

**The Health & Social Care Professionals Council**

**In the matter of an Inquiry pursuant to Part 6 of the Health & Social Care Professionals Act 2005, (as amended) (“The Act”)**

**-and-**

**In the matter of Debaprasad Haldar**

**Report to Council by the Professional Conduct Committee  
Following an Inquiry held pursuant to Section 58 of the Health & Social Care Professionals Act 2005 (“The Act”)**

1. The designated CEO/Registrar of the Occupational Therapist Registration Board served a Notice of Inquiry on the 16<sup>th</sup> March 2023 on Mr. Debaprasad Haldar (“The Registrant”) in relation to certain allegations to be considered in the course of the Inquiry.
2. A complaint dated the 20<sup>th</sup> September 2019 was made to CORU by Ms. Andreyia Ellis Occupational Therapy Manager at St. Mary’s Hospital Phoenix Park Dublin 7 and Mr. Fiachra McGuirk, Hospital Manager St. Mary’s Hospital. That matter was then forwarded to the Preliminary Proceedings Committee in the ordinary way who formed the opinion that there was sufficient cause to warrant further action being taken in relation to the complaint against the Registrant on the grounds of professional misconduct and poor professional performance as defined by Section 50 of the Act. The matter was sent forward to the Professional Conduct Committee (Notice of Inquiry attached).
3.
  - (i) The allegation against the Registrant was that being a registered Occupational Therapist employed at St. Mary’s Hospital Phoenix Park Dublin 7 failed on one or more than one occasion, despite support and/or guidance to demonstrate adequate skill and/or knowledge of occupational therapy as demonstrated by one or more of the following;
    - (a) Drafting of one or more inadequate occupational therapy reports identified by Allegation 1 (a) – (n) inclusive;
    - (b) Failure to provide one or more occupational therapy reports and/or required information in a timely manner or at all in relation to the matters identified at 2 (a) – (e);
    - (c) Failure to recommend appropriate equipment and/or demonstrate any adequate or timely clinical decisions when recommending equipment for the service users identified at 3 (a) – (c);
    - (d) Failure to demonstrate knowledge of basic occupational therapy processes on three dates - 28<sup>th</sup> May 2018, 27<sup>th</sup> March 2019, and 17<sup>th</sup> April 2019.

- (e) Failure to provide any or any adequate handover to one or more of his colleagues prior to going on annual leave in or around the 6<sup>th</sup> June 2019;
  - (f) Failure on one or more occasions to engage appropriately or at all with one or more efforts being made on behalf of his employer to support him in his practice.
- (ii) It was further alleged that the acts, omissions or patterns of conduct that occurred prior to the 28<sup>th</sup> February 2019 outlined at Paragraphs 1 – 6 individually/cumulatively amounted to acts, omissions or patterns of conduct that constitute a breach/breaches of the Code of Professional Conduct & Ethics adopted by the Occupational Therapist Registration Board contained in the Schedule to the Code Bylaw 2014 (S.I.527/2014) which came into effect on 25<sup>th</sup> November 2014 thereby constituting professional misconduct.

The specific breaches alleged were breaches of failing to act in the best interests of service users by –

- Failing to maintain high standards of personal conduct.
- Failing to act within the limits of his knowledge, skill, competence and experience.
- Failing to keep his professional knowledge and skills up to date.
- Failing to communicate with service users, carers and other professionals.
- Failing to keep accurate records.
- Failing to demonstrate ethical awareness.

- (iii) Thereafter it was alleged that on or after the 28<sup>th</sup> February 2019 the breaches alleged were alleged to be breaches of the Code of Professional Conduct & Ethics adopted by the Board contained in the Schedule to the Code of Professional Conduct & Ethics for Occupational Therapists Bylaw 2019 (S.I. 51/2019) which came into effect on 28<sup>th</sup> February 2019. In this instance it was alleged that the Registrant failed to act in the best interests of service users; maintain high standards of personal conduct and behaviour; obey laws, regulations and guidelines; act within the limits of his knowledge, skill, competence and experience; keep his professional knowledge and skills up to date; communicate effectively with service users and others involved in their care; keep accurate records; and demonstrate ethical awareness.

4. The complaints in question were made by Ms. Andreyia Ellis and Mr. Fiachra McGuirk. Ms. Ellis took up her position in 2016 and the issues the subject matter of the Notice of Inquiry were identified by her after she took up the role of Occupational Therapy Manager. The Committee heard that a unique set of circumstances arose in the place of employment of the Registrant at that time. The Registrant had worked for a considerable period of time as a Senior Occupational Therapist from 2006 up to 2017, prior to that from 2004 as an Occupational Therapist. There is no suggestion of any difficulties with his professional conduct during that period.
5. The Committee were told that the unique circumstances that arose in St. Mary's Hospital Phoenix Park Dublin 7 in or around 2016/2017 was the de-congregation

of the Cuan Aoibheann Unit who were being moved into the community. In the main these were high dependency service users with complex physical needs, with life altering conditions and/or life altering injuries. It was a consequent effect of the proposed de-congregation that additional report writing was required because the service users who were being moved out into the community needed to have all their individual complex medical needs met in terms of their new accommodation, access, facilities and services. This meant a significant increase in the nature, detail and level of reports that were required to be furnished by the MDT team including Occupational Therapy. One of these significant complaints that was made against the Registrant was the inadequacy of occupational therapy reports generated by him which arose in or around that time, allied with same there was a concern about the timely provision of reports. There was a further concern about appropriate equipment being recommended and also the clinical reasoning underpinning the recommendations made by the Registrant. In some limited cases it was alleged that he had failed to demonstrate knowledge of basic occupational therapy processes. This comprised the significant element of the allegations. The Registrant denied non-cooperation with Management and denied the allegations. Further, he alleged that he was subject to unfair pressure, bullying, lack of support, failures by Management to act and generally, unfair treatment by Management.

6. The hearing lasted 6 days of contested evidence. The Committee were provided with a very significant bundle of documentation on the iPad. Day 1 of the Inquiry was taken up in the main with legal argument which ultimately was resolved by the Committee. Thereafter the first witness called was Ms. Andreyia Ellis who gave evidence to the Committee over Day 2 and into Day 3 when her cross-examination concluded. Essentially, her evidence was confined to speaking to the issues particularly in relation to report writing and his failures to prioritise the service users in the context of the proposed de-congregation. Such de-congregation required home visits and ensuring that the properties were appropriate and adapted to meet the individual needs. Ms. Ellis confirmed that she put in place new report templates in 2019. It would be fair to say that Ms. Ellis was critical of the Registrant's prioritisation. Ms. Ellis confirmed that there was an internal disciplinary process ongoing for a number of years in connection with the Registrant also and she acknowledged a significant increase in the supervision put in place for the Registrant. It is fair to say that the Registrant was unhappy with the disciplinary process and the level of supervision. The Registrant became stressed as a result of workload and referred to Occupational Health. The Registrant felt that he had been badly treated at that time and that he was under constant criticism and that the Managers were overly critical of him. Arising from the cross-examination of this witness, it was clear that there was a dispute as to the perception of the events in 2016, 2017 and thereafter.

The Committee noted with concern the apparently widespread use by the Registrant of a "*cut and paste*" approach to Occupational Therapy Review Reports on residents where in some cases the name of the original and different author remained at the base of the report as authored by the Registrant.

7. On Day 3 of the Inquiry, just before the introduction of the second witness, an application was made on behalf of the Registrant that the Committee should consider requesting certain undertakings from him, namely that he would undertake to not repeat the conduct the subject matter of the Inquiry and that he would undertake certain educational courses directed at the deficiencies in report writing. The Registrar's position was neutral in relation to the application. The Committee received legal advice. The Committee decided, having carefully considered the matter, that this was a premature application. The Committee noted that it was open to the Committee to request an Undertaking and/or Consent at any time after the matter is referred to it but was of the view at that stage that the Registrar had not completed her evidence such that the Committee could not be satisfied that it had a full understanding of the extent and nature of the evidence to be adduced. The Committee accepted that it should be so satisfied, i.e., that it had a thorough understanding of the evidence before making such a request. The Committee did not decide that such a request was inappropriate but rather that it was premature. The Committee advised the parties that it was open to repeat the application.
8. Ms. Linda Penny gave evidence on Day 3 and Day 4 of the Inquiry. Her evidence dealt with her experiences with the Registrant. Initially she attended St. Mary's Hospital once a week to provide cover for Ms. Ellis and on a fulltime basis from February 2018. She confirmed she did not find the Registrant's report writing to be of a very high standard and that she was concerned about same. She identified those concerns to the Committee by way of reference to specific documentation. She gave evidence to the Committee of the type of report she would have expected following home visits which were taking place as a result of the de-congregation process. Ms. Penny outlined to the Committee the feedback that she had provided to the Registrant in relation to his report writing. She considered that some of the errors were basic with poor legibility and lack of clarity. She confirmed that she had a long period of sick leave during this period as did the Registrant. She also confirmed that she had not made any complaint about the Registrant.
9. Ms. Penny's evidence continued on Day 4 which was very much in the same vein as previously. She had interactions with the Registrant, primarily in relation to report writing, certain aspects of home visits where matters were not dealt with appropriately, in particular about the agreed non-provision of a toilet sling for a particular service user. Ms. Penny further gave evidence in relation to what she regarded as inadequate occupational therapy reports speaking to Paragraph 1 (i) and Paragraph (j) of the Notice of Inquiry. She also provided evidence to the Committee in relation to failures to provide reports in a timely manner speaking to Allegations 2 (a) 2(b). Ms. Penny further spoke to Allegations 3 (a) and 3(b) in the Notice of Inquiry and 4 (a) and Allegation 6.

Ms. Penny accepted that the Registrant complained of stress and overwork. She agreed that there was an increase in the workload and pressure to complete the de-congregation project. She acknowledged that, because of her expertise being in home adaptations and equipment that she was very experienced in same. She

accepted that the Registrant's expertise lay in the area of long term care cases. She also accepted that reports on long term care cases/residents would not usually contain significant changes every 6 or 12 months. She confirmed that she met with the Registrant to assist him in his report writing in the changed circumstances of the de-congregation project.

10. Thereafter the Committee heard evidence from Hospital Manager, Mr. Fiachra McGuirk. Mr. McGuirk's evidence was directed to a single issue that arose about a recommendation of appropriate equipment arising from a home visit for a particular Service User described as D and referred to in Allegation 3 (a). Mr. McGuirk's evidence did not disclose any significant complaint made to him in relation to the toilet measurements in question. Further, Mr. McGuirk told the Committee that he engaged with the Registrant in September 2017 about his supervision during Ms. Ellis' maternity leave. Mr. McGuirk confirmed that he had meetings with the Registrant about the issues the Registrant had raised including complaints about workload, stress, over-supervision, dignity at work, micro-management of the Registrant, flexi time and lack of value and respect. He confirmed that the Registrant was subject to a disciplinary process concerning certain issues with which the Registrant did not engage. He confirmed that the Registrant had worked in St. Mary's pre both his and Ms. Ellis' appointment to St. Mary's. He did not give any specific evidence of issues around the clinical conduct of the Registrant other than the issue over the toilet height and about which Mr. McGuirk's recollection was somewhat vague.
11. Thereafter following the completion of the factual evidence the expert Ms. Linda Horgan commenced her evidence at the conclusion or towards the end of Day 4 and Day 5. The cross-examination commenced on Day 6.

The Committee notes that because the Committee decided to request an Undertaking and Consent from the Registrant and the Registrant has agreed to provide that Undertaking and Consent it is not necessary to refer Council in any meaningful way to the evidence of Ms. Linda Horgan as same only becomes relevant when the Committee has to make a decision as to whether or not the proven facts, if found proven as to fact, amount to either professional misconduct or poor professional performance. However, the Committee wishes to note the following concerns arising from the evidence of the expert –

- (i) The expert's report did not mirror the allegations numbered 1 – 4 in the Notice of Inquiry and therefore the expert opinion provided by her in relation to Allegations 1 – 4 were not in relation to those in the Notice of Inquiry.
- (ii) The report did not reflect the definition of professional misconduct as set out at Section 50 of the Act.
- (iii) The Committee could not accept that the HSE document entitled Therapy Project Office Guidelines are a substitution for or applicable to the Code of Professional Conduct & Ethics for Occupational Therapists (both S.I.

527/2014 and S.I. 51/2017) for the purposes of the Committee making a finding of professional misconduct under Section 50 of the Act.

- (iv) There was a concern about the level of appreciation of the requirement of “*seriousness*” to ground a finding of professional misconduct and/or poor professional performance.

12. On Day 6 of the Inquiry at the commencement of the day application was made again that the Committee would request an Undertaking from the Registrant and the Committee having heard the parties and received legal advice decided that it would prefer that the cross-examination of the expert to be concluded before it would make a decision. When the cross-examination of the expert concluded the Committee retired and decided to request certain Undertakings and Consents from the Registrant.

The Undertakings and Consents sought and obtained from the Registrant are as follows –

- (i) An Undertaking that the Registrant would not repeat the conduct the subject matter of the Inquiry (Section 61 (1) (a) of the Act)
- (ii) Pursuant to Section 61 (1) (b) of the Act undertake to cooperate with CORU in obtaining and completing a placement/mentorship/observer role designed to address the clinical deficiencies identified in the Notice of Inquiry, with that process to be of at least 120 hours duration and to be completed within 6 months or such further time as may be agreed between the parties. Both parties are to cooperate fully with the process and work positively to implement same.

If this process is not in place within 6 months or such further time as agreed between the parties, the Undertaking will lapse.

If the Undertaking lapses the Registrant consents to being censured by the Council.

- (iii) Pursuant to Section 61 (1) (b) of the Act an Undertaking to complete;
  - (a) A course on communications; and
  - (b) A course on report writing that has been identified to the Committee in the course of the evidence on Day 3 and undertaking to do so at his own expense. Evidence of satisfactory completion of same to be furnished to CORU within a period of 12 months.

13. At the commencement, the Chairman stated that the Committee considered it proportionate and appropriate to request an Undertaking and Consent from the Registrant and the Committee indicated in giving its decision that it would provide its rationale as to why it decided to request the Undertakings and Consents from the Registrant and the Committee does so now:

- (i) The Committee noted that the Registrant had worked without any difficulty for the HSE from 2004 to 2017 or thereabouts. There was no suggestion of interpersonal issues or other factors. It was clear to the Committee that the Registrant was someone who was used to working as an Occupational Therapist in a particular way but that new and fresh views about the operation of the Department were brought into the Department when Ms. Ellis became Departmental Manager. It is well understood that changes in management can cause a ripple effect or reluctance to change or embrace the new position.
- (ii) The more significant event that occurred in or around this time (allied to the change in the management) was the de-congregation of highly vulnerable service users who had complex medical and other needs. This was a very big task in that it required St. Mary's Hospital to locate, approve of and, if necessary, alter housing to suit the accommodation needs of such service users in the community. The needs of the service users were determined by reports from members of the MDT including Occupational Therapy. It is self-evident that this resulted in a significant increase in workload for all members of the MDT but in particular for Occupational Therapists who have to marry the disabilities of the service users with suitably adapted property. This created an environment where the Registrant who had a long-standing relationship with most of these service users felt himself under increasing pressure to deliver reports on the service users and the necessary accommodations required.
- (iii) There is no suggestion that up to the time of the de-congregation, the Registrant was challenged or brought under criticism for his report writing or presentation. There is no suggestion of a lack of care on the part of the Registrant. It is clear to the Committee that there were differing views as to the management of the de-congregation issues including that of the Registrant.
- (iv) The Committee was told by Counsel for the Registrant that the Registrant acknowledged that there were deficiencies in his report writing skills in particular and also in his communication skills. Such an acknowledgment is clear evidence of insight on the part of the Registrant that there are aspects to his practice that require to be addressed and that he is willing to work on same.
- (v) The Committee was told that the Registrant continued to work for the HSE until June 2022 when he ceased that employment. After he ceased his employment in St. Mary's he then worked in Lusk Community Nursing Home employed by the HSE and thereafter from August 2022 to January 2023 in Kiltipper Woods Care Centre and from January 2023 to July 2023 he worked in Sandyford. Since that time the Committee understands that he has not been in employment but is currently seeking employment. The

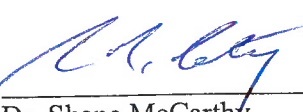
Committee notes that he was in employment in St. Mary's for almost 20 years and apparently without incident until 2017.

- (vi) In addition to the foregoing courses, the Committee came to the view that every effort should be made to place the Registrant in a position such as a mentored position or an observer's role which role would be directed to the clinical issues identified in the Notice of Inquiry. Without being prescriptive, the Committee recommends that the use of standardised diagnostic tests and the rationale for the recommendations of equipment be included in the process being undertaken by the Registrant.
- (vii) Arising from that, the Committee requested and the Registrant agree that the Registrant and CORU would endeavour to put the Registrant into a position where he could over a period of 6 months duration undergo not less than 120 hours addressing the clinical deficiencies identified in the Notice of Inquiry.
- (viii) The Committee considers that in view of the insight shown by the Registrant and his agreement to engage positively in this remedial process that is strong evidence of an intention to remedy the deficiencies in his practice. The Committee also considers that due regard must be had to the context and circumstances in which the Registrant found himself working in 2018 and 2019. There was a clear acknowledgment in the evidence from Ms. Penny that the Registrant's expertise and work history had been primarily confined to long term stay residents. Whilst it might be fair to say that the Registrant did not help his own cause in the changed circumstances in which he found himself, insufficient efforts were made to upskill the Registrant.
- (ix) The Committee is satisfied that the Registrant has always sought to act in the best interests of service users and to maintain high standards of personal conduct. The Committee sees nothing to suggest that he treated service users with anything other than kindness, care and professionalism, albeit not necessarily to the standard one would always wish. In those circumstances the Committee is satisfied that if the Registrant engages wholeheartedly with the proposed internship/moderatorship/observer role that that provides a clear path for him to rectify the deficiencies identified in his practice.
- (x) For all of the foregoing reasons that the Registrant does not present a danger to the public and that the deficiencies in his communication skills, report writing, and the few clinical issues will be well addressed within the confines of his compliance with the Undertakings and Consents provided and the public are thereby protected.

14. In effect, the Committee would like to see the Registrant take this opportunity and treat the mentorship/internship/observership as a professional development plan

that will assist him. If he does so the Committee believes he would be successful.

15. Having heard all of the evidence the Committee is satisfied that if it had found all the allegations proven as to fact (and the Committee is not saying it would have) and if the Committee had come to consider the recommendation as to sanction, the Committee considers that the recommended sanction would be likely to be at the level of conditions directed to deficiencies identified by the evidence. This is not a case in which sanctions at the higher end of the spectrum would be appropriate.
16. The Committee considers that requesting and accepting an Undertaking and Consent utilises a mechanism whereby the Act allows the Committee to give a second chance in appropriate cases to a Registrant. The Committee considers that, in the particular circumstances of this case, the Registrant is a person who should be given a second chance. The second chance that has been formulated for him is one that the Committee believes will work to his benefit provided he embraces it wholeheartedly. The Committee accepts that there are deficiencies in the Registrant's report writing with a lack of clarity, a lack of clinical detail and a strong tendency (which must be deprecated) to cut and paste from previous reports. This is all capable of remediation by the Registrant together with the other issues.
17. It is confirmed to the Council and is evident from the transcript of Day 6 that the Registrant provided the Undertaking and Consent as sought by the Committee and gave same under Oath. This therefore concludes the process. The Committee assures the Council that it considers this was appropriate and proportionate in the circumstances and allows the Registrant an opportunity to continue with his career with the benefit of the courses and process put in place which can only enhance his professional career, whilst ensuring the protection of the public.

Signed  14/3/2024  
Dr. Shane McCarthy  
Chairperson