Section 29 Case Meeting

23 March 2021

157-197 Buckingham Palace Road, London SW1W 9SP

Members present
Alan Clamp (in the Chair), Chief Executive, Professional Standards Authority
Mark Stobbs, Director of Scrutiny & Quality, Professional Standards Authority
Kisha Punchihewa, Head of Legal, Professional Standards Authority

In attendance
Michael May, Solicitor, Legal Advisor, Edwards & Co Solicitors

Observers
Kellie Moorwood, Solicitor, Edwards & Co Solicitors
Rachael Martin, Team Coordinator, Professional Standards Authority

1. Definitions

1.1 In this meeting note, standard abbreviations have been used. Definitions of the standard abbreviations used by the Authority, together with any abbreviations used specifically for this case are set out in the table at Annex A.

2. Purpose of this note

2.1 This meeting note records a summary of the Members' consideration of the relevant decision about the Registrant made by the regulator's panel, and the Authority's decision whether or not to refer the case to the court under Section 29 of the Act.

3. The Authority's powers of referral under Section 29 of the Act

3.1 The Authority may refer a case to the relevant court if it considers that a relevant decision (a finding, a penalty or both) is not sufficient for the protection of the public.

3.2 Consideration of whether a decision is sufficient for the protection of the public involves consideration of whether it is sufficient:

- to protect the health, safety and well-being of the public
- to maintain public confidence in the profession concerned, and
- to maintain proper professional standards and conduct for members of that profession.

3.3 This will also involve consideration of whether the panel's decision was one that a disciplinary tribunal, having regard to the relevant facts and to the object of the disciplinary proceedings, could not reasonably have reached; or was otherwise manifestly inappropriate having regard to the safety of the public and the reputation of the profession (applying *Ruscillo*[1]).

4. Conflicts of interest

4.1 One of the Members declared that on reading through the exhibits considered by the panel at the HCPC hearing she recognised the name of a former colleague and friend who is a HCPC employee on an internal email. The Member noted that this individual had no decisive involvement in the case. The Members concluded that in the circumstances there was no conflict of interest.

5. Jurisdiction

5.1 The Legal Advisor confirmed that the Authority had jurisdiction to consider the case under Section 29 of the Act. Any referral in this case would be to the High Court of Justice of Northern Ireland and the statutory time limit for an appeal would expire on 26 March 2021.

6. The relevant decision

6.1 The relevant decision is the Determination of the Panel following a hearing which concluded on [redacted].

6.2 The Panel's Determination which includes the charges and findings is set out at Annex B.

7. Documents before the meeting

7.1 The following documents were available to the Members:

- Determination of the Panel dated [redacted]
- The Authority's Detailed Case Review
- Transcripts of the hearing dated [redacted]
- Legal report by Edwards & Co Solicitors dated [redacted]
- CPD documents
- Final hearing bundle
- Hearing outcome letter
- ICP Bundle
- ICP Decision

[1] CRHP v Ruscillo [2004] EWCA Civ 1356

- Registrant's bundle
- Link to newspaper article regarding the registrant
- The HCPC's Indicative Sanctions Guidance
- The Authority's Section 29 Case Meeting Manual

7.2 The Members and the Legal Advisor were provided with a copy of a response from the HCPC to the Authority's Notification of s.29 Meeting.

8. Background

8.1 The allegations arose during the Registrant's employment as a Paramedic with the Ambulance Service Health and Social Care Trust. The Registrant notified the HCPC on that he had been involved in a road traffic collision on and that the matter was pending further investigation. In an email of , he confirmed to the HCPC that he had not been at the time of the traffic collision.

8.2 Following enquiries with the Registrant's employer it was confirmed that on the Registrant arrived at the Ambulance Station for a 8:30pm shift and was observed to have been driving erratically and was noted . Concerns were raised by a colleague and subsequently escalated to the Acting Station Officer. The Registrant was attending a patient in a hospital emergency department when Colleague 1 arrived and spoke with the Registrant. Colleague 1's evidence was that the Registrant had a glazed look and was walking slowly and in an unsteady manner . When asked whether he had been , the Registrant confirmed that he had The Registrant was asked to cease his duties and was taken home. The Registrant was suspended on pending further investigation and was subsequently redeployed as an Ambulance Care Attendant.

8.3 On , the Registrant was driving his daughter to a gymnastics class at and lost control of the car, which landed on its roof in a hedge. The Registrant left the scene of the accident and returned home. The Police visited him at home at and took him to the station where he was . A subsequent . The Registrant was convicted on a guilty plea on and was disqualified for 16 months (with the option of reducing the period to 12 months on completion of an approved course) and fined £250.00.

8.4 At the start of the HCPC hearing the Registrant made an application for the matter to the transferred to the . This was opposed by the HCPC and declined by the Panel.

8.5 The allegations considered by the Panel were in relation to his conviction for . The Panel found the statutory grounds of misconduct and conviction were well founded. The

Panel found that the Registrant's fitness to practise was impaired on the public component only and imposed a caution order for 3 years.

9. Applying Section 29 of the 2002 Act

9.1 The Members considered all the documents before them and received legal advice.

9.2 The Members discussed the following concerns about the decision:

The HCPC's Investigation

9.3 The Members were concerned that the HCPC had failed to fully investigate the Registrant's . The Members noted the absence of any independent expert evidence which would give an opinion on matters such as the . Neither was there any evidence before the Panel in terms of tests to confirm the Registrant's .

9.4 The Members were mindful that the length of

9.5 The Members were therefore concerned that the HCPC had not instructed independent to examine the Registrant at the investigation stage in order that the HCPC could have made an informed decision on the appropriate charges to bring. The Members noted that are matters which require specialist input and that staff who are not qualified do not have the relevant expertise to conclude whether a Registrant has a impairing . The Members therefore felt that the Panel had limited solid evidence to support their finding that was not a concern which led them to make a finding of not impaired on the personal component.

9.6 The Members were mindful that the HCPC's approach in relation to cases was not in line with other regulators in that they did not automatically request that a Registrant be . The Members considered that a more proactive approach in relation to such cases and request for would ensure that thorough investigations were undertaken and that if a matter is referred for a final hearing, Panels were tooled with sufficient evidence on which to make their findings.

9.7 The Members were mindful that as they did not have a copy of the investigation plan it was difficult to know exactly what evidence was taken into account by the IC. Therefore, given the absence of any charge relating to a and the absence of any express reference to a in the IC decision the Members concluded that this factor was not taken into account by the IC. The Members considered whether this was an appropriate decision. They acknowledged that the Registrant provided considerable information to the HCPC which was before the Panel, but what was clearly missing was an independent giving an opinion on the Registrant's current fitness to practise based on a tests.

9.8 The Members noted that a letter from a , following a request from the HCPC to provide information on the Registrant's , provided some information about the Registrant's . The Registrant had attended the where the saw him. In that letter, which was sent in , the which she considered to be likely to affect his work if not managed appropriately. The also acknowledged in her letter that .

9.9 The Members felt that, whilst it was reasonable for the HCPC to have taken account of this letter, it did not provide sufficient evidence that should not have been an allegation in this case. The Members concluded that further independent assessment was required to support any decision and that given its absence the HCPC failed to adequately investigate this case before referring it to the IC and then a Panel.

9.10 The Members also felt that on receipt of this letter the IC should have been asked to consider referral to the given the future risk identified. The period of which was relatively brief at the time the letter was written.

9.11 The Members noted that the Panel had given credit to the Registrant's insight and credibility but were mindful that there were clear indicators within the evidence that the Registrant had concealed his for some time. The Members doubted whether the Panel were able to say that they could definitively conclude that the future risk the Registrant posed was currently being sufficiently managed. The Members considered that the HCPC had not gathered evidence to support such a finding, so the Panel did not have the basis to support its decision.

Lack of expert advice

9.12 As a result of the investigative failings, the Members were concerned by the lack of expert advice available to the Panel. The Panel was presented with results of various tests to determine the Registrant's current , but there was no analysis of these by independent experts. The Members were further concerned that the only evidence before the Panel about what was considered a normal range within the results submitted came from the Registrant.

9.13 The Members considered that the Panel failed to sufficiently scrutinise what evidence they did have before them given the lack of any objective evidence. The Members considered that in the circumstances, the Panel should have adjourned to seek independent advice from an expert witness.

9.14 The Members concluded that given the lack of expert advice to inform their decision making the Panel was not in a position to determine that the Registrant was fit to practice without any continued support or a requirement to continue to demonstrate and report to the HCPC.

Referral to the

9.15 The Members did not consider that it was appropriate to criticise the Panel's decision not to refer the case to the given that it had no expert evidence to support such a decision. However, the Members felt that this was clearly a case in that the misconduct and conviction were a consequence of the Registrant's and all three were interlinked.

9.16 The Members felt that the error in not referring the case to the appropriate Panel was a result of failings at the investigating stage. The case was routed incorrectly and the decision not to refer to the IC was made without sufficient support or evidence regarding the Registrant's current .

Potential undercharging

9.17 The Members considered whether the HCPC had undercharged the case since the allegations did not capture the fact that the Registrant whilst attending work under the had attended a call and treated a patient with a colleague. The Members were concerned that within the exhibits received from the HCPC there was no indication that this further misconduct was identified at the investigating stage and considered necessary to form part of the allegations.

9.18 The Members were deeply concerned about this aspect of the case since this has a clear and direct impact on public confidence and protection although they noted that there was no suggestion any harm was caused.

Conclusion on insufficiency for public protection

9.19 The Members concluded that the panel's decision to impose a 3-year caution order was insufficient for public protection. In reaching this decision the Members took into account

- (i) the registrant had what appeared to have been a longstanding and (ii) he had previously not taken steps to seek help and (iii) hid the from his family and colleagues
- given the context of this case the Panel was not presented with sufficient evidence in the form of expert advice to determine whether or not future risk was no longer a concern and that the Registrant no longer needed support to address his .

9.20 The Members were concerned that there could be risks in the Registrant continuing to practise and that assumptions and conclusions had been made at the investigating stage without expertise to support these. This led to the Panel having inadequate evidence to consider the future risk the Registrant posed and amounted to a serious procedural irregularity which meant the Members were unable to determine whether the outcome of the case was insufficient.[2]

[2] *Ruscillo* at [72]

10. Referral to court

10.1 Having concluded that the Panel's Determination raised concerns of serious procedural irregularity, the Members moved on to consider whether they should exercise the Authority's discretion to refer this case to the relevant court.

10.2 In considering the exercise of the Authority's discretion, the Members received legal advice as to the prospects of success and took into account the need to use the Authority's resources proportionately and in the public interest.

10.3 Taking into account those considerations, along with advice on the prospects of success, the Members agreed that the potential risk of harm was serious enough that the Authority should exercise its power under Section 29 and refer this case to the High Court of Justice of Northern Ireland.

10/11/21

Alan Clamp (Chair) **Dated**

11. Annex A – Definitions

11.1 In this note the following definitions and abbreviations will apply:

The Authority	The Professional Standards Authority for Health and Social Care
The Panel	Conduct and Competence Panel of the Health & Care Professions Tribunal Service
The Registrant	
The Regulator	HCPC
HCPC	Health & Care Professions Council
The Act	The National Health Service Reform and Health Care Professions Act 2002 as amended
The Members	The Authority as constituted for this Section 29 case meeting
The Determination	The Determination of the Panel sitting on
The Court	The High Court of Justice of Northern Ireland
The SP	Regulator's Sanctions Policy