Social Worker: Keith Ian Hemans
Registration Number: SW30645
Fitness to Practise: Final Hearing

Dates of hearing: 3-17 May 2022

Hearing Venue: Remote hearing

Hearing outcome: Removal order

Interim order: Interim suspension order (18 months)

Introduction and attendees

1. This is a hearing held under Part 5 of The Social Workers Regulations 2018 (the regulations).

2. Mr Hemans did not attend and was not represented.

3. Social Work England was represented by Ms Sophie Sharpe as instructed by Capsticks LLP.

Adjudicators	**Role**
Sara Nathan	Chair
Stella Elliott	Social Worker Adjudicator
Moriam Bartlett	Lay Adjudicator

Harry Frost	Hearings Officer
Khadija Rafiq	Hearing Support Officer
Gerry Coll	Legal Adviser

Service of Notice:

4. Mr Hemans did not attend and was not represented. The panel of adjudicators (the panel) was informed by Ms Sharpe that notice of this hearing was sent to Mr Hemans by recorded delivery and email to his postal and email addresses on the Social Work England Register (the Register). Ms Sharpe submitted that the notice of this hearing had been duly served.

5. The panel of adjudicators had careful regard to the documents contained in the final hearing service bundle as follows:
   • A copy of the notice of this final hearing dated 30 March 2022 and addressed to Mr Hemans at his postal and email addresses as they each appear on the Register.
   • An extract from the Register detailing Mr Hemans' registered postal and email addresses.
   • A copy of a signed Statement of service, on behalf of Social Work England, confirming that on 30 March 2022 the writer sent by ordinary first class post and special next day delivery to Mr Hemans at the address referred to above the Notice of Hearing and related documents.

• A copy of the Royal Mail Track and Trace Document indicating "signed for" delivery in the name of Mr Hemans' registered address on 31 March 2022.

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

7. Having had regard to rule 14, 15 and 44 of the Social Work England (fitness to practise) Rules 2019 as amended (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 Mr Hemans in accordance with the rules.

Proceeding in the absence of the social worker

8. The panel heard the submissions of Ms Sharpe on behalf of Social Work England. Ms Sharpe submitted that notice of this hearing had been duly served, no application for an adjournment had been made by Mr Hemans and as such there was no guarantee that adjourning today's proceedings would secure his attendance. Ms Sharpe further submitted that the last contact with Mr Hemans had been in February 2021. He had not engaged or responded to correspondence since then. She pointed out that considerable time had elapsed since the events giving rise to this hearing and, that five witnesses were in attendance. She therefore invited the panel to proceed in the interests of justice and the expeditious disposal of this matter.

9. 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 and the cases of *R v Jones* [2003] UKPC, *General Medical Council v Adeogba* [2016] EWCA Civ 162.

10. The panel considered all of the information before it, together with the submissions made by Ms Sharpe on behalf of Social Work England. The panel noted that Mr Hemans had been sent notice of today's hearing and the panel was satisfied that he was or should be aware of today's hearing.

11. The panel, therefore, concluded that Mr Hemans had chosen voluntarily to absent himself. The panel had no reason to believe that an adjournment would result in Mr Hemans' attendance. Having weighed the interests of Mr Hemans 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 decided to proceed in Mr Hemans' absence.

Allegations

12. The regulatory concerns in this case arose from a referral on 2 August 2018 made to the Health and Care Professions Council (the HCPC) Mr Hemans'

former regulator. The referral was made by the Associate Director of Social Care at East London Foundation Trust (the Trust), Mr Hemans' former employer. The concerns for consideration by this panel are that Mr Hemans:

While working as a care coordinator (band 6 social worker) at East London Foundation Trust based at Spring House as part of the Biggleswade Community Mental Health Team (CMHT") between 1 January 2016 and 17 August 2017

1. You did not provide an appropriate level of care to service users, in that you failed to:

1.1 visit service user A at appropriate and / or regular intervals before their death
1.2 record accurate information into service user A's clinical records

1.3 visit service users on your case load at appropriate and / or regular intervals, for one or more of the service users listed in Schedule 1
1.4 complete robust care plans, risk assessments and purposeful interventions, for one or more of the service users listed in Schedule 2

1.5 liaise appropriately with other professional services to provide appropriate support to service user B

2. Your conduct at regulatory concern 1.2 above was dishonest in that you recorded falsified information.

3. Your fitness to practise is impaired by reason of your misconduct.

Schedules referred to		
	Schedule 1	**Schedule 2**
1	Service User C	Service User A
2	Service User D	Service User C
3	Service User G	Service User H
4	Service User B	Service User I
5	Service User E	Service User J
6	Service User O	Service User K

7	Service User F	Service User L
8	Service User L	Service User M
9	Service User M	Service User N
10	Service User Q	Service User O
11	Service User S	Service User Q
12		Service User R
13		Service User S
14		Service User T

Preliminary matters

13. There were no preliminary matters

Summary of Evidence

Background

14. Mr Hemans was working as a care coordinator (Band 6 social worker) at Spring House, part of the Biggleswade CMHT as a qualified social worker between 1 January 2016 and 17 August 2017. Mr Hemans' role included visiting service users in their homes, providing support to service users so that they were able to live in the community, undertaking care planning, preparing risk assessments, and reviewing these documents in line with the Trust-wide Care Programme Approach (CPA).

15. Spring House CMHT is a multi-disciplinary assessment team which provides mental care and treatment for adults with more complex and enduring mental health needs, who can benefit from specialist support. The team provides care and treatment to people in the community who are experiencing mental health difficulties, promoting positive mental health and independence; ensuring improved access to appropriate services and resources, ensuring timely discharge from hospital, and reducing the need for hospital admissions.

16. Spring House CMHT employs a range of staff in different roles including social workers such as Mr Hemans, as care coordinators. Care coordinators

could also be registered nurses. Other professional colleagues included general practitioner medical doctors and specialist mental health registrars.

17. Social Work England called evidence from five witnesses. These persons were:

    (i) Ms Suzaan Jenkinson. Ms Jenkinson was the Adult Safeguarding Lead who conducted the workplace disciplinary internal investigation.

    (ii) Mr Marcus Booth. Mr Booth was the Deputy Team Manager at Spring House CMHT and undertook a preliminary investigation.

    (iii) Mr Patrick Moore. Mr Moore was the Operational Manager for Mid-Bedfordshire Mental Health Services. He also undertook a preliminary investigation.

    (iv) Mr Mike King. Mr King was the service Manager within the Bedfordshire Mental Health Directorate. He has since retired from that role. He also undertook a preliminary investigation.

    (v) Mrs. Lystra Wilson (formerly Ms Sheppard). Mrs. Wilson was the Clinical Lead at Biggleswade CMHT. She was Mr Hemans' direct line manager.

<u>Summary of evidence for Social Work England</u>

18. Head of regulatory concern 1.

    You did not provide an appropriate level of care to service users, in that you failed to:

    1.1 visit service user A at appropriate and / or regular intervals before their death

19. On 1 August 2017 the Trust was informed by service user A's mother that service user A had been found dead in his flat. Mr King reviewed all notes on the Trust's case management recording system (RiO) that day.

20. Mr King met Mr Hemans on 2 August 2017. Mr Hemans confirmed that he was the care coordinator for service user A and had been for some time. Mr Hemans acknowledged that he had not had contact with service user A since 21 April 2017, nor had he tried to make contact with service user A by contacting his mother. Mr Hemans reviewed his paper notebook and diary, in which he sometimes recorded visits and contacts, but could not find evidence of any further visits or contact with service user A or his mother after 21 April 2017.

21. The Trust disapproved of any other documentation recording other than on the RiO system. Paper records had been abolished in 2015. RiO ought to have been the only repository for service users records as they were then immediately available to the care coordinator's professional colleagues, were securely stored and were readily updated by professionals in that format.

22. In an investigation interview on 4 December 2017, Mr Hemans admitted to Mr King that he had not visited or attempted to visit service user A since April 2017 but said that May 2017 "*was manic*" with a high number of referrals and that he had been off sick or on annual leave for some time.

23. There was an operational policy which directed the work of care coordinators at the CMHT. The Operations Policy did not specify the regularity of visits to service users but witnesses told the panel that the complex needs of the service users on the CPA (as service user A was), would not have been met by a care coordinator if contact was less than once per month, unless they were working towards discharge. In his investigation interview on 4 December 2017, Mr Hemans said that the contact with service user A was "…*monthly*."

24. At an outpatient appointment on 13 February 2017, it was recorded in RiO that service user A was seen by the care coordinator at *"two-weekly"* intervals. There was no further record of a successful home visit until 14 March 2017 and no further visits recorded until 21 April 2017. At an outpatient appointment on 13 June 2017, it was recorded that service user A was seen monthly.

25. Mr Hemans had a duty under paragraph 3.4 of the CPA Policy to ensure a level of consistency in care during his planned and unplanned absence, which included visits to service users. If service users do not engage, they should be discussed at a multi-disciplinary team meeting.

26. As service user A was not engaging and was not responding to treatments offered under the CPA, the only way to support him effectively would have been to visit him. By not doing so, Mr Hemans put service user A at risk through a lack of support. The impact of this was that service user A was not provided with the level of support and care needed to enable him to live with his mental health condition.

27. In his internal interview, Mr Hemans raised concerns as to the frequency and adequacy of his supervision and a lack of support. Mr Hemans reported that he had been given time in July 2017 to catch up on file work, and that he had prioritised this work over visits to service user A.

Subhead 1.2 record accurate information into service user A's clinical records

28. On 1 August 2017, Mr King looked at all the notes on the RiO system. Mr King noted that the last care plan uploaded onto RiO for service user A was dated July 2015 and the last risk assessment was dated 1 August 2016.

29. Mr King then contacted the Director of Bedfordshire Mental Health Service, Ms Michelle Bradley on 1 August 2017 and informed her of the incident. Mr King observed, at that point, that further documents had been added to RiO since his first review earlier in the day. Mr King undertook a preliminary investigation.

30. Mr King noted that on 1 August 2017, a care plan and a risk assessment had been added to service user A's records. Neither document had been on RiO at the time of Mr King's earlier review of the documents.

31. Mr King found that the document properties indicated that they had both been created on the afternoon of 1 August 2017. The documents showed the date 17 October 2016, but both had been uploaded after 1700 hours on 1 August 2017.

32. On 2 August 2017, Mr King spoke to Mr Hemans in the presence of Mrs. Wilson. Mr Hemans stated that the care plan and risk assessment had both been written prior to 1 August 2017, and that he had updated them yesterday (i.e., on 1 August 2017) and subsequently uploaded them onto RiO from his personal folder. Mr Hemans said that he had saved the documents in his personal folder on the server (H drive) and had put them into the Biggleswade team folder (L drive) on 1 August 2017.
33. Following clearance from the Information Governance Manager, IT provided a copy of Mr Hemans' personal folder dated 31 July 2017 as at 1200 hours. The folder was searched both manually and electronically for any documents with service user A's surname in them; no documents were identified. Mr Hemans' folder within the team folder on the L drive was

empty as of 0700 on 1 August 2017.

34. The date of creation on the respective document properties, and the absence of the documents in either the personal or team drives, did not support Mr Hemans' account as to the creation of the documents. It was concluded that the information entered by Mr Hemans on service user A's records was inaccurate in that it was backdated to give the impression that the care plan and risk assessment were in place prior to service user A's death.

35. In his investigatory interview, Mr Hemans initially said that the documents were on drives on his laptop, as he had described to Mr King. However, following a private discussion with his union representative, Mr Hemans said that the files were, in fact, on an unencrypted memory stick. Mr Hemans explained that the creation date on the file properties of the documents were 1 August 2017 as the documents were incomplete and he had copied and pasted the files. Mr Hemans said that he had not told the investigators about the memory stick as staff were not allowed to use an unencrypted memory stick.

36. On 8 May 2018, during his second investigatory interview, Mr Hemans provided the memory stick on which he said he had saved the documents. The documents were identified with the file names "*05 made up risk"* and *"care plan template 2016."* The file properties showed that both documents were created on 30 August 2017 – nearly a month after the death of service user A – and they were modified by Bernice Hemans, Mr Hemans' wife, on the same date. The information on the memory stick documents and the RiO documents was identical, save for that the memory stick documents did not have a date.

37. Mr Hemans had a duty under the health Records Policy to "*…ensure confidentiality, integrity, accuracy, and appropriate availability of records*." And to create records that were *"…factual, consistent and be written according to Trust policy and accepted professional standards.*"

38. During the course of the internal disciplinary hearing, Mr Hemans admitted that he had falsified the case note because he did not want to get into trouble.

Subhead 1.3 visit service users on your case load at appropriate and / or regular intervals

39. Once service users are accepted to secondary mental health care under the CPA Policy, they have already been assessed by a doctor as being non-treatable in hospital. All of the service users therefore have long-term mental health issues. The service users required a proactive approach, with input from a variety of professionals and services, and it is the care coordinator's job to provide this.

40. The Operations Policy requires that *"The needs of the service user and the range of elements included in their care plan should determine this."* In reality however, due to the complex needs of the service users who were on the CPA, a care coordinator would not have been able to meet the needs of the service users if contact was less than once per month.

41. It was expected that a service user would be seen by their care coordinator for assessment while in hospital. A service user who is discharged from hospital must have been seen within 7 days of discharge as *"The period around hospital discharge following an admission for mental health needs is a time of particularly high risk of suicide. Therefore the need for proper assessment prior to discharge and effective follow up afterwards is essential"*

42. Paragraph 3.4 of the CPA Policy requires that care coordinators ensure a level of consistency in care during planned and unplanned absences, which included making arrangements to visit service users.

43. The risks attached to not visiting or contacting service users regularly can be that service users' needs are not met in that they are not provided with the level of care and support needed to live with their mental health conditions.

<u>Schedule 1 service users</u>

<u>Service User B</u>

44. During the reallocation of Mr Hemans' cases, following his suspension, Mr Moore identified concerns as to the frequency of visits to service user B (also referred to as "DC"). Mr Moore conducted a preliminary investigation into the care received by service user B.

45. Service user B was referred to CMHT in 2010 when he was diagnosed with alcohol dependence, depression, and borderline personality disorder traits. Service User B had made several suicide attempts.

46. On 15 June 2016, service user B's notes on RiO recorded that Mr Hemans had attended a care plan review in which *"weekly contact by care coordinator requested by doctor.*"

47. In a supervision session on 29 June 2016, it was recorded that *"…due to* [service user B] *relapsing the plan is for weekly contact to assess mental state."*. This plan was reiterated in the records of a supervision session on 29 July 2016, where it was recorded *"…due to* [service user B] *relapsing the plan is for weekly contact to assess mental state."*.

48. The contacts with service user B, made by Mr Hemans, and drawn from the service user's records on RiO, together with Mr Hemans' diaries for 2016 and 2017, demonstrated that between 31 March 2016 and 4 April 2017, Mr Hemans had successfully visited service user B on six occasions.

49. Following the request of 15 June 2016 for weekly visits/contact by the doctor, Mr Hemans visited only five times in 10 months, not weekly, as was required.

50. There were two incidences of service user B taking deliberate overdoses. The first occurred in June 2016 and was documented within service user B's notes; the second occurred in September 2016 and resulted in admission to hospital and was reported by service user B's wife to Mr Moore. Between the first and second overdoses, the level of support agreed meant that Mr Hemans should have carried out 14 visits but he had, in fact, only undertaken four.

Service User C

51. Following a concern raised by an agency nurse who was reviewing case records of service users allocated to Mr Hemans, Mr Booth undertook a review of Mr Hemans' whole caseload of service users.

52. Mr Booth undertook his review by reviewing the case notes for service users allocated to Mr Hemans on RiO. Mr Booth also reviewed the L drive, which was a shared drive accessible to staff within Biggleswade CMHT. Care plans, needs assessments, risk assessments and reviews should not have been stored on the L drive, but saved to RiO. The L drive was nonetheless reviewed in case documents had been saved to it by Mr Hemans instead of being uploaded to RiO.

53. Mr Booth also reviewed Mr Hemans' electronic calendar diary and his paper diary to check for records of visits to service users. There were no appointments saved within either the electronic or paper diaries. Mr Booth distilled his findings into a matrix, which he referred to in the exhibits bundle.

54. Service User C was allocated to Mr Hemans on 13 March 2017. Mr Hemans had not visited service user C between the date of allocation and Mr Hemans' suspension on 2 August 2017.

55. Extracts of service user C's care notes were produced. The records exhibited showed that service user C was referred for a care coordinator on 13 March 2017 by a doctor. There were no recorded visits to service user C between allocation and Mr Hemans' suspension on 2 August 2017.

56. In his internal interview, Mr Hemans said that he could not recall service user C and said that he was unaware that service user C was allocated to him, notwithstanding that service user C had been discussed with Mr Hemans at a meeting with Mr King and Mrs. Wilson on 10 July 2017.

Service User D

57. Service User D was allocated to Mr Hemans on 23 November 2016. Mr Hemans first met with service user D on 2 December 2016. Mr Hemans did

not visit service user D again until 27 April 2017, a gap in visits of almost 5 months.

58. In his internal interview, Mr Hemans said that he was not a good record keeper but could not produce any evidence of having seen service user D on an earlier occasion.

Service User E

59. Service User E was allocated to Mr Hemans on 31 May 2017 when she was an inpatient. Care coordinators are expected to attend inpatient appointments after allocation to start work with the patient prior to their discharge to give the patient a clear care coordinated plan for support.

60. Service User E was not seen by Mr Hemans until 19 July 2017, almost two months after allocation and one month after her discharge from hospital. This was in breach of the CPA Policy Expectation to visit service users within 7 days of their discharge from hospital.

61. Service User E was detained for assessment in hospital under section 2 of the Mental Health Act 1983 due to increasing concerns around her mental health; this indicates that there were significant concerns around service user E's mental health in the community.

62. In his internal interview, Mr Hemans said that he was not initially aware that service user E had been allocated to him and that he had been on sick leave for some of the time. He had been instructed by managers not to do clinical work at this time and to update his records.

Service User F

63. Service User F was allocated to Mr Hemans on 24 March 2016. Service User F was visited by Mr Hemans approximately once a month; however, the records suggest that service user F was unwell and struggling, he was sleeping in his car and neighbours had raised concerns. As a result, service user F should have been visited more frequently than once a month.

64. In his internal interview, Mr Hemans said that service user F did not want regular contact.

Service User G

65. Service User G was allocated to Mr Hemans on 22 January 2016. Service User G had been known to services since 2005 and known to Mr Hemans since 2009. Service User G had a diagnosis of paranoid schizophrenia.

66. Service User G was in hospital at the time of allocation to Mr Hemans. He was discharged to CMHT on 21 January 2016. Mr Hemans did not visit the service user within 7 days of his discharge, in breach of paragraph 8.5 of the CPA Policy. There were no recorded visits to service user G between his discharge from hospital and readmission.

67. Service User G was readmitted to hospital on 21 February 2016 and discharged on 26 February 2016. Mr Hemans did not visit service user G until 5 April 2016. This delay in visits was a further breach of paragraph 8.5 of the CPA Policy.

68. Following his discharge from hospital, Mr Hemans saw service user G on a number of occasions.

69. During a visit on 9 June 2017, service user G was recorded to have reported psychotic symptoms, such as hearing voices, being electrocuted through the walls and people having the ability to plant thoughts in his head. Mr Hemans visited service user G on 11 July 2017 and attempted a visit on 24 July 2017 which was unsuccessful, in that service user G was not seen. There was no further visit to service user G by Mr Hemans before his suspension in August 2017. Given service user G's presentation, Mr Hemans should have referred service user G back to his GP and seen him more frequently.

70. In his internal interview, Mr Hemans said that he could not remember the case and that the information was probably on a paper file. Mr Hemans showed some visits recorded in his diary.

Service User L

71. Service User L was allocated to Mr Hemans on 10 April 2017 for an assessment of needs to be undertaken. Mr Hemans did not visit service user L until 19 July 2017.

72. In his internal interview, Mr Hemans said that service user L's assessment was completed on paper.

Service User M

73. Service User M was allocated to Mr Hemans on 7 March 2012. Service User M was visited by Mr Hemans approximately monthly between July 2016 and December 2016; after this there were long gaps between visits conducted by Mr Hemans between 4 April 2017 and 19 July 2017.

74. In his internal interview, Mr Hemans said that a support worker also visited service user M on an alternate basis. Mr Hemans was unable to show a care plan on the system which outlined the level of support provided by the support worker.

Service User O

75. Service User O was allocated to Mr Hemans on 6 October 2016. Mr Hemans saw service user O on 24 October 2016 and then did not see him again until his suspension on 2 August 2017. Service User O had been referred to services by his GP who reported that he was a depressed man in his 50s, who had made "multiple self-harm/suicide attempts" and was therefore considered to be high risk.

76. Mr Hemans said that he did not realise that service user O remained on his caseload and that, to his recollection, there was a plan to refer service user O to counselling and then discharge him from the team. Mr Hemans believed that the team administrator would close the case but "did not want to blame them".

Service User Q

77. Service User Q was allocated to Mr Hemans on 6 June 2016. Mr Booth noted that there long gaps between visits despite the service user reporting that she was distressed.

78. Mr Hemans had visited the service user on 4 August 2016, and then not again until 9/10 November 2016. There was a gap in visits of longer than four weeks between 10 January 2017 and 17 March 2017 when a visit was arranged, but the service user did not attend.

79. In his internal interview, Mr Hemans said that service user Q was originally seen two-weekly and that a week never went by without contact with service user Q, though this was not reflected in the records.

Service User S

80. Service User S was allocated to Mr Hemans on 19 November 2014. There were instances of gaps between contact with service user S, including between 21 November 2016 (which was a telephone call) and 9 March 2017, when service user S cancelled his appointment. There is reference to the service user having been seen "last week" in Mr Hemans' supervision on 15 February 2017 but there were no records of any visits to service user S since 6 October 2016.

81. In his internal interview, Mr Hemans was unable to explain why there was no recorded contact from him as the care coordinator.

Subhead 1.4 complete robust care plans, risk assessments and purposeful interventions

82. All CMHT cases must have a risk assessment and a care plan in place. The operational policy sets out that all members of the clinical teams are responsible for ensuring that all activity is captured on the Trust and Local Authority data systems, which includes the risk assessment and care plan. The operational policy also requires that:

    "Clinical staff are responsible for ensuring that each service user has an appropriate care plan and risk assessment in place which identifies key areas of need and actions to be taken to address these needs,"

It also provides that
"*Clinical staff are also responsible for ensuring that the care plans and risk assessments are regularly update[d] with new information and that they are subject to a minimum review period as set out in the Trust's CPA Policies and Procedures.*"

83. The CPA Policy sets out that:

"When a service user has been accepted by any professional within secondary mental health services, the professional involved must, in collaboration with the service user, complete an assessment of need and risk."

84. The CPA Policy highlights that "*Risks are not static and therefore require regular review and assessment in response to the service user's changing presentation and circumstances.*"

85. The care plans and risk assessments are circulated among all services working with the service users in order to ensure their needs are met. The care plans and risk assessments should be reviewed and updated, at a minimum, on a 6 monthly basis.

86. The operational policy highlights the kinds of interventions to be provided by CMHT which are intended to *"reduce and shorten distress and suffering"* and include matters such as psychological therapies and counselling, daytime activities, support with housing and finance and management of substance misuse.

<u>Service User A</u>

87. Service User A died in August 2017, as set out above.

88. Mr King reviewed service user A's file on RiO on 1 August 2017 and conducted a preliminary investigation into the care received by service user A. As already outlined above, a risk assessment and care plan were uploaded by Mr Hemans on 1 August 2017.

89. Mr King reviewed the care plan and the risk assessment from service user A's file. Mr King found that both documents were "thin on content" and therefore not robust (WS MK, para. 30).

90. In particular, Mr King noted that at service user's views for risk issue in the care plan, very little information was recorded *"I keep myself to myself."* There should have been a sufficient level of detail recorded as to what the service user wanted and how their goal would be achieved. Overall, Mr King concluded that the care plan *"reads as if there is no problem at all with PC"* which was not the case.

91. In relation to the risk assessment, the section entitled risk issues, Mr Hemans recorded *"risk to self/Poor self-care"*; under interventions/actions, Mr Hemans had recorded *"monitoring in the community*." Mr King observed that this provided insufficient details. The risks section should have set out the level of risk involved and why. The interventions/actions should have set out what was being monitored, how and why.

92. The care plan set out very few goals and no meaningful interventions. An example of this is at 'Recovery focused healthy lifestyle plans' where it was recorded under 'service user views' "[service user A] *to stop drinking alcohol*; [service user A] *to stop using cannabis*." The interventions/actions column for this risk was left blank. Mr King highlights that the interventions column should have detailed how this going to be achieved, with agreed plans on who will do what to help the service user.

93. Overall, Mr King observed that both the care plan and risk assessment documents were poorly prepared and not fit for their intended purpose.

<u>Service User C</u>

94. Service User C was allocated to Mr Hemans on 13 March 2017. Service User C was reported to have low mood and wanted a care coordinator to support them. Mr Hemans had not completed a care plan or risk assessment for service user C. The risk assessment on the file had been completed by their general practitioner.

95. Mr Hemans had never visited service user C and had not undertaken any work with him. At a minimum, Mr Hemans should have conducted at least an initial assessment and produced a brief care plan around supporting the service user to fill his time during the day or a self-help book to support the service user at home.

96. In his internal interview, Mr Hemans said that he was not aware that service user C was allocated to him.

Service User H

97. Service User H was allocated to Mr Hemans on 2 June 2016.

98. On Mr Booth's review, there was a care plan in place dated 3 June 2016. Care plans should be updated at least every 6 months; the care plan on service user H's file was therefore very out of date.

99. A risk assessment for service user H was dated 20 May 2016. It had been updated by Dr. Kittler on 29 August 2017. Service User H had a number of stressors including going through a divorce; in April and May 2017, service user H expressed that he was struggling, crying himself to sleep, struggling to find a purpose in life and, on 16 May 2017, that he was *"hearing voices and finding this difficult to control"* and said that he was suicidal. The risk assessment was not updated by Mr Hemans to reflect these risks, nor was an action plan put in place. Mr Booth concluded that this left service user H at risk as he was not receiving a suitable standard of care to manage his mental health issues or receiving purposeful interventions.

100. In his internal interview, Mr Hemans was unable to explain why the care plan was not completed or why there had been no offer of intervention for services to support service user H with debt, homelessness, or relationship issues. He described service user H as a reserved individual who was unpredictable, therefore the risks ranged, in Mr Hemans' opinion from medium to high.

Service User I

101. Service User I was allocated to Mr Hemans on 19 November 2014.

102. On Mr Booth's review, there was a risk assessment dated 23 May 2016 which had not been updated following the service user's overdose on 25 July 2016. Mr Booth noted that there had been no previous risk of overdose.

103. There was not an up to date care plan for service user I.

104. In his internal interview, Mr Hemans was unable to comment on the lack of updated risk assessments, care plans, carer's assessment, and direct payment for service user I and his/or his wife; Mr Hemans was unable to explain why there was no evidence of this work having been undertaken.

Service User J

105. Service User J was allocated to Mr Hemans on 26 October 2016. Mr Hemans took over from another care coordinator.

106. Service User J was considered to be a "complex case" with frequent self-harm and hospital admissions, notwithstanding this, Mr Hemans had not prepared a care plan for service user J.

107. In his internal interview, Mr Hemans was unable to explain the lack of care plan for service user J.

Service User K

108. Service User K was allocated to Mr Hemans on 24 October 2016.

109. On Mr Booth's review of Service User K's file, he noted that Mr Hemans had not produced a care plan or a risk assessment.

110. In his internal interview, Mr Hemans said that the paperwork for this case was in his desk drawer on a piece of paper.

111. The documents produced from Mr Hemans' desk drawer were exhibited. One of them appeared to relate to Service User K. The document appears to be incomplete.

Service User L

112. Service User L was allocated to Mr Hemans on 10 April 2017.

113. Mr Hemans had not produced a care plan for service user L and though a risk assessment had been completed by Mr Hemans, it had not been updated.

114. In his internal interview, Mr Hemans explained that "the assessment" had been completed on paper.

Service User M

115. Service User M was allocated to Mr Hemans on 7 March 2012.

116. Mr Hemans had completed a care plan which was dated 16 June 2016. This was not uploaded to the service user's RiO file until 27 March 2017. Consequently, the care plan was not accessible to other professionals, who were not able to see the service user's goals and targets.

117. Service User M is recorded to have moved to another area in a case note dated 19 July 2017; notwithstanding this, the file remained open and no further interventions were recorded. It was not clear who was currently caring for the service user.

118. In his internal interview, Mr Hemans said that service user M's risk assessment was in a paper file and the documents would be on the paper file and should also be on the team drive. The team drive was accessed during the preliminary investigation and no assessments were found there. In relation to the lack of transfer documents, Mr Hemans said he would normally have faxed paperwork to the receiving team, but in this instance, he was on annual leave and when he returned service user M had moved. Mr Hemans expected that someone else should have completed the

paperwork. Mr Hemans was unable to show a care plan on the system that detailed the support given by the support worker.

Service User N

119. Service User N was allocated to Mr Hemans on 26 January 2017.

120. On Mr Booth's review, it was noted that Mr Hemans had not produced a care plan or a risk assessment for service user N.

121. In his internal interview, Mr Hemans said he had made arrangements to meet service user N to complete a risk assessment and care plan before he was suspended in August 2017.

Service User O

122. Service User O was allocated to Mr Hemans on 6 October 2016.

123. Service User O was recorded as being 'high risk' due to being a "depressed man in his 50s" with "multiple self-harm/suicide attempts" Despite these indications, Mr Booth's review found that Mr Hemans had not produced a care plan or a risk assessment for the service user.

124. Mr Hemans said that he had completed a "team assessment" for the service user and that the plan had been to refer service user O to counselling and then discharge him. Mr Hemans had not realised that service user O remained on his caseload.

Service User Q

125. Service User Q was allocated to Mr Hemans on 6 June 2016.

126. On Mr Booth's review, there was no care plan for service user Q; a document that had been saved as a care plan on RiO was, in fact, a consent form.

127. A risk assessment dated 10 November 2016 was saved to RiO. Service User Q had reported being sexually assaulted in December 2016, but Mr Hemans had not updated the risk assessment to reflect this.

128. In his internal interview, Mr Hemans said that the care plan was not completed, as the meeting arranged to look at the care plan did not take place. Mr Hemans then said that he believed an assessment and care plan were completed.

Service User R

129. Service User R was allocated to Mr Hemans on 19 November 2014.

130. Though there was a care plan for this service user, there was no form of intervention work; it was noted that there was *"no purpose to his* [Mr Hemans'] *work.*"

131. In his internal interview, Mr Hemans was unable to explain the reduction in support for this service user (such as after a joint visit by the crisis team) but did say that he had some sick leave.

Service User S

132. Service User S was allocated to Mr Hemans on 19 November 2014.

133. On Mr Booth's review, there was a care plan uploaded to RiO in 2017 but was dated 5 December 2016.

134. Though it was noted in October 2016 that service user S had turned down psychological treatment, it remained on the care plan as an objective. This demonstrated that the care plans were not being regularly updated to reflect changes in circumstance.

135. The risk assessment for service user S was dated 16 May 2016 and was therefore considerably out of date.

Service User T

136. Service User T was allocated to Mr Hemans on 31 May 2016.

137. Mr Hemans had not completed a risk assessment for service user T until 17 May 2017, almost a year after allocation.

138. In his internal interview, Mr Hemans said that he had taken over the case from another worker and that a risk assessment and care plan were already in place**.**

Subhead 1.5 liaise appropriately with other professional services to provide appropriate support to service user B

139. Paragraph 5.2 of the CPA Policy sets out that service users under the CPA have complex needs that need to be met by a number of services. It was Mr Hemans' job as care coordinator to coordinate these services.

140. Service User B was *"a vulnerable man with several diagnoses of mental disorder and also uses alcohol regularly*." On 8 June 2016, it was reported that service user B had taken a significant drug overdose. The overdose and the current stressors were noted in the clinic letter sent by the consultant psychiatrist.

141. On Mr Moore's review of the case, service user B's wife informed him that she had often contacted Mr Hemans asking for help with various issues to which she did not receive a response. Some of the stressors to service user B, and his wife who acted as service user B's carer, were legal issues surrounding contact with their grandson, financial issues and debt, and the lack of transport for appointments and collecting service user B's medication.

142. Service User B's wife reported that she had not been offered an assessment for a carer's allowance and had not been made aware of any Motability schemes. There is no evidence within service user B's progress notes to indicate that Mr Hemans had offered an assessment for carers' allowance, or a Motability scheme; though an entry dated 28 December 2016 recorded that service user B's wife had got a new car.

143. Mr Moore observed that, at the time of Mr Hemans working with service user B, these were new policies and social workers were actively encouraged to conduct assessments as *"the Government had a pot of money allocated for this specific purpose."* Service User B, and his wife, would have been eligible for financial assistance under these schemes.

144. As a result of not attending outpatient appointments in January and April 2017, service user B was discharged from CMHT services after seven years of involvement.

145. In addition to the lack of assessment for Carer's Allowance and Motability schemes, service user B's care plan identified that referrals would be made to P2R (Path 2 Recovery, an alcohol, and drugs service) and to Psychology. Service User B had made a number of suicide attempts and continued to use alcohol regularly.

146. There was no evidence that Mr Hemans had made either referral, and there was no follow up discussion about these services in the progress notes.

Head of regulatory concern 2. Your conduct at regulatory concern 1.2 above was dishonest in that you recorded falsified information.

147. Social Work England alleged that Mr Hemans had acted dishonestly in recording inaccurate information in service user A's clinical records. The care plan and risk assessment uploaded to service user A's clinical notes on 1 August 2017 were falsified in that they were 'backdated' (to 17 October 2016) to create the impression that those documents had been created and in place prior to service user A's death when this was not the case.

148. Creating a care plan and risk assessment in order to mislead those accessing service user A's care records after his death is fundamentally dishonest and would be considered to be so by an ordinary, decent person.

149. Mr Hemans initially explained in his interview that the documents had been prepared on his laptop and that they had been saved to a different drive. When informed of service user A's death, Mr Hemans said he had

tried to ask the Team Manager if he should upload them to RiO. Having not received a response, Mr Hemans asked others and the consensus was that he should upload them.

150. Mr Hemans then, having consulted with his union representative, admitted that the documents had been saved to an unencrypted memory stick, though he remained insistent that he had created the documents prior to service user A's death. He explained that he had not told the investigators about this as the Trust did not permit the use of unencrypted memory sticks for patient information**.**

Summary of evidence for Mr Hemans

151. The evidence for Mr Hemans consisted of a response bundle prepared by his then representatives for an earlier stage in the life of this case. It had not been modified or updated by Mr Hemans and his last contact with Social Work England was in February 2021.

152. In respect of two service users, service user O and service user C Mr Hemans defence was that he owed no duty to the service users. He had not been aware and had not been made aware by anyone that the service users were part of his caseload. Accordingly, he could not be responsible for them.

153. Mr Hemans suggested that he found the RiO system very difficult to work with. He struggled with data entry and so made paper records instead. These consisted of diary entries, notebook entries and completing pro forma assessment forms manually. The records were kept by him in the office. He also said that he had made digital entries on a thumb drive. Mr Hemans suggested that these records were made in a timely manner.

154. Mr Hemans suggested that he had been disadvantaged by inadequate and ineffective supervision in the workplace. He had not been told that cases had been added to his caseload. He had not been assisted to reach his best by the lack of leadership and direction made available to him. There was evidence that Mr Hemans had been offered and had taken protected time in order to catch up with record keeping when he had fallen significantly behind.

Finding and reasons on facts

155. The panel accepted the advice of the legal adviser. The panel was aware that the burden of proving the facts was on Social Work England. Mr Hemans did not have to prove anything. The individual limbs of each head and subhead of regulatory concern could only be found proved if the panel was satisfied on the balance of probabilities. In reaching its decision, the panel took into account all of the testimony given under oath or affirmation by the witnesses and of all of the witness statements. The panel had full regard to the extensive documentary evidence contained within the bundles including the response bundle provided on behalf of Mr Hemans.

156. The panel considered schedule 1 and 2 together, where appropriate, and records the decision on both of these in the same place.

157. The panel paid close attention to the nature and quality of the contemporary records relied on by Ms Sharpe on behalf of Social Work England. There was nothing to suggest that the records were not complete in regard to the relevant entries or had later been altered. The entries appeared to have been made routinely and with internally consistent detail which pointed to their reliability as records of events.

158. The records in regard to regulatory concern 2, completed by Mr Hemans, also appeared to have the character of trustworthy and complete records. The issue for the panel to resolve was whether there was persuasive evidence that the records were the result of a knowing and a deliberate act of falsification by Mr Hemans in order to deceive the reader regarding the quality of the records and the dates on which they had been made. If so, was this dishonest of him?

159. In this regard, the panel applied the objective test for dishonesty mandated by the Supreme Court in *Ivey v Genting casinos (UK) LTD* [2017] UKSC 67.

160. The panel made the following assessment of the witnesses.

Ms Jenkinson.

161. The panel noted that Ms Jenkinson is a registered social worker. She impressed the panel as being a good witness who was fair and balanced in her testimony. She was measured in dealing with questions from the panel. When she was unable to answer the question due to the passage of time,

she was open and straightforward in accepting that. The panel did not feel that Ms Jenkinson carried any ill will towards Mr Hemans. Ms Jenkins impressed the panel as being an objective and dispassionate witness. The evidence which underpinned her earlier internal disciplinary investigation was explored in some detail. The panel considered that she had followed the evidence to its conclusions and there was no sense that she had marshalled evidence in order to support a case against Mr Hemans. In fact, she had followed all the lines of enquiry Mr Hemans himself suggested, including looking at his paper records, excavating his desk drawer, and interviewing the three staff members he suggested. The panel considered this both a thorough and a fair approach.

Patrick Moore.

162. The panel considered that Mr Moore - a registered social worker, who had previously provided some professional supervision to the care coordinators on the unit, including Mr Hemans - was an honest witness who had conceded that there had been a lack of meaningful supervision of Mr Hemans in the workplace, which could have adversely impacted service users. He accepted that supervision, which should have been at least monthly, had been weak and that no further action had been taken to insist that Mr Hemans attended supervision when he declined or refused to do so. The evidence covered by Mr Moore was narrower in scope than that of Ms Jenkinson. The panel was satisfied that Mr Moore was a straightforward and objective witness. He had not started work in the unit until after Mr Hemans' suspension and was only acquainted with him through infrequent professional group supervision.

Mike King.

163. Mr King was also a witness whose evidence was much narrower in scope than Ms Jenkinson's. He completed one element of the investigation but in the panel's view this was done in a thorough and transparent way. He impressed the panel as a credible and reliable witness who had been present in the workplace at the time of these events, and so was well placed to assist the panel. He conducted an investigation meeting in July 2017 and had explored thoroughly all of the elements which were under review. Mr King appeared to be on top of the evidence and was prepared to accept deficiencies in the council systems which had, on one view, facilitated Mr Hemans' conduct. He acknowledged that if a care coordinator wish to evade scrutiny, they could do so without being challenged or disciplined. The panel considered that Mr King was not a biased witness in any way.

Mrs. Wilson.

164. Mrs. Wilson had been Mr Hemans line manager. She was no longer in this role and appeared to have accepted demotions which resulted in her now resuming front line work as a registered hospital nurse. Mrs. Wilson accepted, appropriately, that her supervision of Mr Hemans had been inadequate. Despite the circumstances, Mrs. Wilson showed no ill will towards Mr Hemans. She reiterated to the panel that Mr Hemans had shown, at times, excellent work and, before these events, had given the appearance of being deeply committed to the wellbeing of service users. She told the panel as she had the disciplinary hearing, that in hindsight she should have taken Mr Hemans down the competency route before this happened. The panel considered that Mrs. Wilson had revealed in an open and transparent way, elements of her own poor practice, especially as a line manager. The panel considered that she had not been evasive in her testimony. In the panel's view, her response to examination in chief and panel's questions supported her credibility and reliability. She was helpful in giving a number of insights into Mr Hemans poor practice.

Mr Booth.

165. Mr Booth impressed the panel as being a very honest witness who had nothing to prove. His evidence was very extensive, consistent with his substantial role in the investigation of this matter. His experience, as a nurse, in the field of practice and approach to his professional responsibilities to service users was helpful to the panel. The panel considered that Mr Booth had a clear grasp of all of the extensive detail in this matter and also had an objective, professionally dispassionate overview. He acknowledged that at times, during his investigation and dealings with the disciplinary proceedings, he had been distressed by the impact that Mr Hemans actions had had on service users, and the risks to which they were exposed. The panel considered that Mr Booth was a very credible and very reliable witness. Mr Booth had assisted the panel by expanding on the CPA, which care coordinators such as Mr Hemans had been expected to follow in the course of their duties. The panel understood that the care coordinators were part of the multi-disciplinary team which included social workers and medical practitioners such as nurses and general practitioners. The care programme was intended to actively engage with service users a purposeful and managed way which aimed to assess and meet their immediate needs and to assist the service user, where possible, to exit the programme. The intention was to allow service users to manage their health conditions using community resources in a way which avoided unnecessary hospital

admissions and crises. The care coordinator's role, the panel understood, was central to delivering this approach which meant that the care coordinator was responsible for creating or updating a risk assessment and the care plan within four months of the case being allocated to the individual care coordinator. Contacts with service users should be regular, at least fortnightly in the beginning, and should be purposefully driven towards the overall objective of exiting the programme and restoring the service user to community services. In Mr Booth's testimony, the days of "tea and chat" with service users were over.

166. The panel recognised that in coming to a conclusion on the individual heads and subheads of regulatory concerns, Social Work England had identified that in regulatory concern 1 the panel had to be satisfied that Mr Hemans had a duty to act and had failed in those duties; no reasonable care coordinator would have failed to act in the circumstances. The panel accepted that if Mr Hemans could not reasonably have known that the service users case had been allocated to him, then no duty would arise. This was important because in two cases, Mr Hemans had expressly said in his response bundle that this was the case.

1.1. *failed to visit service user A at appropriate and / or regular intervals before their death*

167. The panel was satisfied that this subhead was proved. Service user A had been reported to have died unexpectedly by his mother. Service user A had been allocated to Mr Hemans in 2016 at a time when service user A had been in crisis. Service user A's needs appeared to fall closely under the care model of rehabilitation and management referred to by Mr Booth. The panel was satisfied that the evidence demonstrated that service user A ought to have been visited at least monthly and perhaps more frequently than that in the early stages of his engagement with the service. That would have been appropriate and would have been sufficiently regular to meet service user A's needs, at least earlier in Mr Hemans' involvement. The visits should have included purposeful interventions as required by the council's policies. There should have been regularly updated records showing the proactive steps taken in response to an appropriate assessment and care planning process by the care coordinator, in this case Mr Hemans. Leaving aside the disputed assessment and care plan relied on at one time by Mr Hemans, the records which reliably demonstrate contact with service user A reveal only sporadic contacts with long gaps between them. The uncontroversial records demonstrate that Mr Hemans last saw service user A four months before his death. Even prior to April 2017, any contact had

been sporadic and not in any way regular. Had it been the case that these contacts were appropriate for service user A, he would have been a candidate for discharge from this intensive service. In fact, service user A's needs were very much greater than that. Service user A was, in the evidence of all of the relevant witnesses available to the panel, at real risk of serious self-harm. Mr Hemans' obligation was to support service user A and promote an improvement or return to community provision. Mr Hemans failed in that duty. Mr Hemans clearly, in the panel's view, failed to visit and support service user A with the frequency and regularity demanded. The panel was unable to identify a verifiable and uncontroversial record of contact with service user A by Mr Hemans which pointed to anything material done by Mr Hemans to assist service user A. Mr Hemans' involvement as care coordinator for service user A fell very far short of the minimum necessary to support service user A. That conclusion was supported by the actions taken by Mr Hemans after service user A's death had become known. As observed below under regulatory concern 2, Mr Hemans took steps to create a risk assessment and care plan for service user A after the service user's death. The panel considered that this was an acknowledgement by Mr Hemans that these steps should have been taken by him in a timely manner in accordance with his duty to service user A as his allocated care coordinator.

1.2. *failed to record accurate information into service user A's clinical records*

168. The panel was satisfied that this subhead of regulatory concern was proved. Mr Hemans had an obligation to service user A to record accurate information which was gained from the visits required by service user A's clinical needs. There were sporadic records made by Mr Hemans, leaving aside the disputed care plan and risk assessment. The sporadic records may not have been inaccurate, but the panel was satisfied that without having carried out the appropriate visits which were mandated under the council's policies and the underlying care model employed, the empty spaces occupied by missing records represented inaccurate information.

169. There was not sufficient timely recording of information relating to service user A's case which would allow the care model to be implemented purposefully for his benefit. The panel was satisfied that Mr Hemans did not do a care plan or a risk assessment which fulfilled his obligation to service user A in that these things should have been done very early in the course of service user A's involvement with the service. Ms Jenkinson exhibited the relevant policy which states at paragraph 3.0:

'3.0 Duties

All individuals

All individuals must ensure confidentiality, integrity, accuracy and appropriate availability of records. All individuals are personally responsible for the records they create or use and will not be allowed access to RiO or any other electronic clinical system until they have completed training at this Trust.'

The panel accepted Ms Jenkinson's evidence that during the course of her disciplinary investigation, Mr Hemans had initially admitted that he had not uploaded a risk assessment and care plan onto the RiO system.

170. The panel also accepted Ms Jenkinson's evidence that he then later admitted to her that his risk assessment and care plan had been made after service user A's death. The panel was satisfied that a care plan and risk assessment which was constructed in the circumstances could not be said to be an accurate record of information. Ms Jenkinson acknowledged that the records of the disciplinary investigation conducted by her did not explicitly record that latter admission by Mr Hemans. However, the panel was satisfied that Ms Jenkinson had already demonstrated a willingness to be fair to Mr Hemans. The panel concluded that Ms Jenkinson's memory was clear and was unaffected by the passage of time and the events on the review. The panel considered that Ms Jenkinson was a truthful and reliable witness and that Mr Hemans' latter admission had been honestly and faithfully recalled by her.

1.3. *failed to visit service users on your case load at appropriate and / or regular intervals, for one or more of the service users listed in Schedule 1*

171. The panel found that each limb of this subhead of regulatory concern was found proved in both aspects with the sole exception of the first alternative in the limb relating to service user E. Ms Sharpe on behalf of Social Work England invited the panel to find that Mr Hemans failed service user E only in respect of the infrequency of his visits. The panel agreed for reasons explained below. The panel considered that the evidence in support of that conclusion was overwhelming.

172. The panel approached this subhead of regulatory concern by considering each service user referred to in turn in schedule 1. For the reasons referred to by the panel in 1.1 above, Mr Hemans had a duty to visit each of the service users at an appropriate and at a regular interval under

the council's policy and is mandated by the model of care provision referred to by Mr Booth.

173. The panel was satisfied that all of the service users set out in the schedule had been allocated to Mr Hemans. The panel accepted the evidence of Ms Jenkinson regarding the process of allocation and way in which care coordinators became responsible for persons allocated to them. Ms Jenkinson had said there were four ways by which a care coordinator could be allocated a case:

1. Service users could be allocated to the appropriate care coordinator by a paper record being placed in the relevant office pigeonhole. Care coordinators were responsible for ensuring that anything in their pigeonhole was collected by them and acted upon.

2. Service users could be allocated a case in a multi-disciplinary team meeting. It was the responsibility of the care coordinators to attend multi-disciplinary team meetings at which, among other things, new service users would be discussed. This attendance was mandatory unless the care coordinator was on leave.

3. On occasion a case might be allocated through the MDT meeting minutes, without there being a discussion. Each care coordinator was expected to read these minutes.

4. The panel accepted Ms Jenkinson's evidence that in situations where a care coordinator, in particular Mr Hemans, had declined to attend a multi-disciplinary team meeting a case could still validly be allocated to the care coordinator by details being uploaded to the care coordinator's caseload on the RiO system. Ms Jenkinson satisfied the panel that every care coordinator's duty was to make themselves familiar with all of the entries on their RiO system pages.

174. A care coordinator could not avoid their obligations to a service user by neglecting to familiarise themselves with the up to date contents of their RiO pages. In addition, a care coordinator's caseload would be discussed with the care coordinators supervisor during supervision meetings which occurred regularly or at least were intended to occur regularly. Even if the care coordinator was unavailable to attend supervision the panel was satisfied that there was an expectation that appropriate supervision would require the care coordinator to know the extent of his or her caseload so as to participate effectively and meaningfully in supervision sessions. Ms Jenkinson informed the panel that, when she interviewed Mr Hemans' three

colleagues, they told her that the four routes meant that the allocation could be clunky or convoluted, but they had never not been aware of a case allocated to them.

175. Mr Booth said that each care coordinator was an autonomous practitioner, independently responsible for managing their own time and caseload. An essential part of this was appropriate time management. Accordingly, as a care coordinator, Mr Hemans was responsible for ensuring that he was familiar with his case load in all respects. The panel was satisfied that this supported the conclusion that Mr Hemans had a duty to do this in accordance with his duties to the service users allocated to him in one of the foregoing ways.

176. Mr Hemans disputed that service users O and E had been allocated to his case load in a way that made him aware of his obligations to the service users. The panel gave very careful consideration to this. It accepted that an obligation by Mr Hemans as care coordinator could only exist if an allocation was made to him in one of the regular ways which was part of the units custom and practice. The panel rejected the possibility that any of the witnesses had inflated or falsified their testimony. The panel discounted that any of the service users listed in schedule 1 were allocated to Mr Hemans inadvertently or irregularly. The panel accepted that Mr Hemans knew or ought to have known the extent of this case load on a daily basis. It did not conclude that the weakness of the supervision system was an adequate excuse or reason for his not knowing the cases allocated to him.

Service user C.

177. This limb of the subhead is proved. The evidence confirmed that service user C was allocated to Mr Hemans as care coordinator in October 2016. The evidence available to the panel confirmed that this case was discussed with him on three occasions that could be identified in his supervision by Mrs. Wilson. The panel was satisfied that Mr Hemans could not plausibly dispute that he did not know that the case had been part of his case load. In any event, Mr Hemans assertion of ignorance did not go any way to meet the evidence which supported that this case had been allocated to him. In essence, it was a bare denial and was in effect a challenge to the regulator to prove the contrary. In the panel's view, the contrary was unarguably established for the reasons set out above.

178. Service user C had not been seen by Mr Hemans. The service user had been allocated to his case load for five months. A care plan and a risk assessment should have been completed by the end of the fourth month in

order to meet the policy. A doctor had completed a risk assessment in relation to service user C, but the visits which should have followed from that together with the assessments and other paper records were not done by Mr Hemans. Mr Booth told the panel that in his opinion there appeared to be no compassion or empathy shown by Mr Hemans when discussing the alleged neglect in this case. He summarised Mr Hemans lack of any work in this case as poor and neglectful practice.

Service user D.

179. This limb of the subhead is proved. Service user D that was a person deemed to be at risk of suicide. The records available demonstrated a gap of five months between December 2016 and April 2017 during which Mr Hemans failed to visit service user D once. Service user D had been in hospital leading up to December 2016.

180. The evidence in support of this limb was very substantial. Mr Booth in his testimony pointed out that if service user D did not require to be seen for such a long period of time, he would not have been allocated a care coordinator. In Mr Booth's opinion, this was another example which illustrated Mr Hemans' lack of impetus to see people. The panel found that Mr Hemans was under an obligation to see service user D at least on his being discharged from hospital and at regular intervals of at least once per month, and perhaps more often, as set out in the policy.

Service user G.

181. Service user G was a patient with a history of hospital admissions during the period that Mr Hemans was responsible for him as care coordinator. The records indicated that no visits took place between January and April 2017 during which time service user G had been admitted to and then discharged from hospital. The policy indicates that appropriate visits would have taken place when service user G returned home from hospital and at other critical points and with sufficient regularity to allow the care coordinator to identify a developing crisis in advance of hospitalisation.

182. Hospitalisation might have been avoided or accelerated depending on service user G's circumstances. Without any visits these opportunities to help service user G were passed up, contrary to the policy and contrary to the purpose of allocating service user G to a care coordinator. In the circumstances the panel found that Mr Hemans had failed in his obligations to service user G to visit him appropriately and at regular intervals.

Service user B.

183. This limb of the subhead is proved. The evidence of Mr Moore was important to the panel. Mr Moore took the panel to records which established that weekly contact had been requested by service user B. In fact only four out of a possible 14 visits had been made. Mr Moore found this troubling. The service user had many complex needs including his financial difficulties, his homelessness and his difficulties accessing transport for support and rehabilitative outings.

184. Service user B was recorded as having already made deliberate attempts at overdose. He was a suicide risk. The visits fell far below the level of what would have been appropriate and sufficiently regular in the circumstances.

Service user E.

185. Service user E had been diagnosed as bipolar and had been allocated to Mr Hemans on 31 May 2016 when Mr Hemans was absent on annual leave. The panel agreed with Ms Sharpe on behalf of Social Work England that because the first visit to service user E had been completed within seven days by another care coordinator it could not be said that Mr Hemans had failed to visit the service user appropriately for the purposes of that first visit. Accordingly, the policy was met in that regard and no failure occurred.

186. The panel however was satisfied that Mr Hemans had failed in his duty to service user E to visit him regularly after this. Mr Hemans recorded that the service user was not at home when he called on one occasion and left a note. There was a live issue however as to whether Mr Hemans had attended at the correct address.

187. In any event, the visit was unannounced and unplanned. The testimony from Ms Jenkinson and Mr Booth was that purposeful visits designed to promote the service users transit from the service to more routine community services should be planned visits. The service user should be contacted in advance and an agreement made regarding the proposed visit.

188. The care coordinator should have attempted to use visits to identify needs which could be addressed and progress which could be made or alternatively identify an impending crisis. The unplanned and unproductive sporadic attempted visits to service user E underpinned, in the panel's view, Mr Hemans failure in purposeful interventions and fully justified the panel finding the limb proved in the second alternative.

Service user O.

189. The panel found this limb proved in both aspects. Service user O had been allocated to Mr Hemans as the service user's care coordinator on 6 October 2016. The records which are available confirm that Mr Hemans saw the service user on 24 October 2016 and not after that. Mr Hemans was suspended from work on 2 August 2017. Mr Booth's testimony which the panel accepted made it clear that this was a service user whose needs called for appropriate and regular visits.

190. The service user was a man in his 50s and had been diagnosed as being depressed. The records show that he had made multiple self-harm or suicide attempts. Mr Booth explained that the service user was therefore considered to be at a high risk.

191. For the reasons set out already in regard to other service users, the absence of any visits after the first visit constituted, in the panel's opinion, a clear breach of Mr Hemans' obligations to service user O. He did not adhere to the policy.

192. Mr Hemans asserted in his defence that he did not realise that service user O had remained on his case load after that first visit. Mr Hemans suggested that there had been a plan. and to then discharge him from the team. Mr Hemans suggested that the failure to close the case, so that it appeared to remain on his case load, lay with his team administrator although he "did not want to blame them".

193. The panel was satisfied that Mr Booth and Ms Jenkins in particular had made an exhaustive search of all of the relevant records. The exhibits bundle in this case was particularly large. No witness was able to identify any record, or any note, or any form of confirmation from any other witness, including Mrs. Wilson, that supported any suggestion that suggested service user O might pass out of Mr Hemans caseload for any reason. In the response bundle prepared by Mr Hemans, he did not point to any document which would support his assertion. The panel was entirely satisfied that Mr Hemans assertion was, at best, mistaken. The panel was confident that service user O remained on Mr Hemans' caseload but was neglected.

Service user F.

194. The panel found this limb of regulatory concern proved in both aspects. Ms Jenkinson's testimony was that the records of a multi-disciplinary team meeting reported that more frequent visits than monthly

were necessary for a person who was then psychiatrically ill and refusing medication. The minutes suggest that he should be monitored closely and so pointed towards visits being more frequent. The policy was designed to be flexible so that when service users were in greater need, their needs could be assessed and resources marshalled to help them appropriately.

195. The evidence suggested that service user F was a person who required more appropriate and frequent visits from his care coordinator than the sporadic, unplanned similarly purposeless visits actually done by Mr Hemans. Mr Booth's evidence suggested that if Mr Hemans had made more frequent visits, he may have been armed with the information to assess service user F for a compulsory hospital admission. In the circumstances, that might well have been in the best interests of service user F. It was in Mr Booth's opinion, a lost opportunity.

Service user L.

196. The panel found this limb of regulatory concern proved in both aspects. The only information available to support any visits or assessments made by Mr Hemans was an incomplete paper draft assessment later found in Mr Hemans' desk drawer. As Mr Booth observed, paper records had been phased out by no later than 2015. Despite that, Mr Hemans had not even scanned the paper record into the RiO system which would have made it available to his professional colleagues. No assessment had been arranged. In the panel's view, Mr Hemans had failed in his obligations to service user L.

Service user M.

197. The panel found this limb of regulatory concern proved in both aspects. This service user had been on Mr Hemans caseload for a very significant period of time. The service user had first been allocated to Mr Hemans as care coordinator in 2012. Despite that, the records showed there were very long periods when no visits took place. A care plan was added to the RiO system by Mr Hemans in March 2017. This was eight months after the plan had been completed in 2016.

198. There was information available on the records that suggested service user M may have moved out of the area, which should have prompted the case to be closed, at the least. On one view, it might have prompted a referral to another area to promote service user M's care. The panel found that there were no focused interventions or a plan for service user M with proposed outcomes that would measure his progress and

continuing needs. The necessity for service user M to remain on the caseload was, at best, uncertain.

Service user Q.

199. The panel concluded that, service user Q had been very let down by Mr Hemans. The panel found that this limb of regulatory concern was proved in both aspects. Service user Q presented with a number of concerning indicators of high risk, including her reports of having self-harmed and having parted from her husband. There was a history of non-attendance at a day centre. Despite this, Mr Hemans had not been prompted to follow up with service user Q in order to assist her possibly helping her to make contact with the police following her report that she had been sexually assaulted. She had not reported the matter and Mr Hemans had done nothing about that. Service user Q contacted the service to complain that she felt unsupported by Mr Hemans and requested a change of care coordinator.

200. Service user Q required an increase in the care and support that she was receiving. In the panel's view of the evidence, it could only conclude that Mr Hemans had not only failed in his obligations to the service user under the policy but had failed to reach even the minimum standard expected of any social worker for a service user with these needs. A risk assessment should have been completed by Mr Hemans following service user Q's report of sexual assault to reflect on the change in circumstances. There should have been an increased history of visits.

Service user S.

201. The panel found this limb of regulatory concern proved in both aspects. A period of accumulating risks leading up to the end of December 2016. Service user S had reported having been assaulted in November 2016. Further, he always found the Christmas period a particularly troubling time. Service user S had been abused over the Christmas period and he found this time difficult. Mr Hemans appeared to have recognised that service user S required more attention. He recorded that the service user should be offered more visits. Despite that however as to Mr Hemans' did not offer appointments to service user S. Records in March 2017 showed a call from the service user cancelling an appointment at that time. In the panel's view, the evidence supported that this was a service user required the increased visits noted by Mr Hemans. In effect Mr Hemans had denied the service user the services to which he himself had said were necessary and to which the service user was entitled.

1.4 complete robust care plans, risk assessments and purposeful interventions, for one or more of the service users listed in Schedule 2

202. The panel was entirely satisfied with the evidence of, among others Ms Jenkinson, who explained to the panel the importance of care plans being created and updated. Further, she dealt with the need to create a risk assessment and to be updated, when necessary, as the service users' needs changed. Underpinning all of this was the care model of service provision. Ms Jenkinson and Mr Booth had explained that purposeful interventions were interventions which identified important changes in a service users life, responded to updated risk assessments and care plans and were directed at assisting the service user to exit the service for other less intensive community-based resources, if appropriate. Equally, the witnesses explained, and the panel fully accepted, that purposeful interventions also extended to preventing unnecessary hospital admissions or arranging for hospital admissions where appropriate, earlier than might occur if helpful for the service user.

203. The panel considered that in not a single case referenced in schedule 2 could it be said that Mr Hemans had done what any reasonable social worker acting as a care coordinator would have done in the circumstances of these cases.

Service user A.

204. The panel found this limb of regulatory concern proved in all aspects. The service user had been discovered by his mother, dead in his home. Mr Hemans had been allocated to service user A. Despite the existence of a care plan and risk assessment, later admitted, by Mr Hemans, according to Ms Jenkinson's evidence, which the panel accepted, to have been made after service user A had died, Mr King's assessment of the content was uncomplimentary. The content was "thin" and fell far short of a sufficient level of detail which would have been expected in this case.

205. Mr King considered that the care plan read as though the service user was not a cause for concern, which was very far from the case. The care plan set out few goals and did not meaningfully record any plans for purposeful interventions or support for the service user. Even had the risk assessment and care plan been completed in a timely manner, Mr King considered that both documents were ill-prepared and not fit for purpose. The panel was satisfied that Mr Hemans had failed in his obligation to complete a robust care plan, a risk assessment and identify purposeful interventions for service user A.

Service user C.

206. The panel found this limb of regulatory concern proved in all aspects. Mr Booth had placed service user C's case at the top of his list and noted that service user C had not been seen by Mr Hemans after the allocation for a period of five months. The risk assessment and care plan should have been completed by the end of the fourth month at the latest. Service user C had never been seen by Mr Hemans. Mr Hemans sought to excuse this by asserting that he did not know that service user C was part of his case load. The panel found that this was a wholly inadequate response by Mr Hemans.

207. It was clear from the system of allocation and from the fact that Mr Hemans had been appointed to act as an autonomous social worker in his role as care coordinator, he had a duty to act in this case. The panel was satisfied that this case had properly been allocated to Mr Hemans, and that Mr Hemans had a responsibility to make himself aware of the case as part of his case management responsibilities. Had Mr Hemans acted as he was obliged to do, he would have recognised from his allocations in the RiO system that service user C was part of his case load. A doctor had completed the risk assessment in this case. Mr Hemans had not conducted any visits and had not completed any records, contrary to his obligations to do so.

Service user H.

208. The panel found this limb of regulatory concern proved in all aspects. Service User H had made a phone call to the duty service in 2017, saying that he felt suicidal. Service User H had been suicidal several times previously. There were a number of stressors in his life which exacerbated his symptoms, including his current homelessness.

209. The panel was satisfied by all the evidence that by May 2017, service user H was in crisis. Mr Hemans appears to have called service user H in May but had not, as he ought to have done, updated the risk assessment for a man who was in a high risk group Mr Booth had explained that men in their 50s, with a previous history of mental health problems or substance abuse, and with relationship challenges, had a heightened risk of suicide. Service User H was in this category, was homeless and other risks had escalated.

210. There was nothing in the risk assessment and care plan that suggested any need for updating, contrary to the clear indicators observed by Mr Booth from the records. Mr Booth observed that visits had been reduced to service user H, despite not having conducted an updated risk assessment which would support that decision.

Service user I.

211. The panel found this limb of regulatory concern proved in all aspects. Service user I had been allocated to Mr Hemans in July 2014. The records showed an active care plan and that despite an incident in which service user I had overdosed, the risk assessment had not been updated in response. Ms Jenkinson and Mr Booth had both explained to the panel that any risk of harm required that the risk assessment and care plan both should be updated at the earliest point possible.

212. The records demonstrated that there were only erratic contacts made by Mr Hemans with service user I. He had not visited the service user while he was in hospital. A period of three months had passed between July and October 2016 following the service users discharge from hospital without a visit from Mr Hemans. Mr Hemans had failed in his obligations towards service user I.

Service user J.

213. The panel found this limb of regulatory concern proved in all aspects. The panel was satisfied by the testimony of Mr Booth, Ms Jenkinson, and by the records available, that no care plan had been put in place by Mr Hemans in any format, digital or written.

214. Service user J had been allocated to Mr Hemans in October 2016 but had not been seen by Mr Hemans until January 2017. Service user J's history included that and he was a frequent self-harmer and had experienced a number of periods as an inpatient in hospital, including compulsorily. The policy and the care plan model all suggested that the service user should have been visited more frequently than once a month but had been denied the service by Mr Hemans. The panel was satisfied that Mr Hemans had failed in his obligations to the service user.

Service User K.

215. The panel found this limb of regulatory concern proved in all aspects. In this case, the panel was satisfied that there had been no risk assessment and no care plan adequately drawn up. There was an inadequate paper record which had not been uploaded to the RiO system and in any event did not meet the minimum necessary for any service user.

216. Mr Hemans had asserted that a risk assessment and care plan had been completed and was available on paper. Only the unsigned partially completed assessment was located in his desk drawer. It became known

that Service User K had moved out of the area. In the circumstances Mr Hemans was required to close the case and perhaps to make a referral to the services who were now responsible for Service User K. Mr Hemans had done neither of these things.

217. The panel was satisfied that Mr Hemans had breached all of these obligations under this subhead of regulatory concern.

Service user L.

218. The panel was satisfied that this limb of regulatory concern was proved in all aspects. Service user L had been allocated to Mr Hemans in April 2017 but he had not visited the service user until July. Ms Jenkinson's testimony was that Mr Hemans had been required to discuss this case at a multi-disciplinary team meeting but the risk assessment had not been updated in order to facilitate this adequately. A needs assessment was located for service user L in Mr Hemans' desk drawer. The care plan had not been done by Mr Hemans.

219. The panel recognised that Mr Hemans had experienced a period of sickness absence from work during that time. However this explained only a relatively short period of a lack of progress. As in other cases, a handwritten needs assessment any desk drawer was of no value to Mr Hemans' professional colleagues and was a disservice to service user L.

Service user M.

220. The panel was satisfied that this limb of regulatory concern was proved in all aspects. The service user had been in the service since 2012. The panel was satisfied that Mr Hemans visits however were erratic and there were long gaps evident between the visits - often of three months or more. The care plan and risk assessment for the service user were a year out of date at the point that Mr Hemans was suspended from work. This was another service user who was found to have moved out of the area and so the case ought to have been closed and perhaps a referral made to a service in his new area.

Service user N.

221. The panel was satisfied that this limb of regulatory concern was proved in all its aspects. The panel was satisfied by the witnesses testimony and the records produced that there was no care plan and no risk assessment. Service user N had experienced a period of crisis and yet seven months elapsed before a needs assessment was completed by Mr Hemans.

Mr Hemans visits to the service user could only be described as sporadic. In this case, Mr Hemans had fallen far short of his obligations to service user N.

Service user O.

222. The panel was satisfied that this limb of regulatory concern was proved in all its aspects. This case appeared to be the trigger for the investigation conducted by Mrs. Jenkinson. There was a concern by doctor and the investigators that service user O may have died since he had last been contacted, but fortunately he had not. The circumstances of this case in particular with its complete disconnection between the service and the service user O appeared to have astonished Mrs. Jenkinson and Mr Booth.

223. The panel decided that service user O appeared to have been forgotten about. No care plan and no risk assessment had been completed by Mr Hemans for a service user who was actively suicidal and self-harming at the point of coming into the service. No documentation was recorded. Ms Jenkinson referred the panel to records of a multi-disciplinary team meeting in October 2016 which described the service user as being at high risk. This was the point at which the case was then allocated to Mr Hemans.

224. As discussed earlier, Mr Hemans assertion that he did not know anything about service user O was untenable in the panel's view of the evidence. Ms Jenkinson pointed the panel to supervision notes and multi-disciplinary team notes which confirmed that Mr Hemans was aware of the service user.

225. The notes that did exist, found in paper form in the desk drawer with the other records, noted graphic details of the service users suicidal actions. Mr Hemans had not attempted to address the somewhat obvious point that these notes could not exist in his desk drawer with his other records if he was wholly unaware of the service user. Further, Ms Jenkinson took the panel to the notes of the multi-disciplinary team meeting on 19 December 2016. These recorded that Mr Hemans claimed to have assessed service user O and that he was ready for discharge. The panel was satisfied that Mr Hemans had fallen very far short of his obligations to service user O.

Service user Q.

226. The panel was satisfied that this limb of regulatory concern was proved in all aspects. Service user Q had first been assigned to Mr Hemans in mid-2016. The first visit did not occur until six weeks after allocation and again not until 6 weeks after allocation and not again until November 2016. Service user Q said that she had been sexually assaulted. There was no risk

assessment referring to this new important information to accommodate this by Mr Hemans, and no update of the care plan, despite a number of accelerating risks.

227. Ms Jenkinson was able to identify a crisis care plan and a consent form only. The risk assessment should have reflected all of the changes in service user Q's life and it was expected that Mr Hemans would form a plan, as part of a purposeful intervention, to help her get in touch with the police if she felt able to do so. Ms Jenkinson said that it was expected that an increase in support would follow a disclosure of sexual assault. Service user Q had written that she had not felt supported by Mr Hemans and asked to be allocated a new care coordinator.

Service user R.

228. The panel was satisfied that this limb of regulatory concern was proved in all aspects. Ms Jenkinson satisfied the panel from records that service user R had been allocated to Mr Hemans in 2014. From the records available, Mr Hemans appears to have been engaged with this individual but not in a purposeful way.

229. There was no evidence that the panel could find of directed plans for purposeful interventions. Mr Hemans appeared from the papers to have had a good relationship with the service user, but the evidence for the service user remaining within the service was, in Mr Booth's evidence, "thin". There was no care plan. The risk assessment had not been updated. There was no evidence of any purposeful or directional interventions consistent with the aims of the service and the best interests of the service user.

Service user T.

230. The panel was satisfied that this limb of regulatory concern was proved in all aspects. The panel was satisfied that a care plan appeared to be in place. However, the risk assessment which was associated with the service user was completed a year after the care plan. Service user T had been diagnosed as a paranoid schizophrenic. The case records that did exist suggested a service user who required significant and targeted interventions but the records that the panel saw show no detail of any engagement undertaken by Mr Hemans.

Subhead 1.5 failed to liaise appropriately with other professional services to provide appropriate support to service user B

231. The panel was satisfied that this subhead of regulatory concern was proved. The panel entirely accepted the evidence of Mr Moore. His review of the records established that service user B had been with the service for at least seven years. The service user was a man with complex needs, was vulnerable, and had several diagnoses of mental disorders.

232. In June 2016 service user B was understood to have taken a significant drug overdose from a letter sent to the service by a consultant psychiatrist. The letter explained the current stressors which appear to have driven service user B into crisis. Service user B's wife had told Mr Moore that Mr Hemans had failed to respond to her requests to help her with several issues she had experienced acting as service user B's carer.

233. There were issues regarding contact with their grandson, debt issues, and a lack of transport for appointments and for collecting the service users' medication. Service user B's wife told Mr Moore that she had not been offered an assessment for carers allowance and was unaware of the Motability scheme. Mr Moore had found no evidence in the service users' progress notes to indicate that Mr Hemans had identified that either of these benefits may apply. Mr Moore evidence was that the service user and his wife were likely to be eligible under both schemes, which each had the potential to make a significant difference in improving the service user's life.

234. Mr Moore observed that records showed that service user B had been discharged from the CMHT services because he had failed to attend outpatient appointments in both January and April 2017. This was consistent with service user B experiencing difficulty in attending appointments because he was unable to access transport. The panel was satisfied that properly liaised with other professional services; service user B might not have been discharged from a community service which he had benefited from for seven years.

235. Steps might have been taken to alert the community service to delay discharge until appropriate scheme applications had been made and decided. Mr Moore also identified that referrals were to have been made, by Mr Hemans, to associated services. It was intended, according to the records, that a referral would be made to the P2R (Path to Recovery) alcohol and drugs service. This referral had not been made attempting suicide and continuing to consume alcohol regularly.

236. The panel was satisfied that Mr Hemans had failed in his obligations to service user B in that he did not liaise appropriately with other professional services to provide appropriate support.

Your conduct at regulatory concern 1.2 above was dishonest in that you recorded falsified information

237. The panel recognised that in approaching its decision-making regarding the allegation of dishonesty it had to consider two discrete matters in turn. The panel first had to establish what was Mr Hemans' state of knowledge or belief regarding the records uploaded only after service user A's death. The panel then had to consider whether the ordinary and decent member of the public would regard what Mr Hemans did in that state of knowledge as being a dishonest thing to do.

238. The panel looked carefully at all of the evidence presented which identified all of the records which had been in place before service user A's death. The panel was satisfied that the search for records carried out by Ms Jenkinson and Mr Booth had been exhaustive. This had been underpinned by a desire to be entirely fair to Mr Hemans. Mr Hemans had suggested that physical records existed in diaries and other paper records beyond those held in the RiO system. The panel was satisfied that all of the records had been recovered and had been included in the workplace disciplinary investigation. In the panel's view, there was nothing further to be recovered or disclosed.

239. The case against Mr Hemans is that he acted dishonestly in recording inaccurate and falsified information in service user A's clinical records. The care plan and risk assessment which, had been uploaded on the RiO system after Mr King first looked in the file on 1 August 2017 were dated 17 October 2016, before the service user's death. The allegation is that these records were falsely and misleadingly backdated with the intention of Mr Hemans falsely being credited with having made the records in a timely way.

240. Ms Jenkinson satisfied the panel that the care plan and risk assessment could only have been completed after the service user had died. No paper records existed in any format which accorded with a contemporaneous care plan and risk assessment being done. The panel accepted Ms Jenkinson's evidence that Mr Hemans' first account was that the records had been on the H and L drives, and that his second account was that he had completed them on a memory stick USB thumb drive. He said that although he had only uploaded them on the RiO system on 1 August 2017, they had been completed on the date certified.

241. Ms Jenkinson explained that as part of her investigation she arranged for the memory stick records to be verified by reference to the document properties. These disclosed that the records could not have been created there before the date of the service user's death. Ms Jenkinson explained that Mr Hemans had accepted during the disciplinary hearing process that his account concerning the memory stick was untrue. Mr Hemans conceded to her that he had panicked when he realised that there would be consequences for him for not having completed the records properly in the context of an enquiry into the service user's death. Mr Hemans said to her that in this state of mind, he had fabricated the records to protect himself.

242. Ms Jenkinson was taken to the minutes of the disciplinary hearing by Ms Sharpe. Ms Jenkinson was able to identify an entry in the records which she associated with Mr Hemans' admission to her. She acknowledged that the record did not on its face, represent an unequivocal record of his admission to her. However, she was quite clear in her recollection. The panel was satisfied that she was an honest witness and was not motivated by any malice or ill intention towards Mr Hemans.

243. The panel recognised that human memories are fallible and are subject to reconstruction by subsequent events and in particular by revisiting events in the witness's mind. Mrs. Jenkinson satisfied the panel that her memory was clear, specific, and uncomplicated. The panel considered that she had provided a true account of Mr Hemans' admission, given to her at a time when his false evidence had been exposed.

244. The panel reminded itself that it must not be persuaded that dishonesty by a social worker had been proved by any evidence which was inconsequential, elliptical, or insubstantial. The panel was satisfied that Ms Jenkinson's evidence was the opposite of this. It was a simple recounting of the admission made to her by Mr Hemans.

245. The panel appreciated that it was given no evidence as to where the care plan and risk assessment for service user A had originated. But it had been given clear evidence that the documents did not come from RiO, the L drive, the H drive, nor the memory stick – contrary to Mr Hemans' successive claims.

246. The panel also reminded itself that Mr Hemans had submitted many testimonials supportive of his good character by former colleagues and by work colleagues current in 2020, all of the testimonials together spoke warmly of his good character, and his commitment to the needs of service

users, his honesty, and his diligence. He was remembered by many former colleagues as having been well-liked by service users and colleagues alike. In the circumstances, the panel reminded itself that it should be slow to find that Mr Hemans had acted in a way wholly at odds with his colleagues' account of him.

247. The panel accepted the testimonials on Mr Heman's behalf at face value. They had been offered by responsible persons who knew Mr Hemans and could reliably attest to his character and good conduct. There were however two matters which had to be considered.

248. First, Mr Heman's current employment, although in a healthcare setting, was not in the capacity of an autonomous independent social worker responsible for managing his workload. He acted in a subordinate capacity in response to directions given to him and in a role designed to support other professionals who were autonomous. Accordingly, those colleagues were unable to assist the panel with an assessment of Mr Heman's actions as an independent professional.

249. That was not to say however that these good testimonials had no value.

250. Second, the panel had to consider that none of Mr Heman's former colleagues appeared to be aware of the gravity of his failings towards vulnerable service users. In any event, none of the testimonials contemplated the possibility of Mr Hemans acting in panic, in the face of a possible enquiry related to a service user's death.

251. The panel considered that Ms Jenkinson’s testimony faithfully recorded Mr Heman's admission to her when his false defence had collapsed. The panel accepted that Mr Heman's admission had been given by him consciously and honestly. Although that admission was not repeated in this process, it was a substantial admission which had to be given full weight in the whole circumstances. The panel did not overlook the possibility that the admission was an appeal for sympathy in the disciplinary process. The panel however was satisfied that all of the evidence taken together meant that Mr Hemans had knowingly created misleading documents, falsely backdated, and uploaded them onto the RiO system to mislead the investigation by Ms Jenkinson and others.

252. The panel considered that any honest and decent person would recognise that Mr Hemans had acted dishonestly in uploading the falsely backdated records.

253. The panel was satisfied that this head of regulatory concern is proved.

Finding and reasons on grounds

254. Having found heads and limbs of concern 1 (with the exception of the first alternative regarding service user E in subhead 1.2) and regulatory concern 2 proved, the panel went on to decide whether under rule 32, Mr. Hemans' actions amounted to one of the statutory grounds for impairment in terms of regulation 25(2); in this case, misconduct.

255. Ms Sharpe submitted that the proved concerns were individually and certainly taken together, sufficiently serious to constitute misconduct. Ms Sharpe referred the panel to three codes which bound Mr. Hemans and the particular standards that she said he breached:

The workplace standards;

1. The Trust's Band 6 Social Worker Job Description;
2. The Trust's operational policy – Bedfordshire Adult Community Mental Health Teams;
3. Trust-wide CPA Policy**;**
4. Clinical Risk Assessment and Management Policy;
5. Health Records Policy.

The proficiency standards that applied to Mr. Hemans were applicable to the social worker by virtue of Part 5 of the Health Professions Order 2001;

the HCPC Standards of Proficiency for Social Workers in England 2012 and replaced by the 2017 edition.

The ethical standards found in;

the HCPC Standards of Conduct, Performance and Ethics (2016).

The panel accepted the legal adviser's advice.

256. The panel understood that a finding of misconduct was a matter for the panel's independent professional judgement. There is no statutory definition of misconduct, but the panel had regard to the guidance of Lord Clyde in *Roylance v GMC (No2)* [2001] 1 AC 311: '*Misconduct is a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be found by reference to the rules and standards ordinarily required to be*

followed by a …practitioner in the particular circumstances." The conduct must be serious in that it falls well below the required standards. The panel recognised that breaches of standards in and of themselves might not necessarily amount to misconduct.

257. The panel agreed with Ms Sharpe's submission that Mr. Hemans' disregard for the Trust's operational policy had been a serious breach of the standards expected of him. Mr. Hemans equally breached important standards imposed on him by the Trust in support of the CPA and clinical risk management and health records policies. These were grave and shameful failings by Mr. Hemans. The client group of service users who entrusted their care to Mr. Hemans as their care coordinator had a right to expect that the service designed to interrupt potentially catastrophic self-harming and other damaging behaviours by them would be addressed in a purposeful and positive way.

258. The panel had found that the policies together were intended to support very vulnerable service users to progress out of urgent crisis. The intention was to secure an improvement so that service users no longer required high need provision and were safely returned to a more routine and less intensive community-based service consistent with well-managed health conditions. Their wellbeing was likely to have been markedly improved by a care coordinator whose commitment to the needs of service users was put into effect, in obedience to the policies. Mr. Hemans' breaches of the workplace codes was summed up by Mr. Booth in his evidence as suggesting that Mr. Hemans appeared to show '…a lack of empathy or compassion.' In these circumstances, Mr. Hemans' multiple breaches of the code amounted to misconduct. It pointed towards his being unfit to practise without some form of restriction.

259. The panel also identified several breaches of the 2012 proficiency standards by Mr. Hemans. These were:

Standard 1 *– be able to practise safely and effectively within their scope of practice*

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

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

Standard 2 *– be able to practise with the legal and ethical boundaries of their profession*

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

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

Standard 3 *– be able maintain fitness to practise*

Standard 3.3 *- understand both the need to keep skills and knowledge up-to-date and the importance of career-long learning*

Standard 4 *– be able to practise as an autonomous professional, exercising their own professional judgement*

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*

Standard 4.2 *- be able to initiate resolution of issues and be able to exercise personal initiative*

Standard 9 *- be able to work appropriately with others*

Standard 9.2 *- be able to work with service users and carers to enable them to assess and make informed decisions about their needs, circumstances, risks, preferred options, and resources*

Standard 9.6 *- be able to work in partnership with others, including those working in other agencies and roles*

Standard 14 *- be able to draw on appropriate knowledge and skills to inform practice*

Standard 14.3 *- be able to prepare, implement, review, evaluate, revise, and conclude plans to meet needs and circumstances in conjunction with service users and carers.*

260. The panel considered that the nature and gravity of each of the regulatory concerns found proved directly impacted on and infringed the above standards. The panel considered that Mr. Hemans' professional colleagues were likely to be appalled at the scope and extent of his breaches of the 2012 proficiency standards. This was supported by the evidence of Mr. Booth who, while always being measured and careful in his testimony, was not always able to conceal his sadness or his disappointment at the impact that Mr. Hemans' conduct had on service users. The panel considered that each breach of the standards fell far short of what Mr. Hemans had professed to aspire to in taking up his role as care coordinator. The gravity of his shortcomings was illustrated by service user Q who felt so unsupported that she wrote to the service asking for a different care coordinator to be allocated to her. Other service users were badly let down. Benefits claims that would have made a huge difference to service user B were not applied for by Mr. Hemans. Any one of the heads of concern could equally well serve as an exemplar of a grave dereliction in duty amounting to misconduct by Mr. Hemans.

261. Although the panel agreed with Ms. Sharpe that the later 2017 edition of the proficiency standards was also relevant, it was sufficient to confine itself to consideration of the 2012 edition for the purpose of deciding on misconduct.

262. The panel identified that Mr. Hemans had also breached the 2016 ethical standards to which he had bound himself in assuming his role in his capacity as a Band 6 social worker. He ought to have known that his primary duty was to protect and promote the interests of service users and to do so in line with his own professional duties and obligations. The role that he carried out was, the panel acknowledged, a stressful and demanding one. Plus supervision and management may not have been as rigorous as they should have been. However, the panel considered that the evidence showed that he alone among his colleagues disregarded the urgent needs of the service users who placed their trust in the care coordinators. Relevant examples of Mr. Hemans' ethical breaches were;

Standard 2 *– Communicate appropriately and effectively;*
Standard 6 *– Manage risk;*
Standard 9 *– Be honest and trustworthy;*
Standard 10 *– Keep records of your work.*

Mr. Hemans had failed to manage the risks to which his service users were exposed. Arguably, he exacerbated them by neglecting to identify and

respond to the changes in their lives, sometimes worrying changes. Mr. Hemans failed them by neglecting to make relevant, timely and accessible records which were reliable. Even worse, Mr. Hemans had created false records in an inept attempt to conceal his neglect of a service user who had died. The service management had to explore the circumstances of the death and the lessons to be learned. There was the possibility of other enquiries. Mr. Hemans' dishonest construction of fictitious records including a false care plan and risk assessment misdirected his professional colleagues until their examination of the facts revealed the truth. Other social workers would be shocked to learn of these circumstances.

263. The panel considered that the breaches by Mr. Hemans of the 2016 standards in regulatory concern 2 were deliberate. They were persisted in for an extended period of time. Several professional colleagues had been misled and their valuable time and resources misused in uncovering the truth. In these circumstances, the panel was not in doubt that Mr. Hemans' dishonesty also breached the 2016 standards.

264. Mr. Hemans had not managed the multiple risks, had failed to keep clear and accurate records, and had not been honest. The panel considered that professional colleagues would regard Mr. Hemans' conduct as deplorable and unacceptable. In the panel's view, the reputation of the profession may have been damaged by Mr. Hemans' actions and the trust and confidence placed in social workers by vulnerable service users had been jeopardised. Mr. Hemans' dishonesty amounted to a breach of one of the fundamental tenets, which can be regarded as the bedrock of the profession of social work. The public expects honesty in social workers, in part because of the power that professionals have over the lives of vulnerable service users. Any dishonesty by a social worker has the potential to erode the safety and wellbeing of service users who need to be able to place great trust in the social workers appointed to help them.

265. The panel considered that each of the subheads and heads of regulatory concern on their own was enough to amount to misconduct. The gravity of Mr. Hemans' misconduct is also shown by the breadth of Mr. Hemans' breaches of the standards referred to above. In the panel's view, trust and confidence in the profession would be undermined if it did not find misconduct.

266. The panel found that Mr. Hemans' actions were serious and can be properly described as serious professional misconduct. Therefore, the panel

found that the matters found proved in regulatory concerns 1 and 2, both individually and taken together, all amounted to misconduct.

Finding and reasons on current impairment

267. Having found misconduct, the panel went on to consider whether, as a result of that misconduct, Mr. Hemans' fitness to practise is currently impaired.

268. In reaching its decision, the panel was mindful that the question of impairment is a matter of the panel's professional judgement. The panel was required to decide whether the social worker's fitness to practise is impaired as of today's date.

269. The panel took into account all of the evidence that it had received during the proceedings, the submissions made by Ms Sharpe and the response bundle submitted on Mr. Hemans' behalf before he disengaged with the process in February 2021. Mr. Hemans had asserted that his actions should be seen in the context of the inadequate supervision that he had received and the difficulties he claimed to have had in operating the RiO system.

270. The panel took into account the Sanctions Guidance published by Social Work England and in particular pages 8 to 12 which outlined the factors to be taken into account when determining impairment.

271. The panel also took into account the guidance provided in *Cohen v General Medical Council* [2008] EWHC 581. The panel considered:

(i) whether the Registrant's conduct was easily remediable;

(ii) whether it had been remedied; and

(iii) whether it was highly unlikely to be repeated.

The panel concluded that it was not easy to remedy any one aspect of the regulatory concerns, all of which had revealed a troubling, underlying attitudinal predisposition by Mr. Hemans. Contrary to the tenets of the profession, one former colleague had described him as exhibiting a lack of empathy and compassion.

272. In concern 1, Mr. Hemans had not offered any explanation for his behaviours which explained or mitigated his conduct in any material way. The panel accepted, as the witnesses had accepted, that his supervision in

the *workplace* was inadequate over a very long period of time. His failings had not been identified and acted on effectively throughout 2016 and 2017, although he had been relieved of some duties and given protected time to remedy his record keeping. Mr. Hemans' purported difficulties in working with the digital RiO system was not encountered by any of his colleagues to such an extent as claimed by Mr. Hemans. There was assistance with the system, seemingly freely available. The panel could not accept that he was unfamiliar with the use of computers in the light of his elaborate false written records which were discussed under regulatory concern 2.

273. The panel found that the continued failings over a very long time could only be explained by Mr. Hemans' attitude toward his professional responsibilities.

274. The panel found that Mr. Hemans' actions in concern 2 also suggested an underlying harmful attitude held by Mr. Hemans that permitted him to conceive, execute and maintain for a considerable time a false record of care planning and risk assessment for a service user. The detail in the records was troubling. When offered an opportunity to own the truth, Mr. Hemans 'doubled down' on his bogus assertion that the records were properly dated and were reliable. The panel considered that Mr. Hemans had never at any time shown any insight or appreciation of the confusion, hurt and distrust which must have arisen from his actions.

275. The panel recognised that dishonesty, while deeply troubling, may have a context or a background which might help to explain, though not excuse, the concerns. Dishonesty is difficult to remediate but in the panel's view, the process of remediation could be identified in a social worker who has shown insight and real sorrow and regret for his actions. Such a social worker might be seen to attempt to re-balance his or her professional centre of gravity. The panel has been unable to identify anything like that in Mr. Hemans' limited engagement. He suggested instead that he was the victim of unfairness by his managers and of an overwhelming workload. However, the panel noted that his case load at the time of suspension was very much lighter than that of his colleagues. It paid close attention to the amount of work Mr Hemans must have done to create the strikingly detailed false records. In reality, had Mr. Hemans shown the same application to his service users, he would not have betrayed their trust and earned the censure of his professional colleagues.

276. The panel considered that there had not been any material recognition by Mr. Hemans of the extent of his misconduct, and the impact that it had on vulnerable service users, their families, their carers and on his

professional colleagues. The dishonesty found proved in this case was not easily remedied and the panel had no evidence of remediation from Mr. Hemans. The panel noted that Mr. Hemans had no previous regulatory findings recorded against him. He had acquired very supportive and substantial testimonials from past and more recent colleagues. However, while valuable, these testimonials do not have the effect of suggesting that Mr. Hemans has the capacity for a return to autonomous and responsible professional practice. They do not, in any of the testimonials, refer to Mr. Hemans expressing any insight, shame, or regret. The creditable engagement by Mr. Hemans in completing relevant courses is therefore undermined by the absence of any expression of commitment to the public and service users that would begin to bridge the great gap in Mr. Hemans' fitness to practice.

277. The panel considered and applied the following test borrowing from the Fifth Shipman Report and formulated in the High Court by Cox J in *Council for Healthcare* Regulatory *Excellence v Nursing and Midwifery Council and Grant* [2011] EWHC 927 (Admin) at paragraph 76:

'Do our findings of fact in respect of [Mr. Hemans'] *misconduct, … show that his fitness to practise is impaired in the sense that she:*

(a) has in the past acted and/or is liable to act in the future so as to put a [service user] *or at unwarranted risk of harm; and/or*

(b) has in the past brought and/or is liable in the future to bring the [social work] *profession into disrepute; and/or*

(c) has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the [social work] *profession; and/or*

(d) has in the past acted dishonestly and/or is liable to act dishonestly in the future?'

278. The panel was in no doubt that Mr. Hemans' misconduct, in this case, engages all four of the limbs in the Grant test.

279. The panel was satisfied that Mr. Hemans' actions in his numerously repeated failures of his service users and multiple disregards of his duties to them had placed them at grave risk of harm. The panel could not ignore that, on the evidence, some had come to real harm. Service user Q was so unhappy at Mr. Hemans' neglect that she asked to be allocated to a new

care coordinator. This was wholly at variance with what could have been expected of him. Mr. Hemans had shown no remorse for or insight into the impact of his actions. The panel considered that there was a real risk of a future repetition by a social worker said to have shown no empathy of compassion.

280. The panel was also satisfied that Mr. Hemans' actions had brought the profession into disrepute. Social Workers occupy a position of privilege and trust in society and are expected at all times to be professional, placing the needs of service users above their own. The public also expects social workers to act conscientiously to discharge their statutory obligations in securing reviews which are meaningful, complete, and focused on the needs of the service user. By acting in a way that deprived both service users and their carers in some instances, of the support and practical help to ameliorate the hardships in their lives, Mr. Hemans' actions undermined public trust and confidence in the profession. The panel, therefore, decided that limb (b) of the test was also engaged.

281. Honesty is a fundamental tenet of the profession and the social worker's misconduct, in this case, involved deliberate and calculated dishonesty, limbs (c) and (d) of the Grant test were both therefore engaged.

282. In the absence of up-to-date information from Mr. Hemans of any significant steps taken by him to address his dishonesty or to demonstrate meaningful insight, the panel concluded that Mr. Hemans' fitness to practise is currently impaired on the grounds of public protection.

283. Furthermore, the panel considered that the confidence in the profession held by a fully informed member of the public who was aware of the circumstances of this case would be undermined if a finding of impairment was not made. The panel decided that a finding of current impairment was required to declare and uphold standards of conduct and to maintain confidence in the profession.

284. The panel, therefore, found Mr. Hemans' fitness to practise to be impaired on the grounds of public protection, including the wider public interests subsumed under that head.

Decision on sanction

285. Ms Sharpe submitted that the panel's findings in respect of Mr Hemans' impairment required that a sanction be imposed in order to

protect the public. Ms Sharpe reminded the panel that the statutory objective of public protection includes protecting vulnerable service users, the public and Mr Hemans' professional colleagues from risk of harm. It extends also to supporting and preserving the public's trust and confidence in the social work profession, and it serves to declare and uphold the standards to which social workers in England are held.

286. Ms Sharpe addressed the panel on relevant sections of the Sanctions Guidance published by Social Work England and submitted that the appropriate and proportionate sanction was a long suspension or a removal order.

287. Ms Sharpe invited the panel to consider that no substantial proof of remorse, insight and remediation had been found. Accordingly taking no action, giving advice, or issuing a warning would be inappropriate or unworkable. In any event, such a sanction was regarded as exceptional. No exceptional circumstances existed in Mr Hemans' case.

288. Ms Sharpe reminded the panel that its findings in respect of Mr Hemans' underlying attitudinal issues were likely to make a conditions of practice order impractical. That was because conditions of practice were more often appropriate in matters confined solely to clinical failings or ill health. That was not the case here. In any event, the Sanctions Guidance stated that dishonesty is not usually met by a conditions of practice order.

289. Ms Sharpe invited the panel to consider that Mr Hemans had been found to have a troubling underlying attitudinal disposition that remained unaddressed in any of his communications with Social Work England. Further, Ms Sharpe submitted that Mr Hemans had circumvented the limited attempts made in the workplace to supervise and manage him. That suggested that Mr Hemans was unlikely to work constructively with a conditions of practice order.

290. Ms Sharpe reminded the panel that a sanction was not intended to punish a social worker but to protect the public in a proportionate way and, if possible, restore Mr. Hemans to unrestricted professional practice. His professional restoration however depended on Mr Hemans taking the elementary steps of

- first, acknowledging the gravity of his disregard for his duty to service users in his caseload,

- second, expressing an appropriate level of regret and remorse, and

– third, beginning practical remediation including a reflective statement and professional development courses aimed directly at addressing the professional failures for which he had been responsible.

Ms Sharpe said that Mr Hemans had not done any of these things.

291. Ms Sharpe submitted that the panel could make a suspension order for up to three years. She reminded the panel that the impact of Mr Hemans' failings on service users had been 'grave' in the panel's words. He had engaged in a continued and elaborate cover up of the extent of his failings, aimed at hiding the true extent of his misconduct. He had created the false records of a risk assessment and care plan for service users A on 17 August 2017 and only finally admitted the truth in the course of his workplace disciplinary hearing, nearly a year later, in July 2018.

292. Ms Sharpe reminded the panel that a lengthy suspension might have a deskilling effect and can, in certain circumstances, be counter to an effective and safe return to practise. However a short suspension might not serve to fully protect the public, including sustaining the public's trust and confidence in the profession.

293. Ms Sharpe submitted that the aggravating features of Mr Hemans' case included that he had breached fundamental tenets of the profession including failing to protect service users, and by his dishonesty.

294. The panel accepted the legal adviser's advice.

295. The panel reminded itself that the purpose of imposing a sanction is not to punish Mr. Hemans, but to protect the public, which included securing the wider public interest of maintaining trust and confidence in the profession. The panel's objective was to consider what sanction, if any, was necessary in order to fully protect the public, applying the least restrictive but equally effective alternative in every case.

296. Before considering the individual options open to it, the panel identified what it considered to be the relevant aggravating and mitigating features in the case.

297. The panel identified the following mitigating factors:

- Mr Hemans had no previous regulatory findings recorded against him;

- Mr Hemans reported that he had been badly served by inadequate supervision over a long period of time;

- There was some evidence of poor management, including his line manager saying Mr Hemans should have been put on a capability programme a long time before these matters escalated;

- There had been some engagement with the fitness to practise process up until February 2021.

298. The panel identified the following aggravating factors:

- Mr Hemans' dishonesty was intentional and persisted for many months, his elaborate attempted cover up was designed to save his professional career and reputation;

- He had not expressed remorse or empathy for the service users who he had endangered and failed in his duty towards. He has not expressed remorse for the impact that his failings had on their families;

- Mr Hemans had been working with a much lower caseload than that of his colleagues in the period leading up to service user A's death;

- In not one single case had it been observed that any one service users had been sufficiently or adequately supported by Mr Hemans – the opposite had been abundantly demonstrated in every case;

- There is a real risk of repetition of professional failure and dishonesty with harmful consequences for service users.

299. The panel had regard to paragraph 1 of the Sanctions Guidance which states:

'Social Work England's overarching objective is to protect the public. We do so by protecting, promoting, and maintaining the health and wellbeing 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.'

300. The panel then went on to consider each of the available sanctions in ascending order of restrictiveness.

301. The panel first considered whether this was an appropriate case for it to take no further action, or to impose an advice or a warning order. The panel decided that the misconduct found proved in this case was very serious and extended to a calculated and elaborate act of dishonesty. The panel had identified a continuing risk to the public caused by Mr Hemans' continuing lack of insight. Mr Hemans had not remediated his misconduct, nor had he given any indication of a wish to do so.

302. The panel noted that these sanctions would place no active restriction on Mr Hemans' practice should he return to the profession. Accordingly, the panel concluded that to take no further action, or to impose an advice or warning order would be insufficient to protect the public and would fail to address the wider public interest concerns in this case.

303. The panel next considered the imposition of a conditions of practice order. The panel had regard to the Sanctions Guidance and noted that such orders are more commonly appropriate in cases involving errors in clinical practice, a lack of competence, or ill-health. In this case, the misconduct found was the breaching of professional obligations to at least fourteen service users and their family members. Mr Hemans' professional colleagues had been burdened by having to take on his cases and put right the harm done by him as far as was possible for a very long time. Plus the dishonest construction and submission of an untrue risk assessment and care plan for a service user who was already dead at the time the documents were written and uploaded to the RiO system, meant that conditions of practice were not appropriate.

304. Mr Hemans had not demonstrated any understanding of his failures and dishonesty. He had not shown any remorse or any commitment to act differently if the opportunity arose. Mr Hemans had subverted the workplace supervision and management process for years, inadequate though it was. The panel could have no confidence that Mr Hemans would meaningfully engage with a conditions of practice order.

305. In any event, nothing submitted by Mr Hemans to Social Work England in the period leading up to his disengagement contained any expression of Mr Hemans' wish to embark on the essential, searching steps necessary to attempt to rebuild confidence and trust in him as a social worker. He had not given the panel any hint of his appreciation that the far

off potential for him to return to some form of practice that required registration would demand his full commitment and application. He had not shown any appreciation that his actions had resulted in damage to the public's trust and confidence in the profession. The panel therefore concluded that in all of these circumstances, it was not possible to formulate any workable conditions that would address this misconduct, protect the public or address the wider public interest concerns in this case.

306. The panel gave careful consideration to the imposition of a suspension order. The panel noted that a suspension order would protect the public as it would temporarily remove Mr Hemans from the register. The panel also noted that in suitable cases, a suspension order could also mark the wider public interest concerns, including upholding standards and maintaining confidence in the profession. The panel had regard to paragraph 96 of the Sanctions Guidance which states:

'…If the suspension is aimed primarily at maintaining confidence in the profession or setting the professional standards to be observed, then a sanction of suspension up to one year may be appropriate. Given the risk of deskilling, decision makers should consider whether a case warranting a period of suspension longer than one year on the grounds of public confidence might be more appropriately disposed of by means of a removal order.'

307. The panel also had regard to paragraphs 106-109 of the Sanctions Guidance. In the panel's view paragraph 106 is of particular significance in this case. It provides:

'Social workers are routinely trusted with access to people's homes, and highly sensitive and confidential information. They are also routinely trusted to manage budgets including scarce public resources. Any individual dishonesty is likely to threaten public confidence in the proper discharge of these responsibilities by all social workers.'

The panel considered that these observations had direct relevance for Mr Hemans' dishonest actions.

308. The impact of serious dishonesty was further set out at paragraph 109 of the guidance.

'*Evidence of professional competence cannot mitigate serious or persistent dishonesty. Such conduct is highly damaging to public trust in social workers and is therefore usually likely to warrant suspension or removal from the register*.'

Although the panel had received an unusually substantial number of complementary testimonials on Mr Hemans' behalf, the panel agreed that these were limited by a number of material considerations,

- they were written without a full appreciation of the extent of Mr Heman's dishonesty,
- they were unlikely to be written again in the same terms were their authors given a copy of this determination.

Mr Hemans' professional competence as a social worker, at best doubtful, could not, as said in the guidance, mitigate his dishonesty.

309. Taking this guidance into account, the panel concluded that Mr Hemans' dishonesty in this case was particularly serious. Unusually, Mr Hemans' long list of repeated professional failures in duty weighed almost as heavily against him as his dishonest actions. The panel was satisfied that these failures in professional obligations not only had the potential to place service users at risk of significant harm but would unquestionably undermine public confidence in the profession.

310. The panel had no evidence that Mr Hemans had properly reflected on and understood the seriousness of his misconduct. There was nothing material in regard to genuine insight, other than the effects on him of bad management. This was not a case where a social worker had been shamed by the realisation of his failures. The panel agreed that in all of the circumstances, it would be failing in its duty to protect the public if it were to support Mr Hemans' return to practise.

311. Taking all of the above factors into consideration, the panel concluded that a suspension order would not be the appropriate and proportionate sanction in this case.

312. The panel had particular regard to paragraph 97 of the Sanctions Guidance which reads:

'*A removal order must be made where the adjudicators conclude that no other outcome would be enough to protect the public, maintain confidence in the profession or maintain proper professional standards for social workers in England. A decision to impose a removal order should explain why lesser sanctions are insufficient to meet these objectives*.'

313. Accordingly, for the reasons set out above, the panel concluded that a removal order was the only sanction that would sufficiently protect the public, maintain confidence in the profession and maintain proper

professional standards of conduct and behaviour for social workers in England.

Interim order

314. Ms Sharpe made an application for an interim suspension order for a period of 18 months in case Mr Hemans exercises his right to appeal to the High Court against the decision of this panel.

315. The panel accepted the advice of the legal adviser, that in accordance with Paragraph 11(1)(b) of Schedule 2 of the regulations the panel may make any interim order it considers necessary for the protection of the public, which includes the public interest, or is in the best interests of the social worker. He also advised the panel that an interim order can only be made if it is necessary and must not be merely desirable.

316. For the reasons set out in the substantive decision, the panel was convinced that there remained a continuing risk to service users were Mr Hemans permitted to return to practise without restriction. Therefore, an interim order was necessary to protect the public. Furthermore, for the reasons set out in its substantive decision, the panel was also satisfied that an interim order is in the wider public interest. Members of the public would be troubled to learn that the social worker was entitled to practise if an order was not made to cover the statutory appeal period.

317. The panel considered whether an interim conditions of practice order would be sufficient in the circumstances, but concluded, for the same reasons as set out in its substantive decision, that such an order would be insufficient in the circumstances of this case.

318. For the reasons above, the panel concluded that an interim order of suspension was necessary for the protection of the public and was also required in the public interest.

319. The panel gave consideration to the length of the interim order and concluded that a period of 18 months was appropriate in order to allow sufficient time for an appeal to be heard by the High Court, if Mr Hemans exercises his right to appeal.

320. The panel therefore decided to impose an interim suspension order for a period of 18 months under paragraph 11(1)(b) of Schedule 2 of The Social Workers Regulations 2018. If there is no appeal against the final order, the order will expire after 28 days from notice of this decision, when

the appeal period expires. If there is an appeal against the final order, the order expires when the appeal is withdrawn or otherwise finally resolved.

Right of Appeal

321. 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,

(ii) to make a final order.

322. 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.

323. 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.

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