

Social worker: Collette Bradshaw

Registration number: SW4816

Fitness to Practise

Final Hearing

Dates of hearing: Tuesday 18 to Tuesday 25 April 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 Bradshaw did not attend and was not represented.
3. Social Work England was represented by Ms Michaels of Counsel instructed by Capsticks LLP.

Adjudicators	Role
Tim Skelton	Chair
Belinda Henson	Social worker adjudicator
David Crompton	Lay adjudicator

Paul Harris	Hearings officer
Wallis Crump	Hearings support officer
Scott McDonnell	Legal adviser

Service of notice:

4. Ms Bradshaw did not attend and was not represented. The panel of adjudicators (hereafter “the panel”) was informed by Ms Michaels that notice of the hearing was sent to Ms Bradshaw by email and special delivery service to the email address and home address provided by the social worker (namely their registered email address and home address as they appear on the Social Work England register). Ms Michaels 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 the final hearing dated 16 March 2023 and addressed to Ms Bradshaw at her email and home address which she provided to Social Work England;
 - An extract from the Social Work England Register as at 16 March 2023 detailing Ms Bradshaw’s registered email address and home address;
 - A copy of a signed statement of service, on behalf of Social Work England, confirming that on 16 March 2023 the writer sent by email and special delivery service to Ms Bradshaw at the address referred to above: notice of hearing and related documents;
 - A copy of the Royal Mail Track and Trace Document indicating “signed for” delivery to Ms Bradshaw’s registered home address at 11.02am on 17 March 2023.
6. The panel accepted the advice of the legal adviser in relation to service of notice.

7. Having had regard to the Social Work England (Fitness to Practise) Rules 2019 (as amended) (“the Rules”) 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 Bradshaw in accordance with Rules 14, 15, 44 and 45.

Proceeding in the absence of the social worker:

8. The panel heard the submissions of Ms Michaels on behalf of Social Work England. Ms Michaels submitted that notice of this hearing had been duly served, no application for an adjournment had been made by Ms Bradshaw and as such there was no guarantee that adjourning today’s proceedings would secure her attendance.
9. Ms Michaels further submitted that Ms Bradshaw had voluntarily absented herself from these proceedings. The panel should consider all of the circumstances and balance fairness to the parties including Social Work England. Ms Michaels submitted that Ms Bradshaw had chosen not to attend and there was no requirement for the panel to postpone the hearing. Ms Michaels referred the panel to an email from Ms Bradshaw to Social Work England dated 29 March 2021 in which she stated that she did not wish to practise as a social worker. Ms Michaels therefore invited the panel to proceed in the interests of justice and the expeditious disposal of this hearing.
10. 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 the cases of *R v Jones [2003] UKPC*; *General Medical Council v Adeogba [2016] EWCA Civ 162 etc*; and Rule 43 of the Rules. The panel was also referred to the case of *Sanusi v The General Medical Council (2019) EWCA Civ 1172* when considering whether to proceed.
11. The panel considered all of the information before it, together with the submissions made by Ms Michaels on behalf of Social Work England. The panel noted that Ms Bradshaw had been sent notice of today’s hearing and the panel was satisfied that she was or should be aware of today’s hearing.
12. The panel, therefore, concluded that Ms Bradshaw had chosen voluntarily to absent herself. The panel had no reason to believe that an adjournment would result in Ms Bradshaw’s attendance. The panel noted that there had been no meaningful engagement with these proceedings by Ms Bradshaw since March 2021, when she had last been in contact with Social Work England. She had not responded to correspondence since then and had not indicated whether or not she intended to attend the hearing.
13. The panel took account of the fact that witnesses had been invited to attend these proceedings and were available to give evidence. Having weighed the interests of Ms Bradshaw 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 Bradshaw’s absence in the interests of fairness.
14. The panel noted all the documentation presented in support of the hearing, namely the hearing timetable (5 pages), the statement of case (22 pages), a hearsay application (7

pages), the statements bundle (48 pages), the final hearing bundle (311 pages), Ms Bradshaw's response (2 pages) and the service and supplementary bundle (38 pages).

Allegations:

15. The allegations against Ms Bradshaw arising out of the regulatory concerns referred by the Case Examiners on 24 June 2022 are:

Whilst registered as a social worker;

1. Between July 2020 and December 2020, you failed to safeguard service users as set out in Schedule A when working at Cheshire East Council.

2. Between September 2020 and December 2020, you failed to communicate adequately, or at all, with service users and third parties who had left messages for you at Cheshire East Council.

3. Between July 2020 and December 2020, you failed to maintain clear, accurate and up to date case records at Cheshire East Council in relation to those service users set out in Schedule B.

4. Between 27 October 2020 and 8 December 2020, you practised as a Grade 9 Registered Mental Health Social Worker at Cheshire East Council whilst suspended from the Social Work England register.

5. Your conduct in respect of Allegation 4 was dishonest.

The matters outlined in paragraphs 1, 2, 3, 4 and 5 amount to the statutory ground of misconduct.

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

Schedule A

(a) Failed to ensure the immediate safety and well-being of Service User 2 following a visit on 12 November 2020;

(b) Failed to carry out a risk assessment with Service User 2;

(c) Failed to liaise with the police regarding Service User 2;

(d) Failed to provide Service User 2 details for supporting agencies and sexual health clinics until 30 November 2020;

(e) Failed to complete the needs assessment for Service User 3;

(f) Failed to ensure the immediate safety and well-being of Service User 4 by failing to take any action following a referral by the Ambulance Service;

(g) Failed to complete a needs assessment for Service User 4 following the appointment on 18 September 2020;

(h) Failed to directly contact or refer Service User 5 to the Stoke Local Authority via their GP for an assessment,

Schedule B

- (a) Service User 2;
- (b) Service User 3;
- (c) Service User 4;
- (d) Service User 5;
- (e) Service User 9;
- (f) Service User 10;
- (g) Service User 11;
- (h) Service User 12;
- (i) Service User 13;
- (j) Service User 14;
- (k) Service User 15;
- (l) Service User 16;
- (m) Service User 17;
- (n) Service User 18;
- (o) Service User 19;
- (p) Service User 20

Preliminary matters:

Hearsay application

16. Ms Michaels made an application for hearsay evidence to be admitted to the proceedings.
17. Ms Michaels indicated that the hearsay evidence was referred to in the statement of case and was contained within the hearing bundle. This evidence comprised of the witness statement of GJ and the record of a telephone attendance note between Ms Bradshaw and a member of the Hearings Team, RM, which was now exhibited by JR.
18. Ms Michaels referred the panel to Case Management Directions in this case, whereby Ms Bradshaw was required to confirm by 3 April 2023 whether she objected to this hearsay evidence being admitted. Ms Bradshaw had not provided any response.

19. Ms Michaels provided the background to the case and that the allegations before the panel related to a referral on or around 8 December 2020 from TF, Team Manager at Cheshire East Council (“the Council”).
20. It was reported that Ms Bradshaw had been employed as an agency worker at the Council from 27 July 2020 and had continued to work despite having been suspended from the Social Work England register on 27 October 2020. TF was notified by Ms Bradshaw on 8 December 2020 that she had been suspended. Ms Bradshaw had stated she had been unaware of her suspension until this was discovered by her agency during an audit of records.
21. On 23 December 2020, TF contacted Social Work England again, indicating that further concerns regarding the Social Worker’s practice had come to light since Ms Bradshaw had left her post. These concerns related to a failure to safeguard service users, poor record keeping and shortfalls in communication.
22. Ms Michaels indicated that the hearsay evidence that Social Work England sought to rely upon regarding the two witnesses related to Ms Bradshaw working as a social worker when she knew that she was suspended from her practice.
23. Ms Michaels referred the panel to the case law and legal authorities that the panel should consider when deciding whether or not to grant the application and also to the Rules, which permit the panel to admit evidence where it considered it fair to do so.
24. Ms Michaels submitted that the panel could address fairness by considering the weight it should attach to any hearsay evidence.
25. With regard to the evidence of GJ, Ms Michaels informed the panel that he is the Information Governance Officer at Social Work England and was the allocated investigator for this matter. Ms Michaels submitted that GJ’s statement was a production statement, in that he exhibited correspondence with Ms Bradshaw.
26. Ms Michaels submitted that GJ’s statement was relevant to paragraphs 4 and 5 of the allegations as it demonstrated that Ms Bradshaw knew about her suspension. Ms Michaels referred the panel to GJ’s statement where he stated that on 13 October 2020, he contacted Ms Bradshaw to inform her that an interim order application was being considered by the Case Examiners. Ms Bradshaw responded on 14 October 2020. A copy of this correspondence was produced by GJ.
27. Ms Michaels referred to GJ noting that on 27 October 2020, Ms Bradshaw was notified of the outcome of the application by the Social Work England Hearings Team by email and that a copy of the interim order application determination was also enclosed. A further letter was sent to Ms Michaels by the Case Review Officer on 5 November 2020.
28. Ms Michaels submitted that Social Work England did not intend calling GJ to give evidence as his role was to produce documents and Ms Bradshaw had not objected to his evidence.

29. With regard to JR, Ms Michaels informed the panel that he is the Adjudications Manager at Social Work England and his evidence was also a production statement. This statement exhibited a single file note of a telephone call between a Hearings Support Officer and Ms Bradshaw on 21 October 2020, to introduce themselves prior to the hearing and offer assistance to Ms Bradshaw.
30. Ms Michaels submitted that JR's statement was also relevant to paragraphs 4 and 5 of the allegation in that the file note indicates that Ms Bradshaw was aware of the interim order hearing.
31. Ms Michaels submitted that it was fair in all the circumstances to admit the hearsay evidence of GJ and JR.
32. Ms Michaels submitted that the evidence was not sole and decisive because Social Work England also relied upon the evidence of TF, who was the Team manager at the time and who spoke to Ms Bradshaw regarding her suspension. She supervised Ms Bradshaw and was responsible for overseeing her caseload.
33. Ms Michaels submitted that the evidence of GJ and JR was reliable and their statements exhibited Ms Bradshaw's own responses. Ms Michaels submitted that the panel would have the opportunity to explore the circumstances in which Ms Bradshaw notified her employer of her suspension with TF, which form the basis of allegation 4 and 5.
34. Ms Michaels submitted that there was no evidence to suggest that either witness had reasons to fabricate their accounts. Ms Bradshaw had been given the opportunity to object to the evidence being admitted as hearsay and had not done so.
35. Ms Michaels submitted that although Ms Bradshaw would not have the opportunity to cross-examine either witness if GJ's and JR's accounts were admitted as hearsay, the panel would be required to consider carefully what weight they gave to those accounts once all of the evidence had been heard.
36. Ms Michaels submitted that Ms Bradshaw had been given the opportunity to object to the admission of the evidence of GJ and JR and she had not done so.
37. Ms Michaels reminded the panel that Ms Bradshaw had not provided a direct response to the allegations and since 20 March 2021 she had not responded to any further communications or provided any observations concerning the case investigation report.
38. Ms Michaels referred the panel to Ms Bradshaw's email dated 29 March 2021 and her response therein to the concerns raised by the Council. Within that email Ms Bradshaw stated she no longer wished to practice as a social worker and wrote *"This system is a farce and I find it totally unacceptable the way I have been accused and investigated, I have never been shown any evidence of this allegation and quite frankly do not want to waste any more of my precious time in a profession that hangs draws and quarters without solid proof, evidence or investigation."*

Legal Advice:

39. The legal adviser advised the panel that hearsay evidence is a written or oral statement made otherwise than by a witness giving their own first-hand evidence in proceedings, which is tendered as evidence of the matters stated and which is relied on in court to prove the truth of the matters stated.
40. In order for hearsay evidence to be admissible it was required to be both relevant and fair to admit it. Further, there was no absolute rule that a person facing disciplinary proceedings is able to cross examine a witness, *R (Bonhoeffer) v GMC [2011] EWHC 1585 (Admin)*.
41. The panel was reminded that what is fair is fact sensitive and will depend on the circumstances of the case, particularly the nature and subject matter of the proceedings.
42. The panel was referred to *Thorneycroft v NMC [2014] EWHC 1565 (Admin)* and that a panel, when deciding whether or not to admit hearsay evidence, is entitled to take account of the fact that it can give less weight to the evidence than if the maker of the statement was available to be cross-examined. In addition a good and cogent reason for non-attendance of the witness is an important factor. However, the absence of a good reason will not automatically result in the exclusion of evidence.
43. The panel was advised that it should think carefully before allowing hearsay evidence where the evidence was not admitted by Ms Bradshaw and it was the sole or decisive evidence in relation to the allegations. However, in the current instance Social Work England sought to rely on the evidence of TF in relation to the allegations.
44. The panel was referred to Rule 32 (b)(vii) of the Rules, which states that the panel may “admit evidence where they consider it fair to do so, whether or not such evidence would be admissible before the courts”.

Panel decision:

45. The panel decided to grant the application.
46. The panel considered that the evidence of GJ was relevant and it was fair to admit it to the proceedings. Ms Bradshaw had not objected to GJ’s evidence and it was not the sole and decisive evidence regarding the allegations before the panel. There was no suggestion that the evidence was unreliable and there was no reason to consider that it had been fabricated. The panel was satisfied that it could consider and attach due weight to the evidence of GJ once all of the evidence had been heard.
47. With regard to the evidence of JR the panel noted that the purpose of admitting that witness’s evidence was to produce a telephone attendance note dated 21 October 2020 that had been completed by a hearing support officer who had now left their employment with Social Work England. The panel decided that the evidence of JR should be admitted for the same reasons as GJ.

Summary of evidence:

48. Ms Michaels reminded the panel of the background of the case as described within the hearsay application.
49. Aside from this Ms Michaels submitted that TF raised concerns regarding Ms Bradshaw's practice to Social Work England via email on 9 December 2021 when she became aware that Ms Bradshaw was suspended from practising as a social worker. Ms Bradshaw had been employed as a social worker with the Council from 27 July 2020 until 8 December 2020 as a Grade 9 Registered Mental Health Social Worker.
50. On 8 December 2020 Ms Bradshaw sent an email to TF informing her that she had been suspended from the social work register for a year from October 2020 until October 2021. It was Miss Bradshaw's position that Social Work England failed to inform her of the outcome of an interim order application containing an allegation made against her, and her suspension had been brought to her attention the previous week by the agency that had placed her with the Council. This suspension came to the agency's notice as a result of them updating their records.
51. Following TF's referral of Ms Bradshaw to Social Work England on 9 December 2020 she further contacted Social Work England on 23 December 2020 to highlight concerns regarding Ms Bradshaw's practise. Ms Bradshaw had been allocated the case and a safeguarding case was opened on 6 November 2020 following Service User 2 having reported a serious sexual assault to the police. Ms Michaels submitted that Ms Bradshaw had failed to consult with the police and failed to make contact with Service User 2 until 26 November 2020. Ms Bradshaw had apparently been given guidance in supervision on how to progress the case but had failed to follow this.
52. With regard to Service User 3, once Ms Bradshaw left her employment another member of the team, SO was allocated to that service user. Ms Michaels submitted that SO identified safeguarding concerns of potential financial abuse during her first call to the service user. Ms Bradshaw had been working with Service User 3 since she joined the team in July. Service User 3 informed SO that she had discussed these financial concerns with Ms Bradshaw, but there was nothing documented nor a safeguarding concern raised.
53. Ms Michaels reminded the panel that Ms Bradshaw had informed Social Work England by email on 29 March 2021 that she no longer wished to practise as a social worker.
54. Ms Michaels submitted that the panel would hear evidence from a number of witnesses.
55. Ms Michaels referred the panel to TF, Ms Bradshaw's team manager, who made two referrals to Social Work England and had allocated the case of Service User 2 to Ms Bradshaw. TF noted that Ms Bradshaw failed to record any safeguarding notes and it was TF's position that she would have expected Ms Bradshaw to complete more work relating to this case including contacting the police.

56. With regard to Service User 3, Ms Michaels submitted that Ms Bradshaw was allocated that case on 20 August 2020. On 29 September 2020, Cheshire Wirral Partnership NHS Foundation Trust requested a needs assessment in respect of Service User 3. However, Ms Bradshaw did not complete this and ultimately it was completed by SO who took over the case after Ms Bradshaw left.
57. Ms Michaels referred to matters regarding Service User 4 who had been allocated to Ms Bradshaw. TF reported concerns regarding the case as the service user had expressed suicidal ideation for several weeks and had stopped taking medication, but there were no notes on the system to confirm that Ms Bradshaw had made any contact with the service user.
58. Ms Michaels referred the panel to NT who would provide evidence regarding Service User 2. NT was allocated Service User 2 on 8 December 2020 and upon taking over the case reported a number of concerns regarding the lack of records that should have been completed by Ms Bradshaw including safeguarding and risk assessments.
59. Ms Michaels informed the panel that it would hear evidence from SO who was allocated Service User 3 in December 2020. Upon taking the case over SO identified that no assessment had been completed by Ms Bradshaw, nor a support plan. There was no evidence of correspondence with any other providers regarding the availability of accommodation spaces that would have been appropriate for Service User 3. SO observed that Ms Bradshaw had made telephone communication with Service User 3 and had visited her, but there was little information on this on the case notes.
60. Ms Michaels indicated that the panel would be provided with the hearsay evidence of GJ and JR, which related to allegation 4 and 5 which would support the allegation that Ms Bradshaw knew that she was suspended.

Social Work England

61. TF was called to give oral evidence. TF confirmed her role as Ms Bradshaw's team manager at the Council. She supervised Ms Bradshaw and was responsible for overseeing her caseload.
62. TF confirmed that she had provided two statements regarding the allegations, that the contents were true, and she wished to adopt the contents of those statements.
63. TF was asked a number of questions by Ms Michaels. TF confirmed that Ms Bradshaw had been employed as a Grade 9 Registered Mental Health Social Worker and described Ms Bradshaw's role and responsibilities. TF provided oversight of Ms Bradshaw's caseload and supervision of her, the latter taking place every 4 to 6 weeks.
64. TF referred to supervision notes of 27 November 2020 when it was agreed that Ms Bradshaw should tighten her boundaries and time with service users. TF noted that Ms Bradshaw was struggling to catch up and document her paperwork.

65. TF confirmed that Ms Bradshaw had failed to inform her that she had been suspended from the social work register since October 2020 and that TF had only become aware of this the week after Ms Bradshaw's agency had identified the issue. TF recalled that Ms Bradshaw had telephoned her to inform her, she "*was not fazed or bothered*". TF thought that Ms Bradshaw was upbeat for someone facing such a significant event.
66. TF recalled that the agency telephoned her on 8 December 2020 advising that they didn't know why Ms Bradshaw had been suspended and that this information came to light during routine checks on 3 December 2020.
67. TF referred to further correspondence between the Council and the agency relating to the discovery of the suspension and seeking to identify why the suspension had not been flagged up sooner.
68. In their email of 14 January 2021, the agency informed the Council that Ms Bradshaw's suspension came into effect on 28 October 2020. The agency confirmed that their initial checks did not indicate any issues with Ms Bradshaw's practice or registration, but a further Social Work England online check completed on 3 December 2020 showed Ms Bradshaw as having been suspended from practice. As Ms Bradshaw's Manager, TF was concerned that the agency had failed to inform her about the suspension as soon as they had become aware.
69. Ms Michaels then asked TF if she had any concerns regarding Ms Bradshaw's practice. TF referred to Ms Bradshaw failing to carry out assessments during October and November 2020 for a number of service users that she was responsible for. TF did not think that Ms Bradshaw was performing to the required standards. TF confirmed that Ms Bradshaw had been given induction training when she joined the Council and therefore knew what was expected of her and how to complete her role and duties.
70. TF referred to Ms Bradshaw's care of Service User 2 who had been subject to a serious sexual assault. Ms Bradshaw had not completed the required procedures to support the service user including safeguarding and liaising with the police. TF identified delays in Ms Bradshaw completing the work that she should have done and that notes had not been completed. During supervision it became apparent that Ms Bradshaw had not carried out the actions directed by TF.
71. TF recalled that after Ms Bradshaw left NT took over the case of Service User 2. NT had been unable to find any note of a safeguarding enquiry that should have been carried out. It may have been that Ms Bradshaw had completed various tasks, but this was not documented or recorded. NT informed the panel that Ms Bradshaw's conduct had the potential for significant harm to be caused to Service User 2 as it could not be established if they had the necessary support and strategies in place to ensure that any risks were

addressed. TF stated that it was important for any matters to be recorded because if they weren't, then nobody knew if necessary tasks had been undertaken.

72. Ms Michaels then asked TF about Service User 3. TF confirmed that that service user had been allocated to Ms Bradshaw on 20 August 2020 and a referral had been made on 29 September 2020 for an adult needs assessment (ANA) to be completed. Ms Michaels asked if Ms Bradshaw had completed the ANA. TF said that Ms Bradshaw said she had. TF described the process, namely that an ANA would be completed, TF would read and approve it or reject for further work. TF said that an ANA should take one week. However, Ms Bradshaw failed to complete the ANA in the 4 months prior to her departure. TF would have expected the ANA to be completed by then.
73. TF referred to NT taking over the case of Service User 3 who informed TF that Ms Bradshaw *"hadn't done anything"* and no formal notes had been left except for a few handwritten comments on a notepad, which did not assist to any degree. Ms Bradshaw hadn't updated Service User 3's case on the Council's IT systems.
74. TF told the panel that Service User 3's circumstances were that she was unwell and had needs at home. There was the possibility of Service User 3 coming to harm due to the controlling behaviour by her brother including financial exploitation. TF considered that there was an immediate safeguarding issue that needed to be addressed, but had not been dealt with by Ms Bradshaw.
75. Ms Michaels then asked TF about Service User 4. TF stated that the team received an adult safeguarding notification (ASN) from the North West Ambulance Service on 9 November 2020 in relation to Service User 4. An ambulance crew had been called out by the police after receiving a call from Service User 4 that she was going to end her life. She had expressed frustration around the coronavirus pandemic rules and was feeling lonely. The ambulance crew made the referral to the Council as they felt she would benefit from an ANA.
76. TF confirmed that Service User 4 was already known to the Council and Ms Bradshaw had already been allocated to her. Ms Bradshaw carried out a home visit to complete the ANA for on 18 September 2020 and added further notes to record that she was working on the assessment on 28 September 2020. On 6 October 2020, Ms Bradshaw recorded that Service User 4 had had a *"meltdown"* on 29 September 2020 which resulted in her cutting herself and *"residing to her bed for the week"*. TF viewed the Council IT system *"Liquid Logic"* and found that Ms Bradshaw had not completed the ANA as required. Ultimately the ANA was completed by another social worker.
77. TF informed the panel that whilst she was not aware of any actual harm caused to the service user as a result of the delays in following up the concern, the potential risks

associated with this delay should be considered given the claims by the service user to be suicidal and the potential risk of her not eating and drinking (*“with her residing to her bed”*). Ms Bradshaw offered practical support from the mental health team to (assist with access to the community, care needs) but as the ANA was not completed by her, the support that could have been put in place for Service User 4 was not. There was no actual harm from Ms Bradshaw taking no action in this case, but this could have potentially resulted in serious harm or accidental death.

78. Ms Michaels asked TF about Service User 5. TF informed the panel that the case hadn't been allocated to Ms Bradshaw, but she was contacted by the service user's mother when on duty. Ms Bradshaw asked TF for some advice. The mother was concerned about vulnerabilities, finances and specifically whether the service user should be referred back to the community mental health team (CMHT). TF advised Ms Bradshaw that as the service user was registered outside of the area the Council wouldn't be able to help and he would need to be referred to the CMHT in their area via his current GP.
79. TF informed the panel that she had checked the case records, but the call received by the mother was not recorded. Ms Bradshaw had contacted an accommodation provider, but there was no record of Ms Bradshaw making contact directly with the service user or whether he was referred to his Local Authority via his GP for a mental health assessment as TF had suggested.
80. TF told the panel that she would have expected Ms Bradshaw to make a return call to the mother immediately to inform her of the need to contact the GP in the area. TF had sent an email to Ms Bradshaw setting out the position and any follow up steps. TF noted that there was no record of Ms Bradshaw actioning any of TF's advice.
81. TF would have expected Ms Bradshaw to have completed the follow up on the same day as TF's email. TF considered that the fact that Service User 5 had nowhere to reside and was living in a B&B, and there were concerns around his mental health and his financial stability, meant that the delay in Ms Bradshaw responding to this concern was unacceptable.
82. Ms Michaels then asked TF about ANAs. TF informed the panel that an ANA is an assessment for adults to assess their strengths and needs in terms of several “domains” of daily living. This included physical and mental health, eating and nutrition, personal care, staying safe at home, moving and transfers around home, home and living conditions, social relationships, work, training, education, caring for others, support from unpaid carers and any identified risks. This assessment generates an indicative budget if eligible under these domains which provide a budget for ongoing care that has been identified as required.

83. TF informed the panel that there was no specific time frame for completion of an ANA, but she considered that one should be completed within 28 days to meet the requirements of the Care Act 2014. TF informed the panel that if an ANA was delayed this could have unforeseen consequences for the service user including further strain on their circumstances and their problems could get worse.
84. TF confirmed to the panel that between July 2020 and December 2020 Ms Bradshaw was required to complete 16 ANA reports. However, during that time she had only completed one, that being for Service User 21. The ANAs that hadn't been completed related to Service Users 2,3,4,5 9,10,11,12,13,14,15,16,17,18,19 and 20.
85. TF considered that it may have been the case that Ms Bradshaw had visited some of the service users, but this was not documented. It appeared that nothing had happened and no care was identified or sought.
86. Ms Michaels then asked TF about the team "messaging book". TF explained that the team messaging book was an IT system used to notify social workers of calls received from services users or third parties where the allocated social worker was unavailable, for example, they might have been on a service user visit.
87. Calls would come through to the duty team and they would send Teams messages on the message book for the social worker to review to notify the social worker that a call was received. Whilst there wasn't a specific policy or procedure for how to use the teams messaging book, this being specifically designed for the mental health team only, TF would expect a social worker to review the message book when they had availability to do so and if not every day, every other day. The Team messaging book included messages for the whole team. Social workers were expected to review the message book to identify whether they had missed a call and a note had been left for them to return a call.
88. TF confirmed that Ms Bradshaw was shown how to use the Team messaging book by another social worker. As part of the induction process, TF arranged for new starters to sit with a team member on duty.
89. TF informed the panel that Ms Bradshaw had failed to acknowledge or action a significant number of messages although some of the messages at the beginning of her employment had been actioned. TF was clear that Ms Bradshaw knew about the team messaging book and how to use it due to her induction training.
90. Ms Michaels asked TF what would be the impact of Ms Bradshaw not responding. TF told the panel that the service user would have to call back and there could be a significant adverse effect upon them including their mental health. It could not be discounted that there would be a risk of escalation for the service user including becoming suicidal.

91. Ms Michaels asked TF how she thought Ms Bradshaw had performed. TF replied that she did not think that Ms Bradshaw had performed very well at all across all areas. Ms Bradshaw had not completed assessments, not completed visits, not actioned safeguarding requirements and failed to record key actions.
92. TF considered that Ms Bradshaw had lied to her about what she had been doing and that she had re-assured TF that everything was alright. TF felt very let down and was thankful that “nothing sinister or serious had happened” in light of Ms Bradshaw’s behaviour.
93. The panel then asked a number of questions of TF. The panel noted that TF had asked SO to support Ms Bradshaw in September 2020 regarding safeguarding processes and completing documentation as it was new to her. TF indicated that the purpose of this support was to reassure TF that Ms Bradshaw understood the process. TF reviewed the case records and considered Ms Bradshaw had initially performed well.
94. TF confirmed that the section 42 enquiry under the Care Act 2014 relating to Service User 2 was the only one that Ms Bradshaw had been allocated and she had not had one before.
95. The panel then referred to the Council’s Adult Services Practice Guidance & Procedures dated 3 March 2016 (the procedures). The panel noted at paragraph 5.1 that a social worker must be suitably experienced and considered competent to undertake the role of Enquiry Lead. The panel questioned whether Ms Bradshaw was suitably experienced noting that she had not conducted a safeguarding role in the past.
96. TF replied that Ms Bradshaw was an experienced social worker who had worked in the field of risk and would have been used to considering safeguarding issues. All engagement with service users related to safety. Any social worker would be familiar with safeguarding and their statutory responsibilities under the Care Act 2014. Ms Bradshaw had worked as a member of a CMHT before and had been qualified as a social worker for several years. TF informed the panel that she was always available to assist and chaired safeguarding meetings.
97. The panel referred to paragraph 5.1 of the procedures which stated that *“Team Managers/ATM must oversee safeguarding enquiries and provide ongoing supervision and support for the Enquiry lead. Where there is a decision that a partner organisation will lead an enquiry, the allocating Team Manager/ATM must be satisfied that appropriate support and supervision is available for the person leading the enquiry message”*. TF confirmed that she had not chaired the safeguarding meeting regarding Service User 2, but had given direction and guidance to Ms Bradshaw.

98. The panel referred to paragraph 5.3 of the procedures and the potential criminal investigation strategy discussion that should take place. TF had discussed the plan of action regarding Service User 2 with Ms Bradshaw and informed the panel that the police had the lead.
99. TF confirmed that a planning meeting in accordance with the procedures had not been called. TF said that the procedures were guidance, but not mandated.
100. With regard to an outcomes meeting being completed in accordance with the procedures TF informed the panel that at the time Ms Bradshaw was still trying to see the service user and the process had been ongoing at the time.
101. TF accepted that there were times when Ms Bradshaw should have been chased up, but at the time the team were operating in the middle of the Covid 19 pandemic.
102. TF was happy at the time that Ms Bradshaw had a lot of experience as a care co-ordinator and was sufficiently experienced to perform her role. TF had been told by Ms Bradshaw that she had gone out to see service users and carried out the required actions. Ms Bradshaw had given TF enough evidence of doing a lot of work, but she hadn't documented it.
103. The legal adviser asked if it was possible that TF had been managed by Ms Bradshaw in that TF had been told what she wanted to hear. TF accepted that this may have been the case.
104. TF was asked why Ms Bradshaw had been permitted to fail to complete more than a dozen ANAs over a period of 4 months. TF informed the panel that in hindsight she should have intervened and challenged Ms Bradshaw including performing an audit.
105. NT was then called to give evidence. NT confirmed that she had provided two statements regarding the allegations, that the contents were true, and she wished to adopt the contents of those statements. NT confirmed that she had been in her role as a social worker with the Council for 6 years. She described her role and responsibilities working as a social worker and mental health professional as part of the CMHT.
106. NT confirmed that she had been allocated the case of Service User 2 on 8 December 2020 and continued conduct of that case until earlier this year. Ms Michaels asked why Service User 2 had been referred to the Council. NT informed the panel that Service User 2 had initially been referred in 2018 for support from the mental health re-enablement team. In 2020 the service user suffered from a deterioration in her mental health and attended the accident and emergency department of her local hospital in October 2020. At that

time Service User 2 disclosed a serious sexual assault in London and she was supported by the clinical team.

107. Between 2018 and 2020 Service User 2 had no social care intervention, but was subject to regular reviews. Ms Michaels referred NT to Service User 2's case notes completed by Ms Bradshaw and NT confirmed that there was no evidence of a safeguarding enquiry, information gathering or a referral. NT described the case notes as "*sketchy*" and they did not address safeguarding concerns. Ms Bradshaw did not appear to have contacted the police. Nothing was recorded regarding taking action concerning the serious sexual assault, nor was there any record of speaking with the police. NT said that she had spoken with the lead police investigator who confirmed that Ms Bradshaw had not made contact. The first contact was made by NT.
108. NT informed the panel that Ms Bradshaw should have known to call the police as this was a basic procedure. She should have contacted the referrer and conducted basic information gathering. NT referred the panel to a case note completed on 8 December 2020 which contained a reference to a discussion between NT and TF to discuss the referral. There was no record on the system of any safeguarding action. NT described the case notes as a running record regarding Service User 2 and nothing was recorded anywhere on the council's IT system.
109. NT noted that there was no offer of a safety plan for Service User 2, which should have taken place in light of the very serious disclosure. This would have identified if Service User 2 knew the people who had assaulted her, if she was going to meet with them again and identify any risks or threats to her. NT informed the panel that this action should have taken place on the day that Ms Bradshaw had been allocated the case in light of the gravity and seriousness of the disclosure by Service User 2.
110. NT noted that Ms Bradshaw hadn't completed a risk assessment for Service User 2 and had not made a timely response. There was no record of support by Ms Bradshaw to the service user. She could have provided practical help such as accessing Service User 2's GP or a sexual health clinic, but didn't.
111. NT informed the panel that a multi-disciplinary team would have been available, but wasn't used. There was no discussion with team members or children's services. Ms Bradshaw had not identified who the alleged perpetrator was or if they were known to the service user or her son. Risk had not been assessed regarding the son.
112. Ms Michaels asked NT how Ms Bradshaw would have known what to do. NT replied that Ms Bradshaw would be aware of how to manage risk, she was a qualified social worker who would know the requirements of the Children's Act 2014 and had access to training

including being provided with it during her induction. Further, Ms Bradshaw could seek advice from her manager and colleagues.

113. Ms Michaels asked NT what the impact was of Ms Bradshaw's actions regarding Service User 2. NT said that her inaction had exposed Service User 2 to a potential future risk. No safety plan had been put in place to mitigate any risks to Service User 2 and her son. NT told the panel that there was a wider risk to the public as well as further inquiries by Ms Bradshaw could have identified a risk to others.
114. NT told the panel that there would have been an emotional impact by Ms Bradshaw's conduct on Service User 2. This included losing faith in the service and profession due to the time that it had taken to progress matters. NT was clear that Ms Bradshaw had failed to address Service User 2's concerns.
115. The panel then asked a number of questions of NT. NT confirmed that the referral regarding Service User 2 was made by the police. Service User 2 had also disclosed the serious assault to a health care professional. The referral from the police contained the detail that Service User 2 had suffered a serious sexual assault. The threshold had been met to have a strategy discussion or meeting.
116. It was NT's opinion that Ms Bradshaw should have exercised her professional curiosity and begun to build a picture. However, Ms Bradshaw hadn't contacted the police. NT told the panel that Ms Bradshaw would have known how to proceed by the signposting matrix on the council's IT system, which clearly set out how to deal with a referral. NT also said that Ms Bradshaw was an experienced social worker who would know how to conduct information gathering and conduct a risk assessment as this was part of her statutory duties.
117. The panel referred NT to a case note entry dated 30 November 2020. NT indicated that due to the content it was her view that Ms Bradshaw did have an earlier conversation with Service User 2, but this was not recorded. NT told the panel that Ms Bradshaw should have responded to the referral in a timely way and certainly with 24 or 48 hours at the latest.
118. The panel asked NT what Service User 2 would have wanted to happen. NT told the panel that from her experience Service User 2 would have wanted to discuss her case and circumstances and for Ms Bradshaw to engage with her, but there was no evidence of this.
119. Ms Michaels then asked NT what should have happened before any strategy meeting or discussion. NT indicated that Ms Bradshaw should have conducted some preliminary enquiries and exercised her professional curiosity. NT said that there was a complete

absence of that. Ms Bradshaw should have started building a picture from the very beginning.

120. SO was then called to give evidence. SO confirmed that she had provided a statement dated 14 February 2023 regarding the allegations, that the contents were true, and she wished to adopt the contents of that statement. SO confirmed that she had been in her role as a social worker with the Council since August 2015. She described her role and responsibilities working as a social worker including supporting adult needs, being on duty and conducting safeguarding.
121. Ms Michaels asked SO about Service User 3. SO confirmed that she had been allocated that service user from December 2020 until the middle of 2021 and that she had taken over the case from Ms Bradshaw. The original referral had been made on 29 September 2020.
122. SO informed the panel that an ANA was required for Service User 3 as she had been in hospital, had support needs and accommodation needs as her home was not suitable for her circumstances. SO was asked about Ms Bradshaw's involvement in the case and what SO found when she took it over. SO said that there was not much information, but a short summary. There was no complete picture. TF had provided SO with some handwritten notes completed by Ms Bradshaw on a note pad, which she handed in on leaving the council, but there was little useful information within it. Ms Michaels asked SO about what information Ms Bradshaw had placed on the council's IT system. SO said that an assessment hadn't been completed. A document had been opened, but only a couple of sentences had been written.
123. SO was referred to a statement that she had completed in April 2021 at the request of TF regarding Ms Bradshaw's management of Service User 3's case. SO indicated that upon taking over the case SO was advised of concerns regarding Service User 3's brother and his management of her money. This had been identified by the service user's social prescriber at the GP surgery. She provided information that Service User 3 was unhappy with the amount of money she was being provided with and she was scared to confront her brother regarding this matter. Within the note pad left by Ms Bradshaw she had noted a visit on 21 September 2020 and that the brother was managing Service User 3's finances due to her previous "high" spending of "£1000s", but there was no further information about contact with Service User 3 about this issue. SO arranged a face to face meeting with Service User 3 and the brother. SO told the panel that Ms Bradshaw should have raised finances as a safeguarding issue.
124. SO told the panel that Ms Bradshaw should have exercised her professional curiosity about the brother's behaviour. SO told the panel that when she did meet Service User 3 and the brother he was openly derogatory about his sister and it was clear that there were issues. Ms Bradshaw should have responded to this.

125. SO told the panel that when she was allocated the case and met with Service User 3 she immediately raised a safeguarding concern and a full s42 enquiry was completed. SO was clear that Ms Bradshaw would have been aware of financial exploitation from 21 September 2020, but did nothing about it. In addition SO was concerned that Ms Bradshaw had been dishonest with Service User 3 and her family. They had told her that Ms Bradshaw confirmed an ANA had been completed, sent for action and the service user was on a waiting list for accommodation. This was not the case. No ANA had been completed.
126. SO told the panel that no actual harm had been caused to Service User 3. However, there was a risk of emotional harm and physical harm as her accommodation wasn't fit for her as it had stairs, which presented a risk of her falling.
127. The panel then asked a number of questions. SO confirmed that a referral had been made on 16 December 2020 by Service User 3's social prescriber at the GP surgery. However, from Ms Bradshaw's notepad SO was clear that she had been put on notice on 21 September 2020 that Service User 3 may be suffering financial exploitation by her brother. SO said that after that meeting an ANA could have been written up within a week.

Closing submissions

Social Work England

128. Ms Michaels submitted that having heard the evidence from TF, NT and SO and reading the hearsay evidence of GJ and JR, the panel would be able to find that the allegations were proved. Ms Michaels submitted that the witness' evidence was cogent and consistent with their written evidence. Ms Michaels reminded the panel that no admission had been made by Ms Bradshaw so the panel was required to determine all of the facts in the case. Ms Michaels reminded the panel of the burden and standard of proof.
129. Ms Michaels submitted that with regard to allegation 1 and Schedule A it was clear that Ms Bradshaw had failed to safeguard those Service Users. TF had provided evidence on this allegation establishing that this was the case. SO had also demonstrated that Ms Bradshaw had failed in her duties. The disclosure from Service User 2 was very serious and Ms Bradshaw would have known the correct procedures to follow. TF was confident that Ms Bradshaw had the knowledge and training throughout her career. TF had confirmed that Ms Bradshaw didn't make any notes regarding an s42 enquiry or safeguarding. She also hadn't contacted the necessary agencies such as the police. No support had been offered regarding sexual health nor any action taken to protect Service User 2's son. NT told the panel that the potential impact on Service User 2 of Ms Bradshaw's lack of action could have caused things to go tragically wrong.

130. With regard to Service User 3 Ms Michaels submitted that the panel had heard evidence from TF to establish that the allegation was proved. Ms Bradshaw had met with Service User 3 on 21 September 2020. On 6 October 2020 an ANA had been started. However, no further work had been completed. There had been no ANA or support plan.
131. Ms Michaels referred to the evidence of SO, which also supported the allegation and demonstrated Ms Bradshaw's lack of action. Ms Bradshaw hadn't completed any case notes or raised safeguarding concerns when it was clear that this should have been done.
132. Ms Michaels then referred the panel to the allegation regarding Service User 4. TF had provided evidence of Service User 4's suicidal ideation provided by the ambulance staff who attended upon Service User 4 and completed an ASN. TF confirmed that subsequently Ms Bradshaw hadn't completed an ANA as she had been required to do or provide the necessary support.
133. With regard to Service User 5 Ms Bradshaw hadn't been allocated that service user as she had been on duty when the service user's mother contacted the service. Ms Bradshaw had asked for advice and TF had directed her to complete various actions as Service User 5 was outside of the area. No records had been completed by Ms Bradshaw confirming that she had followed TF's direction.
134. Ms Michaels then referred the panel to allegation 2. She submitted that TF had demonstrated that Ms Bradshaw had failed to acknowledge messages and she would have known how to do so from her induction.
135. With regard to allegation 3 Ms Michaels submitted that the panel had heard evidence that Ms Bradshaw had not maintained clear and accurate records. TF had confirmed that Ms Bradshaw had not documented the work that she told TF she had done. This was the case regarding Service User 2 and SO confirmed regarding Service User 3 that an ANA had not been carried out or recorded. As for Service User 4 no case notes had been completed since 6 October 2020. There were no notes regarding Service User 5.
136. Ms Michaels then referred the panel to the other service users detailed in allegation 2. TF had provided a screen shot from the council's IT system "Liquid Logic", which demonstrated that Ms Bradshaw had not completed the ANAs required for those service users.
137. Ms Michaels then made submissions regarding allegation 4 regarding Ms Bradshaw practising while suspended. The panel had heard that TF was informed by Ms Bradshaw on 8 December 2020 that she had been suspended in October 2020. TF confirmed that Ms Bradshaw was aware of the complaint leading to her suspension. TF then carried out further checks and established that Ms Bradshaw had been suspended on 27 October 2020. Ms Michaels submitted that Ms Bradshaw was fully aware that she was suspended as Social Work England had been in regular contact with her leading up to the hearing in October and Ms Bradshaw had responded to various emails from the hearings team. Evidence supporting that allegation was detailed in the evidence of GJ and JR.

138. Ms Michaels then referred the panel to allegation 5 and the issue of dishonesty. Ms Michaels referred the panel to the two stage test and the evidence of GJ and JR, which she submitted, demonstrated that Ms Bradshaw had been dishonest.

Ms Bradshaw

139. Ms Bradshaw was not present, had not provided any written submissions and had not engaged with Social Work England concerning this hearing.

Legal Advice

140. The panel heard and accepted the advice of the legal adviser who referred them to the Social Work England Fitness to Practise Rules 2019, Rule 32 (c) (i) (a), which requires the panel to determine any disputed facts at the outset of the hearing. The panel heard and accepted detailed advice from the legal adviser in respect of the approach to take in determining findings of facts and the burden and standard of proof. The panel heard advice on the issues of credibility and reliability, on hearsay evidence and what weight to attach to such evidence.
141. The panel heard and accepted advice on the two stage test to be applied when considering an allegation of dishonesty in accordance with *Ivey v Genting Casinos (UK) LTD t/a Crockfords [2017] UKSC 67*, namely “what was the [defendant's] actual state of knowledge or belief as to the facts; and was his conduct dishonest by the standards of ordinary decent people?”
142. The panel was reminded of the fact that Ms Bradshaw was not present or represented and therefore it was incumbent on the panel and legal adviser to ensure that they explored any weaknesses there might be present in Social Work England’s case.

Finding and reasons on facts

143. The panel retired to reach its decision on facts.
144. In the circumstances, having considered all the written and oral evidence and on the balance of probabilities the panel made the following findings:

1. Between July 2020 and December 2020, you failed to safeguard service users as set out in Schedule A when working at Cheshire East Council.

Schedule A

- (a) Failed to ensure the immediate safety and well-being of Service User 2 following a visit on 12 November 2020;
- (b) Failed to carry out a risk assessment with Service User 2;
- (c) Failed to liaise with the police regarding Service User 2;

(d) Failed to provide Service User 2 details for supporting agencies and sexual health clinics until 30 November 2020;

(e) Failed to complete the needs assessment for Service User 3;

(f) Failed to ensure the immediate safety and well-being of Service User 4 by failing to take any action following a referral by the Ambulance Service;

(g) Failed to complete a needs assessment for Service User 4 following the appointment on 18 September 2020;

(h) Failed to directly contact or refer Service User 5 to the Stoke Local Authority via their GP for an assessment,

FOUND PROVED IN ITS ENTIRETY

145. The panel relied upon the evidence within the hearing bundle and the evidence of the witnesses that was provided during the course of the hearing.
146. With regard to 1a, the panel noted that Service User 2 had been allocated to Ms Bradshaw on 9 November 2020 following a referral on 6 November 2020. The service user had disclosed a serious sexual assault, but Ms Bradshaw did not carry out the actions that were required to ensure her safety and wellbeing. No records or plan had been completed and it was clear from the evidence that Ms Bradshaw did not contact the necessary agencies.
147. As for 1b, no risk assessment had been completed by Ms Bradshaw. There was no evidence that one existed or any indication that it had been done.
148. With regard to 1c, the panel noted the evidence of NT who upon taking over the case and speaking with the lead police investigator informed NT that she was the first contact that had been made.
149. The panel considered 1d, and relied upon the evidence of TF who confirmed that Ms Bradshaw did not provide Service User 2 with follow up counselling or support from sexual health services until 30 November 2020. The panel took account of TF's supervision meeting with Ms Bradshaw on 27 November 2020 when she had been directed to do this.
150. With regard to 1e, the panel noted that no needs assessment had been completed for Service User 3 regarding the issues of accommodation and finances. TF had chased Ms Bradshaw to complete this piece of work and been told it would "follow shortly", however it was never completed.
151. As for 1f, the panel took account of the referral by the ambulance service and TF asking Ms Bradshaw if she had completed the work required. There was no record of this being completed.
152. With regard to 1g, the panel noted that there was no evidence that Ms Bradshaw had completed the required needs assessment.

153. The panel considered 1h, and noted the email of 21 October 2020 from TF to Ms Bradshaw providing advice and direction regarding engagement with Service User 5 to progress his case with his local authority in Stoke. There was no evidence that Ms Bradshaw had carried this out.

2. Between September 2020 and December 2020, you failed to communicate adequately, or at all, with service users and third parties who had left messages for you at Cheshire East Council.

FOUND NOT PROVED

154. The panel noted that evidence had been provided by TF of Ms Bradshaw failing to record that she had responded to messages left on the team messaging book. However, the panel did not consider that this established that Ms Bradshaw had failed to communicate with others as there were other means of communication available to team members. It was not the sole communication vehicle. The panel was given evidence that there were other methods of communicating, which included telephone calls, emails and case note alerts. The panel noted that no documentary evidence had been provided of training, a formal induction or supervision regarding communication tools. In the absence of a clear policy as to Ms Bradshaw's responsibilities with regard to communications, the panel concluded that there was not sufficient evidence of a failure to communicate adequately.

3. Between July 2020 and December 2020, you failed to maintain clear, accurate and up to date case records at Cheshire East Council in relation to those service users set out in Schedule B.

Schedule B

- (a) Service User 2;
- (b) Service User 3;
- (c) Service User 4;
- (d) Service User 5;
- (e) Service User 9;
- (f) Service User 10;
- (g) Service User 11;
- (h) Service User 12;
- (i) Service User 13;
- (j) Service User 14;
- (k) Service User 15;
- (l) Service User 16;
- (m) Service User 17;

(n) Service User 18;

(o) Service User 19;

(p) Service User 20.

FOUND PROVED IN ITS ENTIRETY EXCEPT FOR 3 c) to p), WHICH ARE NOT PROVED

155. With regard to 3a, the panel decided that the records kept by Ms Bradshaw regarding Service User 2 were inadequate and didn't record actions conducted relating to her case. It was clear from the evidence that Ms Bradshaw had met with Service User 2 on 12 November 2020, but she had not recorded this.
156. As for 3b, the panel reviewed the handwritten notes completed by Ms Bradshaw on her notepad on 21 September 2020 and noted that these were not placed on the council IT system in good time and not within 48 hours.
157. With regard to 3c, the panel did not consider that it had been provided with evidence to demonstrate this failing.
158. The panel considered 3d, and decided that although there were no notes recorded by Ms Bradshaw regarding contacting Service User 5 this may have been due to her failing to carry out the directions of TF. If Ms Bradshaw did not complete a task it was unlikely that there would be a record of that.
159. With regard to 3e to 3p the panel found that there was no specific evidence of matters not being recorded regarding Service Users 9 to 20. Whilst it is evident that there was a lack of detailed case records for the cases in question, the substantive allegation already found proved was that Ms Bradshaw had failed to undertake the necessary actions to safeguard service users. This being the case, the panel took the view that Ms Bradshaw could not record notes for tasks that she had not undertaken.

4. Between 27 October 2020 and 8 December 2020, you practised as a Grade 9 Registered Mental Health Social Worker at Cheshire East Council whilst suspended from the Social Work England register.

FOUND PROVED

160. The panel had been provided with evidence that Ms Bradshaw was suspended from her practice on 27 October 2020. TF confirmed that Ms Bradshaw was employed by the Council from 27 July 2020 and continued to practice until 8 December 2020 when Ms Bradshaw informed her that she had been suspended.

5. Your conduct in respect of Allegation 4 was dishonest.

FOUND PROVED

161. The panel noted the evidence of JR who produced a telephone attendance note dated 21 October 2020 detailing a conversation between RM, a Hearing Support Officer at Social Work England and Ms Bradshaw. This confirmed that Ms Bradshaw knew about the fitness to practise hearing that was due to take place on 27 October 2020. The panel also

took account of the evidence of GJ, which showed that Ms Bradshaw had been communicating with Social Work England in the weeks leading up to the hearing on 27 October 2020. The panel also noted the letter produced by GJ, which was sent to Ms Bradshaw on 27 October 2020 providing the outcome of the hearing and that she had been suspended from her practice.

162. The panel decided that it was clear that Ms Bradshaw knew she had been suspended from her practice on 27 October 2020. The panel decided that as she continued to practise as a social worker despite being suspended and did not inform her employer of her suspension Ms Bradshaw had been dishonest. Furthermore, the panel concluded that any member of the public being aware of the facts of this case would conclude that Ms Bradshaw had acted dishonestly.

Finding and reasons on grounds:

163. Ms Michaels reminded the panel that whether the facts found proved amount to misconduct is a matter of judgement for the adjudicators, rather than a matter of proof. Ms Michaels referred the panel to the case of *Roylance v General Medical Council (No 2)* and that misconduct was defined as *“a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.” “[T]he 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.”*
164. Ms Michaels submitted that Ms Bradshaw was in breach of Social Work England’s Professional Standards 2019 (the standards) and Ms Michaels referred the panel to those standards, in particular the requirement to;
- 2.1: Be open, honest, reliable and fair.
 - 2.5: Actively listen to understand people, using a range of appropriate communication methods to build relationships.
 - 3.2: use information from a range of appropriate sources, including supervision, to inform assessments, to analyse risk and to make a professional decision.
 - 3.11: Maintain clear, accurate, legible and up to date records, documenting how I arrive at my decisions.
 - 3.10: Establish and maintain skills in information and communication technology and adapt my practice to new ways of working, as appropriate.
 - 3.12: use my assessment skills to respond quickly to dangerous situations and take any necessary protective action.
 - 5.2: behave in a way that would bring into question my suitability to work as a social worker.
 - 6.6: Declare to the appropriate authority and Social Work England anything that might affect my ability to do my job competently or may affect my fitness to practise, or if I am

subject to criminal proceedings or a regulatory finding is made against me, anywhere in the world.

6.7: Cooperate with any investigations by my employer, Social Work England, or another agency, into my fitness to practise or the fitness to practise of others.

165. Ms Michaels referred the panel to the objectives of Social Work England and the three parts of public protection, namely protecting the public from harm, maintaining public confidence, and declaring and upholding professional standards. Ms Michaels submitted that Ms Bradshaw was in breach of all three of these parts.
166. Ms Michaels submitted that Ms Bradshaw was an experienced social worker, but she did not carry out the work that she should have. There had been a real risk of harm or serious harm to vulnerable service users by Ms Bradshaw's action or inaction.
167. Ms Michaels submitted that there had been a clear breach of the standards by Ms Bradshaw continuing to work after she was suspended from her practice. Ms Bradshaw had been dishonest and it would be very difficult for her to demonstrate remediation and ensure that there was trust in the profession.
168. Ms Michaels referred the panel to the cases of *PSA v GMC and Battah [2022] 6 WLUK 139* and *GMC v Danadio [2021] EWHC 562 (Admin)*. Ms Michaels submitted that a deliberate and knowing breach of an order imposed by a regulator was an extremely serious matter and impacted on all three limbs of public protection.
169. The panel heard and accepted legal advice from the legal adviser on the issue of misconduct. The panel was reminded that it should at all times have in mind the overriding objective of Social Work England, which includes its duty to protect the public, promote and maintain public confidence in social workers in England and to promote and maintain proper professional standards for social workers in England.
170. The panel was referred to *R(on the application of Remedy UK Limited) v GMC [2010] EWHC 1245 (Admin)* and that misconduct is of two principal kinds. First it may involve sufficiently serious misconduct in the exercise of professional practice such that it can properly be described as misconduct going to fitness to practise. Secondly, it can involve conduct of a morally culpable or otherwise disgraceful kind, which may, and often will occur, out-with the course of professional practice itself, but which brings disgrace upon the registrant and thereby prejudices the reputation of the profession.
171. The panel considered the nature of the alleged misconduct and the standards that Ms Michaels had referred to. The panel concluded that regarding the failure to safeguard service users the following standards were engaged:
 - 3.2: use information from a range of appropriate sources, including supervision, to inform assessments, to analyse risk and to make a professional decision.
 - 3.12: use my assessment skills to respond quickly to dangerous situations and take any necessary protective action.

172. With regard to the failure to maintain accurate records the following standard was engaged:
- 3.11: Maintain clear, accurate, legible and up to date records, documenting how I arrive at my decisions.
173. With regard to the finding of dishonesty the following standards were engaged:
- 2.1: Be open, honest, reliable and fair.
- 5.2: behave in a way that would bring into question my suitability to work as a social worker.
- 6.6: Declare to the appropriate authority and Social Work England anything that might affect my ability to do my job competently or may affect my fitness to practise, or if I am subject to criminal proceedings or a regulatory finding is made against me, anywhere in the world.
174. The panel decided that the conduct of Ms Bradshaw in relation to the proven facts in charge 1 did amount to serious professional misconduct.
175. Ms Bradshaw was an experienced social worker. She had demonstrated a significant lack of action and had failed to demonstrate a basic level of competence when performing duties that were an inherent part of her practice. The panel determined that it was a fundamental duty of a social worker to protect vulnerable service users from a risk of harm. Ms Bradshaw had failed to take any action to protect and mitigate the risk identified for a number of service users over several months.
176. The panel considered that there may be a degree of mitigation in that some management direction and oversight was lacking, but there was no evidence of Ms Bradshaw raising concerns with TF about the tasks she had been allocated to complete.
177. With regard to charges 3a and 3b the panel decided that the facts proven did not amount to serious professional misconduct. Whilst the shortfalls in record keeping identified in two cases were below the standard expected of a social worker, the panel considered that these two isolated cases were not so far below the standard required as to amount to misconduct. The panel decided that the threshold had not been met for it to conclude a finding of serious professional misconduct. The panel considered that such conduct could have been addressed at a local level.
178. The panel decided that the conduct arising from the proven facts in charges 4 and 5 did amount to serious professional misconduct. It was clear that Ms Bradshaw should not have been working when she was suspended. Ms Bradshaw had chosen to defy the regulator. The panel found it hard to consider a more blatant course of action than that demonstrated by Ms Bradshaw when she chose to not inform her employer of the outcome of the hearing on 27 October 2020 and to continue working as a social worker when she knew that she had been suspended.

Finding and reasons on current impairment:

179. Ms Michaels addressed the panel on the issue of impairment. Ms Michaels submitted that the panel should look forward as well as considering Ms Bradshaw's past actions. The panel should consider public protection and if Ms Bradshaw's conduct was remediable.
180. Ms Michaels reminded the panel about the email sent by Ms Bradshaw to Social Work England on 29 March 2021 in which she said: *"I no longer wish to practice as a social worker and will not be wanting to re-register with Social Work England. This system is a farce and I find it totally unacceptable the way I have been accused and investigated, I have never been shown any evidence of this allegation and quite frankly do not want to waste any more of my precious time in a profession that hangs draws and quarters without solid proof, evidence or investigation. Social Work England and also HCPC previously are pointless organisations and have done nothing to support or enhance Social Workers in their role and equally in times of need and stress. Will you totally remove my details from Social Work England register."*
181. Ms Michaels submitted that Ms Bradshaw had not engaged with the investigation and hearing process and had not addressed the concerns that had been raised. Ms Michaels submitted that there was no evidence that Ms Bradshaw had considered the concerns and the impact on very vulnerable service users. Further, Ms Bradshaw had not reflected on how her actions may have affected the standing and reputation of the profession.
182. Ms Michael submitted that it was very difficult to remediate dishonesty. The panel had found the allegation of dishonesty proved contrary to Ms Bradshaw denying knowledge of the interim order, which had resulted in her suspension from her practice in October 2020. Ms Michaels submitted that Ms Bradshaw had attempted to deflect blame and there was a risk of repetition. Ms Michaels submitted that Ms Bradshaw's practice was currently impaired as she had departed from the standards expected of her and she had placed service users at risk.
183. The panel heard and accepted the advice of the legal adviser in relation to impairment. The panel was referred to the personal and public elements of impairment and the cases of *Cohen v GMC [2008] EWHC 581 (Admin)* and *Yeong v GMC [2009] EWHC 1923(Admin)* and *CHRE v NMC & Grant [2011] EWHC 927 (Admin)*.
184. The panel was also referred to the four tests identified by Dame Janet Smith in her 5th Shipman Report and cited in *CHRE v (1) NMC and (2) Grant*. The panel was advised to consider whether:
 - a- The social worker has in the past and/or is liable in the future to place service users at unwarranted risk of harm.
 - b- The social worker has in the past brought and/or is liable in the future to bring the profession into disrepute.

c- The social worker has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the profession.

d- Has the social worker in the past acted dishonestly and/or is liable to act dishonestly in the future.

185. When considering the question of impairment, the panel took into account Social Work England's 'Impairment and sanctions guidance'.
186. The panel determined that Ms Bradshaw had in the past, and is liable in the future, to place service users at risk of harm. Ms Bradshaw had failed to observe the basic tenets of the social work profession and had been dishonest.
187. The panel considered whether or not Ms Bradshaw's conduct was remediable. The panel acknowledged that the shortfalls in her practice could be remediated with training, support and supervision. However, the act of dishonesty would be challenging to remediate as it reflected adversely on the behaviour of Ms Bradshaw. In any event the panel found that there was no evidence of remediation.
188. Ms Bradshaw had provided no input regarding this issue that would evidence that she had properly reflected and fully understood the seriousness of her misconduct. She had demonstrated no remorse for her behaviour. Ms Bradshaw had not taken any responsibility for her actions and she had not taken ownership of her conduct.
189. The panel referred to Ms Bradshaw's email dated 29 March 2021 to Social Work England and took the view that she was in denial. It was clear that she knew that she had been dishonest, but chose to ignore this and instead criticised the regulator. The panel decided that, but for the intervention of the agency by conducting routine checks, Ms Bradshaw would have almost certainly continued to practise as a social worker despite being suspended.
190. The panel considered that there was a considerable risk of Ms Bradshaw repeating the behaviour and misconduct that the panel had found proved.
191. The panel decided that Ms Bradshaw's practice is currently impaired. Further, the panel when considering the wider public interest decided that a finding of impairment was necessary to maintain public confidence and to uphold the standards of the profession.

Decision and reasons on sanction:

192. The panel heard submissions from Ms Michaels who submitted that in all of the circumstances of this case a removal order was the most appropriate sanction to be made by the panel.
193. Ms Michaels submitted that there were limited mitigating factors in this case, namely that the panel had found that there could have been greater management oversight, but this was countered by Ms Bradshaw failing to raise any concerns regarding her workload.

194. Ms Michaels referred the panel to a variety of aggravating factors. Ms Michaels submitted that Ms Bradshaw's conduct breached the basic tenets of social work and she was an experienced social worker. There had been repeated failings by Ms Bradshaw regarding the support she should have provided to multiple vulnerable service users. Ms Bradshaw had exposed those service users to a serious risk of harm by her action or inaction. Ms Michaels submitted that Ms Bradshaw's dishonesty was a significant factor in placing any sanction at the highest level.
195. Ms Michaels reminded the panel that Ms Bradshaw had not engaged with the regulator. She had failed to demonstrate any insight, remediation or remorse.
196. With regard to the sanctions available to the panel Ms Michaels submitted that taking no action was not appropriate given the nature of the concerns and the findings of the panel. The allegations were serious and exposed others to the risk of harm. Ms Michaels submitted that for these reasons advice or a warning were not appropriate, in particular when considering the risk to the public, the lack of insight or remediation.
197. Ms Michaels then referred the panel to the sanction of conditions. She submitted that conditions were less appropriate when considering the character and attitudinal failings of Ms Bradshaw. The panel should also consider the wider public interest. Ms Michaels submitted that Ms Bradshaw had demonstrated no remorse or insight.
198. Ms Michaels submitted that conditions would not be appropriate in the current case and it would not be possible to formulate workable conditions in light of the risk of repetition and harm posed by Ms Bradshaw to the public.
199. Ms Michaels reminded the panel that Ms Bradshaw had continued to work when suspended from her practice and she had been dishonest. Ms Michaels submitted that this made conditions less appropriate due to Ms Bradshaw's attitudinal failings. Ms Michaels submitted that an informed member of the public would be concerned if conditions were imposed.
200. Ms Michaels then addressed the panel on the sanction of a suspension order. Ms Bradshaw had failed to demonstrate insight, remediation or remorse. Ms Michaels submitted that dishonesty was hard to remediate. Ms Bradshaw had failed to be transparent and had disregarded the regulator. Ms Michaels submitted that Ms Bradshaw's misconduct had been knowing and deliberate. There had been a complete lack of candour. Ms Michaels submitted that in light of this Ms Bradshaw would not respond positively to being suspended from her practice.
201. Ms Michaels reminded the panel of the principles described in *General Medical Council v Donadio [2021] EWHC 562 (Admin)* that where a tribunal is assessing gravity in a case involving a 'knowing regulatory breach' by a registrant, it should consider both the dishonesty and the fact and effect of the regulatory breach, in its own right. A regulatory breach of an order imposed directly and personally on a registrant adds to the gravity of the breach and goes directly to the overarching objective of the protection of the public.

202. Ms Michaels submitted that a removal order was the most appropriate sanction in this case. No other outcome would protect the public sufficiently. Ms Bradshaw had been intentionally dishonest and had deliberately ignored the suspension order that had been put in place on 27 October 2020 and she had continued to practise. Ms Michaels submitted that a clear message needed to be sent to the profession and the public that this behaviour was unacceptable.
203. The panel heard and accepted the advice of the legal adviser with regard to sanction. The panel should consider that the imposition of a sanction is primarily to protect the public, not to punish Ms Bradshaw, although a sanction may have a punitive effect.
204. The panel should consider what sanctions are available and refer to Social Work England's "Sanctions Guidance". The panel must start from the least restrictive sanction. Insight and remediation are important factors. The panel should also identify any aggravating and mitigating factors in the case when deliberating on sanction.
205. When considering the question of sanction, the panel took into account Social Work England's 'Impairment and sanctions guidance'.
206. The panel applied the principle of proportionality by weighing Ms Bradshaw's interests with the public interest and by considering each available sanction in ascending order of severity. The panel considered the mitigating and aggravating factors in determining what sanction, if any, to impose.
207. The panel identified one mitigating factor in the context of failing to safeguard, in that management oversight of Ms Bradshaw's practice was on occasion lacking. However, this was tempered by Ms Bradshaw failing to raise concerns regarding her work-load with her team leader.
208. The panel identified several aggravating factors in this case. Ms Bradshaw's misconduct was repeated over a period of time. It related to multiple vulnerable service users and placed them at the risk of serious harm. The panel was clear that but for the checks by Ms Bradshaw's agency she would have almost certainly carried on practising for longer.
209. Ms Bradshaw had been dishonest by failing to inform her employer that she had been suspended from her practice, but had also deliberately disobeyed the order of her regulator suspending her. The panel noted from Social Work England's "Guidance for Suspended Social Workers" that it is illegal to practice as a social worker when suspended and Ms Bradshaw had deliberately continued to practise.

No action, warning or advice

210. The panel decided that none of these options were appropriate, noting the seriousness of Ms Bradshaw's misconduct and the requirement to protect the public, which would not be achieved by taking no action or giving Ms Bradshaw a warning or advice.

Conditions

- 211. The panel decided that in light of Ms Bradshaw's demonstrated dishonesty it could not identify any workable conditions, which would be able to address the risk that Ms Bradshaw posed to service users given her behaviour and attitudes as demonstrated by her misconduct.
- 212. Ms Bradshaw's misconduct was so very serious that conditions would not ensure public confidence in the social work profession. The panel considered that there was no evidence that Ms Bradshaw would comply with any conditions given her failure to adhere to basic social work principles. Ms Bradshaw had failed to demonstrate insight, reflection, remediation or a willingness to engage and improve.

Suspension

- 213. The panel then considered whether or not a suspension order would be appropriate. The panel was mindful of the objectives of Social Work England and the three elements of public protection, namely protecting the public from harm, maintaining public confidence, and declaring and upholding professional standards. The panel also considered the continuing risk posed by Ms Bradshaw to service users and her lack of engagement with these proceedings.
- 214. The panel took account of the email sent by Ms Bradshaw on 29 March 2021 to Social Work England when she stated *"I no longer wish to practice as a social worker and will not be wanting to re-register with Social Work England..... Will you totally remove my details from Social Work England register."*
- 215. The panel decided that due to the very serious nature of Ms Bradshaw's misconduct, as well as her lack of engagement, combined with no evidence of remediation or insight, that a suspension order could not be made. A suspension order was not sufficient to protect the public, public confidence in the profession, nor to reflect the public interest in declaring and upholding proper standards of conduct and behaviour.

Removal Order

- 216. The panel, having concluded that a suspension order would not protect the public nor meet the wider public interest, decided that the proportionate order was a removal order.
- 217. The panel took into account the Impairment and Sanctions Guidance which states that *"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."*
- 218. The panel also noted that a removal order may be appropriate in cases involving dishonesty, a persistent lack of insight into the seriousness of a social worker's actions or

consequences and “social workers who are unwilling and/or unable to remediate (for example, where there is clear evidence that they do not wish to practise as a social worker in the future)”

219. The panel considered that a removal order is a sanction of last resort and should be reserved for those categories of cases where there is no other means of protecting the public and the wider public interest. The panel decided that Ms Bradshaw’s case falls into this category because of the nature and gravity of her misconduct and the ongoing risk of repetition.
220. The panel concluded that Ms Bradshaw’s current impairment and continuing risk to service users required that she should be removed from the register to protect the public from harm. The panel was satisfied that any lesser sanction would also undermine public trust and confidence in the profession and would be wholly insufficient to maintain professional standards.
221. In reaching this conclusion the panel balanced the public interest against Ms Bradshaw’s interests. The panel took into account the consequential personal and professional impact a removal order may have upon Ms Bradshaw, but concluded that these considerations were significantly outweighed by the panel’s duty to give priority to public protection and the wider public interest.

Interim order:

222. In light of its findings on sanction, the panel next considered an application by Ms Michaels for an interim suspension order to cover the appeal period before the final order becomes effective. An interim order would be necessary in accordance with Schedule 2, paragraph 11 (b) of the Social Workers Regulations 2018 to cover the appeal period. Ms Michaels submitted that an interim order was necessary to protect the public in light of the findings made by the panel. Ms Michaels invited the panel to revoke any interim suspension order that had been put in place in preparation for this hearing.
223. The panel heard and accepted the advice of the legal adviser with regard to the imposition of an interim order. The test is that it is necessary for the protection of the public and/or in the best interests of the social worker.
224. The panel considered whether to impose an interim order. It was mindful of its earlier findings and the risk of repetition and decided that it would be wholly incompatible with those earlier findings to permit Ms Bradshaw to practise during the appeal period.
225. Accordingly, the panel concluded that an interim suspension order of 18 months 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 removal shall take effect when the appeal period expires.

The panel revoked any interim suspension order that had been put in place in preparation for this hearing.

Right of appeal:

226. 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.
227. 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.
228. 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.
229. 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:

230. 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
231. 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:

232. 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>.