Fitness to Practise Committee, 10 October 2013

Fitness to Practise Annual Report 2013-14 development

Introduction

The 2012-13 Fitness to Practise Annual Report was approved by both Committee and Council in Summer 2013. The Committee asked for an opportunity to discuss the content and structure of the report so consideration could be given to how it is produced. The 2012-13 Annual Report is attached as an appendix to this paper

Decision

The Committee is asked to consider the paper and make suggestions for how the format may be varied in future versions.

Background information

The Annual Report is used by a range of stakeholders to understand the Fitness to Practise activity in the previous financial year. The approach taken to date is to maintain the format and content, so that easy comparison across financial years can be made.

Resource implications

Changes to format may have impact on resources within Fitness to Practise or Communications teams to produce the underlying data, write the text, or to format the document. There may be external resources required to assist with any changes to the formatting. Until the scope of change - if any - is known, these are impossible to predict.

Financial implications

See resource implications above.

Appendices

Appendix One: Fitness to Practise Annual Report 2012-13

Date of paper

30 September 2013

[front cover]

1 April 2012 to 31 March 2013 [strapline]

Fitness to practise annual report 2013 [title]

Contents

Executive summary

Welcome to the tenth fitness to practise annual report of the Health and Care Professions Council (HCPC) covering the period 1 April 2012 to 31 March 2013. This report provides information about the HCPC's work in considering allegations about the fitness to practise of HCPC registrants.

On Wednesday 1 August 2012, we became responsible for the regulation of Social Workers in England when the regulatory responsibilities of the General Social Care Council (GSCC) were transferred across to us. That new responsibility resulted, in part, to the increase of 44 per cent in the number of complaints received. However, despite the increase in the number of individuals on our Register, only 0.53 per cent of registrants were made the subject of a new complaint in 2012–13. This compares to 0.42 per cent in 2011–12.

Included in the transfer of regulatory responsibilities from the GSCC, were open cases that had not yet concluded. More information about these cases can be found in Appendix three of this report. Social workers in England are now subject to the same regulatory regime as all of the other professions that are regulated by the HCPC.

This year also saw an increase in the number of complaints that are made by members of the public. We also saw an increase (in percentage and volume) in the number of complaints that are closed without referral to a final hearing. We are looking at why this is the case and at ways in which we can develop understanding of the regulatory process for those who interact with it.

Our activities in 2012–13 also included commissioning research on the understanding of public protection. This work, titled 'Understanding Public Protection; Exploring Views on the Fitness to Practise of Health and Care Professionals', was undertaken by the Picker Institute Europe on our behalf. The report looks at perceptions of fitness to practise, specifically whether / how views differed on what information might be relevant to the regulator. Overall, the findings supported the 'case by case' approach that we take in relation to the investigation and management of fitness to practise cases.

We continuously look at ways that we can improve and develop our processes and in 2013–14 this will include looking at ways that we can improve the experience that individuals (be it complainant, registrant or witness) have with the fitness to practise process. This is to ensure fairness and justice to all those that have cause to interact with it. We are also carefully considering the recommendations of the report of the Public Inquiry into failings in care at the Mid-Staffordshire NHS Foundation Trust and the action we might take in relation to implementing those recommendations.

In 2013–14 we will also start a pilot to assess the use and value of mediation in our regulatory processes. This forms part of our commitment to look at alternative mechanisms for resolving cases whilst at the same time ensuring

the rights of the registrant are balanced with our overriding objective of public protection.

I hope you find this report of interest. If you have any feedback or comments, please email me at ftpnoncaserelated@hcpc-uk.org

Kelly Johnson
Director of Fitness to Practise

Introduction

About us (the Health and Care Professions Council)

We are the Health and Care Professions Council (HCPC), a regulator set up to protect the public. To do this, we keep a register of those who meet our standards for their training, professional skills and behaviour. We can take action if someone on our Register falls below our standards.

In the year 1 April 2012 to 31 March 2013 we regulated members of the following 16 professions.

- Arts therapists
- Biomedical scientists
- Chiropodists / podiatrists
- Clinical scientists
- Dietitians
- Hearing aid dispensers
- Occupational therapists
- Operating department practitioners
- Orthoptists
- Paramedics
- Physiotherapists
- Practitioner psychologists
- Prosthetists / orthotists
- Radiographers
- Social workers in England
- Speech and language therapists

Each of the professions we regulate has one or more ‘protected titles’ (protected titles include titles like ‘physiotherapist’ and ‘operating department practitioner’).

Anyone who uses a protected title and is not registered with us is breaking the law, and could be prosecuted. It is also an offence for a person who is not a registered hearing aid dispenser to perform the functions of a dispenser of hearing aids.

For a full list of protected titles and for further information about the protected function of hearing aid dispensers, please go to our website at www.hcpc-uk.org. Registration can be checked either by logging on to www.hcpc-uk.org/check or calling +44(0)845 300 6184.

Our main functions

To protect the public, we:

- set standards for the education and training, professional skills, conduct, performance, ethics and health of registrants (the professionals who are on our Register);
- keep a register of professionals who meet those standards;
- approve programmes which professionals must complete before they can register with us; and
- take action when professionals on our Register do not meet our standards.

For an up-to-date list of the professions we regulate, or to learn more about the role of a particular profession, see www.hcpc-uk.org

What is 'fitness to practise'?

When we say that a professional is 'fit to practise' we mean that they have the skills, knowledge and character to practise their profession safely and effectively. However, fitness to practise is not just about professional performance. It also includes acts by a professional which may affect public protection or confidence in the profession. This may include matters not directly related to professional practice.

What is the purpose of the fitness to practise process?

Our fitness to practise process is designed to protect the public from those who are not fit to practise. If a professional's fitness to practise is 'impaired,' it means that there are concerns about their ability to practise safely and effectively. This may mean that they should not practice at all, or that they should be limited in what they are allowed to do. We will take appropriate actions to make this happen.

Sometimes professionals make mistakes that are unlikely to be repeated. This means that the person's overall fitness to practise is unlikely to be 'impaired.' People sometimes make mistakes or have a one-off instance of unprofessional conduct or behaviour. Our processes do not mean that we will pursue every isolated or minor mistake. However, if a professional is found to fall below our standards, we will take action.

What to expect

If a concern about a professional is raised with us, you can expect us to treat everyone involved in the case fairly and explain what will happen at each stage of the process. We will keep everyone involved in the case up-to-date with the progress of our investigation. We allocate a case manager to each case. They are neutral and do not take the side of either the registrant or the person who makes us aware of concerns.

Their role is to manage the case throughout the process and to gather relevant information. They act as a contact for everyone involved in the case. They cannot give legal advice. However, they can explain how the process works and what panels consider when making decisions.

Raising a fitness to practise concern

Anyone can contact us and raise a concern about a registered professional. This includes members of the public, employers, the police and other professionals. You can find information about how to tell us about a fitness to practise concern in our brochure How to raise a concern, which can be found on our website at www.hcpc-uk.org/publications/brochures

What types of case can the HCPC consider?

We consider every case individually. However, a professional's fitness to practise is likely to be impaired if the evidence shows that they:

- were dishonest, committed fraud or abused someone's trust;
- exploited a vulnerable person;
- failed to respect service users' rights to make choices about their own care;
- have health problems which they have not dealt with, and which may affect the safety of service users;
- hid mistakes or tried to block our investigation;
- had an improper relationship with a service user;
- carried out reckless or deliberately harmful acts;
- seriously or persistently failed to meet standards;
- were involved in sexual misconduct or indecency (including any involvement in child pornography);
- have a substance abuse or misuse problem;
- have been violent or displayed threatening behaviour; or
- carried out other, equally serious, activities which affect public confidence in the profession.

We can also consider concerns about whether an entry to the HCPC Register has been made fraudulently or incorrectly. For example, the person may have provided false information when they applied to be registered or we may have registered them by mistake.

What can't the HCPC do?

We are not able to:

- consider cases about professionals who are not registered with us;
- consider cases about organisations (we only deal with cases about individual professionals);
- get involved in clinical care;
- deal with customer-service issues;

– arrange refunds or compensation;
– fine a professional;
– give legal advice; or
– make a professional apologise.

Fitness to practise brochures

For more information about the fitness to practise process, please contact us to request one of the following brochures.

- How to raise a concern
- Information for witnesses
- The fitness to practise process – information for employers and managers
- What happens if a concern is raised about me?

You can also find these publications at www.hcpc-uk.org/publications/brochures

Practice notes

The HCPC has a number of practice notes in place for the various stages of the fitness to practise process. Practice notes are issued by the Council for the guidance of Practice Committee Panels and to assist those appearing before them. New practice notes are issued on a regular basis and all current notes are reviewed to ensure that they are fit for purpose. All of the HCPC's practice notes are publicly available on our website at www.hcpc-uk.org/publications/practicenotes

Partners and panels

The HCPC uses the profession-specific knowledge of HCPC 'partners' to help carry out its work. Partners are drawn from a wide variety of backgrounds – including clinical practice, education and management. We also use lay partners to sit on our panels. Lay panel members are individuals who are not and have never been eligible to be on the HCPC register. At least one registrant partner and one lay partner sit on our panels to ensure that we have appropriate public input and professional expertise in the decision-making process.

At every public hearing there is also a legal assessor. The legal assessor does not take part in the decision-making process, but gives the panel and the others involved advice and information on law and legal procedure. The HCPC does not use legally qualified panel chairs as we feel that the role of a legal assessor is an important safeguard in fitness to practise proceedings, ensuring that all parties are treated fairly. Any advice given to panels is stated in the public element of the hearing. At HCPC hearings, the legal assessor does not sit with the panel. This step has been taken to signify their independence from the panel and their role in giving advice to all those who are in attendance at the hearing.

The HCPC's Council members do not sit on our Fitness to Practise Panels. This is to maintain separation between those who set Council policy and those who make decisions in relation to individual fitness to practise cases. This contributes to ensuring that our hearings are fair, independent and impartial. Furthermore, employees of the HCPC are not involved in the decision-making process. This ensures decisions are made independently and are free from any bias.

Standard of proof

The HCPC uses the 'civil standard of proof' in its final hearing fitness to practise cases. This means that panels consider, on the balance of probabilities, whether an allegation is proven.

Transfer of regulatory responsibilities from the General Social Care Council

On Wednesday 1 August 2013 the HCPC became responsible for the regulation of social workers in England following the abolition of the General Social Care Council (GSCC). As a result, all open conduct cases being dealt with by the GSCC were transferred to the HCPC. More information about the cases that were transferred can be found in Appendix three of this report. For simplicity and consistency with previous years' annual report, we do not report on the transfer cases in the main text of this report.

Cases received in 2012–13

This section contains information about the number and the type of fitness to practise concerns received about registrants. It also provides information about who raised these concerns. A concern is only classed as an 'allegation' when it meets our standard of acceptance for allegations.

The standard of acceptance sets out the information we must have for a case to be treated as an allegation. As a minimum this information:

- must be in writing (fitness to practise concerns may also be taken over the telephone if a complainant has any accessibility difficulties);

- must include the professional's name; and

- must give enough detail about the concerns to enable the professional to understand these concerns and to respond to them.

The policy also recognises that, while concerns are raised about only a small minority of HCPC registrants, investigating these concerns takes a great deal of time and effort. So it is important that HCPC's resources are used effectively to protect the public and are not diverted into investigating matters which do not give cause for concern. Where cases are closed we will, wherever we can, signpost complainants to other organisations that may be able to help with the issues they have raised.

Any case which does not meet the standard of acceptance is classed as an 'enquiry'. In these circumstances we will always seek further information. Many enquiries then become allegations once we have this additional information. The HCPC's Standard of Acceptance for Allegations policy explains our approach more fully. This year we have reviewed the policy to ensure it continues to be fit for purpose. We do not envisage that the changes will significantly affect the numbers of cases that would meet the requirements of the policy. For further information, please see the Standards of Acceptance for Allegations Policy on our website at www.hcpc-uk.org/publications/policy

Table 1 shows the number of cases received in 2012–13 compared to the total number of professionals registered by the HCPC (as of 31 March 2013).

Table 1 Total number of cases received in 2012–13

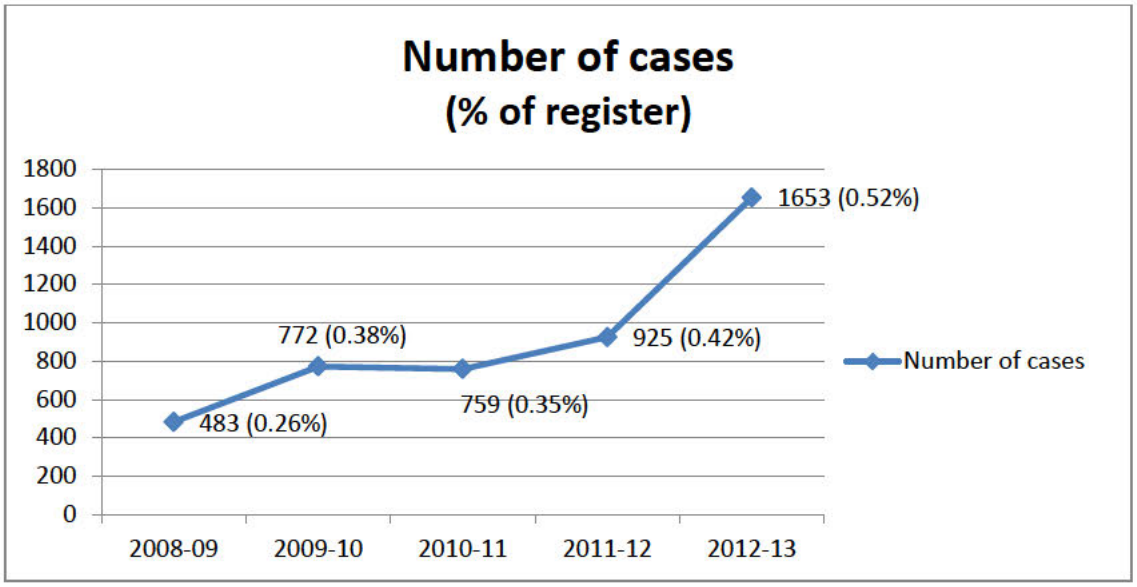
	Number of cases	Total number of registrants	% of registrants subject to complaints
2012–13	1653	310,942	0.53

The proportion of HCPC registrants who have had a fitness to practise concern raised about them has also increased slightly, from 0.42 per cent of all professionals on the Register in 2011–12 to 0.53 per cent in 2012–13. This still means that only about one in 200 registrants were the subject of a concern about their fitness to practise. It should be noted that in a few instances a registrant will be the subject of more than one case.

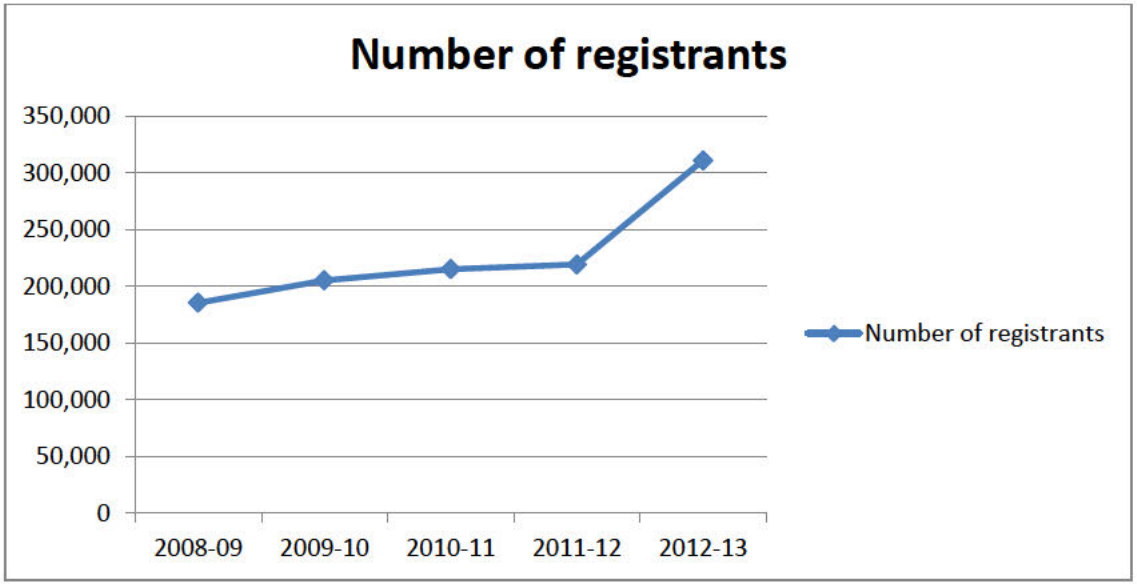
Compared to 2011–12 the number of cases received in 2012–13 increased by 44 per cent (in actual numbers, an increase of 728 cases). The number of professionals registered by the HCPC has also increased over the same period, by 30 per cent. This reflects the HCPC's regulation of Social Workers in England from Wednesday 1 August 2012 following the closure of the former General Social Care Council (GSCC).

Graphs 1a and 1b shows the number of fitness to practise concerns received between 2008–09 and 2012–13 compared to the total number of HCPC registrants. The changes in volumes relate to the changes in our standard of acceptance.

Graph 1a Total numbers of cases and percentage of register



Graph 1b Total number of registrants on HCPC register



Where a case does not meet the standard of acceptance, even after we have sought further information, or the concerns that have been raised do not relate to fitness to practise, the case is closed.

In 2012–13, 706 cases were closed without being considered by a panel of the HCPC's Investigating Committee, a 54 per cent increase compared to 2011–12. This change relates to the change in the standard of acceptance, and the fact that we have received more complaints overall.

In 2012–13, the average length of time for cases to be closed without being considered by a panel of the Investigating Committee was a median average

of three months and a mean average of four months. There has been no change from the previous year.

Table 2 Length of time from receipt to closure of cases that are not considered by Investigating Committee

Number of months	Number of cases	Cumulative number of cases	% of cases	Cumulative % of cases
0–4	482	482	65.5	65.5
5–8	179	661	24.3	89.8
9–12	44	705	5.9	95.7
13–16	19	724	2.6	98.3
17–20	10	734	1.4	99.7
over 20	2	736	0.3	100
Total	736	736	100	100

Article 22(6) of the Health and Social Work Professions Order 2001

Article 22(6) of the Health and Social Work Professions Order 2001 enables the HCPC to investigate a matter even where a concern has not been raised with us in the normal way (for example, in response to a media report or where information has been provided by someone who does not want to raise a concern formally). This is an important way we can use our legal powers to protect the public.

Article 22(6) is also important in 'self-referral' cases. We encourage all professionals on the HCPC Register to self-refer any issue which may affect their fitness to practise. Standard 4 of the HCPC's Standards of Conduct, Performance and Ethics states that "You must provide (to us and any other relevant regulators) any important information about your conduct and competence". All self-referrals are assessed to determine if the information provided suggests the registrant's fitness to practise may be impaired and whether it may be appropriate for us to investigate the matter further using the Article 22(6) provision.

Cases by profession and complainant type

The following tables and graphs show information about who raised fitness to practise concerns in 2012–13 and how many cases were received for each of the professions the HCPC regulates. The total number of cases received in 2012–13 was 1653 (Table 1, page 11).

Table 3 provides information about the source of the concerns which gave rise to these 1653 cases. In 2012-13 members of the public were the largest complainant group, making up just over 38 per cent of cases (25 per cent in 2011–12). Historically employers have usually been the largest complainant

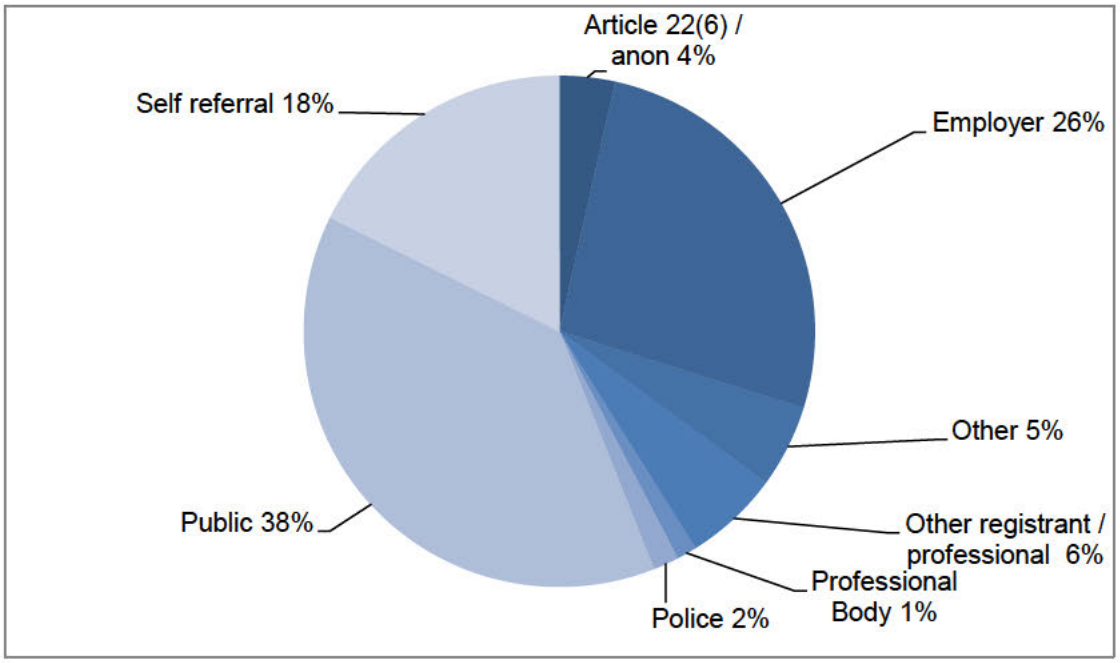
group. The exception was 2010–11 when members of the public again formed the largest group.

In 2012–13 employers were the second largest source of concerns, comprising 26 per cent of the total. This has decreased from the previous year when the proportion was 31 per cent.

Table 3 Who raised concerns in 2012–13?

Type of complainant	20124–132	% of cases
Article 22(6) / anon	58	3.5
Employer	435	26.3
Other	87	5.3
Other registrant / professional	99	5.9
Professional body	21	1.3
Police	27	1.6
Public	634	38.4
Self referral	292	17.7
Total	**1653**	**100**

Graph 2 Who raised concerns in 2012–13?



The category 'Other' in Table 3 and Graph 2 includes solicitors acting as complainants, hospitals / clinics (when not acting in the capacity of employer), colleagues who are not registrants and the Disclosure and Barring Service (incorporating the former Independent Safeguarding Authority), which notifies us of individuals who have been barred from working with vulnerable adults and / or children.

Table 4 provides information on the breakdown of cases received by profession and gives a comparison to the Register as a whole.

Table 4 Cases by profession

Profession	Number of cases	% of total cases	Number of registrants	% of the Register	% of registrants subject to complaints
Arts therapists	7	0.42	3,185	1.02	0.22
Biomedical scientists	37	2.24	22,402	7.20	0.17
Chiropodists / podiatrists	53	3.21	12,754	4.10	0.42
Clinical scientists	9	0.54	4,847	1.56	0.19
Dietitians	13	0.79	7,890	2.54	0.16
Hearing aid dispensers	25	1.51	1,806	0.58	1.38
Occupational therapists	76	4.60	33,717	10.84	0.23
Operating department practitioners	45	2.72	11,246	3.62	0.40
Orthoptists	2	0.12	1,329	0.43	0.15
Paramedics	262	15.85	19,373	6.23	1.35
Physiotherapists	123	7.44	46,842	15.06	0.26
Practitioner psychologists	179	10.83	19,341	6.22	0.93
Prosthetists / orthotists	1	0.06	936	0.30	0.11
Radiographers	55	3.33	27,820	8.95	0.20
Social Workers	733	44.34	83,421	26.83	0.88
Speech and language therapists	33	2.00	14,033	4.51	0.24
Total	**1,653**	**100**	**310,942**	**100**	**0.53**

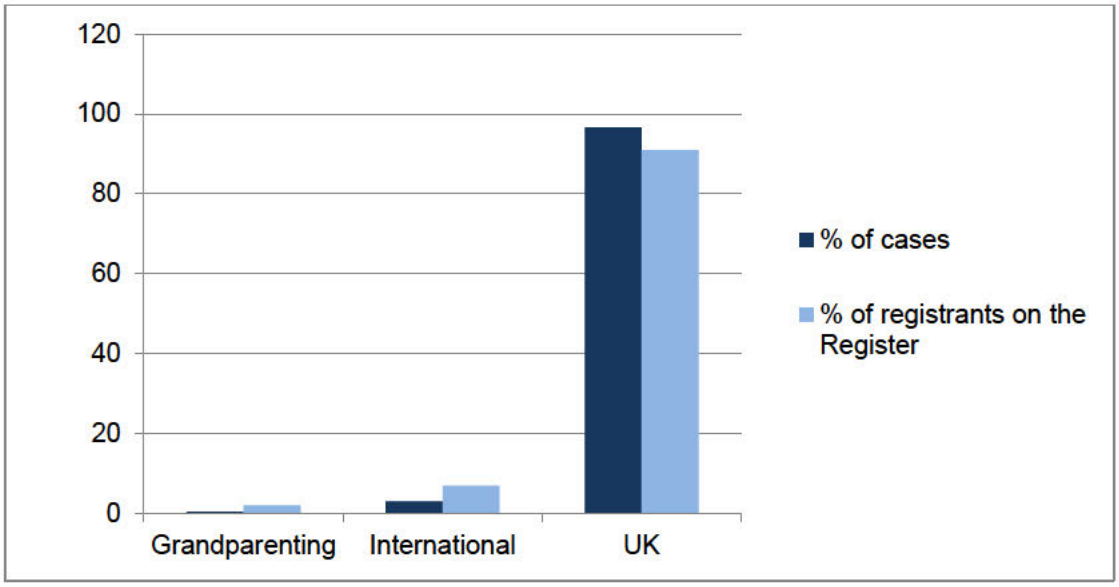
Table 5 Cases by profession and complainant type

Profession	Article 22(6) / Anon	Employer	Other	Other registrant	Police	Professional body	Public	Self referral	Total
Arts therapists	0	3	2	0	0	0	1	1	7
Biomedical scientists	3	11	2	13	0	0	0	8	37
Chiropodists / podiatrists	3	7	2	4	3	1	28	5	53
Clinical scientists	1	1	1	3	0	0	2	1	9
Dietitians	1	5	0	0	0	1	3	3	13
Hearing aid dispensers	2	8	0	1	0	2	11	1	25
Occupational therapists	4	27	0	7	0	1	19	18	76
Operating department practitioners	2	29	1	1	1	1	3	7	45
Orthoptists	0	0	0	0	0	0	1	1	2
Paramedics	26	87	15	17	1	0	18	98	262
Physiotherapists	0	25	10	4	6	3	56	19	123
Practitioner psychologists	2	20	23	19	1	1	100	13	179
Prosthetists / orthotists	1	0	0	0	0	0	0	0	1
Radiographers	1	25	2	5	5	0	4	13	55
Social workers in England	12	176	30	22	10	11	371	101	733
Speech and language therapists	0	11	1	1	0	0	16	4	33
Total	58	435	89	97	27	21	633	293	1,653

Cases by route to registration

Graph 3 shows the number of cases by route to registration and demonstrates a close correlation between the proportion of registrants who entered the HCPC Register by a particular route and the percentage of fitness to practise cases. There were only three grandparenting cases received in 2012–13, and the number of international cases received also fell from the previous year.

Graph 3 Cases by route to registration 2012–13



Convictions

The professions regulated by the HCPC are exempt from the Rehabilitation of Offenders Act. This has meant that convictions are never regarded as 'spent' and can be taken into account in relation to a registrant's fitness to practise. Home Office Circular 6/2006 provides that the HCPC must be notified when a registrant is convicted or cautioned for an offence in England and Wales. Similar arrangements apply for Northern Ireland and Scotland.

The types of offence we have been notified of in 2012–13 have included (this list is not exhaustive):

- assault;
- criminal damage;
- drink driving;
- drugs possession;
- fraud; and.
- possession of child pornography.

Investigating Committee panels

The role of an Investigating Committee Panel (ICP) is to consider allegations made against registrants and to decide whether there is a 'case to answer.'

The Investigating Committee can decide that:

- more information is needed;
- there is a 'case to answer' (which means the matter will proceed to a final hearing); or
- there is 'no case to answer' (which means that the case does not meet the 'realistic prospect' test).

An ICP meets in private to conduct a paper-based consideration of the allegation. Neither the registrant nor the complainant appears before the ICP. The panel must decide whether or not there is a 'case to answer' based on the documents before it. The test that the panel applies when making its decision is the 'realistic prospect' test. The panel must decide whether there is a 'realistic prospect' that the HCPC will be able to establish that the registrant's fitness to practise is impaired.

The Panel must be satisfied that there is a realistic or genuine possibility that the HCPC, which has the burden of proof, will be able to prove:

1. the facts alleged;
2. that those facts amount to the statutory ground (eg misconduct); and
3. as a result of 1 and 2, that the Registrant's fitness to practise is impaired.

Only cases that meet all three elements of the 'realistic prospect' test can be referred for consideration at a final hearing. Panels must consider the allegation as whole. Examples of 'no case to answer' decisions can be found on page 20.

In some cases there may be information which proves the facts of a case. However, the panel may consider that there is no realistic prospect of establishing that the facts amount to the ground(s) of the allegation (eg misconduct, lack of competence etc). Likewise, panels may consider that there is sufficient information to establish that there is a realistic prospect of proving the facts and the ground(s) of the allegation but there is no realistic prospect of establishing that the registrant's fitness to practise is impaired. This could be because the incident that gave rise to the concern was an isolated lapse that is unlikely to recur, or there is evidence to show the registrant has taken action to correct the behaviour that led to the allegation being made. Such cases would result in a 'no case to answer' decision and the case would not proceed.

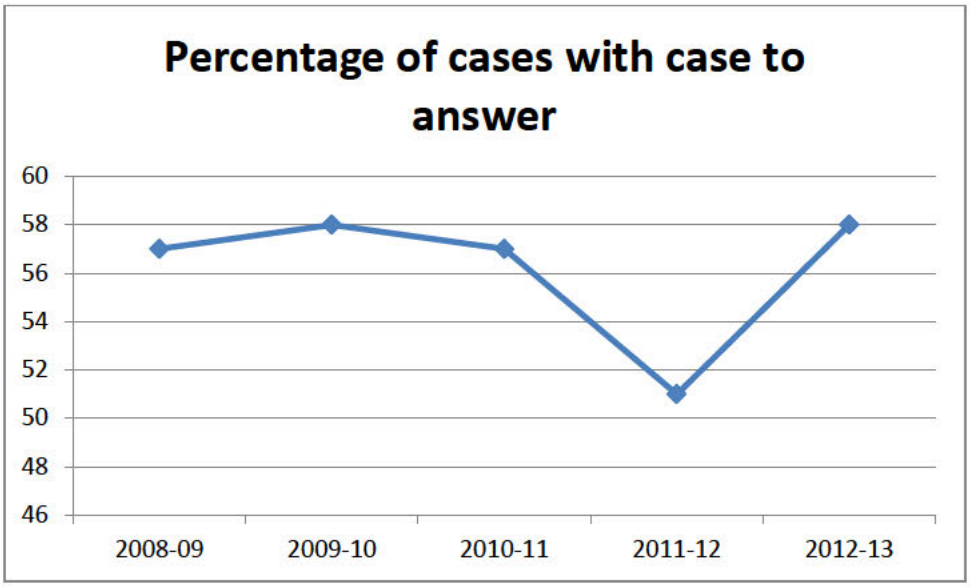
The HCPC has been continuing to monitor the number of cases receiving a 'case to answer' decision at ICP stage and to refine the ICP decision-making process. In 2010–11, the HCPC introduced the use of 'learning points' as an additional tool available to ICPs. Learning points can only be used by ICPs in cases where the panel concludes that there is a realistic prospect of proving the facts and statutory ground of the allegation but not fitness to practise impairment. The panel may include learning points or comments on other matters arising from the statutory ground of the allegation, which the panel considers should be brought to the attention of the registrant. Learning points must be general in nature and are designed to act as guidance only. The introduction of learning points is considered to help ensure that the fitness to practise process is proportionate and that matters are referred for consideration at a final hearing only when the 'realistic prospect' test is fully met. In 2012–13 ICPs issued learning points in seven cases.

In 2012–13 563 cases were considered by an ICP. Of those cases, 20 were considered at ICP twice as panels had requested further information. This is an increase from the 516 cases that went to an ICP in 2011–12.

Graph 4 shows the percentage of 'case to answer' decisions each year from 2007–08 to 2012–13. The 'case to answer' rate for 2012–13 is 58 per cent. This is up seven per cent from 2011-12. This may in part be explained by the higher number of cases that were closed prior to being considered by an Investigating Committee in 2012–13 on the basis that they did not meet the HCPC's standard of acceptance for allegations.

The 'case to answer' rate for 2012–13 does not include cases where further information was requested by the panel. If those cases were taken into account, the percentage of 'case to answer' decisions would reduce in relation to the total number of cases that were considered at ICP during 2012–13. Similarly, the 'case to answer' rate reduced by 18 per cent of all cases received in 2012–13, including the cases that were closed prior to ICP. The case to answer rate is 24 per cent, when taking into account all cases closed at, or prior to ICP stage.

Graph 4 Percentage of allegations with a case to answer decision



Decisions by Investigating Committee panels

Table 6 Examples of no case to answer decisions

This table shows a range of professions that were considered at Investigating Committee. The examples describe the case as considered, and the decision of the panel with a brief rationale.

Type of issue	Reason for no case to answer decision
A biomedical scientist was alleged to have given instructions to colleagues in relation to genital samples coding cards that was contrary to the instruction agreed at a senior clinical staff meeting. It was further alleged that the registrant did not ensure that his team members coded cards in relation to genital samples in line with the clinical decision at the meeting and that he did not challenge his peers' recommendations for coding of the cards in a professionally appropriate manner.	The Panel was satisfied that there was sufficient evidence to support the facts of the allegation. However the Panel considered that the facts alleged were insufficient to establish a realistic prospect that the HCPC would be able to prove that the registrant's fitness to practise is currently impaired. The Panel particularly noted a degree of insight on the part of the registrant and evidence of his current competence provided by his line manager.
It was alleged that a dietitian took part	The Panel was satisfied that there

in an advertorial to promote a brand of vitamin water and did not give a balanced review of the nutritional aspects of the vitamin water in that he highlighted the positive qualities of the vitamin water but did not highlight the potential negative nutritional aspects of the vitamin water. It was further alleged that the registrant's actions had the potential to mislead the public as to nutritional quality of the vitamin water.	was credible evidence to provide a realistic prospect of establishing the facts of the allegation. However**,** the Panel felt that the registrant provided accurate information but that the registrant could have given a more balanced review of the product by explaining the negative aspects of the product. On this occasion the Panel was of the view that the HCPC did not have a realistic prospect of proving misconduct and therefore there was no case to answer.
Competency concerns in relation to an occupational therapist regarding the assessment of a service user, specifically: - acting outside scope of practice; - failing to provide evidence to support recommendations; - failure to inform colleagues of important information in relation to a service user; and - failure to liaise with members of the multidisciplinary team in relation to a service user;	The Panel noted that there was sufficient credible evidence to provide a realistic chance of establishing the facts and the grounds of the allegation. However, it did not consider that there was a realistic prospect of establishing current impairment. In reaching its decision, the Panel noted that the registrant admitted the facts and provided information to demonstrated that she had reflected on the matter and shown insight into her failings. The Panel was satisfied that this was an isolated incident, which was unlikely to be repeated in the future. The Panel issued the registrant with a learning point around the need to work collaboratively with members of the multidisciplinary team.
An operating department practitioner knowingly ordered controlled drugs from a pharmacy using a false name on the requisition form.	The registrant admitted the facts but denied acting dishonestly. The Panel was satisfied that the registrant was not acting dishonestly and that she did not gain from using a false name in that the drugs she ordered were used within a clinical setting for a patient and were not for personal

	use. The Panel also accepted the registrant's submissions that she used a false name to highlight procedural problems around the ordering and dispensations of controlled drugs within the hospital she worked at.
It was alleged that a paramedic falsified medical records by recording a patient's blood pressure without taking a reading. It was further alleged that the registrant did not carry out a thorough assessment of the patient.	The Panel found that there was sufficient evidence in the available documents to support the facts of the allegation. The Panel determined that the Registrant's actions were considered not to be best practice; however the Panel acknowledged there was no detriment to the service user. The Panel concluded that there was no realistic prospect of the HCPC establishing that the registrant's fitness to practice is impaired and noted that the registrant had undertaken additional training, in response to the learning points identified by the his employer.
Bullying and harassment of colleagues by a practitioner psychologist	The Panel did not find the realistic prospect test was met in relation to the bulk of the particulars. For those particulars where there was a realistic prospect of establishing the facts, the Panel was also satisfied that those facts, if proven, were capable of amounting to misconduct. However, the Panel was not satisfied that there was a realistic prospect of establishing current impairment as the Panel was of the view that those particulars related to employment issues, which would be more appropriately addressed by the employer at a local level. The Panel issued the registrant with a learning point, reminding the registrant of the need to

	communicate professionally and empathetically with colleagues and staff at all levels.
A radiographer was alleged to have performed an x-ray on a colleague without a request card or clinical need and he: -falsely advised colleagues that a request card for the x-ray had been obtained prior to the x-ray being performed; and -failed to report the incident to a manager in a timely manner.	Despite the Panel being of the view that the allegations in this case were very serious, and that there was evidence to provide a realistic prospect of establishing the facts and grounds of the allegation, it considered the registrant's responses to the allegations and the positive references provided to support the registrant. Having considered these, the Panel is satisfied that the registrant has shown insight and remorse regarding his actions and the Panel has noted that the conduct which gave rise to the allegations was isolated. As such, on this occasion the Panel was satisfied that there is insufficient evidence to establish that the Registrant's fitness to practise is impaired.

Case to answer decisions by complainant type

Table 7 shows the number of ‘case to answer’ decisions by complainant type. Fitness to practise concerns received from anonymous complainants and / or where the HCPC proceeds with the case under Article 22(6) of the Health and Social Work Professions Order represent the highest percentage of ‘case to answer’ decisions. In 2012–13, 68 fitness to practise concerns from that complainant group were considered at ICP. Of those, 77 per cent received a ‘case to answer’ decision. Members of the public are the largest complainant category. In 2012-13, 634 fitness to practise concerns were raised by the members of the public. Of those cases, 108 were considered at ICP, nineteen per cent of which received a ‘case to answer’ decision. This represents a two per cent increase in the number of ‘case to answer’ decisions made in respect of concerns raised by members of the public since 2011–12.

Table 7 Case to answer by complainant

	Number of case to answer	Number of no case to answer	Total	% case to answer
Article 22(6) / anon	52	16	68	76.5
Employer	188	68	256	73.4
Other	14	6	20	70.0
Other registrant	6	16	22	27.3
Police	7	8	15	46.7
Professional body	1	1	2	50.
Public	20	88	108	18.5
Self referral	13	19	32	40.6
Total	**301**	**222**	**523**	**57.6**

Case to answer decisions and route to registration

Table 8 shows that there is a consistency between the percentage of registrants who entered the Register via a certain route and the number of fitness to practise concerns raised in relation to those registrants.

Table 8 Case to answer and route to registration

Route to registration	Number of case to answer	% of allegations	Number of no case to answer	% of allegations	Total allegations	% of allegations
Grandparenting	6	2	2	1	8	2
International	22	7	13	6	35	6
UK	273	91	207	93	480	92
Total	301	100	222	100	523	100

Time taken from receipt of allegation to Investigating Panel

Table 9 shows the length of time taken for allegations to be put before an ICP in 2012–13. The table shows that eighty three per cent of allegations were considered by a panel within eight months of receipt. This is up from 2011–12, when 77.9 per cent of allegations were considered by an ICP within eight months of receipt. The mean length of time taken for a matter to be considered by an ICP is seven months from receipt of the allegation and the median length of time is five months. This has remained constant with the 2011–12 cases.

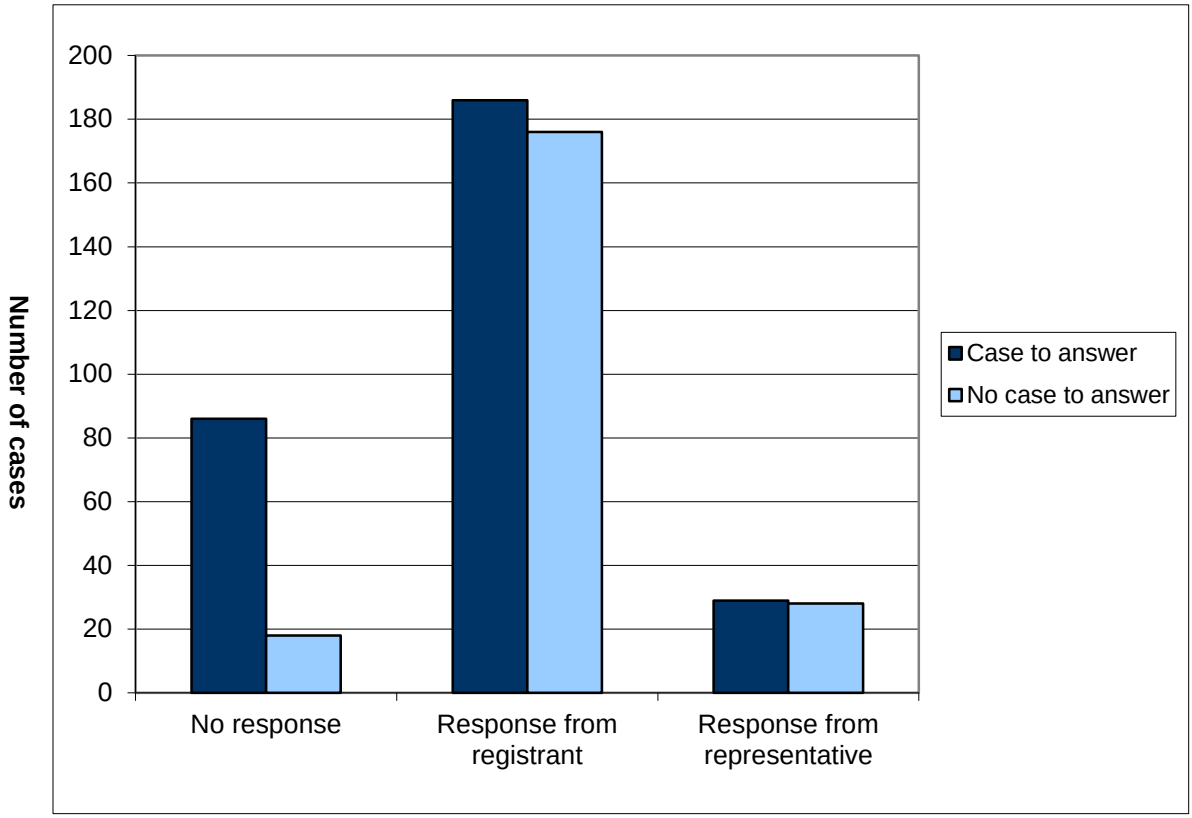
Table 9 Length of time from receipt of allegation to Investigating Panel

Number of months	Number of cases	Cumulative number of cases	% of cases	Cumulative % of cases
0 to 4	298	298	57	57
5 to 8	134	432	25.6	82.6
9 to 12	41	473	7.8	90.4
13 to 16	26	499	5	95.4
17 to 20	19	518	3.6	99
21 to 24	2	520	0.4	99.4
25 to 28	2	522	0.4	99.8
29 to 32	0	522	0	99.8
over 33	1	523	0.2	100
Total	**523**	**523**	**100**	**100**

Case to answer decisions and representations

Graph 4 provides information on ‘case to answer’ and ‘no case to answer’ decisions and representations received in response to allegations. In 2012-13, representations were made to the ICP by either the registrant or their representative in 419 of the 523 cases where a decision was made by a panel of the Investigating Committee. A total of 222 cases considered by an ICP resulted in a ‘no case to answer’ decision. Of this number, 204 were cases where representations were provided. By contrast, only 18 cases resulted in a ‘no case to answer’ decision being made where no representations were provided by the registrant or their representative.

Graph 4 Representations provided to Investigating Panel



Interim orders

In certain circumstances, panels of our practice committees may impose an ‘interim conditions of practice order’ or an ‘interim suspension order’ on registrants subject to a fitness to practise investigation. This power is used when the nature and severity of the allegation is such that, if the registrant remains free to practice without restraint, they may pose a risk to the public or to themselves. Panels will only impose an interim order when they feel that the public or the registrant involved require immediate protection. Panels will also consider the potential impact on public confidence in the regulatory process should a registrant be allowed to continue to practise without restriction whilst subject to an allegation. An interim order takes effect immediately and its duration is set out in the Health and Social Work Professions Order 2001. It cannot last for more than 18 months. If a case has not concluded before the expiry of the interim order, the HCPC must apply to the relevant court to have the order extended.

An interim order prevents a registrant from practising, or places limits on their practice, whilst the investigation is on-going and will remain until the case is heard.

A practice committee panel may make an interim order to take effect either before a final decision is made in relation to an allegation or pending an appeal against such a final decision. Case managers from the Fitness to Practise Department acting in their capacity of presenting officers present the majority of applications for interim orders and reviews of interim orders. This is to ensure resources are used to their best effect.

Table 10 shows the number of interim orders by profession and the number of cases where an interim order has been granted, reviewed or revoked. In 2012–13, 43 applications for interim orders were made. Thirty nine of those orders were granted and four were not granted. Operating department practitioners and paramedics had the highest number of applications considered.

The legislation we are governed by provides that we have to review an interim order six months after it is first imposed and every three months thereafter. The regular review mechanism is particularly important given that an interim order will restrict or prevent a registrant from practising altogether pending a final hearing decision. Applications are usually made at the initial stage of the investigation; therefore a review may also take place if new evidence becomes available after the order was imposed. In some cases an interim suspension order may be replaced with an interim conditions of practice order if the panel consider this will adequately protect the public. In 2012–13 there were eight cases where an interim order was revoked by a review panel.

The maximum length of time a panel can impose an interim order is 18 months, therefore in 2012–13 we applied to the High Court for an extension of an interim order in ten cases. All of applications were granted and extended for a period between four and twelve months.

Table 10 Number of interim orders by profession

Profession	Applications considered	Applications granted	Applications not granted	Orders reviewed	Orders revoked on review
Arts therapists	0	0	0	0	0
Biomedical scientists	1	1	0	16	0
Chiropodists / podiatrists	4	4	0	7	2
Clinical scientists	0	0	0	0	0
Dietitians	0	0	0	0	0
Hearing aid dispensers	2	1	1	0	0
Occupational therapists	3	3	0	9	0
Operating department practitioners	9	8	1	42	2
Orthoptists	0	0	0	0	0
Paramedics	9	9	0	33	2
Physiotherapists	3	3	0	26	2
Practitioner psychologists	2	2	0	9	0
Prosthetists / orthotists	0	0	0	0	0
Radiographers	1	1	0	5	0
Social workers in England	7	5	2	0	0
Speech and language therapists	2	2	0	4	0
Total	**43**	**39**	**4**	**151**	**8**

Final hearings

Two hundred and twenty eight cases were concluded in 2012–13, involving 226 registrants (two registrants had more than one allegation considered at their hearing). Hearings where allegations were well founded concerned only 0.07 per cent of registrants on the HCPC Register.

Most hearings are held in public, as required by our legislation, the Health and Social Work Professions Order 2001. Occasionally a hearing, or part of it, may be heard in private in certain circumstances.

The HCPC is obliged to hold hearings in the UK country of the registrant concerned. The majority of hearings take place in London at the HCPC's offices. Where appropriate, proceedings are held in locations other than regional centres, for example, to accommodate attendees with restricted mobility. In 2012–13 hearings took place in Aberdeen, Belfast, Cardiff, Durham, Dundee, Edinburgh, Glasgow, London, Manchester, Newcastle and Nottingham.

Table 11 illustrates the number of public hearings that were held from 2008–09 to 2012–13, including cases that were adjourned or were not concluded. It details the number of public hearings heard in relation to interim orders, final hearings and reviews of substantive decisions. Some cases will have been considered at more than one hearing in the same year, for example, if proceedings ran out of time and a new date had to be arranged. Further sections of this report deal specifically with cases that were concluded at final hearing.

Table 11 Number of public hearings

Year	Interim order and review	Final hearing	Review hearing	Restoration hearing	Article 30(7)	Total
2008–09	85	219	92	0	0	396
2009–10	141	331	95	0	0	567
2010–11	171	404	99	2	1	677
2011–12	197	405	126	3	1	732
2012–13	194	228	141	1	1	565

Time taken from receipt of allegation to final hearing

Table 12 shows the length of time it took for cases to conclude, measured from the date of receipt of the allegation. The table also shows the number and percentage of allegations cumulatively as the length of time increases.

The length of time taken for cases that were referred for a hearing to conclude was a mean of 16 and a median of 14 months from receipt of the allegation. In 2011–12 the mean average length of time was 17 months and the median average length of time was 15 months.

The length of hearings can be extended for a number of reasons. These include protracted investigations, legal argument, availability of parties and requests for adjournments, which can all delay proceedings. Where criminal investigations have begun, the HCPC will wait for the conclusion of court proceedings. Criminal cases are often lengthy in nature and can extend the time it takes for a case to reach a hearing.

Table 12 sets out the length of time for a case to conclude from receipt of the allegation to final hearing, which was a mean average of 16 months and median average of 14 months.

Table 12 Length of time from receipt of allegation to final hearing

Number of months	Number of cases	Cumulative number of cases	% of cases	Cumulative % cases
0 to 4	0	0	0	0
5 to 8	23	23	10.1	10.1
9 to 12	66	89	28.9	39
13 to 16	62	151	27.2	66.2
17 to 20	37	188	16.2	82.4
21 to 24	13	201	5.7	88.1
25 to 28	6	207	2.6	90.7
29 to 32	10	217	4.4	95.1
33 to 36	5	222	2.2	97.3
Over 36	6	228	2.6	100
Total	**228**	**228**	**100**	**100**

Table 13 sets out the total length of time to close all cases from the point an allegation was received to case closure at different points in the fitness to practise process. The total length of time was a mean average of nine months and a median average of six months.

Table 13 Length of time to close all cases, including those closed pre-ICP, those where no case to answer is found and those concluded at final hearing

Number of months	Number of cases	Cumulative number of cases	% of cases	Cumulative % cases
0 to 4	560	560	47.3	47.3
5 to 8	303	863	25.6	72.9
9 to 12	137	1000	11.6	84.5
13 to 16	92	1092	7.8	92.3
17 to 20	51	1143	4.3	96.6
21 to 24	14	1157	1.2	97.8
25 to 28	6	1163	0.5	98.3
29 to 32	10	1173	0.8	99.1
33 to 36	5	1178	0.4	99.5
Over 36	7	1185	0.6	1185
Total	**1185**	**228**	**100**	**100**

Days of hearing

Panels of the Investigating Committee, Conduct and Competence Committee and Health Committee met on 894 hearing days in 2012–13 to consider final hearing cases. This includes where more than one hearing takes place on the same day. This number includes cases that were part heard or adjourned.

Panels of the Investigating Committee hear final hearing cases concerning fraudulent or incorrect entry to the Register only. There was one case in 2012–13.

Panels may hear more than one case on some days to make the best use of time available. Of the 228 final hearing cases that concluded in 2012–13, it took an average of 2.5 days to conclude cases. This has increased slightly from 2011–12, when the average was two days and reflects the increasing complexity of cases.

What powers do panels have?

The purpose of fitness to practise proceedings is to protect the public, not to punish registrants. Panels carefully consider all the individual circumstances of each case and take into account what has been said by all parties involved before making any decision.

Panels must first consider whether the facts of any allegations against a registrant are proven. They then have to decide whether any of the proven facts amount to the ‘ground’ set out in the allegation, for example misconduct or lack of competence and if, as a result, the registrant’s fitness to practise is

currently impaired. If the panel decide a registrant's fitness to practise is impaired they will then go on to consider whether to impose a sanction.

In cases where the ground of the allegations solely concerns health or lack of competence, the panel hearing the case does not have the option to make a striking off order in the first instance. It is recognised that in cases where ill health has impaired fitness to practise or where competence has fallen below expected standards, that it may be possible for the registrant to remedy the situation over time. The registrant may be provided the opportunity to seek treatment or training and may be able to return to practice if a panel is satisfied that it is a safe option.

If a panel decides there are still concerns about the registrant being fit to practise, they can:

- take no further action or order mediation (a process where an independent person helps the registrant and the other people involved agree on a solution to issues);

- caution the registrant (place a warning on their registration details for between one to five years);

- make conditions of practice that the registrant must work under;

- suspend the registrant from practising; or

- strike the registrant's name from the Register, which means they cannot practice.

In cases of incorrect or fraudulent entry to the Register, the options available to the panel are to take no action, to amend the entry on the Register (for example to change the modality of a registrant) or to remove the person from the Register.

Suspension or conditions of practice orders must be reviewed before they expire. At the review a panel can continue or vary the original order. For health and competency cases, registration must have been suspended, or had conditions, or a combination of both, for at least two years before the panel can make a striking off order. Registrants can also request early reviews of any order if circumstances have changed and they are able to demonstrate this to the panel.

Outcomes at final hearings

Table 14 is a summary of the outcomes of hearings that concluded in 2012–2013. It does not include cases that were adjourned or part heard. Decisions from all public hearings where fitness to practise is considered to be impaired are published on our website at www.hcpc-uk.org. Details of cases that are considered to be not well founded are not published on the HCPC website

unless specifically requested by the registrant concerned. A list of cases that were well founded is included in Appendix one of this report.

Table 14 Outcome by type of committee

Committee	Amended	Caution	Conditions of practice	No further action	Not well found	Removed (incorrect/ fraudulent entry)	Struck off	Suspension	Voluntary removal	Total
Conduct and Competence Committee	0	40	14	1	53	0	44	61	12	225
Health Committee	0	1	0	0	1	0	0	0	0	2
Investigating Committee	0	0	0	0	0	1	0	0	0	1

Outcome by profession

Table 15 shows what sanctions were made in relation to the different professions the HCPC regulates. In some cases there was more than one allegation against the same registrant. The table sets out the sanctions imposed per case, rather than by registrant.

Table 15 Sanctions imposed by profession

	Caution	Conditions of practice	No further action	Not well founded	Removed (fraudulent / incorrect)	Struck off	Suspended	Voluntary removal (consent)	Total
therapists	0	0	0	0	0	0	0	0	0
medical ntists	4	4	0	3	1	4	1	0	17
opodists / iatrists	0	0	0	6	0	3	2	0	11
ical scientists	0	0	1	1	0	1	0	0	3
itians	0	0	0	0	0	0	1	0	1
ring aid pensers	0	0	0	2	0	1	1	1	5
upational apists	3	3	0	4	0	4	11	1	26
rating artment ctitioners	5	1	0	2	0	4	7	1	20
noptists	0	0	0	0	0	0	0	0	0
amedics	11	1	0	16	0	16	24	2	70
siotherapists	9	4	0	7	0	7	4	2	33
ctitioner chologists	3	0	0	7	0	0	3	0	13
sthetists / otists	1	0	0	0	0	0	0	0	1
iographers	5	0	0	6	0	3	3	3	20
ial workers in land	0	0	0	0	0	0	1	0	1
ech and guage apists	0	1	0	0	0	1	3	1	6
al 2012/13	41	14	1	54	1	44	61	11	227

Outcome and representation of registrants

All registrants are invited to attend their final hearing. Some attend and represent themselves, whilst others bring a union or professional body representative or have professional representation, for example a solicitor or lawyer. Some registrants choose not to attend, but they can submit written representations for the panel to consider in their absence.

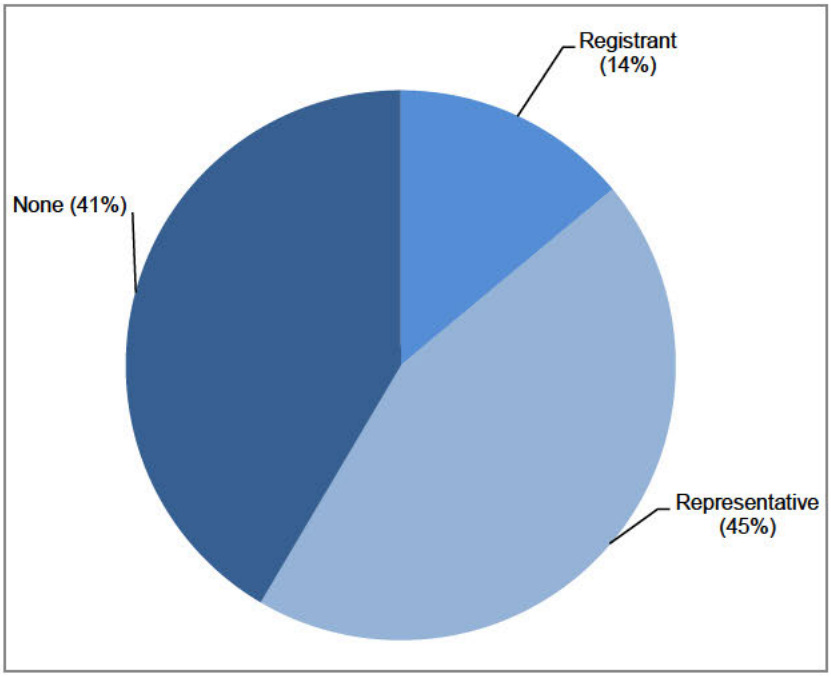
The HCPC encourages registrants to participate in their hearings where possible. It aims to make information about hearings and their procedures accessible and transparent in order to maximise participation.

Panels may proceed in a registrant's absence if they are satisfied that the HCPC has properly served notice of the hearing and that it is just to do so. Panels cannot draw any adverse conclusions from the fact that a registrant may fail to attend their hearing. They will receive independent legal advice from the legal assessor in relation to choosing whether or not to proceed in the absence of the registrant.

The panel must be satisfied that in all the circumstances, it would be appropriate to proceed in the registrant's absence. The HCPC's Practice Note, Proceeding in the Absence of the Registrant provides further information on this.

In 2012–13, 14 per cent of registrants represented themselves, with a further 45 per cent choosing to be represented by a professional. This combined figure of 59 per cent is a slight reduction from 2011–12, when registrants or representatives attended in 67 per cent of cases.

Graph 6 Representation at final hearings



Graph 6 shows that the proportion of registrants at a final hearing representing themselves has remained constant with 15 per cent of cases in 2012–13, compared with 13 per cent in 2011–12. The number of registrants with a representative dropped from 54 per cent in 2011–12 to 45 per cent in 2012–13. There was also a change in the numbers of final hearings with no representation, rising from 33 per cent in 2011–12 to 42 per cent in 2012–13.

Table 16 details outcomes of final hearings and whether the registrant attended alone, with a representative or was absent from proceedings.

Table 16 Outcome and representation at final hearings

Outcome	Registrant	Representative	None	Total
Amended	0	0	0	0
Caution	11	19	11	41
Conditions of practice	1	13	0	14
No further action	0	1	0	1
Not well found	6	42	6	54
Removed	0	0	1	1
Struck off	3	8	33	44
Suspension	9	19	33	61
Voluntary removal	1	0	11	12
Total	**31**	**102**	**95**	**228**

Outcome and route to registration

Table 17 shows the correlation between routes to registration and the outcomes of final hearings. As with case to answer decisions at ICP, the percentage of hearings where fitness to practise is found to be impaired broadly correlates with the percentage of registrants on the Register and their route to registration. The number of hearings concerning registrants who entered the Register via the UK approved route was 87 per cent.

Table 17 Outcome and route to registration

Route to Registration	Amended	Caution	Conditions of practice	No further action	Not well founded	Removed	Struck off	Suspension	Voluntary removal	Total cases	% of cases	% of registrants on the register
Grandparenting	0	0	0	0	3	0	3	0	0	6	2.6	2
International	0	6	0	0	6	0	4	6	0	22	9.6	7
UK	0	35	14	1	45	1	37	55	12	200	87.7	91
Total	0	41	14	1	54	1	44	61	12	228	100.0	100

Conduct and Competence Committee panels

Panels of the Conduct and Competence Committee consider allegations that a registrant's fitness to practise is impaired by reason of misconduct, lack of competence, a conviction or caution for a criminal offence, or a determination by another regulator responsible for health or social care.

Misconduct

In 2012–13 the majority of cases heard at a final hearing, 72 per cent, related to allegations that the registrant's fitness to practise was impaired by reason of their misconduct. In 2011–12, the proportion of misconduct cases was 77 per cent. Some cases also concerned other types of allegations concerning lack of competence or a conviction. Some of the misconduct allegations that were considered included:

- attending work under the influence of alcohol;
- bullying and harassment of colleagues;
- engaging in sexual relationships with a service user;
- failing to provide adequate care;
- false claims to qualifications; and
- self-administration of medication.

Case studies 1 and 2 below give an illustration of the types of issue that are considered where allegations relate to matters of misconduct. They have been based on real cases that have been anonymised.

Misconduct case study 1

A physiotherapist received a Caution Order after being found to have entered appointments in the physiotherapy department's diary for 'ghost patients'. The registrant entered fictitious service user names and also entered appointments for dates when service users did not in fact have appointments.
In giving evidence the registrant admitted the allegation. The explanation given was that he had done this in order to provide free time for research, audit and development purposes. The registrant acknowledged that his actions were dishonest.

In considering whether the registrant's behaviour amounted to misconduct the panel had regard to his 20 years' experience as a physiotherapist and the fact that he must have known the importance in a busy health department of maintaining an accurate diary system. The panel observed that any dishonest interference with that diary system is an extremely serious matter.

Considering the question of whether the registrant's fitness to practise was impaired by his misconduct the panel acknowledged his admission that he had recorded false appointments and that his actions had been dishonest. The panel also noted, though, that the registrant had not been entirely cooperative with the investigation carried out by his employer. The panel considered too that the registrant displayed limited insight. He did not fully appreciate the significance of his dishonest actions and had not fully understood the impact of what he had done because he continued to maintain that service users had not been put at risk.

The panel remarked in particular that a departmental diary system is put in place so that service users are offered a service that responds to their needs. Undermining the integrity of the system in the way the registrant had done potentially puts service users at risk of not receiving treatment in a timely manner.

In determining the appropriate sanction the panel had regard to the nature of the dishonesty and found it to be at the lower end of the scale. The panel noted in particular that the registrant had received no financial or personal gain by his dishonesty. The dishonesty appeared to the panel to be an aberration in an otherwise glowing 20 year career.

The panel was also impressed by evidence it heard from the registrant's colleagues who spoke highly of his commitment, his professional abilities and the trust they placed in him. In conclusion the panel was reassured that there was a very low risk of repetition of the misconduct and took the view that the public interest would not be served by removing the registrant from his professional practice.

Misconduct case study 2

A practitioner psychologist who was responsible for assessments and clinical care of service users with learning difficulties and behavioural problems was given a Suspension Order for twelve months after a panel of the Conduct and Competence Committee found that his record-keeping had been unsatisfactory over a lengthy period. This poor record-keeping included failure to maintain clinical records and to complete discharge summaries, letters and reports.

The panel found that as an experienced practitioner who had previously demonstrated competence the registrant should have been aware of the need to communicate effectively with service users and other practitioners, including through timely letters, reports and written summaries. The fact he did not do so put service users and others at risk.

The panel commented that effective communication and records are essential to plan and monitor treatments and outcomes. There were lengthy periods when the registrant did not record notes for service users and he also treated vulnerable service users using his memory of previous visits rather than written records. The panel considered that these failures amounted to misconduct.

Although the registrant expressed his deep shame and admitted poor prioritisation of his record-keeping the panel had no evidence that the weaknesses impairing his fitness to practise at the time had been remedied. In the panel's view the registrant's misconduct created a serious risk of harm to service users. The panel therefore found the registrant's fitness to practise continued to be impaired.

In the judgement of the panel there was a real risk of repetition of the misconduct because the lapses were neither isolated nor minor. There had been a sustained course of misconduct involving a serious lack of professionalism. The panel decided that a Suspension Order was the appropriate sanction.

Lack of competence

There were 110 allegations heard at final hearing that concerned issues of lack of competence in 2012–13. These included:

- failure to provide adequate service user care;
- inadequate clinical knowledge; and
- poor record-keeping.

Lack of competence allegations were most frequently cited as a reason of impairment of fitness to practise after allegations of misconduct in 2012–13. Of the 110 allegations concerning competence, only 25 related solely to lack of competence, rather than being alleged in the alternative (ie misconduct and / or lack of competence). In 2011–12, there were similar proportions of these cases, with 151 allegations relating to lack of competence, with only 22 having no misconduct or other aspects.

The case study below is an example of a hearing that considered an allegation that related solely to lack of competence.

Lack of competence case study 1

A speech and language therapist was suspended from the Register for a period of twelve months after a panel of the Conduct and Competence Committee found persistent failings in the registrant's performance in a number of key areas, and in particular her communication skills and the application of clinical skills and judgement.

The panel determined that the facts proved amounted to a lack of competence and not misconduct. In reaching this conclusion the panel was influenced by the evidence it heard from the registrant's supervisor that the registrant always displayed a cooperative attitude and endeavoured to reach the professional standards expected of her. The panel commended the registrant for acknowledging areas where she agreed she had fallen below the required standard and where she believed she could have done better.

The panel found the registrant's fitness to practise to be impaired because, although she gave evidence that she had tried to maintain her professional knowledge, there was no evidence that she had been able to satisfactorily address what were persistent and significant failures in key areas of professional competence.

From the evidence of her employer it was also clear to the panel that the shortcomings in the registrant's performance had impacted on her work for some years. It appeared to the panel that, during at least her final year of practice, a genuine effort had been made to assist her to return to an acceptable level of professional practice.

Despite the best efforts of those involved, however, this attempt had failed and the difficulties of achieving further significant progress were described by her supervisor as "insurmountable". It was also apparent to the panel that, while no service users came to harm, there was a significant potential for harm if the registrant's supervisor had not been present to intervene and assist as necessary.

The panel was urged by the registrant's representative to consider a Conditions of Practice Order as an appropriate, proportionate and adequate sanction. The panel gave that option a great deal of careful thought but concluded that there were no conditions of practice which could adequately protect the public unless these were so tightly drawn as to prevent the registrant from working other than under close and detailed direction by an experienced practitioner. In the panel's view such conditions would be unrealistic and unworkable and would effectively amount to a suspension.

Accordingly the panel concluded that a Suspension Order was the only sanction available to it which could provide an adequate level of public protection.

Lack of competence case study 2

A biomedical scientist was made the subject of conditions of practice after a panel found that on two occasions the registrant had failed to report blood sample abnormalities, indicating possible acute leukaemia, to a consultant haematologist. On the first occasion the registrant had also not recognised the salient features in the sample.

The panel considered whether the facts proved amounted to misconduct but found that the registrant's errors were in the nature of mistakes. There had been no wilful acts or omissions. The panel found the registrant open and honest in the evidence he gave and it was apparent to the panel that he was an experienced, professional and dedicated biomedical scientist who understood the potentially serious consequences of the errors he had made.

The registrant had genuinely tried to explain or find reasons for the errors. The panel therefore found that the facts amounted to a lack of competence.

The panel also found the registrant's fitness to practise to be impaired by reason of his lack of competence. This was because, although he had shown some insight by accepting he had made mistakes, the registrant had not undertaken remediation since he was no longer working as a biomedical scientist. Furthermore his errors were such that the likelihood of their being repeated was unpredictable. The registrant had demonstrated competence in his biomedical scientist role for most of the time but there had nonetheless been serious lapses. The panel noted too that leukaemia may need to be treated urgently and delayed diagnosis may have had serious consequences.

The panel found that the registrant was not safe to practise as an autonomous biomedical scientist.

In the panel's judgement a Conditions of Practice Order would protect the public and be proportionate as it would allow the registrant to continue to work in the profession in which he had worked without any issues for a number of years and allow him to remediate his lack of competence.

Convictions / cautions

There were 47 cases considered by panels where the registrant had been convicted or cautioned for a criminal offence. Of those, 40 related solely to allegations of convictions or cautions and did not include other types of allegation.

Criminal convictions or cautions were the third most frequent ground of allegations considered in 2012–13. This situation was unchanged from 2011–12. Under the Home Office Circular 6/2006, the HCPC is notified when a registrant is convicted or cautioned for an offence in England and Wales. Separate but similar arrangements apply in Scotland and Northern Ireland. The case study below is an example of a case concerning an allegation relating to a criminal conviction.

Conviction case study

An operating department practitioner was suspended for twelve months after being cautioned by police for two offences of theft by an employee.

The panel noted that the offences related to theft by the registrant of Remifentanil – a morphine-based controlled drug – from hospitals where he was working.

The panel noted from evidence provided by the police that the registrant had been seen in an operating theatre, apparently alone, with a syringe in his hand. The syringe was taken from him and a search of the theatre revealed a blood-stained tissue and three empty ampoules of Remifentanil. Irregularities were also found with the last two entries in the drugs record book for the theatre.

In a police interview the registrant admitted that he had taken two ampoules of the controlled drug from the drugs cabinet while he was at work and that he had mixed the drug with water and self-administered it by injection. He told police that the solution gave him a five minute “high”. The registrant also told police that he had previously stolen two ampoules of Remifentanil from another hospital within the preceding two weeks.

The panel regarded the registrant’s actions as a serious matter. His self-administration of a controlled drug while at work inevitably had an adverse impact on his ability to function effectively as an operating department practitioner and so was bound to present a risk to patients.

The offences were also ones of dishonesty, made the more serious as involving, albeit indirectly, theft from the public purse. The registrant had not engaged with the fitness to practise process and had neither shown insight nor expressed regret for his criminal behaviour. The panel was satisfied that he had breached fundamental tenets of the requirement that registrants should act in the interests of service users and should act always with integrity.

Accordingly the panel found the registrant’s fitness to practise to be impaired.

The panel found a Suspension Order to be the appropriate sanction. In reaching this conclusion the panel noted that, as is made clear in the HCPC’s Indicative Sanctions

Policy, such an order is punitive in nature and if the evidence suggests a registrant will be unable to resolve his failings striking off may be the more appropriate option.

The panel stopped short of striking off the registrant, however, because a relatively short period had elapsed since his drugs misuse had come to light and he had so far been afforded little opportunity to address issues which may have contributed to that misuse.

Health Committee panels

Panels of the Health Committee consider allegations that registrants' fitness to practise is impaired by reason of their physical and / or mental health. Many registrants manage a health condition effectively and work within any limitations their condition may present. However the HCPC can take action when the health of a registrant is considered to be affecting their ability to practice safely and effectively.

The HCPC presenting officer at a Health Committee hearing will often make an application for proceedings to be heard in private. Often sensitive matters regarding registrants' ill-health are discussed and it may not be appropriate for that information to be discussed in public session.

The Health Committee considered two cases in 201–13. Of those cases one resulted in a caution and the other was not well founded.

Not well founded

Once a panel of the Investigating Committee has determined there is a case to answer in relation to the allegation made, the HCPC is obliged to proceed with the case. Final hearings that are 'not well founded' involve cases where, at the hearing, the panel does not find the facts have been proved to the required standard or concludes that, even if those facts are provided they do not amount to the statutory ground (eg misconduct) or show that fitness to practise is impaired. In that event, the hearing concludes and no further action is taken. In 2012–13 there were 54 cases considered to be not well founded at final hearing. This is a reduction of 14 cases (21%) compared to last year. There was a similar drop of 20 per cent in the previous year, which illustrates that the quality of allegations and investigations continues to improve. The Fitness to Practise Department has continued to ensure that Investigating Panels receive regular refresher training on the 'case to answer' stage in order to ensure that only cases that meet the realistic prospect test as outlined on page 17 are referred to a final hearing.

Table 18 sets out the number of not well founded cases between 2008–09 and 2012–13.

Table 18 Cases not well-founded

Year	Number of not well found	Total number of concluded cases	% of cases not well found
2008–09	40	175	22.9
2009–10	76	256	29.7
2010–11	85	315	27.0
2011–12	68	287	23.7
2012–13	54	228	23.7

In half of the cases (27 cases) which were not well founded, registrants demonstrated that their fitness to practise was not impaired. The test is that fitness to practise is impaired and so is based on a registrant's circumstances at the time of the hearing. If registrants are able to demonstrate insight and can show that any shortcomings have been remedied, panels may not find fitness to practise currently impaired.

In some cases, even though the facts may be judged to amount to the ground of the allegation (eg misconduct, lack of competence), a panel may determine that the ground does not amount to an impairment of current fitness to practise. For example, if an allegation was minor in nature or an isolated incident, and where reoccurrence is unlikely. In 2012–13 this occurred in nine cases (17%).

In other cases the facts of an allegation may not be proved to the required standard (the balance of probabilities). This may be due to the standard or nature of the evidence before the Panel. We review any cases that are not well founded on facts to explore if an alternative form of disposal would have been appropriate, and links to our work on discontinuance of allegations where there is insufficient evidence to prove the case, or where a registrant can enter an agreement to voluntarily be removed from the Register. We are monitoring the levels of not well founded cases to ensure that we are utilising our resources appropriately, and that we minimise the impact of public hearings on the parties involved.

Not well founded case study

A panel of the Conduct and Competence Committee considered an allegation that the registrant, a paramedic, had failed to maintain adequate security in respect of a controlled drug. In particular the registrant had stored a morphine sulphate injection in a jacket pocket and had subsequently become unaware of the location of the jacket.

The Panel heard oral evidence from a Clinical Support Officer from the registrant's employing trust along with oral representations from the HCPC and the registrant.

The registrant admitted the facts of the allegations but did not accept that they amounted to misconduct. The registrant stated that the morphine had been placed into a fleece jacket with the intention of putting it in the ambulance safe. The fleece was

removed, however, upon entering the ambulance and the registrant had forgotten where it had been placed following an emergency call. The registrant told the Panel that this practice for storing morphine had been changed immediately after the incident and morphine was now always stored in a pouch affixed to the paramedic's belt.

The Panel decided that the actions of the registrant amounted to misconduct. The Panel noted that the registrant was in breach of the protocol for the storage of morphine sulphate and that this was not admitted to the registrant's employers afterwards for fear of the consequences.

It was noted, however, that this was an isolated incident and the registrant had demonstrated insight by fully adhering to the appropriate storage procedures following the receipt of a written warning from the trust. Accordingly the Panel was satisfied that there was no risk of repetition in the future. Furthermore, although there had been a breach of in-house protocol, the Panel was satisfied that the fleece in which the morphine had been placed was at all times in a secure place and presented no risk to patients. Consequently the Panel found that the allegation that the registrant's fitness to practise was impaired as a result of misconduct was not well founded.

Suspension and conditions of practice review hearings

Any suspension or conditions of practice order that is imposed must be reviewed by a further panel prior to its expiry date. A review may also take place at any time at the request of the registrant concerned or the HCPC. Registrants may request reviews if they are experiencing difficulties complying with conditions imposed or if new evidence relating to the original order comes to light.

The HCPC can also request a review of an order if, for example, it has evidence that the registrant concerned has breached any condition imposed by a panel.

If a suspension order was imposed, a review panel will look for evidence to satisfy it that the issues that led to the original order have been addressed and that the registrant concerned no longer poses a risk to the public.

If a review panel is not satisfied that the registrant concerned is fit to practice, the panel may:

- extend an existing conditions of practice order;
- further extend a suspension order; or
- strike the registrant's name from the Register, which means they cannot practice.

In 2012–13 141 review hearings were held. Table 19 shows the decisions that were made by review panels in 2012–13.

Table 19 Review hearing decisions

	Review Hearings										
	Adjourned / part heard	Article 30(7)	Caution	Conditions of practice	Order revoked	Not restored	Restored	Struck off	Suspension	Voluntary removal (consent)	Total
Arts therapists	0	0	0	0	2	0	0	0	1	0	3
Biomedical scientists	0	0	0	5	3	0	0	1	7	0	16
Chiropodists / podiatrists	0	0	0	1	0	0	0	3	4	1	9
Clinical scientists	0	0	0	1	0	0	0	0	1	1	3
Dietitians	0	0	0	0	0	0	0	0	2	1	3
Hearing aid dispensers	0	0	0	0	1	0	0	2	1	0	4
Occupational therapists	0	0	0	2	3	0	0	4	7	0	16
Operating department practitioners	0	0	0	0	0	0	0	4	4	0	8
Orthoptists	0	0	0	0	0	0	0	0	0	0	0
Paramedics	0	0	1	0	5	0	0	2	8	1	17
Physiotherapists	1	1	1	4	9	0	0	4	7	0	27
Practitioner psychologists	1	0	0	0	4	0	0	1	1	0	7
Prosthetists / orthotists	0	0	0	1	1	0	0	0	0	0	2
Radiographers	0	0	0	5	1	0	0	6	5	0	17
Social workers in England	0	0	0	0	0	0	0	0	0	0	0
Speech and language therapists	0	0	0	0	1	0	0	2	6	0	9
Total	2	1	2	19	30	0	0	29	54	4	141

The reviews of the suspension and conditions of practice orders are described in detail below:

Suspension orders

Outcome of review	Number	%
Suspension confirmed at review	46	46
Existing suspension replaced with conditions of practice	3	3
Suspension expired, further suspension imposed	6	6
Caution imposed at review of suspension	2	2
Registrant struck off following review of suspension	28	28
Registrant removed by voluntary agreement following period of suspension	4	4
No further action following review of suspension	11	11
Total	100	100

Conditions of practice orders

Outcome of review	Number	%
Conditions confirmed	4	10.3
Conditions varied	12	30.8
Existing COP replaced with suspension	2	5.1
Registrant struck off following review of conditions	1	2.6
No further action following review of suspension	20	51.3
Total	39	100

Restoration hearings

A person who has been struck off the HCPC Register by a Practice Committee and wishes to be restored to the Register, can apply for restoration under Article 33(1) of the Health and Social Work Professions Order 2001.

An application for restoration to the Register following a striking-off order cannot be made until five years have elapsed since the striking off order came

into force. In addition, a person may not make more than one application for restoration in any twelve-month period.

In applying for restoration, the burden of proof is upon the applicant. This means it is for the applicant to prove that he or she should be restored to the Register and not for the HCPC to prove the contrary. The procedure is generally the same as other fitness to practise proceedings, however in accordance with Rule 13 (10) of the procedural rules, the applicant presents his or her case first and then it is for the HCPC presenting officer to make submissions after that.

If a Panel grants an application for restoration, it may do so unconditionally or subject to the applicant:

- meeting any applicable education and training requirements specified by the Council; or
- complying with a conditions of practice order imposed by the Panel.

In 2012–13, one applicant was granted restoration to the Register.

Article 30(7) hearings

Article 30(7) of the Health and Social Work Professions Order 2001 enables a striking off order to be reviewed at any time where “new evidence relevant to a striking-off order” becomes available after a striking-off order has been made.

Registrants making applications under Article 30(7) must demonstrate to a Practice Committee that:

- they are in possession of “new evidence” which has not been considered as part of the previous investigation or hearing;

- the new evidence is relevant to any or all of the following:

    - the finding that the allegations were well founded
    - the finding that fitness to practise is impaired
    - the decision to impose a striking-off order; and

- there is a reasonable explanation as to why the evidence was not available at the time of the original hearing; or

- provide evidence that the registrant was not afforded a reasonable opportunity to attend (if the registrant did not attend the hearing at which the striking-off order was made).

In 2012–13 one application for a review of a striking-off order was considered under Article 30(7) of the Health and Social Work Professions Order 2001. At that review, a Panel decided that the striking off order should remain.

Disposal of cases by consent

The HCPC’s consent process is a means by which the HCPC and the registrant concerned may seek to conclude a case without the need for a contested hearing. In such cases, the HCPC and the registrant consent to conclude the case by agreeing an order of the kind which the Panel would have been likely to make had the matter proceeded to a fully contested hearing. The HCPC and the registrant may also agree to enter into a Voluntary Removal Agreement, whereby the HCPC agrees to allow the registrant to remove themselves from the HCPC Register on the provision that the registrant fully admits the allegation that has been made against them and no longer wishes to practise in their profession. Voluntary Removal Agreements have the effect of a striking off order.

Cases can only be disposed of in this manner with the authorisation of a panel of a Practice Committee.

The HCPC will only consider resolving a case by consent:

- after an Investigating Committee Panel has found that there is a ‘case to answer’, so that a proper assessment has been made of the nature, extent and viability of the allegation;

- where the registrant is willing to admit the allegation in full (a registrant’s insight into, and willingness to address failings are key elements in the fitness to practise process and it would be inappropriate to dispose of a case by consent where the registrant denies liability); and

- where any remedial action agreed between the registrant and the HCPC is consistent with the expected outcome if the case was to proceed to a contested hearing.

The process may also be used when existing conditions of practice orders or suspension orders are reviewed. This enables orders to be varied, replaced or revoked without the need for a contested hearing.

In order to ensure the HCPC fulfils its obligation to protect the public, neither the HCPC nor a Panel would agree to resolve a case by consent unless they are satisfied that:

- the appropriate level of public protection is being secured; and

- doing so would not be detrimental to the wider public interest.

In 2012–13, eleven cases were concluded via the HCPC’s consent arrangements at final hearing.

Further information on the process can be found in the Practice Note Disposal of Cases by consent practice note at www.hcpc-uk.org/publications/practicenotes

Discontinuance

Occasionally, after the Investigating Committee has determined that there is a ‘case to answer’ in respect of an allegation, objective appraisal of the detailed evidence which has been gathered since that decision was made may reveal that it is insufficient for the HCPC to sustain a realistic prospect of proving the whole or part of the allegation at a final hearing.

Where such a situation arises, the HCPC may apply to a panel to discontinue the proceedings. The HCPC may apply to discontinue the whole or part of an allegation.

In 2012–13, following applications by the HCPC, allegations were discontinued in eight separate cases by a panel.

The role of the Professional Standards Authority and High Court cases

The Professional Standards Authority (PSA) – formerly known as the Council for Healthcare Regulatory Excellence (CHRE) – is the body that promotes best-practice and consistency in the regulation of healthcare professionals for the nine UK healthcare regulatory bodies.

The PSA can refer a regulator's final decision in a fitness to practise case to the High Court (or in Scotland, the Court of Session). They can do this if it is felt that a decision by the regulatory body is unduly lenient and that such a referral is in the public interest.

In 2012–13, two cases were referred to the High Court by PSA. One was remitted back for a Conduct and Competence hearing, and the other was rejected, with the sanction of striking off remaining.

In 2012–13 three registrants appealed the decisions made by the Conduct and Competence Committee. One appeal was concluded, resulting in a dismissal of the appeal with the original panel decision remaining. A second appeal had started but not concluded by 31 March 2013. A further appeal was withdrawn by the registrant before an appeal hearing and the original sanction remained.

Update on developments for 2012–13

Health and Social Care Act

The government's Health and Social Care Bill received Royal Assent on Tuesday 27 March 2012, resulting in the transfer of the regulation of social workers in England from the General Social Care Council (GSCC) to the Health Professions Council from Wednesday 1 August 2012. Four hundred and seventy six cases were transferred on the closure of the GSCC. Each of these cases was reviewed by the HCPC in order to assess the risk and nature of the case, and whether there was sufficient evidence to continue the case following HCPC processes. More information on these cases can be found in appendix 3 of this report.

Case Management System

The new paperless Fitness to Practise Case Management System went live on Monday 2 April 2012. All historic and existing cases were migrated to the system and all new cases were then logged on the new system. Work is currently underway on phase 2 of the Case Management System which should build in improvements to the system based on our experience of using the system.

How to raise a concern

If you would like to raise a concern about a professional registered by the HCPC, please write to our Director of Fitness to Practise at the following address.

Fitness to Practise Department
The Health Professions Council
Park House
184 Kennington Park Road
London SE11 4BU

If you need advice, or feel your concerns should be taken over the telephone, you can also contact a member of the Fitness to Practise Department on:

tel +44 (0)20 7840 9814
freephone 0800 328 4218 (UK only)
fax +44 (0)20 7582 4874

You may also find our ‘Reporting a concern’ form useful, available at http://www.hcpc-uk.org/complaints

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Appendix one

Summary of decisions made by final hearing panels in 2012–13

More details of the decisions made by final hearing Panels are published on the HCPC website at: www.hcpc-uk.org/complaints/hearings

Date of decision	First name	Last name	Profession	Outcome	Committee type	Details of case
4 April 2012	James	Torrie	Operating department 9ractitioner	Struck off	Conduct and Competence	Did not prioritise workload, communicate effectively and understand risk management.
4 April 2012	Michael Healey	Field	Radiographer	Removed by consent	Conduct and Competence	Lack of competence with use of equipment. Failure to report missing logbook.
4 April 2012	David	Payne-Smith	Practitioner psychologist	Suspension	Conduct and Competence	Breach of service user confidentiality.
19 April 2012	Clive	Jordan	Paramedic	Suspension	Conduct and Competence	Inadequate assessment, patient care and clinical reasoning skills.
20 April 2012	Ian	Hancock	Practitioner psychologist	Caution	Conduct and Competence	Inadequate assessment, patient care and clinical reasoning skills.

20 April 2012	David S	Oliver	Paramedic	Struck off	Conduct and Competence	Engaged in sexually explicit exchanges with a person believed to be a minor.
23 April 2012	Scott	Tomkinson	Physiotherapist	Caution	Conduct and Competence	Police caution for production of cannabis.
24 April 2012	James Frederick	Cladingboel	Paramedic	Caution	Conduct and Competence	Self-Administration of Entonox.
25 April 2012	John R	Raison	Operating department practitioner	Suspension	Conduct and Competence	Theft of drugs from theatre and self-administration of whilst on duty.
26 April 2012	Christopher P	Dinsdale	Paramedic	Suspension	Conduct and Competence	Administered drugs to a patient using an unauthorised method.
27 April 2012	James	Bryan	Paramedic	Removed by consent	Conduct and Competence	Administration of incorrect drug to patient. Failed to complete PRF and hand over properly.
27 April 2012	Mark	Small	Paramedic	Caution	Conduct and Competence	Posted inappropriate comments on a social networking site.
2 May 2012	Daniel F	Gray	Paramedic	Caution	Conduct and Competence	Took a service vehicle for personal use whilst on duty.
3 May 2012	John L	Finch	Radiographer	Struck off	Conduct and Competence	Inappropriate behaviour towards service users and colleagues.

4 May 2012	Michael	Davies	Paramedic	Struck off	Conduct and Competence	Failed to provide appropriate care to a patient and colluded with colleagues to alter the PRF.
4 May 2012	David	Glover	Paramedic	Struck off	Conduct and Competence	Failed to provide appropriate care to a patient and colluded with colleagues to alter the PRF.
9 May 2012	Karen J	Clark	Occupational therapist	Suspension	Conduct and Competence	Poor assessment, patient care and clinical reasoning skills.
9 May 2012	Mark A	Kinder	Physiotherapist	Struck off	Conduct and Competence	Police caution for possessing indecent images of children.
11 May 2012	Michael M	Ogilvie	Paramedic	Struck off	Conduct and Competence	Downloaded, viewed and stored indecent images of children.
11 May 2012	Gerald J	Higgins	Biomedical scientist	Conditions of Practice	Conduct and Competence	Convicted of doing an act of cruelty to a child.
11 May 2012	Nigel T	Moore	Paramedic	Suspension	Conduct and Competence	Convicted of driving a motor vehicle with excess alcohol.
11 May 2012	Gerald J	Higgins	Biomedical scientist	Conditions of Practice	Conduct and Competence	Convicted of doing an act of cruelty to a child.

14 May 2012	Kim	Carvell	Operating department practitioner	Caution	Conduct and Competence	Police caution for theft by employee.
15 May 2012	Andrina	Mccormack	Practitioner psychologist	Caution	Conduct and Competence	Acted outside of remit when preparing report.
15 May 2012	David	Davies	Paramedic	Caution	Conduct and Competence	Did not perform assessment and treatment to a Patient.
15 May 2012	Fraser C	Ferguson	Physiotherapist	Caution	Conduct and Competence	Falsely recorded patient appointments.
22 May 2012	Mary	Simons	Occupational therapist	Suspension	Conduct and Competence	Inadequate clinical reasoning and workload management.
23 May 2012	Laura J	Hopkins	Occupational therapist	Suspension	Conduct and Competence	Inadequate clinical skills.
25 May 2012	Paul	Summers	Paramedic	Caution	Conduct and Competence	Did not perform a suitable assessment of a patient.
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
30 May 2012	Firopo	Tibetan	Physiotherapist	Caution	Conduct and Competence	Provided an inaccurate CV to recruitment agency.
6 June 2012	Darren	Cornish	Paramedic	Caution	Conduct and Competence	Police caution for possession of controlled drug.
6 June 2012	Adele	Swanton	Physiotherapist	Caution	Conduct and Competence	Police caution for theft

7 June 2012	Ashish	Bhutani	Physiotherapist	Suspension	Conduct and Competence	Sexual misconduct towards a patient.
8 June 2012	Paul	Spencer	Physiotherapist	Struck off	Conduct and Competence	Convicted of making indecent photographs of children.
12 June 2012	Edward	Trickett	Paramedic	Struck off	Conduct and Competence	Convicted of sexual activity with a child.
12 June 2012	Victoria E	Parker	Paramedic	Struck off	Conduct and Competence	Sabotaged ambulance vehicle to avoid attending a patient.
18 June 2012	Simon	Wade	Paramedic	Struck off	Conduct and Competence	Convicted of theft, fraud and possession of drugs.
18 June 2012	Megan E	Phillips	Physiotherapist	Caution	Conduct and Competence	Convicted of fraud.
19 June 2012	Adele J	Copeman - King	Paramedic	Paramedic	Conduct and Competence	Inadequate clinical care and communication with service user.
20 June 2012	Semiat D	Yinusa	Biomedical scientist	Caution	Conduct and Competence	Convicted of assault by beating.
25 June 2012	Karl	Pharoah	Paramedic	Suspension	Conduct and Competence	Convicted of assault by beating and breach of a court order.
27 June 2012	Emmanuel	Ansanyi	Radiographer	Caution	Conduct and Competence	Inappropriate clinical treatment and deletion of clinical records.
28 June 2012	Taru	Pahwa	Operating department practitioner	Suspension	Conduct and Competence	Police Cautions for theft.

10 July 2012	Godfrey M	Bunce	Paramedic	Struck off	Conduct and Competence	Inadequate clinical care and communication with service user.
11 July 2012	Philip W	Crosby	Radiographer	Suspension	Conduct and Competence	Clinical errors and failure to comply with practice restrictions.
13 July 2012	Francis	Benyure	Biomedical scientist	Caution	Conduct and Competence	Convicted of prohibited purchase of a endangered species.
18 July 2012	Julie	Hose	Paramedic	Caution	Conduct and Competence	Inappropriate behaviour towards a service user.
19 July 2012	Oluwaleke G	Sokunbi	Physiotherapist	Struck off	Conduct and Competence	Provided false information during recruitment.
19 July 2012	Donald	Maciver	Occupational therapist	Caution	Conduct and Competence	Convicted of Breach of the Peace and Fraud.
20 July 2012	Benjamin	Jones	Operating department practitioner	Suspension	Conduct and Competence	Stole and self-administered drugs from work.
13 August 2012	Carl A	Brzakalik	Paramedic	Struck off	Conduct and Competence	Convicted of theft.
16 August 2012	Julian	Anderson	Paramedic	Suspension	Conduct and Competence	Convicted of driving a motor vehicle with excess alcohol.
20 August 2012	Bernard J	Peacher	Paramedic	Removed by consent	Conduct and Competence	Failure to provide adequate patient care.
22 August 2012	Lyndsey J	Mcconnell	Speech and language therapist	Suspension	Conduct and Competence	Poor clinical skills.

22 August 2012	Pamela E	Smith	Speech and language therapist	Removed by consent	Conduct and Competence	Bullying and harassment of colleagues.
29 August 2012	Kevin Darin	Adams	Paramedic	Suspension	Conduct and Competence	Continued to practice when HCPC registration had lapsed.
4 September 2012	Mark	Burns	Practitioner psychologist	Suspension	Conduct and Competence	Poor record keeping.
5 September 2012	Umalini	Kathirgamanathan	Occupational therapist	Suspension	Conduct and Competence	Poor clinical skills.
5 September 2012	Alan R D	Clark	Paramedic	Suspension	Conduct and Competence	Inappropriate behaviour towards a service user and inadequate clinical care.
7 September 2012	Fazal	Karim	Radiographer	Caution	Conduct and Competence	Inappropriate behaviour with service users.
10 September 2012	Intisar	Osman	Occupational therapist	Caution	Conduct and Competence	Convicted for driving a motor vehicle with excess alcohol.
11 September 2012	Roy M	Stubbs	Paramedic	Struck off	Conduct and Competence	Breached service user confidentiality and provided inadequate clinical care.
11 September 2012	Paul F	Westrop	Paramedic	Suspension	Conduct and Competence	Inadequate treatment of a service user.
12 September 2012	Joerg F	Thieme	Radiographer	Caution	Conduct and Competence	Performed unauthorised scans on service user and self.

13 September 2012	Philip Robert	Abigail-Grimes	Paramedic	Suspension	Conduct and Competence	Inadequate clinical care and dishonesty.
19 September 2012	Raymond	Collins	Operating department practitioner	Struck off	Conduct and Competence	Self-administered drugs whilst on duty.
19 September 2012	Ahmed S	Omar	Radiographer	Caution	Conduct and Competence	Inappropriate behaviour towards colleagues.
19 September 2012	Ralph	Short	Paramedic	Caution	Conduct and Competence	Inadequate clinical care and misleading behaviour.
21 September 2012	David Robert	Taylor	Hearing aid dispenser	Struck off	Conduct and Competence	Dishonestly miss sold goods to service users.
21 September 2012	Sadia	Iqbal	Biomedical scientist	Removed	Conduct and Competence	Incorrect entry on the HCPC Register.
25 September 2012	Teresa A	Polanska	Occupational therapist	Suspension	Conduct and Competence	Inadequate record keeping and clinical skills.
25 September 2012	Rachel	Davis	Occupational therapist	Struck off	Conduct and Competence	Fraudulently claimed sick pay.
26 September 2012	Carol A	Hoyland	Physiotherapist	Caution	Conduct and Competence	Breached service user confidentiality.
27 September	Sharat C	Sharma	Occupational therapist	Suspension	Conduct and Competence	Inadequate clinical skills and knowledge.

2012						
27 September 2012	James	Nelson	Paramedic	Struck off	Conduct and Competence	Refused to attend an emergency call.
1 October 2012	Anthony E	Bryan	Operating department practitioner	Caution	Conduct and Competence	Inadequate management of controlled drugs and completion of clinical records.
3 October 2012	Danny	Brown	Physiotherapist	Conditions of Practice	Conduct and Competence	Inadequate clinical, assessment and reasoning skills.
4 October 2012	Sulaiman G	Gegbe	Biomedical scientist	Suspension	Conduct and Competence	Inadequate clinical care and inappropriate behaviour on work premises.
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
9 October 2012	Adam J	Cutler	Biomedical scientist	Struck off	Conduct and Competence	Placed concealed video recording equipment in two shared houses.
9 October 2012	William E	Chamberlain	Paramedic	Struck off	Conduct and Competence	Convicted of voyeurism.
10 October 2012	Karen L	Elliott	Speech and language therapist	Struck off	Conduct and Competence	Inadequate record keeping, time management and acted outside of remit.

11 October 2012	Suresh	Chandra	Occupational therapist	Suspension	Conduct and Competence	Inadequate clinical reasoning, record keeping and communication with colleagues.
12 October 2012	Senthil Kumar	Meialagan	Occupational therapist	Struck off	Conduct and Competence	Conviction for sexual assault.
17 October 2012	Nigel P	Webb	Paramedic	Suspension	Conduct and Competence	Inappropriate sexual behaviour towards a member of the public.
19 October 2012	Leeto B	Thale	Chiropodists / podiatrist	Suspension	Conduct and Competence	Falsified clinical records and inadequate clinical care.
24 October 2012	Morag J	Cole	Occupational therapist	Suspension	Conduct and Competence	Inadequate clinical care, record keeping and communication with colleagues.
24 October 2012	Stuart	Alves	Paramedic	Struck off	Conduct and Competence	Dishonestly issued false course certification to a doctor.
26 October 2012	Gotchagorn	Mustow	Physiotherapist	Conditions of Practice	Conduct and Competence	Inadequate clinical care, record keeping and time management.
29 October 2012	Qamar	Zaman	Biomedical scientist	Caution	Conduct and Competence	Made false data entries which compromised patient safety.
30 October 2012	Elizabeth M	Ashford	Speech and language therapist	Removed by consent	Conduct and Competence	Inadequate record keeping and clinical care.

1 November 2012	Shavnam	Dosanjh	Practitioner psychologist	Suspension	Conduct and Competence	Inadequate record keeping.
2 November 2012	Joseph	Yusupoff	Practitioner psychologist	No further action	Conduct and Competence	Inappropriate relationship with a service user.
2 November 2012	Margaret	Harper	Dietitian	Suspension	Conduct and Competence	Inadequate clinical, record keeping and communication skills.
5 November 2012	Geoffrey	Till	Paramedic	Suspension	Conduct and Competence	Inadequate clinical care and record keeping.
5 November 2012	Toly	Lau	Physiotherapist	Caution	Conduct and Competence	Convicted of Theft.
7 November 2012	Wietse H	Zeijlemaker	Physiotherapist	Struck off	Conduct and Competence	Inadequate record keeping and inappropriate admission of service users to Trust premises.
8 November 2012	Ross M	Taggart	Physiotherapist	Suspension	Conduct and Competence	Inadequate record keeping.
13 November 2012	Martin W	Swain	Operating department practitioner	Suspension	Conduct and Competence	Intimidation and harassment of a colleague.
15 November 2012	Barry John	Fogg	Paramedic	Suspension	Conduct and Competence	Inadequate clinical care, record keeping and communication with colleagues.
20 November 2012	Maisie	Noel	Speech and language therapist	Suspension	Conduct and Competence	Inadequate clinical skills and reasoning.

20 November 2012	Ramani	Ramaswamy	Radiographer	Suspension	Conduct and Competence	Unable to perform routine imaging processes.
22 November 2012	Gary	Gordon	Prosthetist / orthotist	Caution	Conduct and Competence	Failed to declare financial interests.
22 November 2012	David	Rosser	Occupational therapist	Suspension	Conduct and Competence	Breached patient confidentiality.
26 November 2012	Sadie	Strain	Speech and language therapist	Removed by consent	Conduct and Competence	Inadequate record keeping.
26 November 2012	Jason	Mastin	Operating department practitioner	Suspension	Conduct and Competence	Convicted of harassment and threatening and abusive behaviour towards colleagues.
29 November 2012	Morteza	Pourfarzam	Clinical scientist	Struck off	Conduct and Competence	Dishonestly used NHS resources and staff for financial gain.
30 November 2012	Marjorie J	Linton	Radiographer	Struck off	Conduct and Competence	Inadequate clinical care and communication with service users. Failed to respect patient dignity.
30 November 2012	Rajesh T	Mallick	Physiotherapist	Suspension	Conduct and Competence	Inadequate clinical care and record keeping.
4 December 2012	Angela D	Bone	Paramedic	Suspension	Conduct and Competence	Inadequate clinical assessment and intervention.
5 December 2012	Rebecca	King	Operating department practitioner	Struck off	Conduct and Competence	Dishonestly failed to dispose of controlled substance.

5 December 2012	Katherine	Parkinson	Speech and language therapist	Suspension	Conduct and Competence	Inadequate clinical care, storage of clinical records and supervision of staff.
6 December 2012	Lisa	Hubbard	Paramedic	Struck off	Conduct and Competence	Inadequate clinical care and communication with patients.
11 December 2012	Chantal D M	Hamon	Occupational therapist	Suspension	Conduct and Competence	Inadequate clinical care, record keeping and communication with service users.
12 December 2012	Marian	Schouten	Physiotherapist	Suspension	Conduct and Competence	Inadequate record keeping and treatment programmes.
13 December 2012	Charles P	Hill	Radiographer	Suspension	Conduct and Competence	Inadequate clinical knowledge. Actions placed patients at risk.
13 December 2012	Michaela	Lareine	Paramedic	Caution	Conduct and Competence	Left patient unattended and failed to carry out regular reassessment.
17 December 2012	Peter	McAnna	Hearing aid dispenser	Removed by consent	Conduct and Competence	Inadequate record keeping and referral of a patient.
18 December 2012	Lee	Blayney	Paramedic	Suspension	Conduct and Competence	Recreational use of illegal drugs.
20 December 2012	Theodore Onyemaechi	Ogumba	Biomedical scientist	Struck off	Conduct and Competence	Failure to follow standard procedures and repeated clinical errors.

21 December 2012	Howard	Price	Chiropodists / podiatrist	Struck off	Conduct and Competence	Sexually motivated behaviour towards a service user.
21 December 2012	Julian N	Mcfarlane	Physiotherapist	Removed by consent	Conduct and Competence	Inadequate clinical care and communication with service users.
21 December 2012	Anthony Colin	Moss	Social worker	Struck off	Conduct and Competence	Aggressive behaviour towards a service user.
3 January 2013	Tina	Mill	Radiographer	Removed by consent	Conduct and Competence	Inadequate clinical skills.
7 January 2013	Colin H	Jackman	Paramedic	Struck off	Conduct and Competence	Failed to respond appropriately to an emergency call. Inadequate clinical care.
8 January 2013	Bula J	Muanda	Biomedical scientist	Caution	Conduct and Competence	Convicted for possession of a false passport. Dishonestly failed to declare conviction.
9 January 2013	Claire A	Jolly	Paramedic	Suspension	Conduct and Competence	Inadequate diagnosis and clinical care.
9 January 2013	Tony	Mountain	Paramedic	Suspension	Conduct and Competence	Inappropriate behaviour towards colleagues. Failed to assist an injured pedestrian.
10 January 2013	David J	Styles	Biomedical scientist	Conditions of Practice	Conduct and Competence	Inadequate assessment of blood film results.

11 January 2013	Deborah	Gosling	Paramedic	Conditions of Practice	Conduct and Competence	Inadequate clinical care and skills and poor communication with colleagues.
14 January 2013	Emily A	Blake	Occupational therapist	Struck off	Conduct and Competence	Caution for fraud by false representation.
15 January 2013	Adriaan T	Kraaijestein	Physiotherapist	Suspension	Conduct and Competence	Inadequate maintenance and storage of clinical records.
15 January 2013	Niall	Fitzpatrick	Occupational therapist	Conditions of Practice	Conduct and Competence	Inadequate clinical record keeping.
17 January 2013	Clive F	Kemp	Occupational therapist	Struck off	Conduct and Competence	Inadequate record keeping, communication with colleagues and clinical decision making.
17 January 2013	Martin	Hill	Paramedic	Suspension	Conduct and Competence	Clinical error and dishonesty.
18 January 2013	Graham J	Small	Speech and language therapist	Conditions of Practice	Conduct and Competence	Failed to obtain patient consent and provide adequate supervision to students.
18 January 2013	Karen L	Brierley	Occupational therapist	Conditions of Practice	Conduct and Competence	Inadequate clinical care, record keeping and communication with colleagues.
18 January 2013	Glenn	Mapanao	Physiotherapist	Caution	Conduct and Competence	Police caution for assault by beating.

18 January 2013	Steven Thomas	Snook	Social worker	Struck off	Conduct and Competence	Convicted for sexual activity with a child by a person in a Position of Trust.
23 January 2013	Nicola j	Newman	Operating department practitioner	Struck off	Conduct and Competence	Stole drugs from work for personal use.
29 January 2013	Shangara	Madar	Operating department practitioner	Caution	Conduct and Competence	Inappropriate behaviour towards a colleague.
29 January 2013	Emma	Barrett	Occupational therapist	Conditions of Practice	Conduct and Competence	Inadequate record keeping.
29 January 2013	Waryla	Abrahams	Social worker	Struck off	Conduct and Competence	Convicted of five counts of dishonestly making a false representation.
31 January 2013	Rana H R	Tipu	Physiotherapist	Struck off	Conduct and Competence	Made false representations to an overseas professional body.
4 February 2013	Louise	Birch	Physiotherapist	Conditions of Practice	Conduct and Competence	Convicted of driving a motor vehicle with excess alcohol.
4 February 2013	Wendy Iris	Wilson	Social worker	Removed by consent	Conduct and Competence	Made false expense claims at work and convicted of fraud.
4 February 2013	William	Goodwillie	Social worker	Removed by consent	Conduct and Competence	Inadequate clinical assessment and record keeping.

5 February 2013	Kabir	Mahmud	Occupational therapist	Caution	Conduct and Competence	Convicted of four counts of assault.
6 February 2013	Clayton	Thompson	Practitioner psychologist	Caution	Conduct and Competence	Continued to practise when HCPC registration had lapsed.
8 February 2013	Brian	Dornan	Operating department practitioner	Caution	Conduct and Competence	Plagiarism of a professional article.
13 February 2013	Peter D	Collins	Chiropodists / podiatrist	Struck off	Conduct and Competence	Inadequate clinical care, communication with patients and record keeping. Dishonesty.
13 February 2013	Neil	Mcmaster	Biomedical scientist	Struck off	Conduct and Competence	Convicted of making and possessing indecent images of children.
13 February 2013	Jane Elizabeth	Lamb	Social worker	Suspension	Conduct and Competence	Convicted of driving a motor vehicle with excess alcohol.
18 February 2013	Christopher	Warren	Operating department practitioner	Caution	Conduct and Competence	Convicted of assault by beating.
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
21 February 2013	Louise	Staffell	Paramedic	Suspension	Conduct and Competence	Convicted of driving a motor vehicle with excess alcohol.
21 February 2013	Kim M	Shaw	Operating department	Removed by consent	Conduct and Competence	Dishonesty and inadequate

			practitioner			communication with colleagues.
21 February 2013	Alice Sai	Turay	Social worker	Suspension	Conduct and Competence	Convicted of Fraud.
22 February 2013	Bramley J	Wright	Radiographer	Caution	Conduct and Competence	Convicted of Retaining Wrongful Credit.
22 February 2013	Michael Xavier	Takie	Radiographer	Struck off	Conduct and Competence	Convicted of Obtaining a Pecuniary Advantage by Deception.
25 February 2013	Gillon P	Haggan	Chiropodists / podiatrist	Suspension	Conduct and Competence	Dishonestly provided false information when applying for employment.
27 February 2013	Christopher W	Moss	Paramedic	Suspension	Conduct and Competence	Aggressive behaviour towards a service user.
28 February 2013	Carol	Walker	Radiographer	Removed by consent	Conduct and Competence	Unsafe clinical practice and inadequate clinical skills.
28 February 2013	Philip	Bishop	Paramedic	Suspension	Conduct and Competence	Inadequate clinical care and record keeping.
4 March 2013	Roger G	Watson	Physiotherapist	Struck off	Conduct and Competence	Convicted of Sexual Assault.
5 March 2013	Adelle	Wilkinson	Paramedic	Caution	Conduct and Competence	Inadequate clinical care and record keeping.
5 March 2013	Shauny	Napier	Operating department practitioner	Suspension	Conduct and Competence	Convicted of Theft of prescription drugs.
11 March 2013	David	Flower	Operating department	Conditions of Practice	Conduct and Competence	Attended work under the influence of alcohol.

			practitioner			
12 March 2013	Kevin	Stevenson	Paramedic	Suspension	Conduct and Competence	Inadequate clinical care and disposal of morphine.
12 March 2013	Kevin	Stevenson	Paramedic	Suspension	Conduct and Competence	Inadequate clinical care and disposal of morphine.
15 March 2013	Lynne	Griffiths	Social worker	Conditions of Practice	Conduct and Competence	Inadequate standard of care.
19 March 2013	Craig H	Susdorf	Paramedic	Suspension	Conduct and Competence	Delayed basic and advanced life support. Allowed an unqualified individual to drive an ambulance.
19 March 2013	Helen M	Hoskins	Biomedical scientist	Conditions of Practice	Conduct and Competence	Attended work under the influence of alcohol. Convicted for driving a motor vehicle with excess alcohol.
19 March 2013	Philip A	Rule	Hearing aid dispenser	Suspension	Conduct and Competence	Theft from employer.
19 March 2013	Clare Linda	Bowthorpe-Weller	Social worker	Suspension	Conduct and Competence	Inadequate management of caseload and fabrication of service user records.
21 March 2013	Amanda Claire	Wild	Social worker	Suspension	Conduct and Competence	Inadequate standard of care for service users.

21 March 2013	Julie	Hayden	Social worker	Suspension	Conduct and Competence	Inadequate standard of care for service users
25 March 2013	Timothy John	Phillips	Social worker	Suspension	Conduct and Competence	Failed to maintain a professional relationship with service users.
26 March 2013	Peter James Newton	Taylor	Social worker	Struck off	Conduct and Competence	Convicted for Fraud.
26 March 2013	Muhammed Khurshid-ul	Haque	Social worker	Suspension	Conduct and Competence	Allowed children to live in an unsafe environment.
26 March 2013	Joanne Marie	Mcgovern	Social worker	Struck off	Conduct and Competence	Did not maintain professional boundaries with a service user.
26 March 2013	Eudora Iyabo Mariam	Peters	Social worker	Struck off	Conduct and Competence	Created false records about visits to service users.
26 March 2013	Raymond	Douieb	Social worker	Removed by consent	Conduct and Competence	Did not follow safeguarding procedures.
27 March 2013	Russell John	Bland	Operating department practitioner	Struck off	Conduct and Competence	Inappropriately touched a colleague.
28 March 2013	John Joseph	Dullaghan	Social worker	Caution	Conduct and Competence	Crossed professional boundaries with a service user.
28 March 2013	Rachael Anne	Miles	Social worker	Struck off	Conduct and Competence	Provided false and misleading information regarding absences.

						from work.
28 March 2013	Jino	Philip	Social worker	Suspension	Conduct and Competence	Put service users at risk and did not communicate effectively with service users and colleagues.

Appendix two

Historic statistics

Cases received

Number of cases received 2002-03 to 2012-13

Year	Number of cases	Total number of registrants	% of registrants subject to complaints
2002-03	70	144,141	0.05
2003-04	134	144,834	0.09
2004-05	172	160,513	0.11
2005-06	316	169,366	0.19
2006-07	322	177,230	0.18
2007-08	424	178,289	0.24
2008-09	483	185,554	0.26
2009-10	772	205,311	0.38
2010-11	759	215,083	0.35
2011-12	925	219,162	0.42
2012-13	1653	310,942	0.52

Who makes complaints 2006–13

Type of complaint	2005-06	% of cases	2006-07	% of cases	2007-08	% of cases	2008-09	% of cases	2009-10	% of cases	2010-11	% of cases	2011-12	% of cases
Article 22(6) / Anonymous	58	18	35	11	63	15	64	13	108	14	166	22	284	3
BPS / AEP transfer*	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	44	6	0	0	0	
Employer	123	39	161	50	171	40	202	42	254	33	217	29	288	3
Other	15	5	1	0.3	5	1	16	3	30	4	21	3	46	
Other Registrant / professional	28	9	16	5	42	10	56	12	60	8	75	10	52	
Police	24	8	31	10	35	8	36	7	39	5	25	3	27	
Professional body	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/
Public	68	21	78	24	108	25	109	23	237	31	255	34	228	2
Self referral	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/
Total	316	100	322	100.3	424	99	483	100	772	101	759	101	925	10

*These are cases that were transferred from the British Psychological Society to the HPC

Cases by profession – 2005–13

Profession	2005–2006	2006–2007	2007–2008	2008–2009	2009–2010	2010-2011	2011-12	2012-13
Arts therapists	2	4	16	8	5	4	4	7
Biomedical scientists	21	18	26	46	39	37	66	37
Chiropodists / podiatrists	62	38	40	62	76	78	55	53
Clinical scientists	3	2	6	8	4	10	9	9
Dietitians	7	6	14	1	12	9	12	12
Hearing aid dispensers	0	0	0	0	0	44	19	25
Occupational therapists	38	40	45	55	78	62	95	74
Operating department practitioners	19	22	38	55	38	39	63	45
Orthoptists	0	1	3	0	2	0	2	2
Paramedics	43	81	94	99	163	188	252	262
Physiotherapists	79	52	85	95	126	104	119	122
Practitioner psychologists	N/A	N/A	N/A	N/A	149	118	138	180
Prosthetists / orthotists	3	3	3	6	7	1	2	1
Radiographers	27	44	32	34	47	40	58	56
Social workers	N/A	N/A	N/A	N/A	N/A	N/A	N/A	734
Speech and language therapists	12	11	22	14	26	25	25	34
Total	**316**	**322**	**424**	483	772	759	920	1653

Cases by route to registration – 2006–13

Route to registration	2005-06	% of cases	2006-07	% of cases	2007-08	% of cases	2008-09	% of cases	2009-10	% of cases	2010-11	% of cases	2011-12	c
Grandparenting	35	11	15	5	15	3.5	21	4	24	3	32	4	20	
International	30	9.5	29	9	36	8.5	35	7	63	8	40	5	57	
UK	242	77	278	86	373	88	425	88	685	89	687	91	848	
Not known	9	2.5	0	0	0	0	2	0	0	0	0	0	0	
Total	316	100	322	100	424	100	483	99	772	100	759	100	925	

Investigating Committee

Allegations where a case to answer decision was reached 2004-05 to 2012-13

Year	% of allegations with case to answer decision
2004-05	44
2005-06	58
2006-07	65
2007-08	62
2008-09	57
2009-10	58
2010-11	57
2011-12	51
2012-13	58

Percentage case to answer, comparison of 2005–06, 2006–07, 2007–08, 2008–09, 2009–10, 2011–12 and 2012-13

	2005-06	**2006-07**	**2007-08**	**2008-09**	**2009-10**	**2010-11**	2011-12	2012-13
22(6)/Anon	**58**	**86**	**61**	**49**	69	72	50	
BPS transfer cases*	**0**	**0**	**0**	**0**	7	0	0	
Employer	**81**	**84**	**84**	**81**	80	82	69	
Other	**0**	**0**	**56**	**34**	79	57	63	
Other registrant / professional	**60**	**46**	**77**	**67**	62	29	50	
Police	**26**	**28**	**31**	**37**	50	54	38	
Public	**18**	**33**	**29**	**22**	22	22	17	

Representations provided to Investigating Panel by profession 2006–13

	Case to answer				No case to answer				
Year	No response	Response from registrant	Response from representative	Total case to answer	No response	Response from registrant	Response from representative	Total case to answer	Total cases
2005-06	32	52	14	101	N/A	N/A	N/A	70	171
2006-07	40	79	28	147	3	66	4	73	220
2007-08	59	85	9	153	17	68	6	91	244
2008-09	61	131	14	206	21	115	13	149	355
2009-10	70	200	21	291	14	177	7	198	489
2010-11	84	185	25	294	10	195	13	218	512
2011-12	49	182	21	252	28	197	21	246	498
2012-13	86	186	29	301	18	176	28	222	523

Interim orders

Interim order hearings 2004-05 to 2012-13

Year	Applications granted	Orders reviewed	Orders revoked on review	Number of cases	% of allegations where interim order was imposed
2004-05	15	0	0	172	8.7
2005-06	15	12	1	316	4.7
2006-07	17	38	1	322	5.3
2007-08	19	52	3	424	4.5
2008-09	27	55	1	483	5.6
2009-10	49	86	6	772	6.3
2010-11	44	123	6	759	5.8
2011-12	49	142	4	925	5.3
2012-13	39	151	8	1653	2.4
TOTAL	274	659	30	5826	4.7

Final hearings

Number of public hearings 2004-05 to 2012-13

Year	Interim order and review	Final hearing	Review hearing	Restoration hearing	Article 30(7)	Total
2004-05	25	66	11	1	0	103
2005-06	28	86	26	0	0	140
2006-07	55	125	42	0	0	222
2007-08	71	187	66	0	0	324
2008-09	85	219	92	0	0	396
2009-10	141	331	95	0	0	567
2010-11	171	404	99	2	1	677
2011-12	197	405	126	3	1	732
2012-13	194	228	141	1	1	565

Representation at final hearings 2006-07 to 2012-13

	Type of representation		
Year	Registrant	Representative	None
2006-07	13	46	43
2007-08	17	80	59
2008-09	21	74	80
2009-10	44	114	98
2010-11	41	160	113
2011-12	38	155	94
2012-13	31	102	95

Suspension and conditions of practice review hearings

Number of review hearings 2004-05 to 2012-13

Year	Number of review hearings
2004-05	11
2005-06	26
2006-07	42
2007-08	66
2008-09	92
2009-10	95
2010-11	99
2011-12	126
2012-13	141

Appendix three

General Social Care Council transfer cases

Introduction

Following the closure of the General Social Care Council (GSCC) on Tuesday 31 July 2012, all open conduct cases were transferred to the HCPC for continued investigation, hearing or review.

The General Social Care Council (Transfer of Register and Abolition – Transitional and Saving Provision) Order of Council 2012 provided that, in relation to outstanding conduct matters which were transferred to it by the GSCC, the HCPC should make "such arrangements as it considers just for the disposal of the matter". The HCPC therefore drafted 'just disposal criteria' which was applied to all cases on transfer. All cases were reviewed on an individual basis and assessed to determine the most appropriate approach.

Investigating committee

Two hundred and seventeen legacy cases were transferred at the stage of the process. Of these cases, 120 were considered at Investigating Committee between 1 August 2012 and 31 March 2013. Of these, 100 were considered to have a case to answer. Of these cases, 98 were referred to the Conduct and Competence Committee, with the remaining two being referred to the Health Committee. The case to answer rate for these cases is therefore 83 per cent. This is significantly higher than the case to answer rate of the non-transfer cases contained elsewhere in this report (58 per cent).

A further 28 cases were listed for consideration by the Investigating Committee between April to June 2013. At 31 March 2013, there were 36 cases (15 per cent of those transferred) that were still being investigated and were not scheduled for an Investigating Committee consideration. The remainder of the cases have been closed as they do not meet the standard of acceptance for allegations.

Final hearings

Twenty transfer cases have been concluded at a final hearing of the Conduct and Competence Committee. Seven registrants have been struck off, and a further three removed from the Register through a voluntary agreement; seven registrants have been suspended; one registrant was cautioned; one case was not well founded and one conditions of practice was imposed.

Interim orders

The HCPC has applied for 32 interim orders in cases that transferred from GSCC, this includes a number of cases that had an interim order in place at the time of the transfer. Only one of these cases did not have an interim order imposed by the Committee. Twenty nine cases had an interim suspension order imposed, with the remaining two cases having interim conditions orders granted.

Reviewing existing suspensions and conditions of practice

Forty five cases were transferred from the GSCC with an on-going suspension or where the registrant was subject to conditional registration. These cases require review by the HCPC and as of 31 March 2013, thirteen cases had been reviewed.

Six cases with an existing suspension order had this sanction continued; three cases had a suspension revoked; two cases had a suspension changed to a conditions of practice order.

One case had its conditions varied as a result of the review with another case having its conditions continued.