

Case Examiner Decision

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FTP-52006

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The role of the case examiners

The case examiners perform a filtering function in the fitness to practise process, and their primary role is to determine whether the case ought to be considered by adjudicators at a formal hearing. The wider purpose of the fitness to practise process is not to discipline the social worker for past conduct, but rather to consider whether the social worker's current fitness to practise might be impaired because of the issues highlighted. In reaching their decisions, case examiners are mindful that Social Work England's primary objective is to protect the public.

Case examiners apply the 'realistic prospect' test. As part of their role, the case examiners will consider whether there is a realistic prospect:

- the facts alleged could be found proven by adjudicators
- adjudicators could find that one of the statutory grounds for impairment is engaged
- adjudicators could find the social worker's fitness to practise is currently impaired

Case examiners review cases on the papers only. The case examiners are limited, in that, they are unable to hear and test live evidence, and therefore they are unable to make findings of fact.

Decision summary

Decision summary	
Preliminary outcome(s)	Accepted disposal proposed - warning order (3 years)
Final outcome	Accepted disposal - warning order (3 years)
Date of the preliminary decision	27 April 2023
Date of final decision	23 May 2023

Executive summary

The case examiners are satisfied that there is a realistic prospect that:

1. The factual concerns (excluding regulatory concern 3a) could be found proven by the adjudicators;
2. Those concerns could amount to the statutory ground of misconduct [REDACTED]
3. The adjudicators could conclude that the social worker's fitness to practise is currently impaired.

The case examiners do not consider it to be in the public interest for the matter to be referred to a final hearing and that the case can be concluded by way of accepted disposal.

As such, the case examiners notified the social worker of their intention to resolve the case with a **warning order of 3 years**. The social worker accepted the case examiner's proposal, in full. The case examiners again considered the public interest and remain of the view that a warning order remains the minimum necessary to protect the public and maintain public confidence in the profession.

The case examiners have considered all of the documents made available within the evidence bundle. Key evidence is referred to throughout their decision and the case examiners' full reasoning is set out below.

The complaint and our regulatory concerns

The initial complaint

The complainant	The complaint was raised by the social worker's former employer, Manchester City Council.
Date the complaint was received	28 September 2016
Complaint summary	The concerns raised relate to the period when the social worker was acting in the capacity of a team manager in children services. It is alleged that the social worker did not provide sufficient management oversight and support to social workers in their team which resulted in children being placed at risk of serious harm. The concerns are outlined in more detail in the regulatory concerns as drafted. The case examiners note that subsequent referrals were received in respect of the same social worker by this employer and there is a linked case FTP71899.

Regulatory concerns

1. In your capacity as a manager, you failed to adequately respond to safeguarding concerns in respect of Child A and Child X.
 - 1.1 You failed to properly assess the risk to Child A and Baby X on a number of occasions between May and September 2016.
 - 1.2 You failed to escalate Child A's case to your line manager between May and September 2016.
 - 1.3 You failed to protect Child A between May and September 2016.

2. You failed to adequately discharge your management responsibilities in or between May and September 2016.

2.1 You failed to appropriately manage the social worker assigned to Child A's case in a professional manner.

2.2 You failed to ensure appropriate record keeping in Child A's case.

2.3 As a result of 2.2, there was no robust audit trail available.

3.



The matters set out at regulatory concern (1) and (2) amount to the statutory ground of misconduct.



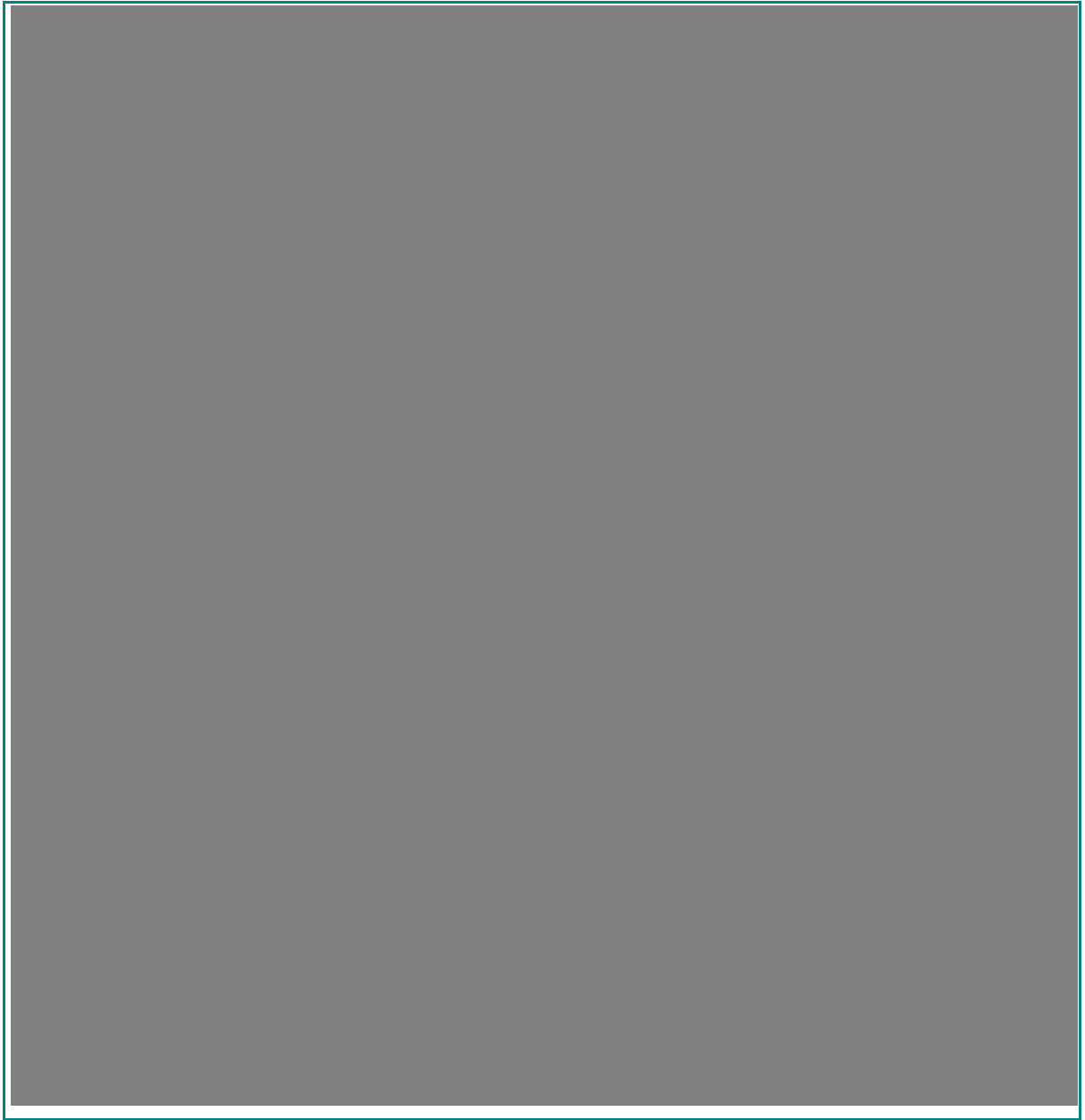
Your fitness to practise as a social worker is impaired by reason of your misconduct



Preliminary issues

Investigation		
Are the case examiners satisfied that the social worker has been notified of the grounds for investigation?	Yes	☒
	No	☐
Are the case examiners satisfied that the social worker has had reasonable opportunity to make written representations to the investigators?	Yes	☒
	No	☐
Are the case examiners satisfied that they have all relevant evidence available to them, or that adequate attempts have been made to obtain evidence that is not available?	Yes	☒
	No	☐
Are the case examiners satisfied that it was not proportionate or necessary to offer the complainant the opportunity to provide final written representations; or that they were provided a reasonable opportunity to do so where required.	Yes	☒
	No	☐

Requests for further information or submissions, or any other preliminary issues that have arisen



The realistic prospect test

Fitness to practise history

The case examiners have been informed that there is no previous fitness to practise history.

Decision summary

Is there a realistic prospect of the adjudicators finding the social worker's fitness to practise is impaired?

Yes



No



The case examiners have determined that there is a realistic prospect of regulatory concerns 1 and 2 in full and 3b being found proven, that those concerns could amount to the statutory ground of misconduct [REDACTED] and that the social worker's fitness to practise could be found impaired on the ground of misconduct.

Reasoning

Facts

1. In your capacity as a manager you failed to adequately respond to safeguarding concerns in respect of Child A and Child X.

1.1 You failed to properly assess the risk to Child A and Baby X on a number of occasions between May and September 2016.

1.3 You failed to protect Child A between May and September 2016.

The case examiners have reviewed all the evidence and have seen the investigation report including investigation interviews, case records, supervision notes, serious case review findings, along with the social worker's response to the concerns raised. The case examiners note the concerns in 1.1 and 1.3 are similar in nature and refer to the same evidence and therefore they will address them together.

The case examiners have been provided with numerous detailed overviews of the case, however in summary, the case examiners have noted the history/chronology to this case:

- The family were known to Children's Social Care, due to a child previously suffering significant harm in 2013, who subsequently died whilst in the care of father.
- Following court proceedings, Child A was returned to the care of mother on a care order on 31 July 2014, where parental responsibility was shared with the local authority. The father of Child A was to have no unsupervised contact with Child A due to historic domestic violence.
- There were reports from a family intervention worker in May 2015 that an unknown male was seen entering Child A's home with a key. This was discussed within supervisions between the social worker and the allocated social worker in June, August and September 2015. Within these supervisions it is recorded that Child A has made reference to 'daddy' in the home to school staff, however that the mother has denied any contact with father. Within this discussion, concerns were also discussed about mother's non-engagement with services and that the identity of the unknown male remained outstanding and it was not clear if this was the father. However, the supervision on 9 September 2015 states *'letter to mum asking her to call into the office to see TM (team manager and this social worker) to discuss revocation of care order'*.
- A subsequent supervision record in January 2016, completed by the social worker state that *'statement to be completed to discharge the care order'*.
- On 4 May 2016, Child A made a significant disclosure to their schoolteacher stating that *'I don't love mummy she smacks me'* and Child A stated that they were scared and that their mother smacks and kicks them all the time. This was reported to a duty social worker, who liaised with the social worker, who is reported to have assessed at this time that it was not a direct disclosure and therefore Child A would be less likely to have a mark and as such, it would be dealt with the next day.
- On 5 May 2016, the allocated social worker contacted school and agreed to attend school to see Child A. Child A had been noted to have a cut under their eye by the school and the allocated social worker observed this and completed some direct work with Child A. Child A is recorded by the school to have stated they were not allowed to say how they sustained the cut and stated, *'mummy said no'* and was distressed upon questioning. The child was also recorded by the school as stating, *'I'm not going home with mummy...she's naughty'*. The school also advised at this time that Child A became upset and distressed towards home time. The school reported that the allocated social worker spoke with the social worker and the advice provided was that Child A was not in any immediate danger and could remain in the family home.

- The allocated social worker was reported to have contacted the police to try to arrange a strategy meeting and raised this with the social worker. The social worker does not appear to have taken any action or provided advice as to any alternative action the allocated social worker could have taken.
- The Independent Reviewing Officer (IRO) for Child A emailed both the allocated social worker and the social worker after a conversation with the allocated social worker on 6 May 2016. The IRO expressed concerns that the child had been seen with an injury and had been reluctant to return home; mother's lack of engagement; that mother was pregnant, and the father was unknown and that it was unclear who was attending the home. The IRO considered that there were immediate safeguarding concerns that weekend and that a welfare check was needed, and that the child should be visited that date and spoken with along with their mother. They also raised that it was not acceptable for the police to decline to attend a strategy meeting.
- The social worker did not respond to the email from the IRO until 9 May 2016, asking the allocated social worker for an update.
- The child was visited on 9 May 2016 by the allocated social worker.
- The allocated social worker and social worker saw the mother in the office on 10 May 2016, where the mother denied hitting Child A and this appears to have been accepted by the social worker and no further action taken.
- There is evidence to suggest that the mother was not engaging with children's social care during May and June 2016.
- A pre-birth assessment was commenced in respect of Baby X. At the handover to the allocated social worker, the social worker has recorded in the supervision discussion on 22 July 2016 that *'likely outcome will be CIN (child in need) planning'*. This was prior to any assessment taking place. The allocated social worker stated in the internal employer's investigation meeting that *'the case was passed to (them) as CIN planning required and outcome is confirmed following assessment'*. Whilst the case examiners have not seen the pre-birth assessment, documentation confirms that the outcome was CIN and that this was signed off by the social worker. The evidence suggests that the concerns in May were not documented within the assessment.
- Baby X was discharged from hospital on 1 September 2016.
- On 6 September 2016, a health visitor saw Baby X and sees a bruise on the inner ear of Baby X which the mother had pointed out to them. At this point, Baby X is seen by medical professionals and the outcome is that this is likely an inflicted injury and non-accidental. Both Baby X and Child A are removed from the mother's care into foster care.

- Strategy meetings at this time identified that the police held information relating to domestic violence incidents that had occurred at the mother's address throughout 2015 and 2016 which included father of Child A.
- DNA testing completed later in September 2016 confirmed that Baby X and Child A were full siblings and therefore confirming that the mother had continued to have some level of contact with the father of Child A.

The case examiners have noted the interviews held with senior managers and staff within the authority as part of the disciplinary investigation as well as the serious case review that took place in respect of both children. The case examiners, in considering whether the social worker failed to adequately respond to safeguarding concerns, risk assess and protect Child A and Baby X, have looked at what would have been expected.

The evidence suggests that:

- When Child A made disclosures on 5 and 6 May 2016 that the child should have been seen in the home that day, in order that appropriate risk assessments could have been completed.
- A strategy meeting should have been convened to share information between agencies, including information held by police relating to domestic violence and the social worker should have escalated or intervened if the allocated worker was struggling to ensure this happened. Section 47 (s47) enquiries should have been undertaken to consider the risks present in Child A's home.
- The social worker should have appropriately challenged the mother in respect of the injuries seen on Child A in May, especially in light of the fact that the social worker had highlighted the mother's lack of engagement at this time and previously.
- The social worker should have escalated the case to their managers, in order that there was more scrutiny from senior managers and further oversight of the risks present.
- The social worker was aware of the history of the case, having had oversight during 2015/16, therefore the pre-birth assessment should have included more of the history and known risks within the family in order to appropriately consider the risks to Baby X.

The case examiners are satisfied from the evidence available that there were a number of missed opportunities to safeguard and risk assess both children by the social worker and as a result, the social worker failed to adequately safeguard both Child A and Baby X.

As such, the case examiners are satisfied there is a realistic prospect of adjudicators finding concerns 1.1 and 1.3 proven.

1.2 You failed to escalate Child A's case to your line manager between May and September 2016.

The case examiners have reviewed the evidence in the form of supervision notes between the social worker and their manager from the period January 2016 to August 2016. The case examiners note that there is no record of Child A's case being discussed in any of these supervision sessions.

The case examiners note that in the fact-finding interview conducted with the social worker on 2 November 2016, the social worker refers to this case as '*massive case historically for Mum and Dad*'. The social worker provided detail to the background of the case. However, despite the social worker referring to the case in this way, it is of note that there is no record of the social worker discussing or escalating any concerns in respect of this case with their managers.

In considering what the social worker failed to do, the case examiners have looked at what would have been expected in the circumstances. The case examiners have reviewed interview notes completed with one of the social worker's managers as part of the employer's investigation meeting and they note the manager states that the social worker did not discuss the case of Child A with them. Further, the manager states that they would have expected the social worker to have raised this case given the circumstances previously and particularly at the point when the school raised concerns about the disclosure in May 2016.

The case examiners have seen an interview with another senior manager completed in August 2021 by the regulator, who again has stated that given the risks involved in this case, the social worker should have escalated this case. The manager advised that this would have provided further opportunity for scrutiny of the case to ensure that adequate oversight and risk assessments were completed.

As such, the case examiners are of the view that the evidence suggests that the social worker did not escalate this case to their line manager and their failure to do so, meant that safeguarding concerns were not appropriately addressed in respect of Child A and Baby X.

The case examiners are satisfied that there is a realistic prospect of adjudicators finding this concern proven.

2. You failed to adequately discharge your management responsibilities in or between May and September 2016.

2.1 You failed to appropriately manage the social worker assigned to Child A's case in a professional manner.

The case examiners have reviewed the evidence including witness statements, supervision records completed by the social worker and members of their team.

The case examiners note that the allocated social worker for Child A in May 2016 had limited experience in statutory social work and the evidence suggests that this was a high risk and complex case. However, there appears to have been no handover to the allocated social worker when the case was allocated to them.

The evidence suggests that this allocated worker did not receive the same level of supervision to the other allocated social workers who worked on the case, despite this worker's lack of experience. Given the allocated social worker's lack of experience, the evidence further suggests that sufficient guidance and advice was not provided to the allocated social worker at key stages, for instance at the point the child had disclosed an injury.

The allocated social worker raised in supervision that they were experiencing anxiety and stress around their workload and sleep. However, the evidence suggests that the social worker did not consider what supportive measures could be put in place to support the social worker. The social worker appears to have issued a management instruction in respect of the allocated social worker needing to bring their statutory visits up to date.

The case examiners have considered what would have been expected in the circumstances and they note that senior managers within the investigation reports provided statements that suggest the social worker should have provided additional support and supervision to the allocated worker of Child A during this period. The evidence suggests that the management oversight of Child A's case was not considered to be robust, especially in light of the allocated social worker's previous experience.

The case examiners are therefore satisfied that there is a realistic prospect of adjudicators finding this concern proven.

2.2 You failed to ensure appropriate record keeping in Child A's case.

2.3 As a result of 2.2, there was no robust audit trail available.

The case examiners have address both 2.2 and 2.3 together, as the evidence relates to both concerns.

The case examiners have seen evidence in the form of interviews conducted with the social worker, senior managers and some of the recordings in respect of Child A's case.

The evidence suggests that there were very limited case notes in respect of this case and there were limited records of key decisions and rationale for actions taken made by the social worker. The investigating officer for the internal investigation noted that *'there was no management footprint - it was not clear what details had been discussed regarding Child A'*.

The case examiners have seen interviews with the social worker within the internal investigation meeting, where they are questioned on the record keeping at this time and the social worker appears to accept that the recording was not of an appropriate standard.

The case examiners have again considered what would be expected of the social worker and they note comments by senior managers and the professional standards that were in place at the time. They note the managers state, *'the social worker should have ensured that their record keeping on Child A's case was comprehensive and up to date, in order to create a clear link between the actions and decisions made, and the reasoning behind each decision'*. They note, *'there was not an audit trail in terms of the management oversight that the social worker should have maintained'*. It would be expected that *'the social worker maintained these records and ensured that evidence of management input and oversight was present on Child A's file'*.

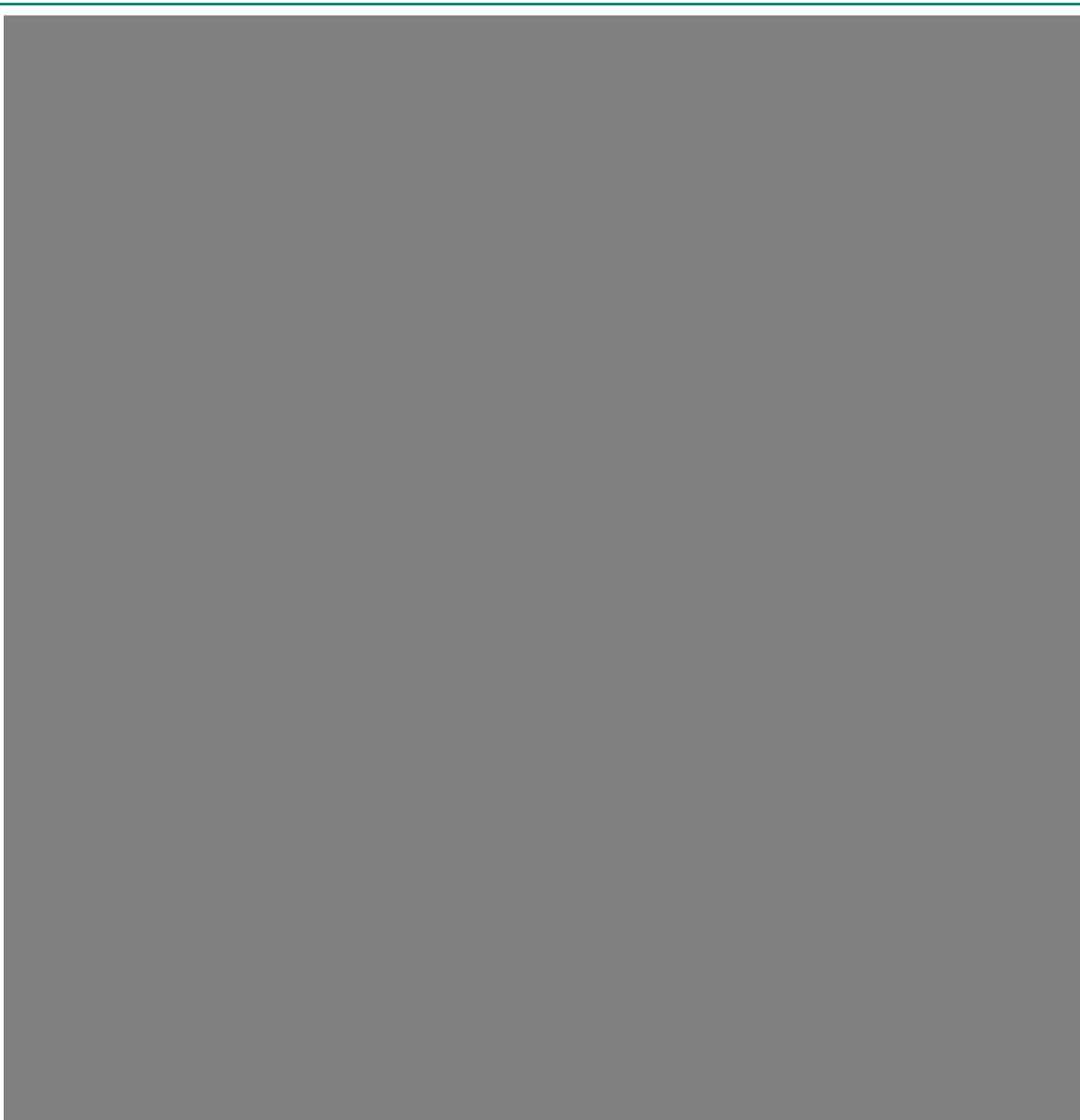
Professional standards in place at the time, namely Health and Care Professional Council (HCPC) standards of conduct, performance and ethics (2016) 10.1 state *'You must keep full, clear and accurate records for everyone you care for, treat or provide services to'*.

The evidence suggests that the social worker did not maintain or keep records in line with these expectations and standards.

The case examiners are therefore satisfied that there is a realistic prospect of adjudicators finding these concerns (2.2 and 2.3) proven.

3.





Grounds

The case examiners must now consider whether the facts of concerns 1, 2 and 3b, if proven, would amount to the relevant statutory grounds, in this case misconduct (concerns 1 and 2) and [REDACTED]

Misconduct

The case examiners are aware that misconduct denotes serious acts or omissions which represent a significant departure from what would be proper in the circumstances or conduct that is morally reprehensible and likely to bring the profession into disrepute.

Therefore, the case examiners have considered what adjudicators may reasonably expect from the social worker, and how they may view the alleged actions/omissions by the social

worker in relation to standards which were in place at the time of the alleged conduct, namely, the Health and Care Professions Council (HCPC) standards of conduct, performance and ethics (2016). The case examiners consider that the following standards may have been breached:

2.6 You must share relevant information, where appropriate, with colleagues involved in the care, treatment or other services provided to the service user.

4.2 You must continue to provide appropriate supervision and support to those you delegate work to.

6.1 You must take all reasonable steps to reduce the risk of harm to services users, carers and colleagues as far as possible.

7.3 You must take appropriate action if you have concerns about the safety or wellbeing of children or vulnerable adults.

9.1 You must make sure that your conduct justifies the public's trust and confidence in you as a social worker.

10.1 You must keep full, clear and accurate records for everyone you care for, treat or provide services to.

The case examiners are aware that falling short of the standards may not always amount to misconduct, but they consider that adjudicators in this instance may determine that the threshold for misconduct has been reached. Where there has been an allegation of a social worker not acting when made aware of safeguarding concerns, not keeping accurate records, not providing sufficient support and supervision to more junior staff, adjudicators are likely to view this as serious.

The case examiners note that in this instance harm was caused to a vulnerable baby who was less than two weeks old at the time; the social worker's alleged actions may have contributed to this, in that sufficient safeguards were not in place to monitor the family more closely.

The case examiners note the social worker's submissions that there were wider concerns present within the local authority where they worked [REDACTED]

[REDACTED] The case examiners note that the social worker was experienced by over 20 years, and that they had been at this authority for a number of years (since approximately 2006) and in the position of a manager for over 5 years at the time of the alleged conduct. Further, the case examiners note that the social

worker does not appear to have escalated or requested additional support from their managers and senior workers in respect of this case. The case examiners consider that safeguarding and record keeping are fundamental tenets of social work, and a social worker with such extensive experience would be expected to practice in line with their professional standards, or escalate this to senior managers, if unable to do so, even in difficult working environments.

Whilst the case examiners have considered this in respect of mitigating factors, they consider, despite this, the social was aware of the expectations and failed to take the appropriate action.

Where it is alleged that a social worker has not taken action in respect of safeguarding concerns, this would not align with HCPC standard 2.6, 6.1, 7.3 and 9.1.

Where it is alleged that a social worker has not maintained accurate, legible and clear records, this would not align with HCPC standard 10.1.

Where it is alleged that a social worker has not provided appropriate supervision and support to more junior staff, this would not align with HCPC standard 4.2.

If the matters were to be found proven by adjudicators, the case examiners conclude the conduct described is likely to suggest a significant departure from the professional standards detailed above. Furthermore, the case examiners consider that the alleged conduct would likely impact upon the public's confidence in the social worker.

The case examiners are satisfied there is a realistic prospect of adjudicators finding these matters (concern 1 and 2) amount to the statutory ground of misconduct.

Impairment

The personal element of impairment

In considering the personal element of impairment, the case examiners have considered the test set out in the case examiner guidance (2022), namely whether the conduct is

remediable; whether the social worker has undergone remediation and demonstrated insight; and whether there is a likelihood the matters alleged will be repeated.

The case examiners are of the view that the conduct did not arise from a character flaw such as dishonesty, and as such it is possible to remediate in a variety of ways such as additional training and reflection.

In the case examiners' view, any risk of repetition is likely to depend on the statutory ground established by adjudicators. For this reason, they have laid out separate considerations below.



Misconduct

The case examiners have carefully considered the social worker's insight and remorse into their alleged conduct. They consider that despite the alleged conduct occurring almost seven years ago, the social worker does not appear to have expressed any remorse and demonstrated limited insight into how their alleged conduct impacted upon both the children and their colleague. The case examiners note that the social worker has, however, considered what they may do differently in similar circumstances. The case examiners would have liked to have seen reflections from the social worker on how this conduct may be viewed. However, positively, the case examiners note that the social worker has

reflected upon [REDACTED]

Furthermore, the case examiners are in the unique position in this instance of being able to see how the social worker has practised in the years since the alleged conduct. The case examiners are mindful that there is a linked case, where concerns were raised about the social worker's practice immediately after this alleged conduct at the referral local authority. However, the case examiners note that the evidence suggests that the social worker has practised safely and to the required standards since 2019 at their new employer. The case examiners note, also, that the social worker is currently employed in a similar capacity as a team manager and supervising social workers as well as dealing with safeguarding concerns. The case examiners note that three references have been received from the social worker's current employer over the time of the investigation, all of which confirm that the social worker has practised to the required standards and that no fitness to practise concerns have been raised in respect of them in the last four years. The case examiners note that the social worker's practice has been audited and they have been open with their current employer about the concerns raised against them.

As such, despite the limited insight, the case examiners must conclude that due to the evidence of the social worker's practise in the intervening years, that the risk of repetition is low.

The public element of impairment

The case examiners next considered whether the social worker's actions have the potential to undermine public confidence in the social work profession, or the maintenance of proper standards for social workers. Public interest includes the need to uphold proper standards of conduct and behaviour and the need to maintain the public's trust and confidence in the profession.

The case examiners consider there is evidence to indicate that the social worker did not respond appropriately to safeguarding concerns, despite having prior knowledge of the high level of risk. In this particular instance, the social worker failed to maintain records to evidence decision making and they did not provide appropriate support and supervision to more junior staff.

It is noted that the alleged concerns occurred in 2016 and the evidence provided by the social worker's current employer suggests that there have been no further concerns of a similar nature since 2019. However, the case examiners consider that some concerns are so serious that action is required even if the social worker poses no current risk to the public. This is because a failure to make a finding of impairment against a social worker in such cases might undermine public confidence in social work as a profession. The case examiners consider that these concerns would be viewed dimly by the public as they relate

to an experienced social worker, who would be expected to be able to meet the core tenets of their role.

The case examiners are of the view that a member of the public would be concerned to learn that a social worker had been allowed to practise without sanction from their regulator in these circumstances due to the serious nature of the alleged conduct.

Furthermore, public confidence in the social work profession and the regulator may be undermined if a finding of impairment was not made.

Accordingly, the case examiners are satisfied that there is a realistic prospect of the adjudicators making a finding of current impairment.

The public interest

Decision summary

Is there a public interest in referring the case to a hearing?	Yes	☐
	No	☒

Referral criteria

Is there a conflict in the evidence that must be resolved at a hearing?	Yes	☐
	No	☒
Does the social worker dispute any or all of the key facts of the case?	Yes	☐
	No	☒
Could a removal order be required?	Yes	☐
	No	☒
Would not holding a public hearing carry a real risk of damaging public confidence in Social Work England's regulation of the profession?	Yes	☐
	No	☒
Is a hearing necessary to maintain public confidence in the profession, and to uphold the professional standards of social workers?	Yes	☐
	No	☒

Additional reasoning

The case examiners have noted that the social worker has stated that they do not consider their fitness to practise to be currently impaired. The case examiners have therefore considered whether a referral to a hearing may be necessary in the public interest. The case examiners have therefore considered whether a referral to a hearing may be necessary in the public interest. The case examiners have noted the following:

- There is no conflict in evidence in this case and the social worker has accepted the facts.
- The social worker is clear that they accept that their practice fell short of the standards expected of them. The social worker stated that their

The social worker's representative has outlined that the social worker accepts, *'that [they] made a number of honest mistakes'* and that they have *'reflected long and hard on the lessons to be learnt, taken them on board, and obtained training to correct and update her practice'*.

- The case examiners are of the view that there is no longer a risk of repetition, therefore the purpose of any sanction is to mark the seriousness of the alleged conduct and satisfy the public interest.
- The case examiners recognise that not all professionals will have an innate understanding of how and when the public interest may be engaged, or how exactly this might impact upon findings concerning current fitness to practise.
- The accepted disposal process will provide the social worker an opportunity to review the case examiners' reasoning on impairment and reflect on whether they are able to accept a finding of impairment. It is open to the social worker to reject any accepted disposal proposal and request a hearing if they wish to explore the question of impairment in more detail.
- The case examiners are also of the view that the public would be satisfied to see the regulator take prompt, firm action in this case, with the publication of an accepted disposal decision providing a steer to the public and the profession on the importance of adhering to the professional standards expected of social workers in England.

Accepted disposal

Case outcome

Proposed outcome	No further action	☐
	Advice	☐
	Warning order	☒
	Conditions of practice order	☐
	Suspension order	☐
Proposed duration	3 years	

Reasoning

In considering the appropriate outcome in this case, the case examiners had regard to Social Work England's sanctions guidance (December 2022) and reminded themselves that the purpose of sanction is not to punish the social worker but to protect the public and the wider public interest.

In determining the most appropriate and proportionate outcome in this case, the case examiners considered the available options in ascending order of seriousness.

The case examiners determined that taking no further action was not appropriate in a case where it has been alleged that the social worker has not acted appropriate in response to safeguarding concerns involving children. Taking no further action is not sufficient to mark the seriousness with which the case examiners view the social worker's alleged conduct and fails to safeguard the wider public interest.

The case examiners next considered whether offering advice would be sufficient in this case. An advice order will normally set out the steps a social worker should take to address the behaviour that led to the regulatory proceedings. The case examiners consider that the social worker has taken the necessary steps to address the shortfalls in their practice, therefore advice is not appropriate in this instance. Further, the case examiners consider that advice would not be sufficient to mark the seriousness with which they view the social worker's alleged conduct.

The case examiners next considered issuing a warning and determined that this was the most appropriate and proportionate response in this case and was the minimum necessary

to protect the public and the wider public interest. The case examiners do not consider it necessary to impose restrictions on the social worker's practice as they have already determined that there is no need to restrict the social worker's practice. The purpose of any warning is to mark the seriousness with which the case examiners view this conduct and to satisfy the wider public interest. A warning would serve as a clear expression of disapproval of the social worker's conduct. Further, a warning will be a signal that any repetition will be highly likely to result in a more severe sanction.

In considering the duration of the warning, the case examiners have had regard to the sanctions guidance which states, *'1 year may be appropriate for an isolated incident of relatively low seriousness. In these cases, the primary objective of the warning is to highlight the professional standards expected of social workers. 3 years may be appropriate for more serious concerns. This helps to maintain public confidence and highlight the professional standards. The period also allows more time for the social worker to show that they have addressed any risk of repetition.'*

The case examiners are of the view that the alleged conduct would not be considered of 'low seriousness'. They note that the social worker has practised for the last four years with no concerns raised against them. However, the case examiners consider that the alleged conduct is serious and therefore three years would be appropriate in this instance as it would mark the seriousness of the conduct. The case examiners consider that a period of three years is the minimum necessary to maintain public confidence and to send a message to the public, the profession and the social worker about the standards expected from social workers. The case examiners considered that a five-year duration would be disproportionate and hence would be punitive.

The case examiners did go on to consider whether the next sanctions, conditions of practice and suspension, were more appropriate in this case. They considered conditions or suspension would be appropriate where there is still a risk of repetition. As noted above, the case examiners have already determined that the risk of repetition is low and as such the case examiners considered that a conditions of practice order would not be necessary in this case. The case examiners considered that suspension from the register would also be a disproportionate and punitive outcome. In particular, a suspension would risk deskilling the social worker and the case examiners consider that it is in the public interest to allow the social worker to remain in practice.

To conclude, the case examiners have decided to propose to the social worker a warning order of three-year duration. They will now notify the social worker of their intention and seek the social worker's agreement to dispose of the matter accordingly. The social worker will be offered **14 days** to respond. If the social worker does not agree, or if the case

examiners revise their decision regarding the public interest in this case, the matter will proceed to a final hearing.

Content of the warning

The case examiners formally warn the social worker as follows:

An allegation of not taking appropriate action in relation to safeguarding concerns raised about children, not providing sufficient support and oversight to more junior members of staff and not keeping clear, accurate records to demonstrate decision making are serious. The matters alleged may have contributed to the harm experienced by the children in question. They also have the potential to have an adverse impact on the public's confidence in the social work profession.

The conduct that led to this complaint should not be repeated. Any similar conduct or matters brought to the attention of the regulator are likely to result in a more serious outcome.

The case examiners warn that as a social worker, you must display behaviour which does not fall short of the professional standards. The case examiners remind the social worker of the Social Work England professional standards (2019).

As a social worker I will:

3.2 Use information from a range of appropriate sources, including supervision, to inform assessments, to analyse risk, and to make a professional decision.

3.8 Clarify where the accountability lies for delegated work and fulfil that responsibility when it lies with me.

3.9 Make sure that relevant colleagues and agencies are informed about identified risks and the outcomes and implications of assessments and decisions I make.

3.11 Maintain clear, accurate, legible and up to date records, documenting how I arrive at my decisions.

This warning will remain published for three years.

Response from the social worker

The social worker responded on 23 May 2023 and accepted the proposal in full.

Case examiners' response and final decision

The case examiners have again considered the public interest in this matter and, as they have not been presented with any new evidence that might change their previous assessment, they are satisfied that it remains to be the case that the public interest in this case can be fulfilled through the accepted disposal process.

The case examiners therefore direct that Social Work England implement a 3 year warning order.