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	Lorna Allan
Registration number	3032274
Part of Register	Support Workers in a Care Home Service for Adults
Current or most recent town of employment	Edinburgh
Sanction	Warning to stay on your registration for a period of 60 months
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 warning 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 at the hearing were that on or around 3 May 2019 while employed as a Social Care Assistant by City of Edinburgh Council at Drumbrae Care Home in Edinburgh, and during that employment, you did, in relation to service user AA:

    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

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

Representation

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

6. You were represented by [information redacted], Thompson's Solicitors (your representative).

Findings of Fact

7. You admitted certain facts in a statement of agreed facts. The crucial admissions were that you and your colleague were both responsible for completing a 'tug-test' on all four clips to check that they were attached before using the hoist to lift AA and that your failure to check that all four clips were attached to the hoist contributed to AA falling from the hoist to the floor.

8. We heard the evidence in your case at the same time as that in the related case of ZZ. The findings in fact applied to both cases.

9. In the event, for the reasons set out below, we found all of the facts alleged against you to be proved.

10. 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.

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

12. Since 20 October 2014, you have been registered on the part of the Register for Support Workers in a Care Home Service for Adults (hereinafter referred to as SWCHSA). You were a registered Worker on 3 May 2019.

13. You have been employed by City of Edinburgh Council since 2004 and have worked at [information redacted] since 15 November 2021.

14. Since 4 February 2016, ZZ (ZZ) was registered on the part of the Register for Support Workers in a Care Home Service for Adults (SWCHSA). He was a registered Worker on 3 May 2019.

15. 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. [information redacted]. [information redacted]. She relied on assistance for the tasks of daily living.

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

17. You were on the permanent staff at Drumbrae Care Home. You worked there for many years.

18. ZZ was an agency worker assigned to work at Drumbrae that day by ASA.

19. 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.

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

21. 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 a hoist. We will refer to the operation involved in getting AA from the bed to the wheelchair as "the lifting operation".

22. 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.

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

24. 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.

25. 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.

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

27. 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 you and ZZ 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.

28. 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.

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

30. The sling used by you and ZZ 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.

31. 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.

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

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

34. 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 Workers 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.

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

36. 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. You attached the hooks at the end of the straps over the lugs near AA's left shoulder. It snapped into place. You did the same thing with the clip on the strap on the leg section.

37. At about the same time, ZZ was engaged in the same task on the other side of AA. He 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.

38. ZZ then tried to attach the strap on the section of the sling supporting AA's right leg. He did not put the clip on the strap securely over the lug. But whatever he did created the visual impression, from your vantage point, that the clip was over the lug. The strap must have been hanging down vertically from a point close to the lug. You 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 ZZ, put the loop over the lug.

39. At the start of the lifting operation, you were to AA's left and ZZ was to her right. You 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.

40. Before ZZ took up position at the foot of the bed near AA's feet, where he ought to have been, you, without warning ZZ, operated the hoist and AA, in the sling, started to rise from the bed. At that moment, ZZ was not

attending to AA and was not in position. He noticed that you 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. ZZ moved to try and place his hands on AA's feet to prevent them getting into contact with the bedrail. We do not make a finding about whether he actually touched AA's feet and ankles or whether he took the weight of her left leg or foot.

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

42. The lifting operation controlled by you 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 ZZ was 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.

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

44. The control of the movement of the hoist was at all times in your hands. You also controlled the bed.

45. 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 ZZ had attended to - was flapping free.

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

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

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

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

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

51. XX left, then VV, the [information redacted], arrived at the room. ZZ was in AA's room, near the room door. She spoke to him. She asked whether he had been trained. He said yes. He also mentioned that he had worked for [information redacted]. She asked him to go and do other work.

52. 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].

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

54. Both you and ZZ 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 you had conducted a tug test on the straps on ZZ's side of the hoist. It would likely have been prevented if she had gradually raised the hoist above the bed.

55. 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.

56. Your representative and the SSSC agreed certain facts in a statement of agreed facts. The agreement was not binding on ZZ. We did not think it right to encourage ZZ to agree to facts unless we were convinced that he knew the consequences. This meant that the Presenter led more evidence, more slowly than she would have done had ZZ 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>

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

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

59. ZZ was adamant that he was sufficiently trained and knew what he was doing with the Arjo hoist and Silvalea sling. He was very careful to make clear to the Panel that he 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.

60. 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.

61. 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. ZZ did not dispute that the plan was appropriate, and the equipment was suitable, sufficient and in good repair.

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

<u>Hearsay</u>

63. 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.

64. 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. You accepted that the statements were, in the circumstances, admissible although subject to the weight to be given to them. ZZ referred to the statements given by YY when he examined other witnesses. He pointed out that in a statement made to her employer on 19 November 2020 (55), she said it was normal for you to be grumpy. He did not oppose the hearsay application. We decided to admit the hearsay evidence of YY.

65. In her handwritten statement on 3 May 2019, YY appears to be saying that when she got to the room, you 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 your position.

66. 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. You 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. ZZ, referred to the statements given by SS when he examined other witnesses. He did not oppose the hearsay application. However, we noted that when he gave evidence, and on other occasions, ZZ said that the HSE statement was not, in all respects, an accurate note of what he had told SS. Accordingly, we have placed no weight on the statement given by him to HSE.

67. In the same way, because the police officer who took ZZ's statement was not called, and ZZ said that it was not accurate, we have placed no weight on the statement he gave to the police.

68. The legal advice given by the Chair about fact 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.

69. 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.

70. 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.

71. 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 you or ZZ's positions, 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.

72. 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.

73. 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.

74. 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.

ZZ's position

75. ZZ says that the hooks that he attached were securely in place. He says that he did not see the fall but reckons that AA was ejected from the head end of the sling. He says that he thought that the sling was flat when she fell out.

76. In his personal statement form (676) he said that you operated the wrong button which led to the incident and the bed itself was too high.

77. ZZ's 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 you 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.

78. ZZ denies that he reattached the clip when you went out of the room.

Your position

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

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

81. We think you were probably working that way because you were not happy about having been paired with ZZ and were in a rush. Your evidence was that at the start of your shift when you were paired with ZZ, you mentioned the skills mix to her supervisor. As you explained in evidence, personal

care tasks would take longer when you were paired with ZZ because some female residents did not want a man to attend to them.

ZZ’s handwritten statements

82. When deciding what happened we considered ZZ’s handwritten statements. Not long after AA fell, ZZ was asked to give a statement. XX asked him if she could take his statement, but he said that he would rather write it out. He did so.

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

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

85. The second statement (313) was written and signed on 8 May 2019, said that “everything was in place”. He added that when he saw the sling rising up, he saw you 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 his position that you went ahead without making sure he was in position. He continued that he moved from his side to control AA’s feet and as soon as the feet “passed the bed”, AA fell down. He said that “looking up, everything was in place”. His position is that AA fell from the sling even though it was attached at four points to the hoist. He continued “Lorna asked me … ZZ 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”. He continues, “So she [you] started crying and went to call YY”. He then says that the alarm was sounded. He ends by saying that “we checked the sling and the hoist, but nothing was wrong”.

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

87. You admit that you were to blame for not checking the clips on both sides.

What happened

88. 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.

89. 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. ZZ's evidence was that when he attached (or thought he had attached) his clips, AA was properly positioned on the sling, with her shoulders in it. That being so, even if you 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 you 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.

90. 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.

91. 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 ZZ 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 ZZ 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.

92. 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. ZZ was adamant that AA fell from the sling with all four points attached.

93. A further difficulty for ZZ's account is that in oral evidence he never gave a clear and consistent account of how AA came to be ejected from the head end of the sling. On his own evidence, he was near AA's feet when she fell, and it is difficult to understand how he could not have clearly seen what happened. In the end, we took the view that the reason he could not give a clear and consistent account is that AA fell feet first.

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

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

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

97. We accept ZZ's evidence that you 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. You did not let ZZ take up position. His written statement (308) mentions you trying to do the lift with one hand. That you were rushing is consistent with her having been unhappy about the staff allocation earlier in the day. In evidence, you said there was more work for you if you were paired with ZZ. 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. You did not tug-test ZZ's clips. You did not lower and profile the bed. You went ahead before ZZ was fully in position.

98. 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>

99. ZZ says you are lying when you say that the reason for the fall was that the leg clip that ought to have been fixed by ZZ was not attached or became detached during the lifting operation.

100. ZZ's evidence was that, as an agency worker, he was an outsider and, right from the start, the permanent staff put their heads together to put the blame on him.

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

102. XX denied that she had been involved in a conspiracy to blame ZZ. We note that when she gave evidence, she did not try to spare you 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 ZZ alone. She gave ZZ the opportunity to put his account in writing on the day of the event.

103. 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.

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

105. We note that when VV arrived in the room she said, "We are here to support our colleagues", or something like that. ZZ says the phrase supports his argument that permanent staff conspired against him. He says that he was not one of the colleagues because he was agency staff. We do not think that phrase carried that meaning.

106. 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.

107. 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 ZZ. She did not spare you 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.

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

109. ZZ's 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 you, ZZ and YY. XX typed her statement.

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

Impairment

111. You did not admit that your fitness to practise is currently impaired. We heard submissions from the Presenter and then from your representative.

112. Your representative submitted that whatever the situation on 3 May 2019, your fitness to practise was not presently impaired. She pointed out that you had been taken off hoist duties for around two years but had then been retrained, returned to work, and worked without incident since then.

113. We decided that what happened on the day was misconduct. Your failure to manually make sure that all points were attached using a tug-test was a failure to carry out a safety-critical task that had very serious consequences. It was made worse by the fact that you had the bed too high and did not begin the operation by lowering the bed. You also started the lift before your colleague was ready. Your communication with your colleague was poor. Your conduct fell short of the standards set out in parts 4.3, 5.1, 5.7 and 6.1, of the Code.

114. We accept that you are remorseful and have insight into what went wrong. You have cooperated and accepted blame for your part in the incident from an early stage. You have been retrained. We have received positive references for you.

115. When deciding whether there is current impairment, the law requires us to look at the seriousness of the conduct, the risk of repetition, the protection of the public, and the interest in maintaining public confidence in the profession and its regulator. Accordingly, even after nearly five years of being back at work and retraining, and taking into account your insight and remorse, this case demands that we make a finding of current impairment because of the seriousness of what happened and the need to maintain public interest in the profession and its regulator. A well-informed member of the public would expect a professional regulator to act where a Worker's misconduct had contributed to a death.

Sanction

116. Having made a finding of current impairment, we moved on to consider sanction. This was not the kind of exceptional case where we could make no order. The recognition of the public interest requires more than that. The Presenter suggested that a warning to remain on your Registration for five years would be appropriate. We noted that but went on to consider the other options. We did not think there was a focus for conditions. This

ruled out a warning and conditions. As for suspension and suspension and conditions, we did not think that this is the kind of case where suspension, necessitating time out of the workplace to reflect or improve before returning to work, was appropriate. You had reflected for five years on what you had done. We considered removal. There are some cases where an individual must suffer removal in order to protect the collective reputation of the profession, even though the removal would have harsh consequences for the individual. This is a case where your carelessness has led to a death. Put in those stark terms, removal might seem to be justified. We drew back from removal on the grounds that it would not be proportionate; the public interest could be met by giving you a warning to stay on your record for five years. According to your references, you are and have been, with the exception of this one occasion, a caring and diligent Worker. You have had the chance to demonstrate that over the years since the incident. You are now safe to carry out hoisting tasks. There is a public interest in keeping people who have a good past record and references in the profession to do good for others in the future.