

Social worker: Joanne Helen
Marshall
Registration number: SW53766
Fitness to Practise
Final Hearing

Dates of hearing: 18 March 2024 to 22 March 2024

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. Ms Marshall did not attend and was not represented.
3. Social Work England was represented by Ms Marte Alnaes, Counsel instructed by Capsticks LLP.
4. The panel of adjudicators conducting this hearing (the “panel”) and the other people involved in it were as follows:

Adjudicators	Role
Debbie Hill	Chair
Jill Wells	Social worker adjudicator
Sue Ware	Lay adjudicator

Robyn Watts	Hearings officer
Sam Harvey	Hearings support officer
Neville Sorab	Legal adviser

Service of notice:

5. The panel was informed by Ms Alnaes that notice of this hearing was sent to Ms Marshall by email and special delivery to an email address and postal address, respectively, provided by the social worker as they appear on the Social Work England register. Ms Alnaes submitted that the notice of this hearing had been duly served.
6. The panel of adjudicators had careful regard to the documents contained in the final hearing service bundle as follows:
 - A copy of the Notice of Meeting dated 01 February 2024 addressed to Ms Marshall at her email address and postal address as they appear on the Social Work England Register;
 - An extract from the Social Work England Register detailing Ms Marshall’s registered email address and postal address;
 - A copy of a signed Statement of Service, on behalf of Social Work England. This confirmed that on 01 February 2024 – more than 28 days before this hearing – a

Notice of Hearing and related documents were sent by email and special delivery to Ms Marshall at her registered email address and postal address; and

- A Hearing Participation Response Form in which Ms Marshall sets out that she will not be attending the Final Hearing, enclosing her written submissions to be considered by the panel.
7. The panel accepted the advice of the legal adviser in relation to service of notice. This included reference to Rules 14, 15, 44 and 45 of Social Work England's Fitness to Practise Rules 2019 (as amended) (the "FTP Rules 2019").
 8. Having had regard to all of the information before it in relation to the service of notice, the panel was satisfied that notice of this hearing had been served on Ms Marshall in accordance with Rules 44 and 45 of the FTP Rules 2019.

Proceeding in the absence of the social worker:

9. The panel heard the submissions of Ms Alnaes on behalf of Social Work England. Ms Alnaes submitted that:
 - a. notice of this hearing had been duly served;
 - b. that the notice of hearing sets out that the hearing can proceed in Ms Marshall's absence;
 - c. Ms Marshall had completed a Hearing Participation Response Form on 12 February 2024 confirming that she would not be attending the hearing, and as such, she had voluntarily absented herself from the hearing. Ms Marshall has indicated her lack of participation is as a result of health conditions;
 - d. no application for an adjournment had been made by Ms Marshall and as such there was no indication that adjourning today's hearing would secure her attendance; and
 - e. it is fair to proceed in Ms Marshall's absence and she would not be prejudiced in the Final Hearing proceeding.
10. Ms Alnaes therefore invited the panel to proceed in the interests of justice and the expeditious disposal of this hearing.
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 Rule 43 of the Rules and the cases of *R v Jones* [2002] UKHL 5; *General Medical Council v Adeogba* [2016] EWCA Civ 162. The panel also took into account Social Work England's guidance "*Service of notices and proceeding in the absence of the social worker*".

12. The panel considered all of the information before it, together with the submissions made by Ms Alnaes on behalf of Social Work England. The panel noted that Ms Marshall had been sent notice of today's meeting. The panel considered that:

- a. Ms Marshall was served with the notice of hearing in which it was set out that, in her absence, the hearing may take place in her absence;
- b. Ms Marshall was aware of the hearing;
- c. Ms Marshall has voluntarily absented herself from the hearing through her completed a Hearing Participation Response Form on 12 February 2024. The panel notes Ms Marshall's absence as a result of health conditions;
- d. Ms Marshall has not requested to adjourn the meeting;
- e. Any adjournment would be unlikely to secure the attendance of Ms Marshall in the future; and
- f. Given the length of time passed since the allegations (nearly four years), and Ms Marshall's voluntary absence at this hearing, it is considered that it is in Ms Marshall's own interests to proceed with the Final Hearing.

13. Given the reasoning in paragraph 12, the panel determined to proceed in Ms Marshall's absence.

Allegations:

14. Ms Marshall faces the following allegations:

Whilst working as a registered social worker:

1. *Between or around April 2020 and November 2020, you did not maintain appropriate management oversight and/or scrutiny of one or more of the following cases, in that you:*
 - i. *In relation to Case K*
 - a. *signed off a report, which lacked important information in respect of the case history*
 - b. *Failed to allocate the case to a social worker or refer the case back until 13 November 2020, despite having been asked to do this on 16 October 2020*
 - c. *Failed to request a strategy discussion, despite having been asked to do this on 16 October 2020*
 - ii. *signed off a closure decision on an assessment regarding Case ET, which did not*

- a. *sufficiently identify the concerns and risks*
 - b. *address that the safety plan was not being followed*
- iii. *signed off an assessment containing a data breach in Case D*
- iv. *signed off an assessment in regards of Case TB, which did not*
 - a. *address the risks and concerns in relation to the father's drug use*
 - b. *include contingency plans*
 - c. *include the father's voice*
- v. *signed off an assessment in relation to Case T, which*
 - a. *relied too much on a previous assessment*
 - b. *did not include sufficient updating information*
 - c. *did not sufficiently address the risks present*
- 2. *Between, on, or around 18 September 2020 and 21 September 2020, you did not ensure that Child J was appropriately safeguarded in that you:*
 - i. *failed to recognise the risk of harm to Child J*
 - ii. *did not adequately communicate concerns about Child J to your manager*
- 3. *On or around 21 September 2020, you did not maintain an accurate record in that you placed a case note on Child J's file which did not accurately reflect your communication with your manager*

Your actions in Paragraph 1-3 of the allegations constitute misconduct

By reason of your misconduct your fitness to practise is impaired.

Summary of evidence:

15. Social Work England adduced witness statements from:

- a. Ms Teresa Wheeler, Service Manager at Sheffield County Council (the "council"), was senior to Ms Marshall's Senior Fieldwork Manager role. At the time of the allegations, Ms Marshall was managed by Ms Wheeler who had oversight of four teams including Ms Marshall's team.
- b. Ms Helen Serlin, Senior Fieldwork Manager at the council, responsible for a team of social workers. At the time of the allegations, Ms Serlin was an Advanced Social Work Practitioner working in a team managed by Ms Thompson.

- c. Ms Susan Thompson, Service Manager at the council. At the time of the allegations, Ms Thompson was a Senior Fieldwork Manager, responsible for a team of social workers.

All attended the hearing to answer questions under oath/affirmation.

16. Ms Marshall did not attend to give evidence or call any witnesses.

17. In addition to the witness statements, the panel was provided with a number of exhibits from each witness. Throughout the final hearing, the panel took into account all the evidence provided, applying the relevant weight when making its deliberations.

Ms Teresa Wheeler

18. Ms Wheeler tendered two written statements as evidence. She provided the following evidence:

- a. At the time of the allegations, the council had seven managers and two service managers. Above the service managers are the directors. The two service managers, one of whom was Ms Wheeler, split the seven teams between them. The service managers had oversight of the whole service; they supervised the team managers and had general case discussions, they allocated cases and were involved in decision-making at all levels, helping social workers make decisions on their cases.
- b. Ms Marshall was a team manager and Ms Wheeler managed Ms Marshall; they met monthly. Ms Marshall and Ms Thompson's teams were "buddy teams" and were support for each other. Ms Marshall and Ms Thompson had a good relationship. Ms Marshall joined the team as an agency worker before Ms Wheeler started. Ms Marshall's previous manager at the council had thought highly of her.
- c. As a team manager, Ms Marshall would have had between five and seven social workers that she would oversee, supervise and support with their development and learning. This was as well as having oversight on case discussions and case management. She was part of a team of seven managers. She would have time on allocations which is where each manager would spend a week looking at new cases coming over from the hub, this is where safeguarding referrals are assessed, and decisions made to progress. This could be anything from five to forty plus cases. They would be responsible for putting together an action plan, reading the information that comes through, sending out a social worker to do a duty visit or making sure it was allocated to a social worker that had appropriate capacity.
- d. During lockdown, not all social workers could get onto the online system at once if you were working from home. The system would kick you off if too many people tried to get on. You could get online a couple of hours in the afternoon. Ms Marshall would work flexibly, starting in the early morning, have time off in the afternoon, and then work later on in the evening. **[PRIVATE]** and national

guidelines meant that she worked from home. This only caused a problem, at times, when Ms Marshall was not contactable in the afternoon. [PRIVATE].

- e. Lockdown was a challenging time to start a new role. Most staff were working from home unless there was an actual reason to attend a site. The probationary period for a new starter allowed the new starter to see their manager, complete training and allow social workers and managers to get acquainted with their roles.
- f. Weekly team meetings took place on a Wednesday to run through what was happening in each person's team, whether any cover was needed and whether there were any personal appointments upcoming. Cases of concerns could also be raised which may require escalation. Monthly 1:1 supervision meetings took place where general wellbeing, case management and whether training was required would be discussed. Supervision occurred monthly, however, there is a gap in the supervision records of Ms Marshall between June 2020 and September 2020 as Ms Wheeler did not put the records on the system.
- g. In relation to signing off a social worker's assessment, in general, if a manager cannot answer all questions they have from what is written in an assessment, they should not close the case. The role of a line manager is to ensure that all this information is there.
- h. Ms Wheeler expected her managers to safeguard children and to reflect on the information provided to them as part of their work.
- i. Hundreds of children's cases would have been opened and closed during Ms Marshall's employment. Some of these cases had been reopened because the concerns within them had not been addressed. Hundreds of cases had been appropriately closed by Ms Marshall.
- j. Ms Wheeler was of the view that Ms Marshall would not have been under any more pressure than any of the other managers. She accepted that there were individuals within Ms Marshall's team causing additional work for Ms Marshall, and Ms Wheeler gave her support and guidance in relation to this.
- k. Ms Wheeler set out that her relationship with Ms Marshall was professional enough for both to do their jobs. Ms Marshall said that she did not always want to approach Ms Wheeler and requested to move to the other manager, which Ms Wheeler took quite personally, and asked that they work through any issues which Ms Marshall agreed to.
- l. Ms Wheeler monitored Ms Marshall through team meetings, seeing how Ms Marshall interacted with other people, seeing how Ms Marshall conducted herself, checking supervision records, and reviewing assessments that closed down. Every Monday morning, there would be a meeting to look at assessments that had not been closed down within 10 days.

Child J:

- m. In the case of Child J, on Friday 18 September 2020, Ms Marshall told Ms Wheeler that Child J had a bruise. Ms Marshall was sat next to Ms Wheeler in the office on that day and Ms Wheeler had heard Ms Marshall on the phone with Ms Serlin (a social worker reporting to Ms Marshall). It was concerning that a Looked-After Child in foster placement had a bruise in his groin area without any explanation being given. Ms Wheeler advised Ms Marshall to tell Ms Serlin to speak to the child in school and to provisionally book a medical.
- n. A little bit later in the day, Ms Wheeler was sat with Ms Marshall. She said Ms Serlin had seen the child and that there was a clear explanation that he had fallen in school and that the child's account was consistent with the bruise. Ms Wheeler's only concern was that it had not been reported to the school by the foster carer and it needed to be rechecked whether the foster carer had reported it to the school. Ms Marshall cancelled the medical which had been booked. Ms Wheeler supported the decision for the medical to be cancelled on the information that she had received from Ms Marshall. This information being that the child had given a clear explanation on how they got the bruise and they were not worried about going home. Ms Wheeler said the child could go home. Ms Wheeler made hand written notes of the discussions she had with Ms Marshall about the case and the decision. These notes were not placed on the system until concerns were raised about the decision to not go ahead with a medical.
- o. Ms Wheeler first became aware that the information given to her by Ms Marshall on Friday in relation to Child J was not full or accurate when she received an email from Ms Thompson on Monday morning 21 September 2020 saying that there was no plausible explanation for the bruise. It was clear that this was not the version of events that Ms Wheeler had been told on the Friday before. Ms Wheeler was shocked, for someone to be saying that there was no plausible explanation for the bruise. As far as Ms Wheeler was concerned, she had a plausible explanation. Ms Wheeler was worried about the child, that they had allowed Child J to go home without being fully investigated.
- p. Ms Wheeler disagrees with the notes made by Ms Marshall dated 21 September 2020, and thinks that Ms Marshall added these notes to cover herself. In particular:
 - i. Ms Marshall states that Child J gave Ms Serlin three different accounts at the school might be truthful but this was not what was relayed to her.
 - ii. Ms Wheeler did not know that Ms Serlin was worried about Child J's presentation and the lack of eye contact.
 - iii. Ms Wheeler did not know about the foster carer not being honest.
 - iv. Ms Wheeler did not know that Ms Serlin was worried about the decision not to medical the child and about sending him back to placement because of how the foster carer had reacted.

- v. Although Ms Wheeler agreed to not having a Child Protection Medical, this was on the advice Ms Marshall had given to her. Ms Wheeler thinks that Ms Marshall was dishonest.
- q. Following the case with Child J, more cases were checked which caused further concerns. All cases which Ms Marshall had been involved in were audited.

Case K:

- r. This was a family of five or six. The parents were not engaging. There was very violent domestic abuse within that home. The children were all witness to the mother being seriously beaten by the father, whilst pregnant. At one point she had to escape to a neighbour whilst she was naked.
- s. This was a case that had been closed quickly. It had been signed off with no past history, which is the important bit as it really brought the safeguarding concerns to light and not all the information had gone to conference. The case was then not presented correctly at conference and the children did not go on a plan when they should have done. The conversation with the managers on the review concluded that the decision-making was not right, and it needed to go to an Initial Case Conference and for the children to put on a Plan. It was concerning because Ms Marshall was not able to see that the threshold had been met that the children were at a risk of physical and emotional harm.
- t. Ms Marshall should have signed off a completed report that had the full history in it with recommendations for the children to go on a plan. However, Ms Marshall signed off a report when she knew the history was not included. The case did go back to conference with the correct information after it was reviewed and the children were subsequently put on a Plan.

Case ET:

- u. This was about a girl of about 12 or 13 years old who was a previously Looked After Child on a Child Protection Plan with a risk of family breakdown. When an assessment takes place, the social worker will scale risk, then the manager will then read this and will complete their recommendations and either close assessment or add further direction. The child in this case had gone back home and the case had been closed by Ms Marshall on a scaling of seven on the safety scaling. On the scale, one is the worst risk possible to the child and ten is where the child is safe. The council only really closes cases on a seven, but wants to be on eights or nines at least.
- v. Ms Wheeler reviewed the information and scaled the case as a three. Her opinion was that the case was a lot more concerning. The assessments had been poor and had not identified concerns. For instance, that the child had made two attempts to end her life. Someone had gone out and done a minimal assessment, just accepted that she had tried to end her life again and closed the case. They were supposed to go and do whatever had been asked in the action plan, do a full

assessment and established if there is any way the council could have prevented it, and seen what the parents and wider family members were doing. It must be assessed how safe it is to close the case and for the council not to be involved. The case bounced back because of the second attempt to end her life, after it had been opened less than ten days.

- w. The decision by Ms Marshall to sign off on the closure was concerning because the child was left at significant risk of harm; she could have died. Ms Marshall failed to adhere to professional standards in respect of safeguarding in this situation. She should have sent the assessment back and asked to be clearer and to include the father. It had just not been challenged or read thoroughly. The school and mental health team were scaling the case at a four, which is usually a conference scoring. This was not a case that would have been closed, but escalated at Initial Child Protection Conference ("ICPC"). The child's case has been opened a very long time following this.
- x. Ms Wheeler was of the view that the safety plan could not have been followed by the mother as Child T had made another suicide attempt.

Case D:

- y. The father was a person in this case posing a concern that a child had suffered significant harm. The child concerned was not a family member but all this information about him was written on another person's file. The child had previously lived at the same address as the person, but was no longer and the information had been pulled through from when they had lived together.
- z. There was no risk of harm for this child, but there was a breach of GDPR data policies, as false information was on a child's file. The case was rightly closed, because the families were not linked but information was on a file that should not have been. Ms Marshall should have removed the information and not just signed off an assessment that was false.

Case TB:

- aa. A poor assessment had been carried out for this case. Concerns had come in about drug use from the father and domestic abuse in the home. Ms Marshall had just written up that the parents had separated and the case was closed, without addressing or discussing the drug use. There was no contingency plan in case the parents did resume the relationship and the father became involved again. The mother had said that she did not want the father's involvement. This is basic social work practice that we need to be including fathers and this Parental Responsibility overrules the mother's wishes and feelings. It had been written that there was no evidence to suggest that children had been emotionally harmed, which was not the case.
- bb. Ms Marshall should have challenged the assessment and asked for the social worker to carry out more detailed work. The council cannot make a decision when

the concerns are not addressed from the referral in the assessment. There was a failing to safeguard where there was a risk of physical and emotional harm, as well as neglect, and the children's case was opened up for a significant amount of time after the case was initially closed by Ms Marshall, which indicated that the children were in need of a service and intervention.

Case T:

- cc. The case had been opened and closed despite the fact that there was significant, violent abuse in the home. The mother had been beaten and had her head stamped on by the father. The concern had come from a family member. There was a safety plan in place which stated that the father was not supposed to be in the home, and any contact was supposed to be supervised by the grandparents which was not happening. The mother was also terminally ill and all 11 children were home-schooled.
- dd. The case should not have been closed by Ms Marshall. It was concerning that she had closed it because the children had been harmed previously through physical beatings, and one had been in foster care, remaining there until adulthood. It had also been reported that there were no injuries on the mother, but she would not know this as the mother wore full traditional dress so they would not be visible. A child with disabilities was also not mentioned in the assessment. The oldest child had also been found on railway lines trying to end her life due to her mother's illness and having to care for all these children.
- ee. Ms Marshall breached Safeguarding Practice Policies; there was no action to address any domestic abuse. When the case has come back in, the manager needs to read and create an action plan. She had not said to the social worker to address the domestic abuse but that was the main concern, as well as the fact that the father was in the home when he should not have been. She had allowed the social worker to pull through information that had been in a previous assessment.
- ff. Ms Marshall should have challenged the information, requested a more thorough assessment to ascertain the level of domestic abuse. With what these children had witnessed, it should have at least been a section 47 leading to an ICPC. There was a risk of physical and emotional harm. A child could have died.
- gg. There was a general pattern of not addressing safeguarding, not challenging assessment, not having the full information to make decisions and not identifying safeguarding risks or threshold.
- hh. Ms Marshall had been put on an action plan on 27 November 2020 because of concerns with her practice. Ms Wheeler and Ms Marshall discussed issues in relation to Ms Marshall's confidence and manager training which would support her development; however, this was limited due to COVID restrictions.
- ii. Ms Wheeler assigned Ms Khadra Sheel as Ms Marshall's mentor. The plan was that they would meet and have case discussions and have some observations of

her practice. Nothing happened at all because they did not have the best relationship. Ms Marshall questioned why Ms Wheeler had picked Ms Sheel. Ms Wheeler responded that she picked Ms Sheel because she is very good, very open, her team work well and performed well. Ms Sheel had the least close relationship to her than anyone else.

- jj. On speaking to them both together, Ms Wheeler left them to it to support Ms Marshall. Ms Marshall felt this was a punishment and not a support. Ms Marshall kept saying she did not think she needed it, that her confidence was fine and she had gotten over any past issues. Ms Wheeler clearly challenged this and said that she did not think she had.
- kk. Ms Wheeler considers herself to be a very approachable person, but very structured, very child focused. All plans have to be focused on children and Ms Wheeler is really driven to get the best possible outcomes for children. If work would come to Ms Wheeler and it is not right or someone would make a decision about a child and she does not think is the right decision, Ms Wheeler would be the first so say something. Ms Marshall did not like the challenge and she would be quick to blame someone else. Ms Marshall would say that she had challenged a social worker when I could tell she had not. Ms Wheeler would agree with the references that her relationship with Ms Marshall was difficult.
- ll. Ms Marshall resigned on 29 November 2020. Had Ms Marshall not resigned, the council would not have extended her probation and would have continued with the disciplinary process. The council had already started Dismissal Procedures. Ms Wheeler considered that Ms Marshall was not performing at the level expected of a junior manager. Part of the problem was that she did not recognise her own issues with decision-making.

Ms Helen Serlin

19. Ms Serlin tendered her written statements as evidence and provided the following evidence:

- a. At the time of the allegations, Ms Serlin was an Advanced Social Work Practitioner. Ms Serlin was managed by Ms Thompson at the time. Ms Serlin's role involved promoting the service, taking the lead on cases and attending strategy meetings. Ms Marshall was the Duty Manager (which included Allocations) at the time of the concerns.
- b. Ms Serlin view was that all social workers had to adapt to the change of circumstances brought about by COVID. It was not more fast-paced than usual during the COVID period, and when she felt under stress, Ms Serlin would check in with her line manager.
- c. Ms Serlin got on fine with Ms Marshall, but Ms Marshall would not be the first manager that Ms Serlin would go to if she had a problem; that would be her line manager, Ms Thompson.

- d. Ms Serlin received a call from the Supervising Social Worker (“SSW”) to the foster carer of Child J whilst she was driving to the office. The role of the SSW was to support the foster carer that Child J was placed with. The SSW rang to tell Ms Serlin that Child J had a bruise in their groin area, near their genitals, and the SSW was concerned because it had taken the foster carer three to four days to report it. To have a bruise in the groin area is incredibly unusual. Ms Serlin spoke to Ms Marshall and explained what had happened and it was agreed that a medical needed to be set up. Ms Serlin got the duty worker to organise the medical and made her way to the school with the SSW, who had liaised with the school. Child J gave three different versions of events and would not look at Ms Serlin, which was unusual for Child J, whom Ms Serlin knew very well. Child J said it happened at school, but there was no school record of any incident taking place, or any teacher witnessing the incident.
- e. Ms Serlin called Ms Marshall as Ms Thompson was absent that day. Ms Serlin went through the details of situation, saying that Child J gave three different version of events and would not look at Ms Serlin, and said that Child J needs a medical. Ms Marshall disagreed with Ms Serlin’s opinion to have a medical, but said that she would speak to Ms Wheeler. After speaking with Ms Wheeler, Ms Marshall told Ms Serlin that Child J has not made a disclosure and it could have been an accident, so a medical was not needed. Ms Serlin said that she disagreed. The headteacher of Child J’s school, who was also the safeguarding lead for the school and the SWW also thought a medical was required. Ms Serlin said she felt powerless as she could not override the decision not to have a medical, and in hindsight, considers that she should have spoken to Ms Wheeler directly.
- f. On Sunday 20 September 2020, Ms Serlin sent an email to Ms Thompson to let her know her concerns. After the weekend, Ms Serlin spoke with Ms Wheeler directly about the incident.

Ms Susan Thompson

20. Ms Thompson tendered her written statements as evidence and provided the following evidence:

- a. At the time of the allegations, Ms Thompson was in the East Area Fieldwork Team as a Senior Fieldwork Manager. She managed a team of about six or seven social workers of varying experience. Ms Thompson’s responsibility was primarily to make sure that the social workers were doing what they should be to keep the children safe and adhere to the council practice standards.
- b. When Ms Marshall was an agency social worker from May 2019 to February 2020, Mr Thompson supervised Ms Marshall and Ms Marshall did very well. Only one issue arose with a Person Posing Risk which needed a few reviews. Therefore, when the manager role came up, Ms Thompson was happy to support Ms Marshall.

- c. Ms Thompson has a very good relationship with Ms Marshall. She assisted Ms Marshall as a manager, advising her on how to deal with her team. Ms Thompson thought that Ms Marshall lacked some confidence as a team manager. Some of Ms Marshall's team spoke to Ms Thompson about Ms Marshall and went to her when they needed more support (such as clarity on what to do next and requesting clearer direction). Ms Thompson was of the view that Ms Marshall had a team which was no more challenging than other teams, although one social worker would speak disrespectfully to Ms Marshall and Ms Thompson supported Ms Marshall in dealing with this. Further, Ms Thompson was aware that one social worker in Ms Marshall's team was not performing well, and she had offered for the social worker to move to her team but the social worker had declined. Ms Marshall confided in Ms Thompson that she was not particularly happy to be given a mentor, but Ms Thompson told Ms Marshall to consider it as an opportunity.
- d. During COVID, some managers came into the office and some did not. Ms Thompson came into the office daily but Ms Marshall did not. Ms Marshall told Ms Thompson that she preferred to work at home. Ms Thompson believed that this caused issues with Ms Marshall's team who saw her as less available so would seek advice from Ms Thompson. The caseloads were not especially challenging during COVID, but Covid caused challenges and staff felt under stress due to this.
- e. Ms Thomson picked up the email concerning Child J on the morning of Monday 21 September 2020 after it was sent by Ms Serlin on the evening of Sunday 20 September 2020. On the face of it, Ms Thompson's first thoughts were that it was confusing because she did not have all the information, just Ms Serlin's perspective. Ms Thomson needed to understand the rationale as to why Child J did not have a medical. Any bruise a child sustains that is unexplained would require a medical, as well as a strategy discussion.
- f. Ms Thompson shared Ms Serlin's concerns that were in her email with Ms Wheeler. As soon as she got into the office, Ms Thompson spoke to Ms Wheeler, as well as contacting Ms Marshall. Ms Wheeler's understanding was that there was a plausible explanation as to why he got the bruise on the information that was shared with her by Ms Marshall. This was why she was under this impression that Child J did not need a medical. On hearing this information, Ms Wheeler looked confused and went back to her handwritten notes to reinforce this.

Ms Marshall

- 21. Ms Marshall did not attend the Final Hearing to provide oral evidence, but provided written submissions which contained the following evidence:
 - a. Up until the part of 2020, no concerns had raised regarding Ms Marshall's practice, understanding of risk, and policies, or decision making to ensure a child's safety.

- b. Ms Marshall acknowledges that there were occasions when she did not consult Ms Wheeler when she should have done. Ms Marshall did seek advice and support from colleagues when she felt she needed it. But on reflection Ms Marshall accepts that she could have communicated more with her colleagues and line manager.
- c. Whilst a mentor was identified to support Ms Marshall in 2020, the nature of this support was not clear to either the mentor or Ms Marshall following a three-way meeting. This mentor was someone Ms Marshall would approach in any event to speak to for support and advice, so it did not achieve much.
- d. Ms Marshall took complex cases from two other teams which put additional pressure on the workers. Ms Marshall had 2 senior workers off sick for periods of time, 3 further experienced workers left her team within months of each other, and another worker was being monitored and supported in terms of their capabilities and mental health. Ms Marshall defended her team. She listened to them and was aware of the work and personal/health pressures on them all. Ms Marshall is not averse to working complex cases as they are some of the more interesting ones. Ms Marshall was only managing her team's workload and wellbeing.
- e. Ms Marshall was learning a new job as a new Team Manager. The team were extremely challenging in terms of characters and had not had a manager for a considerable amount of time before Ms Marshall joined. All other managers and Ms Marshall's line manager were aware of these challenges which included Ms Marshall's team being disrespectful and rude towards her behind my back, in front of her fellow manager (which in turn she did challenge). This experience had a negative impact on Ms Marshall's confidence in starting and continuing a new role in such an environment. Ms Marshall worked as hard as she could whilst there to ensure she did the job to the best of her abilities.
- f. During COVID, Ms Marshall worked long hours from 8am to 11pm on many occasions in order to keep up with the changing and challenging pace of the job during COVID. Ms Marshall also went into the office twice a week.
- g. Ms Marshall was not aware of any action plan commencing (informally or formally) prior to Ms Wheeler advising her on 27 November 2020 that the council was commencing dismissal procedures. Ms Wheeler's reference to Ms Marshall being placed on an action plan on 27 November 2020 contradicts itself as one of the actions was to attend the manager training course in October 2020 (which would have been in the past).
- h. Ms Marshall was and never has been blasé about anything relating to safeguarding children or the processes and procedures relating to the role. She always listens to her peers; her line manager (Ms Wheeler), and senior management. She understood the serious nature of the discussions from the outset.

- i. [PRIVATE]
- j. [PRIVATE]
- k. [PRIVATE]
- l. [PRIVATE]
- m. Since leaving the Council, Ms Marshall has had time to reflect on the pressures on herself and everyone else. Whilst she is proud of how she and my team dealt with the pressures, she accepts that when working at such a fast pace, remotely and in difficult circumstances, things can be overlooked or rushed. Ms Marshall was also mentally and emotionally exhausted at times and was planning to book some leave.
- n. Ms Marshall loved being a social worker and she was committed to doing to her very best at all times. She had never worked as hard as she did when practicing as a Manager at the Council. It still really upsets her that her long and much-loved career ended as it did.
- o. If Ms Marshall wished to continue or return to any form of social work or social care practice, she would complete any training within any monitoring and support package recommended to enhance her learning and practice. However, as it stands, Ms Marshall does not wish to return to any of social work or social care practice.

Case K:

- p. Ms Marshall understood that some historical information has been missing prior to the case going to the ICPC. Ms Marshall did not have sight of this historical information. Ms Marshall also understood that a PBA would need to be completed prior to escalating the case to the ICPC following the more recent referral from midwifery, as the council would need to assess the risk/protective factors.
- q. During the meeting on 27/11/20 Ms Wheeler raised that Ms Marshall had not held a Strategy Meeting for this case. Again, Ms Marshall responded that she understood that an assessment would be needed from midwifery services, before escalating the case.
- r. Ms Marshall denies causing any intentional delay.

Case ET:

- s. From recollection the safety plan was being followed by the mother and ET, and had been for some time prior to closure. The allocated social worker reported to Ms Marshall that at the time of closure that agencies were happy for the case to close with ongoing support and a safety plan in place. Ms Marshall does not recall the content of the safety plan/closure record, but she would have reviewed this as part of the closure process.

- t. However shortly after closure, Ms Marshall understands that ET took an overdose and a new referral was made. The council was aware that ET had taken an overdose at the point of closure also, but the allocated social worker spoke to the mother about this and established that it was linked to her girlfriend not responding to messages.
- u. Ms Marshall believes that support from CAMHS/Emotional Wellbeing worker via Early Intervention Team, and support from school around emotional wellbeing, was part of the safety plan.

Case D:

- v. D was initially linked to other children in the household at the point of referral. However, this was found to be inaccurate following social worker enquiries. D's father was not same father as the other children. D was therefore not considered to be at any risk. The social worker met and spoke with D's mother when her address was established. There was a problem with the computer system at the point the social worker was going to record the updated address and family details, so this was not done when the case was reviewed. Ms Marshall spoke to the social worker about this, and she had searched through her notes trying to recover the missing information to put on the LiquidLogic Recording System ("the System"). Due to sickness, Ms Marshall thinks another social worker in her team followed this up and amended the details prior to case closure.
- w. D and his mother previously lived at the address of the referred family and it had come up on records as being at the same address.
- x. Ms Marshall liaised with IT and the Safeguarding Hub concerning the need for D to be separated from the other children on the System and the requirement for D's address details to be changed. Ms Marshall considered that a solution to this situation would be to delete D's referral on the System and amend the referral relating to the children to remove D's name from their referral in order for any data breach to be prevented. However, the Safeguarding Hub advised that at the point of referral, he was down as being at same address, so his details needed to stay.

Case T:

- y. Ms Marshall cannot recall much detail about this case other than it had recently closed to another team and the social worker who visited found no evidence that an incident had taken place.
- z. Ms Marshall recalls this case came to her team during allocation week. Ms Marshall accepts that the assessment would have been very brief and did pull through recent information from previous assessment (which the System does automatically). Ms Marshall recalls advising the social worker to review this information and amend as necessary to ensure current assessment information regarding the referral was reflected.

Child J:

- aa. Ms Marshall considers that she did appropriately communicate the concerns to management at the time. However, it was a very brief chat whilst Ms Marshall was on the phone to the allocated social worker, Ms Serlin. Ms Marshall notes that Ms Serlin stated that there had been 3 different accounts given by J, but at no point during their two discussions on the day, did she tell Ms Marshall the details of more than one explanation. If 3 accounts had been given, Ms Marshall would have told Ms Wheeler this and recorded as such on the System given this is key information.
- bb. Ms Marshall sets out that she could have dealt with this situation differently. She is aware of section 47 processes and accepts that she should have continued with a medical and strategy meeting in order to assess the potential harm to Child J and ensured that steps were taken to ensure their safety.

Finding and reasons on facts:

- 22. The panel accepted the advice from the legal adviser, which included that it was for Social Work England to prove the allegations upon the balance of probabilities. Any admissibility issues, reliability issues or veracity of the evidence will be set out below.
- 23. The panel was aware that: objective evidence, such as contemporaneous documents, are of the utmost importance; the reliability of evidence should not be considered in isolation; the confident delivery and demeanour of a witnesses' evidence is not a reliable guide to whether they are telling the truth; and witness evidence (in most cases) is not the only relevant part of the evidence – memories are fluid and malleable.
- 24. The panel proceeded with Ms Wheeler's evidence with caution. The concerns in relation to Ms Marshall's practice arose as a result of decision making in the case of Child J. Both Ms Marshall and Ms Wheeler came to the same conclusion that no medical was required for Child J. Both Ms Wheeler and Ms Marshall did not record their decision making for Child J on the system until concerns were raised by Ms Thompson. Although Ms Wheeler made hand written notes, these were undated and brief. Both Ms Marshall and Ms Wheeler were adamant that their account of the information shared was accurate. Following the concerns in relation to Child J, Ms Wheeler chose to undertake a full audit of Ms Marshall's cases. The panel considers there to be a potential conflict of interest in Ms Wheeler undertaking the audit, which has not been made available to the panel. Ms Wheeler referred Ms Marshall to Social Work England in relation to 6 cases as a result of the audit. Ms Wheeler conceded in response to panel questions that all of Ms Marshall's cases were audited and hundreds were closed appropriately. Further, the panel notes a fractious working relationship between Ms Wheeler and Ms Marshall given that Ms Marshall said that she did not always want to approach Ms Wheeler. Ms Marshall had requested to move to another manager before the initial concerns arose, which Ms Wheeler admits that she took quite personally.

25. The panel assessed the facts of each contested allegation separately. The panel took into account all the evidence placed before it.

Allegation 1(i)(a) – Between or around April 2020 and November 2020, you did not maintain appropriate management oversight and/or scrutiny in relation to Case K, in that you signed off a report, which lacked important information in respect of the case history – PROVED

26. In evidence, Ms Wheeler implies that Ms Marshall had management oversight over Case K, and set out that Ms Marshall signed off the report with no past history. As a result, the safeguarding concerns were not brought to light and not all the information had gone to the ICPC. Consequently, the case was not presented correctly at the ICPC and the children did not go on a plan when they should have done.

27. In her submissions, Ms Marshall appears to accept that she had management oversight over Case K, and understood that some historical information was missing prior to the case going to the ICPC. Ms Marshall also understood that a PBA (which the panel believe to be a Pre-Birth Assessment) would need to be completed prior to escalating the case to the ICPC following the more recent referral from midwifery, as the council would need to assess the risk/protective factors.

28. The panel considers the allegation proved given that it is not in dispute that some historical information was missing prior to the case going to the ICPC.

Allegation 1(i)(b) – Between or around April 2020 and November 2020, you did not maintain appropriate management oversight and/or scrutiny in relation to Case K, in that you failed to allocate the case to a social worker or refer the case back until 13 November 2020, despite having been asked to do this on 16 October 2020 – PROVED

29. In the System notes in relation to Case K dated 16 October 2020, the panel notes that the case actions were: *“Health to confirm pregnancy and to screen this in to the Hub. The case should go to section 47 and to ICPC”*. The panel considers the action *“The case should go to ... ICPC”* as an action to refer the case back, and given that action is needed in this case, it is inferred that a social worker would need to be allocated to this case.

30. Within the provided documentation, the panel could not find any evidence that Ms Marshall allocated this case to a social worker or that she referred the case back.

31. In her evidence, Ms Marshall explains the reasons for her delay (awaiting an assessment) but denies causing any intentional delay.

32. The panel considers the allegation proved given there was a delay (which is not disputed); case actions were given on 16 October 2020 to refer the case back (and implicitly that a social worker would need to be allocated to this case); and the panel could not find any evidence that Ms Marshall referred the case back or allocated this case to a social worker.

Allegation 1(i)(c) – Between or around April 2020 and November 2020, you did not maintain appropriate management oversight and/or scrutiny in relation to Case K, in that you failed to request a strategy discussion, despite having been asked to do this on 16 October 2020 – PROVED

33. In her evidence, Ms Marshall submitted that *“During the meeting on 27/11/20 [Ms Wheeler] raised that I had not held a Strategy Meeting for this case, and I responded with the same — that I understood we would be doing an assessment before escalating the case.”* Through this answer, Ms Marshall implies that she knew that a strategy discussion was needed, but pending an assessment.

34. In the System notes in relation to Case K dated 16 October 2020, the panel notes that the case actions were: *“Health to confirm pregnancy and to screen this in to the Hub. The case should go to section 47 and to ICPC”*. The panel considers the action *“The case should go to section 47 and to ICPC”* as a request for a strategy discussion. Consequently, the panel consider this allegation proved.

Allegation 1(ii)(a) – Between or around April 2020 and November 2020, you did not maintain appropriate management oversight and/or scrutiny, in that you signed off a closure decision on an assessment regarding Case ET, which did not sufficiently identify the concerns and risks – PROVED

35. In an email dated 23 November 2020 from Ms Wheeler to Ms Marshall, Ms Wheeler states:

“The assessment is poor and has not been challenged. [...] I am worried that we have no [sic] established safety and a child has tried to end her life twice. [...] It closed on a 7 when other professionals have said much lower. You and [...] may have further information that gives you more knowledge to keep this scaling although with the information on LL I would scale this as a 3.”

Ms Marshall responded to this email with *“I think I read the assessment when I was very tired at the end of a day. No excuse I know.”* This email exchange implies that both Ms Wheeler and Ms Marshall knew that Ms Marshall had management oversight of Case ET.

36. This email exchange indicates to the panel that Ms Marshall agrees that she signed off on a closure decision which did not sufficiently identify the concerns and risks. Consequently, the panel considers this allegation to be proved.

Allegation 1(ii)(b) – Between or around April 2020 and November 2020, you did not maintain appropriate management oversight and/or scrutiny, in that you signed off a closure decision on an assessment regarding Case ET, which did not address that the safety plan was not being followed – NOT PROVED

37. The assessment document refers to the safety plan being followed. Ms Wheeler was of the view that the mother could not have been following the safety plan as medication was still within the reach of Child ET.

38. In her evidence, Ms Marshall set out that the safety plan was being followed by the mother, and had been for some time prior to closure.

39. Within the provided documentation, the panel could not find any evidence that the medication was still within reach of Child ET, and that Child ET overdosed on medication from the home. The panel has not been provided any other rationale why the safety plan was not being followed. Consequently, the panel does not find this allegation proved.

Allegation 1(iii) – Between or around April 2020 and November 2020, you did not maintain appropriate management oversight and/or scrutiny, in that you signed off an assessment containing a data breach in Case D – PROVED

40. In her evidence, Ms Wheeler implied that Ms Marshall had management oversight of Case D, and said:

“There was no risk of harm for this child, but there was a breach of GDPR data policies, as false information was on a child’s file. The case was rightly closed, because the families were not linked but information was on a file that should not have been. [Ms Marshall] should have removed the information and not just signed off an assessment that was false.”

41. In her evidence, Ms Marshall appears to accept that she had management oversight of Case D, and set out that she:

“Liaised with IT and the Safeguarding Hub concerning the need for D to be separated from the other children on LiquidLogic and the requirement for D’s address details to be changed. [...] However, the Safeguarding Hub advised that at the point of referral, he was down as being at same address, so his details needed to stay.”

42. The panel considered there to be no dispute that Ms Marshall signed off an assessment containing a data breach in Case D. Consequently, the panel find the allegation proved.

Allegation 1(iv)(a) – Between or around April 2020 and November 2020, you did not maintain appropriate management oversight and/or scrutiny, in that you signed off an assessment in regards of Case TB, which did not address the risks and concerns in relation to the father’s drug use – PROVED

43. The panel has seen the assessment and considers that it identifies the risk in relation to TB father’s drug use, but it does not address the risk. Ms Marshall did not provide any evidence in relation to TB. In her evidence, Ms Wheeler implies that Ms Marshall had had management oversight of Case TB. As set out by Ms Wheeler, the council cannot make a decision when the concerns are not addressed from the referral in the assessment. Consequently, the panel find the allegation proved.

Allegation 1(iv)(b) – Between or around April 2020 and November 2020, you did not maintain appropriate management oversight and/or scrutiny, in that you signed off an assessment in regards of Case TB, which did not include contingency plans – PROVED

44. Ms Wheeler provided evidence that “[t]here was no contingency plan in case the parents did resume the relationship and the father became involved again.” This is supported by the assessment which did not include any contingency plan. Ms Marshall did not provide any evidence in relation to TB. Consequently, the panel find the allegation proved.

Allegation 1(iv)(c) – Between or around April 2020 and November 2020, you did not maintain appropriate management oversight and/or scrutiny, in that you signed off an assessment in regards of Case TB, which did not include the father’s voice – NOT PROVED

45. Ms Wheeler provided evidence that “[t]his is basic social work practice that we need to be including fathers and this Parental Responsibility overrules the mum’s wishes and feelings.”

46. In the assessment dated 23 September 2020, there is an entry which is anonymised, but states at page 18: “[...] denied assaulting[...] and also denied that they had been arguing in response to discussions about the anonymous referral.” Further, at page 18, it is written: “[...] enjoys spending time with the children and has enjoyed recent trips out to Manchester and Cleethorpes. [...] does not think that there are any concerns that need addressing.” Although the source of this information has been redacted, the panel considers on the balance of probabilities that this is the father’s voice, given the references to denying assault and spending time with the children. It is unclear whether this information from the father has been retrieved from a previous assessment, however the earliest assessment before the panel, in relation to Case TB, is from 23 September 2020.

47. Consequently, the panel find the allegation not proved.

Allegation 1(v)(a) – Between or around April 2020 and November 2020, you did not maintain appropriate management oversight and/or scrutiny, in that you signed off an assessment in relation to Case T, which relied too much on a previous assessment – PROVED

48. In her evidence, Ms Wheeler implies that Ms Marshall had management oversight of Case T, and provided evidence that Ms Marshall “*had allowed the social worker to pull through information that had been in a previous assessment.*” In her evidence, Ms Marshall implies that she had management oversight of Case T and set out that she “*accepts that the assessment would have been very brief and did pull through recent information from previous assessment (which LiquidLogic does automatically).*” Further, Ms Marshall “*recalls advising the social worker to review this information and amend as necessary to ensure current assessment information regarding the referral was reflected.*”

49. Upon review of the record dated 12 November 2020, the panel considered a lot of the information was repeated from the record of 23 September 2020. It was upon this information that an assessment was made. It did not appear that the record of 12 November 2020 was reviewed and amended as necessary to ensure the current situation was reflected. Consequently, the panel find the allegation proved.

Allegation 1(v)(b) – Between or around April 2020 and November 2020, you did not maintain appropriate management oversight and/or scrutiny, in that you signed off an assessment in relation to Case T, which did not include sufficient updating information – PROVED

50. For the reasons set out in paragraphs 48 and 49, the panel find the allegation proved.

Allegation 1(v)(c) – Between or around April 2020 and November 2020, you did not maintain appropriate management oversight and/or scrutiny, in that you signed off an assessment in relation to Case T, which did not sufficiently address the risks present – PROVED

51. For the reasons set out in paragraphs 48 and 49, the panel find the allegation proved.

Allegation 2(i) – Between, on, or around 18 September 2020 and 21 September 2020, you did not ensure that Child J was appropriately safeguarded in that you failed to recognise the risk of harm to Child J – PROVED

52. Ms Marshall's evidence is that she had a very brief chat with Ms Serlin who only gave her one explanation for the bruise on Child J, not three. If Ms Serlin had given her three different explanations for the bruise on Child J, she would have told Ms Wheeler all three and recorded all this information on the System. Ms Marshall also states that she could have handled the situation differently and continued with a medical and a strategy meeting in order to assess the potential harm to Child J, and had taken steps to ensure their safety.
53. Ms Serlin's evidence is that she told Ms Marshall on Friday 18 September 2020 that Child J gave three different version of events and would not look at her. Ms Serlin gave her opinion to Ms Marshall that Child J needs a medical. When the medical was not agreed, on Sunday 20 September 2020, Ms Serlin emailed Ms Thompson with her concerns. Ms Thomson relayed these concerns to Ms Wheeler who received them on Monday 21 September 2020.
54. On balance, the panel find the allegation proved given that it is not clear what information Ms Marshall received from the Ms Serlin on Friday 18 September 2020, as both provide differing versions. The panel notes it cannot find motivation for either Ms Marshall or Ms Serlin to not be truthful about their respective accounts. However, the record for Child J, dated 21 September 2020, sets out that Ms Serlin told Ms Marshall that there were three separate accounts on how Child J hurt themselves, which would support Ms Serlin's account. Further, Ms Marshall does state that she could have handled the situation differently and continued with a medical in order to assess the potential harm to Child J. In hindsight, it appears that Ms Marshall accepts that there was a risk and that a medical would have helped assess this risk.

Allegation 2(ii) – Between, on, or around 18 September 2020 and 21 September 2020, you did not ensure that Child J was appropriately safeguarded in that you did not adequately communicate concerns about Child J to your manager – PROVED

55. Ms Wheeler's evidence is that Ms Marshall relayed to her that Ms Serlin had seen the child and that there was a clear explanation that he had fallen in school and that the child's account was consistent with the bruise. Consequently, Ms Wheeler agreed with Ms Marshall's decision to cancel the medical. It was only on Monday 21 September 2020 that Ms Wheeler became aware of three accounts for the bruise and other concerns that Ms Serlin had in relation to Child J's response, following an email from Ms Thompson. Ms Wheeler and Ms Marshall did not record their accounts onto the system until these concerns were raised. However, Ms Wheeler has produced a handwritten note of the discussion, though brief and undated, which does seem to corroborate her account.
56. Given the reasoning set out in paragraphs 52-55 above, the panel considers that that Ms Marshall did not adequately communicate concerns about Child J to Ms Wheeler, and find this allegation proved.

Allegation 3 – On or around 21 September 2020, you did not maintain an accurate record in that you placed a case note on Child J’s file which did not accurately reflect your communication with your manager – PROVED

57. The record for Child J, dated 21 September 2020, sets out that Ms Serlin told Ms Marshall that there were three separate accounts on how Child J acquired a bruise, and that Ms Serlin was worried about Child J’s presentation and the lack of eye contact. Ms Wheeler has stated that she had not been made aware of these factors by Ms Marshall as it is not what Ms Marshall relayed to her on 18 September 2020. The record does not state what Ms Marshall told Ms Wheeler. Ms Wheeler’s position is somewhat supported by the brief undated notes that she made.
58. Ms Marshall makes no specific comment in relation to this allegation but makes a general comment about her case recording stating: *“I would like to say that I take pride I always write accurate and detailed case notes that this has not been questioned during my 16 year career in social work.”*
59. Consequently, on a balance of probabilities, the panel find this allegation proved.

Finding and reasons on grounds:

60. On behalf of Social Work England, Ms Alnaes submitted that:
- a. The factual findings in allegations 1 and 2 puts Ms Marshall in breach of Social Work England’s Professional Standards (“Standards”), in particular:
 - 3.1: I will work within legal and ethical frameworks, using my professional authority and judgment appropriately.
 - 3.4: I will recognise the risk indicators of different forms of abuse and neglect and their impact on people, their families and their support networks.
 - 3.8: I will clarify where the accountability lies for delegated work and fulfil that responsibility when it lies with me.
 - 3:12: I will use my assessment skills to respond quickly to dangerous situations and take any necessary protective actions.
 - b. The factual findings in allegation 3 put Ms Marshall in breach of Social Work England’s Professional Standards, in particular:
 - 3:11: I will maintain clear, accurate, legible and up to date records, documenting how I arrive at my decisions.
 - c. The conduct leading to each of the allegations are all in breach of several of Social Work England Professional Standards and it is submitted that this is strong evidence that the conduct falls short of what would be proper in the circumstances.

- d. The evidence of Ms Wheeler makes it clear that Ms Marshall failed to follow templates and policies which were provided to her, including providing sufficient and up-to-date information in reports and providing information in a timely manner. This put child service users at risk of harm. Ms Marshall fell far short of what was expected of her.
- e. The data breach found in allegation 1(iii) fell below the standards expected of a social worker.
- f. Allegations 2 and 3, in relation to Child J, Ms Marshall made a decision which was one that would not have been made by another social worker in the circumstances. Ms Marshall also failed to properly relay information which resulted in Child J being sent back to a foster carer which risked further harm to Child J.
- g. Ms Marshall's conduct has both put the public at risk, and risked damaging the public's confidence in the profession.

61. The panel accepted the advice of the legal adviser that it must pursue the overarching objective – to protect the public – when exercising its functions. The panel must first consider whether the proven allegations amounted to the statutory ground of misconduct. Neither party bears the burden of proof.

62. The panel accepted and applied the following definition of “*misconduct*”:

“...some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be found by reference to the rules and standards ordinarily required to be followed by a practitioner in the particular circumstances. The misconduct is qualified in two respects. First, it is qualified by the word ‘professional’ which links the misconduct to the profession. Secondly, the misconduct is qualified by the word ‘serious’. It is not any professional misconduct which will qualify. The professional misconduct must be serious.”

63. The panel also took into account the observation of J Collins in *Nandi v GMC [2004] EWHC 2317 (Admin)* that: *“The adjective ‘serious’ must be given its proper weight and in other contexts there has been reference to conduct which would be regarded as deplorable by fellow practitioners.”*

Allegation 1(i)(a)

64. The panel considered that, in relation to allegation 1(i)(a), Ms Marshall's actions fell short of what would be proper in the circumstances, placing child service users at risk of harm. What would have been proper in the circumstances would have been for Ms Marshall to ensure that the report had all important information, including historical information, before she signed it off. The panel considers that Ms Marshall did not use her judgement properly, in breach of Standard 3.1.

65. The panel considers that Ms Marshall's actions in relation to allegation 1(i)(a) amount to misconduct.

Allegations 1(i)(b) and 1(i)(c)

66. The panel considered that, in relation to allegations 1(i)(b) and 1(i)(c), Ms Marshall's actions fell short of what would be proper in the circumstances and were deplorable, placing child service users at risk of harm. What would have been proper in the circumstances would have been for Ms Marshall to have promptly referred the case back or allocated it to a social worker, and requested a strategy discussion. Ms Marshall's actions were deplorable in that she was asked to do these things by a senior manager but did not do so in a timely manner. The panel did not find evidence that Ms Marshall disagreed with the tasked actions. The panel considers that Ms Marshall did not use her judgement properly, in breach of Standard 3.1; and did not fulfil her responsibility for delegated work, in breach of Standard 3.8.

67. The panel considers that Ms Marshall's actions in relation to allegations 1(i)(b) and 1(i)(c) amount to misconduct.

Allegation 1(ii)(a)

68. The panel considered that, in relation to allegation 1(ii)(a), Ms Marshall's actions fell short of what would be proper in the circumstances, placing a child at risk of harm. What would have been proper in the circumstances would have been for Ms Marshall to have ensured that the assessment sufficiently identified the concerns and risks before deciding whether the case should be closed. The panel considers that Ms Marshall did not use her judgement properly, in breach of Standard 3.1; did not recognise risk, in breach of Standard 3.4; and did not use her assessment skills to take any necessary protective actions, in breach of Standard 3.12.

69. The panel considers that Ms Marshall's actions in relation to allegation 1(ii)(a) amount to misconduct.

Allegation 1(iii)

70. The panel noted that Ms Marshall liaised with IT and the Safeguarding Hub concerning the need for D to be separated from the other children on the System, and the requirement for D's address details to be changed. However, Ms Marshall should have ensured that the information was removed, prior to signing off the assessment. Whilst this data breach fell short of what would be proper in the circumstances, in the panel's view it does not meet the threshold of serious misconduct.

71. The panel does not consider that Ms Marshall's actions in relation to allegation 1(iii) amount to misconduct.

Allegations 1(iv)(a) and 1(iv)(b)

72. The panel considered that, in relation to allegations 1(iv)(a) and 1(iv)(b), Ms Marshall's actions fell short of what would be proper in the circumstances, placing a child at risk of harm. What would have been proper in the circumstances would have been for Ms Marshall to have signed off the assessment only when it sufficiently addressed the concerns and risks, and

included a contingency plan. The panel considers that Ms Marshall did not use her judgement appropriately, in breach of Standard 3.1; did not recognise risk, in breach of Standard 3.4; and did not use her assessment skills to take any necessary protective actions, in breach of Standard 3.12.

73. The panel considers that Ms Marshall's actions in relation to allegations 1(iv)(a) and 1(iv)(b) amount to misconduct.

Allegations 1(v)(a), 1(v)(b) and 1(v)(c)

74. The panel considered that allegations 1(v)(a) (*"relied too much on a previous assessment"*) and 1(v)(b) (*"did not include sufficient updating information"*) amounted to the same facts.
75. The panel considered that, in relation to allegations 1(v)(a), 1(v)(b) and 1(v)(c), Ms Marshall's actions fell short of what would be proper in the circumstances, placing child service users at risk of harm. What would have been proper in the circumstances would have been for Ms Marshall to have signed off the assessment only when the information contained in the assessment was up to date and which sufficiently addressed the risks present. The panel considers that Ms Marshall did not use her judgement properly, in breach of Standard 3.1; did not recognise risk, in breach of Standard 3.4; and did not use her assessment skills to take any necessary protective actions, in breach of Standard 3.12.
76. The panel considers that Ms Marshall's actions in relation to allegations 1(v)(a), 1(v)(b) and 1(v)(c) amount to misconduct.

Allegation 2

77. The panel considered that, in relation to allegation 2, Ms Marshall's actions fell short of what would be proper in the circumstances and were deplorable, placing Child J at risk of harm. What would have been proper in the circumstances would have been for Ms Marshall to have recognised the risk of harm to Child J and agree for a medical examination for the child. The information which Ms Marshall received from the social worker should have been adequately communicated to her manager. Ms Marshall's actions were deplorable in that she omitted to take account of all the information which was provided to her when making her assessment of the risk of harm to Child J, and further failed to provide a full account of the circumstances to her manager which meant that her manager made her assessment of the risk of harm to Child J based on partial facts. The panel considers that Ms Marshall did not use her judgement properly, in breach of Standard 3.1; did not recognise risk, in breach of Standard 3.4; and did not use her assessment skills to take any necessary protective actions, in breach of Standard 3.12.
78. The panel considers that Ms Marshall's actions in relation to allegation 2 and 1(v)(c) amount to misconduct.

Allegation 3

79. The panel considered that, in relation to allegation 3, Ms Marshall's actions fell short of what would be proper in the circumstances, placing Child J at risk of harm. What would have been

proper in the circumstances would have been for Ms Marshall to have added on Child J's case notes, a note accurately recording her communications with her manager.

80. The panel considers that Ms Marshall did not use her judgement properly, in breach of Standard 3.1; failed to maintain clear, accurate, legible and up to date records, which documented her decision making, in breach of Standard 3.11; and did not use her assessment skills to take any necessary protective actions, in breach of Standard 3.12.
81. The panel considers that Ms Marshall's actions in relation to allegation 3 amount to misconduct.
82. Consequently, taken cumulatively, the panel found that the proven facts at allegations 1 to 3, apart from allegation 1(iii), demonstrate that Ms Marshall's conduct amount to the statutory ground of misconduct.

Finding and reasons on current impairment:

83. On behalf of Social Work England, Ms Alnaes submitted that Ms Marshall was currently impaired on the basis that:

- a. Ms Marshall has provided no evidence of remediation and denies all of the concerns raised.
- b. Ms Marshall seems to show no insight or understanding of the severity of the potential consequences, and in some cases, consequences which materialised as a result of her decisions. It is therefore submitted that there is a high risk of repetition.
- c. There are some mitigating features in the case:

- I. **[PRIVATE]**

- II. Ms Marshall said she was struggling with her memory.
 - III. There were difficult working conditions at the time due to COVID.

However, due to the lack of insight and remediation, a lack of motivation to remediate her failings, and that Ms Marshall has expressed that she has no intention to work as a social worker in the future, it is submitted that the mitigation does little to decrease the seriousness of Ms Marshall's failings.

- d. Because of the ongoing risk to the public, a finding of impairment should be made on the basis that Ms Marshall is liable in the future to put the public at risk and liable in the future to bring the profession into disrepute.
 - e. Further, a finding of impairment should be made in the wider public interest due to the serious nature of the failings, and that the public would expect that action is taken, and if none is seen to be taken, this would damage the public's confidence in the profession.

84. The panel accepted the advice of the legal adviser that when considering impairment, the panel should consider whether Ms Marshall is currently impaired in relation to the misconduct found. The panel was asked by the legal adviser to consider:

- a. whether Ms Marshall has acted in the past and/or is liable in the future to act so as to put a service user at unwarranted risk of harm;
- b. whether Ms Marshall has in the past and/or is liable in the future to bring the social work profession into disrepute;
- c. whether Ms Marshall has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the social work profession; and
- d. whether Ms Marshall has in the past acted dishonestly and/or is liable to act dishonestly in the future.

85. When considering the question of impairment, the panel took into account Social Work England's "*Impairment and sanctions guidance*".

Whether Ms Marshall has acted in the past and/or is liable in the future to act so as to put a service user at unwarranted risk of harm

86. The panel considers that Ms Marshall has acted in the past so as to put service users at unwarranted risk of harm in that she:

- a. Signed off a report which lacked important information;
- b. Failed to refer a case back or allocate a case to a social worker, despite having been asked to do so by her manager;
- c. Failed to request a strategy discussion, despite having been asked to do so by her manager;
- d. Signed off three assessments which did not sufficiently identify the concerns and risks, and one of which did not include a contingency plan;
- e. Signed off an assessment which did not contain sufficient updated information; and
- f. Failed to recognise the risk of harm faced by a child service user, adequately communicate these concerns to her manager, and adequately record the communications with her manager.

87. The panel does not have information before it that Ms Marshall has gained sufficient insight or undertaken any remediation so as not to place service users at unwarranted risk of harm in the future. In particular:

- a. Ms Marshall has expressed some insight into the misconduct. In particular:
 - i. that there were occasions when she did not consult Ms Wheeler when she should have done;

- ii. she accepts that she could have communicated more with her colleagues and line manager; and
 - iii. that she could have handled the situation differently and continued with a medical and a strategy meeting in order to assess the potential harm to Child J.
- b. However, the panel is of the view that the current level of insight demonstrated is not sufficient so as not to put services users at unwarranted risk of harm in the future.
 - c. The panel has not seen any evidence of remediation undertaken by Ms Marshall, which has been hampered by Ms Marshall's non-attendance at this Final Hearing. Consequently, the panel does not have before it evidence of remediation which demonstrates that Ms Marshall will not put services users at unwarranted risk of harm in the future.

Whether Ms Marshall has in the past and/or is liable in the future to bring the social work profession into disrepute

- 88. For the reasons set out in paragraph 87, the panel considers that Ms Marshall has in the past brought the social work profession into disrepute.
- 89. For the reasons set out in paragraph 88, the panel does not have information before it that Ms Marshall has gained sufficient insight or undertaken any remediation so as not to bring the social work profession into disrepute in the future.

Whether Ms Marshall has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the social work profession

- 90. The panel considers that Ms Marshall has breached a fundamental tenet of the social work profession, namely promoting the safety and wellbeing of service users.
- 91. For the reasons set out in paragraph 88, the panel does not have information before it that Ms Marshall has gained sufficient insight or undertaken any remediation so as not to breach a fundamental tenet of the social work profession in the future.

Panel's conclusion on impairment

- 92. In light of the above, the panel considers Ms Marshall's practice to be impaired. The panel considers that impairment is also found in the wider public interest. The wider public interest includes the elements of public protection, maintaining public confidence in the profession and declaring and upholding proper standards of conduct and behaviour.

Decision and reasons on sanction:

- 93. On behalf of Social Work England, Ms Alnaes submitted that a suspension order for 18 months is an appropriate sanction. She submitted that:

- a. Ms Marshall's failings can be remedied, but she has shown a persistent lack of insight and an unwillingness and inability to remediate.
 - b. Further, Ms Marshall has indicated that she no longer wishes to return to social work.
 - c. A conditions of practice order could have been appropriate if Ms Marshall had displayed insight and remediation.
 - d. Ms Marshall has some mitigation in that:
 - i. **[PRIVATE]**
 - ii. the allegations took place during the COVID pandemic which resulted in everyone having to adapt to new working practices; and
 - iii. she was in a new role as a manager during this period.
 - e. Consequently, a removal order would be disproportionate in the circumstances.
 - f. A suspension order can be reviewed depending on Ms Marshall's insight and remediation.
94. The panel accepted the advice of the legal adviser that it must again pursue the overarching objective when exercising its functions. The purpose of a sanction is not to be punitive although a sanction imposed may have a punitive effect. The panel considered the least restrictive sanction first and then moved up the sanctions ladder as appropriate. The panel had regard to the Social Work England Sanctions Guidance, updated in December 2022.
95. The panel considered the following to be mitigating factors in this case:
- a. Ms Marshall had health concerns which may have impacted upon her practice. **[PRIVATE]** which required Ms Marshall to shield (which appeared to be criticised by her team members and colleagues) due to the COVID pandemic at the time;
 - b. Ms Marshall started her role as manager one month prior to the COVID pandemic, which would not have given her the opportunity to develop and establish working relationships with her new team prior to a mandatory change in working arrangements;
 - c. Ms Marshall had a difficult working relationship with Ms Wheeler prior to the concerns arising. Ms Marshall had the insight to request a change of manager in order to find a healthier working relationship, but this was declined;
 - d. All of Ms Marshall's cases since appointment as manager were audited by Ms Wheeler, which numbered in the hundreds according to Ms Wheeler. Of which, significant concerns were found in only six cases;
 - e. Ms Marshall was managing a team which had not had a manager for an extended period of time. This team included agency workers who left at short notice; a

member who was underperforming; and a member who undermined Ms Marshall as confirmed by another manager;

- f. During the time of the allegations, Ms Marshall was new in her management role with the Council; and
- g. Prior to her role as a manager, Ms Marshall performed very well as a social worker.

96. The panel considered the following to be aggravating factors in this case:

- a. For the reasons set out in paragraph 87, the panel has before it only limited insight;
- b. The panel does not have any evidence of remediation undertaken by Ms Marshall;
- c. Ms Marshall has shown no remorse for her actions; and
- d. Ms Marshall's misconduct put children at risk of harm.

97. In light of its findings in relation to misconduct and impairment, the panel finds that taking no action, issuing advice, or issuing a warning would not adequately protect the public, or be in the wider public interest of maintaining public confidence in the profession and declaring and upholding proper standards of conduct and behaviour.

98. The panel then considered whether a conditions of practice order would be proportionate and appropriate in the circumstances. The panel found that the failings were linked to Ms Marshall's performance as a manager and the circumstances in which she found herself. The panel noted, in particular, that prior to her role as a manager, Ms Marshall performed very well as a social worker, as confirmed by two managers who attended as witnesses. Consequently, the panel was of the view that conditions of practice would be proportionate to mitigate any risk to the public, and it is in the wider public interest to keep good social workers in practice.

99. The panel considered a conditions of practice period of two years would assist Ms Marshall to digest the decision, reflect upon her actions, obtain a social work role and demonstrate a willingness to return to social work.

100. The conditions of practice are:

- 1. *You must notify Social Work England within 7 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, agency or any organisation with which you have a contract or arrangement to provide social work or educational services, and any reporter or workplace supervisor referred to in these conditions.*

3. *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.*
4. *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.*
5. *You must inform Social Work England if you apply for social work employment / self-employment (paid or voluntary) outside England within 7 days of the date of application.*
6. *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].*
7.
 - a. *At any time you are employed, or providing social work services, which require you to be registered with Social Work England; you must place yourself and remain under the supervision of a workplace supervisor nominated by the employer, 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.*
8. *You must provide reports from your workplace supervisor to Social Work England every 3 months and at least 14 days prior to any review, and Social Work England will make these reports available to any reporter referred to in these conditions on request.*
9. *You shall not engage in single-handed social work practice and shall only take up social work employment where another registered social worker is employed at the same organisation.*
10. *You must not be responsible for the work of any other social worker or student social worker.*
11. *You must read Social Work England's 'Professional Standards' (July 2019), and provide a written reflection 6 months after these conditions take effect, focusing on how your conduct was allegedly below the accepted standard of a social worker, outlining what you should have done differently, in relation to:*
 - a. *Signing off a report which lacked important information;*

- b. Failing to refer a case back or allocate a case to a social worker, despite having been asked to do so by a manager;*
- c. Failing to request a strategy discussion, despite having been asked to do so by a manager;*
- d. Signing off three assessment which did not sufficiently identify the concerns and risks, and one of which did not include a contingency plan;*
- e. Signing off an assessment which did not contain sufficient updated information; and*
- f. Failing to recognise the risk of harm faced by a child service user, adequately communicating these concerns with a manager, and adequately record the communications with a manager.*

12.

- a. You must undertake a minimum of 35 hours of CPD in relation to updating knowledge or skills in your chosen area of social work.*
- b. You must provide evidence of CPD undertaken to Social Work England within 12 months of these conditions taking effect.*

13. 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 12, above:

- a. Any organisation or person employing or contracting with you to undertake social work services whether paid or voluntary.*
- b. Any locum, agency or out-of-hours service you are registered with or apply to be registered with in order to secure employment or contracts to undertake social work services whether paid or voluntary (at the time of application).*
- c. 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).*
- d. 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 14 days from the activation of condition 13.

14. You must permit Social Work England to disclose the above conditions, 1 to 13, to any person requesting information about your registration status.

101. The panel included condition 10 to mitigate the risks posed by Ms Marshall acting in a managerial position during the conditions of practice period. The panel included conditions 11 and 12 to mitigate the risk posed by Ms Marshall having not practiced as a social worker for an extended period of time.
102. For the reasons set out in paragraphs 98-101, the panel considered that a suspension order was disproportionate to address the risk to the public and the wider public interest.
103. The panel considered that any reviewing panel would be greatly assisted by the attendance of Ms Marshall.

Interim order:

104. In light of its findings on sanction, the panel next considered an application by Ms Alnaes for an interim conditions of practice order with the same conditions as set out at paragraph 100 to cover the appeal period before the final order becomes effective.
105. 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 not to impose an interim order.
106. Accordingly, the panel concluded that an interim conditions of practice order with the same conditions as set out at paragraph 100 is necessary for the protection of the public. When the appeal period expires, this interim order will come to an end unless an appeal has been filed with the High Court. If there is no appeal, the final order of 22 March 2024 shall take effect when the appeal period expires.

Right of appeal:

107. Under Paragraph 16(1)(a) of Schedule 2 of the regulations, the social worker may appeal to the High Court against the decision of adjudicators:
 - a. the decision of adjudicators:
 - i. to make an interim order, other than an interim order made at the same time as a final order under Paragraph 11(1)(b),
 - ii. not to revoke or vary such an order,
 - iii. to make a final order.
 - b. the decision of the regulator on review of an interim order, or a final order, other than a decision to revoke the order.
108. Under Paragraph 16(2) of Schedule 2 of the regulations an appeal must be filed before the end of the period of 28 days beginning with the day after the day on which the social worker is notified of the decision complained of.

109. Under Regulation 9(4) of the regulations this order may not be recorded until the expiry of the period within which an appeal against the order could be made, or where an appeal against the order has been made, before the appeal is withdrawn or otherwise finally disposed of.
110. This notice is served in accordance with Rules 44 and 45 of the Social Work England Fitness to Practice Rules 2019 (as amended).

Review of final orders:

111. Under Paragraph 15(1), 15(2) and 15(3) of Schedule 2 of the regulations:
- 15(1) The regulator must review a suspension order or a conditions of practice order, before its expiry
 - 15(2) The regulator may review a final order where new evidence relevant to the order has become available after the making of the order, or when requested to do so by the social worker
 - 15(3) A request by the social worker under sub-paragraph (2) must be made within such period as the regulator determines in rules made under Regulation 25(5), and a final order does not have effect until after the expiry of that period
112. Under Rule 16(aa) of the rules a social worker requesting a review of a final order under Paragraph 15 of Schedule 2 must make the request within 28 days of the day on which they are notified of the order.

The Professional Standards Authority:

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