to the Code, he submitted that your conduct amounted to breaches of paragraphs 1.1, 1.2, 1.4, 2.2, 3.10, 5.1, 5.7, 5.8 and 6.1 of the Code and as such, your actions amounted to misconduct.

Further, he submitted that the Panel could not be satisfied that there was not a risk of repetition in the future. He submitted that in failing to acknowledge your misconduct you demonstrated a lack of insight. Further, it was submitted that your conduct demonstrated a pattern of behaviour whereby you ignored the interest of residents and so the Panel should conclude that your actions were attitudinal in nature, and thus carried a risk of repetition in the future. If repeated, there was a high risk of harm to residents. Further, he submitted that public confidence in the Register and the SSSC as the regulator would be undermined if there was no finding of current impairment, having regard to the seriousness of the misconduct. Accordingly, he submitted, your fitness to practise is impaired.

Legal advice and relevant legal principles

The Chair reminded the Panel that, in considering whether on proved facts your fitness to practise is impaired, there was no burden or standard of proof; and that the decision on impairment is a matter for the Panel's judgment alone.

The Chair also reminded the Panel that it had to determine whether your fitness to practice is impaired today, taking into account your conduct at the time of the events and any relevant factors since then, such as whether the matters are remediable, have been remedied and the likelihood of repetition.

The Panel's determination on misconduct and impairment

The Panel first gave consideration to whether your actions as found proved amounted to misconduct.

In accordance with Rule 36.1 of the Rules, the Panel gave consideration to the terms of the Code. The Panel also gave consideration to the terms of the Decisions Guidance.

Further the Panel had regard to your comments within the Personal Statement Form where you stated that you had no intention to cause any of the residents emotional or physical harm and that you acted in the best interests of the residents.

The Panel concluded that your conduct, with exception of that specified in allegation 1.g., constituted a departure from parts 1.1, 1.2, 1.4, 2.2, 3.10, 5.1, 5.7, 5.8 and 6.1 of the Code. AA was a vulnerable resident entitled to dignity and respect from her carers, which your conduct failed to show. In assisting AA, you handled her on more than one occasion in an unacceptable manner. Whether by pushing, pulling or grabbing her, and together, you failed to treat her with dignity, respect and as an individual. Your insistence that she should walk, made loudly and in an abrupt manner, as spoken to by both witness ZZ and XX, was inappropriate. You caused her physical and emotional distress by encouraging her to walk when she did not want to, and in a manner which she was uncomfortable with.

Your communications with resident BB, by denying her choice, and with CC by shouting at him, were also inappropriate and demonstrated a lack of respect for them, which manifested itself it their distress, and thus emotional harm.

Together, your conduct towards them all demonstrates a failure on your part to recognise and use responsibly the power you had as their carer. You caused residents AA, BB and CC emotional harm, and in the case of resident AA physical distress, and thus harm, and placed her at unnecessary risk of falling. Your conduct towards resident DD placed her at risk of physical harm and further demonstrated a failure on your part to use responsibly your power as her carer.

All of which puts your suitability to work in social services into question. The Panel has no hesitation in concluding that your actions fell short of the standards of conduct reasonably to be expected of a person working in social care; and in characterising your actions as misconduct.

As regards allegation 1.g., the Panel was not satisfied that your actions in tying the dressing gown of resident AA was misconduct. In that regard, the Panel had regard to the evidence of ZZ who was equivocal, in light of what she observed as to the ability of resident AA to remove the dressing gown cord, as to whether the dressing gown had been tied in such a manner as to have deliberately prevented resident AA from removing it.
Having found the facts proved, with exception of allegation 1.g., amounted to misconduct, the Panel went on to consider whether, as a result, your fitness to practice is impaired. In doing so, the Panel had regard to the Decisions Guidance and balanced various mitigating and aggravating factors.

The Panel was mindful that the question of impairment is one to be addressed on the facts known at this time and, in light of the same, should include a consideration of whether, looking forward, your misconduct is likely to be repeated.

The Panel had regard to the absence of any prior action having been taken on your ability to practice. The Panel also had regard to the absence of any subsequent concerns as to your fitness to practise but noted that you had been subject to a Temporary Suspension Order (TSO) during the regulatory

proceedings. The Panel had regard to the positive comments made by some of the witnesses as to your care practices. However, the Panel noted that the incidents giving rise to the allegations demonstrated a pattern of similar behaviour and concluded that it demonstrated an attitudinal concern as to the care offered by you and was serious. Grabbing, pulling, pushing and rushing residents, shouting at them or speaking abruptly to them and moving them inappropriately not only puts service users at unwarranted risk of harm, when looked at together it resonates an underlying attempt by you to exercise control over residents and an abuse of your position. In light of that, the Panel had no hesitation in concluding that your actions bring the social care profession into disrepute. Further, when taken together, your actions demonstrate a lack of compassion towards the care needs of the residents under your care and therefore was such as to render your conduct a failure to observe a fundamental tenet of the profession. Looking forward, the Panel concluded that in light of the pattern of behaviour and the absence of any demonstrated insight or remediation, there was a material risk of repetition. The Panel therefore determines that your fitness to practise is impaired.

Sanction

Submissions

The Presenter reminded the Panel that it was to act proportionally, and not punitively, although any order might have a punitive effect. He invited the Panel to have regard to the Decisions Guidance.

He submitted that in light of the findings of the Panel on impairment, including the serious nature of your misconduct, it was not appropriate to conclude the case with no sanction.

A warning was not appropriate either in light of the seriousness of your misconduct, the risk of repetition and the lack of insight shown by you.

The imposition of conditions on your Registration was said not to be appropriate because your misconduct was not simply a performance issue but went to an attitudinal concern as to your desire to exercise control over residents. Furthermore, there was no demonstrated willingness on your part to engage with conditions on your practice, and you had not demonstrated any insight. The public interest, it was said, required more by way of sanction.

Conditions and a warning were said to be inadequate for the same reasons.

As for the possibility of suspension, the Presenter submitted that it was not sufficient where you had not accepted your misconduct, demonstrated insight or any prospect that your conduct might be remediated.

Suspension with conditions was said to be inadequate for the same reasons.

Accordingly, the only proportionate order was one of removal from the Register. He submitted that such a course of action was proportionate when your actions were fundamentally incompatible with SSSC Registration.

Determination on sanction

The Panel had regard to the Decisions Guidance and considered first whether it was appropriate to impose no sanction. The Panel determined that such a disposal would not be appropriate. The Panel reminded itself that it found your misconduct to be serious and because repeated, in the absence of evidence to mitigate the possibility, likely to be repeated in the future. To impose no order would not reflect the seriousness of your actions; and there were no exceptional factors to justify not imposing a sanction.

The Panel then considered whether a warning would be appropriate. Whilst not at the higher end of seriousness, your misconduct was nevertheless serious and demonstrated an attitudinal concern which has not been remediated, and which, in the absence of any evidence of insight on your part, puts the public at risk of harm going forward. The Panel determined that a warning would not adequately protect the public nor the public interest.

The Panel next considered whether conditions on your Registration would be appropriate. The Panel was not satisfied that conditions would be adequate to protect the public or maintain confidence in the profession. Your conduct demonstrated an underlying attitudinal concern. The Panel, in the absence of any evidence of insight on your part, was not satisfied that conditions, if imposed, would address the underlying concern as to lack of compassion towards service users or the risk of harm to the public in the future. Furthermore, your conduct towards various residents was such that conditions on your Registration would not suffice to address the need to maintain public confidence in the profession.

The Panel also determined that a warning with conditions would also fail to adequately protect against the risk of harm going forward or adequately mark the seriousness of your conduct, for the reasons already given.

The Panel next considered whether a period of suspension would be proportionate. Whilst the Panel considered that suspension would send a message to you, the profession and the public that your conduct was not appropriate, the Panel was concerned that its findings identified an attitudinal concern as to your care of vulnerable people. In the absence of any evidence of you having recognised that, acknowledged it, or sought to address it, the Panel was not satisfied that, in the event of a return to work after a period of suspension, the concern that lies at the heart of your misconduct, namely a lack of compassion for service users, would not remain. In light of that, the Panel did not consider that a period of suspension alone would adequately protect the public or be adequate in the public interest.

As for suspension with conditions, the Panel gave consideration to whether you could, during a period of suspension, address the concern identified as to your attitude towards service users. However, without any evidence that you had identified the same, were willing to address it, or could address it, the Panel was not satisfied that there was a material prospect that such a sanction would be workable.

Accordingly, the Panel concluded that the only proportionate sanction for the protection of the public and the maintenance of public confidence in the profession was one of removal of your name from the Register. Whilst the Panel recognises that the effect of such order is to preclude you from practising your chosen profession, it determined that removal was the only proportionate response to the findings it had reached.

In imposing that order, the Panel reminded itself that your conduct did amount to an abuse of trust on your part towards the residents in your care. Your conduct was serious, and your pattern of behaviour demonstrated an underlying concerning lack of compassion for service users. There was no material comfort available to the Panel at this time to alleviate its concerns.

In light of the finding of the Panel it will not be open to you to apply for restoration to the Register as a social services worker within three years of the date of the Removal Order.