Social Worker: Elaine Lillian McDowell
Registration Number: SW53690
Fitness to Practise:
Final Hearing

Date(s) of hearing:	3 – 7 October 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.

2. Ms McDowell did not attend and was not represented.

3. Social Work England was represented by Mr Carey, instructed by Capsticks LLP.

Adjudicators	**Role**
Lesley White	Chair
Rachael Kumar	Social Work Adjudicator
Jenny Childs	Lay Adjudicator

Tom Stoker	Hearings Officer
Wallis Crump	Hearings Support Officer
William Hoskins	Legal Adviser

Service of Notice:

4. The panel of adjudicators (hereafter "the panel") was informed by Mr Carey that notice of this hearing was sent to Ms McDowell by recorded delivery and first -class post to her address on the Social Work Register (the Register) and to a separate address ["the Trace address"] identified by Social Work England as being an address at which she was likely to be located. The Notice of Hearing was also sent by email to Ms McDowell's registered email address which was copied to another email address identified by the Trace. Mr Carey submitted that the notice of this hearing had been duly served.

5. The panel of adjudicators (hereafter the panel) had careful regard to the documents contained in the final hearing service bundle as follows:
   - A copy of the notice of the final hearing dated 2 September 2022 and addressed to Ms McDowell at her address as it appears on the Social Work England Register; a copy of the notice of final hearing dated 2 September 2022 and sent to the Trace address; and an email attaching the notice of final hearing sent to Ms McDowell's registered email address;
   - An extract from the Social Work England Register detailing Ms McDowell's registered postal and email addresses;
   - A copy of a signed Statement of Service, on behalf of Social Work England, confirming that on 2 September 2022 the writer sent by ordinary first-class post and special next day delivery to Ms McDowell at the addresses referred to above: Notice of Hearing and related documents;
   - A copy of the Royal Mail Track and Trace Document indicating "signed for" delivery in the name of McDowell at the Trace address at 11.43 am on 3 September 2009; also, documentation showing the notice sent to Ms McDowell's registered address had been returned to sender as Ms McDowell was no longer at that address. The

email attaching the Notice of Hearing sent to Ms McDowell's registered email address was not returned as "not delivered".

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

7. Having had regard to Rule 14 of the Fitness to Practise Rules 2019 (as amended) 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 Ms McDowell in accordance with Rules 44 and 45 of the 2019 Rules.

Proceeding in the absence of the social worker:

8. The panel heard the submissions of Mr Carey on behalf of Social Work England. Mr Carey submitted that notice of this hearing had been duly served, no application for an adjournment had been made by Ms McDowell and as such there was no guarantee that adjourning today's proceedings would secure her attendance. Mr Carey informed the panel that there had been no engagement with the proceedings on the part of Ms McDowell. He therefore invited the panel to proceed in the interests of justice and the expeditious disposal of this hearing.

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 of the Rules and the case of *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 Mr Carey on behalf of Social Work England. The panel noted that Ms McDowell had been sent notice of today's hearing and the panel was satisfied that she was or should be aware of today's hearing. The panel noted that there was evidence that Ms McDowell had actually received the notice of hearing either at the trace address or via email and probably by both means.

11. The panel, therefore, concluded that Ms McDowell had chosen voluntarily to absent herself. The panel had no reason to believe that an adjournment would result in her attendance on a future occasion. Having weighed the interests of Ms McDowell in regard to her attendance at the hearing with those of Social Work England and the public interest in an expeditious disposal of this hearing, the panel determined to proceed in Ms McDowell's absence.

Allegation(s) (as amended following discontinuance)

12. Whilst registered as a Social Worker at Bristol City Council;

    1.On 20 February 2019, when you facilitated an emergency placement for Service User from an Extra Care Housing flat to a nursing home you:

1.1. Failed to safeguard a service user in that you did not consult the staff involved with Service User 1's care; and

1.2. Made false records to substantiate your decision to make the emergency placement.

2. In or around between June 2018 and February 2019, you failed to maintain appropriate boundaries with Service User 1 in that you:

2.1. Visited Service User 1 too frequently including on weekends;

2.2. Visited Service User 1's flat alone;

2.3. Allowed your family members to deliver support to Service User 1 and receive payment;

2.4. ~~Communicated inappropriately with Service User 1;~~ and

2.5. Asked a family member of Service User 1 for Service User 1's PIN.

3. Your actions were dishonest in that you:

3.1. Deliberately provided untrue information to Service User 1's care provider about the reasons for which you had facilitated an emergency placement for Service User 1;

3.2. Recorded false information in relation to the frequency of your visits to Service User 1;

3.3. Asked a family member of Service User 1 to lie to other family members about your reasons for using 'Just Checking' equipment in Service User 1's flat; and

3.4. Denied that the person you allowed to deliver support to Service User 1 was your daughter when challenged by care staff.

The matters outlined in Allegation paragraphs 1 to 3 amount to the statutory ground of misconduct. Your fitness to practise is impaired by reason of misconduct.

Preliminary matters: Application to discontinue Paragraph 2.4

13. Mr Carey outlined the position of Social Work England in relation to Paragraph 2.4. He explained that, following an earlier application in relation to the potential admissibility of hearsay evidence, the evidence remaining in support of this allegation was now such that there was no longer a realistic prospect of a finding that Paragraph 2.4 was proved.

14. Mr Carey referred the panel to Rule 27 (2) of the 2019 Rules and to Social Work England's guidance in relation to discontinuance. He submitted that the remaining evidence in support of this paragraph was tenuous and inconsistent. One witness stated that Service User 1 was "scared" of Ms McDowell, another said that Ms McDowell used inappropriate informal language such as "darling". Mr Carey submitted that even if the latter was proved, it would not amount to misconduct.

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

16. The panel decided that there was no longer a realistic prospect of paragraph 2.4 being found proved. The panel noted that the witness who had described Service User 1 as being scared of Ms McDowell gave no examples of inappropriate language. Inappropriate use of the word "darling" would in any event be most unlikely to amount to misconduct.

17. Accordingly, the panel decided to allow the application to discontinue in respect of paragraph 2.4.

Summary of Evidence

18. The panel heard oral evidence from KH, Team Manager in the Bristol "Discharge to Assess" team and Ms McDowell's line manager, TJ, a Senior Practitioner in that team, and LK, Service Manager in the North and West Community Team at Bristol Council. LK had carried out an investigation in respect of the matters which form the basis for the Allegation in this case. All of these witnesses had provided witness statements which they confirmed at the outset of their evidence.

19. KH explained the nature of the accommodation which Service User 1 occupied prior to the emergency transfer initiated by Ms McDowell and the circumstances in which an emergency transfer from that accommodation to a nursing home could be appropriate. The accommodation, at an address known as "Bluebell Gardens", was a housing complex where support staff were available. It was categorised as "extra care" housing, as distinct from a residential nursing home. KH was not at work when Service User 1 was transferred and so had no direct knowledge of what had occurred but she told the panel that she would expect all avenues to be explored with existing staff and management before such a transfer was arranged and that, if there were concerns about Service User 1's cognitive capacity, she would expect a written capacity assessment and a recorded "best interests" decision to be created. She had not found these documents when she was told by staff about the transfer and was concerned that, from the reports she had received, there appeared to have been little, if any, discussion in relation to Service User 1's emergency transfer. She said that, in her experience, such a move could be very distressing to a Service User and she had never known a case before this in which, as was reported in this case, a Service User had been transferred without even being

permitted to finish a meal. She regarded what she understood to have happened as well beyond the limits of acceptable social work practice.

20. Tim Jones told the panel that the Discharge to Assess team was designed to undertake short term interventions in care before a different Review Team became involved. He would not expect a member of the team to have a long-standing involvement with a Service User. He confirmed that in a case involving emergency transfer where there were concerns about cognition, a capacity assessment should be recorded and show that the statutory criteria under the Care Act 2014 had been met. He said that a "best interest" decision, following the capacity assessment, should normally be made after discussions which would include the management team, care staff, family members and any appropriate medical practitioner; it should also be recorded. He had authorised the emergency transfer of Service User 1 on the basis of what he was told in a telephone conversation by Ms McDowell. Although he had no specific recollection of the conversation, the case notes indicated that Ms McDowell had told him that Service User 1 was unsafe at Bluebell Gardens, had cognitively declined and needed to be placed in residential care for her own safety. TJ confirmed that this was the kind of conversation which would have taken place prior to an emergency transfer. He emphasised that if it was not possible to record the capacity assessment and "best interests" decision at the time, a record should be created as soon as it was possible to do so. He had no clear recollection of sending emails to the various individuals referred to in the recorded case notes but assumed he would have done so.

21. LK produced her investigation report which included records of interviews with Service User 1, who was now deceased, care staff at Bluebell Gardens and relatives of Service User 1. The report also included various emails sent in 2019 and transcripts of recorded case notes. LK said that she had searched for a written capacity assessment and "best interests" decision but had not found either of these records. An investigation of the computer system had revealed that a capacity assessment had been opened on the system but then closed without any of the details being filled in. A "best interests" decision could not be recorded on the system unless a capacity assessment had been carried out. She also told the panel that she had seen the care records for Service User 1 but that such records were not, as a matter of normal process, included in an investigation report of the type which she had completed. No separate record was kept at Bluebell Gardens which would enable her to identify the number of occasions on which Ms McDowell had visited Service User 1. She considered that Service User 1 was able to provide her with a reliable account of events during the interview she had conducted and that the care staff and family members she interviewed had also provided reliable evidence.

22. LK's report included records of the interviews she carried out and those which had been adjudged admissible by a previous panel at a preliminary meeting were appended to her report and included in the documents available to the panel.

23. In his closing submissions, Mr Carey directed the panel, in particular, to the passages in the interviews carried out by LK which, he maintained, supported the factual allegations. He accepted that this evidence had not been tested as it had not been possible to call the various individuals who had been interviewed but he invited the panel to treat the evidence as reliable and reminded the panel of LK's view in this respect. In relation to the issue of dishonesty, he referred the panel to the test set out in the leading case of *Ivey v Genting Casinos (UK) Ltd* [2017] UKSC67.

24. The legal adviser reminded the panel of the burden and standard of proof, of the requirement to draw no adverse inference from Ms McDowell's absence, and of the need for the panel carefully to assess the weight to be given to the admissible hearsay evidence from individuals who had not given oral evidence. He also referred to *Ivey* in relation to dishonesty.

Finding and reasons on facts

25. The panel considered each part of the Allegation separately. The panel was satisfied on the basis of the evidence given by KH, TJ and LK that Ms McDowell was a registered social worker at Bristol City Council at the time of the relevant events.

1.On 20 February 2019, when you facilitated an emergency placement for Service User from an Extra Care Housing flat to a nursing home you:

1.1. Failed to safeguard a service user in that you did not consult the staff involved with Service User 1's care;

26. The panel had regard to the email from LM, Assistant Care Manager at Bluebell Gardens, to KH dated 2 April 2019. In that email LM wrote: "On *20th February 2019 SU1's social worker Elaine was standing in the communal area looking worried, when I asked her if everything was ok, she said that "it is not working here for SU1" within 20 minutes Elaine had removed SU1 from Bluebell Gardens and told us that the move was approved by her manager. When I asked why she felt it wasn't working here for SU1 she didn't give a clear answer".*

27. This account was confirmed in LM's interview with LK on 12 July 2019. When asked whether Ms McDowell had discussed the move to Hartcliffe Nursing Home she replied "*Not before it happened...I was surprised as there are normally meetings if a move is needed and there [were] no discussions about Elaine's concerns about the care which was being provided".*

28. An email of the same date from SM, Assistant Housing Manager at Bluebell Gardens, to KH stated "*I have never experience (sic) such a fast move it all appeared to be rushed and normally we arrange a meeting between all parties to discuss options".*

29. The panel also noted the absence of any capacity assessment and "best interests" decision which would be expected to result from relevant discussions.

30. The panel accepts that the contents of the emails from LM and SM are accurate and that the account of this matter given by LM at her interview is also accurate. Accordingly, the panel finds that sub-paragraph 1.1 is Proved.

1.2. Made false records to substantiate your decision to make the emergency placement.

31. The panel had regard to the case notes recorded by Ms McDowell. In the case notes Ms McDowell recorded that "*a capacity assessment was completed.... a best interest was carried out by telephone, I spoke to SU1 brother and cousin.... they both agreed that SU1 had deteriorated since her last hospital admission.... I spoke to sara the scheme manager of Bluebell Gardens and L and they agreed that SU1 cognition had deteriorated and she was not allowing carers to support her.... there (sic) opinion is ECH is not the appropriate setting at the moment and SU1 requires 24/7 support in a more appropriate setting...."*

32. The panel has already noted that there is no evidence that a capacity assessment or best interest decision was ever made. LK's search for these documents indicated that, contrary to the case notes, neither of these steps was undertaken. The accounts of SM and LM, to which reference has already been made, directly contradict the case notes. When members of SU1's family were interviewed and asked whether they thought SU1 needed to go to a care home the answer was "*No"*. And later, in answer to a different question, "*SU1 doesn't need full time nursing care"*. The family members said they were "*surprised"* at the move and "*it seemed strange*".

33. The panel therefore finds that the case notes recorded by Ms McDowell were false and that the only conceivable motive for recording such false notes was to substantiate her decision to make the emergency placement. Accordingly, the panel finds sub-paragraph 1.2 is Proved.

2. In or around between June 2018 and February 2019, you failed to maintain appropriate boundaries with Service User 1 in that you:

2.1. Visited Service User 1 too frequently including on weekends;

34. The panel took into account the email from LM of 2 April 2019 in which LM wrote *"I have concerns regarding Elaine. I feel that she is very invested in SU 1's welfare. She visits SU1 daily and stays with SU1 for hours each day"*. In her interview with LK, LM said that Ms McDowell visited SU1 "*a couple of times a week to go shopping"* and that she had concerns about that. The panel also noted that SU1 had said, in her interview with LK and when asked how often she saw Ms McDowell "*2/3 times a week and at least once.... she was always around" ...*

35. The panel was told by KH and TJ that this pattern of involvement with a particular client was highly unusual in the context of the work carried out by the "Discharge to Assess" team which was intended to make short term interventions before a review could be carried out.

36. The panel recognised that LM's evidence was not completely consistent but accepted its general thrust and further accepted the evidence of SU1. In view of this evidence and the explanations provided by KH and TJ in relation to the nature of the work which the team carried out, the panel finds Sub-paragraph 2.1 Proved.

2.2. Visited Service User 1's flat alone;

37. In relation to this allegation, Mr Carey referred the panel to the notes of interview with members of SU1's family. However, these notes do not, in the panel's judgement support this sub-paragraph of the Allegation. The note of interview in this respect reads: "*She was left alone in Service User 1's house <u>with B</u> when we were packing up..."* [emphasis added]. B was Ms McDowell's Personal Assistant and the family were told by Ms McDowell that she was a trainee social worker. Mr Carey also referred to the case notes in which Ms McDowell had recorded "*I asked her permission to collect [certain items] ...and for her neighbour to supervise my access into the property"*. There was no evidence as to whether this visit had actually taken place and, in any event, it seemed to be envisaged that a neighbour would be present.

38. Accordingly, the panel is not satisfied on a balance of probability that Ms McDowell had visited SU1's flat alone. This sub-paragraph is therefore found Not Proved.

2.3. Allowed your family members to deliver support to Service User 1 and receive payment;

39. The panel took into account the interview with family members carried out by LK. During the course of that interview a family member stated *"Elaine said she knew a lady called Mrs [redacted] (her daughter, G), though not known at the time. G went to Asda weekly and took her to the Mall once... [Elaine] asked me to lie for her and say that G was not*

her daughter.... Elaine did not initially tell us G was her daughter.... Elaine's son/cousin helped SU1 to move her furniture to Bluebell Gardens and SU1 paid him. Her husband put up curtains and SU1 paid him. She paid G cash £12 per hour".

40. The panel noted that during the course of this interview the family member concerned made clear that the family had, at the time, been very grateful to Ms McDowell for the help she had given SU1. *"We had never met a social worker so involved & she took the strain off us. At that time family members were positive and DF invited Elaine with her grandchildren down to his farm".*

41. The panel accepted the accuracy and reliability of the information given in this interview by family members. Accordingly, the panel finds sub-paragraph 2.3 of the Allegation proved.

2.5. Asked a family member of Service User 1 for Service User 1's PIN.

42. During the course of the interview with family members, the family member concerned said "*Elaine asked me for SU1's pin number as she was concerned about an electricity bill. I asked RH to look at the bank statement and it was all normal, no unusual sums of money coming out. I was uncomfortable with this. I would not give her the pin number".*

43. The panel accepts this evidence and finds sub-paragraph 2.4 of the Allegation is Proved

3. Your actions were dishonest in that you:

3.1. Deliberately provided untrue information to Service User 1's care provider about the reasons for which you had facilitated an emergency placement for Service User 1;

44. This sub-paragraph of the Allegation is understood to refer to the staff at Bluebell Gardens. Mr Carey referred the panel, in particular, to a passage in the interview with LM, conducted in July 2019, in which LM is noted as saying "*Ten minutes before they left, I saw Elaine waiting for a taxi & asked her if everything was ok and she said no and she was taking SU1 somewhere safe. I asked her why and she said it was because the staff cannot provide the care, saying she needs 24-hour care*". Mr Carey submitted that this explanation was deliberately untrue.

45. This account is not the same as that given in LM's email of 2 April 2019 in which she wrote "*.... when I asked her if everything was ok she said that "it is not working here for SU1" ..... when I asked why she felt it wasn't working here for SU1 she didn't give a clear answer".*

46. The email from SM of the same date refers to Ms McDowell telling her *"It wasn't working as the sensors which she had put in every room including bathroom have picked up that SU1 walking around her flat at night.... Elaine felt that this was unsafe and that the care staff are not doing their job".* The email states that LM was present during this conversation.

47. Although these accounts are not necessarily mutually inconsistent, they are significantly different in detail and the panel has borne in mind that it has not been possible to test any of this evidence. It has also borne in mind that the evidence to support an inference of dishonesty must be cogent.

48. The panel has concluded that the difference in these accounts is such that it would be unsafe to rely upon this hearsay evidence to establish the factual allegation in sub-paragraph 3.1. Accordingly, sub-paragraph 3.1 of the Allegation is Not Proved.

> *3.2. Recorded false information in relation to the frequency of your visits to Service User 1;*

49. In her investigation report LK noted the account of LM that Ms McDowell visited daily (Monday to Friday) for several hours. She wrote *"Case notes for the period SU1 lived at the ECH (Extra Care Housing) do not detail regular visits:*

> *18.01.2018-20.07.2018- 25 visits were recorded on LAS casenotes;*
>
> *18.12.2018-28.02.2019 8 visits were recorded on LAS casenotes".*

50. The panel has not seen any of these records and further notes that this allegation is that Ms McDowell "recorded false information" which would suggest to an ordinary reader that she had actually entered inaccurate information in the record rather than simply omitting to record visits that had taken place.

51. The panel has concluded that the absence of the records prevents it from examining this sub-paragraph in an appropriate way. Accordingly sub-paragraph 3.2, is Not Proved.

> *3.3. Asked a family member of Service User 1 to lie to other family members about your reasons for using 'Just Checking' equipment in Service User 1's flat; and*

52. The basis for this factual allegation comes from LK's interview with family members in which it was stated *"Elaine called PH and said she had fitted "Just Checking" in the flat. She said it was to monitor the staff, but that she had told staff it was to check on SU1. She asked PH not to tell RH or DF about it".*

53. The panel accepts the accuracy of this account but considers that asking PH "not to tell RH or DF about it" is not the same as asking that individual to lie about it. Accordingly sub-paragraph 3.3 of the Allegation is Not Proved.

3.4. Denied that the person you allowed to deliver support to Service User 1 was your daughter when challenged by care staff.

54. LM said during the course of her interview with LK that she had discovered that "G" was Ms McDowell's daughter. *"I made it clear to Elaine I knew. We were talking about G trying to change her hours and I said "your daughter". Elaine got angry and denied this and then 2 days later she move (sic)SU1"*

55. The panel accepts this evidence. Applying the test set out in *Ivey*, Ms McDowell's denial was clearly dishonest. Accordingly, sub-paragraph 3.4 is Proved.

Finding and reasons on grounds

56. The panel had regard to the submissions made by Mr Carey, both written and oral, and to the legal advice it received. It recognised that the question of misconduct was a matter for its judgment in the light of the applicable standards. The panel also recognised that not every departure from those standards could properly be categorised as misconduct. A serious departure from generally accepted professional standards was required if a particular breach of standards was to be classified as misconduct.

57. The panel considered the standards identified by Mr Carey in the written statement of Case. It decided that the following standards were engaged by the factual findings it had reached.

Health and Care Professions Council Standards of proficiency, social workers in England (2017)

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

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

2.8 recognise that relationships with service users and carers should be based on respect and honesty

3.1 understand the need to maintain high standards of personal and professional conduct

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

9.4 be able to support service users' and carers' rights to control their lives and make informed choices about the services they receive

9.6 be able to work in partnership with others, including service users and carers, and those working in other agencies and roles

10.1 be able to keep accurate, comprehensive and comprehensible records in accordance with applicable legislation, protocols and guidelines

Health and Care Professions Council Standards of Conduct, Performance and Ethics (2016)

1.2 You must work in partnership with service users and carers, involving them, where appropriate, in decisions about the care, treatment or other services to be provided.

1.4 You must make sure that you have consent from service users or other appropriate authority before you provide care, treatment or other services.

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

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

6.2 You must not do anything, or allow someone else to do anything, which could put the health or safety of a service user, carer or colleague at unacceptable risk.

9.1 You must make sure that your conduct justifies the public's trust and confidence in you and your profession.

58. The panel considered that Ms McDowell had breached each of these standards. The way in which she had executed the emergency transfer of SU 1 had not been in the service user's interests and had compromised the service user's dignity. She had not sought to work collaboratively with other carers or to obtain appropriate consent and the records she had created in relation to the transfer were false in that they did not reflect what had actually occurred. They were liable to cause harm in future because they were seriously misleading.

59. Ms McDowell had also seriously breached appropriate professional boundaries. She had visited SU 1 far more frequently than was justified by her professional role and had obtained payment from SU1 for services provided by members of her own family. She had sought to obtain SU I's PIN. In so doing she had departed from high standards of personal and professional conduct and had potentially exposed SU1 to unwarranted risks through the involvement of unauthorised individuals in her care.

60. Finally, she had behaved dishonestly when challenged by Ms M about her daughter's involvement. The panel accepted the submission of Mr Carey that in view of the false notes created by Ms McDowell this particular incident of dishonesty could not be regarded as an isolated, momentary lapse.

61. The panel considered that each of the factual matters found proved at Paragraphs 1,2 and 3 of the Allegation were individually serious enough to be categorised as misconduct.

Finding and reasons on current impairment

62. Mr Carey referred the panel to the leading cases of *Cohen v General Medical Council* [2008] EWHC581 (Admin) and *CHRE v NMC & Grant* [2011] EWHC 927 (Admin). Applying the principles in these authorities, he submitted that Ms McDowell's fitness to practise is currently impaired.

63. The legal adviser reminded the panel that its judgment in relation to impairment must be exercised at today's date and that, in addition to considering whether any misconduct was remediable and had been remedied, the panel was obliged to consider whether the public interest required a finding of impairment to be made.

64. The panel first considered whether the misconduct it had identified was, in principle, remediable. The misconduct was attitudinal in nature and such misconduct was always more difficult to remedy than misconduct which resulted from some deficiency in professional skill. Nevertheless, the panel concluded that, in principle, the misconduct could be remedied although it would require strongly persuasive evidence to show that it had, in fact, been remedied.

65. Ms McDowell had decided to take no part in the regulatory process. She had chosen not to attend this hearing. She had submitted no evidence to show that she had reflected on the issues that had arisen in this case and taken steps to address those issues constructively. The panel therefore concluded that she had developed little, if any, insight into the significance of her misconduct and that the risk of repetition was high. In these circumstances a finding of impairment is required to protect the public.

66. The panel went on to consider the public interest. It had regard to the guidance of Dame Janet Smith, endorsed in *Grant*. Accordingly, it considered whether Ms McDowell:

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

(b) whether she has in the past brought and/or is liable in the future to bring the profession into disrepute; and/or

(c) whether she has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the profession; and/or

(d) whether she has in the past acted dishonestly and/or is liable to act dishonestly in the future.

67. The panel decided that each of these four limbs were engaged in this case. Ms McDowell had placed SU 1 at unwarranted risk of harm both through the manner in which she had chosen to execute an emergency transfer, her falsification of the records and through the involvement of unauthorised individuals in her care. In acting in this way she brought the profession into disrepute and breached a number of fundamental tenets of the profession; in particular she placed her own interests before the interests of SU1. She had also acted dishonestly.

68. In these circumstances the panel decided that a finding of current impairment is required on public interest grounds. A reasonable and fully informed member of the public would be disturbed if no such finding was made. Such a finding is necessary to maintain the reputation of the profession and to declare and uphold proper standards of conduct for members of the profession.

Decision on sanction

69. Mr Carey referred the panel to Social Work England's Sanctions Guidance and in particular to the paragraphs dealing with dishonesty. He submitted that this was a case in which the appropriate and proportionate sanction was a removal order.

70. The legal adviser reminded the panel that the purpose of sanction was not to punish a registrant but to arrive at a proportionate outcome to the case, having regard to the need to protect the public and to safeguard the reputation of the profession.

71. The panel determined that it was necessary to make a final order. To take no further action would be wholly inappropriate in view of the seriousness of the case.

72. The panel considered aggravating and mitigating circumstances.

73. Ms McDowell's misconduct was extremely serious in itself. It involved the mistreatment of a vulnerable service user. This mistreatment included an inappropriate transfer from an environment in which the service user was happy to an environment which, evidence in the bundle of documents suggested, the service user was less happy and in circumstances where she was not permitted to finish a meal before being removed from

Bluebell Gardens. It also involved dishonesty towards colleagues and the falsification of notes.

74. The panel was unable to identify any mitigating circumstances in relation to what had occurred. Ms McDowell had taken no part in these proceedings and had not sought to put forward any mitigation. The panel has already concluded that she has not developed appropriate insight into the seriousness of her misconduct and there is a high risk of repetition.

75. The panel had regard to the Sanctions Guidance and, in particular, to paragraphs 103 and 107.

> *103. Social workers hold privileged positions of trust. Their role often requires them to engage with people over extended periods when those people may be highly vulnerable. It is essential to the effective delivery of social work that the public can trust social workers implicitly. Any abuse of trust by a social worker is a serious and unacceptable risk in terms of public protection and confidence in the profession as a whole.*
>
> *107. 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.*

76. The panel considered sanction in ascending order. It had regard to the principle of proportionality and its responsibility to impose the least restrictive sanction which would satisfy the public interest.

77. The panel concluded that to give a warning would clearly be inappropriate. A warning would not restrict Ms McDowell's practice and the panel had identified a high risk of repetition of the misconduct. Further, a warning would not be a proportionate response to the seriousness of the misconduct.

78. The panel next considered a conditions of practice order. The misconduct in this case was attitudinal. The panel concluded that it was not able to formulate conditions which would satisfactorily address the risk of repetition. Further, such an order would not satisfy the public interest in view of the seriousness of the misconduct.

79. The panel next considered a suspension order. The panel noted that Ms McDowell's misconduct had occurred more than three years ago. She had resigned from her employment without participating in the inquiry instituted by her employers. She had chosen not to participate in these regulatory proceedings. There was no evidence before

the panel of any contrition or remorse for what had occurred. There had been no apology to the family of SU1. In these circumstances the panel concluded that a suspension order would serve no purpose and would not in any event be sufficient to satisfy the public interest.

80. The panel decided that a removal order is the only outcome which is sufficient to protect the public, maintain confidence in the profession and maintain proper professional standards for social workers in England. The panel has concluded that any lesser sanction would fail to satisfy the public interest.

Interim order

81. In light of its findings on Sanction, the panel next considered an application by Mr Carey for an Interim Suspension Order to cover the appeal period before the Sanction becomes operative.

82. The panel next considered whether to impose an interim order. It was mindful of its earlier findings and decided that it would be wholly incompatible with those earlier findings and the imposition of a Removal Order to conclude that an Interim Suspension Order was not necessary for the protection of the public or otherwise in the public interest for the appeal period.

83. Accordingly, the panel concluded that an Interim Suspension Order should be imposed on public protection and public interest grounds. It determined that it is appropriate that the Interim Suspension Order be imposed for a period of 18 months to cover the appeal period. When the appeal period expires this Interim Order will come to an end unless there has been an application to appeal. If there is no appeal the Removal Order shall apply when the appeal period expires.

Right of Appeal

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

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

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

    (iii) to make a final order.

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

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

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

Review of final orders

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

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

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

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