Section 29 Case Meeting

1 December 2022

157-197 Buckingham Palace Road, London SW1W 9SP

professional standards authority

Lesley Margaret Rossle

Members present
Antony Townsend (in the Chair), Board Member, Professional Standards Authority
Christine Braithwaite, Director of Standards & Policy, Professional Standards Authority
Kisha Punchihewa, Head of Legal, Professional Standards Authority

In attendance
Fenella Morris, Counsel, 39 Essex Chambers

Observers
Rachael Martin, Scrutiny Team Coordinator, Professional Standards Authority
Dami Olatuyi, Accreditation Officer, Professional Standards Authority
Rebecca Senior-Carroll, Lawyer, Professional Standards Authority
Simon Wiklund, Head of Legal, Professional Standards Authority

This meeting was held remotely

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 The Members did not have any conflicts 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 England and Wales and the statutory time limit for an appeal would expire on 9 December 2022.

6. The relevant decision

6.1 The relevant decision is the Determination of the Panel following a hearing which concluded on 4 October 2022.

7. Documents before the meeting

7.1 The following documents were available to the Members:

- Determination of the panel dated 4 October 2022
- The Authority's Detailed Case Review
- Transcripts of the hearing dated 26 September 2022 – 4 October 2022
- Counsel's Note dated 29 November 2022
- Exhibits
- SWE'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 SWE to the Authority's Notification of s.29 Meeting. The Members considered the response having received legal advice and after they had reached a conclusion on the sufficiency on the outcome.

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

8. Background

8.1 At the material time the Registrant was working as an Advanced Practitioner and was allocated as the Safeguarding Co-Ordinator for concerns.

8.2 The allegations concern a failure to investigate safeguarding concerns in relation to Service User 1 (SU1). SU1 was an elderly woman with dementia and left side paralysis following a stroke. She was also nonverbal for a time and required full time care. SU1 resided in a Care Home.

8.3 Several concerns had been raised by professionals and SU1's daughter, Person A. The Registrant did not investigate the concerns and produced a report which blamed Person A. The Registrant also forwarded an email from Person A to the Care Home when Person A had asked her not to. This was a breach of confidentiality and potentially put SU1 at risk. This resulted in the Care Home blocking Person A from accessing SU1's records. The Registrant admitted this concern.

8.4 The Panel found all the concerns to amount to misconduct. The Panel found that the failure to undertake an appropriate safeguarding assessment of SU1 amounted to serious professional misconduct. The Panel characterised the misconduct as a series of failings to investigate and share conclusions with the CQC and other professionals.

8.5 The Registrant was found impaired on both public protection and public interest grounds. The Panel found an absence of insight and remediation in relation to allegation 1 and a failure to fully investigate safeguarding concerns in relation to SU1's standard of care at the Care Home. The Panel noted that the Registrant continued to blame others and appeared to have no recognition that her misconduct meant that SU1 continued to be exposed to a risk of harm. The Panel acknowledged that the Registrant had apologised for forwarding the email to the Care Home (allegation 2). The Panel assessed the Registrant to have partial insight in relation to this concern.

8.6 The Panel imposed a suspension order with review for 3 years on the basis that the misconduct was remediable in principle.

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:

Was the registrant's misconduct fundamentally incompatible with continued registration?

9.3 The Panel found the misconduct to be remediable in principle. This implies they did not consider it to be fundamentally incompatible with continued registration.

9.4 The Members felt that the misconduct was fundamentally incompatible with continued registration on the grounds of the demonstratable bias to the investigation and safeguarding failure. These activities were basic requirements of social work, and particularly in the context of a safeguarding investigation of a

vulnerable service user. Although a single incident, this was a serious case of misconduct in which the Registrant persisted with her conduct and continued to make unwarranted accusations against Person A.

Did the Panel have due regard to its seriousness?

9.5 The Members considered whether the Panel had fully grasped the seriousness of the misconduct. The Panel appeared to have reached an appropriate view of the seriousness when considering the allegations, but this thinking was not continued at later stages when considering sanction.

9.6 The Panel had failed to consider any aggravating factors or give a specific analysis of their findings addressing the seriousness. Had the Panel addressed mitigating factors it is possible that this would have concentrated their minds on the fact that a removal was appropriate. This failure was a contributory error which could have resulted in a different outcome.

9.7 The fact that the Panel considered the misconduct in principle remediable would also suggest that they did not have due regard to its seriousness. The Members considered that more was needed from the Registrant in terms of insight and remediation for the Panel to have reached a view that the misconduct was remediable.

Should SWE have drawn the Registrant's previous caution to the attention of the Panel at the sanction stage and had the Panel considered the caution, could it have made a material difference to the outcome?

9.8 The Registrant was given a three-year caution in 2013 by the HCPC for allegations of misconduct. The allegations concerned similar matters about the Registrant's attitude, albeit in the context of working with colleagues and failing to work collaboratively with colleagues on mental health assessments. This information was not before the Panel and not referred to by SWE in submissions on impairment.

9.9 The Members considered whether the Panel's conclusions on impairment and sanction might have been different had the Panel been aware of this.

9.10 The Members felt it could have made a difference and the parallels in the cases were obvious. It was entirely relevant for the Panel to have had this information before them and would have added to their assessment in terms of the risk of repetition and remediation and attitude.

9.11 The Members concluded that this omission was a potential serious procedural irregularity.

Did the Panel sufficiently address the Registrant's insight, and if not, was its failure to do so such that its decision is insufficient to protect the public?

9.12 The Panel found that the Registrant *'did not have a high level of insight'* in relation to both allegations.

9.13 The Members felt this was a generous assessment as in reality the Registrant had no insight in relation to allegation 1. The Registrant took no responsibility for her actions throughout the hearing and continued to deflect blame. She

showed no understanding of how her actions put SU1 at risk of harm and caused problems for Person A in relation to the data breach. She did not set out how she would conduct a similar investigation differently, aside from saying that in hindsight she would have involved the Police. The Registrant was entrenched in her position that she had conducted a thorough investigation and Person A was to blame for the safeguarding issues. There was also no indication that any remediation had taken place or would take place, in part because the Registrant said she did not intend to return to the profession.

9.14 The Panel credited the Registrant with partial insight and remediation in relation to allegation 2. Although the Registrant did apologise she did not show an understanding of why her conduct was serious and the risks it created for SU1, and she perpetuated this in her conduct. This was acknowledged by the Panel, and they identified that there was work to do in terms of addressing the risk of repetition.

9.15 The Members considered that the Panel did address the Registrant's insight but failed to address this fully at the sanction stage. In addition, the Panel's findings that insight could develop over time appeared wishful given the limited evidence of insight and the lapse of time since the misconduct occurred, in which her insight had failed to develop fully.

Did the Panel correctly apply the sanctions guidance in concluding that a sanction less than removal was sufficient to protect the public?

9.16 The Members considered the SG helpful in focusing the Panel's minds on specific issues. However, in relation to sanction and in particular suspension and removal the SG was unhelpful in terms of building a framework for asking questions to help decide sanction – particularly in borderline cases. Furthermore, the examples provided in the SG were not helpful in this particular case.

9.17 The fact that the Panel failed to adequately articulate their reasons led the Members to conclude that the Panel did not correctly apply the SG. This was to some extent exacerbated by the Panel's failure to identify aggravating and mitigating factors. Had these been identified this would have assisted the Panel's direction of thoughts and may have helped them in applying the SG.

Was the Panel, on the material before it, entitled to form the view that the Registrant would develop insight and/or remediate during her suspension?

9.18 The Members felt that there was no evidence of insight or remediation before the Panel.

9.19 The Members acknowledged that deference would need to be afforded to the Panel as they had had the benefit of hearing evidence from the Registrant when assessing her insight. However, the Members remained concerned that the Panel had not evaluated the significance of its findings in terms of insight at the sanction stage.

Conclusion on insufficiency for public protection

9.20 The Members concluded that this was a serious case of misconduct which relates to fundamental duties of social care involving a vulnerable individual.

9.21 The Members determined that currently the outcome was sufficient in as much as the Registrant is the subject of a suspension order but felt there were many errors in the Panel's approach to the questions that they were required to ask themselves. In addition, the procedural error in relation to the previous caution not being placed before the Panel rendered the decision not sufficient on grounds of public confidence.

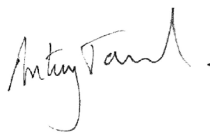
9.22 In light of their concerns, the Members concluded that the SWE's failure to inform the Panel of the Registrant's previous caution was a serious procedural irregularity which meant the Members were unable to determine that the outcome of the case was sufficient.[2]

10. Referral to court

10.1 Having concluded that the Panel's Determination was insufficient for public protection, 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 Authority should exercise its power under Section 29 and refer this case to the High Court of Justice of England and Wales.



28th April 2023

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Antony Townsend (Chair) **Dated**

[2] *Ruscillo* at [72]

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	A Fitness to Practise Panel of the Social Work England
The Registrant	Lesley Margaret Rossle
The Regulator	Social Work England
SWE	Social Work England
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 4 October 2022
The Court	The High Court of Justice of England and Wales
The SG	Regulator's Indicative Sanctions Guidance