

Case Examiner Decision
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FTP-71539

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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 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	
Provisional decision	Accepted disposal – warning order (5 years)
Final outcome	Accepted disposal – warning order (5 years)
Date of the final decision	27 April 2021

Executive summary

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

1. The factual concerns could be found proven by the adjudicators;
2. Those concerns could amount to the statutory ground of misconduct;
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 5 years.

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 social worker made a self-referral to HCPC and this was followed by a referral from the social worker's employer, Southend on Sea Borough Council.
Date the complaint was received	5 June 2019 13 August 2019
Complaint summary	The employer raised concerns that the social worker had not effectively managed safeguarding concerns or followed relevant policy and procedures in line with her role as Practice Lead in the Single Point of Access Team. The concerns related to seven individual cases.

Regulatory concerns

Whilst registered as a social worker, you:

1. did not effectively manage safeguarding work or demonstrate the recommended knowledge of safeguarding policy and procedure in respect of:
 - I. Service user A
 - II. Services user B
 - III. Services user C
 - IV. Services user D
 - V. Services user E
 - VI. Services user F
 - VII. Services user G

Your conduct as set out in Regulatory Concern 1 amounts to misconduct;

Your practice as a social worker is impaired by reason of misconduct.

Preliminary issues

Conflicts of interest

Declaration: *I am not aware of any material conflicts of interest that could impact upon my consideration of this case.*

Lay case examiner

Oliver Carr

Professional case examiner

Kirsty Madden

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



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 concern 1 being found proven, that those concerns could amount to the statutory ground of misconduct, and that the social worker's fitness to practise could be found impaired.

Reasoning

Facts

Service User A

Service User A (SUA) was a female in her eighties residing in a residential care home. An adult safeguarding concern was sent to Single Point of Access (SPOA) on December 12 2018 by SUA's daughter. The concern related to concerns of neglect by the residential care home; SUA had fallen whilst unattended in the care home and suffered a bleed to the brain. SUA died as a result of the bleed on the brain acquired from the fall. The safeguarding concern raised concerns about the safety of other residents in addition to SUA.

The case examiners note that from the information provided to them that the social worker did not follow the Southend, Essex and Thurrock (SET) Safeguarding Adults Guidelines potentially leaving vulnerable adults at risk. The case examiners note the following evidence:

- No evidence of a completed initial risk assessment
- No social work visit to the residential care home
- No social work contact made with the residential care home
- The social worker informed SUA's daughter on 14 December 2018: *"advised I was unable to proceed with my enquiries until the Coroner has completed an outcome"*
This is contrary to guidelines which state *"Safeguarding procedures should be started when an adult dies if abuse is suspected as being a contributing factor and there are lessons to be learnt or there is a possibility that others are or may be affected."*

The social worker within their correspondence with Social Work England acknowledges the regulatory concerns and their *"failings"* with regards to all seven cases identified.

With regards to SUA the social worker states: *"I should have sought further advice on the action required for this case from the outset, I should have visited the care home and completed a risk assessment within the statutory timescales, in addition to the discussion I held with (SUA's) daughter."*

"When my Manager did not know the process for working with the Coroner and I 'thought I knew' I should have checked with the Safeguarding Policy and in the Working with the Coroner Guidance which was revised and provided to me in March 2019. I should have recognised that my Manager did not have this knowledge and escalated this case to the Senior Manager for our Team."

Service User B (Care Home)

A safeguarding adult concern form was received by SPOA on 8 January 2018, documenting concerns for the safety of the residents at a Care Home (Organisational Safeguarding Investigation). The concern was in relation to an incident the previous evening where an employee was found in the manager's office holding a knife, appearing distressed and extremely emotional.

The case examiners note that from the information provided to them that the social worker did not follow the Southend, Essex and Thurrock (SET) Safeguarding Adults Guidelines potentially leaving vulnerable adults at risk. The case examiners note the following evidence:

- No evidence of initial information being gathered or facts being clarified
- Contact made by telephone with the care home manager – Southend on Sea Borough Council Disciplinary Hearing Briefing Document states *"it is noted that*

this manager was one of the alleged perpetrators in this case and was subsequently subject to disciplinary action and dismissed. Therefore, this would not have informed a reliable or robust risk management plan for the residents in the care home.”

- No social work visit to the care home until 24 April 2019
- No conversation with residents or staff of the care home until 24 April 2019
- Enquires were not completed within 20 working days
- An internal investigation by the care home was not submitted to the social worker until 24 April 2019 despite being completed 23 January 2019 with no evidence on file that the social worker tracked the progress of this report.

The social worker within their correspondence with Social Work England acknowledges the regulatory concerns and their “*failings*” with regards to all seven cases identified.

With regards to SUB the social worker states: “*I should also have contacted the owners of the company and maintained a close relationship as they proceeded with their internal investigation. If I had done so, then such a length of time drift would not have occurred.*”

Service User C

Service User C (SUC) was a female in her nineties residing in a residential care home. An adult safeguarding concern was sent to SPOA on 18 September 2018 by the manager of the care home. The concern was that night staff had removed the call bell with the intention of preventing SUC from using it to seek assistance during the night.

The case examiners note that from the information provided to them that the social worker did not follow the Southend, Essex and Thurrock (SET) Safeguarding Adults Guidelines potentially leaving vulnerable adult(s) at risk. The case examiners note the following evidence:

- As Practice Lead the social worker was responsible for allocation of cases. Due to timescales set out in safeguarding guidance prompt allocation is required to achieve the timescales and ensure effective safeguarding.
- The adult safeguarding concern received by SPOA on 18 September 2018 was assigned to the social worker
- No activity is recorded on SUC’s case until the social worker allocated the case to another social worker on 10 October 2018

- The Care Quality Commission were not informed about the concern until 10 October 2018 (completed by newly allocated social worker)

The social worker within their correspondence with Social Work England acknowledges the regulatory concerns and their “failings” with regards to all seven cases identified.

With regards to SUC the social worker states: *“I made two errors from the outset, I allocated it to myself to wait for a Social Worker to have capacity to commence the enquiries, I wrote call to the home as a case note but did not visit the person in their placement or complete a Risk Assessment. Both of which are required in the Safeguarding Guidance. I let the Safeguard ‘sit’ on my allocated caseload for two weeks before allocating it to a Social Worker.”*

Service User D

Service User D (SUD) is a female in her seventies who lives independently and not previously known to social work services. SPOA received an email on 11 January 2019 from SUD’s son outlining concerns about SUD’s safety and welfare. The concerns related to potential mental health issues including hoarding. Furthermore, the son raised concerns regarding his mother’s partner and possible financial abuse. A request was made for a welfare check.

The case examiners note that from the information provided to them that the social worker did not follow the Southend, Essex and Thurrock (SET) Safeguarding Adults Guidelines and the Care Act 2014, potentially leaving a vulnerable adult at risk. The case examiners note the following evidence:

- Following a second unsuccessful visit on 22 January 2019 by the social worker there is no evidence of any action being taken on the case of SUD until the social worker transferred it to a locality team on 16 April 2019.

The Disciplinary Hearing Briefing Document includes comment that *“the nature of the referral email from (SUD’s son) to the Single Point of Access was considered urgent and two visits to SUD’s home were undertaken within a short period of time. These two visits resulted in no contact with SUD. There was no further activity noted on the Social Care Record until 16th April 2019 when the case was transferred from (the social worker) to a long-term social work team for action. If this case warranted action in April 2019 following a period of inactivity for nearly three months, it is reasonable to conclude that this action should have been taken sooner; otherwise, the case would have been closed by (the social worker).”*

The Care Act 2014 gives statutory guidance (2018) on the assessment process, which is applicable in this case, reinforcing the statement in the briefing document, it states:

“6.26 - Where an individual with urgent needs approaches or is referred to the local authority, the local authority should provide an immediate response and meet the individual’s care and support needs”.

The social worker within their correspondence with Social Work England acknowledges the regulatory concerns and their “failings” with regards to all seven cases identified.

With regards to SUD the social worker states: *“I can see the timing mistake for SUD clearly. The dedicated case work time and administrative support were barriers, but I am responsible for not escalating my concerns sooner.”*

Service User E

Service User E (SUE) was a male in his seventies, living alone in a sheltered accommodation complex. He was visited by a care agency four times daily. An email concern was received by SPOA on 19 December 2019 from SUE’s friend, the concern had initially been sent to the Safeguarding Adults Board. The concern outlined that SUE was in bed permanently and was not getting adequate nutrition despite care support in place.

SUE died as a result of a house fire in April 2019 the cause of which was smoking in bed.

The case examiners note that from the information provided to them that the social worker did not follow the Southend, Essex and Thurrock (SET) Safeguarding Adults Guidelines, potentially leaving a vulnerable adult at risk. The case examiners note the following evidence:

- No contact or social work visit was undertaken to SUE
- No social work assessment was completed with regards to SUE

The social worker within their correspondence with Social Work England acknowledges the regulatory concerns and their “failings” with regards to all seven cases identified.

With regards to SUE the social worker states: *“I regret not addressing the earlier (December 2019) report more robustly as the indicators of concern due to his vulnerability regarding being able to access food were there, even though the report did not come in as a Safeguard.”*

I recognise the circumstances I was working in that caused me to not chase up the scoping work I asked the Access Officer to do, if I had followed up with her and she had collected that information, I would have allocated a worker to visit SUE."

Service User F

Service User F (SUF) was a female in her seventies residing in a residential care home. An adult safeguarding concern was received by SPOA on 7 January 2019, made by the care home manager. The concerns were regarding potential sexual abuse by a member of care home staff following comments made by SUF to their daughter.

The case examiners note that from the information provided to them that the social worker did not follow the Southend, Essex and Thurrock (SET) Safeguarding Adults Guidelines, potentially leaving vulnerable adult(s) at risk. The case examiners note the following evidence:

- Safeguarding concern opened and closed the same day (7 January 2019) authorised by the social worker
- No social work contact with SUF or visit to the care home
- No initial information gathered, or initial risk assessment completed by the social worker
- No social work contact with family, including daughter, who was identified in the adult safeguarding concern

The social worker within their correspondence with Social Work England acknowledges the regulatory concerns and their *"failings"* with regards to all seven cases identified.

With regards to SUF the social worker states: *"I had no experience of Safeguarding in relation to allegations of a sexual nature. I made a poor decision to close the case initially based on a telephone conversation with the care home Manager and I did not visit the adult concerned, establish her capacity or consent in relation to Safeguarding and I do not recall consulting with the Team Manger on this Safeguard initially."*

Service User G

Service User G (SUG) is a male who had significant head injury and complex needs. A referral was received by SPOA on 26 March 2018 from a solicitor requesting a Care Act assessment and financial assessment.

The case examiners note that from the information provided to them that the social worker did not follow the Southend, Essex and Thurrock (SET) Safeguarding Adults

Guidelines and the Care Act 2014, potentially leaving a vulnerable adult at risk. The case examiners note the following evidence:

- Referral received 26 March 2018 and assessment written up 17 April 2019 (outside of timescales)

The social worker within their correspondence with Social Work England acknowledges the regulatory concerns and their “failings” with regards to all seven cases identified.

With regards to SUG the social worker states: “(SUG) was not waiting on my assessment and he was not left without support at any time, but I should have completed the assessment within 28 days of the visit to his home. This was my responsibility and is clearly defined within the Care Act (2014).”

The case examiners have determined that there is a realistic prospect of adjudicators finding regulatory concern 1 proven, in full, on the facts presented.

Grounds

The case examiners are aware that misconduct is signified by a significant departure of what would be proper in the circumstances, or otherwise, conduct that is morally reprehensible and likely to bring discredit on the profession.

To assist in considering what would be proper, case examiners have considered the social worker’s conduct in relation to the relevant professional standards. These are the HCPC (Health and Care Professions Council) Standards of proficiency. The case examiners are of the view from the information presented to them that there is strong evidence to indicate that the social worker did significantly depart from a number of expected standards during their management of the seven cases put forward within regulatory concern 1. These include the following:

Registrant social workers must:

1 be able to practise safely and effectively within their scope of practice.

1.1 know the limits of their practice and when to seek advice or refer to another professional

1.3 be able to undertake assessments of risk, need and capacity and respond appropriately

1.4 be able to recognise and respond appropriately to unexpected situations and manage uncertainty

1.5 be able to recognise signs of harm, abuse and neglect and know how to respond appropriately

2. be able to practise within the legal and ethical boundaries of their profession.

2.2 understand the need to promote the best interests of service users and carers at all times

2.3 understand the need to protect, safeguard and promote the wellbeing of children, young people and vulnerable adults

2.6 be able to exercise authority as a social worker within the appropriate legal and ethical frameworks

2.7 understand the need to respect and uphold the rights, dignity, values and autonomy of every service user and carer

4. be able to practise as an autonomous professional, exercising their own professional judgement

4. 1 be able to assess a situation, determine its nature and severity and call upon the required knowledge and experience to deal with it

4. 3 recognise that they are personally responsible for, and must be able to justify, their decisions and recommendations

4. 4 be able to make informed judgements on complex issues using the information available

4. 5 be able to make and receive referrals appropriately

As well as the number of standards allegedly breached, the case examiners have taken further factors into account when considering whether the social worker's acts or omissions represent a 'significant' departure from the professional standards required of a social worker. These include:

- the number of case examples put forward whereby the social worker's practice was not within accordance with the relevant standards, local safeguarding guidelines and associated legal frameworks.
- the nature of the evidence and clear risk of actual and potential harm to vulnerable service users.
- the apparent pattern of poor decision making, without reference to local safeguarding guidelines and associated legal frameworks.

- Evidence put forward within the internal disciplinary process by Head of Service (PM) is clear that there is an expectation that a Practice Lead would *“have an understanding of the safeguarding guidance...”*
- Evidence put forward within the internal disciplinary process by Head of Service (PM) notes the gravity of the concern (SUB): ‘PM was asked if it was acceptable that no visit had been made in a safeguarding case for four months. He stated *“No”* and raised further concerns about transferrable risk, *“if it’s about a resident then you’re potentially placing the resident at risk but you’re also potentially placing the rest of the residents at risk because whatever has or hasn’t happened for a particular client then that might not have happened for another client.”*

After careful consideration of the evidence, the case examiners are satisfied there is a realistic prospect of adjudicators determining that the departure from the professional standards was sufficiently significant to amount to misconduct.

Impairment

The current impairment test has two limbs: the personal element and the public interest element.

Personal Impairment

The case examiners are aware that when considering personal impairment, they must consider whether the conduct is remediable; whether the social worker has undergone remediation and demonstrated full and genuine insight; and, whether there is a likelihood of repetition.

Remediation

While the regulatory concern is considered by the case examiners to indicate a serious breach of a number of professional standards, the case examiners are satisfied that the social worker’s alleged conduct is remediable, for example, by satisfactory completion of education or training courses, and by being able to demonstrate the ability to consistently perform to the required standards.

The case examiners note that the actions giving rise to the regulatory concern took place in 2018 – 2019. The case examiners have noted relevant training records provided by the social worker and an updated position from the social worker’s employer indicating no current concerns with their practice. Although the case examiners note the social worker has not provided explicit evidence of attendance at the training events, they have no reason to question the accuracy of what has been provided. Furthermore, the case examiners note that the social worker has now accepted a permanent position in an

alternative team, which does not deal directly with safeguarding referrals to the local authority, and this position is at a lower grade, with no supervisory responsibility.

Insight

The case examiners have been provided with strong evidence of insight from the social worker regarding the regulatory concern. The social worker's extensive responses are reflective and indicate that the social worker accepts responsibility for the regulatory concern. The social worker wholly acknowledges the serious nature of the concern and potential risk to service users, due to not following safeguarding guidelines. The social worker has acknowledged how public confidence in the profession will have been undermined by their management of the case.

Risk of repetition

Case examiner guidance (paragraph 19) states the risk of repetition is higher when the social worker fails to fully understand what they have done wrong; and that insight needs to be complete rather than partial. In this case, the case examiners have noted good insight and reflection on the part of the social worker, indicating that they do fully understand both where and why their professional practice fell significantly short of the required standard, and what action they should have taken instead.

While clarifying that they are not seeking to detract from their own responsibilities in relation to these matters, the social worker in their submissions does raise concerns regarding the supervision and support that they received at the time they were in the position of Practice Lead. Since moving into subsequent posts, the social worker states that they have felt significantly more supported and supervised more effectively, and this, together with more training has led them to change their practice. Furthermore, the case examiners note that the social worker has detailed a number of significant personal events which occurred during the time when the concerns were raised and impacted on their personal well-being.

The social worker's employer reference would indicate that the social worker is now in a social work position and grade in line with their ability and skillset and would appear to support the social worker's understanding that they are now practising safely and effectively.

In conclusion, given the degree of insight and remediation demonstrated by the social worker, together with evidence that the social worker has consistently practised effectively over a number of years since managing the case of Service User A, the case examiners are satisfied that any risk of repetition is low.

Public interest

The case examiners are aware that when considering public interest, they must consider whether there is a risk to the public; whether the alleged conduct represents a significant departure from professional standards; and whether the alleged conduct has the potential to undermine trust and confidence in the social work profession.

In this instance, the evidence indicates that the social worker's actions and omissions did place a number of vulnerable service users at potential risk of harm.

Public confidence

The case examiners are of the view that, notwithstanding the perceived low risk of future repetition, a failure to sanction a social worker who repeatedly failed to take appropriate action, by not following local safeguarding guidelines, to protect vulnerable adults, is likely to undermine the public's confidence in social work as a profession.

Accordingly, the case examiners have concluded there is a realistic prospect that a finding of current impairment would be made by adjudicators, should the regulatory concern be found proven.

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	☒

Reasoning

Having established there is a realistic prospect of finding current impairment, the case examiners must turn their minds to whether it is in the public interest to refer this matter to a final hearing, or whether they can propose an 'accepted disposal' outcome to the social worker.

Acceptance of impairment

The case examiners are mindful of their guidance, which provides that they must refer matters to a hearing when there is disagreement about the underlying facts of the case which give rise to the allegations of impairment. In this case, the social worker has admitted the facts and has indicated that they are aware of the serious nature of their alleged actions and omissions.

Risk to public safety

The case examiners consider there is a clear risk to the public should these actions be repeated. However, having determined the risk of repetition to be low, they consider that it can be appropriately managed by one of the disposal options available to the case examiners, without the need to refer this matter to a hearing. While this matter represents a significant departure from the professional standards, the case examiners do not consider that permanently removing the social worker from the register to protect the public is the most appropriate option.

Upholding standards

The case examiners are aware of the regulator's duty to uphold proper standards within the profession. They are further aware that this can be achieved, without referral to a hearing, by the publication of their decision on the regulator's public website. Their guidance supports this approach in all but the most serious cases. The publication of their decision is dependent on the social worker agreeing to an 'accepted disposal' of this case.

Public confidence and duty to act proportionately

Lastly, the case examiners have considered what view the public might take. The case examiners have reminded themselves that the focus of the fitness to practise process is to protect and not to punish, and therefore consider the public would support a proportionate approach to resolving this case, without the need to refer to a hearing.

Considering all the factors discussed above, the case examiners have determined the public interest does not require them to refer this matter to a hearing. Alternatively, they will seek to resolve this matter, with the social worker's consent, by way of an 'accepted disposal'.

Accepted disposal

Case outcome		
Proposed outcome	No further action	☐
	Advice	☐
	Warning order	☒
	Conditions of practice order	☐
	Suspension order	☐
Proposed duration	5 years	

Reasoning

When considering the appropriate outcome, the case examiners have referred to their Sanctions Guidance (2019) and reminded themselves that they are required to suggest the minimum sanction necessary to protect the public. The case examiners are aware they must choose the most appropriate sanction necessary to protect the public.

As described above, the case examiners have concluded that the public interest in this case can be satisfied without referral to a hearing and have therefore determined in this instance that it would be appropriate, fair and proportionate to offer the social worker the opportunity to consider resolving this matter through accepted disposal.

The case examiners considered taking no further action but noted that this would not be appropriate in this case given the seriousness of the concern. Case examiners have identified that there is evidence to suggest a significant departure from the HCPC's Professional Standards of proficiency. Taking no further action would not provide the necessary level of public protection and would not satisfy 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 believe that issuing advice is not sufficient to mark the seriousness with which they viewed the departure from professional standards and the potential risk to vulnerable adults.

The case examiners consider that a warning addresses the seriousness of the departure from standards, protecting the public from any repetition of similar actions or behaviours.

A published warning will satisfy the public interest into the issues of concern and send a message of disapproval to the social worker. The case examiners have considered the length of any warning order imposed and have taken the view that a five-year warning order would be proportionate given the serious nature of the concerns, balancing the insight shown by the social worker and the positive reference provided by their current employer alongside the gravity of concerns and the number of vulnerable people placed at potential risk of harm. The case examiners have noted the sanctions guidance which states, *“five years may be appropriate for serious cases that have fallen only marginally short of requiring restriction of registration, to maintain confidence in the profession and where it is necessary to send a clear signal about the standards expected. The timeframe presents an extended period over which the social worker must demonstrate that there is no risk of repetition.”*

The case examiners also considered whether conditions of practice might be an appropriate sanction. The case examiners have taken into account that any sanction imposed is not intended to be punitive but to ensure the social worker is safe to practise going forward; in this case the social worker has demonstrated a significant amount of reflection regarding the concerns, recognising the seriousness and accepting of the concern in full. The social worker has undertaken relevant training, has engaged with managerial support and supervision and accepted a role at a lower grade without supervisory responsibility. Taking into account the social worker’s reflective submissions training record and change in role, the case examiners consider conditions of practise to be a duplication of the actions already undertaken by the social worker in these circumstances.

The case examiners will now notify the social worker of their intention to suggest a published warning and seek the social worker’s agreement to dispose of the matter accordingly. If the social worker does not agree, or if the case examiners subsequently revise their decision regarding the public interest in this case, the matter will proceed to a final hearing. The case examiners consider that 14 days is a reasonable timeframe for the social worker to decide whether to accept this proposed accepted disposal.

Content of the warning

The case examiners formally warn the social worker as follows:

Working within the relevant legal framework and adhering to local policy and procedures are integral to the social work role. Failure to do so, and/or carry out associated tasks

such as assessment and risk management can lead to service users being placed at risk of, or suffering harm.

You must adhere to Social Work England's (2019) professional standards for registered social workers and pay particular attention to the following standards to prevent repetition of a similar concerns.

3 Be accountable for the quality of my practice and the decisions I make.

As a social worker I will:

3.1 Work within legal and ethical frameworks, using my professional authority and judgement appropriately.

3.3 Apply my knowledge and skills to address the social care needs of individuals and their families commonly arising from physical and mental ill health, disability, substance misuse, abuse or neglect, to enhance quality of life and wellbeing.

3.4 Recognise the risk indicators of different forms of abuse and neglect and their impact on people, their families and their support networks.

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

3.12 Use my assessment skills to respond quickly to dangerous situations and take any necessary protective action.

3.15 Recognise and respond to behaviour that may indicate resistance to change, ambivalent or selective cooperation with services, and recognise when there is a need for immediate action.

4 Maintain my continuing professional development.

As a social worker, I will:

4.3 Keep my practice up to date and record how I use research, theories and frameworks to inform my practice and my professional judgement.

6. Promote ethical practice and report concerns.

As a social worker, I will:

6.2 Reflect on my working environment and where necessary challenge practices, systems and processes to uphold Social Work England's professional standards.

Your conduct could have an adverse effect on the public's confidence in you as a social worker. It may also damage the reputation of the social work profession. This conduct 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.

First response from the social worker

The social worker sent a signed response on 19 April 2021 to confirm that they had read the case examiners' decision and the 'further information about accepted disposal' guidance document. They signed to confirm they understand the terms of the proposed disposal of their fitness to practise case and wished to suggest amendments to the sanction proposed.

The social worker put forward:

"I have read the case examiners rationale for their decision and agree that a warning is an appropriate sanction due to the serious nature of my departure from expected standards in 2018/2019.

However, I have sought to remediate my practice and have consistently performed to the required standards since.

I accept that the regulators primary role is public protection and would ask for an amendment to a proportionate warning of four years is considered, as almost three years have passed since my practice was impaired."

Case examiners' first response and decision

The social worker responded to the case examiners on 19 April 2021. The social worker accepted the offer of a warning order but made representations that the duration of the warning should be four, rather than five years.

The case examiners should make clear that the statutory framework which governs their decision-making process does not allow for them to alter the duration of a sanction once

an offer has been made. But in any event, case examiner guidance permits warnings of one, three or five years only, and the case examiners remain of the view that a warning order, published for five years, is the appropriate sanction in this particular case.

In conclusion, the case examiners request the social worker is re-offered the warning order with a five-year term. She should be given 14 days to respond to this offer.

If the social worker does not agree, or if no response is received, the matter will proceed to a final hearing.

Second response from the social worker

The social worker sent an email response on 26 April 2021 to confirm that they had read the case examiners' decision and the 'further information about accepted disposal' guidance document.

They confirmed that they understand the terms of the proposed disposal of their fitness to practise case and accept the warning in full.

Case examiners' response and final decision

The case examiners have reviewed their decision, paying particular regard to the overarching objective of Social Work England: protection of the public, the maintenance of public confidence in the social work profession and upholding professional standards.

Case examiners are satisfied that an accepted disposal (warning) is a fair and proportionate way to address the concerns and is the minimum necessary to protect the public and satisfy the wider public interest. They therefore remain of the view it is not in the public interest to refer this matter to a hearing.