

Social worker: Justine Carroll

Registration number: SW102055

Fitness to Practise

Final Hearing

Dates of hearing: 30 January 2023 to 06 February 2023

Hearing venue: Remote hearing

Hearing Outcome: Fitness to practise impaired, 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 (as amended) (“the regulations”).
2. Ms Carroll did not attend and was not represented.
3. Social Work England was represented by Ms Mercer case presenter instructed by Capsticks LLP.

Adjudicators	Role
Debbie Hill	Chair
Ian Vinall	Social worker adjudicator
Catherine Beckett	Lay adjudicator

Simone Ferris	Hearings officer
Loren Mace	Hearings support officer
Charlotte Mitchell-Dunn	Legal adviser

Service of notice:

4. Ms Carroll did not attend and was not represented. The panel of adjudicators (hereafter “the panel”) was informed by Ms Mercer that notice of this hearing was sent to Ms Carroll by email to an address provided by Ms Carroll (namely their registered address as it appears on the Social Work England register). Ms Mercer submitted that the notice of this hearing had been duly served.
5. 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 15 December 2022 and addressed to Ms Carroll at their address, which they provided to Social Work England;
 - An extract from the Social Work England Register as at 15 December 2022 detailing Ms Carroll’s registered address;
 - A copy of a signed statement of service, on behalf of Social Work England, confirming that on 15 December 2022 the writer sent by email to Ms Carroll at the address referred to above: notice of hearing and related documents;
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 44-46 and all 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 Carroll in accordance with the Rules.

Proceeding in the absence of the social worker:

8. The panel heard the submissions of Ms Mercer on behalf of Social Work England. Ms Mercer submitted that notice of this hearing had been duly served, no application for an adjournment had been made by Ms Carroll and as such, there was no guarantee that adjourning today's proceedings would secure their attendance. Ms Mercer further submitted that Ms Carroll had made clear in her representation that she did not wish to attend the hearing. She 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*. The panel also took into account Social Work England guidance 'Service of notices and proceeding in the absence of the social worker'.
10. The panel considered all the information before it, together with the submissions made by Ms Mercer on behalf of Social Work England. The panel considered that Ms Carroll had been sent notice of today's hearing and the panel was satisfied that she was or should be aware of today's hearing.
11. The panel therefore concluded that Ms Carroll had chosen voluntarily to absent herself. The panel had no reason to believe that an adjournment would result in Ms Carroll's attendance. The panel noted Ms Carroll's email dated 2 November 2022, which states as follows;

"As already communicated, I would be unable to attend any further hearings and I am unwilling to submit any further responses to requests for evidence I have already submitted over the last four years."
12. Having weighed the interests of Ms Carroll 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 Carroll's absence.

Preliminary matters:

13. The panel were satisfied that, pursuant to rule 37 and 38 of the Social Work England Fitness to Practise Rules 2019 (as amended), parts of the hearing should be held in private.
14. [PRIVATE]

Allegations:

1. The allegations arising out of the regulatory concerns referred by the Case Examiners on 2 December 2020 are:
 - 1.1 Whilst working for Hampshire County Council and working with Family 1 in August 2017 you did not safeguard children in that you:
 - a. did not complete a visit before 3 August 2017 as instructed, or at all;

b. did not complete a child and family assessment within 15 days, or at all.

1.2. Whilst working for Hampshire County Council and working with family 2 in July and August 2017 you did not safeguard children in that you:

- a. did not complete visits between the date the case was allocated to you on 16 July 2017 and 14 August 2017;
- b. did not prepare a pre-birth assessment for a hearing, which was due to take place on 29 August 2017.

2. [PRIVATE]

3. You suffer from one or more adverse health conditions as set out in Schedule A which impact your ability to practise as a social worker.

[PRIVATE]

Your conduct in allegations 1.1 and /or 1.2 and / or 2 above amounts to the statutory ground of misconduct.

The matters set out in allegation 3 above amount to the statutory ground of adverse health.

As a result of your misconduct and / or your adverse health, your fitness to practise is impaired.

Background

- 15. On 12 July 2018, the Health and Care Professions Council received a referral regarding the Respondent social worker, Justine Carroll ("the Social Worker"). The referral was made by Hampshire County Council.
- 16. The Social Worker was a social worker within the Referral and Assessment Team at Hampshire County Council. The Social Worker joined the team on 10 October 2016.

Summary of evidence:

- 17. The witness bundle contained written statements from 4 witnesses:
 - i) ("JG") – (Team Manager in the Referral and Assessment Team at Hampshire County Council at the time of the concerns)
 - ii) ("AS") - (Head of Family Safeguarding at Portsmouth City Council)
 - iii) [PRIVATE]
 - iv) [PRIVATE]

18. Ms Mercer confirmed to the panel that she intended to call witnesses JG, [PRIVATE] unless the panel had questions for AS. The panel confirmed that it had no questions for AS.

Evidence of JG

19. In her witness statement JG says:

1. At the time of the concerns in this case (2017-2018), JG was employed as the Team Manager in the Referral and Assessment Team at the Council. In this role, JG managed nine social workers. JG was ultimately responsible for case management of all the cases allocated to the social workers. Although the social workers managed the cases themselves, JG had direct responsibility for ensuring compliance with statutory timeframes and quality assurance.
2. Ms Carroll was a social worker within the team that JG managed at the Council. Ms Carroll joined the team on 10 October 2016. JG was her line manager.
3. JG began to have concerns about Ms Carroll's practice around August 2017.

Family 1

4. JG allocated Family 1 to Ms Carroll on 1 August 2017. All new cases referred to the Council would come through a workflow JG had access to. Ms Carroll was given clear instruction for the child to be spoken to within a set time frame (preferably within 72 hours, but no later than 3 August 2017). A child and family assessment was also to be completed within 15 working days. The child had to be seen within 5 working days of allocation, so by 6 August 2017, so JG would have expected Ms Carroll to have completed the initial visit.
5. When a case is allocated, a note is added to the case record with reference to the timescales.
6. JG states, *"From memory, the Social Worker did not complete this visit at all. I remember this because the Social Worker went on two weeks' annual leave on 14 August 2017 and before she went, I expected a case update from her so that it could be managed during her absence."*
7. When a Social Worker goes on leave, they inform the Team Manager of all visits that need covering and who they have arranged that with. They highlight high-risk cases to ensure oversight, and any outstanding work that they have not managed to complete.
8. JG did not receive any case update from Ms Carroll prior to her leave. Due to this, it was decided that the Team Manager should go through all her cases to ensure that they had adequate cover and that there was oversight on any high-risk cases or outstanding work. It was only because they had gone through all her cases that they recognised this family had not been seen at all.
9. A child and family assessment is used to gather information about the child and their family to understand their needs. The assessment is used to make decisions about

what (if any) ongoing intervention and support is needed. This assessment must be completed within 15 working days as per the Munro Report, after the death of “Baby P”. The Report also changed the format of the assessment so that they were more in-depth and considered the history of the family, not just the trigger event. This information is provided to all new social workers to the Department as part of their induction and it is reviewed within supervision.

10. JG stated Ms Carroll was employed in the Department for two years before coming to the Referral and Assessment Team, and Ms Carroll would have known this.
11. The child and family assessment was not completed by Ms Carroll. JG reallocated Family 1’s case to a different Social Worker, CO, when Ms Carroll went on leave because the visit to the child needed completing urgently.
12. On 17 August 2017, CO completed the child and family assessment for Family 1.
13. JG was concerned about Ms Carroll’s actions in respect of Family 1, because the child and the family had not been seen at all.
14. JG states *“We have measures in place (i.e. to undertake initial visits and assessments) in order to safeguard children. To a certain degree, you can only be confident a child is safe if you have seen them in person, but the Social Worker had not done this. There was therefore an increased risk to the child because of the Social Worker’s actions.”*
15. When Ms Carroll returned to work following her leave, JG recalls she had an informal discussion with her about Family 1’s case on 30 August 2017. JG states, *“I will have asked her in that meeting to explain why she had not carried out the initial visit to the child. From memory, I believe that I explained to her that if she had not had time to complete the visit, she should have highlighted that with me as her manager and I asked her to make sure she did this in the future going forward. From my perspective, it was the Social Worker’s responsibility to inform me that the visit needed cover, but she did not do so. The nature of how we discovered the fact she had not completed the visit was what caused me most concern; the fact she had gone on leave without informing anyone about it. I recall that the caseloads were quite high at that time.”*

Family 2

16. Family 2 was another family that had been allocated to Ms Carroll. Ms Carroll had been allocated the case to carry out a pre-birth assessment for the purposes of an upcoming court hearing, which was due to take place on 29 August 2017.
17. This case concerned private child law proceedings; the mother had care of her son but there were domestic violence concerns around her partner. Her son’s father wanted full custody of their son and was seeking this in the Family Court. At the same time, the mother was pregnant again (which is why the Family Court had requested a pre-birth assessment, so that they could assess the known risk of domestic violence to the unborn child).

18. The Family Court had also requested a section 7 report to be completed, which is a report on what is best for a child (the son), including their wishes and feelings about proposed custody arrangements.
19. JG states, *"From memory, another social worker completed the section 7 report, but the Social Worker was asked to complete (i) an addendum to the section 7 report and (ii) the pre-birth assessment. Both the addendum to the section 7 report and the pre-birth assessment would have been requested from Ms Carroll in a set timeframe (the Family Court would have directed it to be filed by a certain date)."*
20. Ms Carroll did not complete the section 7 report or the assessment. Ms Carroll did not complete the pre-birth assessment in time.
21. On 17 August 2017, the mother in the case called the Council's office. JG states, *"She was angry and upset because she explained she had received no contact from the Social Worker and was worried that she would lose her unborn child. Because she was so upset, I invited her into the office to discuss the matter. Again, she explained that she was very worried she would lose her unborn child and was really keen for the pre-birth assessment to outline her parenting. She was angry that the Social Worker had not attempted to contact her to undertake the assessment. There were no records held by the Council that indicated that the Social Worker had attempted to visit with the mother (Family 2) to undertake the pre-birth assessment."*
22. At this time, the Social Worker was on annual leave (for two weeks from 14 August 2017), so I made the decision to reallocate the case

Case loads

23. At the time Ms Carroll went on annual leave, she had 33 cases. JG states this *"was within the same margins as the rest of the team (every social worker had a similar level of cases). I do remember that at the time each member of the team had around 30-35 cases, but now the Council has implemented a procedure that prevents social workers from having more than 25 cases."*
24. JG States *"As a qualified Social Worker myself, I know what it is like to have 25+ cases and it can sometimes prevent meaningful work taking place. However, my view is that there was myself (Team Manager) and an Assistant Team Manager (EM) at the time, so if the Social Worker was concerned about her ability to progress cases, she should have highlighted that to us. We could have put measures in place to support her. The Social Worker had accountability for her cases. The Social Worker did not raise any issues or concerns with me about her caseload, workload or ability to complete assigned tasks, nor with the Assistant Team Manager as the Assistant Team Manager would have raised it with me. As the Social Worker went on leave without updating me as Team Manager, it meant that we could not offer her the support to ensure the safeguarding of the children on her caseload."*

25. After their informal discussion on 30 August 2017, JG stated Ms Carroll appeared to keep on top of her caseload. Ms Carroll was proactive with visiting children and completing assessments, both overdue and current.

[PRIVATE]

26. [PRIVATE]

27. [PRIVATE]

28. [PRIVATE]

29. [PRIVATE]

30. [PRIVATE]

31. [PRIVATE]

32. [PRIVATE]

33. [PRIVATE]

34. [PRIVATE]

20. JG was called to give evidence; she confirmed her witness statement and the information within the documents exhibited to her statement. Within her evidence, she confirmed that, alongside the case management system, Ms Carroll was provided with a spreadsheet populated by JG with allocations, and this was sent out via email to the whole team. She said there was not an example of the spreadsheet within the bundle, but the panel would have to take her word that it was sent out regularly. JG confirmed that Ms Carroll also had an obligation to check her allocations on the case management system. JG confirmed that, in respect of Family 2, she would have allocated the matter to Ms Carroll after the referral. [PRIVATE]. She accepted that Ms Carroll's case load was high but stated that Ms Carroll hadn't raised any concerns that she was aware of.

[PRIVATE]

21. [PRIVATE]

1. [PRIVATE]

2. [PRIVATE]

3. [PRIVATE]

4. [PRIVATE]

5. [PRIVATE]

6. [PRIVATE]

7. [PRIVATE]

8. [PRIVATE]

9. [PRIVATE]

10. [PRIVATE]

11. [PRIVATE]

12. [PRIVATE]

13. [PRIVATE]

[PRIVATE]

22. [PRIVATE]

1) [PRIVATE]

2) [PRIVATE]

3) [PRIVATE]

4) [PRIVATE]

5) [PRIVATE]

6) [PRIVATE]

7) [PRIVATE]

8) [PRIVATE]

9) [PRIVATE]

10) [PRIVATE]

11) [PRIVATE]

23. [PRIVATE]

[PRIVATE]

24. [PRIVATE]

1. [PRIVATE]

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8. [PRIVATE]
9. [PRIVATE]
10. [PRIVATE]
11. [PRIVATE]
12. [PRIVATE]
13. [PRIVATE]
14. [PRIVATE]
25. [PRIVATE]
26. [PRIVATE]
27. While Ms Carroll did not attend the hearing, the panel noted the representations that she provided, and the document entitled response to concerns, which sets out the following:

“ ... The management instruction for Family 1s case was issued on 1st August 2017 with the child to be seen no later than 3rd August 2017. I wasn't made aware such an urgent case had been added to my caseload on the internal system and therefore may have missed the initial visit request due to a high workload that day, as unless the internal system of caseloads is accessed there is no notification for the social worker assigned. Our team manager and/or duty social worker accessed the internal system daily to check if referral assessments or deadlines for visits had been missed, they would then flag this to the assigned social worker or, if the referral were urgent and the social worker unable to complete the visit the duty social worker would attend in their place. This case was not brought to my attention at any time before I began annual leave in mid August and was only highlighted when the Police raised further concerns on 14th August 2017. It was then reallocated as I was on pre-booked annual leave and progressed to S47. Family 2s case was reallocated to me from the social worker who had completed the initial assessment with the lady, as she had requested a change of case handler. I have a recollection of speaking to the lady by phone or face to face however, this is a case I had little involvement with 5 years ago and without my notes, which were kept by my office when my employment was terminated, I would be unable to comment on the specifics of the case before it was reallocated to a colleague (I believe E) and taken forward to the court appearance.”

[PRIVATE]

[PRIVATE]

[PRIVATE]

[PRIVATE]

[PRIVATE]

[PRIVATE]

[PRIVATE]

[PRIVATE]

[PRIVATE]

[PRIVATE]

[PRIVATE]

“... During my time with Social Work England, the Munro Report was passed to help reduce the numbers of missed opportunities to protect children within our service and beyond. It was recommended that a social worker should be allocated no more than 17 cases at a time. Whilst it is understood that this was only a recommendation and the number of service users in our area would frequently make this an impossible target to achieve, our department was working with extreme numbers during the time these 2 case concerns were raised. You have confirmed I was allocated 48 cases at the time, this would have been 48 families and not the number of children which, due to siblings in a household, would have been much higher (around 67 I believe). At this level of intense workload, mistakes and missed opportunities are bound to happen, even with the most professional and experienced social workers in the department. This workload pressure was raised as a concern by multiple staff members during discussions.”

[PRIVATE]

[PRIVATE]

[PRIVATE]

28. [PRIVATE]

[PRIVATE]

Finding and reasons on facts:

29. The panel accepted the advice from the legal adviser, which included the following:

- a. It is for Social Work England to prove the allegations upon the balance of probabilities;

- b. All the evidence should be considered before making findings of credibility, and when making such findings, the panel should not rely exclusively on demeanour;
- c. Hearsay evidence must be treated with caution and consideration given to the weight, if any, that can be afforded to it;
- d. Ms Carroll is not in attendance at the hearing, however her non-engagement with the hearing should not be considered an indication of guilt;
- e. Ms Carroll is of previous good character, which must be considered when determining the likelihood of her acting as alleged. It is one factor to consider together with all the evidence in the round;

1. The allegations arising out of the regulatory concerns referred by the Case Examiners on 2 December 2020 are:

1.1 Whilst working for Hampshire County Council and working with Family 1 in August 2017, you did not safeguard children in that you:

a. did not complete a visit before 3 August 2017 as instructed, or at all;

- 30. The panel considered the evidence of JG, whom the panel found to be a clear and credible witness. Within her witness statement, JG clearly stated that she allocated Family 1 to Ms Carroll and Ms Carroll was given clear instructions for the child to be spoken to within a set time frame, preferably within 72 hours, but no later than 3 August 2017.
- 31. The panel noted within Ms Carroll's representations that she did not dispute that Family 1's case was allocated to her. Ms Carroll states within those representations that she wasn't made aware such an urgent case had been added to her caseload, and she may have missed the initial visit request due to a high workload that day. As unless the internal system of caseloads is accessed, there is no notification for the social worker assigned.
- 32. In determining this matter, the panel had regard to the oral evidence of JG, who stated that Ms Carroll would have also been provided with a spreadsheet in relation to the matters which were allocated to her. This spreadsheet was compiled by JG and sent out to the team on email to inform them of the case that they had been allocated.
- 33. The panel further determined that Ms Carroll had an obligation to check the internal system and check the matters which were allocated to her and the urgency of those matters. The panel noted the evidence of JG that while the caseloads were high, Ms Carroll hadn't raised any concerns that JG was aware of.
- 34. The panel noted, the child within Family 1 had to be seen within 5 working days of allocation, so at the latest by 6 August 2017, and there were no records to suggest that any visit was completed by Ms Carroll at any point.

35. The panel therefore determined that Family 1's case was allocated to Ms Carroll, that she was provided with clear instructions to complete a visit to the child before 3 August 2017, and that she failed to do so.

36. The panel therefore found Paragraph 1.1 a of the allegation proved.

1. The allegations arising out of the regulatory concerns referred by the Case Examiners on 2 December 2020 are:

1.1 Whilst working for Hampshire County Council and working with Family 1 in August 2017 you did not safeguard children in that you:

b. did not complete a child and family assessment within 15 days, or at all.

37. The panel considered the evidence of JG. Within her witness statement, JG stated as follows;

"A child and family assessment is used to gather information about the child and their family to understand their needs. The assessment is used to make decisions about what (if any) ongoing intervention and support is needed. This assessment must be completed within 15 working days as per the Munro Report, after the death of "Baby P". The Report also changed the format of the assessment so that they were more in-depth and considered the history of the family, not just the trigger event. This information is provided to all new social workers to the Department as part of their induction and it is reviewed within supervision. As the Social Worker (Ms Carroll) was employed in the Department for two years before coming to the Referral and Assessment Team, she would have known this. This child and family assessment was not completed by the Social Worker."

38. The panel noted that Ms Carroll raised in her representations that the case was not brought to her attention, at any time before she began annual leave in mid-August and was only highlighted when the Police raised further concerns on 14 August 2017.

39. The panel, having found that Family 1's case was allocated to Ms Carroll, again determined that Ms Carroll should have been aware of the urgency of the case and the deadlines involved.

40. The panel noted that Ms Carroll before going on annual leave ought to have reviewed her case load, checked for any urgent deadlines, and made arrangements should she not be able to meet such deadlines. She later stated the 4 October 2017 meeting that JG referred to was a pre annual leave handover meeting so she was clearly aware that such a meeting should take place before annual leave.

41. The panel noted that there was no evidence to show Ms Carroll completed a child and family assessment within 15 days, or at all, and therefore the panel found Paragraph 1.1 b of the allegation proved.

1.2. Whilst working for Hampshire County Council and working with family 2 in July and August 2017, you did not safeguard children in that you:

a. did not complete visits between the date the case was allocated to you on 16 July 2017 and 14 August 2017;

- 42. The panel considered the evidence of JG that on 17 August 2017, the mother in the case called the Council's office. The mother was angry and upset because she explained she had received no contact from Ms Carroll and was worried that she would lose her unborn child. Because she was so upset, JG invited her into the office to discuss the matter. The mother explained that she was very worried she would lose her unborn child. She was angry that the Social Worker had not attempted to contact her.
- 43. JG notes in her witness statement that there were no records held by the Council that indicated that Ms Carroll had attempted to visit with the mother to undertake the pre-birth assessment.
- 44. The panel noted that representations from Ms Carroll that without her notes, she would be unable to comment on the specifics of this case.
- 45. The panel had no reason to doubt the evidence of JG. There were no records held by the Council that indicated that Ms Carroll had attempted to visit with the mother. The panel determined that visits would have been required in this case and there is no dispute that the matter was allocated to Ms Carroll, therefore the panel found Paragraph 1.2 a of the allegation proved.

1.2. Whilst working for Hampshire County Council and working with family 2 in July and August 2017, you did not safeguard children in that you:

b. did not prepare a pre-birth assessment for a hearing, which was due to take place on 29 August 2017.

- 46. The panel considered the evidence of JG, that as the allocated social worker Ms Carroll would have been expected to complete a pre-birth assessment, and this would have been requested in a set timeframe, as the Family Court would have directed it to be filed by a certain date.
- 47. The panel noted the evidence in respect of the mother in the case calling the Council's office, because she had had no contact from Ms Carroll, and was worried that she would lose her unborn child.
- 48. The panel determined that as the allocated social worker, Ms Carroll would have been required to prepare a pre-birth assessment, and the panel had no evidence before it to suggest that such an assessment was completed by Ms Carroll.
- 49. The panel therefore found Paragraph 1.2 b of the allegation proved.

2. [PRIVATE]

50. [PRIVATE]

51. [PRIVATE]

52. [PRIVATE]

53. [PRIVATE]

54. [PRIVATE]

55. [PRIVATE]

56. [PRIVATE]

57. [PRIVATE]

58. [PRIVATE]

59. [PRIVATE]

60. [PRIVATE]

3. [PRIVATE]

61. [PRIVATE]

62. [PRIVATE]

63. [PRIVATE]

64. [PRIVATE]

65. [PRIVATE]

66. [PRIVATE]

67. [PRIVATE]

68. [PRIVATE]

69. [PRIVATE]

70. [PRIVATE]

71. [PRIVATE]

72. [PRIVATE]

73. [PRIVATE]

74. [PRIVATE]

75. [PRIVATE]

Misconduct and impairment - submissions:

76. The panel heard submissions from Ms Mercer on behalf of Social Work England. She submitted that the facts found proved amounted to misconduct.
77. Ms Mercer submitted that the misconduct was serious. She stated that the conduct was in breach of the following standards:

HCPC's Standards of Conduct, Performance and Ethics 2016:

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

7.6 You must acknowledge and act on concerns raised to you, investigating, escalating, or dealing with those concerns where it is appropriate for you to do so.

[PRIVATE]

78. Ms Mercer set out the test in respect of current impairment. She submitted that Ms Carroll had shown no insight. She submitted that based on Ms Carroll's lack of engagement, there was a real risk of repetition. On this basis, she submitted Ms Carroll's fitness to practice was currently impaired.

Panel considerations:

79. The panel considered all the evidence and the submissions. The panel accepted the advice of the legal adviser and was aware that:
- The overriding objective of Social Work England is to protect the public, which includes maintaining public confidence in social workers and maintaining professional standards of social workers.
 - Whether the facts found amount to misconduct is a matter for the panel's independent judgement.
 - There is no statutory definition of misconduct, but the panel had regard to the guidance given 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 standards ordinarily required to be followed by a... practitioner in the particular circumstances'.
 - The conduct must be serious and fall well below the required standards (*Nandi v GMC* [2004] EWHC 2317).

- e. A social worker's conduct should be considered in the light of any standards of conduct, performance and ethics or other fitness to practise requirements that were applicable to the social worker at the time of the alleged misconduct.
- f. When considering impairment, the panel should consider whether the misconduct is remediable and, if so, whether it has been remedied and what insight has been demonstrated by Ms Carroll. The panel must also determine whether the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of current impairment were not made.
- g. The panel should have regard to the relevant guidance issued by Social Work England.

Finding and reasons on misconduct:

80. The panel considered that the proved facts of the allegation amounted to a breach of the following HCPC Standards of Conduct, Performance and Ethics (2016):

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

7.7 You must acknowledge and act on concerns raised to you, investigating, escalating, or dealing with those concerns where it is appropriate for you to do so.

[PRIVATE]

81. The panel acknowledged that Ms Carroll's breaches of the above standards occurred in circumstances where she had a high case load. However, the panel were satisfied that the proved allegations amounted to a significant failure to adhere to the standards expected of someone in Ms Carroll's position as a social worker.
82. The panel noted in respect of paragraphs 1.1 and 1.2 of the allegations, Ms Carroll failed to conduct visits and complete assessments in respect of vulnerable child service users. While Ms Carroll had a high case load, visiting children and completing assessments, within a timely manner, was a fundamental part of her role. Ms Carroll ought to have prioritised her workload effectively or sought assistance if the workload became unmanageable.
83. The panel considered that Ms Carroll's failings in respect of Family 1 and 2 were serious, and in the case of Family 2 occurred in the circumstances where there was later police involvement in the case. The panel considered that Ms Carroll's failure to visit Family 1 and 2 could have resulted in significant harm to multiple child service users.
84. [PRIVATE]
85. [PRIVATE]
86. The panel determined that all of the facts found proven amounted to misconduct.

Finding and reasons on current impairment:

87. Having determined that the proved facts amount to misconduct, the panel considered whether Ms Carroll's fitness to practise is currently impaired.
88. The panel had regard to the questions posed by Dame Janet Smith in her fifth Shipman report endorsed in the case of Council for Healthcare Regulatory Excellence v Nursing and Midwifery Council and Grant [2011] EWHC 927 Admin. In light of its findings on misconduct the panel concluded that Ms Carroll had, in the past:
 - i. acted so as to put a member of the public at unwarranted risk of harm;
 - ii. brought the profession of social work into disrepute;
 - iii. breached fundamental tenets of the social work profession (in relation to safeguarding the vulnerable);
89. The panel considered that Ms Carroll's misconduct in relation to paragraphs 1.1 and 1.2 of the allegations were capable of remediation. [PRIVATE]
90. While Ms Carroll referenced within her representations her high case load, she has not acknowledged the potential harm that could have resulted from her failures in respect of Family 1 and 2, or addressed any steps she would take in the future to prevent such failures re-occurring.
91. [PRIVATE]
92. There was no evidence to support the fact that Ms Carroll has accepted or acknowledged her conduct. The panel noted that there was engagement in the regulatory process however Ms Carroll declined to participate in the hearing. The panel concluded that Ms Carroll had not evidenced remediation, for example her efforts to retrain or address the failings in her practise.
93. The panel has partial information regarding the work that Ms Carroll is undertaking, namely working as a Learning Support Assistant with 16+ and Adult LDD students, however the panel believe that this work is not taking place in a social work capacity. The panel has seen no evidence to support the fact that Ms Carroll has undertaken any relevant training or continuing professional development to address the concerns raised.
94. The panel noted Ms Carroll has provided no evidence of insight. Ms Carroll has not apologised for her actions nor has she expressed remorse or regret. There is no evidence that Ms Carroll has reflected on her conduct and the impact it may have had upon service users, [PRIVATE] or the social work profession as a whole.
95. The panel therefore considered that Ms Carroll has not demonstrated remediation or insight. Ms Carroll has had ample opportunity to provide such evidence within a written response or during the hearing.

96. Ms Carroll's conduct placed vulnerable child service users at risk of harm. [PRIVATE]. Her misconduct relates to failings in her core obligations as a social worker. The panel considered that Ms Carroll's conduct amounted to a breach of a fundamental tenet of the profession. Due to these findings, together with an absence of evidenced remediation and limited insight, the panel concluded that there was a high risk of repetition of the misconduct.
97. The panel was satisfied that a finding of impaired fitness to practise was necessary to protect the public, particularly vulnerable service users. Further, the panel considered that reasonable, well informed, members of the public would be very concerned about Ms Carroll's conduct and the potential consequences of her failings. The panel therefore concluded that a finding of impaired fitness to practise was necessary to maintain and promote public confidence in the social work profession.
98. Given that Ms Carroll's misconduct related to breaches of fundamental tenets of social work, namely the safeguarding of vulnerable service users, the panel was satisfied that professional standards would not be promoted and maintained by a finding that Ms Carroll's fitness to practise is not currently impaired, particularly considering the panel's assessment of limited insight and an absence of remediation.
99. The panel therefore concluded that, because of Ms Carroll's misconduct, a finding of impaired fitness to practise was necessary to protect the public, promote and maintain public confidence in the social work profession and declare and uphold proper professional standards.

Summary of submissions - Sanction:

100. Ms Mercer, on behalf of Social Work England, submitted that, considering the nature of the misconduct, the appropriate sanction was one of suspension for up to a three-year period. She argued that such a sanction would protect the public and the wider public interest, considering the severity of the misconduct, but this was a case which fell short of a removal order.
101. Ms Mercer highlighted the mitigating factors, namely Ms Carroll's personal mitigation and her good character. In respect of the aggravating factors, she stated that Ms Carroll lacked insight and remorse and her conduct caused a risk of harm to vulnerable child service users [PRIVATE].
102. Ms Mercer submitted that it was necessary to impose a sanction that restricted Ms Carroll's practice, as nothing else would protect the public. She argued that, considering Ms Carroll's lack of engagement with the regulatory process, conditions would not be workable and proportionate.
103. Ms Mercer argued that a suspension was the most appropriate outcome and that a suspension ought to be imposed for up to a 3-year period to protect the public. She argued that this sanction was proportionate in the circumstances.

Determination and reasons – Sanction:

104. The panel accepted the advice of the legal adviser, that it must again pursue the overarching objective when exercising its functions. The panel must apply the principle of proportionality, balancing Ms Carroll's interests with the public interest. The purpose of a sanction is not to be punitive, although a sanction imposed may have a punitive effect. The panel considered the least restrictive sanction first and then moved up the sanctions ladder as appropriate. The panel had regard to the Social Work England Impairment and Sanctions Guidance, published in December 2022, together with its determination of grounds and impairment.
105. The panel reminded itself that it had concluded that Ms Carroll's fitness to practise was found to be impaired, due to serious misconduct.
106. In relation to aggravating features, the panel reminded itself of its findings in paragraph 83-84;

83. The panel considered that Ms Carroll's failings in respect of Family 1 and 2 were serious, and in the case of Family 2 occurred in the circumstances where there was later police involvement in the case. The panel considered that Ms Carroll's failure to visit Family 1 and 2 could have resulted in significant harm to multiple child service users.

[PRIVATE]

107. Further, the panel noted that an aggravating feature of this case was the fact that Ms Carroll lacked insight and remorse. Ms Carroll has also shown no evidence of remediation.
108. In relation to mitigating features, the panel noted that Ms Carroll was of good character. *[PRIVATE]*. The panel also took into consideration Ms Carroll's high case load.
109. The panel considered that taking no action, or issuing advice or a warning, would not adequately reflect the serious nature of Ms Carroll's misconduct. These outcomes would not adequately protect the public, as they would not restrict Ms Carroll's practice. The panel has assessed there to be a risk of repetition, and so considered that the public could not currently be adequately protected unless Ms Carroll's practice is restricted. Further, taking no action, or issuing advice or a warning, would not maintain public confidence in the profession or promote proper professional standards, considering the panel's finding that Ms Carroll exposed vulnerable child service users to a risk of harm and *[PRIVATE]*.
110. The panel next considered whether a conditions of practice order would be sufficient to protect the public and wider public interest. The panel, however, noted paragraph 114 of the Impairment and Sanctions Guidance, which states:

114. Conditions of practice may be appropriate in cases where (all of the following):

- the social worker has demonstrated insight*
- the failure or deficiency in practice is capable of being remedied*
- appropriate, proportionate, and workable conditions can be put in place*

- *decision makers are confident the social worker can and will comply with the conditions*
- *the social worker does not pose a risk of harm to the public by being in restricted practice*

111. The panel noted its findings in relation to insight and determined that it could not be confident that Ms Carroll can and will comply with the conditions. The panel noted that Ms Carroll was not currently working as a social worker. The panel was satisfied that workable conditions could not be formulated to adequately protect the public. Further, considering the serious misconduct, the panel was satisfied that conditions would not be sufficient to maintain public confidence, or to promote proper professional standards.

112. The panel went on to consider making a suspension order. The panel noted the submission by Social Work England that a suspension order was appropriate in this case, however the panel consider paragraphs 137-138 of the Impairment and Sanctions Guidance, which state as follows:

“137. Suspension may be appropriate where (all of the following):

- *the concerns represent a serious breach of the professional standards*
- *the social worker has demonstrated some insight*
- *there is evidence to suggest the social worker is willing and able to resolve or remediate their failings*

138. Suspension is likely to be unsuitable in circumstances where (both of the following):

- *the social worker has not demonstrated any insight and remediation*
- *there is limited evidence to suggest they are willing (or able) to resolve or remediate their failings”*

113. [PRIVATE]. However, the panel considered that the Allegation involved serious breaches of the professional standards, as set out in its earlier findings.

114. The panel has found that there was no insight demonstrated into the misconduct in relation to the panel’s findings. Ms Carroll’s conduct in respect of Family 1 and 2 placed vulnerable child service users at risk and there is no evidence before the panel to support the fact that Ms Carroll has accepted or acknowledged the impact of her conduct.

115. [PRIVATE]

116. Further, the panel have seen no evidence of an intention on the part of Ms Carroll to take steps to resolve or remediate her failings.

117. The panel considered paragraph 148 of the Impairment and Sanctions Guidance, which states:

“148. A removal order must be made where the decision makers conclude that no other outcome would be enough to (do one or more of the following):

- protect the public
- maintain confidence in the profession
- maintain proper professional standards for social workers in England”

118. The panel considered that the serious misconduct in which it had found Ms Carroll had placed vulnerable child service users at risk of harm [PRIVATE].

119. [PRIVATE]

120. [PRIVATE]

121. The panel recognised the impact a removal order would have on Ms Carroll and took this into account. However, it considered the public interest outweighed Ms Carroll’s interests. The panel therefore concluded that the only sanction which achieved the aim of public protection in all three limbs was a removal order, with no lesser sanction being sufficient.

Interim Order

122. In light of its findings on sanction, the panel next considered an application by Ms Mercer for an Interim Suspension Order to cover the appeal period before the final order becomes effective.

123. Ms Mercer submitted that, in view of its having made a removal order, an interim order would be appropriate to protect the public and the wider public interest. She submitted that an interim order was necessary because the panel had directed the removal of Ms Carroll’s name from the register, and in the event that there might be an appeal.

124. The panel was advised that it had power to make any interim order it considered necessary to protect the public, or in the best interests of the social worker. The panel was mindful of its earlier finding that it had found that nothing less than a removal order met its findings of impairment. In that case, the panel decided that it would be wholly incompatible with those earlier findings to not protect the public with an interim order to cover the appeal period, or the period until any appeal is resolved.

125. The panel was mindful that it could make any interim order. It considered that, in light of its findings, it was necessary to make an Interim Suspension Order. Since any appeal, if made, is likely to take a long time to resolve, the panel decided to make the interim order for 18 months.

126. Accordingly, the panel concluded that an Interim Suspension Order is necessary for the protection of the public. When the appeal period expires, this interim order will come to an end unless an appeal has been filed with the High Court. If there is no appeal, the final order of a removal order shall take effect when the appeal period expires.

Right of Appeal:

127. Under Paragraph 16(1)(a) of Schedule 2 of the regulations, the social worker may appeal to the High Court against the decision of adjudicators:
- a. 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.
 - b. the decision of the regulator on review of an interim order, or a final order, other than a decision to revoke the order.
128. Under Paragraph 16(2) of Schedule 2 of the regulations an appeal must be filed before the end of the period of 28 days beginning with the day after the day on which the social worker is notified of the decision complained of.
129. Under Regulation 9(4) of the regulations this order may not be recorded until the expiry of the period within which an appeal against the order could be made, or where an appeal against the order has been made, before the appeal is withdrawn or otherwise finally disposed of.
130. This notice is served in accordance with Rules 44 and 45 of the Social Work England Fitness to Practice Rules 2019 (as amended).

Review of final orders:

131. Under Paragraph 15(1), 15(2) and 15(3) of Schedule 2 of the regulations:
- 15(1) The regulator must review a suspension order or a conditions of practice order, before its expiry
 - 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

132. Under Rule 16(aa) of the rules a 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.

The Professional Standards Authority:

133. Please note that in accordance with section 29 of the National Health Service Reform and Health Care Professions Act 2002, a final decision made by Social Work England's panel of adjudicators can be referred by the Professional Standards Authority ("the PSA") to the high court. The PSA can refer this decision to the High Court if it considers that the decision is not sufficient for the protection of the public. Further information about PSA appeals can be found on their website at: <https://www.professionalstandards.org.uk/what-we-do/our-work-with-regulators/decisions-about-practitioners>