# Social worker: Christopher Sleight
# Registration number: SW39860
# Fitness to practise: Final hearing

Date of hearing: Monday 19 June 2023 – Friday 23 June 2022

Hearing Venue: Social Work England Remote hearing

Hearing outcome: Removal Order

Interim order: Interim Suspension Order (18 months)

## Introduction and attendees

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

2. Mr Sleight did not attend the hearing and was not represented.

3. Social Work England was represented by Ms Atkin, presenting officer from Capsticks LLP.

| **Adjudicators** | **Role** |
|---|---|
| Kerry McKevitt | Chair |
| Sarah Redmond | Social Worker Adjudicator |
| Moriam Bartlett | Lay Adjudicator |

| | |
|---|---|
| Andrew Brown | Hearings Officer |
| Sam Harvey | Hearing Support Officer |
| Sean Hammond | Legal Adviser |

## Service of Notice:

4. The panel of adjudicators ("the panel") was informed by Ms Atkin that notice of this hearing was sent to Mr Sleight by Royal Mail special delivery to his registered address as it appears on the Social Work England Register. Ms Atkin further informed the panel that notice of this hearing was sent by electronic mail ("email") to the email address provided by Mr Sleight to Social Work England. Ms Atkin submitted that notice of this hearing had been duly served in accordance with the Social Work England (Fitness to Practise) Rules 2019 (as amended) ("the Rules").

5. The panel had careful regard to the documents contained in the final hearing service bundle as follows:

    • A copy of the notice of final hearing dated 4 May 2023 and addressed to Mr Sleight at his address as it appears on the Social Work England Register;

    • An extract from the Social Work England Register showing Mr Sleight's registered address and the email address that he has provided to Social Work England;

    • A copy of a signed Statement of Service, on behalf of Social Work England, confirming that on 4 May 2023 the writer sent the notice of hearing and related

documents by Royal Mail special delivery to Mr Sleight's registered address and to the email address he has provided to Social Work England;

• A copy of the Royal Mail Track and Trace Document indicating "signed for" delivery to Mr Sleight's registered address at 10.39 am on 9 May 2023.

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

7. Having had regard to Rules 14, 15, 44 and 45 of the Rules and to all of the information before it in relation to the service of notice, the panel was satisfied that notice of this hearing had been served on Mr Sleight in accordance with Rules.

## Proceeding in the absence of the social worker:

8. Ms Atkin invited the panel to exercise its discretion to proceed with the hearing in the absence of Mr Sleight.

9. Ms Atkin referred the panel to an email dated 5 August 2022 sent by Mr Sleight to Social Work England, in which he stated:

*"… I would like to make it clear that I do not wish to participate in any hearing."*

10. Ms Atkin also referred the panel to a further sent email by Mr Sleight to Social Work England dated 15 August 2022, in which he stated:

*"On 05/08/22, I replied to the Case Examiner Operations officer, and also to a paralegal, who both previously emailed me about the hearing that I do not wish to participate in it.*

*Perhaps neither of them pass this communication on to anyone such as yourself who might need to be informed.*

*If there is anyone else who needs to know I would be obliged if you would inform them."*

11. Ms Atkin submitted that on 27 January 2023, in response to an email from Social Work England in relation to case management directions, Mr Sleight sent an email to Social Work England in which he stated:

*"…In regard to the proposed time period on which the hearing may be heard, you may set the date for whenever suits you."*

12. Ms Atkin submitted that having regard to the content of the above emails, it was clear that Mr Sleight has waived his right to attend the hearing and has voluntarily absented himself. She submitted that his engagement was limited to agreeing case management directions and that he had not provided any response to the allegations. Ms Atkin submitted that Mr Sleight had not requested an adjournment and that it was extremely unlikely that an adjournment would result in his attendance.

13. Ms Atkin acknowledged that there may be some disadvantage to Mr Sleight if the panel was to proceed in his absence, however, she submitted that this was mitigated by the fact that he had been afforded the opportunity to provide written submissions and evidence. Ms Atkin submitted that the panel also had the responses provided by Mr Sleight during the local investigation of these matters.

14. Ms Atkin submitted that the allegations relate to events that occurred between 2014 and 2019, and that this six-day hearing has been fixed for several months. Ms Atkin therefore invited the panel to proceed in the interests of justice and the expeditious disposal of this hearing.

15. The panel accepted the advice of the legal adviser. This included reference to Rule 43 of the Rules and the cases of R v Jones [2002] UKHL 5 and General Medical Council v Adeogba [2016] EWCA Civ 162. The panel also took into account Social Work England's guidance in relation to 'Service of notices and proceeding in the absence of the social worker'.

16. The panel considered all of the information before it, together with the submissions made by Ms Atkin.

17. The panel was satisfied that Mr Sleight was aware of today's hearing and that it was clear from the emails that he has sent to Social Work England that he does not wish to participate in this process. The panel was therefore satisfied that Mr Sleight has waived his right to attend the hearing and/or be represented and has voluntarily absented himself. The panel noted that there has been no application for an adjournment and in the circumstances, the panel was satisfied that an adjournment was extremely unlikely to result in Mr Sleight's attendance on a future occasion. The panel was mindful that there may be some disadvantage to Mr Sleight if it exercises its discretion to proceed in his absence. However, the panel noted that Mr Sleight has not engaged in this process and has chosen not to provide a response. The panel also took into account that these allegations relate to matters that occurred as long ago as 2014, that this hearing has been fixed for a number of months, and that Social Work England has arranged for the attendance of three witnesses.

18. Having weighed the interests of Mr Sleight in regard to his attendance at the hearing with those of Social Work England and the public interest in an expeditious disposal of this matter, the panel decided that it would be fair to proceed in Mr Sleight's absence in accordance with Rule 43 of the Rules.

## Preliminary matters:

### Clarification of the wording of paragraph 3 of the allegations

19. Ms Atkins referred the panel to the statement of case served on behalf of Social Work England dated 31 March 2023 and updated on 3 May 2023.

20. Ms Atkin informed the panel that the wording of paragraph 3 of the allegation as set out at the beginning of the statement of case was different to that set out in the body of the

statement of case under the sub-heading 'Paragraph 3'. Ms Atkin informed the panel that the wording of paragraph 3 in the body of the statement of case contained the additional words *"in circumstances where you knew it was required".*

21. Ms Atkin submitted that Social Work England's intended to proceed with the hearing today on the basis of the wording as set out in the body of the statement of case.

22. Ms Atkin submitted that this course of action would cause no prejudice or unfairness to Mr Sleight because the inclusion of the words *"in circumstances where you knew it was required"* did not alter the nature or gravity of paragraph 3 of the allegations. She submitted that it had the effect of narrowing paragraph 3 of the allegations by introducing a further element that Social Work England was required to prove.

23. Ms Atkin informed the panel that on 14 June 2023, Social Work England sent a letter to Mr Sleight clarifying its position in relation to paragraph 3 of the allegations, but Mr Sleight had not responded to the letter.

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

25. The panel was satisfied that the discrepancy in the wording of paragraph 3 allegations contained within Social Work England's statement of case does not cause any prejudice to Mr Sleight. The panel accepted Ms Atkin's submission that the additional words *"in circumstances where you knew it was required"* to paragraph 3 of the allegations had the effect of introducing a further factual element that Social Work England was required to prove. The Panel was satisfied that it did not alter the seriousness or scope of the allegations against Mr Sleight. The panel was further satisfied that when considered as a whole, the statement of case makes it clear how Social Work England puts its case in relation to paragraph 3 of the allegations and the evidence it relies upon. The panel noted that Social Work England sent a letter to Mr Sleight on 14 June 2023 clarifying its position and that Mr Sleight has not raised any objection.

26. The panel therefore decided that it would be fair to allow Social Work England to proceed on the basis that the wording of paragraph 3 of the allegation is as follows:

> *"Your actions at 1.2.2 and/or 1.5 above were dishonest, in that you chose not to make a safeguarding referral and/or sought to prevent a safeguarding referral being made in circumstances where you knew it was required, in an attempt to avoid scrutiny of your practice"*

Application to admit hearsay evidence

27. Ms Atkins made an application to admit the account provided by Ms Vicky Fovargue within an investigation interview with Ms Nicola Fawcett on 7 May 2019 as hearsay. Ms Atkin informed the panel that Ms Fovargue was approached to provide a witness statement in September 2022 but that she felt unable to provide a statement due to health issues.

28. Ms Atkin submitted that Mr Sleight was put on notice of the application to admit Ms Fovargue's account as hearsay in a letter dated 3 April 2023. In that letter, Mr Sleight was asked to indicate whether he had any objection to the application by 2 May 2023. Ms Atkin submitted that to date, no response has been received from Mr Sleight.

29. Ms Atkin referred the panel to the written application to admit Ms Fovargue's account as hearsay contained with Social Work England's statement of case. Ms Atkin adopted the following written submissions:

> *"…Social Work England consider that it is fair in all the circumstances to admit her evidence as hearsay, taking into account in particular that:-*
>
> *i. Ms Fovargue's evidence is not sole and decisive in respect of any of the matters in dispute;*
>
> *ii. Ms Fovargue provided her account during a formal investigation interview, in close proximity to the alleged events;*
>
> *iii. Ms Fawcett, who interviewed Ms Fovargue, is attending to give evidence and can answer questions about the circumstances in which her account was obtained;*
>
> *iv. Ms Fovargue produced contemporaneous notes to support the account she gave in interview, including a note of a discussion between herself and the Social Worker which was independently minuted on 10 April 2019 (Exhibit NF/8);*
>
> *v. Whilst the Social Worker denied that he was trying to prevent a safeguarding referral being made, he accepted during his investigation interview on 24 May 2019 that he had expressed an awareness that it could lead to some review of his performance, and had raised this potential implication with Service User A, which is consistent with Ms Fovargue's account.*

30. The panel accepted the advice of the legal adviser who referred it to rule 32(b)(vii) and to the guidance provided in relation to the admissibility of hearsay in the following cases: Thorneycroft v NMC [2014] EWHC 1565 (Admin) and El Karout v NMC [2019] EWHC 28 (Admin).

31. The panel noted that rule 32(b)(viii) provides:

> *"IIn particular, and without prejudice to any other provision in the regulations, Schedules or Rules, the adjudicators or the regulator may:*
>
> *(vii) admit evidence where they consider it fair to do so, whether or not such evidence would be admissible before the courts."*

32. In reaching its decision, the panel therefore considered whether it would be fair to admit Ms Fovargue's account as hearsay evidence. The panel carefully considered the judgements in the cases of Thorneycroft and El Karout and applied the following principles when considering this application:

*1.1. The admission of the statement of an absent witness should not be regarded as a routine matter. The FTP rules require the Panel to consider the issue of fairness before admitting the evidence.*

*1.2. The fact that the absence of the witness can be reflected in the weight to be attached to their evidence is a factor to weigh in the balance, but it will not always be a sufficient answer to the objection to admissibility.*

*1.3. The existence or otherwise of a good and cogent reason for the non-attendance of the witness is an important factor. However, the absence of a good reason does not automatically result in the exclusion of the evidence.*

*1.4. Where such evidence is the sole or decisive evidence in relation to the charges, the decision whether or not to admit it requires the Panel to make a careful assessment, weighing up the competing factors. To do so, the Panel must consider the issues in the case, the other evidence which is to be called and the potential consequences of admitting the evidence. The Panel must be satisfied either that the evidence is demonstrably reliable, or alternatively that there will be some means of testing its reliability."*

33. The panel therefore acknowledged that it should not admit the proposed hearsay evidence as a matter of routine and that it must carefully consider whether it would be fair for it to be admitted.

34. The panel first considered the form of the proposed hearsay evidence. It noted that the evidence was not in a formal witness statement from Ms Forvargue, but was contained in a record of what Ms Forvargue said to Ms Fawcett during a fact- finding investigation meeting held on 7 May 2019. The panel further noted that 17 May 2019, Ms Forvargue had signed a declaration confirming that the record was an accurate reflection of what was said at the meeting. The panel was satisfied that Ms Forvargue provided her account to Ms Fawcett during a formal investigation process shortly after the events in question, and that she had produced contemporaneous notes to support her account. The panel noted that Ms Forvargue was a professional, employed as a manager of a residential unit. The panel was satisfied that there was no evidence to suggest that she might have a motive to fabricate her account.

35. The panel next considered the reasons put forward for the non-attendance of Ms Forvargue at this hearing. The panel was satisfied that Ms Frorvargue's adverse health amounted to a good and cogent reason for her non-attendance.

36. The panel next considered whether the hearsay evidence was the sole or decisive evidence. The panel was satisfied that there was evidence from multiple sources and therefore Ms Forvargue's account was not the sole or decisive evidence in respect of any of the allegations.

37. The panel considered the issues in the case and the nature and extent of Mr Sleight's challenge to Ms Forvargue's evidence. The panel noted that Mr Sleight has not provided

a response to the allegations and that he has not objected to the admission of Ms Forvargue's account as hearsay evidence.

38. The panel next considered the other available evidence. It noted that Ms Fawcett was due to give evidence at the hearing and that therefore the panel would have the opportunity of asking her about the investigation meeting with Ms Forvargue on 7 May 2019.

39. Having regard to all of the above matters, the panel decided that it would be fair and in the interests of justice to admit the hearsay evidence of Ms Forvargue during this hearing. It would then be for the panel to determine what weight, if any, should be placed upon it.

## Allegations:

40. The allegations arising out of the regulatory concerns referred to a Final Hearing by the Case Examiners on 6 July 2022 are as follows:

*While registered as a social worker in the period between 2014 and 2019*

1. *You failed to take appropriate and/or timely action to safeguard Service User A in that:*

*1.1 you did not report to the police and/or make a safeguarding referral, in response to Service User A disclosing in or around February 2014 that he may have been raped*

*1.2 you did not make a safeguarding referral in response to concerns being raised with you about staff at Residence 1;*

*1.2.1 at any point between 2015 and 2018, despite Service User A raising such concerns with you on more than one occasion;*

*1.2.2 in early April 2019*

*1.3 you did not make a safeguarding referral in response to concerns being raised with you about Service User A providing care to other residents at Residence 1*

*1.4 you did not make a safeguarding referral in respect of one or more incidents involving Service User T and/or did not complete a capacity assessment in respect of his relationship with Service User T*

*1.5 following Service User A repeating, in early April 2019, one or more of the concerns he had previously raised with you, you suggested to his new Care Co-ordinator that a safeguarding referral was not appropriate*

2. *You did not take appropriate safeguarding actions following concerns being raised about Service User A's behaviour towards Service User Z in or around July 2018.*

*3. Your actions at 1.2.2 and/or 1.5 above were dishonest, in that you chose not to make a safeguarding referral and/or sought to prevent a safeguarding referral being made in circumstances where you knew it was required, in an attempt to avoid scrutiny of your practice*

*Your conduct at paragraphs 1 and /or 2 and/or 3 above amount to the statutory ground of misconduct.*

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

## Background:

41. On 28 October 2019, the Health and Care Professions Council ("HCPC"), received a referral from Cambridgeshire County Council ("the Council") regarding Mr Sleight.

42. At the time when concerns regarding Mr Sleight's conduct came to light, he was employed by the Council as a Senior Social Worker within the Fenland Adult Mental Health Team. Mr Sleight had been employed in this role since 15 December 2003.

43. Mr Sleight was allocated to work with Service User A from 2013 as his Care Co-ordinator. Service User A was at the time being managed under the 'Care Programme Approach' Framework, which is a framework used to co-ordinate the treatment, care and support of people with complex care needs. Service User A was living at Residence 1, which was a specialist treatment facility for vulnerable service users who have been diagnosed with a learning disability and/or complex mental health needs.

44. On 25 March 2019, Service User A moved from Residence 1 to Residence 2. As a result, the Care Co-ordinator role was due to be transferred from Mr Sleight to Ms Clare Saunders, given that Residence 2 fell outside of the Social Worker's team catchment area.

45. Following his relocation to Residence 2, in early April 2019 Service User A raised concerns with Ms Vicky Fovargue, the manager of Residence 2. Ms Forvargue contacted Mr Sleight on 9 April 2019 to report these concerns, noting that Service User A had stated that he had raised these matters with Mr Sleight previously but felt that he had not been believed. On the same day, Mr Sleight spoke to Ms Saunders (Service User A's new Care Co-ordinator), who alleges that Mr Sleight queried whether a safeguarding referral was appropriate.

46. On 10 April 2019, Mr Sleight discussed Service User A's concerns with his manager, Ms Karen Reeve, who confirmed that a safeguarding referral was required. This was not completed by Mr Sleight however, and on 16 April 2019 the referral was made by Ms

Rebecca Schmitz, who was the line manager of Service User A's new Care Co-ordinator, Ms Saunders.

47. Mr Sleight was subsequently suspended from his role pending a Disciplinary Investigation by the Council. The investigation was undertaken by Ms Nicola Fawcett and considered allegations that Mr Sleight had failed to deal appropriately with safeguarding concerns raised in respect of Service User A, and that he had attempted to prevent a safeguarding referral being made when Service User A raised concerns with the Manager of Residence 2 in April 2019.

## Summary of Evidence:

48. Prior to the commencement of the hearing, the panel were provided with and considered the following:

- Statement of Case (27 pages);
- Witness Statement Bundle (77 pages);
- Exhibit Bundle (920 pages);
- Social Worker's Response Bundle (containing copies of emails received by Social Work England from Mr Sleight) (11 pages);
- Service and Supplementary Bundle (40 pages);
- Identification Key; and
- Hearing Timetable.

49. Ms Atkin called three witnesses to give oral evidence to the panel, namely:

- Ms Nicola Fawcett, Senior Social Worker at Cambridgeshire County Council;
- Ms Karen Reeve, Social Work Manager with Cambridgeshire and Peterborough Foundation Trust; and
- Ms Clare Saunders, Community Psychiatric Nurse with Cambridgeshire and Peterborough Foundation Trust.

50. During their oral evidence to the panel, each of these witnesses adopted the content of their witness statements made during Social Work England's investigation. In addition, each witness was asked some questions by Ms Atkin and by the panel to clarify parts of their evidence.

## Findings and reasons on facts:

51. The panel was aware that the burden of proving the facts was on Social Work England. The allegations could only be found proved if the panel was satisfied on the balance of probabilities.

52. In reaching its decision the panel took into account the oral testimony of the witnesses who gave evidence and the content of all of the documentary evidence contained in the witness statement and exhibit bundles. In the absence of Mr Sleight, the panel was careful to consider the responses provided by him during the local investigation in relation to these matters.

53. The panel had regard to the oral submissions made by Ms Atkin and to the written submissions made by Social Work England contained within the statement of case.

54. The panel accepted the advice of the legal adviser and had regard to the guidance published by Social Work England.

Paragraph 1 of the allegation

55. The panel noted that the stem of paragraph 1 of the allegation states:

> *"You failed to take appropriate and/or timely action to safeguard Service User A in that:…"*

56. The panel therefore first considered whether Mr Sleight was under a duty to safeguard Service User A and then, what the appropriate and timely action would be if a safeguarding concern arose.

57. The panel noted that Mr Sleight had been employed by the Council in a Senior Social Worker role since 15 December 2003. The panel accepted the evidence of Ms Fawcett that Mr Mr Sleight was required to follow the Adult Safeguarding Policy Practice Guidance Procedure (Cambridgeshire and Peterborough NHS Foundation Trust). A copy of this procedure was exhibited by Ms Fawcett. The panel noted that the Procedure confirms that *"all staff have a duty and responsibility to be aware of the policy, be observant for instances and/or signs of abuse, and to recognise, record and refer instances of suspected abuse"*. The panel noted that abuse is defined as *"a violation of an individual's human and civil rights by any other person or persons*", and that examples of acts which may constitute abuse are set out. In her witness statement, Ms Fawcett stated that *"all social workers would be expected to report safeguarding concerns"* and during her oral evidence to the panel she confirmed the importance of safeguarding and stated that priority should be given to safeguarding whatever the circumstances.

58. The panel noted that in her witness statement, Ms Fawcett stated that *"the process was that a safeguarding referral form was completed and sent to the team manager who would allocate it to a Safeguarding Lead."*

59. The panel further noted that the Adult Safeguarding Policy Practice Guidance Procedure (Cambridgeshire and Peterborough NHS Foundation Trust) which incorporated the multi-agency safeguarding adults procedures of Peterborough and Cambridgeshire Safeguarding Adults Board, that sets out that an initial referral should be made *"immediately on the same day"* and that alert details should be sent to the team *"within 24 hours".*

60. The panel was therefore satisfied that the Adult Safeguarding Policy Practice Guidance Procedure (Cambridgeshire and Peterborough NHS Foundation Trust) clearly sets out what action should be taken in relation to a safeguarding concern and the appropriate timeframe for that action to be taken.

61. In her witness statement, Ms Fawcett stated that Mr Sleight was allocated to work with Service User A from 2013 as his Care Co-ordinator. Service User A was a vulnerable young adult being managed under the 'Care Programme Approach' Framework, which is a framework used to co-ordinate the treatment, care and support of people with complex care needs.

62. The panel was therefore satisfied that in this role, Mr Sleight was under a duty to safeguard Service User A. The panel was also satisfied that as an experienced social worker, Mr Sleight was aware of this fundamental responsibility. In the panel's view, safeguarding is a fundamental tenet of the social work profession.

Paragraph 1.1 of the allegation 1 (Proved)

63. The panel noted that Ms Fawcett and Ms Reeve exhibit the case note made by Mr Sleight in relation to Service User A. In an entry dated 28 January 2014, Mr Sleight recorded that Service User A had disclosed to him that he had been raped. A subsequent entry details Mr Sleight's plan to visit Service User A on 3 February 2014 to discuss *"the rape issue".* In the panel's view, Mr Sleight's choice of phrase suggests that he may have been diminishing the importance of the disclosure made by Service User A. The panel noted that on 3 February 2014, Mr Sleight recorded the following summary of Service User A's account of the rape allegation"

> *"I asked him about the details again. He was with a group of mates in a club, in Wisbech. He knew some of the friends, not others. He got drunk. He does not remember what happened after that but he woke up late night on the floor of the bathroom of one of the guys; he was naked; and there was something hanging out of his backside, a bit like a pile. It was this, plus a sensation of pain, that made him think he might have been raped. He thought it might be one particular guy, because he*

*thinks he was gay. I reflected that being gay does not make a person likely to commit rape; was there anything else that made him think it was that person. No.*

*There were other friends there. He did not ask them what happened, and they did not say anything to him. He did not go to his GP at the time. The thing in his backside healed.*

*He told his dad.*

*He did not report it to the Police because he did not want the hassle.*

*He has not spoken to these friends since."*

64. The panel noted that Mr Sleight had also recorded that he discussed the allegation with Service User A who *"reflected that he is not sure what happened; he cannot remember very well; he did not discuss it with anyone".* Mr Sleight recorded that *"it is a very vague account"* and that he *"did not think that the Police would feel there is enough evidence on which to base any action".* The note goes on to indicate that Mr Sleight discussed *"safeguarding"* with Service User A, but concluded that he did not need to consider a safeguarding plan because Service User A no longer saw these friends and so was not at risk from them. The panel further noted that during the local disciplinary investigation, Mr Sleight stood by his judgement in not making a safeguarding referral in respect of the alleged rape.

65. In the panel's view, the disclosure made by Service User A was extremely serious.

66. The panel accepted the evidence of Ms Fawcett who stated in her witness statement that Mr Sleight "*should have taken safeguarding action in response to this disclosure"* and that a safeguarding referral was required, and that "*regardless of whether the police would investigate the disclosure, the Social Worker should have demonstrated to Service User A that the disclosure was being taken seriously*".

67. The Panel also accepted the evidence of Ms Reeve who stated in her witness statement that:

*"all crimes should be reported to the police"*

*"if there was a crime, it is likely there would also be a safeguarding issue that needed to be raised."*

*"I would have expected a safeguarding concern to be raised in this instance; the Service User was vulnerable".*

68. Having regard to the above, the panel was satisfied on the balance of probabilities that following the disclosure made by Service User A in or around February 2014 that he may have been raped, Mr Sleight failed to take appropriate and/or timely action to safeguard

Service User A in that he did not report the matter to the police and he did not make a safeguarding referral.

69. The Panel therefore found paragraph 1.1 of the allegation proved.

Paragraph 1.2.1 of the allegation (Proved)

70. The panel accepted the evidence provided by Ms Fawcett in her witness statement where she has identified several instances in Service User A's case notes where Service User A has raised concerns about staff at Residence 1 between 2015 and 2018. The panel noted that these included staff calling Service User A *"a loser", "smelly" and "tubby"*, and that staff members:

- Had said to Service User A *'What fucking time is this? I've been waiting 10 minutes";*
- Had suggested that Service User A should walk down the road from his volunteering placement on his own, when this was a country road with no pavement;
- Had told Service User A he couldn't stay up at night, and would have to do the cleaning if he did;
- Had told Service User A that Service User D was the only resident who required care;
- Would not allow service users to watch TV at night in the lounge because staff were watching it;
- Said to Service User A *"get over it, he's had a long life"* with regards to Service User A's granddad dying;

71. The panel noted that in the case note of 27 June 2016, Mr Sleight recorded that Service User A said he was "*being treated like a piece of crap by all the staff*" and that Mr Sleight had recorded that he *"suggested this is a safeguarding issue"* and they *"will need to have a safeguarding meeting".*

72. The panel was satisfied that Mr Sleight recognised that some of these incidents were safeguarding matters.

73. The panel accepted Ms Fawcett's evidence in her witness statement that there is no evidence that Mr Sleight referred any of these matters as safeguarding concerns. The panel also noted Ms Fawcett's evidence that during the local disciplinary investigation, when Mr Sleight was asked why he had not made a safeguarding referral, he cited work pressures.

74. The panel further accepted Ms Fawcett's evidence in her witness statement that:

> *"verbal and psychological abuse from staff is completely unacceptable and has affected Service User A, to the extent that he raised concerns about the incidents"*
>
> *"the verbal and psychological abuse disclosures raised by Service User A warranted a safeguarding referral to be made"*
>
> *"certainly by the time of the later disclosures, this indicated that there had been multiple incidents and this is indicative of a pattern of behaviour"*
>
> *"the lack of safeguarding action may have led to a breakdown of the trust between Service User A and the Social Worker. One of the concerns that Service User A raised with Vicky Fovargue is that he felt that the Social Worker had a tendency to 'side with' Residence 1"*
>
> *"Service User A stated to me during his interview that there was at least on incident he did not tell the Social Worker about (staff taking photos of him on the toilet) because the Social Worker had not 'helped him with the other things"*

75. The panel was satisfied that Mr Sleight should have had regard to the cumulative effect of these incidents upon Service User A and considered whether or not they amounted to a pattern of abusive behaviour by members of staff at Residence 1. In the panel's view, Mr Sleight's failure to take appropriate and timely safeguarding action resulted in Service User A losing confidence in Mr Sleight in his role as his Care Co-ordinator.

76. Having regard to the above, the panel was satisfied on the balance of probabilities that Mr Sleight should have made a safeguarding referral in response to these concerns being raised by Service User A.

77. The panel therefore found paragraph 1.2.1 of the allegation proved.

Paragraph 1.2.2 of the allegation (Proved)

78. The panel accepted the evidence of Ms Saunders who stated in her witness statement that she had received an email from Ms Fovargue stating that Service User A had disclosed to her that he was struggling with psychological abuse he had endured at Residence 1 and that he had discussed this with Mr Sleight but did not feel supported or believed. The panel noted that Ms Saunders exhibited a case note she completed on 9 April 2019. The case note refers to a discussion between Ms Saunders and Mr Sleight about the safeguarding concerns raised by Service User A, in which it is recorded that Mr Sleight stated that *"he did not feel a referral was appropriate due to his history of knowing [Service User A]".*

79. The panel noted that in her witness statement, Ms Saunders stated on 9 April 2019, she was having a discussion with Mr Sleight about Service User A when she received an

email from Ms Forvargue about Service User A. Ms Saunders stated that she asked Mr Sleight if he was going to make a referral and he replied *"I don't think it should go through safeguarding."*.

80. The panel accepted the evidence of Ms Reeve who stated in her witness statement that she had supervision with the Social Worker on 10 April 2019, during which Mr Sleight indicated he *"did not have any safeguarding concerns to report at present".* Mrs Reeve went on to state that they discussed Service User A and that she advised him *"he absolutely needed to raise a safeguarding concern."*

81. The panel noted that Ms Saunders exhibited a copy of an email she received from Mr Sleight dated 12 April 2019, in which he stated *"I will be making a safeguarding referral".* Ms Saunders stated that she believes this was in response to her contacting him again after their discussion on 9 April 2019. Ms Saunders stated that, *"as there was still no safeguarding completed by the Social Worker"* on 16 April 2019, her Manager, Ms Rebecca Schmitz completed a referral.

82. Having regard to the above, the panel was satisfied on the balance of probabilities that Mr Sleight failed to make a safeguarding referral in relation to Service User A in early April 2019 when he should have done so.

83. Accordingly, the panel found paragraph 1.2.2 of the allegation proved.

Paragraph 1.3 of the allegation (Proved)

84. The panel noted the evidence in Ms Fawcett witness statement in which she explains that Service User A was living in a shared bungalow with other residents at Residence 1. Ms Fawcett exhibited a copy of a case note made by Mr Sleight on 17 June 2016 (in which he had recorded that he had spoken to Service User A following a request to ring urgently, and that Service User A had reported that *"he is unhappy about what is happening at Residence 1"* and "*he has been doing the carer's job".* Mr Sleight has recorded that Service User A had helped Service User C (a female resident) to shower, and that he gives Service User M a shave. Mr Sleight recorded that Service User A described feeling "panicky" and that he did not want to return to Residence 1.

85. The panel also noted the evidence of Ms Reeve who stated in her witness statement that within the case note of 17 June 2016, Mr Sleight" recorded *"that this is a safeguarding issue"* but that he subsequently recorded that *"he is unable to action the safeguarding concern due to an emergency that he 'has to deal with now and may take all day, and so I cannot deal with it today".* Ms Reeve stated that *"I do not know from the records if anything related to safeguarding actually took place".*

86. The panel also noted the content of the record of an investigation meeting held on 17 June 2019, exhibited by Ms Fawcett. It is recorded that Mr Sleight suggested that Service

User A had the capacity to make decisions about providing care to other service users and could have decided not to.

87. The panel accepted the evidence of Ms Fawcett who stated in her witness statement that *"Service User A was a vulnerable service user who was feeling responsible for providing care to two other vulnerable service users", "I do not consider that informal action was appropriate in the circumstances of this incident", "[a] safeguarding referral was required"*.

88. Having regard to the above, the panel was satisfied on the balance of probabilities that Mr Sleight failed to make a safeguarding referral in response to concerns being raised that Service User A was providing care to other residents at Residence 1 when he should have done so.

89. The panel therefore found paragraph 1.3 of the allegation proved.

Paragraph 1.4 of the allegation (Proved)

90. The panel noted that in Ms Fawcett's witness statement, she explained that *"various concerns were identified within Service User A's RIO records in relation to Service User A and Service User T (who was another resident at Residence 1)".* These included:

- an incident on 4 September 2017 where Service User T had been sighted by Service User A running around Residence 1 naked from the waist down;
- a suggestion on 27 October 2017 that Service User A and Service User T were in a relationship (including sexual relationship);
- Service User T being pregnant with Service User A's child, as noted on 9 March 2018;
- Service User T having miscarried, as noted on 14 March 2018;
- Service User T banging on Service User A's doors and windows at night, as noted on 23 March 2018;
- Service User A influencing what Service User T bought, knowing about her finances and/or letting her pay for things, as noted in entries in March 2018; and
- Service User T allegedly slapping Service User A, and having previously threatened to hit him, as noted within entries on 24 and 25 April 2018.

91. The panel accepted Ms Fawcett's evidence that *"all of the above incidents are safeguarding concerns, for both Service User A and Service User T"*. She stated that *"the Social Worker should have made a safeguarding referral in relation to the above*

*incidents for Service User A and he should have either made a safeguarding referral for Service User T too, or obtained the details of Service User T's social worker and raised it with them."*. She noted that the concerns were serious and commented that *"a safeguarding referral was necessary both in terms of long-term planning but also to address immediate safeguarding actions. For example, whether the two Service Users should be accommodated at Residence 1."* She also stated that "*a solely informal response was not appropriate".*

92. Ms Fawcett noted that Mr Sleight agreed with the social worker for Service User T, on 9 March 2018, that they would carry out capacity assessments for their respective service users, *"but there is no record of any follow up"*.

93. Ms Fawcett explained that Mr Sleight *"indicated during my second meeting with him on 17 June 2019 that he would not record within the case notes if he felt that the Service User had capacity following an assessment"*. She stated that she understands this and notes *"there is a presumption of capacity when considering such assessments".* She went on to say however that *"as the Social Worker has identified a capacity assessment as being needed in relation to a concern, I would have expected that capacity assessment to have been recorded in the case notes."* She noted that a visit was recorded on 23 March 2018 as a late entry for 12 March 2018, but indicated that this does not evidence that a capacity assessment took place.

94. Having regard to the above, the panel was satisfied on the balance of probabilities that Mr Sleight failed to make a safeguarding referral in respect of Service User A regarding one or more of the incidents involving Service User T when he should have done so.

95. The panel found paragraph 1.4 of the allegation proved.

Paragraph 1.5 of the allegation (Proved)

96. The panel noted that Ms Reeve exhibited a copy of Service User A's case notes from 9 April 2019 which recorded disclosures made by the Service User A that he had been subject to psychological abuse at Residence 1 and that he had not felt supported by Mr Sleight.

97. The panel further noted that Ms Saunders, exhibited a case note she completed on 9 April 2019. The case note refers to a discussion between Ms Saunders and Mr Sleight about the safeguarding concerns raised by Service User A. It is noted that:-

> *"I advised that I will be making a safeguard referral due to [Service User A]'s concerns but also that he does not feel listened to. [The Social Worker] stated he did not feel a referral was appropriate due to his history of knowing [Service User A]. I suggested as I have only just met [Service User A] and [the Social Worker] is CC that*

*he liaise with safeguarding and he discuss this and I'll wait to here [sic]. I took this to supervision with Becky Schmitz"*

98. The panel accepted the evidence in Ms Saunders witness statement in which she stated that she was interviewed by Ms Fawcett on 7 May 2019 during the Council's disciplinary investigation, and confirmed the content and accuracy of exhibited the meeting notes Within the notes, Ms Saunders is noted to have said that she was having a discussion with Mr Sleight about Service User A when an email came through to her about the Service User from Ms Forvargue. Ms Saunders stated that "*the email came through to me from VF on 9.4.19 while [the Social Worker] was talking to me so I asked [the Social Worker] if he was going to make a referral. In my mind I knew that this was a matter that should be referred. It was obvious to me. [The Social Worker] replied I don't think it should go through safeguarding."*

99. In her witness statement, Ms Saunders confirmed her recollection that the Social Worker said that he did not feel a safeguarding referral was appropriate "*due to the Service User's history in that the Service User would often complain about things".* She confirms that she still thought a safeguarding referral was needed and asked the Social Worker to complete this. She states that the Social Worker reiterated that he did not think it should go through safeguarding, *"and so I responded I would leave it for him but that he should speak to MASH to clarify the next course of action".*

100. The panel accepted the evidence of Ms Reeve who stated in her witness statement that she had supervision with the Social Worker on 10 April 2019, during which Mr Sleight indicated he *"did not have any safeguarding concerns to report at present".* Ms Reeve went on to state that they discussed Service User A and that she advised him *"he absolutely needed to raise a safeguarding concern."*

101. The panel noted that Ms Saunders exhibited a copy of an email she received from Mr Sleight dated 12 April 2019, in which he stated *"I will be making a safeguarding referral"* Ms Saunders stated that she believes this was in response to her contacting him again after their discussion on 9 April 2019. Ms Saunders stated that, *"as there was still no safeguarding completed by the Social Worker"* on 16 April 2019, her Manager, Ms Rebecca Schmitz completed a referral.

102. The panel noted that in the record of Mr Sleight's interview conducted by Ms Fawcett on 24 May 2019, he denied that he had said to Ms Saunders that he did not feel a safeguarding referral was appropriate. He stated that he could not recall the conversation very well, but suggested that Ms Saunders had misinterpreted what he had said. He recalled saying that the Service User had a tendency to reflect on the past but *"did not invalidate the rightness of referring the concern to safeguarding"*. Mr Sleight stated that he knew it was appropriate to make a safeguarding referral, and that he had

not completed it due to other priorities denied that he had tried to prevent a referral being made.

103. The panel accepted Ms Saunders evidence that as there was still no safeguarding referral completed by Mr Sleight on 16 April 2019, her Manager, Ms Rebecca Schmitz completed a referral.

104. The panel was satisfied on the balance of probabilities that in early April 2019, after Service User A had repeated concerns that he had previously raised with Mr Sleight, Mr Sleight suggested to Ms Saunders that a safeguarding referral was not appropriate.

105. The panel therefore found paragraph 1.5 of the allegation proved.

Paragraph 2 of the allegation (Not Proved)

106. In relation to this paragraph of the allegation, the panel noted that following a review of Service User A's case notes, Ms Fawcett identified a concern about an incident that occurred between Service User A and Service User Z, after Service User A had moved into the bungalow that house service users with learning disabilities. In her witness statement, Ms Fawcett stated that that Mr Sleight received an email from the Deputy Manager of Residence 1 which stated that "*Service User Z had 'bit his own hand due to being agitated by [Service User A]",* and that *"staff tried to prompt Service User A to leave Service User Z alone, but Service User Z stated that it was fine, Service User Z liked him, and doesn't mind."*

107. Ms Fawcett noted that there is a record of a discussion between the Social Worker and the Deputy Manager of Residence 1, in which the Deputy Manager confirmed that this had not been raised as a safeguarding incident to those involved with Service User Z. She noted that Mr Sleight stated *"if it were to be reported as safeguarding, [Service User A] would be distressed about this, because he is very sensitive about his behaviour, and it might well affect his state of mind, negatively. [Natalie] agreed. I noted that I am thinking of bringing it up with him, to try to avoid it developing further. I asked if they have said anything to him along this line: no. She agreed that I would say that they have reported the incidents to me and I will mention to him that there would be a danger of it becoming a safeguarding issue."*

108. Ms Fawcett stated that she considered that this incident was a safeguarding incident and that a safeguarding referral was required. Ms Fawcett stated that there were concerns about the appropriateness of Service User A's placement in the bungalow, due to both the incidents involving Service User T, and this incident involving Service User Z. She states that, following the incident with Service User Z, she would have copied the Commissioners into the safeguarding referral so that new accommodation could be sought for Service User A.

109. The panel noted that there was no evidence from any other source in relation to this paragraph of the allegation.

110. The panel considered that it did not have sufficient information in relation to the actual incident that involved Service User Z.

111. Applying the requisite burden and standard of proof, the panel therefore found paragraph 2 of the allegation not proved.

Paragraph 3 of the allegation in respect of paragraph 1.2.2 (Proved)

112. Having found paragraph 1.2.2 of the allegation proved, the panel went on to consider whether Mr Sleight's actions were dishonest.

113. In reaching its decision the panel applied the test of dishonesty as set out in the case of Ivey v Genting Casinos (UK) Ltd [2017] UKSC 67.

114. The panel was satisfied that in early April 2019, for the reasons set out at paragraphs 78-82 of this decision, Mr Sleight knew that Service User A had repeated the concerns that he had previously raised with Mr Sleight, about the conduct of the staff at Residence 1, to his new Care Co-ordinator Ms Saunders and that a safeguarding referral was required.

115. The panel considered the content of the record of Ms Forvargue's interview on 7 May 2019. The panel was mindful that it has admitted this evidence as hearsay, which may affect the weight to be attached to the evidence. The panel noted that during the interview with Ms Fawcett, Ms Forvargue referred to the notes of a meeting she had with Mr Sleight on 10 April 2019. Those notes record that Mr Sleight mentioned being concerned *"about the consequences of a formal safeguarding issue" for Service User A, "because some of his behaviour was difficult at [Residence 1] and they were quite tolerant of that", and that he said he was "trying to be pragmatic which was why I didn't follow a formal safeguarding route".* Mr Sleight told subsequently told Ms Forvargue *"I understand what SU says will have implications on me and I might be subjected to disciplinary action. I am just wondering whether to say that to SU or to wait until I have spoken to my own manager. I might not want to say this to SU as I don't want to sway his decision but I feel it might be important SU knows the implication it may have for me and my practice."* In the panel's view, Ms Forvargue's evidence appeared to be reliable and was supported by contemporaneous, minuted notes of the meeting she had with Mr Sleight. The panel was satisfied that it could therefore place considerable weight on her evidence even though it has been admitted as hearsay.

116. The panel noted the evidence of Ms Reeve who stated in her witness statement that she had supervision with Mr Sleight on 10 April 2019, during which Mr Sleight indicated he *"did not have any safeguarding concerns to report at present".* Mrs Reeve went on to

state that they discussed Service User A and that she advised him *“he absolutely needed to raise a safeguarding concern."*

117. The panel further noted that Ms Saunders exhibited a copy of an email she received from Mr Sleight dated 12 April 2019, in which he stated *"I will be making a safeguarding referral"*.

118. The panel was therefore satisfied that Mr Saunders was aware that a safeguarding referral was required.

119. The panel was also satisfied that as of 16 April 2029, Mr Sleight had not made a safeguarding referral.

120. The panel therefore considered Mr Sleight’s explanation for not making a safeguarding referral. The panel noted that when asked during the Council's disciplinary investigation, Mr Sleight stated that there were other matters which he believed took priority, and that he had planned to complete the referral on Tuesday, 16 April 2019 after an outpatient meeting with a service user, but was told to go home. He acknowledged however that he understood safeguarding procedures and confirmed that a safeguarding referral should be made "imminently".

121. The panel considered that Ms Sleight’s explanation was improbable given that he did not take any steps to progress a safeguarding referral between 9 and 16 April 2016.

122. The panel was satisfied that it was more likely than not, having regard to the comments he made to Ms Forvargue, that Mr Sleight’s chose not to make a safeguarding referral in an attempt to avoid scrutiny of his practice. In the circumstances, the panel was satisfied that applying the standards of ordinary decent people, Mr Sleight’s conduct was dishonest.

123. The panel therefore found paragraph 3 of the allegation in respect of paragraph 1.2.2 proved.

Paragraph 3 pf the allegation in respect of paragraph 1.5 (Proved)

124. Having found paragraph 1.5 of the allegation proved, the panel went on to consider whether Mr Sleight’s actions were dishonest.

125. In reaching its decision the panel applied the test of dishonesty as set out in the case of Ivey v Genting Casinos (UK) Ltd [2017] UKSC 67.

126. For the reasons set out in paragraphs 96 to 105 of this decision, the panel was satisfied that in early April 2019, Mr Sleight suggested to Ms Saunders that a safeguarding referral in respect of Service User A was not appropriate, in circumstances where Mr Sleight knew it was required.

127. The panel was satisfied that when Mr Sleight suggested to Ms Saunders that a safeguarding referral was not necessary, he was concerned that if she made a referral, it would call his own practice into question. The panel was further satisfied that by suggesting to Ms Saunders that such a referral was not necessary, Mr Sleight was attempting to delay the inevitable scrutiny of his own practice that would expose the fact that he had not previously made safeguarding referrals in respect of Service User A when he should have done so.

128. The panel was therefore satisfied, on the balance of probabilities that Mr Sleight sought to prevent Ms Saunders from making a safeguarding referral in circumstances where he knew that it was required, in an attempt to avoid scrutiny of his practice. In the circumstances, the panel was satisfied that applying the standards of ordinary decent people, Mr Sleight's conduct was dishonest.

129. The panel therefore found paragraph 3 of the allegation in respect of paragraph 1.5 proved.

## Finding and reasons on grounds

130. Having found paragraphs 1.1, 1.2.1, 1.2.2, 1.3, 1.4, 1.5 and 3 of the allegations proved, the panel went on to consider whether these amounted to the statutory ground of misconduct.

131. The panel recognised that the decision on whether or not the statutory ground of misconduct is established is a matter of independent judgement for the panel.

132. In reaching its decision, the panel therefore took into account all of the evidence presented to it at the fact-finding stage.

133. The panel also had regard to its findings and reasons at the fact-finding stage of this hearing.

134. The panel heard submissions made by Ms Atkin on behalf of Social Work England. Ms Atkin addressed the panel in relation to both misconduct and impairment. Ms Atkin referred the panel to, and adopted, the written submissions contained in Social Work England's Statement of Case. Ms Atkin submitted that Mr Sleight's proven conduct amounted to serious professional misconduct. Furthermore, she submitted that the panel should find Mr Sleight's fitness to practise currently impaired by reason of that misconduct.

135. The panel accepted the advice of the legal adviser who referred the panel to the definition of misconduct found in the case of Roylance v General Medical Council (no 2) [2001] 1 AC 311:

*"Misconduct is a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be found by reference to the rules and standards ordinarily required to be followed by a practitioner in the particular circumstances."*

136. The legal adviser also referred the panel to the decision in the case of Meadow v GMC [2006] EWCA Civ 1319, which made clear that a finding of misconduct by the panel requires serious professional misconduct on the part of a registrant, in this case a social worker.

137. The panel noted that the applicable rules and standards, in force at the relevant time (2014 to 2019), were those provided by the HCPC, namely: The HCPC Standards of Conduct, Performance and Ethics (2012), The HCPC Standards of Conduct, Performance and Ethics (2016), and The HCPC Standards of Proficiency for Social Workers in England (2012).

138. Having regard to those standards, the panel was satisfied that Mr Sleight had breached the following parts of The HCPC Standards of Conduct, Performance and Ethics (2012):

- *1 You must act in the best interests of service users*
- *13 You must behave with honesty and integrity and make sure that your behaviour does not damage the public's confidence in you or your profession.*

139. The panel was further satisfied that Mr Sleight had breached the following parts of The HCPC Standards of Conduct, Performance and Ethics (2016):

- *1.2 You must work in partnership with service users and carers, involving them, where appropriate, in decisions about the care, treatment or other services to be provided.*
- *2.2 You must listen to service users and carers and take account of their needs and wishes.*
- *2.6 You must share relevant information, where appropriate, with colleagues involved in the care, treatment or other services provided to a service user;*
- *6.1 You must take all reasonable steps to reduce the risk of harm to service users, carers and colleagues as far as possible.*
- *6.2 You must not do anything, or allow someone else to do anything, which could put the health or safety of a service user, carer or colleague at unacceptable risk.*
- *7.1 You must report concerns about the safety or well-being of service users promptly and appropriately;*

- *7.2 You must support and encourage others to report concerns and not prevent anyone from raising concerns;*
- *7.3 You must take appropriate action if you have concerns about the safety or well-being of children or vulnerable adults*
- *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.*
- *8.1 You must be open and honest when something has gone wrong with the care, treatment or other services that you provide by [. . .] taking action to put matters right if possible*
- *8.2 You must support service users and carers who want to raise concerns about the care, treatment or other services they have received;*
- *9.1 You must make sure that your conduct justifies the public's trust and confidence in you and your profession.*

140. The panel recognised that not every failure to comply with the provisions of the HCPC Standards will necessarily result in a finding of misconduct. However, the panel was satisfied that in this instance, Mr Sleight's conduct fell far below the standards expected of a registered social worker.

141. In the panel's view, the allegations found proved in this case are of the utmost seriousness. Safeguarding is a fundamental tenet of social work. In this case the panel was satisfied that over a five-year period between 2014 and 2019, Mr Sleight repeatedly failed to take appropriate and prompt action to safeguard Service User A, a vulnerable young adult and other service users.

142. The panel considered that Mr Sleight, as an experienced Senior Social Worker, was fully aware of the of policy and procedures in place. The panel was satisfied that Mr Sleight knew how to make a safeguarding referral and knew that it should be done immediately or at the very least within 24 hours. The panel was further satisfied that Mr Sleight, repeatedly chose not to make a safeguarding referral in respect of Service User A, despite multiple, extremely serious concerns being disclosed to him over a five-year period. In the panel's view Mr Sleight did not provide appropriate support to, or act in the best interests of Service User A and other service users. The panel was of the view that Mr Sleight diminished and minimised Service User A's concerns resulting him feeling unsupported and not believed. The panel was satisfied that not only did this expose Service User A to the risk of harm, but that it also caused actual psychological harm to Service User A in that it led Service User A to lose trust and confidence in Mr Sleight and

resulted in him not reporting other concerns to Mr Sleight as described in the evidence provided by Ms Forvargue.

143. The panel was satisfied that Mr Sleight's repeated failure to take appropriate action to safeguard Service User A was compounded by the fact that in 2019, he dishonestly attempted to prevent his practice being subject to scrutiny. In the panel's view, honesty and integrity is another fundamental tenet of the social work profession. The panel was satisfied that Mr Sleight's proven conduct clearly amounted to a breach of this tenet.

144. In the circumstances, the panel was satisfied that Mr Sleight's conduct, as found proved in paragraphs 1.1, 1.2.1, 1.2.2, 1.3, 1.4, 1.5 and 3 of the allegations fell far below the standards expected of him and could properly be characterised as serious professional misconduct.

## Finding and reasons on current impairment

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

146. In reaching its decision, the panel was mindful that the question of impairment is a matter for the panel's professional judgement. The panel was required to determine whether Mr Sleight's fitness to practise is impaired as at today's date.

147. The panel took into account all of the evidence that it had received during the course of the proceedings, its previous findings and reasons and the submissions made by Ms Atkin.

148. The panel also took into account the Impairment and Sanctions Guidance published by Social Work England (December 2022), which outlined the factors to be taken into account when determining impairment. The panel noted that impairment has two elements to it, the personal and the public element.

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

150. In relation to personal element of impairment, the panel noted that following the judgement in the case of Cohen v GMC (2008) EWHC 581, the three key questions for the panel to determine were:

- Is Mr Sleight's misconduct remediable;
- Has it already been remediated; and
- Is the misconduct likely to be repeated?

151. The panel was of the view that the answer to the first of these questions was that Mr Sleight's misconduct was attitudinal in nature and therefore very difficult to remediate.

The panel was satisfied that Mr Sleight, as an experienced social worker, was fully aware of the necessity and importance of safeguarding and of the policy and procedures in place. However, he repeatedly chose not to take appropriate action to safeguard Service User A, even when advised to do so by other professional colleagues. Mr Sleight then acted dishonestly when he subsequently sought to avoid scrutiny of his practice.

152. The panel next considered whether Mr Sleight has already remediated the misconduct.

153. The panel noted that Mr Sleight has not demonstrated any evidence of remorse for his actions and their consequences in relation to Service User A. The panel noted that during the local disciplinary investigation, Mr Sleight continued to maintain that his opinion was correct and that everyone else was simply wrong. In the panel's view, Mr Sleight has not shown any insight into his actions, either in terms of the risk of harm to Service User A or the reputational damage to the social work profession.

154. The panel further noted that Mr Sleight has not provided any evidence of reflection, training or steps taken to strengthen and improve his practice.

155. The panel therefore concluded that in relation to the second question posed in the case of Cohen, Mr Sleight has not remediated his misconduct.

156. The panel then turned to the third question posed in the case of Cohen. The panel noted that the level of insight and remediation demonstrated by Mr Sleight was central to its determination in relation to the risk of the misconduct being repeated. Given the complete lack of insight and remediation, the panel concluded that there remains a high risk of repetition and a consequential risk of harm to service users. In reaching this decision, the panel also had regard to the evidence of Ms Reeves who told the panel that Mr Sleight was difficult to manage, missed formal supervision sessions and that he failed to undertake mandatory training.

157. The panel next had regard to the test formulated by Dame Janet Smith in her "Fifth Shipman Report" and applied by the High Court in Council for Healthcare Regulatory Excellence v Nursing and Midwifery Council and Grant [2011] EWHC 927 (Admin), to the extent relevant to the facts of the case:

> *"Do our findings of fact in respect of the [social worker's] misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her fitness to practise is impaired in the sense that she/he:*
>
> *(a) has in the past acted and/or is liable to act in the future so as to put a patient or patients at unwarranted risk of harm; and/or*
>
> *(b) has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*

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

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

158. The panel was satisfied that for the reasons set out above, Mr Sleight's conduct not only placed Service User A at risk of harm, but that it also caused actual harm to Service User A. The panel was further satisfied that Mr Sleight's conduct has brought the social work profession into disrepute in the eyes of other professionals and the wider public. In the panel's view, two fundamental tenets of the profession have been breached by Mr Sleight. Accordingly, the panel was satisfied that all four limbs (a) to (d) of the test are engaged in this case both in terms of Mr Sleight's past actions and future behaviour given the risk of repetition identified by the panel.

159. The panel therefore concluded that a finding of current impairment was required on the personal element of impairment.

160. The panel next considered whether a finding of current impairment was also required on the public element of impairment. In so doing, the panel had regard to the following paragraph in Grant, which dealt with wider public interest considerations:

*"In determining whether a practitioner's fitness to practice is impaired…, the panel should generally consider not only whether the practitioner constitutes a present risk to members of the public in his or her current role, but also whether the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances."*

161. In the circumstances of this case, the panel was satisfied that a well-informed member of the public would be very concerned if a finding of impairment were not made given the panel's previous findings in relation to Mr Sleight's repeated failure to take appropriate action to safeguard Service User A and his subsequent dishonest attempt to prevent scrutiny of his practice. The panel therefore determined that a finding of impairment is necessary in order to maintain public confidence in the social work profession.

162. The panel was further satisfied that a finding of impairment was required to mark the seriousness of Mr Sleight's misconduct and to declare and uphold professional standards of conduct. In the panel's view, it is important that it is clear to all social workers and to the wider public that such conduct is not acceptable.

163. The panel therefore found Mr Sleight's fitness to practise to be currently impaired by reason of his misconduct on both the personal and public elements of impairment.

## Decision on sanction

164. Having determined that Mr Sleight's fitness to practise is currently impaired by reason of his misconduct, the panel next went on to consider whether it was impaired to such a degree that it required action to be taken on his registration by way of the imposition of a sanction.

165. In reaching its decision on sanction, the panel has again given careful consideration to all of the evidence it has received during this hearing, and to its findings at the fact-finding, grounds and impairment stages.

166. Ms Atkin informed the panel that Mr Sleight has no previous regulatory findings recorded against him.

167. Ms Atkin submitted that the appropriate sanction in Mr Sleight's case was a Removal Order.

168. The panel accepted the advice of the legal adviser who referred the panel to the Social Work England Impairment and Sanctions Guidance (December 2022).

169. The panel reminded itself that the purpose of imposing a sanction is not to punish Mr Sleight. The purpose is to protect the public, to uphold proper professional standards and to maintain public confidence in the social work profession.

170. The panel had regard to the Impairment and Sanctions Guidance and was mindful of the need to ensure that any sanction imposed is both appropriate and proportionate, properly balancing the interests of Mr Sleight against the need to protect the public, uphold professional standards and maintain public confidence in the profession.

171. The panel noted that it should impose no greater restriction on Mr Sleight's ability to practise as a social worker than is absolutely necessary to address the public protection and wider public interest concerns identified by the panel.

172. The panel noted that it must therefore consider each of the available sanctions in ascending order before determining the appropriate and proportionate sanction.

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

174. In relation to aggravating factors the panel identified the following:

- The misconduct was not an isolated incident. Mr Sleight's repeated failure to take appropriate steps to safeguard Service User A over a five-year period between 2014 and 2019 amounted to a pattern of behaviour;
- Mr Sleight has not shown any remorse for his actions;

- Mr Sleight has not demonstrated any insight into his actions;
- Mr Sleight has not taken any steps to remediate his misconduct;
- Mr Sleight's actions caused actual harm to Service User A and exposed him to the risk of further harm;
- Mr Sleight's actions exposed other service users to the risk of harm;
- Mr Sleight had a reduced caseload of 7 or 8 cases as opposed to the normal average of 19 cases;
- Mr Sleight did not undertake mandatory training and supervision in the workplace and therefore his practice was not up to date and informed;
- Mr Sleight demonstrated an unwillingness to follow management instructions and to accept advice from colleagues; and
- Mr Sleight has not engaged in the fitness to practise investigation undertaken by Social Work England and has not engaged in this hearing;

175. In respect of mitigating factors, the panel identified the following:

- Mr Sleight has had a long career as a social worker and has no previous regulatory findings recorded against him; and
- In or around 2014, there was an extended period of change within his working environment which created a level of complexity in the management structure.

176. The panel next considered what, if any sanction it should impose.

No further action

177. The panel first considered whether this was an appropriate case for it to take no further action.

178. The panel was satisfied that the misconduct found proved in this case was too serious for this to be an appropriate or proportionate course of action. In the panel's view, it would not protect service users from the risk of harm, nor would it meet the wider public interest concerns identified by the panel.

Advice Order or a Warning Order

179. The panel next considered whether an Advice Order or a Warning Order would be an appropriate sanction. The panel noted that these sanctions would not restrict Mr Sleight's practice and would therefore not be appropriate given that the panel has found

that there is a high risk of repetition of the misconduct and a consequential risk of harm to service users. The panel therefore determined that neither of these sanctions would be appropriate in the circumstances of the case.

Conditions of Practice Order

180. The panel next considered the imposition of a Conditions of Practice Order.

181. The panel had regard to the Impairment and Sanctions Guidance in relation to the imposition of a Conditions of Practice Order.

182. The panel noted that paragraph 118 and 119 of the Impairment and Sanctions Guidance sates:

> *"118. Conditions of practice are less likely to be appropriate in cases of character, attitude or behavioural failings. They may also not be appropriate in cases raising wider public interest issues.*
>
> *119. For example, conditions are unlikely to be appropriate in cases of (any of the following):*
>
> - *…*
> - *Dishonesty"*

183. The panel has found that Mr Sleight's misconduct, which includes dishonest conduct, is attitudinal in nature and that there is a high risk of repetition resulting in a consequential risk of harm to service users.

184. The panel therefore concluded that it was not possible to formulate workable conditions of practice that would address these attitudinal concerns and provide an adequate level of public protection.

185. The panel has identified wider public interest considerations in its finding of current impairment. The panel concluded that given the seriousness of the misconduct in this case, a Conditions of Practice Order would be insufficient to meet those wider public interest considerations.

186. The panel also had regard to paragraph 117 of the Impairment and Sanctions Guidance which states:

> *"117. Decision makers must also be satisfied that the social worker is willing to (and capable of) complying with the conditions. Previous breaches of guidance or protocols may raise significant doubt about whether the social worker can (or will) comply with conditions. This is especially true where breaches were deliberate. On*

*the other hand, early engagement with retraining and remediation may indicate that conditions are appropriate and workable."*

187. The panel determined that as a result of Mr Sleight's previous failure to undertake mandatory training and supervision in the workplace, and his lack of engagement in this hearing and the entire fitness to practise process, it has no confidence that Mr Sleight would comply with a Conditions of Practice Order even if it was possible to formulate appropriate conditions.

188. The panel therefore concluded that a Condition of Practice Order was not an appropriate or proportionate sanction in the circumstances of this case.

Suspension Order

189. The panel next gave consideration to the imposition of a Suspension Order.

190. The panel noted that a Suspension Order would protect the public as it would temporarily remove Mr Sleight from practising as a social worker. The panel also noted that in certain cases, a Suspension Order could address the wider public interest concerns, including upholding standards and maintaining confidence in the profession. However, the panel had regard to paragraph 138 of the Impairment and Sanctions Guidance which states:

*"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."*

191. In this case, the panel was satisfied that both of the bullet points in paragraph 138 apply. The panel has already found that Mr Sleight has not demonstrated any insight or remediation and there is no evidence before the panel to suggest that Mr Sleight is willing to resolve or remediate his failings. On the contrary, in the panel's view Mr Sleight has demonstrated a complete lack of engagement in these proceedings.

192. The panel also had regard to the Impairment and Sanctions Guidance in relation to cases involving dishonesty. The panel noted that paragraphs 172 to 175 provide:

*"172. Honesty is key to good social work practice. Social workers are routinely trusted with access to private spaces (such as people's homes), and highly sensitive and confidential information (such as case notes).*

*173. Other organisations also rely on the honesty and integrity of social workers when making important decisions about service users, their relatives and carers. This includes (all of the following):*

- *the police*
- *the courts*
- *local and health authorities*
- *other agencies*

*Because of this, dishonesty is likely to threaten public confidence in the social work profession. This is the case both in professional practice and in the social worker's private life.*

*174. Concerns that raise questions of character (such as dishonesty) may be harder to remediate. This is because it is more difficult to produce objective evidence of reformed character. Evidence of professional competence cannot mitigate serious or persistent dishonesty. Dishonest conduct is highly damaging to public confidence in social work. Therefore, it is likely to warrant a finding of impairment and a more serious sanction of suspension or removal.*

*Dishonesty in professional practice*

*175. The most serious instances of dishonesty in professional practice are those which (do either of the following):*

- *directly harm service users*
- *have the potential to put service users at risk."*

193. Taking this guidance into account, the panel concluded that Mr Sleight's misconduct was of the utmost seriousness. The panel has found that Mr Sleight failed to take appropriate action to safeguard Service User A over a five-year period between 2014 and 2019. The dishonesty occurred in 2019, within Mr Sleight's professional practice when he attempted to prevent scrutiny of his practice and in particular his failings in respect of Service User A.

194. Taking all of the above factors into consideration, the panel determined that a Suspension Order would not be sufficient to protect the public and meet the wider public interest concerns identified by the panel.

Removal Order

195. The panel therefore went on to consider the imposition of a Removal Order.

196. The panel noted the Impairment and Sanctions Guidance 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.

197. In the panel's view, the following three bullet points within paragraph 149 of the Impairment and Sanctions Guidance are applicable in Mr Sleight's case:

> *"149. A removal order may be appropriate in cases involving (any of the following):*
>
> - *…*
> - *dishonesty, especially where persistent and/or concealed (see section 'dishonesty')*
> - *…*
> - *persistent lack of insight into the seriousness of their actions or consequences*
> - *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)*

198. The panel acknowledged that a Removal Order will prevent Mr Sleight from working as a social worker and could therefore have a detrimental effect on his personal and financial interests. The panel took into account the fact that Mr Sleight has had a long career as a social worker and does not have any previous regulatory findings recorded against him. However, the panel was satisfied that on balance, the significant risks to the public and the wider public interest concerns identified in this case are such that they override Mr Sleight's interests in this regard.

199. The panel therefore decided that a Removal Order was the appropriate and proportionate sanction in this case.

## Interim order

200. Ms Atkin made an application for an interim suspension order for a period of 18 months, in the event that Mr Sleight exercises his right to appeal to the High Court against the decision of this panel to impose a Removal Order.

201. The panel accepted the advice of the legal adviser who advised the panel that in accordance with Paragraph 11 of Schedule 2 of The Regulations, the panel may only make an interim order if it considers it is necessary for the protection of the public or in the best interests of the Social Worker.

202. For the reasons set out in the substantive decision, the panel was satisfied that there remained an on-going risk to service users and therefore concluded that an interim order was necessary on the first limb of public protection namely to protect, promote and maintain the health, safety, and well-being of the public.

203. Furthermore, for the reasons set out in its substantive decision the panel was also satisfied that an interim order was necessary in the wider public interest limb of public protection. The panel was satisfied that an ordinary member of the public would be concerned to learn that Mr Sleight was entitled to practise without restriction if an interim order was not made to cover the statutory appeal period.

204. The panel first considered whether an interim conditions of practice order would be the appropriate and proportionate interim order. However, for the same reasons as set out in its substantive decision, that panel concluded that it was not possible to formulate workable conditions of practice that would adequately protect the public or meet the wider public interest concerns previously identified by the panel.

205. The panel therefore concluded that an interim suspension order was necessary for the protection of the public including the wider public interest.

206. The panel gave consideration to the length of the interim suspension order and concluded that a period of 18 months was appropriate. In the panel's view, this would allow sufficient time for an appeal to be heard by the High Court, if Mr Sleight exercises his right to appeal.

207. The panel therefore decided to impose an interim suspension order for a period of 18 months under paragraph 11(1)(b) of Schedule 2 of The Social Workers Regulations 2018.

208. If there is no appeal against the final order, the interim suspension order will expire when the 28-day period for appealing the final order expires. If there is an appeal against the final order, the interim suspension order will expire when the appeal is withdrawn or otherwise finally disposed of.

## Right of Appeal

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

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

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

(iii) to make a final order.

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

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

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