Outcome of Fitness to Practise Panel impairment hearing held on Monday 8, Tuesday 9, Wednesday 10, Thursday 11, Monday 15, Tuesday 16, Wednesday 17, Friday 19, Monday 22, and Tuesday 23 April 2024

Name	Edward Boateng
Registration number	3066060
Part of Register	Support Workers in a Care Home Service for Adults
Current or most recent town of employment	Edinburgh
Sanction	Removal
Date of effect	15 May 2024

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

1. 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 8, Tuesday 9, Wednesday 10, Thursday 11, Monday 15, Tuesday 16, Wednesday 17, Friday 19, Monday 22, and Tuesday 23 April 2024 at Murrayfield Stadium Conference Centre, Edinburgh, EH12 5PJ.

2. At the hearing, the Panel decided that all 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:

3. 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)
    - Scottish Social Services Council (Fitness to Practise) Rules 2016 as amended by the Scottish Social Services Council (Fitness to Practise) (Amendment) Rules 2017 and 2021 (the Rules)
    - Decisions Guidance for Fitness to Practise Panels and Scottish Social Services Council staff dated November 2022 (the Decisions Guidance).

Allegations

4. The allegations against you are that:

   On or around 3 May 2019 while employed as a Care Assistant by ASA Recruitment at Drumbrae Care Home in Edinburgh, and during that employment, you did:

   1. fail to ensure that all four points of the sling were attached to the hoist before lifting service user AA from her bed
   2. by your actions in allegation 1. above, cause AA to fall from the hoist to the floor
   3. by your actions in allegation 1. above, AA sustained serious injury
   4. by your actions in allegation 1. above, AA required hospitalisation where she developed bronchopneumonia and subsequently died
   5. prior to the inspection of the hoist and immediately following the incident, attach a sling clip to the hoist
   6. your actions at 5. were dishonest in that you attempted to conceal the fact that you had failed to attach the two clips at your side of the hoist prior to lifting AA from her bed

   and your fitness to practise is impaired because of your misconduct as set out in allegations 1. – 6.

Representation

5. The SSSC was represented by [information redacted], solicitor (the Presenter).

6. You attended the hearing, but you were not represented.

7. As you know the fact-finding section of your hearing was joined with that in the case of ZZ (ZZ). ZZ was represented by [information redacted], Solicitor, Thompsons Solicitors.

Findings of Fact

8. You did not admit any of the facts alleged. For the reasons set out below, we found all of the facts alleged against you to be proved.

9. We make the following findings about what happened (findings in fact).

10. Since 20 October 2014, ZZ was registered on the part of the Register for Support Workers in a Care Home Service for Adults (hereinafter referred to as SWCHSA). She was a registered Worker on 3 May 2019.

11. ZZ has been employed by City of Edinburgh Council since 2004 and has worked at [information redacted] since 15 November 2021.

12. Since 4 February 2016, you were registered on the part of the Register for Support Workers in a Care Home Service for Adults (SWCHSA). You were a registered Worker on 3 May 2019.

13. On 3 May 2019, AA was a resident in Drumbrae Care Home. It was operated by the City of Edinburgh Council ("CEC"). AA was 90 years old. She suffered [information redacted]. [information redacted]. She relied on assistance for the tasks of daily living.

14. ZZ and you were on shift at Drumbrae Care Home on the morning of 3 May 2019.

15. ZZ was on the permanent staff at Drumbrae Care Home. She worked there for many years.

16. You were an agency worker assigned to work at Drumbrae that day by ASA.

17. It was common for agency workers to work at Drumbrae. The practice was to make a team of two by pairing a member of permanent staff with an agency worker.

18. ZZ and you were paired. ZZ was unhappy about being paired with you. She complained to others. The reason she complained was that because some residents did not want personal care carried out by a man. There would be more work for her than had she been paired with a woman.

19. Although the use of hoists and slings in care homes is a common occurrence, it is nevertheless an operation that carries with it the risk of grave injury to the person being hoisted. If not done correctly and carefully, it carries a risk to the Workers. It is not a remote risk. The risk of severe injury or death is present when a person is lifted with hoist. We will refer to the operation involved in getting AA from bed to wheelchair as "the lifting operation".

20. AA's room had a bed and furniture. With AA lying the normal way round in the bed, the room door was to AA's left. The bedroom had an ensuite bathroom. The door to that was closer to AA's left. Equipment including the hoist and sling was kept in the bathroom.

21. The moving and handling plan for AA had been made on 5 September 2018.

22. A copy was on the wall of AA's room. According to the plan, AA had to be transferred by two people using a hoist. The plan required two carers and a hoist and sling.

23. The occupational therapist who made the plan noted that when AA had been moved in the past, she had sustained injury to her legs so the plan directed the Workers to "keep the hoist tilted back so as to take some pressure off her thighs and only when she is ready to sit should you tilt her into a seated position". This method was intended to reduce the friction between AA's legs and the sling. The plan was suitable and appropriate.

24. AA's bed was a powered model. The up and down movement of the bed was controlled by a handset.

25. The hoist to be used was a Arjo hoist. It was a Maxi Move model. We will refer to it as "the hoist". The hoist worked in conjunction with a sling. The sling carried the person to be moved. Slings came in various shapes and sizes. The sling used by ZZ and you to move AA was a large Silvalea sling. It was a full body sling suitable for a move from bed to chair. It did not have hood type head support.

26. The hoist was on wheels. It was moved manually from place to place. The lifting function was powered and operated from a handset. The entire hoist with the person in the sling would be wheeled to wherever the person hoisted was to be put down.

27. The means of connection of the sling to the hoist was by hooking clips over lugs.

28. The sling used by ZZ and you was a Silvalea sling. It was kept in AA's room. It was the kind of sling required by AA's plan. The shape of the sling was designed to envelope the body of the person lifted and to have the shoulders insider the sling.

29. The sling was compatible with the hook and lug system on the hoist. It was also compatible with other hoists that used a loop system to connect the sling to the hoist.

30. Both you and ZZ were trained in moving and handling and using slings and hoists. You were not formally trained on the clip system but had experience using it. You and ZZ were both competent to use the Arjo hoist and Silvalea sling.

31. ZZ was trained for her employer by an organisation called McSence. You were trained by the agency, ASA.

32. The way in which the operation ought to have been conducted was as follows. After the personal care, the wheelchair ought to have been moved to the foot of the bed on AA's left. The bed ought to have been raised or lowered to about hip height. The sling ought to have been located under AA. Once the sling was in place, the clips ought to have been placed over the lugs on the hoist. The bed ought to have been profiled to put AA into a near sitting position. Each Worker ought to have visually inspected the clips and lugs and on the opposite side as well as his or her own. He or she ought to have pulled down on the straps to make sure that the clips were properly located over the lugs and sling securely attached to the hoist (a tug test). The Worker ought to have pulled on the straps on his or her side and the opposite side. The Workers ought to have spoken to one another to make sure that the tests were done, and they were ready for the lift to begin. The bed then ought to have been lowered to about the height of the seat of the wheelchair. When this was done, the straps and sling would take the strain. Doing so would allow the Workers to make sure that the sling was securely attached to the hoist, and AA was securely in the hoist,

whilst AA was still safely over the bed. Once this was done, before the sling was raised any further, the Worker to AA's right ought to have moved round to AA's left near her feet. The hoist ought then to have been operated to lift AA off the bed so she could be moved without catching her heels on the bed. The Worker who was not operating the hoist ought to have been in position to hold and guide AA's feet to make sure they did not catch on the bed. AA ought to have been raised to the minimum height consistent with safely moving her. She ought to have been transferred in a near sitting position, but a little closer to flat that is usual because of the risk of injury to the skin on AA's thighs (as prescribed in the Manual Handling plan). The hoist was on wheels. The hoist ought then to have been wheeled away from the bed to bring AA from above the bed to over her wheelchair. She ought then to have been lowered into the wheelchair. The sling should then have been disconnected from the hoist. The sling would have been left in situ on the chair. This is not what happened.

33. ZZ and you got AA ready to be moved. They put the sling under her. ZZ was to AA's left and you were to her right. On her side, ZZ put both clips over the lugs.

34. The sling was placed under AA in the correct fashion. There were four points of attachment between the sling and the hoist. Two at the patient's shoulder area. Two on the hoist in front of her torso. ZZ attached the hooks at the end of the straps over the lugs near AA's left shoulder. It snapped into place. She did the same thing with the clip on the strap on the leg section.

35. At about the same time, you were engaged in the same task on the other side of AA. You put the clip over the lug at AA's shoulder. It snapped into place, either then, or when the lift started, and the strap took the strain.

36. You then tried to attach the strap on the section of the sling supporting AA's right leg. You did not put the clip on the strap securely over the lug. But whatever you did created the visual impression, from ZZ's vantage point, that the clip was over the lug. The strap must have been hanging down vertically from a point close to the lug. ZZ could not see the lug from where she was operating the hoist. We do not decide why exactly the clip did not engage with the lug and click into place. Maybe something, part of the strap or sling, got between the hook and the lug. Maybe you put the loop over the lug.

37. At the start of the lifting operation, ZZ was to AA's left and you were to her right. ZZ had both the handset to control the height of the bed and the handset to control the hoist. The hoist and wheelchair were to AA's left.

38. Before you took up position at the foot of the bed near AA's feet, where you ought to have been, ZZ, without warning you, operated the hoist and AA, in the sling, started to rise from the bed. At that moment, you were not attending to AA and were not in position. You noticed that ZZ had started the lift. The bed was not lowered to the lowest height possible. The bed was not profiled to put AA in a sitting position. The hoist was operated, and the straps took the strain. The hoist was used to raise AA to a height

about five feet (1.5 metres) above the floor. This was close to the maximum that could be achieved with the hoist. You moved to try and place your hands on AA's feet to prevent them getting into contact with the bedrail. We do not make a finding about whether you actually touched AA's feet and ankles or whether you took the weight of her left leg or foot.

39. As AA was being moved to her right she emerged from the sling and fell to the floor.

40. The lifting operation controlled by ZZ was not performed gently or gradually. If it had been, the failure to securely attach the sling to the hoist at all four points would have been apparent when AA was still (relatively) safely over the bed. Instead, it only became apparent when AA was being moved to her left. This is true whether or not you were taking some or all of the weight of AA's left leg. The correct procedure would have been for the bed to be lowered away. The Worker with control of the patient's legs would not have to touch them until the patient was hoisted to a position where the hoist was taking the weight and the patient was, or about to be, moved laterally. The position of the second Worker near the feet would also mean that person could intervene if the lifted person slipped from the sling.

41. The hoist was suitable and no defect in the hoist contributed to the fall. The sling was suitable and was not defective.

42. The control of the movement of the hoist was at all times in ZZ's hands. She also controlled the bed.

43. The sling had only been secured at three of the four points. Immediately after AA had fallen, the part of the sling that held AA's right leg, which ought to have been secured to the hoist by the clip on that side - the side which you had attended to - was flapping free.

44. ZZ told you not to touch anything and left the room without setting off the emergency alarm. You did not set off the alarm.

45. When ZZ was out of the room, you did not attend to AA. You put the clip that had detached, or had never been attached, back over the lug.

46. You reattached the clip in order to conceal the fact that you had failed to attach, or attach properly, both clips over their respective lugs. You did so dishonestly, to mislead those investigating what had happened.

47. YY then came to the room with ZZ. ZZ said that the leg clip had been reattached. YY then left again to go downstairs to get help.

48. YY came back with XX. You told XX that AA had hit the ground head first. All four clips were attached.

49. XX left, then VV, the [information redacted], arrived at the room. You were in AA's room, near the room door. She spoke to you. She asked whether

you had been trained. You said yes. You also mentioned that you had worked for [information redacted]. She asked you to go and do other work.

50. Paramedics arrived about 20 minutes after they were called. After they arrived, and had seen the height of the hoist, XX took photographs on her phone. XX also phoned AA's [information redacted].

51. AA left Drumbrae at about 9:30am.

52. Both ZZ and you failed to ensure that all four points of the sling were attached to the hoist before AA was hoisted. The fall is likely to have been prevented if ZZ had conducted a tug test on the straps on your side of the hoist. It would likely have been prevented if she had gradually raised the hoist above the bed.

53. When she fell, AA fractured her left tibia and fibula and hit her head. She was taken to hospital. It was found that she had suffered a bleed on the brain. Whilst in hospital, AA developed bronchopneumonia. She died on 15 May 2019. The primary cause of AA's death was bronchopneumonia following hospital admission for injuries sustained in the fall. The fall caused the death.

54. ZZ's representative and the Presenter agreed certain facts in a statement of agreed facts. The agreement was not binding on you. We did not think it right to encourage you to agree to facts unless we were convinced that you knew the consequences. This meant that the Presenter led more evidence, more slowly than she would have done had you been represented. As we will come on to explain, by the end of the fact-finding section of the hearing, not a great deal was controversial, but what was controversial was hotly disputed and important.

Reasons

<u>Agreed and uncontroversial facts</u>

55. You did not dispute that you were a registered Worker or your personal details. You were at work at Drumbrae on 3 May 2019. You were there for a shift as agency worker. You were paired, as was usual with an agency worker, with a member of the permanent staff, namely ZZ.

56. There was no dispute that ZZ and you went to AA's room and personal care was performed and that AA's manual handling plan was on the wall of her room.

57. You were adamant that you were sufficiently trained and knew what you were doing with the Arjo hoist and Silvalea sling. You were very careful to make clear to the Panel that you knew the difference between the loop attachments on the sling, which were not to be used with this Arjo hoist, and the clips which were to be put over the lugs on this hoist. The loops were used, we understood, with the Oxford hoist, which is more common in care homes.

58. Even though the Arjo manufacturer's booklet said that their slings could be used with their hoist, the witnesses, including WW, the expert engineer, said that even though that is what the booklet said, the Silvalea sling was suitable.

59. We heard evidence about the suitability of the hoist and sling and manual handling plan and how the lifting operation ought to have been done. We heard evidence about the examination of the equipment and the investigations. The local authority's own health and safety team, UU (trainer from [information redacted]), TT (trainer from [information redacted]), and the HSE (SS), considered the plan to be suitable. The expert witness, an expert in lifting operations, WW, too considered the plan to be suitable. All of them thought the hoist and sling chosen were appropriate. The post-incident investigations found the hoist and sling to be in good repair and without defect. We have set out, at length, in the findings how the operation ought to have been performed. You did not dispute that the plan was appropriate, and the equipment was suitable, sufficient and in good repair.

60. Both XX and VV gave evidence about the injuries suffered by AA and what they were told about these injuries and death. ZZ agreed that AA had suffered the injuries set out in the findings. She did not challenge the conclusion that the injuries caused AA's death. You did not dispute that AA was injured and died.

Hearsay

61. In making our findings in fact, we had regard to some hearsay evidence. We were referred to statements and other documents prepared by two witnesses who did not give oral evidence, namely YY and SS. The Presenter asked us to take their evidence into account even though it was hearsay.

62. The Panel was told about the [information redacted] YY giving oral evidence. There were good and cogent reasons for her not giving evidence. The Presenter pointed out that there were some contradictions between the statements given by YY. ZZ accepted that the statements were, in the circumstances, admissible although subject to the weight to be given to them. You referred to the statements given by YY when you examined other witnesses. You pointed out that in a statement made to her employer on 19 November 2020 (55), she said it was normal for ZZ to be grumpy. You did not oppose the hearsay application. We decided to admit the hearsay evidence of YY.

63. In her handwritten statement on 3 May 2019, YY appears to be saying that when she got to the room, ZZ told her that when AA fell, the sling was clipped up in three corners. It also says that when she looked it was clipped up in four corners. This is consistent with ZZ's position.

64. We also decided to admit the hearsay evidence of the HSE investigator, SS. She was the only person at HSE who could speak to the investigation. Her line manager, who had signed off on her report, could do no more than

refer to what SS had done. The Panel was told about the [information redacted] SS giving oral evidence. There were good and cogent reasons for her not giving evidence. ZZ accepted that her report and materials she had prepared were, in the circumstances, admissible although subject to submissions on the weight to be given to them. You, referred to the statements given by SS when you examined other witnesses. You did not oppose the hearsay application. However, we noted that when you gave evidence, and on other occasions, you said that the HSE statement was not, in all respects, an accurate note of what you had told SS. Accordingly, we have placed no weight on the statement given by you to HSE.

65. In the same way, because the police officer who took your statement was not called, and you said that it was not accurate, we have placed no weight on the statement you gave to the police.

66. The legal advice given by the Chair about facts finding was as follows. The burden of proof was on the SSSC. We had to consider the evidence as a whole before drawing conclusions using the balance of probabilities standard. The balance of probabilities standard means that for a fact to be proved, we had to be satisfied that the thing asserted to have happened was more likely than not to have occurred.

67. We had to decide on the credibility and reliability of witnesses. We could do that by assessing their demeanour, but it would usually be better to compare their evidence with that of others which was uncontroversial and with the inherent likelihood of what the witness described. Demeanour is an uncertain guide because different people react to the same situation - whether witnessing an accident or giving evidence - in different ways.

68. We could use the evidence in statements that witnesses accepted that they had made and were the truth. A statement made closer to the time might be more reliable than one made later. But a witness might have a reason for recalling or saying more later than they did at the time. It was a matter of circumstances.

69. The other kind of statements in this case were hearsay statements and reports of YY and SS. We reminded ourselves that before accepting hearsay evidence that contradicted the positions of ZZ or you, we did not have the chance to assess the credibility or reliability of the makers of the statements, beyond how their evidence compared with that of evidence we accepted, and we had not seen them examined or cross-examined.

70. We reminded ourselves that where there are conflicts in the evidence of different witnesses, we could accept one witness's evidence, and reject another's. Where there were conflicts in a single witness's evidence, we could accept part of it and reject part.

71. There was expert evidence. There was no doubt that WW was qualified to give evidence on the issue of lifting operations. Her function was simply to guide us through a specialist area lying out with our normal day-to-day experience. It was not for her to decide the case. Her conclusions about what might or might not have happened were only as good as the

information she was given. We might see the facts differently from her. We could apply her expertise to our understanding of the facts.

72. We were allowed to draw reasonable inferences of fact. We could use the proved circumstances to piece together, like strands in rope, what had happened.

Your position

73. You said that the hooks that he attached were securely in place. You said that you did not see the fall but reckon that AA was ejected from the head end of the sling. You said that you thought that the sling was flat when she fell out.

74. In your personal statement form (676), you said that ZZ operated the wrong button which led to the incident and the bed itself was too high.

75. Your evidence was that AA was moved flat (that is with her back parallel to the floor), or at least flatter than is usual when transferring a person from bed to wheelchair, is consistent with ZZ not profiling the bed and because the bed was high not having much space to AA into a sitting position until she was clear of the bed. For reasons we will come to, we don't think that even if she was lifted relatively flat, it is at all likely she came out of the head end of the sling.

76. You denied that you reattached the clip when ZZ went out of the room.

ZZ's position

77. ZZ said that she would usually have checked both sides. She said that she would normally have lowered the bed. Her evidence was that the clip on your side had come away causing the fall. She said that when she went out of the room, the clip was undone. When she went back it had been reconnected. She was shown the statement she made on the day at 10:30am. ZZ agreed with that and what she had said in her police statement (326) and HSE statement (333).

78. We don't accept that she lowered the bed. When XX went to the room the bed was remarkably high. We also don't accept that she waited for you to get into position before she operated the hoist. We accept your evidence on where you were. We have decided that she acted hastily and without following her training. If she did look across to your clips, she could not see whether they were over the lugs.

79. We think she was probably working that way because she was not happy about having been paired with you and was in a rush. Her evidence was that at the start of her shift when she was paired with you, she mentioned the skills mix to her supervisor. As she explained in evidence, personal care tasks would take longer when she was paired with you because some female residents did not want a man to attend to them.

Your handwritten statements

80. When deciding what happened we considered your handwritten statements. Not long after AA fell, you were asked to give a statement. XX asked you if she could take your statement, but you said that you would rather write it out. You did so.

81. You did not claim that any pressure was put on you to write anything in the statement that was not true. You did not cross-examine XX suggesting that she pressured you into writing, or not writing, anything. You were, as we understood it, left to get on with writing the statement.

82. The first statement (308) was written and signed early on the day of the incident. It is consistent with your position that ZZ pressed ahead with the lifting operation before you were ready and in position near AA's feet. You said that after AA fell, ZZ asked you if you had fixed the bottom clip and you said yes. According to you, ZZ then went out and called YY and pressed the alarm.

83. The second statement (313) was written and signed on 8 May 2019, said that "everything was in place". You added that when you saw the sling rising up, you saw ZZ using her other hand, that is, the hand not on the remote control for the hoist, to control AA's leg. This account too is consistent with your position that ZZ went ahead without making sure you were in position. You continued that you moved from your side to control AA's feet and as soon as the feet "passed the bed", AA fell down. You said that "looking up, everything was in place". Your position is that AA fell from the sling even though it was attached at four points to the hoist. You continued "ZZ asked me … Edward did you put your side in, and I said yes if I didn't one leg would be on bed and one would be up". You continued, "So she [ZZ] started crying and went to call YY". You then said that the alarm was sounded. You end by saying that "we checked the sling and the hoist, but nothing was wrong".

84. We accept what you said about what happened in the room, with the exception of your account of the state of the sling clips immediately after AA fell. What you said about ZZ's behaviour fits with the evidence of her being in a rush and unhappy with your allocation. It is also consistent with AA falling out of the sling because, at least in part, of her undue haste. Had she worked methodically in accordance with her training, as she was meant to, the unclipped strap need not have led to catastrophe.

85. ZZ admits that she was to blame for not checking the clips on both sides.

What happened

86. There were competing eye-witness accounts, so we looked at the rest of the evidence to see if it could help us decide what happened. It did. We were able to decide, on balance of probabilities, that AA fell because the leg clip on her right side was not attached to the hoist. We decided this because we take the view that it is highly unlikely that AA could have fallen out of the sling if all four clips were in place.

87. It is highly unlikely AA fell from the head end because the way in which the sling was made was to cradle and catch round the shoulders of the person being lifted, thereby keeping their shoulders in the head end of the sling. Your evidence was that when you attached (or thought you had attached) your clips, AA was properly positioned on the sling, with her shoulders in it. That being so, even if ZZ had tipped the head end of the sling lower than it ought to have been and AA's head was unsupported, AA is unlikely to have come out. She is unlikely to have come out because her shoulders would not have been able to follow her head. Even if ZZ kept AA flat and put her in a position where her head was lower than her hips, it would have been very difficult because of the shape of the sling to get her to fall out of the head end with all four clips attached.

88. We also note that the design of the Arjo hoist was such that if all four points were attached, the sling would not swing much from side to side even if the hoist were moved abruptly. TT, a moving and handling trainer, described there being much less swing than with an Oxford hoist. This alone means the idea that, with all four clips attached, AA was swung out when the hoist was rapidly pulled back from the bed is unlikely.

89. We have made the findings about what happened informed by what we were told by UU, TT, and WW. UU was a moving and handling trainer from [information redacted]. She could not envisage the accident happening in the way you described. TT, a trainer from [information redacted], who had the advantage of seeing the hoist and similar (if not the same) sling and conducting a re-enactment, which we saw on video, could not produce the circumstances in which the person in the sling could fall out through the head end in the way you described. She carried out her experiment based on anonymised witness statements, so she did not know, for instance, who had been trained by McSence and who by ASA. Their evidence was consistent with that of the engineer and moving and handling expert, WW. None of them had any reason to prefer the position of either party. We were satisfied that each of them was objective and open minded about the possibilities.

90. We were careful not to give too much weight to the reconstruction videos. We did not treat them as conclusive. The people being hoisted in the videos were relatively young and fit. They did not have the same characteristics as AA. The person operating the hoist was not rushing or pulling the hoist away whilst the sling was being raised. Not every imaginable possibility was gone through. Nevertheless, the video footage tended to support the oral evidence that it was very difficult to imagine how AA could have fallen out of the head end of the sling if all four points were attached. You were adamant that AA fell from the sling with all four points attached.

91. A further difficulty for your account is that in oral evidence you never gave a clear and consistent account of how AA came to be ejected from the head end of the sling. On your own evidence, you were near AA's feet when she fell, and it is difficult to understand how you could not have clearly seen

what happened. In the end, we took the view that the reason you could not give a clear and consistent account is that AA fell feet first.

92. YY's statement prepared on the day says that she asked you and ZZ what had happened, and ZZ said that the left leg clip was not secure. YY thought that ZZ was grumpy and said so to the investigation. She was not at all pleased with how VV and CEC handled the incident. She thought that ZZ should have been suspended until after the investigation. This would tend to indicate that she would not lie to make ZZ look better and you worse.

93. It follows that we accept ZZ's evidence about what happened. We realise that ZZ had a reason to lie about what happened. Her reason to lie would have been to spread the blame. Her actions contributed to a preventable fall resulting in AA's death. She had a reason to lessen her responsibility and increase yours. Considering all the evidence, it is more likely than not that the leg strap clip on your side was not attached or was not properly attached.

94. It also follows that we are bound to decide that you put the clip back on when ZZ left AA's room before she returned with YY. YY says that when she arrived all four clips were in place.

95. We accept your evidence that ZZ rushed the lifting operation with the bed too high and started to move AA without pausing for long enough over the bed to see that the clips and straps were taking the strain. She did not let you take up position. Your written statement (308) mentions ZZ trying to do the lift with one hand. That she was rushing is consistent with her having been unhappy about the staff allocation earlier in the day. In evidence, she said there was more work for her if she was paired with you. This was because some female residents did not want a man involved in their personal care. There is independent evidence that the bed and hoist were too high. She did not tug-test your clips. She did not lower and profile the bed. She went ahead before you were fully in position.

96. This is not one of those rare cases where the evidence leaves us in such doubt about what happened that the onus of proof was not discharged.

<u>Suggestion of a conspiracy to shift the blame</u>

97. You said ZZ is lying when she says that the reason for the fall was that the leg clip that ought to have been fixed by you was not attached or became detached during the lifting operation.

98. Your evidence was that as an agency worker you were an outsider and, right from the start, the permanent staff put their heads together to put the blame on you.

99. We do not accept that there was a collusion or conspiracy.

100. XX denied that she had been involved in a conspiracy to blame you. We note that when she gave evidence, she did not try to spare ZZ from blame.

She said it was the responsibility of both Workers to check the clips visually and by tugging. She noticed that the bed was too high. She said the hoist was too high. She did not appear to us to be trying to put the blame on you alone. She gave you the opportunity to put your account in writing on the day of the event.

101. VV was also said to have been part of the collusion. We accept her evidence that when she got to the room her priority was making sure that AA was being attended to and comforted.

102. Another aspect of VV's behaviour that you said supports your submissions that we should find there was an arrangement to put the blame on you is that when VV got to the room, she asked you to leave the room, asked you about your training, and put you to work elsewhere.

103. We note that when VV arrived in the room she said, "We are here to support our colleagues", or something like that. You said the phrase supports your argument that permanent staff conspired against you. You said that you were not one of the colleagues because you were agency staff. We do not think that phrase carried that meaning.

104. VV called her manager and brought in CEC health and safety. She also contacted the Occupational Therapist, RR. CEC put in place investigations by the hoist and sling providers. VV, XX, and CEC appeared to us to be open minded when they investigated.

105. Similarly, if VV was involved in a cover up or conspiracy, she gave no signs of it when she gave evidence. She struck us as a sensible [information redacted] whose priority would have been the welfare of residents and staff, including you. She did not spare ZZ when giving evidence and said that both Workers had the responsibility to work from the lifting plan and work together through the operation. If she put anyone out of the room, it was to make space for AA to be cared for and to preserve her dignity.

106. We accept that VV asked you about your training before sending you back to work. You told her amongst other things, about working at [information redacted]. She still had the home to run. You were coping better than ZZ, who was in tears upset, and VV, who was herself upset and wanted to make sure, briefly, that you were safe to work before sending you back to work. We don't think that this shows she had it in her head, on the day, to put the blame on you.

107. Your suggestion that the responsibility of those coming to answer an alarm or responding to call for help was to be witnesses is wrong-headed. The primary responsibility of YY, XX, VV, and anyone else who responded was to deal with the emergency to keep people safe and give them aid and comfort. Investigation was some way down the list. In any event, photographs were taken of the scene and statements were obtained on the same day. Handwritten statements were obtained from ZZ, you and YY. XX typed her statement.

108. VV did not seek to put all of the blame on you. ZZ was immediately taken off hoist work. She was put through her employer's disciplinary process. She was issued with a final written warning. That she was dealt with in that way is also inconsistent with the suggestion that there was a cover up.

Impairment

109. You did not admit that your fitness to practise is currently impaired on the grounds of misconduct.

Panel's decision

110. We asked the Presenter to make submissions in your case on the issues of misconduct and impairment. She did so by reference to the reasons section in the Initial Notice of Referral. She referred to the law on misconduct and circumstances in which findings of current impairment should be made.

111. In reply, you told us that you were sorry for what had happened. But you maintained that you had not replaced the clip whilst ZZ was out of the room immediately after AA fell.

112. This is a case in which we find that the failures on the day to attach and check the clips are misconduct. Dishonestly reattaching the clip was also misconduct. Your conduct fell short of the standards in section 2.1, 4.3, 4.4, 5.1, 5.7 and 5.8 of the Code. We could not find any mitigation for your conduct. You did not produce any references.

113. The failure to attach and check the clip, though one-off, was a failure to carry out a safety-critical task that had very serious consequences. The failure was not just the failure to attach but was also the failure to use a tug test to check your attachments. You then dishonestly reattached the clip. We are not satisfied that you have had training or experience since the date of the incident to reassure us that you do not pose a continuing risk to service users. We consider this a case in which there is a public protection issue because of the combination of poor practice and dishonesty. A failure to make a finding of impairment would risk the reputation of the social services workforce and its regulator. We consider that your fitness to practise is currently impaired.

Sanction

Panel's decision

114. In reaching its decision, the Panel took into account the findings in fact, decision on impairment, the evidence previously presented, all papers in the bundle, your submissions and those of the Presenter. It also took into account the Rules and the Decisions Guidance.

115. Having reached the view that your fitness to practise is currently impaired by reason of misconduct, we had to move on to decide on sanction. The factors we had to take into account were (i) the seriousness of the Worker's

impairment of fitness to practice; (ii) the protection of the public; (iii) the public interest in maintaining confidence in social services; and (iv) the issue of proportionality.

116. We considered each of the possible disposals in turn. It is not the kind of exceptional case in which taking no action would be appropriate. We considered a warning but the conduct, particularly the persistent dishonesty, means that a warning would not be an appropriate disposal. We considered imposing conditions, but there are no workable and enforceable conditions that would address the dishonesty. Conditions and a warning were not appropriate for the reasons we have given. This is not a case where a suspension with or without conditions would be appropriate. A period of suspension (with or without conditions) might be appropriate where there was insight and remorse. You do not have insight because you do not admit what you did was wrong.

117. Our view is that your conduct, in reattaching the clip, and then persistently denying having done so, is conduct fundamentally incompatible with being a registered social services worker. We recognise that making a Removal Order would affect your ability to work and make a living in the social series workforce, and we realise that it will be seen as marking you as being of bad character. Nevertheless, we consider that it is proportionate to make a Removal Order. The order is necessary for the protection of the public and to maintain the trust and confidence in the social services profession and the SSSC as the regulator of the profession.