Social worker: Toby Jackson
Registration number: Social Worker 27811
Fitness to practise: Final hearing

Date(s) of hearing: Monday 16 November 2020 – Wednesday 18 November 2020.

Hearing Venue: Held remotely

Hearing outcome: Removal Order

Interim order: Interim suspension order for a period of 18 Months

Introduction and attendees

1. This is a hearing of the Fitness to Practise Committee governed by the Transitional and Savings Provisions (Social workers) Regulations 2019 and as a result, the hearing will be held under Part 5 of The Social workers Regulations 2018.

2. Mr Jackson (hereafter "the social worker") did not attend and was not represented.

3. Social Work England was represented by Ms Gillet of Capsticks LLP.

Adjudicators	**Role**
Name: Miriam Karp	Chair
Name: Jacqueline Telfer	Social worker
Name: Alison Lyon	Lay

Name: Jenna Keats	Hearings Officer
Name: Laura Merrill	Hearing Support Officer
Name: Andrew McLoughlin	Legal Adviser

Notice of Service:

4. The social worker did not attend and was not represented. The panel of adjudicators (hereafter "the panel") was informed by Ms Gillet that notice of this hearing was sent to the social worker by email and by special next day delivery service to his address on Social Work Register (the Register). Ms Gillet submitted that the notice of this hearing had been duly served.

5. The panel accepted the advice of the legal adviser in relation to service of notice.

6. Having had regard to Rule 44 of The Fitness to Practise Rules 2019 ("the Rules") and all of the information before it in relation to the service of notice, the panel was satisfied that notice of this hearing had been served on the social worker in accordance with the Rules.

Proceeding in the absence of the social worker:

7. The panel heard the submissions of Ms Gillet on behalf of Social Work England. Ms Gillet submitted that notice of this hearing had been duly served, no application for an adjournment had been made by the social worker and as such there was no guarantee that adjourning today's proceedings would secure his attendance. Ms Gillet further submitted that the social worker had voluntarily absented himself because on receiving the documentation in relation to this hearing he had signed a document dated 16 October 2020 that stated that he "will not be attending the hearing but have already provided written submissions to be considered in advance of the hearing" She therefore invited the panel to proceed in the interests of justice and the expeditious disposal of this hearing.

8. The panel accepted the advice of the legal adviser in relation to the factors it should take into account when considering this application. This included reference to Rule 43 of the Rules and the cases of *R v Jones [2003] UKPC*; *General Medical Council v Adeogba [2016] EWCA Civ 162*.

9. The panel considered all of the information before it, together with the submissions made by Ms Gillet on behalf of Social Work England. The panel considered that it had a discretion whether to proceed which had to be exercised having regard to all the circumstances of which the panel was aware, with fairness to the social worker practitioner being a prime consideration but fairness to the Social Work England and the public's interest also being taken into account The panel noted that the social worker had been sent notice of today's hearing and the panel was satisfied that he was aware of today's hearing.

10. The panel had no reason to believe that an adjournment would result in the social worker's attendance having noted the email dated 15 September 2020 "*I will not be attending the hearing on 16 November 2020 (or any other days, should the date change)"*. The panel therefore determined that the social worker had voluntarily absented himself from these proceedings. Having weighed the interests of the social worker in regard to his attendance at the hearing with those of Social Work England and the public interest in an expeditious disposal of this hearing, the panel determined to proceed in the social worker's absence.

Allegation(s)

11. **The Allegation**

1. This matter was referred by the HCPC's Investigating Committee on 5 February 2019. The allegations were subsequently amended at a preliminary hearing held on 7 November 2019. There are also a number of allegations where the HCPC indicated, at the preliminary hearing, that they would offer no evidence. The final allegations are as follows (the allegations to be discontinued are highlighted):

a. “Whilst registered as a Social worker and employed at Bournemouth City Council, you did not adequately safeguard a number of service users in that:

1) In relation to Service User 1:

A. You did not complete Service User 1’s assessment in a timely manner;

B. Between 8 August 2016 and 4 October 2016, you did not contact Service User 1;

C. Between August 2016 and September 2016, you did not contact Service User 1; (no evidence to be offered)

D. You did not record the start date of the start ASSET assessment;

E. In or around October 2016, you did not ensure that an urgent panel meeting convened in a timely manner.

2) In relation to Service User 2:

A. On one or more occasions between May and October 2016, you did not review and/or update Service User 2’s assessment in a timely manner or at all;

B. Between June 2016 and October 2016 you only undertook 4 contacts for Service User 2 when you were required to undertake 12;

C. On or around July 2016, you did not refer Service User 2 to YOS Reparation Team in a timely manner;

D. You did not increase contact with Service User 2, after Service User 2 had attempted to commit suicide;

E. You did not make contact with Service User 2 for approximately 12 working days despite being informed that Service User 2 had attempted to commit suicide;

F. You did not update Service User 2’s assessment when Service User 2 moved to a different address after the death of a close friend; (no evidence to be offered)

G. On or around July 2016, you did not ensure that a review panel convened in a timely manner;

H. On or around September 2016, you did not liaise with key partners in respect of this service user in a timely manner or at all;

I. On or around October 2016, you did not undertake a review of an assessment for under ASSET plus in a timely manner. (no evidence to be offered)

3) In relation to Service User 3:

A. Between May 2016 and September 2016, you only undertook five contacts for Service User 3 when you were required to undertake 12;

B. On or around September 2016, you did not refer Service User 3 to YOS health services in a timely manner;

C. You did not undertake a vulnerability assessment for Service User 3 in a timely manner;

D. On or around October 2016, you did not undertake a review of an assessment for Under ASSET Plus in a timely manner; (no evidence to be offered)

E. In or around August 2016, you incorrectly advised a Youth Justice Panel that Service User 3 was referred to Youth Offending internal health services when this was not the case.

4) In relation to Service User 4:

A. You did not complete a ROSH assessment for Service User 4 in a timely manner;

B. You did not complete amendments to Service User 4's assessment in a timely manner;

C. You did not record your decision making process not to update Service User 4's assessment, after Service User 4 was recorded to have possessed a dangerous weapon;

D. You did not update the assessment and/or ROSH for closure in a timely manner.

5) In relation to Service User 5:

A. You did not complete Service User 5's assessment adequately and/or in a timely manner;

B. You did not clearly record the Initial Panel meeting date on 24 August 2016 in a timely manner; (no evidence to be offered)

C. You did not ensure that a panel meeting was convened in a timely manner;

D. Between July 2016 and November 2016, you only undertook three contacts for Service User 5 when you were required to undertake eight.

6) In relation to Service User 6:

A. You did not complete Service User 6's assessment in a timely manner or at all;

B. You did not record an assessment "main" outcome to the DTO intervention in a timely manner. (no evidence to be offered)

7) In relation to Service User 7:

A. You only undertook one contact with Service User 7;

B. You did not complete and/or record Service User 7's assessment in a timely manner or at all.

8) In relation to Service User 8:

A. You only undertook one contact with Service User 8;

B. You did not undertake Service User 8's assessment in a timely manner;

C. You did not complete an intervention plan in a timely manner.

9) In relation to Service User 9:

A. You did not adequately complete and/or update Service User 9's assessment in a timely manner;

B. On or around September 2017, you did not review and/or update the intervention plan in a timely manner.

10) In relation to Service User 10:

A. You completed an inadequate assessment in that your assessment contained significant gaps in information from relevant agencies;

B. You did not adequately liaise with relevant agencies including: (no evidence to be offered) i) Social Care; (no evidence to be offered) ii) Police; (no evidence to be offered) iii) SEN. (no evidence to be offered)

C. You did not complete the intervention in a timely manner;

D. On or around November 2017, you did not complete a risk assessment in a timely manner; (no evidence to be offered)

E. On or around September 2017, you did not complete P&P work in a timely manner. (no evidence to be offered)

11) In respect of Service User 11, you did not update this service user's initial assessment in a timely manner.

12. Preliminary matters

    Ms Gillet indicated that she would offer no evidence in relation to allegations: – 1C; 2F; 2 I; 3 D; 5 B; 6 B; 10 B; 10 i,ii and iii; 10 D; 10E and the panel determined that none of those allegations were proved and should therefore be dismissed.

13. In relation to the balance of the allegations, Ms Gillet submitted that as the panel were only to determine disputed facts and that the social worker in an email dated 18 August 2020 indicated that he did not "intend to challenge the evidence of allegations 1 through to 11" following the amendments that had been made by Social Work England, then the facts contained within the allegations should be proved by way of admission by the social worker

14. The panel accepted the advice of the legal adviser and decided that they would treat the facts as proved by reason of the admissions made by the social worker and that there would be no need to formally prove those facts as a result.

15. Accordingly by reason of admission, the facts contained in the following allegations were proved: – 1 A; 1 B; 1 D; 1 E; 2 A; 2 B; 2 C; 2 D; 2 E; 2 G; 2 H; 3 A; 3 B; 3 C; 3 E; 4 A; 4 B; 4 C; 4 D; 5 A; 5 C; 5 D; 6 A; 7 A; 7 B; 8 A; 8 B; 8 C; 9 A; 9 B; 10 A; 10 C 11.

Summary of Evidence

THE BACKGROUND

16. The proven allegations arise from the social worker's employment at the Youth Offending Service at Bournemouth, Christchurch, and Poole Council where he was employed as a Youth Justice Officer between October 2011 and December 2017.

17. In his role he was responsible for working with young people who had been convicted of criminal offences and were referred to the Council. He was responsible for undertaking assessments, creating plans, working with the Service User to reduce the risks of reoffending and liaising with external agencies. He also had to provide advice and reports to the courts to assist in determinations of sentences.

18. All Youth Justice Officers are expected to work to the same standards. The National Standards of Youth Justice set out the timeframes for assessments and expected levels of contact for children and young people within the youth justice system.

19. The proven allegations against the social worker relate to multiple failures in his care of 11 vulnerable service users, between June 2016 and November 2017, including

    - failures to complete actions in a timely manner;
    - failures to make contact with service users as required;
    - failures to complete assessments adequately and/or in a timely manner;
    - and inadequate record keeping.

20. In November 2015, the social worker was put onto his second Informal Performance Improvement Plan (PIP) as there were continuing issues with regard to timeliness, case recording and the level of contact with young people. With support he was able to improve his practice to the required level.

21. In October 2016, a third PIP was initiated to address concerns relating to timeliness of assessments, low contact levels with services users, poor case recording and a failure to complete actions requested by management.

22. In November 2016, shortly after the implementation of the third PIP it was agreed that the concerns would be more appropriately dealt with through a disciplinary process. As part of this process an investigation was formally instigated in December 2016.

23. As part of the investigation, the records of 6 service users were examined. In each of the files it was discovered that assessments and actions had been completed between 5 and 150 days after the deadlines and in some cases not at all. There were serious concerns about the level of contact the social worker had had with the Service users during periods when enhanced support was needed. In particular, a service user whose mother was receiving end of life care and another Service user who had made a suicide attempt.

24. [PRIVATE]

25. In July 2017, the capability hearing resulted in a new 3 months Performance Improvement Plan, with additional training support, and reasonable adjustments were put in place, in light of the recommendations following his diagnosis. This was the 4th performance plan that the social worker had been subject to.

26. Unfortunately, despite being given the extra support to improve his performance the social worker continued to fail to meet the necessary standards and in December 2017 a final capability hearing was convened.

THE SPECIFIC ALLEGATIONS IN DETAIL

27. Mark Hill was the Team Manager, responsible for operational management of the Youth Offending Service at Bournemouth, Christchurch and Poole Council. He was the social worker's line manager from April 2014 and supervised him monthly. He provided evidence in regard to the concerns around all 11 service users. He stated that:-

28. Service User 1. She was subject to a 6 month Referral Order for two counts of assault by beating, as well as a Public Order offence. A Referral Order is an order available for young offenders who plead guilty to an offence. The case was allocated to the social worker on 26 April 2016, which is the date of Service User 1's court appearance. When a case is referred to the Youth Offending Service (Y OS), an initial assessment is due for completion within 15 working days. The purpose of the assessment is to identify the young person's strengths, risks and protective factors associated with offending behaviour and harm to others; and to inform effective intervention programmes. This standard is externally set and all staff in the YOS are clear of this expectation. The expectations are set out in the National Standards for Youth Justice Services. For young people on Court Orders, the National Standards for Youth Justice Services policy document confirms that intervention plans must be completed within 15 working days of sentencing. Staff are made aware of this requirement during their induction to the team and it is regularly reinforced through supervision. The assessment for Service User 1 was completed by the social worker on 24 May 2016 which therefore means it was completed 20 working days following the referral and outside the 15 working day deadline. Some of the young people with whom the social worker worked posed a significant risk to the community and with others that are extremely vulnerable themselves and are at risk of significant harm. The assessment, and therefore the plan that is put in place, is there to reduce the risk of reoffending. Therefore failing to put this plan in place in a timely manner means that the young person may not be able to access resources needed in a timely manner and could have a huge impact on the public and the young person's safety.

29. ASSET and ASSET Plus are electronic documents comprising the assessment and intervention plan for each service user. ASSET Plus replaced ASSET in around June/July 2016. ASSET Plus provides a more holistic assessment of the service user, allowing one record to follow a child or young person throughout their time in the youth justice system. When an ASSET or ASSET Plus assessment is commenced, the start date of the assessment should be inputted. Likewise, the assessment is reviewed during the intervention and at the end of the intervention and an end date should be inputted when the case is closed. The social worker failed to input a start date for the assessment for Service User 1 on 22 September 2016. What was more serious was the delay in the assessment and lack of contact in the case.

30. Contact. The frequency of contact with a service user is determined by the initial assessment. The National Standards for Youth Justice set out the timeframes for making initial contact with the young person. The standards also set out the supervision or contact levels required for each type of order through the 'Scaled Approach' which is based on the level of intensity of intervention necessary. Standard Level contact is 2 times per month; Enhanced Level is 4 times per month and Intensive is 8 times per month. These levels reduce to 1, 2 and 4 contacts after the first 3 months. Service User 1 required the standard supervision level. On 3 August 2016, Service User 1 contacted the social worker by telephone to inform him that her mother was seriously ill and had been given two weeks to live (which had already passed). He then visited the service user on 8 August 2016. The social worker then recorded no further contact with Service User 1 until 4 October 2016. On this date he called Service User 1 but she did not answer. He then visited her on 7 October 2016 and at this meeting Service User 1 advised the social worker that her mother had died on 13 August 2016.

31. The social worker failed to adhere to the level of contact required with the service user in this case. The frequency required was not met in September 2016 even though Service User 1 had notified the social worker on 3 August 2016 that her mother was receiving end of life care. By failing to visit Service User 1 for two months following her disclosure of information the social worker has failed to show the level of care expected. He left a vulnerable service user without support.

32. Panel Meeting. When a Referral Order is given at Court, a panel of two trained community volunteers and a member of the youth offending team are convened within 20 working days. The YOS must write a report for the Panel to consider and the Panel will confirm what work is required and review its implementation and progress. The Panel should then meet every 3 months. The initial panel meeting took place on 16 May 2016. A further panel meeting was then held on 6 July 2016. On 3 October 2016, during supervision with the social worker, it was identified that an

urgent Panel meeting was to take place. It was agreed that the social worker would make contact with the Panel that week; however, this task was not completed until 9 November 2016. This is 27 working days after the discussion in supervision. This was an unacceptable delay.

33. Service User 2 was allocated to the social worker on 24 May 2016, although the case had previously been open to West Sussex. The assessment that was received from West Sussex assessed Service User 2 as having high vulnerability. Service User 2 was subject to a Referral Order.

34. Assessment. When the case was transferred to the Council from West Sussex, the social worker should have reviewed Service User 2's assessment within 15 days. This was because there had been a significant change in circumstances for the service user and the YOS worker would want to reflect on the changes that had brought the service user back into the area. There was no record of any updated assessment having been completed for this service user. The social worker's work with Service User 2 was therefore informed by an out of date assessment. In the supervision session held with the social worker on 5 September 2016, he was instructed to review the assessment for this service user under ASSET Plus. A deadline was provided for this task of 16 September 2016. The deadline for this task was not met. In the supervision notes from October 2016, it is recorded, "High vulnerability – Toby to review under an ASSET Plus by 16.9.16 – carry over – urgent". There was no evidence found of this task having been completed. The timescales for completing an assessment when a service user is transferred to the team are less clear than when a referral is made directly to the team. However, the length of time that it took the social worker to review the assessment for this service user is not acceptable.

35. Contact. This service user was subject to an enhanced level of contact and should therefore have been seen four times per month during the first 12 weeks. The social worker achieved only 4 contacts with this service user between June and October 2016 out of a minimum of 12 possible contacts. Therefore, the minimum level of contacts was not met for any of the months that the social worker held this case.

36. Service User 2 tried to commit suicide by taking a paracetamol overdose on 25 August 2016 and was admitted to hospital for 2 days. On 13 September 2016, the social worker was informed of this information by Service User 2's social worker. This did not prompt the social worker to review his assessment and plan and consider additional support. This was considered unacceptable practice. The social worker made telephone contact with the young person 12 working days after being informed of the incident. He did not have any face to face contact with the service user following notification of the suicide attempt; this is considered as unacceptable practice. Another YOS worker made face to face contact with Service User 2 14 working days after the incident. The level of contact recorded on this case is not an

acceptable level of contact given that this service user was identified from the outset of the case as being highly vulnerable.

37. Reparation Referral. In the supervision meeting held on 23 June 2016, the social worker was asked to make a reparation referral in respect of this service user. Reparation is the equivalent of community service for young people under 18 years. Separate workers within the YOS arrange reparation. Most young people would have some element of reparation as part of our work with them. A referral is made by filling out a form and sending it to the reparation team. The notes from the supervision meeting confirm, "Toby to make reparation referral next week" This was not actioned by the date of the next supervision session on 22 July 2016 as this is still recorded as an action that needs to be completed in the notes from this meeting. Likewise, in the notes from the supervision meeting notes from September 2016, it is recorded that the reparation referral is "yet to be made". This action was still not completed by the date of the supervision meeting held in October 2016 and there was therefore a 65 working day delay from the agreed deadline to complete this task.

38. Review Panel. As this case was handed over from another local authority, the 20 working day timescale to convene a panel did not apply. However, in the meeting notes from the supervision meeting with the social worker on 23 June 2016, he instructed the social worker to "get a local panel set up asap". It was agreed in the meeting that he would seek business support for this that same day. This panel was not arranged until 8 August 2016. This led to a significant delay in reviewing the intervention plan and considering whether it needed to be amended following the change in circumstances.

39. Professional Involvement. In the meeting notes from the supervision meeting with the social worker held on 22 July 2016, it is recorded that he was instructed to "consider with other professionals potential role for YOS health team" and to consider using other contacts towards Service User 2. There were a number of professionals involved with Service User 2 and co-ordinating contacts was important. It would have been possible with prior agreement for the social worker to 'count' other professionals' contacts with this service user as YOS contacts. There was no record of this having been completed. It is noted in the supervision record for September 2016 that this has not been actioned. Working with other partners is key to the role and service, safety of the public and young person. The expectation is that staff will link with key partners, particularly if another partner has a good relationship with the young person as in this case. Effective risk management cannot occur in isolation and the social worker was key to getting Service User 2 engaged with the YOS.

40. Service User 3. He was allocated to the social worker on 17 May 2016 and classified as a Child in Need and was subject to a Referral Order for assault occasioning actual bodily harm.

41. Contact. Service User 3 was subject to an enhanced level of contact which meant that he needed to be seen 4 times per month for the first 12 weeks of his order. Between 17 May 2016 and 13 September 2016, the social worker met with Service User 3 on only 5 occasions out of a possible minimum of 12 contacts. As above, contacts should be recorded on the electronic case management file and the social worker was aware of this requirement. The YOS cannot discharge its' statutory functions if young people are not seen as required by National Standards. The role is to reduce offending and protect the public. In not seeing young people as required, the service user is denied a service and victims and the public are not safeguarded.

42. Vulnerability. In the supervision session held on 23 June 2016, the social worker was instructed to reassess the service user's vulnerability. In the supervision session held on 22 July 2016, this was noted as not having been actioned and a deadline of 29 July 2016 was set. In the following supervision session held on 5 September 2016, this task again had not been completed and another deadline was set as 9 September 2016. However, in the supervision notes from October 2016 this is noted once more as not having been completed by the social worker. No evidence was found that the vulnerability of this service user had been reassessed. If it had been reassessed, this would have been updated on the assessment.

43. Health Referral. In the supervision session on 23 June 2016, the social worker was also instructed to make a referral to health in respect of this service user. The record from this supervision session confirms, "Health referral to be made as part of contract". This would mean an internal referral to the health workers within the YOS. This service user had a history of self-harm and this was the reason for the prompt to make the referral. However, in the following supervision session in July 2016, this action remained outstanding. In the notes from the supervision meeting held in September 2016, it states, "Health referral – Toby to clarify the referral and update asap – not actioned as yet. URGENT action needed". The same note then appears in the supervision record for October 2016. The health referral was then made for this service user on 5 October 2016.

44. However, despite a health referral only being made in October 2016, the social worker's Panel report dated 3 August 2016 advised the Youth Justice Panel that the service user had been referred to the YOS Health Team which was clearly incorrect as of this date. The report completed by the social worker states "[Service User 3] has been referred to YOS Health team for allocation."

45. Service User 4 . Service User 4 was allocated to the social worker on 30 March 2016 and was subject to a Referral Order for possession of a bladed article.

46. Assessment The assessment for Service User 4 was initially completed by the social worker within the 15 working day deadline on 20 April 2016. On 29 April 2016, following a quality assurance process, some changes were required to be made and some gaps that had been left to be completed. The changes and amendments requested were not made to the assessment by the social worker until December 2016. This was over 150 working days from when the assessment had been quality assured and the social worker was asked to make amendments. The amended assessment completed by the social worker was still incomplete. The amended assessment recorded that there was no social care history for the service user. However, a Social Care check completed on 8 December 2016 noted that Service User 4 had had previous involvement with social care. This check confirmed that a referral was made in November 2015 after Service User 4 had been assaulted by a Polish male; an incident in February 2016 when Service User 4 was alleged to have taken a knife home; and an incident in July 2016 when a passer-by had alerted the police that Service User 4 and another male were in the street with plastic imitation guns. All this information was pertinent to the assessment and should have been included within the assessment and review.

47. Any decisions taken on a case would be recorded on the case diary or within line management supervision records. In particular, any decisions to not keep to team policy or National Standards need to be endorsed by a manager.

48. ROSH Assessment. On 27 April 2016, the social worker was instructed to complete a Risk of Serious Harm (ROSH) assessment for Service User 4 during a supervision meeting. The ROSH assessment assesses the risk that a service user may pose to others. The record from this supervision meeting with the social worker confirms, “ROSH will be needed, Toby to action by 6th May”. In the first instance, a ROSH assessment should be completed within 15 working days from the court date or confirmation from the Police of an out of court disposal. Despite being requested to complete the assessment by 6 May 2016, a new deadline of 2 June 2016 was set to complete the ROSH assessment. However, at the supervision meetings held in June, July and September 2016 this task was still not completed by the social worker. The ROSH was not completed by the social worker until 5 December 2016. There was therefore a 145 working day delay from the date that was agreed to complete this task in the supervision meeting in April 2016. Without the ROSH, the YOS have an incomplete assessment and therefore the intervention plan may not be appropriate. This can place victims and members of the public at unnecessary risk. The lack of ROSH also means that the agreed frequency of contact with a service user may not be accurate.

49. End ASSET. The final panel for this service user was held on 23 August 2016. In supervision on 5 September 2016, the social worker was instructed to update the assessment/ROSH for closure. On this date, an email was also sent to the social worker from a colleague reminding him that the intervention end date had passed but the 'end ASSET' had not been inputted into the system. On 22 September 2016, the social worker received a further email from the same colleague again reminding him that the intervention end date had passed for this service user and an 'end ASSET' was still outstanding. The team expectation is that a closure assessment is completed within 15 days of the end date. This task was never completed by the social worker.

50. Service User 5. He was allocated to the social worker on 12 July 2016, having been made subject to a 6 month Referral Order for assault by beating.

51. Assessment. The assessment for this service user should have been completed by 9 August 2016 in order to comply with the 15 working day deadline. In case supervision on 22 July 2016, he was requested to complete the assessment on ASSET Plus. He was chased to complete this action in the supervision meetings held on 5 September 2016 and 3 October 2016 as this action remained outstanding on these dates. The assessment was then quality assured on 7 October 2016 but contained inaccurate information. It was recorded that the service user had no contact with social care when this was incorrect. The social care history of the service user was checked and there were three different incidences of the service user having involvement with social care. Feedback was provided to the social worker on the same day and the assessment was quality assured so that updates could be made. However, the assessment was not returned prior to the social worker going on sick leave on 21 October 2016. The case was then reallocated to a different worker who then made the necessary amendments and completed the work.

52. Panel Meeting. An initial panel should be convened 20 working days from a court referral. This is confirmed in the National Standards for Youth Justice Services policy document which states that in respect of referral orders there should be, "an initial youth offender panel meeting (comprising at least two community members and one member from the YOT) within 20 working days of the court-hearing in order to agree the contract". In the supervision meeting on 22 July 2016, the social worker was asked to convene a panel as soon as possible in respect of this service user. This was chased in the two proceeding supervision sessions held in September and October 2016. The initial panel meeting was not held in respect of this service user until 13 October 2016, which is 63 working days from the court referral. This was therefore 43 working days overdue. This level of delay directly impacts on the ability of the YOS to discharge its statutory function to reduce offending.

53. Contact. Due to the delay in completing the assessment, it was not determined how frequently this service user should be seen i.e. whether he should be subject to standard or enhanced contact. The social worker conducted face to face meetings with this service user on 21 July 2016, 28 September 2016 and 13 October 2016. There were therefore only 3 contacts made with the service user within the first 12 weeks. This was not a sufficient level of contact.

54. Service User 6 was subject to a Detention and Training Order (DTO) and was allocated to the social worker on the day of sentence, 30 June 2016. A DTO is a custodial sentence. Half the sentence will be spent in custody and the other half will be supervised by the YOS in the community. Time is spent on training and education to help to prevent the young person reoffending when their sentence is finished.

55. Assessment. An assessment should have been completed for this service user within 15 working days of the date of allocation (Exhibit 11). The social worker on 22 July 2016, was instructed to complete the ASSET plus assessment that week. No assessment was completed by the social worker for this service user. The deadline for the assessment was therefore not met. The numbers of young people from Dorset being sentenced to custody is very small. These young people are a priority for the team due to the risk that they pose to the community in terms of serious harm re-offending. The lack of assessment undermines the effectiveness of an intervention plan during the custody phase.

56. Service User 7. Service User 7 was referred to the YOS for an Out of Court Disposal (OOCD). An OOCD is a criminal disposal given to a young person as an alternative to going to Court. The case was allocated to the social worker on 23 August 2017. The social worker only undertook one contact with this service user which was a home visit on 5 September 2017. The home visit was for the purpose of completing the assessment for Service User 7. The frequency of contact with a service user is not set until the assessment is completed. The social worker failed to complete the assessment within the required timescale of 15 working days. The assessment was still outstanding at the point that the social worker went on sick leave on 13 October 2017 which was 36 working days after the referral was allocated. The work for the service user cannot start until the assessment has been completed. This delay could mean that a young person does not get the support that they need and continues to offend. The commission of further offences could have significant consequences in terms of training and employment opportunities and therefore it is especially important that out of court work is delivered in a timely manner.

57. Service User 8. Service User 8 had assaulted both his mother and his grandmother who was in her eighties. It was also reported that he had threatened to harm both women with a knife. It was also known that Service User 8 had been previously sexually abused in the recent past and was at risk of sexual exploitation and suicide.

This case was allocated to the social worker on 4 September 2017. The social worker completed only one contact with this service user on 8 September 2017 for the purpose of completing the assessment. However, the assessment for this service user was not completed within the 15 working day deadline. The social worker went on sick leave on 13 October 2017, at which stage the completed assessment was 15 working days overdue. The social worker was reminded of this requirement in the supervision contact he had on 15 September 2017. The notes from this meeting confirm, "[ASSET Plus] due 15 days from allocation". He therefore knew that this action needed to be completed. The initial assessment completed for the service user would then inform an intervention plan. The intervention plan should be attached to the initial assessment. When the social worker requests sign off from a line manager for the assessment, the plan has to be attached to the initial assessment. The intervention plan must therefore also be completed within 15 working days from allocation of a case. The social worker did not start the intervention plan for this service user prior to going on sick leave in October 2017. This task was therefore also overdue for this service user.

58. Service User 9. She was assessed at a risk assessment panel as being at risk of suicide, sexual exploitation, physical harm through use of alcohol and self-harm and emotional harm. She was subject to a long-term Care Order. This case was allocated to the social worker on 23 August 2017.The manager had checked with the social worker prior to allocating this case that he felt OK working with this young person as she had similar issues to those identified for Service User 2 who had committed suicide. The social worker confirmed that he was happy to continue to work with Service User 9.

59. Assessment. The manager had quality assured the assessment on 15 September 2017 on the same date as the initial panel meeting and identified that some significant work was required on the assessment and further information was needed on safety and wellbeing. The social worker failed to update the assessment after being notified that further information was required. He then went on sick leave on 13 October 2017. There was therefore a period of 20 working days during which the assessment could have been updated but was not following the assessment being quality assured. The assessment for this service user was completed on 18 October 2017. This was therefore completed after the 15 working day timescale. Any delay to assessments and intervention plans particularly for more vulnerable and risky service users can be significant and again compromises the ability of the team to deliver its statutory function.

60. Intervention Planning. 'P&P' work refers to the 'Pathways and Planning' section of the ASSET Plus assessment. The 'Pathways and Planning' section is the intervention planning part of the ASSET assessment. As stated above, the intervention plan

should be completed along with the initial assessment, 15 working days after referral. The intervention plan should then be reviewed following the initial panel meeting and updated as appropriate to include what was discussed at the meeting. The intervention plan should be reviewed 15 working days following the initial panel meeting. The panel meeting for this service user was held on 15 September 2017. The intervention plan should have been reviewed and updated 15 working days following this date. However, the social worker did not complete this prior to going on sick leave. If he had, the updated intervention plan would have been saved to the electronic case file.

61. Service User 10. He was subject to an Anti-Social Behaviour Injunction and caused a high level of concern for the Police in relation to assaults and weapons. He had been educated in the past for several years in a special school due to his learning needs and had also had social care involvement. This case was allocated to the social worker on 5 September 2017.

62. Assessment. The manager had provided feedback to the social worker on the assessment on 27 September 2017. The original assessment completed by the social worker had significant gaps in it and was not informed by other relevant agencies. The assessment was then signed off and completed for Service User 10 on 6 October 2017; it was due on 26 September 2017 and was therefore late.

63. Intervention Plan. At the point that the social worker went on sick leave, the 'Planning' section of the ASSET Plus assessment had not been completed. The planning section of ASSET Plus is the intervention plan and covers how risk and vulnerability will be managed. The assessment is to be completed 15 working days from the Court referral date. The assessment should then be reviewed and updated 15 working days following the initial panel meeting. The initial panel meeting was held on 6 October 2017, the young person had failed to attend on an earlier date. The intervention plan should therefore have been updated by 27 October 2017.

64. Service User 11. Service User 11 was subject to a Youth Conditional Caution. This case was allocated to the social worker on 4 August 2017. The social worker completed the assessment and requested sign off on 5 September 2017. He was provided feedback on his ASSET Plus assessment on the same date. The Quality Check outlined the changes requested. In the supervision meeting on 15 September 2017, this service user was discussed and the social worker advised that ASSET Plus had not been updated following the feedback and that this was now overdue. A completion date of 19 September 2017 was agreed. The social worker did not update ASSET Plus by the agreed deadline. The changes identified were not made until 9 October 2017.

Finding and reasons on grounds

65. The panel took into account the advice given by the legal adviser.

66. The panel was satisfied that at all material times the social worker was sufficiently experienced to have the requisite knowledge and skills to complete the tasks for which he was responsible. In short, he knew what was required of him but failed to do it.

67. During his interview with Anna Batty (Team Manager) on 10 and 31 January 2017 as part of the internal investigation process he confirmed that it was his role to manage complex and high-risk cases and stated that he was an experienced practitioner and that he should be able to identify and prioritise in order to address risk.

68. During his investigation meeting on 10 January 2017 he was asked about the expected assessment timeframes and showed a clear understanding of the National Standards without prompting. At the reconvened meeting on 31 January 2017 he demonstrated knowledge of the National Standards for contact with Service users.

69. In his email dated 18 August 2020, he states:

    I fully accept my practice fell well below the standard required and that this put service users at risk. I have no desire to put myself, service users or any Social Work employer in that situation again.

70. The social worker had been subject to several PIPs to help with his issues of time management and completing tasks. In fact, he was subject to an improvement plan during much of the time when the proven allegations had occurred.

71. The panel noted the HCPC standards of conduct performance and ethics (which were the relevant standards at the time) as follows:-

    1. *Standard 1.2: "recognise the need to manage their own workload and resources and be able to practise accordingly"*

    2. *Standard 1.3: "be able to undertake assessments of risk, need and capacity and respond appropriately"*

    3. *Standard 3.3: "understand the need to keep skills and knowledge up to date and the importance of career long learning"*

4. *Standard 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"*

5. *Standard 4.2: "be able to initiate resolution of issues and be able to exercise personal initiative"*

6. *Standard 10.1: "be able to keep accurate, comprehensive and comprehensible records in accordance with applicable legislation, protocols and guidelines"*

7. *Standard 10.2: "recognise the need to manage records and all other information in accordance with applicable legislation, protocols and guidelines"*

8. *Standard 12.1: "be able to use supervision to support and enhance the quality of their social work practice"*

9. *Standard 15.1: "understand the need to maintain the safety of service users, carers and colleagues*

72. The panel considered that the social worker had failed on repeated occasions to comply with the professional standards expected of him as detailed by the HCPC.

73. At the heart of the youth criminal justice system is the idea that positive early intervention can steer a young person away from the path they are currently on before a pattern of criminal behaviour becomes entrenched. Successful intervention is therefore important for the young person but is also necessary for the wider public in order to ensure that their behaviour does not put members of the public at risk from further offending.

74. The panel was satisfied that there was clear evidence from the witnesses that the social worker's actions presented a risk to service users, particularly through significant delays in carrying out assessments and/or failing to carry out an adequate

assessment. Anna Batty at para.11 of her statement, notes the risk of not carrying out regular assessments, stating:

"*The children and young people that Toby dealt with are vulnerable and live potentially quite chaotic lives. If you are not seeing the individual on a regular basis you do not have a picture of their life. Circumstances can change quickly so you do not have a sense of risk and need. Failing to have frequent contact could also lead to delays in obtaining additional support for them. It is important for the young person themselves to be able to forge a relationship and connection with them*."

75. In his statement for the purpose of the final disciplinary hearing David Webb (Service Manager for the Dorset Youth Offending Service) describes the risk when staff do not complete work in a timely manner and do not manage risk and safety adequately:

The work of the YOS involves significant levels of risk in terms of the safety of young people and the public. At its most extreme this can involve risk to life. Failure to complete assessments and plans in a timely manner means the risks cannot be properly or fully identified and addressed. The primary concern is that this leaves the young people and the public at increased risk of significant harm. The secondary concern is that this causes harm to the YOS in terms of its reputation and the confidence of partners and service users in work undertaken by other YOS staff.

76. [Private]

77. The panel was of the view that the sheer number of failings, covering multiple aspects of the role, over a substantial length of time, regarding 11 different Service users elevates these concerns to the level of misconduct. An examination of individual failings also elevates the concerns beyond a competency issue. Failing to contact a Service users after traumatic incidents (for example failing to respond to the news that Service users 1's mother was dying and Service users 2's attempted suicide) should not properly be regarded as lack of competence. Nor can, Allegation 3 E in providing incorrect information to the Youth Justice Panel that Service users 3 had been referred to Internal Health Services, when this had not been done. The panel concluded that the social worker knowingly performed inadequately despite many well documented attempts to address the situation by his employer including no fewer than four PIPs and regular documented monthly supervisions. The social worker himself acknowledged in his personal statement submitted for this *hearing "I regularly reflected on the gap between what I was doing and what I should be achieving… Unrealistic optimism kept me going, when in reality, I should have*

stopped." The panel took into account that his failings had a serious impact on SUs and increased the risk of harm to the public consequently.

78. The failure to follow the protocol of Youth Criminal Court decisions and the giving of incorrect advice to the relevant panels is more than capable of undermining SU's and the public's confidence in the Youth Offending Service, The Youth Criminal Justice system and the Social Work profession as a whole.

Finding and reasons on current impairment

79. [PRIVATE]

80. [PRVIATE]

[PRIVATE]

…

[PRIVATE]

81. The panel was satisfied that the social worker has demonstrated some insight into the concerns raised and the impact of those concerns on the service users in his care. It noted that the social worker himself has concluded that his health issues cannot be mitigated sufficiently for him to practise effectively as a social worker.

82. The panel considered that the social worker's failings are of themselves remediable. However, given that the high level of support, supervision and PIPs did not result in the necessary improvements in his practice there was little likelihood of successful remediation.

83. There was also no evidence before the panel that the social worker had remediated his practice through relevant professional development, evidence of safe practice or testimonials from a current supervisor or colleagues (although he is not currently working as a social worker).

84. The panel therefore concluded that the risk of repetition of the social workers misconduct is high and accordingly the potential risk posed to both service users and the public is also high.

85. The panel noted that despite the social worker stating that he had reflected on these matters at length there was no evidence before the panel of any detailed reflection demonstrating an understanding of the serious impact that his failings had upon the service users in his care.

86. The panel determined that the conduct described and detailed above in the wide ranging and varied serious findings together with a lack of remediation, a high risk of repetition and insufficient insight has resulted in the social worker being currently

impaired. It also determined that there remains a risk to the reputation of the profession if a finding of impairment was not made.

Decision on sanction/warning/advice

87. Having found the social worker's fitness to practise is currently impaired, the panel then considered what, if any, sanction it should impose in this case. The panel noted the submission of Social Work England that removal was the appropriate sanction and was the only sanction that would protect the public and uphold the public interest. She also highlighted that in the personal statement of the social worker he stated that he did not intend to work as a social worker in the future.

88. It had regard to the Sanctions Guidance issued by Social Work England and bore in mind paragraph 1 which states:
"Social Work England's overarching objective is to protect the public. We do so by

"Social Work England's overarching objective is to protect the public. We do so by protecting, promoting, and maintaining the health and well-being of the public; by promoting and maintaining public confidence in social workers in England; and by promoting and maintaining proper professional standards for social workers in England. Our fitness to practise powers enable us to deliver this overarching objective through proportionate sanctions where an individual social worker's fitness to practise is impaired."

89. The panel accepted the advice of the legal adviser.

90. The panel was mindful that the purpose of any sanction is not to punish the social worker, but to protect the public and the wider public interest. The panel applied the principle of proportionality by weighing the social worker's interests with the public interest and by considering each available sanction in ascending order of severity.

The panel identified the following mitigating factors:

1. The full admissions made by the social worker.
2. The social worker had no previous regulatory findings recorded against him.
3. The social worker had engaged with the fitness to practise process and had provided written submissions for the consideration of the panel.

4. The social worker has shown some insight into the shortcomings in his professional practice.
5. [PRIVATE]

The panel identified the following aggravating factors:

1. The direct risk of harm to young and/or vulnerable Service Users and the risk to the wider public caused by the social worker's misconduct.
2. The impact that the misconduct has had on the reputation of the profession in the eyes of the general public.
3. The wide-ranging nature, seriousness and the volume of the findings relating to 11 Service Users, such as, a delay in of 150 days in carrying out an assessment which was still incomplete.
4. The misconduct constituted repeated failings by the social worker to adhere to the fundamental tenets of the profession in putting the interests of Service Users first.
5. The misconduct of the social worker continued over an extended period despite numerous efforts by his employer to address serious shortcomings in the social worker's practice and of which the social worker was fully conscious.
6. The social worker has demonstrated only limited insight into his misconduct, the serious impact of his failings on vulnerable Service Users and has provided no evidence of remediation.

91. No Action, Advice. or Warning. The panel concluded that in the absence of full insight and remediation and given that there were no exceptional circumstances about this case and the wide range and seriousness of the findings, it would be inappropriate to take no action, or to issue advice or a warning. None of these options would be sufficient to protect the public, maintain public confidence and uphold the reputation of the profession.

92. Conditions of Practice Order. The panel went on to consider a conditions of practice order. The panel noted that whilst misconduct was difficult to remediate, it was potentially capable of being remedied however this panel has found it highly unlikely that successful remediation would be achieved. Further, given the social worker's stated intention not to practise as a social worker in the future, the panel did not consider that conditions were workable. Additionally, it would be unreasonable to impose conditions of practice in any event given the fundamental breaches of the tenets of social work.

93. Suspension Order. Having determined that a conditions of practice order would not be appropriate, the panel went on to consider whether a suspension order would be the appropriate and proportionate response. It considered that such an order would protect the public for the period for which it was in place. However, the panel also questioned whether it would satisfy the public interest, in terms of maintaining public confidence in the profession. The panel considered that this was a social worker who had indicated he will not be returning to the profession. Consequently, he has not and is not intending to remediate his social work practice. Further, the panel did not consider that the public interest would be satisfied in keeping a social worker on the register (albeit suspended) in circumstances where that social worker was not minded to develop his insight or undertake any remediation. In addition, this panel as previously stated has found it highly unlikely that successful remediation could be achieved. Consequently, the panel did not consider that a suspension order was the appropriate and proportionate sanction.

94. Removal Order. Having ruled out a suspension order, the panel determined to impose a removal order. It was satisfied that this was the only sanction sufficient to meet the public interest in maintaining the reputation of the profession and protecting the public.

Interim order

95. Ms Gillet made an application under Schedule 2 paragraph 11(1)(b) of the Social Workers Regulations for an interim order of suspension to cover the appeal period before the substantive removal order comes into effect, or if the social worker appeals, until such time as the appeal is withdrawn or otherwise finally disposed of. She applied on the ground of public protection, which includes promoting public confidence in the profession and maintaining standards.

96. Having heard and taken into account the advice of the legal adviser, the panel was satisfied that an interim order was necessary to protect the public for the same reasons as set out in the substantive decision, in particular having found that the social worker continued to pose a risk to members of the public, and of significant harm to service users, given the lack of remediation. In the light of the panel's findings, serious damage would be caused to public confidence if no interim order were to be in place and standards would not be upheld. An interim order was therefore also required to promote and maintain public confidence in the profession and maintain standards for the same reasons as set out in the substantive decision.

97. The panel considered the principle of proportionality and decided to make an interim suspension order for a period of 18 months. In deciding on this length of

interim order (which will expire if no appeal is taken), it took account of the fact that any appeal may take a considerable period of time given the current COVID 19 pandemic and the impact that it has had on court timetables.

Right of Appeal

1. Under paragraph 16 (1) (a) of schedule 2, part 5 of the Social workers Regulations 2018, the Social worker may appeal to the High Court against the decision of adjudicators:

   (i) to make an interim order, other than an interim order made at the same time as a final order under paragraph 11(1)(b),

   (ii) not to revoke or vary such an order,

   (iii) to make a final order.

2. Under paragraph 16 (2) schedule 2, part 5 of the Social workers Regulations 2018 an appeal must be made within 28 days of the day on which the social worker is notified of the decision complained of.

3. Under regulation 9(4), part 3 (Registration of social workers) of the Social workers Regulations 2018, this order can only be recorded on the register 28 days after the Social worker was informed of the decision or, if the social worker appeals within 28 days, when that appeal is exhausted.

4. This notice is served in accordance with rules 44 and 45 of the Social Work England Fitness to Practice Rules 2019.

Review of final orders

5. Under paragraph 15 (2) and 15 (3) of schedule 2, part 4 of the Social workers Regulations 2018:

- 15 (2) – The regulator may review a final order where new evidence relevant to the order has become available after the making of the order, or when requested to do so by the social worker.

- 15 (3) A request by the social worker under sub-paragraph (2) must be made within such period as the regulator determines in rules made under regulation 25(5), and a final order does not have effect until after the expiry of that period.

6. Under rule 16 (aa) of Social Work England's fitness to practise rules, a registered social worker requesting a review of a final order under paragraph 15 of Schedule 2 must make the request within 28 days of the day on which they are notified of the order.

European alert mechanism

7. In accordance with Regulation 67 of the European Union (Recognition of Professional Qualifications) Regulations 2015, Social Work England will inform the competent authorities in all other EEA States that the social worker's right to practise has been prohibited or restricted.

8. The social worker may appeal to the County Court against Social Work England's decision to do so. Any appeal must be made within 28 days of the date when this notice is served on the social worker. This right of appeal is separate from the social worker's right to appeal against the decision and order of the panel.