

**IN THE CARE TRIBUNAL**

**M H**

**v**

**DEPARTMENT OF HEALTH SOCIAL SERVICES AND PUBLIC SAFETY**

**Before:**  
**J.A. Kenneth Irvine (Chairman)**  
**Isobel Elliott-Knox**  
**Sally O’Kane**

**6<sup>th</sup> – 9<sup>th</sup> September 2010**

**Application**

1. The Appellant appealed under Art.42(1)(a) of the Protection of Children and Vulnerable Adults (Northern Ireland) Order 2003, against the decision of the Department of Health Social Services and Public Safety to include her on the Disqualification from Working with Vulnerable Adults (DWVA list), and under Art.11(1)(a) of the said Order, against the decision of the Department of Health Social Services and Public Safety to include her on the Disqualification from Working with Children (DWC) List). Both these Decisions were dated 26<sup>th</sup> August 2009.

**Representation**

2. A Preliminary Hearing was held on 22<sup>nd</sup> April 2010 at which the Appellant was represented by Bobby Rea of Counsel (instructed by Campbell & Co., Solicitors) and the Respondent was represented by Denise McBride of Counsel (instructed by the Departmental Solicitor). At that hearing it was agreed that the appeal be dealt with by way of oral hearing to commence on 6<sup>th</sup> September and Tribunal directed accordingly. On 27<sup>th</sup> August 2010 the Appellant, through her Solicitors, requested that the oral hearing be dispensed with and that the matter be dealt with by the Tribunal on the basis of the papers. The Respondent, through its Solicitor, acceded to this request and accordingly further Directions were issued on 1<sup>st</sup> September 2010 providing that the appeal be so determined.

**Preliminary matters**

3. At the Directions Hearing held on 22<sup>nd</sup> April 2010 the Tribunal made the following Direction which was continued indefinitely at the conclusion of the hearing: That there be Restricted Reporting Order under Regulation 19(1), prohibiting the publication (including by electronic means) in a written

publication available to the public, or the inclusion in a relevant programme for reception in Northern Ireland, of any matter likely to lead members of the public to identify the applicant or any vulnerable adult. For this reason the names of all those referred to in this decision will be replaced by their initials.

### **The evidence**

4. Tribunal had before it a very substantial volume of papers – well in excess of two thousand pages – which included witness statements from numerous employees of the relevant Social Services Trust and from the Appellant, correspondence, minutes of disciplinary hearings (both of the Appellant and of a number of her co-workers), Appellant’s personnel file, care plans and other documentation relating to the vulnerable adult PM, handbooks and other guidance for dealing with vulnerable adults, notes of meetings and other relevant material.

### **The law**

#### **DWVA list**

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

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

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

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

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

#### **DWC list**

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

#### **Three stage test**

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

(i) that there was misconduct,

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

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

## **Definition of Misconduct and harm or risk of harm**

9. The Order does not define misconduct. However, in *Angella Mairs v Secretary of State* [2004] 269.PC the Care Standards Tribunal in Great Britain observed that 'misconduct could range from serious sexual abuse through to physical abuse (including inappropriate physical restraint) and/or poor child care practices in contravention of organisational codes of conduct'. They referred to the case of *Doughty v. General Dental Council* [1987] where misconduct was said to be 'a falling short, whether by omission or commission of the standards of conduct expected from members of [a] profession'.

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

## **Burden of proof**

11. The burden of proof is upon the Department.

## **Standard of proof**

12. The standard of proof is the civil standard, that is, the balance of probability, as defined in *Re H* [1996] AC 563: 'The balance of probability standard means that a court is satisfied an event occurred if the court considers that, on the evidence, the occurrence of the event was more likely than not.'

## **The facts and the evidence**

13. As the Appellant had opted to have the appeal determined without an oral hearing Tribunal did not have the opportunity of questioning her or of assessing her credibility or that of other witnesses. It therefore has had to form its conclusions on the basis of a careful reading of the documentation and extensive and detailed consideration of its contents.

14. The Appellant had been employed as a Home Care Worker by an area Health and Social Care Trust (and its predecessor bodies) from 13<sup>th</sup> August 1999. This work involved calling with elderly clients at their homes and giving them appropriate care. The precise work to be done is set out in Care Plans which are contained in a folder (a 'black book') held in the home of each client. These also contain a Manual Handling Care Plan which sets out instructions as to the manner in which the client is to be handled, for example, whether he/she is weight-bearing or needs the assistance of a Zimmer or rolator or a hoist and how many workers are required for each task. The workers operate in teams and in the relevant case the teams comprised two workers both of whom should be present in order to carry out the work safely and efficiently and in the stipulated time.

## **The Respondent's Evidence**

15. The issues before Tribunal primarily revolved around the treatment of a vulnerable adult, PM. The Respondent submitted seventeen Witness Statements, mainly from other employees of the Trust but also one from PM's son (PM himself along with his wife and daughter having since died). It also furnished Minutes of the Disciplinary Hearing and subsequent Disciplinary Appeal Hearing, and documents from Appellant's Personnel file and from PM's file.

## **The Appellant's Evidence**

16. The Appellant submitted a witness statement, her complete personnel file and the files in respect of Disciplinary Hearings relating to various co-workers who also dealt with PM. The bulk of this documentation was obtained under Discovery.

## **Assessment of the evidence**

17. From its perusal of the evidence Tribunal notes the sequence of relevant events as follows:

1. Appellant, born 2<sup>nd</sup> August 1966, has been a Home Care Worker since 1999. Prior to that she had worked in various private nursing homes. Her experience as a carer, by her own reckoning, spanned almost twenty-eight years.
2. During the period 2000-2004 various complaints about her work were dealt with by discussion with her superiors.
3. She attained NVQ Level 2 in 2003, this being a condition of her employment.
4. She was employed as a Home Care Worker by the Trust (and its predecessors) from 13<sup>th</sup> August 1999 (initially on a temporary basis but from 14<sup>th</sup> January 2000 as permanent staff) up to 17<sup>th</sup> December 2008 when she was summarily dismissed. Prior to 1999 she had worked as a Care Assistant in various nursing homes and also for the Trust's predecessors on a temporary/part-time basis.
5. She received Manual Handling Training in May 2000, March 2003, June 2004, May 2005 and June 2008.
6. She was part of the team providing home care for PM from 13<sup>th</sup> November 2007 to 25<sup>th</sup> January 2008.
7. Moving & Handling Care Plans for PM were prepared on 2<sup>nd</sup> October 2007 (i.e. just prior to MH's involvement with him) and 21<sup>st</sup> January 2008 (i.e. just prior to the termination of her involvement).

8. Various issues arose which led to a Disciplinary Hearing on 17<sup>th</sup> December 2008. Appellant faced four charges of misconduct:
  - i. Falsification of signatures on records;
  - ii. Claiming for travel when not using car;
  - iii. Non adherence to manual handling;
  - iv. Non-attendance to client in line with rota.

The first three charges were found proved and the fourth not proved. There was a finding of gross misconduct on the ground that she had claimed travel expenses falsely and she was summarily dismissed.

9. A Disciplinary Appeal Hearing on 24<sup>th</sup> February 2009 confirmed this finding.

10. The Trust referred her to the Respondent Department under the terms of the Order and DWVA and DWC Listing was confirmed on 25<sup>th</sup> August 2009 and notified to Appellant on 26<sup>th</sup> August 2009.

11. She appealed against the listing on 24<sup>th</sup> November 2009.

18. The Trust was responsible for the provision of home care to PM who was 94 years old. MH's team commenced his care on 13<sup>th</sup> November 2007. He was a complex case and required a 'double rota service', i.e. service by a team of two care workers, three times a day.

19. The duties were set out in the Care Plan dated 2<sup>nd</sup> October 2007 as follows:

**Personal Care**  
**10.15 - 11.00hrs**  
**Mon - Sun**

- Attend to catheter care
- Dispose of used incontinence pads appropriately.
- Body-wash, apply prescribed cream as instructed and E45 as necessary
- Dress
- Transfer from bed by Hoist to commode chair. Then wheel to toilet. When finished, transfer to sitting-room by commode chair and hoist from commode chair to arm chair.

**Toileting**  
**15.00-15.30 Mon-Sun**

- Hoist from armchair into commode-chair and transfer to toilet.
- Sometimes P[] wishes to go to bed at this visit or he may wish to be returned to sitting-room.

**Personal Care**  
**19.30-20.00 Mon-Sun**

- Hoist into commode-chair and transfer to bathroom
- Undress, body-wash and apply prescribed cream as instructed and E45 as necessary.
  - Use incontinence pads as required for overnight protection

20. CMcC, Home Care Officer, stated that given the nature of PM's condition all of the allocated time would have been necessary in order to carry out the

stipulated duties.

21. The Moving and Handling Care Plan prepared on the same date clearly stated that two people were required to carry out all of the transfer tasks. The further Moving and Handling Care Plan prepared on 21<sup>st</sup> January 2008 reiterated the requirement for two people to be involved and for PM to be moved by hoist.

22. Concerns had arisen as to the care provided to PM. CMcC, in her Statement for Tribunal, recorded a visit to Mrs. M.:

Mrs M[] M[] went on to state that M[] H[] picked Mr P[] M[] up on her own one day to put him into the wheeled chair and nearly fell into the hearth with him. I asked Mrs M[] what the other Home Care Worker was doing. Mrs M[] stated that the other Home Care Worker was not there yet and M[] H[] would not wait. A record of Mrs M[]'s responses was also included in my report dated 18 January 2008, as appended hereto and marked "CMcC3". No form of bodily lifting is permitted under any circumstances as there is risk to both the client and worker.

23. The report dated 18<sup>th</sup> January is a record of a meeting which CMcC held with PM and his wife at their home on 16<sup>th</sup> January 2008. The report is signed by both CMcC and Mrs. M. The relevant section of the report reads:

Sure M[] H[] picked P[] up on her own one day to put him into the wheeled chair and nearly fell into the hearth with him. My daughter-in-law saw it and said - did you see that"? I said "what was the other HCW doing"? Mrs. M[] answered "Oh she wasn't here yet and M[] H[] wouldn't wait." When the family members discussed this incident later her son said that they should be using the hoist.

24. PN, who was a member of the Panel which considered Appellant's representations regarding provisional listing on the DWVA and DWC lists, prepared a memorandum following his assessment of the evidence before the panel and this memorandum was made available to Tribunal. MH made much of the alleged lack of clarity in the instructions available to the care team as to the handling of PM. PN's note states:

Care planning and associated material available consistently show the need for 2 workers and the requirement to use a hoist in transfers from bed to commode to chair and vice versa and provide very precise guidance on use of the hoist (Moving and Handling Plans of Care Appendix M and Appendix O in TAB 4b). It has been confirmed that all care planning and associated documentation were available to care workers in the home (the manager conceded that she wrongly had not consulted the documentation when she provided cover on 5.1.2008, when she first became aware of family discontent). An inconsistency in the documentation re the use of a rolator was highlighted in the hearings but it seems accepted that this piece of equipment was not actually in the house in any case.

25. The note continues with PN's assessment of Appellant's evidence to the Disciplinary Hearing and Tribunal is happy to adopt his summary:

Ms H[]'s testimony is uneven throughout. She moves from a position of always reading care plans and associated documentation to not having read them in Mr M[]'s case, to the reading his care plan but not his manual handling information but gave an indication that she had read the work programme (which included manual handling information). Similarly, she moved from always using equipment provided to but not in Mr M[]'s case. Explanation varies from never advised to use the equipment to they asked Mrs. M[] what her husband needed done to she was following the District Nurse's lead and guidance. When questioned, all of the nursing team indicated that they had never advised that Mr M was weight bearing therefore the hoist was not required. The nurse named by Ms H[] indicated that her 5 June 2007 risk assessment (Appendix G in Tab 4b) indicated a hoist was not required as Mr M was mobile, he used to walk with a Zimmer frame prior to his hospital admission (later in June). She indicates that she did not advise Home Care Workers with regard to manual handling at this time. A subsequent risk assessment (Appendix M, TAB 4B) is signed by AMcK and dated 2.10.2007; it provides specific guidance on the use of the hoist and transfer sling from bed to chair and vice versa. An updated risk assessment (21 January 2008) (Appendix O in Tab 4b) reaffirmed the need for a hoist for all transfers; management insist this was conveyed to staff and was available in the home, yet on 24th and 25th January 2008, Mrs. M[] reported to Mrs. McC[] that staff were still not using the electric hoist.

Ms H[], by her own testimony indicated "that she only visited the client for ten minutes for a visit which was to last thirty to thirty-five minutes" (Tab 6 Page 9). She offered by way of explanation that "it maybe took ten minutes to empty Mr M[]'s bag then she would be talking to Mr M[]". Nowhere does the Care Plan limit activity to the emptying of the catheter bag and no less than 30 minutes is allocated for any single visit. Indeed, Mrs. McC[] reports Mr. M[]'s case as "complex" and indicates that "given the nature of Mr. M[]'s case the Home Care Workers would have needed all the allocated time to carry out their duties". Mrs. McC[] replaced the rota team "owing to further deterioration re. Home Care Workers and their relationship with Mr. and Mrs. M[]\* - evidenced by the distressed emotional state of both client and carer". It is reported that Ms M[] was "not the easiest to deal with and was difficult" (TAB 5, P14) but that other workers would have talked to their manager about this. Mrs. McC[] indicated that the client did not complain to her either before or after this rota team (TAB 5, P14).

26. In fairness to MH, it is appropriate to quote extensively from her Statement for the Tribunal:

4. The six person Care Team of which I form part had been asked in November 2007 to include in our Client List the M[] Family. I understand that the previous Care Team had been asked to leave due to differences of opinion with the M[] Family regarding treatment and care of Mr. P[] M[]. I

understand complaints were then made by the M[] Family regarding the Care Team of which I formed part and as a result an investigation was commenced by my employers.

5. Following a Disciplinary Hearing in December 2008 my employers found, inter alia, that I did not adhere to the Manual Handling requirement involving the care of Mr. M[] in that I failed to use a hoist. I accept the factual basis of that finding but as a result of the finding I was placed on the "Disqualification from Working with Vulnerable Adults List" pursuant to the provision of the Protection of Children and Vulnerable Adults (NI) Order 2003.
6. The inclusion on such a list is a wholly disproportionate response. There was no clear guidance given regarding the issue of using a hoist or otherwise and there was certainly confusion as to the mobility or otherwise of this Client. There is a Care Plan Provision for usage of a rolator as well as a hoist - both pieces of equipment represent two different levels of mobility. I also maintain that certain instructions and advices were given by nursing and other staff concerning the use of the hoist and that others also failed to use a hoist in the care of this patient. This confusion is self evident from the fact that my employers felt the need to carry out a fresh risk assessment as to the requirement for a hoist on 21st January 2008. On 25<sup>th</sup> January 2008 my employer replaced the Care Team looking after Mr. M[].

27. Tribunal carefully considered the points made by MH. It notes that so far as the manual handling issue is concerned, she states, 'I accept the factual basis of that finding'. She, however, goes on to say that,

There was no clear guidance given regarding the issue of using a hoist or otherwise and there was certainly confusion as to the mobility or otherwise of this Client. There is a Care Plan Provision for usage of a rolator as well as a hoist - both pieces of equipment represent two different levels of mobility. I also maintain that certain instructions and advices were given by nursing and other staff concerning the use of the hoist and that others also failed to use a hoist in the care of this patient.

28. PM was in hospital from 14<sup>th</sup> July 2007 to 4<sup>th</sup> October 2007. It appears that prior to his hospitalization it had been possible to move him by use of a Zimmer frame. A Risk Assessment carried out on 5<sup>th</sup> June 2007 acknowledged this. However, when he returned home he was no longer weight-bearing and his hospital discharge Care Plan dated 25<sup>th</sup> September 2007 stipulated that a hoist must be used and two workers be used for all transfers. A double rota now became necessary. In passing, Tribunal also noted that while Appellant states that, 'There is a Care Plan Provision for usage of a rolator', it could not find any such provision in the Moving and Handling Care Plans, certainly for those in the relevant periods.

29. Tribunal examined the Care Plans for PM contained in his file and also studied the statements of the various nurses involved with PM's care. The manual handling sections of the Care Plans, both that dated 2<sup>nd</sup> October 2007 and that dated 21<sup>st</sup> January 2008, are manifestly clear in stating that PM is to be moved using a hoist. The nurses, in their Statements for Tribunal, all categorically deny ever advising against the use of the equipment which was stipulated and which was there on the premises to be used. Even if she did

not read the Care Plan (which her duties required her to do) Appellant, as an experienced care worker, should have realized that if an expensive piece of equipment such as a hoist were in the house it was there because it was necessary to use it. Appellant argued that the fact that a further Risk Assessment was carried out in January 2008 was evidence of the prior confusion. Tribunal concluded that the Assessment was carried out not because it was objectively necessary but because the Trust wished to make sure of the situation in the light of MH's statements as to time and equipment required for proper care of PM.

30. The Appellant points out that other members of her team were also charged with failing to adhere to manual handling requirements and that none of them were 'placed on a disqualification list'. She considered this to be 'unfair, arbitrary and in all the circumstances unjust'. Upon Discovery by the Appellant the records of the Disciplinary Proceedings in respect of the other members were furnished to Tribunal and were perused by it. However, regardless of whether or not there is any unfairness in relation to the other members, Tribunal cannot be concerned with the position of third parties; it must direct its mind to the statutory issues involving the Appellant.

31. The Disciplinary Hearing had also dealt with allegations that Appellant had falsified records both by signing work sheets for colleagues who were not present and by claiming traveling expenses not actually incurred. She admitted these offences at the Disciplinary Hearing and it was on account of the false claims that she was found guilty of gross misconduct and summarily dismissed. Her admission of dishonesty in this context can justify a Tribunal in viewing her other evidence with some caution.

32. It is necessary to consider the allegations in the context of the teams who attended to PM both before that including MH and that which succeeded them. The teams both before and after kept full records of what they did for PM, how he was moved and what toileting had been carried out; it would appear that they quite often exceeded the stipulated times when they found it necessary to do so. The MH team frequently spent less than the allocated time with PM, claiming that it was not necessary and that (for example) PM did not want to open his bowels. They tended not to specify in the Work Record Sheets the work done, merely noting 'morning routine', afternoon routine', 'night routine' etc.

33 MH, in her Statement, said, 'I understand that the previous Care Team had been asked to leave due to differences of opinion with the M[] Family regarding treatment and care of Mr. P[] M[].' However, the statement made by CMcC, MH's Home Care Officer, shows that this change was part of a general restructuring of the teams which she managed. There is no record of any complaints by clients or families about the previous team. It was acknowledged by CMcC that Mrs. M could be 'difficult' and 'was not the easiest to deal with' but she told the Disciplinary Appeal Hearing that Mrs. M had not complained about the previous rota team and had not complained since the team had been changed. Indeed, the records show that PM and his wife subsequently expressed themselves content with the care provided by

the new team. The Client Contact Sheet dated 15<sup>th</sup> April 2008 records a visit by CMcC to the M's and notes, 'Both appear to be in v. good form. Home care service being delivered satisfactorily now.'

34. The point was also made that if the MH team found that the time allocated was unnecessary then they should have reported to their line manager so that it could be reallocated to another client. It was also noted that they would appear not to have reported to the manager any concerns about PM or his family. CMcC told the Disciplinary Appeal Hearing that the other Homecare Workers would have come and spoken to her if they had any concerns.

35. Tribunal is satisfied on the evidence before it that there was misconduct by Appellant in at least two respects: (1) in that she failed to adhere to clear instructions regarding manual handling and (2) that by cutting short the times of visits she deprived a vulnerable adult of the care to which he was entitled and which he required. The risks involved in inappropriate manual handling are self-evident and are exemplified by the incident recited above where it appears that a fall was narrowly avoided. Tribunal feels that there are also potential serious dangers involved in depriving an elderly person of adequate time for bowel movements and that by so doing she placed PM at risk of harm. Mrs. M had reported to CMcC that P is 'restless all night if he doesn't get his bowels open.' In February, after the team had been changed, the work record indicated that PM was then having regular bowel movements.

### **Suitability**

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

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

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

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

d. In *Kathleen Jackson v Secretary of State* [2005] 623 PVA the Tribunal

concluded its consideration: 'This leads us to consider the issue of suitability. We have considerable sympathy with the Appellant because she is a woman who has spent most of her working life in the care sector; she has gone to the trouble to get qualifications and she has achieved senior care status. However the very fact that she has had this training and was a senior carer and went on to behave the way she did raises questions about her suitability to work with vulnerable adults.'

38. In *GC v. Department of Health Social Services and Public Safety* 2006/4PC & 2006/4PVA this Tribunal stated, 'We take the view that the appellant simply does not comprehend the nature of the risk to vulnerable adults his actions have caused or would be likely to cause. The public at large and those who find themselves in situations where care is required have a right to expect, indeed to demand, that such people who are placed in such important positions of trust working with vulnerable adults are beyond reproach.'

39. In her Statement to Tribunal as in her original Notice of Appeal Appellant showed a complete lack of appreciation of the seriousness of the possible consequences of her actions or inactions. In her appeal notice she spoke of 'the accepted practice amongst the care workers' as regards the non-adherence to manual handling requirements and further that the signing practice was 'subject to widespread, known and endorsed practice.' There was no evidence before Tribunal of any such widespread or accepted practices and certainly the indication in the evidence was that the practice was to adhere to proper procedures. Even if that were not the case, Tribunal is of the view that it would not excuse conduct which placed a vulnerable adult at risk.

40. The Appellant was a lady of mature years with considerable experience in the care field. She had gained an NVQ level 2 and had undergone extensive and repeated training in manual handling techniques. Indeed, it is noted that in her job applications as far back as 1999 she was making a point of her training in manual handling. She should have been aware of the necessity to adhere to proper manual handling practices as laid down in PM's care plan and should have been aware that the full time allocated to him would have been necessary and should also have been aware of the risks involved in the failure to allow adequate time for regular bowel movements.

41. In her Contract of Employment, which she signed, there was a provision regarding health and safety matters:

#### Health and Safety at Work

Whilst at work you must take reasonable care of the health and safety of both yourself and others with whom you come into contact and who could be affected by your work. You must also comply with the health and safety rules and procedures appertaining to your job and undergo training provided. You must also comply with the Trust's Smoking Policy.

Failure to take reasonable care of the Health and Safety of yourself or others will constitute a disciplinary offence.

42. In her Statement she said, 'I have never been the subject of formal disciplinary proceedings. I accept the fact that there was [*sic*] instances when I received advice and counselling from Line Managers and these are documented in my Personnel File.' It is indeed correct that she had never previously been subjected to disciplinary proceedings but there are numerous instances over the years which are documented in her file where she had been interviewed by management in respect of complaints made by clients including failing to turn up for appointed duties and also frequent or prolonged periods of sick leave. It was further noted that she had failed on numerous occasions to attend meetings with Occupational Health after periods of sick leave and had frequently failed to reply to correspondence.

43. The fact that Appellant has been found guilty of false timekeeping and false accounting for travel expenses raises issues of trust. It is essential that care workers, in particular home care workers who, by definition, go into the homes of vulnerable clients, should demonstrate the highest standards of integrity. Appellant has also fallen short in this respect.

44. Tribunal feels that the Appellant has shown a lack of appreciation of the seriousness of her situation and an inability to try to understand her failings and to improve upon her performance. In her Statement to the Tribunal she showed a total failure to acknowledge that anything was seriously wrong with her conduct and that it had placed the client at risk.

45. Given the nature of her actions, Tribunal believes that public confidence in the provision of services to children would be undermined if she were permitted to work with children given the fact that she is unsuitable to work with vulnerable adults. Tribunal cannot be confident that Appellant would act differently if given a position of trust in relation to children. It therefore concludes that she is also unsuitable to work with children.

### **Decision**

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

**Appeals dismissed.**

**J.A.Kenneth Irvine (Chairman)**

**Isobel Elliott-Knox**

**Sally O'Kane**

14<sup>th</sup> September 2010