

Social Worker: Stephen Joseph
Williamson
Registration Number: SW42473
Fitness to Practise: Final Hearing

Dates of hearing: Monday 18 to Monday 25 July 2022

Hearing Venue: Remote hearing

Hearing outcome: Removal from register

Interim Order: Interim Suspension Order (18 months)

Introduction and attendees

1. This is a hearing held under Part 5 of The Social Workers Regulations 2018.
2. Mr Williamson did not attend and was not represented.
3. Social Work England was represented by Ms Louisa Atkin, instructed by Capsticks. LLP.

Adjudicators	Role
Claire Cheetham	Chair
Jacqueline Telfer	Social Worker Adjudicator
Judith Webb	Lay Adjudicator

Paul Harris	Hearings Officer
Kathryn Tinsley & Arabella Vahey-Crossley	Hearing Support Officers
David Mason	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 Williamson by special delivery and email to his address on the Social Work Register (the Register). Ms Atkin submitted that the notice of this hearing had been duly served.
5. The panel had careful regard to the documents contained in the final hearing service bundle as follows:
 - a. A copy of the notice of the final hearing dated 13 June 2022 and addressed to Mr Williamson at his address as it appears on the Social Work England Register;

- b. An extract from the Social Work England Register detailing Mr Williamson's registered address;
- c. A copy of a signed Statement of Service, on behalf of Social Work England, confirming that on 13 June 2022 the writer sent by special delivery to Mr Williamson at the address referred to above and by email to an address notified to Social Work England by him: Notice of Hearing and related documents;
- d. A copy of the Royal Mail Track and Trace Document indicating "signed for" delivery to Mr Williamson's registered address at 09.07am on 17 June 2022 signed in the name of 'Williamson'.
- e. An email from Mr Williamson to Social Work England dated 14 July 2022 stating:

"Roisin,

I appreciate your time and effort but I am not reading any of the documentation and do not intend to practice again in the future.

I do not intend to attend any future hearings and would like to end this process once and for all.

Steve Williamson"

- 6. The panel accepted the advice of the legal adviser in relation to the service of notice that the duty on Social Work England was to prove that the notice was sent, not necessarily that it had been served.
- 7. Having had regard to Rule 44 and all of the information before it in relation to the service of notice, the panel was satisfied that notice of this hearing had been served on Mr Williamson in accordance with Rules 44 and 45. It was clear the notice had been sent by special delivery and by email and that Mr Williamson had received it.

Proceeding in the absence of the social worker

Submissions on behalf of Social Work England

- 8. The panel heard the submissions of Ms Atkin on behalf of Social Work England. Ms Atkin submitted that notice of this hearing had been duly served and invited the panel to proceed in the interests of justice and the expeditious disposal of this hearing. She referred the panel to the factors to be taken into account approved by the House of Lords in Jones [2003] UKPC.

9. Ms Atkin referred to documentation in the case, in particular Mr Williamson's email of 14 July 2022, which she submitted amounted to a clear waiver by Mr Williamson of his right to attend the hearing. Ms Atkin drew the panel's attention to the warning in Jones that an application to proceed in absence should be considered with great care. She submitted that it is unlikely that an adjournment of the hearing would secure Mr Williamson's attendance and that the circumstances of his absence were that he had shown a clear intent not to attend the hearing.
10. Ms Atkin also submitted that the panel should consider the disadvantage to Mr Williamson caused by him not being present. She referred the panel to the case of General Medical Council v Adeogba [2016] EWCA Civ 162, which she submitted was authority showing that the panel should be primarily concerned with its function to protect the public as contained in the Social Work England's overarching objective.
11. The panel accepted the advice of the legal adviser in relation to the factors it should take into account when considering this application. This included reference to the cases of Jones and Adeogba and Rule 43. He advised that the panel should first satisfy itself that all 'reasonable efforts' had been made to advise Mr Williamson of the hearing. If it was so satisfied, the legal adviser advised, the panel should then consider whether to proceed in the absence of Mr Williamson, or to adjourn the hearing, the only alternative to proceeding in his absence. He advised the panel that it should consider fully the public interest in hearings being held in a timely and fair way.
12. The panel was satisfied that Mr Williamson had chosen voluntarily to absent himself. The panel had no reason to believe that an adjournment would result in his attendance. Having weighed the interests of Mr Williamson's with those of Social Work England and the public interest in an expeditious disposal of this hearing, the panel determined to proceed in Mr Williamson's absence. It was satisfied that it could ensure that Mr Williamson would receive a fair hearing in his absence.

Preliminary issues

Amendment of the allegation

13. Ms Atkin made an application to amend the allegation. She submitted that the panel could do so under its general powers contained in Rule 33 to regulate the conduct of the hearing. Ms Atkin informed the panel that Mr Williamson had been informed that the application would be made in a letter to him of 14 July 2022. He has, she said, made no objection. Ms Atkin submitted that Mr Williamson was not prejudiced by the application which was intended to allow the panel to properly consider the case against him and did not make the allegation more serious.
14. The application was to amend the allegations as follows:

1.3 [In relation to Case E342037] Failed to make ~~any~~ appropriate further checks,

assessments or referrals in relation to the referral of 12 October 2017

1.4 [In relation to Case E342037] Failed to make ~~any~~ appropriate further checks,

referrals or assessments for the referral of 30 October 2017

15. The legal adviser advised that the panel could regulate the conduct of the hearing under Rule 33 and that an amendment could be made if it was in the interests of justice and was fair.
16. The panel accepted the advice of the legal adviser and concluded that the amendment did not prejudice Mr Williamson and that he had received proper notice of it without him making any objection. The panel allowed the amendment.

The inclusion of further documents in the hearing bundle

17. Ms Atkin invited the panel to include in the bundle pages which had appeared in the bundle as disclosed to Mr Williamson but which had appeared as blank pages in the hearing bundle supplied to the panel. The pages referred to were at 387, 391, 402, 404, 414 and 441 of the bundle. Ms Atkin referred the panel to its powers under Rule 33 to regulate its proceedings. The panel accepted the advice of the legal adviser that it should consider whether there was any unfairness to Mr Williamson where he had been provided with the missing pages when disclosure took place.
18. The panel concluded that there was no unfairness in the missing pages being included in its hearing bundle and allowed the application.

The admission of further documents

19. Ms Atkin referred the panel to a supplementary bundle of documents. The contents were records which had been disclosed to Mr Williamson but which had been removed from the hearing bundle to reduce its size. She informed the panel that Social Work England now wanted to include the documents in the material before the panel. The panel accepted the

advice of the legal adviser that it could admit the documents if there was no unfairness to Mr Williamson.

20. The panel concluded that as Mr Williamson had been provided with the documents there was no unfairness to him in now admitting them. It noted that he was not present to object to the application but took account of its finding that he had voluntarily absented himself.

The allegation as amended

1. The allegations arising from the regulatory concerns referred by Social Work England's Case Examiners on 23 July 2021 are:

1. That you, a registered Social Worker, whilst employed by Newcastle County Council as a social worker:

In respect of Case E411128:

1.1 Failed to undertake a joint connected person's risk assessment before deciding that a home was a suitable environment for the child.

In respect of Case E342037:

1.2 Failed to complete a write up and/or assessment after deciding the case was suitable for closure as of 25 October 2017

1.3 Failed to make appropriate further checks, assessments or referrals in relation to the referral of 12 October 2017

1.4 Failed to make appropriate further checks, referrals or assessments for the referral of 30 October 2017

In respect of Case E310626:

1.5 Left a voicemail on the phone number of the perpetrator of domestic violence instead of the victim

Your conduct in Head of Charge 1 above amounts to misconduct.

By reason of your misconduct your fitness to practise as a social worker is impaired.

The case for Social Work England

21. The case presented by Social Work England in relation to the facts was set out in a written statement. In relation to the facts it reads:

“3. On 5 May 2018 a referral was made to the HCPC by Newcastle County Council (‘the Council’) regarding the Respondent social worker, Stephen Williamson (‘the Social Worker’). The Social Worker was employed by the Council as of 2 November 2009.

He began working in the Initial Response Service Team in September 2017.

4. When the Social Worker joined the Initial Response Service Team, as part of the handover process his new Line Manager,

TR, was informed by his previous Line Manager, SP that there were some existing performance issues with the Social Worker and that he was on an informal performance plan which was being reviewed during supervision. The performance issues related to completing assessments on cases which had not been written up within the 45 day timescales, that there were cases which could be or needed to be closed but had not and some cases should have been transferred to another team but had not been due to outstanding work on the case. Whilst he was managed by TR the performance issues persisted despite the support he was receiving.

5. In the case of Case E411128 a report was made to the team regarding a child who had sustained bruising. It was decided that child should be subject to a child protection enquiry and with the consent of the parents the child was to be taken into the care of the local authority for a short period. It was proposed that the child would live with the maternal grandparents pending the outcome of the enquiry. However, the Social Worker failed to carry out a ‘joint connected person’s assessment’ with the fostering agency for the grandparents and their home before agreeing that it was an appropriate place for the child to stay.

6. The Social Worker was allocated Case E342037 where there was domestic violence within the family and the potential physical chastisement. During supervision the case was discussed and the Social Worker stated that there was no indication of any concerns and therefore the case was to be closed. When a new Social Worker carried out what was to be the final visit, the child disclosed that she had been hit by her father and the case was immediately escalated to a strategy meeting and child protection enquiry.

7. When older statutory visits records completed by the Social Worker were checked, there was reference to one of the children having a bandage on their arm during a visit. When the Social Worker asked the father about the bandage the father stated that it was a minor injury which did not result in a hospital visit and that the child had missed school but the school were not informed why. After this visit no further assessment write ups were made. There were no further records or explanations about this incident nor were any further checks undertaken.

8. Case E310626 related to a complaint made about the Social Worker by a service user.

In a domestic violence case the Social Worker was intending to call the mobile number of the victim but instead called the perpetrator and left a voicemail intended for the victim.

9. After the issues with Case E411128 (HoC 1.1), the Social Worker was suspended from work on 28 December 2017. An internal investigation took place resulting in the Social Worker's dismissal from the Council on 13 April 2018.

10. Social Work England will call evidence from the following witnesses:

a. TR, at the time of the allegations, she was the Social Worker's Line Manager from September 2017 to April 2018 and will give evidence on the Social Worker's performance, level of support he received and conduct in respect of three specific cases. She will exhibit the relevant case records and supervision records.

b. GB, was a social worker within the same Team as the Social Worker at the time of the allegations. She was assigned to assist the Social Worker with case E411128. She will give evidence on what if any checks were made by the Social Worker in deciding that the grandparents and their address were a suitable environment for the child in question

c. KB, the Principle Advisor for Newcastle Children Service and Service Manager for the Initial Response Team, chaired the disciplinary hearing and will produce exhibits relating to that hearing. SWE do not propose to call this witness but she will be asked to remain available if the Panel require her for questioning.

d. SD, Service Manager for the Council who conducted the local authority investigation

Head of Charge 1:

1. That you, a registered Social Worker, whilst employed by Newcastle County Council as a social worker:

In respect of Case E411128:

1.1 Failed to undertake a joint connected person's risk assessment before deciding that a home was a suitable environment for the child

11. The case was referred to the Initial Response Service Team after a report had been made about a child who had bruising. The Social Worker was assigned the case. Upon being assigned the case, the Social Worker visited the family's home and consulted with the consultant paediatrician. He then told the family that the baby needed to go to hospital for a Child Protection medical assessment and receive any necessary treatment. An appointment was arranged for the next day and a safety plan was put in place for the maternal aunt to reside with the family that night. The Social Worker asked the parents about the bruising for which they did not have an explanation. It was decided that the child would be subject to a child protection enquiry. (W/S TR, Page 8, Para 26)

12. Another social worker, GB, was assigned to assist the Social Worker and to ask the Social Worker to complete the relevant s.20 paperwork. Under s.20 of the Children's Act 1989, the Council has powers to obtain consent from the parents to take a child into the care of the local authority for a short period of time.

13. TR advised GB to inform the Social Worker that the fostering agency social worker was waiting for the social worker to contact him so they could complete a 'connected person's risk assessment' in order to make arrangements for a joint visit to be completed to the maternal grandparents' home.

14. TR states that the joint connected person's risk assessment must be completed by a social worker from the Council and a fostering agency social worker together in order to be satisfied that it was safe to allow the child to be cared for by the maternal grandparents whilst the child protection enquiry was being completed.

(W/STR, Page 9, Para 29)

15. The Social Worker spoke with the child's grandfather and agreed with the parents that the interim living arrangements could be with the maternal grandparents. However, the Social Worker failed to carry out a 'joint connected person's assessment' with the fostering agency for the grandparents and their home before agreeing that it was an appropriate place for the child. The fostering agency was still waiting to be contacted.

(W/S TR, Page 10, Para 10)

16. The Social Worker upon his return to the office, stated that he had spoken to the grandfather and said 'he's fine, he's fine'. (W/S TR, Page 11, Para 34) The Social Worker failed to contact the fostering agency even though TR had provided clear case direction. When this was raised with the Social Worker he stated that he tried to contact the fostering agency but there was no response. The fostering agency's social worker called the office to say that they had been waiting for the Social Worker to call and waited in the office to meet the Social Worker.

(W/S TR, Page 11 Para 36)

17. GB confirms that whilst she accompanied the Social Worker she did not see him contact the fostering agency and reminded him to call them.

(W/S GB, Page 4, Para 16)

18. TR considered it was important to understand the environment the child would be living in and that the carers were aware of their responsibilities including ensuring all contact with the parents was supervised.

In respect of Case E342037:

1.2 Failed to complete a write up and/or assessment after deciding the case was suitable for closure as of 25 October 2017

19. The Social Worker was allocated a case involving a family where domestic violence was present and there was potential for physical chastisement. TR discussed this case in supervision with the Social Worker and discussed next steps. The Social Worker had last spoken to the children (parents were not present) on 9 November 2017 and had not identified any issues and there was no indication of any concerns. (Exhibit Bundle, TR/06, Page 515) As a result the case was due to be closed. Before the case could be closed the Social Worker needed to write up his assessment from the last visit which was long overdue. The visit had taken place on 9 November 2017 the write up was not completed and the Social Worker was then not able to complete the write up as he was suspended from work on 28 December 2017. As a result the case was assigned to another social worker, LG.

(W/S TR, Page 12, Para 41).

20. When LG carried out a visit on 9 January 2018 she escalated the case to a strategy meeting and child protection enquiry. (Exhibit Bundle, TR/06 Pages 503 –

509) LG told TR that when she spoke with the family they had said everything was fine. When she spoke to the children privately and asked the child 'are you sure you are happy' the child disclosed that she was not happy as her father had 'hit her all the time'.

(W/S TR Page 12 Para 42).

1.3 Failed to make any further checks, or assessments or referrals in relation to the referral of 12 October 2017

21. As a result of the disclosure, TR looked over older statutory visit records that the Social Worker had completed in October 2017. (Exhibit Bundle, TR/06, Page 499-500) the records revealed that one of the children had been absent from school on 11 October 2017 and 12 October 2017 but the school had not been informed as to why the child was absent. This led to the school contacting the mother who informed them that the child had fallen off his bike, hurt his arm and someone had brought him home. As a result of the injury the child was unable to move his arm the following morning. The mother also stated that the father would take the child to a walk in centre. When the child was absent on 12 October 2017 and the father was contacted, the father stated that the child had a cold. The school arranged a welfare check which was unsuccessful and established with health staff that the child had not attended a walk in centre, A & E or seen a GP.

22. On 12 October 2017, the Social Worker conducted a visit and met with the child and father. The Social Worker noticed that the child had a bandaged arm and bruising on his leg. The father said that the child had sustained the injury by falling over a rock. The father claimed that he had informed the school by speaking with reception and did not believe the injury warranted medical assistance.

23. As a result of the visit the Social Worker did not undertake any further assessments or checks and accepted what the father had said as a reasonable explanation. Following the visit the Social Worker was required to produce a write up and brief assessment (Exhibit Bundle, TR/06, Page 511). No further write ups or assessments were undertaken.

24. TR states that not only was this not comprehensive recording as insufficient information had been documented but it was a serious omission as there was no record of any checks about the injury on file. Given the family history she would have expected the Social Worker to have checked for any connections or patterns to obtain a true picture of the incident or to check if the child was suffering from a health condition which could have contributed to the injury. Having seen the bandages on the child the Social Worker ought to have explored the issue and at least considered a visit to the GP. As a result of his failure to do this, it is not clear whether the Social Worker had encouraged the children to share further information

about how they were actually feeling, if he had completed a thorough risk assessment of the visit and if he had taken the necessary steps to manage the risk.

(W/S TR, Page 13, Para 46)

25. As of 25 October 2017, the Social worker was recommending in supervision that the case should be closed (Exhibit Bundle, TR/06, Page 505) 1.4 Failed to make any further checks, referrals or assessments for the referral on 30 October 2017

26. On 30 October 2017 (Exhibit Bundle, TR/06 Page 512) the mother had disclosed a domestic violence incident to the police. As a result of this disclosure no further assessments were conducted by the Social Worker and he accepted the mother's retraction of her account.

In respect of E310626:

1.5 Left a voicemail on the phone number of the perpetrator of domestic violence instead of the victim

27. The Social worker called the wrong number and left a voice message. The case in question was a domestic violence case. The Social Worker intended to call the victim of domestic violence but rather phoned the number belonging to the perpetrator of the violence. This left the victim in a vulnerable position and significantly increased the potential risk of further assault

(W/S KB, Page 4, Para 18).

Matters which are agreed/ disputed between the parties

28. The Social Worker has not engaged with the substantive investigation and on 14 April 2022 the Social Worker expressed his disinterest in reading correspondence concerning the case."

The case for the social worker.

22. Mr Williamson did not attend the hearing nor was he represented. The panel considered the documents in a bundle which included his submissions to the Council in the course of its disciplinary process.

"DISCIPLINARY STATEMENT

I have worked for Newcastle City Council for approximately 9 years and despite the many challenges I have faced I have enjoyed my tenure immensely.

I was suspended from work on 28th December 2017 and have subsequently undergone 3 disciplinary interviews and have been advised that a disciplinary hearing is to be convened on 13th April 2018.

I have also conceded leaving a message for the wrong service user.

None of the above actions have been completed intentionally.

During the disciplinary process I was asked about four cases I had worked with. I feel that the exploration of these cases was completely flawed and ignored the fluidity of child protection work and the role of senior management in the decision making process.

I was further criticised for not updating a child and family assessment for one of the young people I supported. This completely ignored the failure of the service to transfer cases in a timely and effective manner.

It is my view that the entire disciplinary process has been flawed and conducted from a deficit perspective, completely ignoring any good work I've done, positive outcomes as well as my commitment and hard work.

I was advised that I have been on a plan to improve my practice. This was not the case as this was removed some time ago. Indeed my Team Manager had agreed to clarify this matter but failed to do so.

Evidence collected suggests that I was not suited to being a senior practitioner. I must point out that not a single manager has ever told me this.

As for supervision. I value this massively and have never deliberately avoided this support mechanism. Often the needs of service can impact upon supervision. It is fair to say that I have had many more supervision sessions cancelled by managers.

I believe that nine years in IRS is testimony to my resilience. Whether misguided or not I have always pursued visits/engagement with families that I have felt was necessary to a child's safety.

My timescales were highlighted as unsatisfactory. Indeed I was advised that my timescales were a major headache for my employers. I feel that this is completely unfair and reflective of a culture within Newcastle that prioritised timescales above quality. I concede that some of my assessments were out of timescale but not all of them by any means. Indeed some of my assessments were out of timescale as my team manager had refused to authorise them.

A lot is made of my caseload and apparent inability to close cases. No mention is made of the relentless nature of the work. Although I acknowledge that this is a facet of working within IRS that I have sometime struggled with there appears to have been no recognition of the role of allocation, priority and emergency.

There-in lies further mitigation for any errors I have made. My previous manager (SP) had told me how much I would be missed and what an asset I had been to the team. She had no problems with the quality of my assessments. Sadly SP has failed to mention any of this during her interview. Other managers had also authorised assessments during the period my manager continued to refuse to authorise.

I felt bullied, deskilled and lacking in motivation during the period I was managed by TR and felt that nothing I did was good enough. I found TR to be abrupt, controlling and unsupportive. If TR was so worried about my practice, why then did she not tell me directly. It is therefore not surprising that TRs appraisal of my performance is damning.

A previous manager MK has said that they avoided allocating me unborn cases. This is completely inaccurate. Indeed they chaired a strategy meeting and subsequent transfer of a case I was managing. Once again issues highlighted during interview were never broached in Supervision.

I am of the opinion that the culture within Newcastle has become one of blame, criticism and unrealistic demands. Caseloads have become considerably higher than that recommended. Expectations have become give me 10 out of 10 assessments in timescale or else.

Training is invariably the victim of the needs of the service and I have completed limited training because of this. The senior practitioner role has become nothing more than that of a glorified social worker.

During my time in Newcastle I have experienced 2 periods of sickness related to [PRIVATE], [PRIVATE] and work related stress. There is little doubt in my mind that

the culture has become even more oppressive and that mental health breakdown is becoming a regular feature of social work in this department.

Despite the distress signals I have shown at time my working conditions have not improved. Indeed in my opinion they have become markedly worse.

I have tried my best to adhere to HCPC standards and have never had my ability to do so questioned by managers. It is devastating therefore to have SD state that he has uncovered many breaches of these standards. I do not feel that I am gung ho or dangerous practitioner. I do not feel that outcomes in child protection work are based on luck as suggested by SD and resent this inference.

I feel that I still have a lot to offer as a social worker but feel that I have been humiliated by the disciplinary process and made out to be useless, ineffective, dangerous and incompetent. This far from the truth.

I have tendered my notice as regardless of future outcomes I feel that it would be impossible for me to continue to work for the authority. Consequently I am unable to attend the hearing scheduled for 13th April 2018. Consequently I have prepared this statement to be considered at my hearing.

There is little doubt that my identity has been significantly threatened by a daunting, deficit led and outdated process. It is demoralising to see a 35 year career dismantled so savagely and nine years dedicated service to Newcastle City Council completely ignored. I feel that I deserve to retain a mandate to practice whatever the result of this process and will challenge negative outcomes at whatever levels open to me, including OFSTED and HCPC as appropriate.

Worryingly however social workers in other departments/authorities are already talking about my dismissal and this more than a week before the hearing that is meant to examine all available information. I trust this does not mean that the forthcoming hearing is nothing more than a rubber stamp exercise.

Steve Williamson

06/04/2018"

Summary of Evidence

23. The evidence called by Social Work England in support of the Allegation consisted of written evidence in the form of:
- a. A main hearing bundle of exhibits, including the Council's investigation report, the social worker's job description, supervision records and the Council's statutory visit guidance documents.
 - b. A main hearing bundle of witness statements
 - c. A supplemental bundle of service user records
 - d. A further supplemental bundle of service user records
24. Social Work England called three witnesses:
- TR – Mr Williamson's line manager from September 2017 to April 2018
 - GB – an ASYE (Assessed and Supported Year in Employment) social worker who had been assigned to assist Mr Williamson in relation to one of the cases considered by the panel
 - SD - a service manager for Mr Williamson's employer, who conducted an investigation on its behalf into Mr Williamson's conduct and performance
25. The panel also considered the contents of a statement from KB, who chaired a disciplinary hearing which led to Mr Williamson's dismissal.

Submissions on the facts

26. Ms Atkin made submissions on both facts and misconduct on behalf of Social Work England in relation to the three cases and 5 heads of the Allegation starting first with submissions on facts.
27. Ms Atkin said in relation to head 1.1 that Mr Williamson had confirmed to SD in the investigation that he had allowed the child to go home with the grandparents without carrying out any checks on the environment to which the child was going. This was confirmed by the evidence of TR and GB. TR had said in evidence that the expectation was that Mr Williamson would accompany the child to the grandparents' home to check on its suitability. Ms Atkin said that at the time Mr Williamson was at the hospital to support the family and do the necessary paperwork. He had recognised the need to supervise the child

in a public place but not the need to ensure the child was going to safe accommodation. She said that if Mr Williamson could not complete the work allotted to him on that day then it was his responsibility to seek support. He did not appear to have asked GB for support although she had been allocated to assist him. Ms Atkin said that even if Mr Williamson had to spend the day at the hospital, he should not have allowed the child to leave without proper checks being made.

28. In relation to heads 1.2 - 1.4 Ms Atkin said there was no evidence that Mr Williamson had written up his assessment of the case. It had been agreed on 25 October 2017 that it would be completed by 3 November 2017. Ms Atkin said that following a further referral by the police the case had been discussed again in supervision and it was then agreed that the assessment would be completed by 22 December 2017. It had not been completed when Mr Williamson was suspended by the Council on 28 December 2017.
29. Ms Atkin said that Mr Williamson had de-escalated the case even after the second referral. She said that the documents showed that he had recorded different accounts from the parents of the child's injuries without investigating them further. Ms Atkin said there was no indication from the record of 12 October 2017 that he had seen the child alone or explored the different accounts. She said Mr Williamson had recorded problems in seeing the parents without then carrying out any checks with the child's school or GP. Ms Atkin pointed to TR's evidence that she would have expected checks to be made on the family history and sought medical advice as to whether the injury was consistent with the explanations given, as well as whether there had been any pattern of absence at the school. Ms Atkin said it was reasonable to infer from the lack of a record of checks being carried out that they had not been done.
30. In relation to head 1.5, Ms Atkin submitted that Mr Williamson had stated that if the father had said a message had been left on his voice mail it must have been done. Ms Atkin submitted that the father had said the message made him angry and that the message left on the father's phone put the mother in a 'risky' situation. Ms Atkin submitted that Mr Williamson had admitted in his submission to the Council that the message infringed data protection in supplying too much information to the wrong voicemail.

Legal advice

31. The legal adviser advised the panel that although it had heard submissions from Ms Atkin in relation to the facts and misconduct, it should approach them on the basis that they are related to individual parts of the case and should be considered separately.
32. The legal adviser reminded the panel that the burden of proof in the case was upon Social Work England and that Mr Williamson was not required to prove or to disprove anything.
33. The legal adviser advised that the standard of proof is the civil standard, that is on a balance of probabilities. He advised that a fact will be found proved if it is more likely than not to have occurred.

34. The legal adviser advised that the panel should consider each of the heads of the allegation individually. He advised that the word 'failed' in the allegation meant culpably failed and that Social Work England had to prove that there was a duty upon Mr Williamson which he had not complied with.
35. The legal adviser advised that it could accept the evidence of a witness entirely, could reject it entirely or could accept some parts and reject other parts.
36. The legal adviser advised that in considering the evidence it could draw reasonable inferences, that is reasonable conclusions from the evidence it found proved, and which were not conjecture or speculation.
37. The panel accepted the advice of the legal adviser.

The panel's findings and reasons on the facts

38. The panel considered each of the heads of allegation separately. In relation to the witnesses, it considered their evidence on the basis of taking it in to account in relation to the documentary evidence and firmly established facts before it. It considered the reliability and consistency of the evidence in relation to the separate allegations and looked for supporting contemporaneous written evidence where possible. On that basis the panel found the evidence of each of the witnesses it heard from to be consistent, measured and believable. It noted that witnesses were open when they could not answer a question and the panel accepted that the events they were relating took place several years ago.
39. In relation to Mr Williamson, the panel considered the generalised assertions that he felt 'bullied, deskilled and lacking in motivation' and that he found TR to be 'abrupt, controlling and unsupportive' as contained in his 'Disciplinary Statement(s)'.
40. The panel did not find evidence to support those assertions by Mr Williamson, having put Mr Williamson's comments about TR directly to her. It acknowledged that the team which had included Mr Williamson was required to react at short notice to whatever concerns were reported or referred to it. It noted the evidence of SD and TR that the tasks social workers were asked to carry out were based on statutory requirements which the Council was bound to comply with. It also noted TR's evidence that if Mr Williamson could not complete the tasks necessary to his work which had been assigned to him he could ask for support. The panel noted that in relation to one of the cases TR had assigned GB to assist Mr Williamson. The panel accepted TR's evidence that *"I remember he said that he found 'clear direction' for his cases as 'supportive' supervision."*
41. In relation to the heads of allegations, the panel found as follows.

Case E411128:

1.1 Failed to undertake a joint connected person's risk assessment before deciding that a home was a suitable environment for the child.

42. The panel considered the evidence of SD contained in the notes of his investigation in the exhibits bundle that Mr Williamson had admitted that he had sent the child to his grandparents' home without carrying out the joint connected risk assessment with the fostering agency.
43. The evidence of GB supported the allegation that Mr Williamson had not contacted the fostering agency before allowing the child to go home with the grandparents. This is supported again by TR's evidence that on his return to the office Mr Williamson did not have with him the necessary paperwork for an s20 case. Her evidence was that he was vague about its whereabouts and that she instructed him to carry out the necessary checks and consultation with the fostering agency.
44. The panel found that the duty to comply with the s20 procedure was important both for the safety of the child and for the duties it placed upon the Council. It accepted that when a child was taken into its care, the Council was responsible for their safety and that in this case the child had been sent to unchecked carers in an environment by Mr Williamson which had not been assessed and which could have placed the child at risk. It therefore concluded that Mr Williamson had failed to carry out a duty required of him.

The panel found this head proved.

Case E342037:

1.2 Failed to complete a write up and/or assessment after deciding the case was suitable for closure as of 25 October 2017

45. The panel noted the case notes in the exhibits bundle that Mr Williamson had agreed with TR that the assessment would be completed by 25 October 2017. It noted SD's evidence that there was no evidence that the assessment had been written for this case in relation to either of the referrals of the case to the Council when he carried out his investigation. This was a case where there were allegations of domestic violence and where there was the possibility of harm to the children. The assessment had to be completed before the case could be closed. After Mr Williamson was suspended the case was assigned to another social worker. The panel found that Mr Williamson had seen the children in the absence of the parents at some point during October 2017 and had found no concerns. After his suspension another social worker was then assigned to the case and visited the family on 9 January 2018. At this visit one of the children had disclosed to her that the father '*hit him all of the time*'. This social worker then escalated the case to one of child protection.

46. The panel found that Mr Williamson had not completed the assessment which he was under a duty to do. This would have recorded what investigations he had carried out and would have contained a conclusion as to why in Mr Williamson's opinion the case could be closed. The panel found that there was a duty upon Mr Williamson to conclude his written assessment by 25 October 2017 and that his failure to do so left the children involved at risk.

The panel found this head proved.

1.3 Failed to make appropriate further checks, assessments or referrals in relation to the referral of 12 October 2017

47. The panel considered the evidence of TR that after Mr Williamson's suspension she looked at records of statutory visits made by him in October 2017 related to this case. It accepted her evidence that there were inconsistencies between the accounts given of the child's absence from school and the injury in October 2017 which had not been checked. It also accepted her evidence that these were serious concerns which should have been investigated to see if there was any pattern to them, for example absence from school. It accepted TR's evidence that Mr Williamson should at the least have contacted the family GP and that there was no information as to whether Mr Williamson had spoken to the children alone. The panel accepted that as a result there was no evidence that an appropriate investigation had been carried out. It noted that on 25 October 2017 Mr Williamson had advised that the case could be closed.
48. The panel was satisfied that Mr Williamson was under a duty to carry out appropriate checks in this case following the inconsistencies in the accounts of the parents and the other evidence available to him.

The panel found this head proved.

1.4 Failed to make appropriate further checks, referrals or assessments for the referral of 30 October 2017

49. The panel found that the family had been referred to the Council by the police on 30 October 2017 following an incident of alleged domestic violence. It accepted TR's evidence that following this, Mr Williamson should have carried out a proper investigation into the possible risk to the children. The panel found there was evidence that Mr Williamson had faced problems in speaking to the parents, but accepted that this was a cause for concern that should have been investigated. The panel accepted that there were some notes recorded by Mr Williamson but these did not include appropriate checks, assessments or referrals.

50. The panel was satisfied that Mr Williamson was under a duty to carry out appropriate checks in this case following a police referral which he did not carry out.

The panel found this head proved.

Case E310626:

1.5 Left a voicemail on the phone number of the perpetrator of domestic violence instead of the victim

51. The panel noted that at the investigation meeting with SD, Mr Williamson had said that if the father in the case had reported that Mr Williamson had left a message on his voicemail he must have done so. The panel was satisfied from the evidence of TR that whilst there is no specific guidance or rules about leaving messages, it was basic social work practice that care should be taken when doing so.
52. The panel accepted that a message had been left on the voicemail of an alleged perpetrator by Mr Williamson in an alleged domestic violence situation when the message was intended to be heard by the alleged victim. It also accepted that this had angered the alleged perpetrator, or was likely to, and that it placed the alleged victim and family at risk. The panel also noted that Mr Williamson had admitted that there might have been a breach of data protection rules.

The panel found this head proved.

Misconduct

The case for Social Work England

53. The submissions presented by Ms Atkin on behalf of Social Work England in relation to misconduct included what was set out in the written statement of case.

“29. The statutory ground alleged in this case is misconduct. Misconduct has been defined as an act or omission which falls seriously short of what would have been proper in the circumstances. The standard of propriety can be established by reference to the rules and standards ordinarily required to be followed by a practitioner in the circumstances.

30. The conduct alleged falls seriously short of what would have been proper in the circumstances. With respect to HOC 1.1 (Case E411128) as an experienced social worker, the Social Worker failed to carry out an important assessment that would have determined whether a child was being placed in a suitable home with suitable temporary carers. In this particular case there was a historic concern in relation to

the mother's brother who has lived with the grandfather. Not only did the Social Worker fail to do this, he failed to listen to the reminders given by his colleague which were instructions from his Line Manager.

31. With respect to HOC 1.2-1.4 (Case E342037) the Social Worker, aware of the history of domestic violence with the family, failed to act upon referrals and accepted the father's explanation of the injury without making further enquiries. The Social Worker also failed to undertake checks or ask the necessary questions of the children and failed to undertake the necessary assessments/write ups, which left the children exposed to actual harm and risk of further harm. Two significant referrals were made, one involving conflicting information and causes given for the child's injury. The Social Worker ought to have investigated the matter further to determine the cause of the injury. The two conflicting accounts did not cause the Social Worker any concern. Furthermore in respect of the second referral of 30 October 2017, the Social Worker failed to undertake any further assessments or referrals despite this significant development of events. It was not until January 2018 that concerns were picked up on and that was by a new social worker.

32. With respect to HOC 1.5 (Case E310626) placed an already vulnerable victim of domestic violence at further risk of violence and harm. The Social Worker ought to have exercised a greater level of care when phoning the victim and then leaving a message.

33. The conduct puts the Social Worker in breach of the HCPC Standards of Proficiency

(2017):

1 Be able to practise safely and effectively within their scope of practice

1.3 Be able to undertake assessments of risk, need and capacity and respond appropriately

1.4 Be able to recognise and respond appropriately to unexpected situations and manage uncertainty

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 Be able to practise within the legal and ethical boundaries of their profession

2.3 Understand the need to protect, safeguard, promote and prioritise the wellbeing of children, young people and vulnerable adults

2.4 Understand and be able to address, practices which present a risk to or form service users and carers or others

2.5 Be able to manage and weigh up competing or conflicting values or interests to make reasoned professional judgments

4 Be able to practise as an autonomous professional, exercising their own professional judgement

4.5 Be able to work effectively whilst holding alternative competing explanations in mind

4.6 Be able to make and receive referrals appropriately

10 Be able to maintain records appropriately

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

10.2 Recognise the need to manage records and all other information in accordance with applicable legislation, protocols and guidelines

34. The conduct also puts the Social Worker in breach of the HCPC Standards of Conduct, Performance and Ethics 2016:

5 Respect Confidentiality

5.1 You must treat information about service users as confidential

6 Manage Risk

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

7 Report concerns about safety

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.

10 Keep records of your work

10.1 You must keep full, clear accurate records for everyone you care for, treat or provide other services to.

10.2 You must complete all records promptly and as soon as possible after providing care, treatment or other services.”

The case for the social worker.

54. Mr Williamson did not attend the hearing. The panel again considered the documents contained in a bundle which included his submissions to the Council in the course of its disciplinary process in 2018. The panel noted that Mr Williamson had made no further submissions to Social Work England.

Submissions on misconduct

55. On behalf of Social Work England Ms Atkin referred the panel to the case of Roylance v GMC (No.2) [2000] 1 AC 311, at para.35:

“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...in the particular circumstances.”

56. Ms Atkin submitted that all of the standards set out in the Statement of Case applied in this case. Ms Atkin said that the evidence showed that Mr Williamson was not managing risk to service users properly. She said the failings were serious and fundamental to social work practice and went beyond issues of record keeping. Ms Atkin said the evidence showed that Mr Williamson had placed the interests of parents before the risks to children. Ms Atkin also submitted that the evidence suggested that he had not realised or accepted the seriousness of the risks caused by his conduct.

Legal Advice

57. The legal adviser referred to the case of Roylance. He advised the panel to decide whether there was misconduct which was serious and to take in to account all of the relevant standards.
58. The panel accepted his advice

The panel's findings on misconduct

59. The panel considered carefully its findings of fact in relation to misconduct. It proceeded on the basis that there is no burden or standard of proof and that misconduct is a matter for its judgement. It considered each of the standards relied upon by Social Work England and found that they were all relevant in this case.
60. The panel found that all of its findings of fact were serious. In two cases children were placed at direct risk of harm. In the other an alleged victim of domestic violence and their family were exposed to potential risk from the alleged perpetrator of the violence. There was potential for harm in each case, even if no harm actually occurred. The seriousness was a consequence of the potential for harm.
61. The panel accepted that there was a clear indication that Mr Williamson showed a pattern of behaviour in placing the interests of parents before those of children. This was shown by his failure to check if a child was going to safe accommodation with safe carers and in his failure to investigate evidence of harm to a child.
62. The panel found there were breaches of fundamental standards of practice by Mr Williamson and that there was no evidence that he appreciated the risks incurred. It considered carefully what he had said about his workload and management, but found that there was no evidence of excessive workload or unsupportive management. In any event these would not mitigate the failures in this case. The panel found there was a pattern of failure in relation to fundamental social work practice and legal requirements. It accepted what TR had said about case E411128 that a child had been taken into the care of the Council and then placed in a home where they may have been exposed to increased danger. It also accepted that in relation to case E342037, the failure to complete case assessments and to carry out proper investigations placed children at risk. It in addition accepted that in relation to case E310626 there was a serious risk of harm to an alleged victim of domestic violence.
63. The panel considered the possible mitigation on Mr Williamson's behalf raised by his assertions over his workload and his management. The panel found that Mr Williamson had voluntarily decided not to attend this hearing. Whilst the panel took all possible steps to ensure the hearing would be fair in his absence, it considered that there were consequences of his non-attendance. One of the consequences was that his claims over his workload and management may not have been as fully explored as they would have been if he had been present.
64. The panel was satisfied on the basis of its consideration of what Mr Williamson has said that his workload was not greater than that of other social workers in his team and it was unable to find evidence supporting what Mr Williamson had said about TR's treatment of him. Nevertheless the panel concluded that as a senior social worker, Mr Williamson's failures in

relation to fundamental social work practice were such that workload and management style would not have been sufficient to excuse such failures.

65. The panel took full account of its duty to protect the public in its findings. The panel finds that the facts found in this case lead it to conclude that Mr Williamson's conduct fell seriously below the standards expected of him and placed the public at risk.
66. The panel therefore found that the statutory ground of misconduct was made out in this case.

Finding and reasons on grounds

Impairment

Submissions on impairment

67. Ms Atkin on behalf of Social Work England submitted that on the basis of the facts found proved, and the panel's finding of misconduct, Mr Williamson's fitness to practise is currently impaired.
68. Ms Atkin submitted that current impairment is a matter of judgement, not proof. She referred the panel to the relevant parts of Social Work England's Sanctions Guidance (SG), where it refers to the consideration of impairment.
69. The panel was referred by Ms Atkin to the case of Cohen v GMC [2008] EWHC 581 and to the three questions set out at paragraph 65:

"It must be highly relevant in determining if...fitness to practise is impaired that first [the] conduct which led to the charge is easily remediable, second that it has been remedied, and third that it is highly unlikely to be repeated."

70. In relation to remediation, Ms Atkin said that Mr Williamson had not engaged in this hearing, although he had at times been in contact with Social Work England, and that there was therefore no evidence of any attempt at remediation before the panel. Mr Williamson, she said, had stated in his email to Social Work England on 14 April 2022 that he had no intention of returning to social work, which indicated that he did not intend to remedy his deficient practice.
71. Ms Atkin referred the panel to the case of CHRE v NMC & Grant [2011] EWHC 927 (Admin) which establishes an appropriate approach for a tribunal considering impairment, taken from a formulation arrived at in the Shipman enquiry:

"The tribunal should consider whether [their] findings of fact in respect of the [registrant's] misconduct...show that his fitness to practise is impaired in the sense that he:

i. Has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm;

ii. Has in the past brought and/or is liable in the future to bring the...profession into disrepute;

iii. Has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the profession;

.....”

72. Ms Atkin submitted that there was evidence of risk of harm to vulnerable service users and that Mr Williamson’s conduct risked bringing the profession into disrepute. She reminded the panel that the concern relating to case E310626, the voicemail, had resulted in the father making a complaint to the Council. Ms Atkin stated that he had also breached a fundamental tenet of the social work profession, in that the safeguarding of vulnerable service users was a basic requirement of the profession.
73. Ms Atkin submitted that Mr Williamson lacked insight. She said that SD had stated he could not be sure if Mr Williamson did not understand the risks involved in his practice, or whether he sought to avoid difficult conversations with parents. Ms Atkin said that TR had confirmed this view. Ms Atkin stated that Mr Williamson may have made some acknowledgement of his deficiencies but that this was limited.

Legal Advice

74. The legal adviser advised that the panel should use its judgement in deciding upon the issue of impairment. He advised the panel that it should consider whether Mr Williamson’s fitness to practise is currently impaired.
75. The legal adviser referred the panel to the case of in Meadow v GMC (2007) 1 WB 462 where the court said:

“The purpose of (fitness to practise) proceedings is not to punish the practitioner for past misdoings but to protect the public against the acts or omissions of those who are not fit to practise. The [tribunal] looks forward, not back. However, in order to form a view as to the fitness to practise of a person today, it is evident that [the tribunal] will have to take account of the way in which the person concerned has acted or failed to act in the past...”

76. The panel was also referred to the questions set out in the case of Cohen v GMC [2008] EWHC 581 (Admin), where the court said:

“It must be highly relevant in determining if...fitness to practise is impaired that first [the] conduct which led to the charge is easily remediable, second that it has been remedied, and third that it is highly unlikely to be repeated.”

77. The panel was advised by the legal adviser that it should consider whether it was necessary to find current impairment in Mr Williamson’s case to protect the reputation of the profession with the public. He advised that the panel should assume that members of the public were as informed as they were about the case.

The panel’s findings and reasoning on current impairment

78. The panel accepted the advice of the legal adviser.
79. The panel considered its findings of fact and concluded that Mr Williamson’s conduct in respect of each of the cases it has considered posed a risk to vulnerable individuals. In relation to two of the cases, children were subjected to avoidable risk of harm by Mr Williamson’s actions. In the third a victim of suspected domestic abuse and her family were placed at risk. The panel found that Mr Williamson failed to take steps which were basic and fundamental to social work and appeared to have no understanding of the risks he created for those he was meant to be safeguarding.
80. The panel was in no doubt that Mr Williamson’s actions were liable to bring the social work profession into disrepute. Fortunately, none of his actions, or failings to act, caused, so far as the panel is aware, actual harm to any service user. However, they had the potential to do so and the panel concluded that the public would lose confidence in the profession if its regulator took no action over these failings.
81. The failings the panel has found in Mr Williamson’s practice were fundamental and the panel agreed with Ms Atkin’s submission that his failings in relation to safeguarding were a breach of a fundamental tenet of the profession.
82. The panel therefore found that the relevant questions posed by the guidance given in Grant applied in this case and that Mr Williamson’s conduct was in breach of each of them. It then turned to the questions suggested in the case of Cohen. It found that the failings demonstrated by Mr Williamson were capable of remedy, at least in theory, but that there was no evidence that he had sought to remedy them. This led to the inevitable conclusion that if Mr Williamson were to return to practice without restriction, there was a high risk of repetition.
83. It was clear to the panel that since 2018 Mr Williamson has shown that he does not have any intention of seeking to remedy his defective practice and has evinced an intention not to return to social work, and has therefore failed to provide this panel with any evidence of

remedial action. The panel therefore finds that Mr Williamson's deficiencies remain unremedied.

84. The panel has taken into account what TR and SD have said about Mr Williamson's insight into his conduct. Their views are supported by the limited submissions of Mr Williamson, the most recent of which is his Disciplinary Statement of 2018. In this statement he offers no apology for his actions, no remorse and no recognition of the impact his actions may have had on service users, his colleagues or the reputation of the Council. It is therefore not clear whether Mr Williamson fails to appreciate the seriousness of his conduct, or of its potential to cause harm, or whether he avoids difficult conversations, which are at times a basic requirement of social work practice. In the absence of anything more from Mr Williamson, the panel can only conclude that his views of 2018 have not changed. Furthermore, his email to Social Work England of 14 April 2022 would seem to confirm this. In any event, it is clear to the panel that in 2017 and 2018 when the events it has considered took place, Mr Williamson showed very little insight. His only concession was that he may have breached data protection requirements, however a data breach did not form a part of these allegations.
85. The panel finds that if it were to fail to act in Mr Williamson's case by a finding of current impairment, public confidence in the profession would be diminished. It therefore finds that his practice is currently impaired both on public protection grounds and in the public interest.

Sanction

Submissions on sanction

86. Ms Atkin began her submissions on behalf of Social Work England by referring the panel to its Sanctions Guidance. She reminded the panel that sanctions are not intended to be punitive but are intended to protect the public and the public interest.
87. Ms Atkin referred the panel to the Sanctions Guidance at paragraphs 71, 74-76, which deal with taking no action or the issuing of advice or a warning. She submitted that these sanctions were only appropriate where there was no risk to the public. Ms Atkin submitted that in this case they were not appropriate as the panel had identified serious risk to the public. She submitted that Mr Williamson had not engaged with Social Work England or this hearing and that there was a high risk of repetition if he returned to work as a social worker without restriction.
88. Ms Atkin submitted that the next sanction in order of seriousness was one of a conditions of practice order. She submitted that there was no prospect of Mr Williamson complying with conditions and that workable conditions could not be formulated which would address his

limited insight and fundamental failures as demonstrated by the panel's findings of fact and impairment.

89. Ms Atkin then addressed an order of suspension. She referred the panel to the Sanctions Guidance paragraph 92. She said that a suspension order was appropriate where workable conditions could not be formulated, but where the case fell short of an order of removal being appropriate. Ms Atkin said that Mr Williamson had failed to understand the gravity of his conduct, had failed to reflect on what had occurred and had said that he had no intention of returning to social work. A long period of suspension, she submitted, would further de-skill Mr Williamson and that the panel had no information about his present employment or any training undertaken since his dismissal from the Council.
90. Ms Atkin submitted that the serious and fundamental breaches of the requirements of social work found in this case could only be met by an order of removal of Mr Williamson from the register, to protect the public and the public interest.

Legal advice

91. The legal adviser advised the panel that the decision on sanction was a matter of judgement for the panel. He advised that sanctions are not intended to be punitive and that they are intended to protect the public and the public interest. He advised the panel that it should impose the minimum sanction necessary to achieve those objects. The legal adviser advised that the panel should begin by considering the least restrictive sanction and should then consider each of the sanctions open to it in ascending order of restriction. He advised that in considering whether a sanction was appropriate, it could consider the next, more restrictive, sanction.
92. The legal adviser advised the panel to take account of Social Work England's Sanctions Guidance.

The panel's decision and reasoning on sanction

93. The panel accepted the advice of the legal adviser. It also had reference to the Sanctions Guidance in making its decision.
94. The panel first considered whether to take no action and the non-restrictive sanctions of giving advice or a warning. It was clear to the panel that these were inappropriate, given that it has found that Mr Williamson's actions had posed a real risk of harm to vulnerable service users.
95. The panel then considered whether a conditions of practice order was appropriate. It noted that Mr Williamson had already been working under a structured performance plan at the Council at the time these concerns arose. In addition, he had made it clear in his email of 14 July 2022 that he had no intention of practising as a social worker again. He had largely failed to engage with Social Work England and this hearing. The panel found that there was

no reasonable prospect of Mr Williamson engaging with Social Work England in relation to a conditions of practice order. The panel also considered that the imposing of conditions would not meet the public interest in upholding the reputation of the profession, given its findings of serious and fundamental failures by Mr Williamson.

96. The panel then considered whether an order of suspension would be appropriate in this case. The panel noted that an order of suspension would protect the public. However, the panel considered that an order of suspension would achieve nothing in remedying Mr Williamson's deficiencies and would further deskill him. The panel had no information about what Mr Williamson had done since he was dismissed by the Council in 2018. He had provided no evidence of any reflection or remedial activity since then. He appeared to have no willingness to do so as he had stated clearly that he had no intention of returning to social work. The panel had found that Mr Williamson's conduct was a breach of a fundamental tenet of social work, the safeguarding of the vulnerable and that he had failed in other basic requirements of social work. The panel was concerned that he has not shown any understanding of how his actions impacted upon vulnerable service users, the Council, professional colleagues and the public. It was clear to the panel that Mr Williamson's actions would, if not acted upon appropriately, damage the reputation of the profession.
97. The panel then considered the sanction of removal of Mr Williamson from the register in deciding whether an order of suspension was appropriate. The panel was satisfied that whilst an order of suspension would protect the public whilst it was in force, it would achieve nothing in remedying Mr Williamson's deficient practice and was unlikely to cause him to acknowledge the potentially serious consequences of his conduct.
98. The panel concluded that the appropriate sanction in this case was one of removal from the register. Whilst an order of suspension would protect the public, it would have no other purpose. The panel considered that the reputation of the profession would be damaged where serious, fundamental, and unacknowledged deficiencies in Mr Williamson's conduct had been identified and he was allowed to remain on the register where there was no prospect of him addressing these deficiencies. It further considered that the public would lose confidence in the profession if a member whose conduct had been found to be seriously deficient, was kept on its register when there was no willingness to remediate and was contrary to his clear intent not to return to practice.
99. The panel therefore concluded that Mr Williamson should be removed from the register on both public protection and public interest grounds.

Interim order

100. In light of its findings on Sanction, the panel next considered an application by Ms Atkin for an Interim Suspension Order to cover the appeal period before the Sanction becomes operative. She told the panel that there was an interim order in place but that this would expire before the end of the 28 day appeal period. The order of removal would not come

into effect until the appeal period had expired, or the resolution of an appeal by Mr Williamson. Ms Atkin submitted that, on the findings of the panel, Mr Williamson posed a risk to the public. This meant that an order was necessary for public protection.

101. The panel next considered whether to impose an interim order. It was mindful of its earlier findings and decided that it would be wholly incompatible with those earlier findings and the making of a Removal Order to conclude that an Interim Suspension Order was not necessary for the protection of the public or otherwise in the public interest for the appeal period.
102. Accordingly, the panel concluded that an Interim Suspension Order should be imposed on public protection and public interest grounds. It determined that it is appropriate that the Interim Suspension Order be imposed for a period of 18 months to cover the appeal period. When the appeal period expires this Interim Order will come to an end unless there has been an application to appeal. If there is no appeal the Removal Order shall apply when the appeal period expires.

Right of Appeal

103. 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.
104. Under paragraph 16 (2) schedule 2, part 5 of the Social Workers Regulations 2018 an appeal must be made within 28 days of the day on which the social worker is notified of the decision complained of.
105. 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.
106. This notice is served in accordance with rules 44 and 45 of the Social Work England Fitness to Practise Rules 2019.

Review of final orders

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

- 15 (2) – The regulator may review a final order where new evidence relevant to the order has become available after the making of the order, or when requested to do so by the social worker.
- 15 (3) A request by the social worker under sub-paragraph (2) must be made within such period as the regulator determines in rules made under regulation 25(5), and a final order does not have effect until after the expiry of that period.

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