

Social worker: Vincent S Bernard

Registration number: SW122412

Fitness to Practise: Final Hearing

Dates of hearing: 24 July 2023 to 28 July 2023

Hearing venue: Remote hearing

Hearing Outcome: Fitness to practise impaired, conditions of practice order (24 months)

Interim order: Interim conditions of practice 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. Mr Bernard attended and was not represented.
3. Social Work England was represented by Mr Whittingham, instructed by Capsticks LLP.

Adjudicators	Role
Eileen Carr	Chair, Lay adjudicator
Natalie Pickles	Social worker adjudicator
Angela Brown	Lay adjudicator

Hannah Granger	Hearings officer
Khadija Rafiq	Hearings support officer
Clare Pattinson	Legal adviser

Preliminary Matters

Application to amend the regulatory concern

4. Mr Whittingham became aware of a redaction error during his presentation of the case for Social Work England in relation to page 22 and 25 of the exhibits bundle. He brought the error to the attention of the panel and Mr Bernard and requested that the identification of individuals on these pages be corrected. He submitted that, if the panel acceded to his request to change the identifications on these documents, this would impact upon the drafting of some of the regulatory concerns. Mr Whittingham requested that the panel note and correct the errors of redaction contained at pages 22 and 25 of the exhibits bundle.
5. In respect of the request to amend the allegation, Mr Whittingham submitted that the proposed amendments did not affect the main thrust of the regulatory concerns, which were still about Mr Bernard allegedly falling asleep during a supervised contact session. Mr Whittingham reminded the panel that Mr Bernard has adopted the position that he did not fall asleep - the proposed amendment as to which child was in attendance at the visit in question was a better reflection of the evidence to be given to the panel but not fundamental to the concern. The identification issues had been noticed while preparing a witness to give evidence on the morning of the hearing and had not therefore been known to Social Work England before this time. Mr Whittingham submitted that the application was for a minor change which would have very limited prejudice to Mr Bernard. The proposed amendments would not affect Mr Bernard's understanding of what was alleged as this essentially remained the same, but the regulatory concerns would not make sense if the corrections were not made.
6. Mr Bernard indicated that he took no issue with the proposed amendments to the first and second regulatory concerns, however he suggested that the amendment proposed for the

third regulatory concern was too wide and did not reflect the evidence. He proposed an alternative alteration to that suggested by Mr Whittingham.

7. The panel received advice from the legal adviser, which it applied, and had regard to the guidance issued by Social Work England for case examiners on amending regulatory concerns. It was conscious that it had a wide discretion as to the management of the hearing in accordance with paragraph 32(a) of the Social Work England (Fitness to Practise) Rules 2019 ('the rules'), provided that it ensures that the hearing is conducted fairly. It was mindful that regulatory concerns need to be a balanced and proportionate reflection of the case against a social worker, appropriately reflecting the seriousness of the concern. Further, they should be drafted in clear and unambiguous language which enables the social worker concerned, and anyone else reading them, to understand what is being alleged.
8. The panel was satisfied that the redaction issue was an obvious error which did not materially impact the nature of the regulatory concerns or Mr Bernard's understanding of the same. It was therefore content to note and correct the errors.
9. In respect of the proposed amendment to the regulatory concerns, the panel was mindful of the case examiner guidance issued by Social Work England. It considered the impact of the amendment on both the seriousness of the case and the fairness to the social worker and Social Work England. It was satisfied that the amendments proposed by Mr Whittingham, and agreed by Mr Bernard in relation to regulatory concerns 1 and 2 should be permitted. The panel considered that Mr Bernard's suggested amendment was more appropriate in the circumstances for regulatory concern 3, and it therefore adopted that amendment.

Allegation:

10. The allegation, as amended, is that:

Whilst employed as a social worker at Gloucestershire County Council between February 2019 and August 2019:

Child B

1. In relation to Child B **and/or Child B's sister** , you:
 - a. Did not immediately report or escalate safeguarding concerns passed to you by Child B's school on 29 April 2019; and/or,
 - b. Fell asleep whilst supervising a contact session on 11 July 2019.
2. You failed to assess / manage risk to Child B **and/or Child B's sister** by reason of:
 - a. Your behaviour at paragraph 1(a); and/or,
 - b. Your behaviour at paragraph 1(b)
3. You failed to produce / maintain accurate records in that you did not take notes of the contact session involving Child B's **sister** on 11 July 2019.

Child D

4. In relation to Child D, on 30 July 2019 you:
 - a. Failed to complete a Service User Assistance Form requesting food provisions for the family of Child D; and/or,
 - b. Failed to conduct enquiries into the proposed venue for Child D's sleepover.
5. You failed to assess / manage risk to Child D by reason of:
 - a. Your behaviour at paragraph 4(a); and/or,
 - b. Your behaviour at paragraph 4(b)

Child C

6. In relation to Child C, you failed, on one or more occasions after 13 August 2019, to attend handovers on time or at all.
7. You knew or ought to have known that:
 - a. You were required to attend handovers because it had been agreed on or around 13 August 2019 that you would do so; and/or,
 - b. Your attendance at handovers was necessary under the Child Protection Plan in place at the time.
8. You failed to assess / manage risk to Child C by reason of your behaviour at paragraphs 6 and 7.

Your actions at Regulatory concerns 1-8 amount to the statutory ground of lack of competence/capability and/or misconduct.

Your fitness to practise is impaired by virtue of your lack competence/capability and/or misconduct.

Admissions:

11. Rule 32(c)(i)(aa) of the rules states that the panel shall find any facts admitted by a social worker proved. Following the reading of the regulatory concerns into the record, Mr Bernard was invited to indicate whether he made any admissions in respect of the regulatory concerns. Mr Bernard informed the panel that he admitted regulatory concerns 1(a), 2(a), 4(b), 5(b), 7(a) and 7(b). The panel therefore found these regulatory concerns proved by way of Mr Bernard's admissions.
9. The panel noted that Mr Bernard made partial admissions in respect of regulatory concerns 3, 4(a), 6 and 8, and informed him that such admissions would, for the purposes of proving

facts, be treated as a denials and therefore remain to be proved by Social Work England. Mr Bernard confirmed that he maintained his denial of regulatory concerns 1(b), 2(b) and 5(a).

10. In accordance with the rules, the panel then went on to determine the disputed facts.

Summary of evidence:

11. Mr Bernard registered as a social worker on 4 September 2018. He commenced employment as a newly qualified social worker in an Assisted and Supported Year in Employment ('ASYE') with Gloucestershire County Council ('the Council') on 4 February 2019. He was allocated to Safeguarding Team 1, which comprised a permanent manger, a permanent advanced practitioner, two permanent social workers and two long-term agency social workers. His employment was subject to a 6 month probationary period
12. Concerns in respect of Mr Bernard's practice arose early in his employment. His team manager changed in March 2019. By the end of April 2019, the Council had identified concerns in relation to Mr Bernard's practice and he was informed he would be placed on an informal improvement plan. This took effect on 10 May 2019. Mr Bernard's team manager went on sick leave around this time, leaving Mr Bernard to be supervised by the team Advanced Practitioner.
13. By 15 July 2019, although concerns remained about Mr Bernard's conduct and competence, the Council was satisfied that Mr Bernard had made sufficient progress to pass his 3 month probation review. However, on 5 August 2019 a fact-finding investigation was instigated due to ongoing performance related concerns. These included Mr Bernard being accused of falling asleep at a contact session he was supervising on 11 July 2019, which the Council was made aware of on 18 July 2019. Mr Bernard was suspended from his employment on 23 August 2019 pending the outcome of a disciplinary investigation by the Council in respect of his competence and conduct.
14. A disciplinary hearing took place on 29 January 2020, as a consequence of which Mr Bernard was dismissed from his role as an ASYE for the Council with effect from 20 February 2020. On 6 May 2020 the Council referred its concerns about his conduct and competence to Social Work England. Case Examiners considered the regulatory concerns on 30 June 2021 and decided to refer them to a substantive hearing.

Social Work England

12. Mr Whittingham called 3 witnesses to give evidence on behalf of Social Work England, supported by:
 - a. A statement bundle of 46 pages;
 - b. An exhibits bundle of 165 pages;
 - c. A service and supplementary bundle of 43 pages;
 - d. A statement of case of 17 pages;
 - e. An identification key;

f. A draft hearing timetable.

All of the witnesses provided their evidence under affirmation and the panel was grateful for their attendance, which was helpful to it.

Natalie Heath

15. Ms Heath is a social worker who, at the material time, was employed as a senior social worker within Children's Safeguarding Team 1. She joined the Council in 2016 as a newly qualified social worker and is currently employed as an Advance Practitioner in Children's Safeguarding Team 2. She told the panel that she was keen to help Mr Bernard when he joined the Council as she had a *"poor experience"* when she joined the Council as a newly qualified social worker. She therefore tried to make introductions to other teams and provide guidance to him, such as reminding him to take pen and paper to meetings to make notes, and going through paperwork with him. Ms Heath said the team was supportive of each other and Mr Bernard and there was substantial experience for Mr Bernard to call upon. There were also extensive shadowing and development opportunities within the Council as well as an independent support system called the Social Work Academy, which specifically supported ASYE social workers with training, resources and support, including supervision. Ms Heath told the panel that she had no complaints about Mr Bernard personally – she found him to be amenable and *"he joined in with shared lunches"* – but she did raise *"professional process"* issues with her manager in relation to him.
16. The panel found Ms Heath to be a competent, clear, careful and professional social worker and appeared to have been supportive of Mr Bernard in the workplace. It found her responses to questions to be balanced and clear. If she could not recall matters, she said so and did not speculate. She did not offer comment on matters beyond her personal knowledge. The panel considered that the concerns she shared with her manager about Mr Bernard were appropriate and proportionate, and that her advice and guidance to Mr Bernard seemed to be good – she appeared to be an unofficial mentor for him. Ms Heath's oral evidence to the panel was consistent with her witness statement. The panel was satisfied that it could place substantial weight on Ms Heath's evidence.

Karen Goulding

17. Ms Goulding is a social worker who, at the material time, was employed as an Assessment and Safeguarding Head of Service, having joined the Council in 2009. She managed Mr Bernard's manager at the material time and as such was aware of the manager's relationship with their team members. When Mr Bernard's team manager left, Ms Goulding facilitated a handover between the outgoing and incoming manager on 29 March 2019. The notes of that handover, in respect of staffing, were:

"2. Staffing

All staff ok.

Vincent - is ASYE. He's not had previous stat placement. He will need a lot of nurture and support. First 4 weeks, Donna set out clear actions re who to meet.

Vincent needs to be more assertive and needs a lot of support. He is holding two children see above."

18. Ms Goulding provided supervision to Mr Bernard's manager and discussed with her the concerns raised about Mr Bernard's conduct and performance. She was aware of the implementation of the informal improvement plan in May 2019 and when the manager was absent due to ill health at that time, supervised the advanced practitioner (Mr Tinkler) in the management of Mr Bernard. It was she and Mr Tinkler who undertook the ASYE review meeting of Mr Bernard's performance on 15 July 2019 and determined that there had been some improvement in Mr Bernard's performance but not enough to end the plan – they preferred to have the manager review progress against the plan upon her return to work.
19. Ms Goulding told the panel that Mr Bernard's manager was the investigating officer in respect of the disciplinary proceedings which resulted in Mr Bernard's suspension on 23 August 2019 as any hearing would be conducted by a Council employee of equal rank to her. These were the normal arrangements for disciplinary investigations at the Council. Ms Goulding's evidence to the panel was that Mr Bernard *"lacked autonomy and motivation"*.
20. The panel found that Ms Goulding did her best to assist it. However, it recognised the limitations of her role as a Head of Service in this situation, which it accepted was complicated by the absence of Mr Bernard's manager for a period of around two months immediately after the informal improvement plan was implemented. The panel found Ms Goulding's oral evidence to be consistent with her statement and appreciated her openness if she was not able to recall matters. It found her to be a credible witness.

Paul Tinkler

21. Mr Tinkler is a social worker who, at the material time, was employed by the Council as an Advance Practitioner in Safeguarding Team 1. His responsibilities were to raise practice standards and provide support to the team while carrying a full case load. Mr Tinkler told the panel that he was Mr Bernard's mentor, but in the absence of the team manager, he also provided supervision for Mr Bernard. He confirmed Ms Heath's view that Safeguarding Team 1 was experienced, settled and supportive of Mr Bernard.
22. Mr Tinkler provided the panel with factual evidence which was consistent with his statement and that of Ms Heath where they overlapped. He produced a supplementary statement to clarify his substantive statement. The panel found Mr Tinkler to be a consistent and credible witness.
23. The panel was grateful to all three witnesses for attending the hearing and providing written and oral evidence, particularly given the age of the proceedings.

Social worker

24. Mr Bernard attended and gave evidence under oath. He supplied the panel with a bundle of documents which comprised 66 pages. He described to the panel his route to qualification

as a social worker, confirming that he had not undertaken a placement during his training in a statutory setting. He described the additional difficulties that he experienced working outside of London for the first time, and the challenges posed by the rural location and living away from his family. Mr Bernard demonstrated that he was open to suggestion and learning, identifying approaches suggested through the hearing that he said he could apply in practice (such as preparing documentation while awaiting authorisation, rather than only commencing the documents once approval was received). Mr Bernard recognised that he, at the time, lacked “*professional curiosity*” and that he had simply not grasped the extent to which a social worker needed to be suspicious.

25. In the panel’s view, Mr Bernard did a good job of representing himself and responding to the case presented by Social Work England, picking up the process and procedures very quickly. The panel was grateful for his admissions and pragmatic approach however, it had concerns about a number of inconsistencies between his written representations and oral evidence.

Finding and reasons on facts:

26. Mr Whittingham addressed the panel in relation to the concerns about Mr Bernard’s practice, reminding it that the civil burden of proof lay with Social Work England.
27. The panel listened carefully to all the evidence and submissions made. It received advice from the legal adviser, which it applied. The panel had regard to the rules and the regulations, the bundles of documents provided to it in advance of the hearing, and the relevant guidance issued by Social Work England, particularly that in relation to unrepresented social workers and fitness to practice proceedings.
28. In deciding whether a regulatory concern is “well founded” or “proved”, the panel was required to decide firstly whether Social Work England, which bears the burden of proof in relation to the facts alleged, has discharged that burden, on the balance of probability, in relation to each element of each regulatory concern that is not admitted.

1(a) Whilst employed as a social worker at Gloucestershire County Council between February 2019 and August 2019, in relation to Child B and / or Child B’s sister you did not immediately report or escalate safeguarding concerns passed to you by Child B’s school on 29 April 2019; PROVED

29. This regulatory concern was admitted by Mr Bernard without reservation or qualification and therefore found proved by the panel, with no further consideration of the facts, in accordance with Rule 32(c)(1)(aa).

1(b) Whilst employed as a social worker at Gloucestershire County Council between February 2019 and August 2019 in relation to Child B and / or Child B’s sister you fell asleep whilst supervising a contact session on 11 July 2019; PROVED

30. Mr Whittingham reminded the panel that it heard evidence from Ms Heath and Mr Tinkler in relation to this concern. He said that Mr Bernard had a history of drowsiness, there being evidence that he admitted twice being asleep whilst working. Mr Whittingham reminded the panel that in respect of this particular incident, the visit Mr Bernard was supervising was at 4.00 pm in a hot and stuffy room. When Mr Tinkler spoke to Mr Bernard about the incident, Mr Bernard disputed sleeping for 30 minutes as per the email complaint received on 18 July 2019, but accepted that he could have fallen asleep for a few minutes and that he had not been doing anything, just observing. Mr Bernard had not, in Mr Whittingham's submission, put to any witness that he was pressured or threatened to accept this regulatory concern either at the time or to his regulator, but that this was now what was being said despite Mr Bernard's testimony to the panel being that he had felt so sluggish it was hard for him to move but he wanted to be seen as a team player so he agreed to supervise the contact. Mr Whittingham also reminded the panel that both Ms Heath and Mr Tinkler referred to discussions with Mr Bernard about the amount of sleep he got, there being suggestions from them that this was impacted by respectively Mr Bernard gaming until late and stating that he wanted a social life.
31. Mr Bernard told the panel that he did feel drowsy on the day of this supervised contact but that when asked by Mr Tinkler about being asleep over a week later, he was frightened to do anything other than agree that he had been asleep due to the pressure of being on a performance improvement plan. Mr Bernard described the room where contact took place saying only he, the child and the mother were in the room, and the only way for anyone to see into the room was to look through a window in the door. He also suggested that the foster carer, who made the complaint about him sleeping, received the information from her daughter and did not mention it for a week, then included it in an email to Mr Tinkler in which she was clearly very frustrated about other matters. While denying that he had slept during the session, Mr Bernard said his drowsiness was not conscious but rather a physiological response to the hay fever tablets that he was taking. Mr Bernard denied being tired as a result of going to bed late. He accepted that he did play games but not as late as Ms Heath reported. He said that he did not have a social life as he was alone in a flat away from his family and friends with nothing to do so he could not prioritise his social life as suggested by Mr Tinkler – indeed, he told the panel that this suggestion offended and upset him.
32. The panel was aware that Child B came to the Council's attention as a consequence of a number of injuries where there had been concerns about the explanation. She was subject to a Child Protection Plan and there was a safety plan in place. On 21 March 2019 the mother of Child B agreed that there would be no contact between Child B and the mother's partner, who Child B referred to as 'daddy'. Following a child protection medical on 30 April 2019, further injuries were found and Child B, and her younger, non-verbal toddler sister, were placed in emergency foster care on 30 April 2019 as a result.
33. The panel was told by Ms Heath that she returned to the office one day and Mr Bernard *"had his head in his hands... and ... had not looked up"*. He had not heard her conversation with a colleague and reported still being drowsy. She also said in her statement *"I had*

further conversations with the Social Worker after the incident when he had his head in his hands. In these conversations I would discuss sleeping and whether the Social Worker was getting a better routine in the evening. The Social Worker would reply by stating that they were still playing video games until 12-1.00am. I therefore felt that the Social Worker was using the tablets as an excuse because he had a poor routine and did not go to sleep at an earlier time.”. This was not challenged by Mr Bernard in his cross examination of Ms Heath, although it was denied by him when he gave evidence.

34. The panel was mindful that the regulatory concern that Mr Bernard was asleep at the visit did come from an individual who had not given evidence to it. However, it noted Mr Tinkler recorded that the mother of the child concerned was asked at a subsequent contact session whether Mr Bernard had been asleep and confirmed, in the presence of the contact supervisor, that he had. Given that the information appeared to have been cross referenced with the mother, and most importantly admitted by Mr Bernard when spoken to by Mr Tinkler on 19 July 2019, the panel did not consider it unreasonable for the Council to not have sought further evidence that Mr Bernard was asleep at any point while supervising contact. The panel also noted that Mr Bernard’s oral evidence in cross-examination was that he was could be tired when driving home and had on occasion pulled the car over to take some fresh air.
35. The panel then reviewed the information provided by Mr Bernard to Social Work England, observing that these were dated 10 August 2020 and 4 May 2021. The first response to the regulator, which was submitted some 6 months after the termination of Mr Bernard’s employment by the Council, stated:

“The majority of the supervised contact, I was awake and was observing the contact; however, I did not notice the time I fell asleep, because the moment I closed and opened my eyes felt like a moment to me; this was when the contact session finished around 5PM. The mother and child were in front of me, and the child did not seem to be in any distress or appeared to be harmed, and I did not realise at the time I placed a child at risk, therefore, I did not consider I had to report anything to the office, and went straight home.”

The second response from Mr Bernard, over a year after the end of his employment, accepted the regulatory concern and then confirmed *“I have previously stated that I do admit to falling asleep but that was due to a physiological response to antihistamines I was taking at the time and was not intentional”*.

36. The panel recognised that Mr Bernard could have felt pressure or panic when asked about the issue in July 2019, however it did not consider that that explanation could apply to Mr Bernard’s two separate responses to his regulator. It considered these two responses to be most likely to be accurate. The regulator was not required to prove beyond reasonable doubt that Mr Bernard had fallen asleep at some point during the contact session he was supervising, but to establish whether it was more likely than not that it had happened. Given Mr Bernard accepted that it was the end of the day, the room was hot and stuffy, he was sitting observing and not doing anything, he had taken antihistamines which with

hindsight he accepted made him drowsy and he had felt sluggish prior to attending the session, the panel found it more likely than not that Mr Bernard fell asleep at some point towards the end of the contact session he was supervising. This regulatory concern is therefore proved to the requisite standard of proof.

2(a) Whilst employed as a social worker at Gloucestershire County Council between February 2019 and August 2019 you failed to assess / manage risk to Child B and / or Child B's sister by reason of your behaviour at paragraph 1(a); PROVED [school safeguarding concern]

37. This regulatory concern was admitted by Mr Bernard and therefore found proved by the panel, with no further consideration of the facts, in accordance with Rule 32(c)(1)(aa).

2(b) Whilst employed as a social worker at Gloucestershire County Council between February 2019 and August 2019 you failed to assess / manage risk to Child B and / or Child B's sister by reason of your behaviour at paragraph 1(b); PROVED [sleeping]

38. Mr Whittingham submitted that if Mr Bernard was asleep for any part of contact session, as he was the only observer from the Council and the only person able to see the interaction between the mother and the non-verbal child, there had been a clear failure on Mr Bernard's part to assess risk. He submitted that it followed that if risk was not assessed, it could not be managed. He also invited the panel to consider that if, as Mr Bernard reported, he felt so tired and sluggish that it was difficult to move, this was also a risk. Mr Bernard's explanation that he attended the contact session due to pressure to demonstrate he was a team player as a consequence of the improvement plan could be construed as an example of Mr Bernard *"prioritising his professional position above that of the child who was non-verbal and had been removed due to physical injury."*
39. Mr Bernard accepted that if he was found to have been asleep at the contact session, he could not deny that this would amount to failing to manage risk. However, he reiterated that this was neither intentional nor conscious. It was a circumstance he had hoped to avoid but did not.
40. The panel was mindful of the circumstances in which Mr Bernard found himself undertaking his first contact supervision session. It noted that Mr Tinkler was meant to be supervising the session but had been detained elsewhere and had contacted the office to request that the duty social worker take his place – the session therefore had not been planned or prepared for. Mr Bernard agreed to cover the session and in doing so effectively asserted that he was fit to do so – had he not felt sufficiently well or awake to undertake the role, his professional duty was to not volunteer for it, regardless of the potential consequences to him in terms of the improvement plan.
41. Mr Bernard told the panel that he was aware that he was tired and he was checking on the time of the session and getting up from his chair to look out of the window. The panel therefore concluded that Mr Bernard was aware that he was struggling, and that there was

a possibility he may fall asleep, even if he didn't intend to. In those circumstances, he could have terminated the session early rather than perpetuating the risk to the child and the mother as an issue could arise in a second. The panel had found that Mr Bernard was more likely than not to have fallen asleep during the contact session he was observing, and that this meant that he had failed to assess and manage risk as a result. This regulatory concern was proved on the balance of probability.

3. Whilst employed as a social worker at Gloucestershire County Council between February 2019 and August 2019 you failed to produce / maintain accurate records in that you did not take notes of the contact session involving Child B's sister on 11 July 2019; NOT PROVED

42. Mr Whittingham reminded the panel that Mr Bernard admitted not taking notes during the contact session he observed, but said he did produce a record of the session.
43. Mr Bernard was clear that although he had not taken written notes during the session, choosing to focus on observation, and mindful that taking notes can appear oppressive, or returned to the office after the session to make a note, he had inputted an accurate note of the session to the case management system the next morning at around 9.45am.
44. The panel gave careful consideration to the wording of this regulatory concern, noting that Social Work England's case appeared to be that the failure to produce or maintain accurate records related to the failure to take notes. It considered that this would be correct if the regulatory concern said 'and / or' instead of 'in that'. However, it did not. The panel considered that, on the ordinary reading of the concern, the primary regulatory concern was the production or maintenance of accurate records. It had been provided, by Mr Bernard, with a copy of the case note inputted on 12 July 2019 which had a time stamp on it. Whilst the panel accepted that the record could have been fuller, it considered the record contained sufficient information to be acceptable. It noted that none of the Social Work England witnesses suggested that the record was inaccurate or otherwise unacceptable, or that Mr Bernard should be criticised for inputting it into the system less than 24 hours after the session finished. Given this, the regulatory concern fell at this point and there was no need to consider the issue of note taking.
45. The panel was not satisfied that Social Work England had proved each element of this regulatory concern to the requisite standard of proof, and this regulatory concern was therefore not proved.

4(a) Whilst employed as a social worker at Gloucestershire County Council between February 2019 and August 2019 in relation to Child D, on 30 July 2019 you failed to complete a Service User Assistance Form requesting food provisions for the family of Child D; PROVED

46. Mr Whittingham told the panel that Mr Bernard admitted not completing this report because his manager had not approved the completion of it and it had not occurred to him

to complete the form in anticipation of the approval being forthcoming. He reminded the panel that it heard from Ms Heath that Mr Bernard should complete the form and invited the panel to find this regulatory concern proved.

47. Mr Bernard stated that he believed that he should have approval from a manager to do the form prior to filling it in. He thought the suggestion he could do the form pending approval was something that he could take with him for future administrative work.
48. The panel was satisfied on the evidence before it that Mr Bernard did not complete the Service User Assistance form on 30 July 2019 but rather completed it the next day. The panel therefore considered that this regulatory concern was proved on the balance of probability.

4(b) Whilst employed as a social worker at Gloucestershire County Council between February 2019 and August 2019 in relation to Child D, on 30 July 2019 you failed to conduct enquiries into the proposed venue for Child D's sleepover; PROVED

49. This regulatory concern was admitted by Mr Bernard without reservation or qualification and therefore found proved by the panel, with no further consideration of the facts, in accordance with Rule 32(c)(1)(aa).

5(a) Whilst employed as a social worker at Gloucestershire County Council between February 2019 and August 2019 you failed to assess / manage risk to Child D by reason of your behaviour at paragraph 4(a); PROVED [food]

50. Mr Whittingham submitted that the background of Child D's family identified that food and utility money was a problem and that they required assistance. He reminded the panel that Mr Bernard conceded he should have acted more quickly and that the delay meant that the provision of assistance to the family was later than it could have been, thereby putting Child D at risk.
51. Mr Bernard accepted that, on reflection, he could have been more proactive rather than taking at face value what the father of Child D said. However, he told the panel that he had asked the father if he needed assistance, and was reassured that this was not necessary as the father could ask his parents. This was another matter that Mr Bernard said he had learnt since the incident. He told the panel that he accepted that he needed to check and verify and not just take the comments of parents or service users' comments at face value.
52. The panel was conscious that Child D was a 13 year old girl whose mother had been a drug user for more than 15 years. Child D's father was an ex-drug user. There were concerns that Child D was not the priority in the family due to her mother's health issues. Child D was on a Child Protection Plan because they were at risk from neglect, the impact of drugs and their father was not protecting Child D from harm.
53. Given the acceptance of Mr Bernard that he should have been more professionally curious in relation to Child D and her circumstances relating to the sleepover, the panel was satisfied that this regulatory concern was proved on the balance of probability.

5(b) Whilst employed as a social worker at Gloucestershire County Council between February 2019 and August 2019 you failed to assess / manage risk to Child D by reason of your behaviour at paragraph 4(b); PROVED [sleepover]

54. This regulatory concern was admitted by Mr Bernard without reservation or qualification and therefore found proved by the panel, with no further consideration of the facts, in accordance with Rule 32(c)(1)(aa).

6. Whilst employed as a social worker at Gloucestershire County Council between February 2019 and August 2019 in relation to Child C, you failed, on one or more occasions after 13 August 2019, to attend handovers on time or at all; PROVED

55. The failure by Mr Bernard to attend handovers in relation to Child C was, in Mr Whittingham's submission, now accepted by Mr Bernard.
56. Mr Bernard accepted that he should have been more organised regarding timing. He told the panel he *"thought I had enough time but I didn't"*. He said he should have allowed more time between visits or delayed the handover if he could not get there. He accepted that at that time, he was not organised enough to manage his time and he should have been more responsible. He said he had tried to secure cover for the handovers that he had missed but there was not enough time. He assured the panel that this was something he had now learnt.
57. The panel was aware that Child C was a child moving between the care of their parents. Both parents made regulatory concerns against each other. Child C's mother has learning difficulties and the maternal grandparents were hostile and alleged to have assaulted Child C's father previously. The supervision of handovers by the Council was a short term solution to ensure there were no further incidents and implemented as a result of a strategy meeting on 13 August 2019.
58. The panel was satisfied, given Mr Bernard's admission and Mr Tinkler's evidence to it that Mr Bernard did not attend two handovers, that this regulatory concern was proved on the balance of probability.

7(a) Whilst employed as a social worker at Gloucestershire County Council between February 2019 and August 2019 you knew or ought to have known that you were required to attend handovers because it had been agreed on or around 13 August 2019 that you would do so; PROVED,

59. This regulatory concern was admitted by Mr Bernard without reservation or qualification and therefore found proved by the panel, with no further consideration of the facts, in accordance with Rule 32(c)(1)(aa).

7(b) Whilst employed as a social worker at Gloucestershire County Council between February 2019 and August 2019 you knew or ought to have known that your attendance at handovers was necessary under the Child Protection Plan in place at the time; PROVED

60. This regulatory concern was admitted by Mr Bernard without reservation or qualification and therefore found proved by the panel, with no further consideration of the facts, in accordance with Rule 32(c)(1)(aa).

8. Whilst employed as a social worker at Gloucestershire County Council between February 2019 and August 2019 you failed to assess / manage risk to Child C by reason of your behaviour at paragraphs 6 [handover] and 7 [known attendance]; PROVED

61. Social Work England's position is that in failing to attend the handover, Mr Bernard exposed Child C to risk. The arrangements were in place to protect Child C and it was necessary for the Council to supervise the handover to ensure that the handover progressed safely.

62. Mr Bernard told the panel that he accepted that he did place Child C at risk as a result of his conduct, and he did not give his colleagues as much time to act as he should have done.

63. Given the circumstances of this family, and the reasons why the supervision of handovers had been implemented by the Council, in failing to attend the handover, the panel found that Mr Bernard did not manage the risk to Child C appropriately. Accordingly, this regulatory concern was proved to the requisite standard.

Finding and Reasons on Statutory Ground

64. Mr Whittingham submitted that each incident involved in the regulatory concerns is a serious failing on the part of Mr Bernard, involving failure to assess and manage risk. He told the panel that safeguarding is a core duty of a social worker and a fundamental tenet of the profession, and noted that Mr Bernard admitted to the panel that he had failed to manage risk. Mr Whittingham reminded the panel that Social Work England's statement of case identified the standards of practice which were relevant for this case and he submitted that the concerns which were found proved were capable of amounting to misconduct given that there was conduct which was unacceptably low. He observed that the incidents had spanned the full period of Mr Bernard's employment with the Council and reflected a "*solid sample size*" from Mr Bernard's limited caseload across April, July and August 2019.

65. Mr Bernard had demonstrated a failure to assess and manage risk across the period of his employment, which was a critical function of a social worker. Mr Whittingham told the panel that Mr Bernard had repeatedly failed to manage his time, did not self-regulate when he was tired, did not prioritise safeguarding over being a team player and demonstrated too great a willingness to accept things said at face value, which amounted to a lack of professional curiosity. Mr Whittingham reminded the panel that Mr Bernard was in a supportive team and had the benefit of substantial intervention, until the Council decided, in August 2019, that the level of intervention was disproportionate and he was suspended and subsequently dismissed. He invited the panel to find that the statutory grounds of impairment by way of misconduct and lack of competence were engaged for all of the regulatory concerns.

66. Mr Bernard asked the panel to take account of the fact that the Council's investigation did not reflect his entire time with them as his ASYE coordinator at his three month review said that he was doing well with his progression despite the concerns. He also asked the panel to bear in mind that two of the three families involved were not on his caseload – Child B and Child D. He accepted that Child C was on his caseload and said that there were not many concerns raised about his interactions with Child C. Mr Bernard asked the panel to consider that he had not had statutory experience prior to joining the team and he accepted that he did not understand how to gauge immediate risk. He said that his lack of experience and inability to stand up for himself contributed to the situation.
67. The panel received legal advice, which it applied, and gave careful consideration to the guidance issued by Social Work England in relation to the statutory grounds of impairment, as set out within the 'Impairment and Sanctions Guidance'. It was conscious that Social Work England advanced the regulatory concerns as amounting to both lack of competence and misconduct. The panel particularly noted that misconduct involves some act or omission falling short of what is considered proper in the circumstances whereas lack of competence involves a standard of performance which is unacceptably low when judged against the role the social worker was employed to provide. It also had regard to the factors identified in the case of *Calhaem v General Medical Council* [2007] EWHC 2606 (Admin) which explained the respects in which deficient professional performance differed from misconduct and identified 5 principles relevant to the conduct of a registered professional:
- a. Mere negligence does not constitute misconduct, however negligent acts or omissions which are particularly serious may amount to misconduct;
 - b. A single negligent act or omission is less likely to amount to misconduct than multiple acts or omissions but in some circumstances a single act or omission, if grave, could be misconduct;
 - c. Deficient professional performance is different to negligence and misconduct. It connotes a standard of professional performance which is unacceptably low and which, save in exceptional circumstances, has been demonstrated by reference to a fair sample of the doctors work;
 - d. A single instance of negligent treatment, unless very serious indeed, would be unlikely to constitute deficient professional performance;
 - e. It is neither necessary nor appropriate to extend the interpretation of deficient professional performance in order to encompass matters which constitute misconduct.
68. The decision as to whether a statutory ground of impairment was made out in accordance with regulation 25(2) of the Regulations was a matter for the panel to judge, and not something that Social Work England had to prove. The panel could refer to standards of propriety set for social workers when making its determination. By virtue of regulation 16(2)(a) of The Children and Social Work Act 2017 (Transitional and Savings Provisions)

(Social Workers) Regulations 2019, because the allegation relates to a period when the regulator was the Health and Care Professions Council ('HCPC'), the relevant standards of proficiency were those set by the HCPC, which regulated social workers until December 2019. The HCPC also expected its registered professionals to comply with its Standards of Conduct, Performance and Ethics. The panel considered the following Standards of Proficiency for Social Workers [2017] were relevant in this case:

- 1.3 - be able to undertake assessments of risk, need and capacity and respond appropriately;
- 1.5 - be able to recognise signs of harm, abuse and neglect and know how to respond appropriately, including recognising situations which require immediate action;
- 2.1 - understand current legislation applicable to social work with adults, children, young people and families;
- 2.3 - understand the need to protect, safeguard, promote and prioritise the wellbeing of children, young people and vulnerable adults;
- 4.2 - be able to initiate resolution of issues and be able to exercise personal initiative;
- 4.6 - be able to make and receive referrals appropriately;
- 9.7 - be able to contribute effectively to work undertaken as part of a multi-disciplinary team;
- 15.1 - understand the need to maintain the safety of service users, carers and colleagues

and the following Standards of Conduct, Performance and Ethics [2016]:

- 6.1 - You must take all reasonable steps to reduce the risk of harm to service users, carers and colleagues as far as possible
- 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 any concerns about the safety or well-being of service users promptly and appropriately.
- 7.3 - You must take appropriate action if you have concerns about the safety or wellbeing 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.

69. The Panel then considered the incidents individually, rather than each regulatory concern, to assess whether either, both or neither statutory ground of impairment was made out.

Child B – report of safeguarding concern from school on 29 April 2019

70. The background to the regulatory concerns involving Child B is set out above and not repeated. The Panel noted that Mr Bernard has referenced the “*tone*” of the telephone call that he received, and that it came from a teaching assistant, and has indicated that these factors contributed to him not immediately escalating the report. Instead, he took the decision to tell the allocated social worker upon her return to the office. The practical effect of this delay of some three hours was that Child B could have left school and returned home, therefore being exposed to further risk. Had that risk materialised, the Council would be justifiably criticised for not acting upon the report made by the school in a timely fashion. The panel was conscious that Mr Bernard at that point was almost three months into his employment with the Council but considered that any registered social worker should understand that safeguarding children from physical harm was of fundamental importance and therefore any report that a child had suffered physical harm should be treated with priority.
71. Regardless of the tone or seniority of the person reporting the concern, the fact that it had been reported at all should have prompted Mr Bernard to share it within the office and at the very least seek the opinion of the other, more experienced social workers there, as to what he should do.
72. In this case, it was not just any child who was reported to have been harmed – it was a child who was subject to a child protection plan and where a safety plan was in place for just such an eventuality. This information would have been available to Mr Bernard as he made a case note entry of the call in the case management system, which utilised the ‘Child ID’. The panel was satisfied that failing to escalate receipt of this report immediately upon receipt meant that Child B was not safeguarded.
73. Whilst Mr Bernard was early in his career as a social worker, he had obtained a degree in social work and had been working with the Council since the beginning of February 2019. Further, he had chosen to apply for employment within a statutory safeguarding team and therefore should be aware of the obligations that attach to such a role. Regardless of the level of experience, the panel found that this conduct amounted to serious professional misconduct.

Child B / Child B’s sister – falling asleep while supervising contact on 11 July 2019

74. The panel was satisfied that attending a contact session for the purpose of supervising it when not fit enough to do so also amounted to misconduct. Mr Bernard knew that he had been struggling with drowsiness, and that he would be sitting in a room at the end of the day observing the contact. Despite this, he agreed to attend the session. He knew, towards the end of the contact session, that he was becoming drowsy, but did not take steps to mitigate this risk, such as terminating the session, or standing up and walking around. As a consequence of this failure to recognise his state of consciousness and ability to fulfil his

role, regardless of cause, Mr Bernard acted inappropriately, in a professional setting, and placed Child B's sister and mother in a vulnerable position. The panel had no hesitation in concluding that this amounted to serious professional misconduct. This was compounded if, as suggested in Mr Bernard's initial response to his regulator, his immediate thought upon waking was to check if the child was in distress or appeared harmed. By this stage, Mr Bernard was in his sixth month of employment and the panel is concerned that he, at that stage in his career, did not consider possibly falling asleep in a contact supervision session to be conduct which he should, at the very least, report to his manager in case anything untoward had been missed.

75. The panel was conscious that it can be hard to stay awake on occasion – falling asleep is a serious issue given Mr Bernard was aware that he was struggling yet attended the session anyway – however of equal importance was his failing to recognise, record or report that there may have been a time in the session that the mother and child did not have his full attention. Further, simply because the child *“did not seem to be in any distress or appeared to be harmed”* did not mean that harm had not happened. The panel considered Mr Bernard's conduct in relation to the supervision of contact for Child B's sister amounted to the statutory ground of misconduct.

Child D – assistance and sleepover on 30 July 2019

76. The circumstances by which Mr Bernard came to be involved with Child D are set out above and not repeated. In this instance Mr Bernard accepts that he did not demonstrate sufficient professional curiosity and that he took what he was told by the family at face value. The panel noted that Mr Bernard did ask the family about the assistance they required but was satisfied that they had access to sufficient assistance. It was not disputed that he took steps upon his return to the office to secure some support for the family by emailing his manager and completing the Service User Assistance Form the following day. The panel was satisfied that Mr Bernard's conduct in this matter did not amount to professional misconduct. The fact that, some six months into his employment, Mr Bernard was not aware that the role of a social worker is to check and test what they are told and not just accept it at face value was, in the panel's opinion, due to a lack of competence. Similarly, his failure to appreciate that a child who was on a child protection plan and therefore for whose safety the Council was accountable, should not be sleeping anywhere other than the family home was also a concern. Both of these circumstances are relatively routine in nature and should have been identified by Mr Bernard as risks that needed to be managed appropriately.
77. The panel was satisfied that Mr Bernard's handling of his involvement with Child D fell below the standard expected of an ASYE social worker and demonstrated a lack of competence which amounted to the statutory ground of impairment by way of lack of competence.

Child C – failing to attend and supervise contact handovers

78. The circumstances of Child C are set out above and not repeated. This child was allocated to Mr Bernard, and he attended the strategy meeting at which it was agreed that the Council would supervise contact handovers between the parents and their families. Mr Bernard had already experienced difficulties in his relationship with Child C's father and by this point he was in his seventh month of employment with the Council. He was therefore familiar with the area he was expected to cover, and with travel times. He should have been capable of managing his own diary. Notwithstanding this, Mr Bernard admitted failing to manage his time and not attending these handovers on two occasions despite Child C being his allocated case. The panel considered Mr Bernard's failure to ensure he attended these handovers amounted to serious professional misconduct. They should have been prioritised, particularly given his limited caseload at that time. That he did not prioritise this task was not due to lack of experience but failure to manage and prioritise his time appropriately. As a result, Child C was exposed to risk of harm. Whilst the failure to manage time and priorities is a core skill for social workers, in this instance the panel was satisfied that the conduct amounted to the statutory ground of impairment by way of misconduct.

Finding and Reasons on Impairment

79. Mr Whittingham reminded the panel of the case law surrounding the issue of impairment, including the cases of:
- Cohen v General Medical Council [2008] EWHC 581 (Admin) – authority for taking account of the need to protect the public and maintain confidence in the profession by determining if conduct is remediable, has been remedied and is unlikely to be repeated;
 - Council for Healthcare Regulatory Excellence v Nursing and Midwifery Council, Paula Grant [2011] EWHC 927 (Admin) endorsed the test formulated by Dame Janet Smith in her Fifth Shipman Report as to past and future risk of: harm to patients; bringing the profession into disrepute; or breaching a fundamental tenet of the profession;
- and submitted that Social Workers are relied upon by the public, the courts and service users to safeguard a range of service users.
80. The conduct covered by the regulatory concerns, in Mr Whittingham's submission, spanned the duration of Mr Bernard's active employment with the Council and there were a variety of issues where Mr Bernard demonstrated poor time management, poor self-regulation and a lack of initiative or self-autonomy in a number of settings. He submitted that Mr Bernard recognised that he is inexperienced and Mr Whittingham acknowledged that there was some insight on Mr Bernard's part in that he had made early admissions in relation to the regulatory concerns. However, he suggested that there remained an element of minimisation and deflection of the concerns – for example Mr Bernard questioned the motive behind the foster carer complaint which informed the Council that he had been asleep during the contact session on 11 July 2019. Further, there was limited evidence of

remediation – the additional development undertaken was, perhaps understandably, not focused on social work settings. Mr Bernard has conceded that he lacked professional curiosity but has not explained what he would do differently in future. For these reasons, Mr Whittingham submitted that Mr Bernard’s insight was partial rather than complete and that the risk of repetition was elevated further as a consequence of Mr Bernard’s limited professional experience and his inability to demonstrate that he had embedded sound professional skills into his practise.

81. In respect of the public aspect of impairment, Mr Whittingham submitted that an informed member of the public would be concerned if no finding of impairment was made – particularly given that Mr Bernard was the only local authority representative at the supervised contact between a mother and non-verbal child in circumstances where that contact had been restricted due to suspicion that the mother could have caused injuries to her children.
82. Mr Whittingham also addressed the panel in relation to the documents supplied by Mr Bernard, observing that the amount of weight that could be placed on the documents was a matter for the panel but that the referee did not seem to be aware of these proceedings, and did not address the work undertaken by Mr Bernard in his role, specifically in relation to safeguarding. Mr Whittingham invited the panel to find Mr Bernard impaired on both the public and private component of impairment.
83. Mr Bernard asked the panel to consider a number of documents that he had provided, which included information on training he had undertaken with his current employer, a reference from the Head Teacher at the school where he worked as a teaching assistant, and some reflective pieces submitted via the Social Work England CPD portal between 2019 and 2022. He confirmed that he had made the referee aware of his fitness to practice proceedings when he asked her for a reference and said that he would have obtained more detailed references if he had been made aware of the need for them. He stated that he had only had limited time to obtain them. He explained that the continuing professional development he undertook was that provided in school and that he could not access the documents he prepared while working with the Council.
84. Mr Bernard reminded the panel that he admitted he could do better on reflection. He accepted that he should have asked for help rather than put anyone at risk. He also told the panel that he understood the impact or potential impact of his conduct. He denied minimising potential risks but asked the panel to consider that, apart from these allegations, he had done acceptable work for the Council. Mr Bernard stressed that this was not a further attempt to minimise risk and that he understood what could have happened. He also asked the panel to have regard to the fact that he had not repeated any of the inappropriate conduct, except for the handover issue, and submitted that this did not amount to a pattern of behaviour. Rather, he considered them different experiences to

learn from. The incidents were not reflective of his whole professional career and conduct for the Council, which he hoped the panel would take into account.

85. The panel considered Mr Bernard's current fitness to practise firstly from the personal perspective and then from the wider public perspective.
86. In the panel's view, Mr Bernard did not demonstrate complete insight into his standard of professional practice in 2019 either at the time or now. It is satisfied that his insight has developed over the intervening period and during these proceedings. The panel hoped that his insight would continue to develop over time.
87. The panel was unable to identify any remorse by Mr Bernard towards those involved, and noted that he displayed limited insight into the impact of his conduct upon the children concerned, their families, his co-workers, the profession or the public. Mr Bernard's sole focus, then and now, appeared to relate to how he had been impacted by the incidents and subsequent regulatory proceedings. For example, in his 2021 response to Social Work England Mr Bernard said *"I have always been aware that I lacked experience and needed a supportive environment, to nurture me in developing my practice which was why I sought out a position as an ASYE Social Worker"*. He had such a supportive environment with the Council but seems to have lacked self-awareness as to the impact his learning style and approach to his work had upon his colleagues. For example, he thought it acceptable to ask a number of colleagues in the team for their views because he wanted to understand the different ways they would approach scenarios – on the face of it, this is not unreasonable to advance his learning. However, Mr Bernard had no appreciation this appeared to the team as if he was 'shopping around' for the opinion he wanted, and frustrated them as they took time to answer his queries and then he asked others the same thing, taking up time a busy team could ill afford to lose.
88. In respect of remediation, the panel concurred with Mr Whittingham's submission that the conduct in this case was remediable. The panel recognised that Mr Bernard had been unable to secure a social work role having left the Council and his ability to access relevant training and development opportunities was therefore limited. However, the panel was of the view that Mr Bernard could have accessed non-specific training and development in relation to time and diary management and particularly in safeguarding. Further, he could have produced more detailed and recent reflections in relation to his experiences in school, though it noted that Mr Bernard had provided some evidence of relevant development of his knowledge base. He could also, through organisations such as the Social Care Institute for Excellence and the British Association of Social Workers, and many others, easily access online training resources such as webinars, PowerPoint slides, videos and articles, as a focus for his reflection and continuous professional development.
89. The panel was pleased to note that Mr Bernard said he had picked up ideas throughout the hearing which he said would help him in future and hoped that he would get the

opportunity to work on these areas of development. The panel considered that the areas of practice where a lack of competence and misconduct had been found were capable, in themselves, of remediation. However, without appropriate insight, the effectiveness of remediation would be limited. It concluded that in the light of Mr Bernard's lack of insight and remediation, there was a real risk of the shortcomings being repeated and therefore it found him to be impaired on the "personal" aspect of the test for impairment.

90. The panel then moved on to consider the public aspect of impairment. It had regard to the important public policy issues which include the need to maintain confidence in the profession and declare and uphold proper standards of conduct and behaviour. It considered that members of the public and members of the profession would be concerned to learn that a social worker had been found to be impaired by way of lack of competence and misconduct in relation to three families across a period of five months despite support from his team and his ASYE co-ordinator. It determined that public and professional trust and confidence in the profession, professional standards, and the regulator would be undermined if a finding of impairment was not made and its disapproval of his conduct marked. The panel concluded that Mr Bernard's fitness to practise is currently also impaired on the public component of the test for impairment.

Finding and Reasons on Sanction

91. Mr Whittingham invited the panel to consider imposing a sanction which was the least restrictive while adequately addressing the risks identified by the panel, recognising that such a sanction should not be a punishment for Mr Bernard, even if it is inconvenient. He submitted that, having regard to the sanctions guidance, neither advice nor a warning order were appropriate in this case. However, he considered that conditions designed to support Mr Bernard in safe practice could be an appropriate sanction. Mr Whittingham suggested that the concerns about Mr Bernard's practice related to poor deadline management, poor prioritisation and failing to identify safeguarding signs and steps to address them. He said that Social Work England consider those failings to be remediable, as identified when the panel considered impairment. Mr Bernard could be supported and observed by colleagues, while workplace mentorship could help with diary management and the establishment of good practice in relation to recording work commitments. He reminded the panel that it could set the level and frequency of supervision for Mr Bernard, as well as the content and preparation for the same. Given the panel's finding of partial insight, Mr Whittingham suggested that a learning and development plan, along with appropriate reflective work, would assist as Mr Bernard was not a "*generally ineffectual*" social worker – he had been making progress which was documented in his ASYE three month review.
92. Mr Whittingham submitted that the panel could make targeted and proportionate conditions which would adequately address the risks in this matter, though he reminded the

panel that the Council suspended Mr Bernard when it considered that the ongoing intervention required was unsustainable. Mr Whittingham therefore suggested that the panel may wish to consider whether a period of suspension would be appropriate to allow Mr Bernard to independently work on the failings identified by the panel, including time management and identification of safeguarding concerns, prior to seeking employment as a social worker. However Mr Whittingham concluded his representations by submitting that Social Work England considered that conditions of practice would adequately address the finding that Mr Bernard is impaired on the public component given that part of Mr Bernard's difficulty related to his lack of experience. There was no suggestion that there were serious attitudinal issues involved, and there were mitigating features of this case in respect of Mr Bernard's engagement in the regulatory proceedings, early admissions of some facts and previous good character.

93. Mr Bernard confirmed that he would be happy to comply with conditions of practice if he decides that he wishes to return to social work. He told the panel that it was right that any future employer should be aware of the impairment decision and help him with his professional development. He was willing to work with supervision, monitoring and support, and said that if he chose to return to social work, he would be able to satisfy conditions imposed in respect of training and reflection that would reassure Social Work England prior to him applying for roles so that he could develop further insight into what had happened and it could be confident that he had learnt from the situation and would not repeat that conduct. He clarified that he was not saying that he thought conditions on his practice were necessary to protect the public, but rather that he thought Social Work England needed to be confident that he understood the implications of his actions and that he would not repeat them. He would be content to start in an ASYE capacity so the regulator did not need to worry about him.
94. The panel was mindful that each case must be determined on its own merits and therefore Social Work England does not have a tariff of sanctions. It has however issued guidance in respect of sanctions to aid panels to make fair, consistent and transparent decisions. It was aware that clear and cogent reasons should be given, particularly if the panel decided to depart from the guidance. The sanctions guidance provides that sanctions are usually only required where a social worker has not immediately and fully reflected on what has gone wrong and taken the necessary steps to put things right, therefore early insight and successful remediation should carry greater weight when a panel assesses the appropriate level of sanction given that the purpose of fitness to practice proceedings is not to punish but to:
 - a. protect the public by ensuring that registered social workers practise to a minimum universal standard; and
 - b. maintain public confidence in the regulatory process and protect the reputation of the profession;

95. The sanctions available to the panel are contained within Schedule 2 of the Social Workers Regulations 2018 at paragraph 13 and are:
- a. the removal of the social worker's entry from the register (a "removal order");
 - b. suspension of the social worker from practising for such period as is specified in the order (a "suspension order");
 - c. the imposition of a restriction or condition with which the social worker must comply for such period as is specified in the order (a "conditions of practice order");
 - d. the giving of a warning to the social worker regarding their future conduct or performance (a "warning order");
 - e. to take no further action.
96. When determining the appropriate level of sanction, there is an expectation that the sanction is proportionate to the circumstances, protects the public in the least restrictive manner possible and takes account of the wider public interest, striking a proper balance between the interests of the social worker and the public. The identification of aggravating and mitigating features can aid panels in making a decision on sanction. Aggravating factors are features which increase the seriousness of the concerns and are likely to lead to stronger sanctions in order to protect the public, while mitigating factors do not excuse or justify poor conduct or competence but can indicate a reduced ongoing risk posed to service user safety and therefore reduce the severity of the sanction required.
97. The panel considered that there were the following aggravating features in respect of Mr Bernard:
- a. the breaching of fundamental tenets of the profession, particularly in respect of safeguarding and risk;
 - b. on occasions deflecting personal accountability for his actions.
98. The following mitigating factors were also identified by the panel in respect of Mr Bernard:
- a. early admissions;
 - b. full and considered engagement in the regulatory proceedings;
 - c. the ASYE role with the Council was his first experience in a statutory setting;
 - d. his apparent dedication to working in a caring profession.

99. The panel was conscious that the allegations found proved were serious and although it had not been made aware that any harm had materialised for any service users, the potential for harm could not be ignored. Further, the panel considered it imperative that the public have confidence and trust in social work professionals and the regulator. Accordingly, the panel did not consider it appropriate to address this matter by way of no further action, advice or a warning. The misconduct and lack of competence had the potential to have serious consequences even if those consequences had not actually occurred.
100. The panel therefore moved on to consider whether a conditions of practice order would be appropriate. The purpose of a conditions of practice order is to allow a social worker to practise while they are subject to restrictions – usually while taking steps to remediate the regulatory concerns identified and regain fitness to practise. Imposition of a conditions of practice order means that a panel is satisfied that the social worker is capable of practising safely and effectively. Conditions facilitate remediation and rehabilitation. The sanctions guidance provides that for a conditions of practice order to be appropriate, the social worker should demonstrate insight and the panel should be satisfied that public protection can be achieved by restriction of practice and it is not necessary, either for public protection or to maintain confidence in the profession, to take any more restrictive steps. Further, at paragraph 117 of the sanctions guidance, decision makers are advised that they should be *“satisfied that the social worker is willing to (and capable of) complying with the conditions.”*
101. Mr Bernard attended the regulatory proceedings throughout and eloquently explained to the panel his current circumstances, making it clear that he would comply with any conditions should he wish to return to social work. In the event that he did not choose to return to the profession, he told the panel that he understood that any conditions would be held in abeyance until discharged.
102. The panel carefully considered whether any conditions could be drafted in this case to address the concerns it identified, particularly in respect of failing to attend handovers and falling asleep during the supervision of a contact session. It was satisfied that Mr Bernard would accept and engage with any conditions of practice it imposed. The panel considered that it would be possible to formulate conditions which adequately protect the public from the professional failings identified, and that, in the circumstances of this particular case, a conditions of practice order was the appropriate and proportionate sanction to impose given the information available to the panel at present.
103. To assure itself that a conditions of practice order was suitable in the circumstances, the panel considered whether a suspension order could be appropriate but concluded that, given the mitigating features set out above, and the limited aggravating features, as well as the nature of the failings identified, anything more than a conditions of practice order would be disproportionate, excessive and not in the public interest given that it was important that individuals who were committed to the profession were supported to remain in the profession.

104. Having determined that a conditions of practice order was the appropriate and proportionate sanction to impose, the panel considered the length of order, conscious that it is in the public interest to support the return to practice of trained social workers when this can be achieved safely. It noted that the sanctions guidance encourages decision makers to take account of all factors available to them and provides at paragraph 120 that the length of order should allow the social worker to complete any necessary remediation.
105. The panel determined that a conditions of practice order of anything less than one year would not afford Mr Bernard sufficient time to secure employment and then show compliance and progression within that employment, particularly in respect of the failings identified by the panel by way of reflection, insight, remorse and remediation. Anything more than two years would, in the panel's opinion, be punitive and disproportionate in the circumstances. Given that the panel was aware Mr Bernard needed to decide what direction his career lay in, and this may impact when (or if) he decides to seek social work employment, it considered that it was more appropriate to impose a conditions of practice order of a longer length so that Mr Bernard was not pressured by the review that would be undertaken before the order comes to an end. Accordingly, the panel determined that the appropriate length of the conditions of practice order would be two years.
106. The panel considered that a reviewing panel would be assisted (but not bound) by Mr Bernard attending the review and providing testimonials from colleagues he works with on a paid or voluntary basis (whether in the social work field or not). Further, Mr Bernard may find it of assistance to re-start his career in an ASYE role if he returns to practice.
107. The panel therefore imposed the following conditions of practice upon Mr Bernard's registration as a social worker:
1. You must notify Social Work England within 14 days of any professional appointment you accept or are currently undertaking and provide the contact details of your employer, agency or any organisation with which you have a contract or arrangement to provide social work services, whether paid or voluntary.
 2. You must allow Social Work England to exchange information with your employer or any organisation with which you have a contract or arrangement to provide social work or social work educational services, and any reporter or workplace supervisor referred to in these conditions.
 3. At any time you are providing social work services, which require you to be registered with Social Work England, you must:
 - a. agree to the appointment of a reporter nominated by your employer and approved by Social Work England. The reporter must be on Social Work England's register.

- b. not start or continue to work until these arrangements have been approved by Social Work England.
- 4. You must provide reports from your reporter to Social Work England every 3 months and Social Work England will make these reports available to any workplace supervisor referred to in these conditions on request.
- 5. You must inform Social Work England within 7 days of receiving notice of any formal disciplinary proceedings taken against you from the date these conditions take effect.
- 6. You must inform Social Work England within 7 days of receiving notice of any investigations or complaints made against you from the date these conditions take effect.
- 7. You must inform Social Work England if you apply for social work employment (paid or voluntary) outside England within 7 days of the date of application.
- 8. You must inform Social Work England if you are registered or subsequently apply for registration with any other UK regulator, overseas regulator or relevant authority within 7 days of the date of application [for future registration] or 7 days from the date these conditions take effect [for existing registration].
- 9. You must work with your workplace supervisor to formulate a personal development plan, specifically designed to address the shortfalls in the following areas of your practice:
 - a. time management;
 - b. diary management;
 - c. prioritisation of risk;
 - d. safeguarding
- 10. You must provide a copy of your personal development plan to Social Work England within 8 weeks from the date these conditions take effect and provide an updated copy to accompany any report of your workplace reporter.
- 11. At any time you are employed, or providing social work services, which require you to be registered with Social Work England;
 - a. you must place yourself and remain under the close supervision of a workplace supervisor nominated by your employer (who may be the same person as the workplace reporter) and agreed by Social Work

England. The workplace supervisor must be on Social Work England's register.

- b. you must not start or continue to work until these arrangements have been approved by Social Work England.
- 12. You must provide reports from your workplace supervisor to Social Work England every 3 months and Social Work England will make these reports available to any reporter referred to in these conditions on request.
- 13. You must keep your professional commitments under review and limit your social work practice in accordance with your workplace supervisor's advice.
- 14. You must not supervise the work of any other social worker or student social worker.
- 15. You must not work as an independent social worker and must only work as a social worker at premises where other social workers are employed.
- 16. You must not undertake any agency, locum, out-of-hours or on-call duties.
- 17. You must read Social Work England's 'Professional Standards' (July 2019), and provide a written reflection 3 months after these conditions take effect, focusing on how your current practice is consistent with Social Work England's professional standards for social workers.
- 18. You must provide a written copy of your conditions, within 7 days from the date these conditions take effect, to the following parties confirming that your registration is subject to the conditions listed at 1 to 17 above:
 - a. any organisation or person employing or contracting with you to undertake social work services, whether paid or voluntary.
 - b. any prospective employer who would be employing or contracting with you to undertake social work services whether paid or voluntary (at the time of application).
 - c. Any organisation, agency or employer where you are using your social work qualification/knowledge/skills in a non-qualified social work role, whether paid or voluntary.

You must forward written evidence of your compliance with this condition to Social Work England within 7 days from the date these conditions take effect.

- 19. You must permit Social Work England to disclose the above conditions, 1 to 18 to any person requesting information about your registration status.

Interim Order

108. Having determined that Mr Bernard's fitness to practise is impaired and having imposed a conditions of practice order, Mr Whittingham confirmed that Mr Bernard is currently subject to an interim suspension order. Mr Whittingham told the panel that Social Work England was required to provide Mr Bernard with notice of an application to revoke the interim suspension order (which would not usually fall away until the substantive order comes into effect). However, Mr Bernard could waive this notice period. In the event that Mr Bernard was content to waive the notice requirement, Mr Whittingham applied for an interim conditions of practice order in the same terms as that imposed in the substantive order. He submitted that it would be inconsistent with the panel's findings as set out above for it not to impose such an order.
109. Mr Bernard confirmed that he was content to waive the requirement for Social Work England to give him notice of its intention to apply to revoke the existing interim suspension order and did not object to the imposition of an interim conditions of practice order in the same terms as that imposed in the substantive order pending the substantive order taking effect.
110. The panel noted the guidance issued by Social Work England (within the sanctions guidance) in respect of interim orders, in particular that it need not give notice to the social worker of the application for the imposition of an interim order to cover the appeal period or the period before any appeal is heard as the possibility of such an order was included in the notice of hearing.
111. Interim orders can be orders of suspension or orders imposing conditions of practice and last for a maximum of 18 months, with regular reviews being undertaken periodically. The panel was conscious that the regulations set out at Schedule 2, paragraph 11, that it could make an interim order if it found this to be necessary for the protection of the public (including wider public interest grounds) or in the best interests of the social worker.
112. Having regard to the regulations and the guidance issued by Social Work England, the panel was satisfied that an interim order was necessary to protect the interests of the public pending the determination of any appeal for the same reasons as set out in the substantive decision. It determined that in the light of its findings on impairment, serious damage would be caused to public confidence in the profession if no interim order were imposed and standards were not upheld. An interim order was therefore necessary to promote and maintain public confidence in the profession and maintain standards for the reasons set out in the substantive decision.
113. The panel considered the principle of proportionality and decided to make an interim conditions of practice order for a period of 18 months. In deciding on this length of interim order (which will expire in 28 days if no appeal is lodged), it took account of the fact that any

appeal may take some time, particularly in view of the current court timetables for dealing with matters.

114. Given the panel is imposing an interim conditions of practice order, it follows that the panel must also revoke the existing interim suspension order with immediate effect.

Right of Appeal

115. Under paragraph 16 (1) (a) of schedule 2, part 5 of the regulations, Mr Bernard may appeal to the High Court against the decision of the Panel to impose a conditions of practice order.
116. Under paragraph 16 (2) schedule 2, part 5 of the regulations an appeal must be made within 28 days of the day on which Mr Bernard is notified of the decision complained of.
117. Under regulation 9(4), part 3 of the regulations, this order can only be recorded on the register 28 days after Mr Bernard was informed of the decision or, if Mr Bernard appeals within 28 days, when that appeal is exhausted.
118. This notice is served in accordance with rules 44 and 45 of the rules.

Review of final orders

119. Under paragraph 15 (2) and 15 (3) of schedule 2, part 4 of the regulations:
- a. 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 Mr Bernard;
 - b. A request by Mr Bernard 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.
120. Under rule 16 (aa) of the rules, a registered social worker requesting a review of a final order under paragraph 15 of Schedule 2 must make the request within 28 days of the day on which they are notified of the order.

European alert mechanism

121. In accordance with Regulation 67 of the European Union (Recognition of Professional Qualifications) Regulations 2015, Social Work England will inform the competent authorities in all other EEA States that Mr Bernard's right to practise has been prohibited or restricted.

122. Mr Bernard may appeal to the County Court against Social Work England's decision to do so. Any appeal must be made within 28 days of the date when this notice is served on Mr Bernard. This right of appeal is separate from Mr Bernard's right to appeal against the decision and order of the panel.