Social worker: Evelyn Banks
Registration number: SW124250
Fitness to Practise
Final Hearing

Dates of hearing: 06 November 2023 to 17 November 2023
07 May 2024 to 10 May 2024

Hearing venue: Remote hearing

Hearing Outcome: Fitness to practise impaired, suspension order (12 months)

Interim order: Interim suspension order (18 months)

Introduction and attendees:

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

2. Ms Banks attended and was represented by Ms Christina Ramage of the British Association of Social Workers ("BASW") during the fact finding stage, and Mr Gavin Dingley of Counsel during the rest of the Final Hearing.

3. Social Work England was represented by Ms Louisa Atkin, 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**
Alexander Coleman	Chair
Stella Elliott	Social worker adjudicator
Sally Underwood	Lay adjudicator

Wallis Crump	Hearings officer
Natarliya James/ Kathryn Tinsley	Hearings support officer
Neville Sorab	Legal adviser

Allegations:

5. Ms Banks faces the following allegations:

While registered as a social worker:

1. In relation to one or more of the service users identified in Schedule 1, you failed to undertake reviews and/or assessments adequately on one or more occasions;

2. In relation to one or more of the service users identified in Schedule 2, you:

a. failed to independently identify the need to undertake a formal Mental Capacity Assessment; and/or

b. failed to complete a Mental Capacity Assessment of sufficient quality;

3. You failed to take appropriate and/or timely action to meet the needs of one or more service users and/or their families, namely:

a. Service User 1;

b. Service User 2;

c. Service User 3;

d. Service User 4;

e. *Service User 5;*

f. *Service User 6;*

g. *Service User 7;*

4. *You failed to consistently demonstrate that you were capable of safe and effective practice without significant levels of support and/or supervision:*

   a. *whilst employed at Oxfordshire County Council between March 2019 and December 2020;*

   b. *whilst employed at West Northamptonshire Council between April 2021 and February 2022.*

Your conduct as may be found proven at paragraphs 1 – 4 above amounts to the statutory ground of lack of competence or capability.

Your fitness to practise is impaired by reason of your lack of competence or capability.

<u>Schedule 1</u>

1. *Service User 3*
2. *Service User 1*
3. *Service User 8*
4. *Service User 9*
5. *Service User 10*
6. *Service User 11*
7. *Service User 4*
8. *Service User 12*
9. *Service User 13*
10. *Service User 14*

<u>Schedule 2</u>

1. *Service User 9*
2. *Service User 12*
3. *Service User 11*
4. *Service User 15*

5. *Service User 16*

Admissions:

6. Rule 32c(i)(aa) Fitness to Practise Rules 2019 (as amended) (the "Rules") states:

> "*Where facts have been admitted by the social worker, the adjudicators or regulator shall find those facts proved.*"

7. Following the reading of the allegations the panel Chair asked Ms Banks whether she admits any of the allegations.

8. Ms Banks informed the panel that she admitted following allegations:

   a. allegation 1 in relation to service user Service User 14;

   b. allegation 2 in its entirety; and

   c. allegation 4 in its entirety.

9. The panel therefore found allegations 1 (in relation to service user Service User 14), 2 and 4, proved by way of Ms Banks' admissions.

10. The panel noted that Ms Banks denied the following allegations:

    a. allegation 1 in relation to Service Users 1, 3, 4, 8, 9, 10, 11, 12 and 13; and

    b. allegation 3 in its entirety.

11. In line with Rule 32c(i)(a) of the Rules, the panel then went on to determine the disputed facts.

Preliminary matters – admission of evidence:

12. On behalf of Social Work England, Ms Atkin requested that the panel admit into evidence the following:

    a. Ms Banks' former supervisor *[PRIVATE]*. Ms Banks' former supervisor is not being called as a witness on behalf of Social Work England, but Social Work England intends to rely on aspects of her evidence to support or corroborate the evidence of other witnesses attending the hearing.

    b. a production statement from *[PRIVATE]* Associate Solicitor, dated 19 September 2023, serving additional documents on Ms Banks. Ms Banks was informed that Social Work England did not intend to call the Associate Solicitor to the hearing, given that the purpose of the statement is to produce further documents provided by existing witnesses.

13. Ms Atkin reiterated that should the panel admit the evidence from Ms Banks' former supervisor and the Associate Solicitor, it was still within the panel's discretion as to how much weight it will give to such evidence.

14. On behalf of Ms Banks, Ms Ramage did not object to the evidence from Ms Banks' former supervisor and the Associate Solicitor being admitted.

15. The panel accepted the legal adviser's advice that Rule 32(b)(vii) of the Rules sets out that "*The adjudicators or the regulator may admit evidence where they consider it fair to do so, whether or not such evidence would be admissible before the courts*." Further, the legal adviser set out that should the panel admit the evidence, it was within its discretion as to how much weight it will give to such evidence.

16. The panel considered that the evidence from Ms Banks' former supervisor and the Associate Solicitor was relevant to the proceedings and it was fair to admit it. It also noted that it was within its discretion as to how much weight it will give to such evidence.

Summary of evidence:

17. Social Work England adduced witness statements from:

    a. LH *[PRIVATE];*

    b. SM *[PRIVATE];*

    c. BG *[PRIVATE];*

    d. AS *[PRIVATE];*

    e. MC *[PRIVATE];*

    f. MA *[PRIVATE];*

    g. LC *[PRIVATE];*

    h. JH *[PRIVATE];*

    i. KC *[PRIVATE];*

18. Apart from KC, all these witnesses attended the hearing remotely to answer questions asked of them under oath/affirmation. KC's statement was admitted into evidence, was not challenged by Ms Banks, and the panel did not have any questions for KC.

    LH

19. LH provided the following evidence:

    a. LH was Ms Banks' Assessed and Supported Year in Employment ("ASYE") mentor for six-eight months. Ms Banks was the first ASYE candidate that LH supervised, although LH had previously supervised newly qualified social workers.

    b. Ms Banks had not had a statutory placement beforehand. As part of the induction, LH verbally explained to Ms Banks how the organisation worked, what needed to be done, and how it was expected to be done. Ms Banks had previously

completed NHS based placements, but had never visited anyone alone; it was always with someone.

c. Ms Banks' responsibilities were to take on very simple reviews and then increase the complexity of her caseload. Things looked like they were going quite well for the first three and a bit months because Ms Banks was doing simple reviews, but as time went on and her caseload increased and she was given more complex tasks such as carrying out assessments, problems started to arise.

d. During the time that LH was Ms Banks' supervisor, LH saw no progression in her role. LH tried to address this concern.

e. The average caseload for a full time Social Worker within the team was 15 cases, so LH would expect an ASYE to have between 10 to 12 cases depending on the complexity (approximately 90% of that of a full social worker). Ms Banks' caseload went from three to eleven cases during the time LH was Ms Banks' supervisor; LH said that this was slower progression than expected and Ms Banks' cases were simple.

f. Supervision between Ms Banks and LH were weekly at first and should have then reduced to bi-weekly and then monthly. However, LH felt that Ms Banks needed weekly supervision for a bit longer than usual.

g. LH offered Ms Banks day-to-day support as they sat next to each other in the office. Ms Banks would ask LH what she should do next on cases rather than use initiative and thought about what the next step was. LH had concerns that Ms Banks was not learning.

h. LH asked Ms Banks to reflect on social work issues (discrimination and oppression of older adults with mental health; the equality legislation; and deprivation of liberty), but there was no reflection, which is a big requirement in social work. LH found it difficult for Ms Banks to engage.

i. Ms Banks was not proactive in arranging any shadowing or learning. This was flagged to Ms Banks on 25 September 2019, at her six-month review, and on 13 November 2019.

j. Along with Ms Banks, LH started to amend Ms Banks' work. Ms Banks felt that LH was taking chunks out of her work and re-writing it. Eventually Ms Banks bypassed LH to review work and went straight to the managers to get her work signed off because she thought that LH was being patronising, LH was wrong, and that LH should not be changing her assessments so much. But Ms Banks' work just kept coming back. Ms Banks' assessments were returned quite frequently, at least five times, and she was quite exasperated by the fact that she kept sending them and they kept coming back. Quite often, detail was missing, such as Ms Banks would input "*needs help*".

k. A lot of Ms Banks' written work did not make sense. For example, a note read: "*Admin lady, advised she send an mail*." A lot of her notes were like that and LH had to sit and change them. Sometimes Ms Banks entered "*he*" instead of "*she*" and it was not clear who she was talking about in the case notes. LH provided evidence that although different supervisors may have had different styles, all would have picked up on the significant deficiencies in Ms Banks' work.

l. LH does not think that any service users were affected because Ms Banks got instructions from LH and the team to do what she needed to do. The service users' needs were met and the team would certainly not let anything be affected by that.

m. Ms Banks wanted to work closer with older adults with mental illness. Ms Banks did not have any experience with safeguarding and she wanted to start doing some of that, she wanted to be able to identify safeguarding issues.

n. Ms Banks identified in AYSE meeting that she wanted to understand how mental capacity works, when to refer it to somebody, who is a best interest assessor in terms of deprivation of liberty, and just to have discussions about the ethics of making decisions for those who lack capacity. In order to facilitate an effective assessment, there was an agreement that the team would keep her caseload quite simple to get her used to a client group she had not worked with.

o. Ms Banks set very low-level objectives for herself for the year.

p. Ms Banks managed to complete support plans, but with a lot of support and a lot of questions to LH as to what she needed to do.

q. LH was asked by her supervisor to look at all of Ms Banks' work before it got submitted to the practice manager for approval. This was to help Ms Banks to learn and understand what was needed. However, sometimes Ms Banks would send her work to the managers without going through LH.

r. The ASYE personal review of 15 May 2019 went well. This was a low-level review of care and Ms Banks' aim was to assess if the care was appropriate and still meeting the service user's needs. There were no problems with the service user's care when she reviewed it, so ran quite smoothly.

s. LH considered that Ms Banks was keen to engage initially and eager to learn. However, this diminished as the job got harder and Ms Banks struggled to keep up. LH considered that Ms Banks was not very accepting of support.

t. Ms Banks found it difficult when the situation did not run to how she wanted it to run, or find a solution. For example:

    i. Ms Banks was expecting to see the service user's notes on paper but they were on the computer and the care home staff were having problems bringing them up on screen. Instead of saying "*I'll can look at them later*" or "*You can send copies*", everyone sat there for 20 minutes whilst she was trying to get the staff to bring the notes up.

ii. Ms Banks was describing direct payments to Service User 1's daughter when LH was sat next to her. Ms Banks did not understand what was being said (lack of knowledge) and the daughter could not understand either. LH could hear Ms Banks getting more and more tense and then she passed the phone to LH. LH refused and mouthed "*you deal with it*". Ms Banks then put the phone down on the table, and refused to pick back up again. Ms Banks was not able to see why the person was frustrated or ask what would be helpful to them. LH said that Ms Banks had previously been given a booklet explaining direct payments and this had also been verbally explained to her.

iii. Ms Banks failed to give consideration to a bed-bound service user. Ms Banks would ask questions such as "*Can you do your own personal care?*" and when they said "*No*", she did not follow-up with questions such as "*What is it you find difficult?*" This would have enabled Ms Banks to look at what the person might have been able to do themselves, i.e. wash their face and hands, but needed support with a full body wash. It did not allow a person's strengths to be noted or promote independence. There was no conversation and it felt like Ms Banks was running a checklist.

u. There had been some issues from team members that they were a bit concerned about the tone of Ms Banks' voice on the telephone, saying that she was harsh.

v. A suggestion was made during supervision on 25 September 2019 and during her 6-month review dated 10 October 2019 that more complex cases needed to be allocated to Ms Banks. Although her caseload was protected under the ASYE, it was also felt that Ms Banks was not ready for very complex cases because she was unable to do the general assessments of people and it was considered or presumed by managers that she would not be able to manage more than the day-to-day "*bread and butter*" kind of assessments.

w. Ms Banks had completed a Knowledge and Skills Statement ("KSS") self-audit at the six-month mark of her ASYE. LH was concerned that Ms Banks had felt that she met the criteria of an ASYE and that she was ready to move onto passing her ASYE when in LH's opinion and supervision of her, Ms Banks had not completed the things she had stated she had within the document and her conduct did not match what she had written about own abilities.

x. Ms Banks was involved in the procedure of the case of Service User 9, who moved care homes, but with a lot of support. All support provided was verbal, hence there is no written evidence on how much input was needed for the Social Worker to complete this.

y. An individual from the safeguarding team called Ms Banks to confirm whether there was any abuse that she had witnessed of Service User 2. Ms Banks asked them to speak to Service User 2's husband, who was considered to be the perpetrator. Ms Banks did not make any in-depth or professional decision and

did not use her professional judgement. LH's concern was that Ms Banks stated that she had been involved in the safeguarding of Service User 2, but she had not.

z. Ms Banks had written under the Mental Capacity section that she had completed an assessment and care act eligibility for Service User 17 , but there is nothing Ms Banks had written concerning the criteria for Mental Capacity. There was also no evidence that Service User 17's capacity had been considered within Ms Banks' case notes. Under the "*Mental Capacity*" section, Ms Banks stated that she just rang Service User 17's family and asked who has lasting power of attorney, although this was not recorded within case notes. There is no documentary evidence of a capacity assessment, mental capacity assessment and best interest assessment for decision-making. There is no evidence that Ms Banks called Service User 17's son to ask about the lasting power of attorney.

aa. Ms Banks stated that she had requested an urgent care assessment, mental capacity and best interest assessment required for decision-making for service user Service User 18. However, a best interest decision was not needed, as the couple were having services at their home. LH was unsure as to how that demonstrates "*knowing when and how to refer to a best interest assess*" as written by Ms Banks.

bb. On 21 November 2019, LH attempted to address Ms Banks' unexplained absence the previous day. LH states that Ms Banks shouted at her "*You are always picking on me for time keeping*". Ms Banks and LH went into a room where Ms Banks was breathing really loudly and forcibly, and was really annoyed. LH stated that she is used to dealing with people with mental health issues who have outbursts, and it felt like she had to manage it that way. LH sat in one of the chairs and Ms Banks was pacing up and down. Ms Banks was shouting that LH "*stamp all over her*" whilst stamping her feet and screaming "*Why are you picking on me on my timekeeping? You're treating me like a child, you don't do this to anyone else*." LH said that she is her mentor and time keeping is a part of how things work, to that Ms Banks said "*Just because you think I am an ASYE, you stamp all over me and speak to me like child.*" Ms Banks said that LH had ridiculed one of her assessments. LH tried to talk her through it calmly, saying "*I was at that assessment and that did not say that, but you did put it in so I wanted to address that with you.*" Ms Banks then said, "*It is the way you speak to it is the tone of your voice*" and I said, "*Next time I do that, you tell me if I being patronising because I cannot address it if you don't tell me.*" Ms Banks then said LH threatened to fail her, to which LH responded, "*No, we need to work together on your document there are things on there that I recognise that have not really happened.*" It was after this incident that LH decided it was not appropriate for her to supervise Ms Banks any more. LH considered that Ms Banks felt the same way.

cc. At no point did LH tell Ms Banks that she was going to fail her ASYE.

dd. LH is not a close friend of GW (Ms Banks' subsequent supervisor). LH does not know from where Ms Banks believed that GW was being difficult with Ms Banks because LH said that she would fail Ms Banks for the ASYE.

ee. Ms Banks complained to LH that the amount of driving was difficult and tiring. LH told Ms Banks that no one was expecting her to do a lot of visits in one day. Ms Banks further complained to LH that *[PRIVATE].*

ff. If there was any issue affecting Ms Banks' work, including stressors, LH would see how to tackle it. LH said that Ms Banks never discussed the reasoning behind the stress.

gg. *[PRIVATE].*

SM

20. SM provided the following evidence:

a. SM was the Team Manager of the team within which Ms Banks was employed. However, at the time that Ms Banks joined the Team, SM was a Practice Supervisor. Ms Banks joined the team on 18 March 2019 and was a part of the team until 18 December 2020. SM was not Ms Banks' direct supervisor at any time. Ms Banks was line managed by LH from 12 April 2019 until 9 January 2020.

b. SM said that his team was aware that Ms Banks had no previous statutory experience.

c. Ms Banks initially demonstrated enthusiasm in her role and applied herself to the required learning. Therefore, she passed her probation on 18 September 2019.

d. However, on 22 November 2019, Ms Banks' line manager at the time, LH, reported that Ms Banks was finding it difficult to manage complex cases. Ms Banks' ASYE coordinator and Early Professional Development Best Practice Educator, AS, responded to this email on 27 November 2019 suggesting next action steps to take to assist Ms Banks.

e. Ms Banks requested a change of supervisor during a meeting on 9 January 2020. SM said that both LH and Ms Banks came to him to ask for LH to be replaced as Ms Banks' supervisor. GW was the most experienced social worker at the time and had taken on many ASYE's in the past, so she took over supervising Ms Banks. SM said that there was no request from Ms Banks to reject GW from the outset. SM noticed that there was a miscommunication between Ms Banks and her line managers. Therefore, he encouraged Ms Banks and her line managers to have a conversation in person or send an email to allow for a record and consistency. Ms Banks accepted this advice.

f. LH mentioned to SM that in the first three months of Ms Banks' ASYE, LH was providing a lot of one-to-one support with every piece of work that Ms Banks completed which is how she kept up to the standard of work required. However,

from August 2019 LH noticed a deterioration in Ms Banks' progress. LH was unsure why this was happening and Ms Banks was unable to answer that too. LH's observation was that Ms Banks was asked to do work independently and was given an increased number of cases which was starting to affect her performance.

g. Eventually, Ms Banks failed her ASYE as she was not meeting the key standards, based on "*clear cut*" evidence. Ms Banks appealed against the ASYE outcome. The Principal Social Worker at the Council sent Ms Bank's ASYE to another local authority for an independent review, but they upheld the original decision that Ms Banks failed the ASYE. This independent review was undertaken by the ASYE lead officer at Buckinghamshire Council. Ms Banks' line manager at the time she failed the ASYE stated that the level of support the managers and the team were currently offering was no longer sustainable and without this support, Ms Banks would not be able to deliver support safely, effectively and equitably. Further, Ms Banks had a very small proportion of complex cases and even when she was on leave or absent, she was given additional time to complete the necessary pieces of work, showing how much the Council was supporting her in the ASYE process.

h. On 26 June 2020, Ms Banks raised concerns about her then line manager (LH) with allegations of potential bullying. Ms Banks raised three concerns with SM:

   i. Her line manager was speaking to her over the phone in an aggressive tone and repeating questions.

   ii. Her line manager was contacting Ms Banks over the phone and via email constantly which made her feel pressured and was not allowing her to complete her work.

   iii. Her line manager was constantly giving her instructions, which made her feel that the instructions were inconsistent. For example, Ms Banks was instructed to complete a specific task and when she would complete it, her line manager would say it was incorrect.

Ms Banks reiterated to SM that she wanted to be treated with respect and not to be shouted at and to be given opportunity to use her professional judgement, skill and decision making on cases. SM came to the conclusion that there was no evidence of prejudice, harassment or bullying. To protect Ms Banks and her line manager, SM made the decision that Ms Banks' written work would be authorised by another practice supervisor.

i. SM did review aspects of Ms Banks' work. SM had to send an email as the amount of correction required was not able to fit into normal electronic comment box. It was not SM's intention to return a report to a social worker, but rather authorise a report as soon as possible. However, SM had an obligation that reports meet the standard required, so that the needs of the service user are captured. Managers would be expected to review a report on the day it was given to them.

j. The Care Act has mandatory aspects which needed to be fulfilled. Even if different managers had different writing styles, the reports would have been rejected as Ms Banks' reports lacked these mandatory aspects. SM said that there was no intention to victimise Ms Banks. All the managers considered that Ms Banks' work was not up to standard. All the managers were trying to achieve the best outcome for everyone. As the team manager, SM always made sure that he was approachable, including to Ms Banks, in case there were any problems.

k. [PRIVATE].

l. *[PRIVATE]* Ms Banks was given an extension to complete her ASYE and *[PRIVATE].*

m. The Local Authority System contained guidance on a number of processes, including the following:

i. LAS: Basic Navigation;

ii. Completing an Assessment;

iii. Case Notes;

iv. Forms — Creating, Completing, Authorising and Printing;

v. Historical Data — Viewing Historical Data;

vi. Overview Assessment — Hints and Tips on completing;

vii. Safeguarding; and

viii. Support Planning.

n. There is also opportunity to do joint visits with the other workers within the team and sufficient training around each legislation and process is also offered.

o. Another concern in relation to Ms Banks' practice was that although she was completing the assessments, to bring it up to the required standard she had to go through a lot of rejections and management had to amend quite a lot of her work. The assessments could be anything starting from a Care Act assessment, Capacity assessment, or best interest minutes which are Mental Capacity Assessment ("MCA") section 117 reviews. The management reviews and changes caused a delay in completing the process, which adds to the risk to the service user and puts pressure on the service. The amount of revisions required for Ms Banks were unusual for an ASYE at her stage in the programme.

p. Service User 10 was in a care home where their needs were not met sufficiently. In some aspect, we could say they were in a safe place but the priority was to move them to a more suitable atmosphere. Ms Banks delayed the completion of this process. The Care Act Assessment should have been finalised by 16 March 2020, but was only completed on 14 April 2020. The delay was due to multiple rejections. Eventually with significant amendments to the assessment and support, Ms Banks managed to get Service User 10 moved to a new provision.

This demonstrates Ms Banks' lack of ability to work independently. The main impact of Ms Banks' handling of this case was the delay. This meant that Service User 10 was left without adequate care and support. This was creating more frustration and increased risk within the setting Service User 10 was living in and this would be impacting the other service users in that community as well. It is also important to consider the emotional and physical issues the staff at the placement might have had in managing the needs whilst the process was being delayed. Ms Banks had received all the training. Ms Banks had an induction which takes her through the Care Act assessments, support planning and the opportunity to train within our service on how to complete MCA section 117 assessments. Ms Banks was unable to demonstrate why there were delays in completing the process. The expectations of an ASYE at this level with regards to demonstrating professional judgment and authority through an ability to work independently are considerable, given the amount of training they have undergone and being aware of the fact that they have a Social Work England registration. This will be maximised by ongoing training and their line manager's support.

q. Ms Banks lacked communication in the case of Service User 3. There was an instance where Ms Banks booked in a period of respite in August for Service User 3 in December when the informal carer was to go on holiday. There is no evidence to suggest this booking was communicated to Service User 3's family and no one knew what was happening. This led to a crisis, as on one morning on 22 October 2019, Service User 3's informal carer left the house and the team's duty system, who works on the case when Ms Banks was not around, had to organise an urgent respite to support the person and the family. In my professional judgement, not informing the informal carer about the planned respite triggered the action from the carer as they felt not supported in the caring role. If Ms Banks was communicating about the respite in December, this might have prompted the carer to seek immediate respite as it could not wait until December. Maintaining trust and communication is important for a social worker. Further, there were delays in the completion of the Care Act assessment by Ms Banks due to rejections and also delays in organising the appropriate care and support for Service User 3. along with lack of communication. The case was allocated to Ms Banks on 5 June 2019 but the Care Act Assessment was only authorised on 3 July 2019 after five rejections. Ms Banks would have known what to do in order to meet Service User 3's care and support needs through the allocation note. When the case was allocated, the allocation note would have described what is needed to be done, and throughout the process Ms Banks' line manager would have been prompting her to move from one stage to another and the manager would have known this from their own experience as well. Ms Banks did not complete a mental capacity assessment for Service User 3 which indicates that she was working under the presumption that Service User 3 had capacity.

r. Ms Banks had worked on the case of Service User 9 before, and was asked to undertake a reassessment. Ms Banks responded that there are no changes in Service User 9's needs within her support plan review. When her line manager at the time went through the assessment, she identified that there were changes in Service User 9's needs such as changes in medication and how Service User 9 was behaving. Following this, Ms Banks should have carried out a reassessment of Service User 9's needs from her judgement of the situation. Ms Banks did not undertake a mental capacity assessment until specifically asked by her line manager. During the mental capacity assessment, it was evident that Ms Banks was relying on third party information instead of undertaking a formal capacity assessment. The biggest issues in this case was Ms Banks' inability to understand the mental capacity assessment framework and Ms Banks' inability to carry out the mental capacity assessment without prompting. Ms Banks had Mental Capacity Act training and also the feedback she had received from her previous assessments. Additionally, Ms Banks had the opportunity to discuss with her line manager and any other colleagues the appropriate methods and situations in which to carry out mental capacity assessments.

s. When Ms Banks managed to find an alternative care home for Service User 9 to move on to, the process was delayed because the care home Service User 9 was currently staying at asked for a four week notice period. Ms Banks should have negotiated with the care home, which in the first instance she failed to do and had asked Service User 9's husband to do that negotiation instead. SM spoke to the care home managers. SM was able to negotiate the notice to two weeks. The care home manager informed SM that she was not happy with Ms Banks' communication because Ms Banks was demanding, which the manager felt was not appropriate behaviour for a professional. Further, the manager felt that Ms Banks should have made the request directly to them. This impacted upon the reputation of the Council.

t. In Service User 9's case, Ms Banks' returned review suggested that Ms Banks had missed out important information like Service User 9's inability to self-administer medication. In this review, Ms Banks did not demonstrate how Service User 9's needs were being met. Returning a case plan is quite normal, returning a review is quite unusual, especially one which covered so many areas. Many areas of the review required amendments. This review demonstrated Ms Banks' lack of understanding about the social care process and also different services that are available within the organisation. This review had more than one rejection, the first one was on 1 June and the second was on 24 June.

u. There were certain areas of concern identified in Ms Banks' completion of a Care Act overview for Service User 1. Ms Banks first submitted the overview on 26 September 2019. This overview was rejected three times due to significant spelling errors and irrelevant information that did not encapsulate Service User 1's current and the support they required.

AS

21. AS provided the following evidence:

a. AS's main role was to support and coordinate the ASYE in employment in adult social care in Oxfordshire. AS also moderated peoples ASYE portfolios which meant that he would look at a person's portfolio prior to it going to panel and give it an assessment of his opinion as to whether its passed or not. The role of panel is to scrutinise all submitted ASYE portfolios, to make a decision whether a Newly Qualified Social Worker ("NQSW") has successfully completed their ASYE. This is done on the evidence presented by both the NQSW and ASYE assessor. AS was Ms Banks' ASYE coordinator the entire time she was undertaking her ASYE.

b. At the beginning of her ASYE, AS gave Ms Banks a document titled the "*Support and Assessment Agreement*." The purpose of this document is to give an understanding of everyone's roles and responsibilities within ASYE, a clear expectation of what is expected, and to set out the specific support available.

c. AS was of the view that although Ms Banks did not have statutory experience which may have impacted upon her ability to learn on the ASYE, it is down to the individual to make the most of the ASYE.

d. Ms Banks' portfolio was very difficult to moderate. Evidence presented by both Ms Banks and the assessor of her portfolio was very strong but they were offering opposite understandings of passing or not passing the ASYE. AS went back to the Skills for Care Guidance document to offer his professional judgement to the panel. AS was able to navigate a path through the evidence presented by the assessor and Ms Banks and to look at potential pathways the panel could explore given that the evidence was diametrically opposed.

e. At the three-month review on 11 July 2019, Ms Banks was managing and on track and there were no concerns.

f. At the six-month review on 10 October 2019, LH said that Ms Banks was on track, but upon submitting her report 2 weeks later, LH said that on reflection there were one or two areas which were not going so well which were not covered at the review. That is when things started to change regarding Ms Banks' trajectory. If there were any issues discussed during Ms Banks' 6-month review, they were not significant enough at the time of the review to have an implication on her ASYE. AS considers that the things LH raised in Ms Banks' report should have been raised in the 6-month review.

g. On 29 November 2019, AS had a telephone conversation with Ms Banks in which Ms Banks sounded upset when describing her situation with LH. Ms Banks considered that in conversations with LH on 20 and 21 November 2019, LH had been threatening and acting in ways which were not professional, but Ms Banks did not provide specific information. When AS spoke to LH about this on 2

December 2019, LH's comments were diametrically to what Ms Banks had said. LH said that it was Ms Banks' approach that was aggressive.

h. At a meeting on 19 December 2019, LH said that she could no longer cope and feel safe because of Ms Banks' accusations, and to discuss Ms Banks' overall competency to pass the ASYE given her trajectory at that time. Although there tends not be a change in assessor, GW became Ms Banks' new assessor. AS cannot recall if Ms Banks had any objections to GW becoming her line manager. AS recalls that there was a disagreement between Ms Banks and GW about the rigour and accuracy of assessments. GW was also placed approximately a one-hour drive away which, combined with Ms Banks' *[PRIVATE]*, added strain on the relationship between Ms Banks and GW.

i. An interim ASYE review took place on 9 January 2020 given that LH said that Ms Banks was not on track to pass the ASYE. The meeting looked at practicalities, such as the handover from LH to GW and setting out expectations as to how that would go forward. The meeting also enabled Ms Banks to highlight her concerns. Unscheduled interim reviews take place if there are concerns. The unscheduled interim review will maximise the time to address any concern and to try to give the NQSWs as many opportunities as possible to indicate where they are not on track and give them time to develop towards that. Ms Banks had some concerns about travel time and some unresolved issues.

j. The Guidance by Skills for Care sets out that if a NQSW experiences exceptional circumstances for a period of four weeks or over, an ASYE can be put on pause so that it is not measured at that point in time. Ms Banks had two months on pause as a result of her *[PRIVATE]*. Ms Banks' ASYE was due to finish in April 2020 but it ended in June 2020. The pause is a recommendation to ensure the NQSW is being assessed fairly. If someone does not want that to happen, then a conversation will take place and the NQSW has to have a say. The Council will try and make sure it is an informed decision rather than an arbitrary one. AS's recollection is that Ms Banks cited she did not want a pause to her ASYE but then subsequently changed her mind.

k. In a call on 3 April 2020, AS felt that Ms Banks felt slightly aggrieved that her ASYE was being unnecessarily extended. AS explained that when he was talking through the advantages and disadvantages, one of the reasons why this is talked through is to have a fully informed decision. Ms Banks became very agitated and took umbrage at AS's comment of a "*fully informed decision*". AS considers that Ms Banks' thought that AS was saying that she did not have capacity as we use this saying regarding mental health capacity but use this in other situations too. It took a while for Ms Banks to calm down. Ms Banks became very emotional and was no longer discussing things from a rational or logical perspective. Ms Banks felt that AS was in some way trying to upset and/or make her ASYE experience more difficult. It also concerned AS how long it took Ms Banks to bring up her action

plan when it was being discussed, and that she brought up a previous version of the action plan.

l. By 10 April 2020, the situation was becoming increasingly complex and difficult to manage.

m. Ms Banks' ASYE was officially restarted on 6 May 2020 and she could now be assessed. Her ASYE had been on pause *[PRIVATE].*

n. On 12 May 2020, Ms Banks wanted her assessor changed again.

o. AS could not find why Ms Banks felt disparaged as a result of an email from GW to Ms Banks on 12 May 2020. AS did not witness any instance where Ms Banks was disparaged by a member of staff.

p. In a one-to-one meeting between AS and Ms Banks on 20 May 2020, AS noted the lack of clarity and speed of response by Ms Banks. AS identified a gap between Ms Banks' written evidence and what she was able to verbalise. Her written work was good quality, with a well-articulated understanding of her practice. There was definitely a difference between what she could do verbally and in writing. In the same meeting, Ms Banks stated that she had received unfair treatment by SM, with Ms Banks wishing to discuss a recent email from SM to herself. She described the content of his email as being "*disturbing*" and his "*attitude was disrespectful*." This was in relation to her recent paperwork not being authorised due to perceived errors by her seniors within her written work. Alongside this, Ms Banks was dissatisfied with different pieces of written work being reviewed by multiple seniors for authorisation. Review by multiple seniors is due to availability within the team on a given day and this practice occurs throughout the Council and Ms Banks appeared to have no grounds for a grievance. After listening to her complaints, AS established that this sat outside of his remit as ASYE coordinator. However, if Ms Banks did believe that she was subject to unfair treatment, AS recommended that she should raise a grievance with HR as per the Council's policy. AS does not know if Ms Banks raised this with HR.

q. In her final review on 2 June 2020, GW told Ms Banks that she did not pass her ASYE. AS believes that Ms Banks received the support she needed to pass the ASYE and more.

<u>BG</u>

22. BG provided the following evidence:

a. BG had just started her role when she began overseeing Ms Banks' work.

b. In her role, BG does the authorisations for forms. BG reads over the forms to see if there are any issues and gaps in the forms.

c. BG was asked to prepare a professional feedback form for Ms Banks which addressed the following issues:

i. BG was concerned about Ms Banks contacting her further to discuss areas that need to be reviewed, as BG felt this was repetitive of the emails she had send Ms Banks. Further, BG felt that she was falling into a supervisory role, which was not BG's role. BG said that she did not give Ms Banks conflicting feedback.

ii. A Council employee raised concerns about Ms Banks contacting the Council's software team a lot to request support in completing forms.

d. The case of Service User 19 was allocated to Ms Banks on 11 June 2020 to complete a support plan and s.117 review. BG's notes indicate that the start date of the care home placement was incorrect and it was listed as a different date in different areas in the Care Notes and documents. The issue is that it seems Ms Banks was relying on the Care Notes rather than direct documentation in relation to the placement and BG would have expected someone of Ms Banks' level to look at the documentation and double-check as there is always room for error.

e. BG identified that the domiciliary care form for Service User 12 had been finalised by Ms Banks on the 30 June 2020 without an authorisation signature and was not re-assigned to HSPO in order for care sourcing to be started. Further, BG returned the domiciliary care form on several occasions to Ms Banks as it was incorrect.

f. Ms Banks called BG to discuss whether an MCA was required for Service User 20. BG initially said that she did not think an MCA was required. However, BG then called Ms Banks back regarding the stroke and advised her to enquire with professionals and Service User 20's spouse. So even BG had to think about it.

g. BG noted that Ms Banks had noted on the case notes for Service User 12 that "*All service user have to have LPA, and we need it in our system.*" LPA stands for lasting power of attorney but not all service users have them in place. BG also notes that in a case note dated 11 August 2020, that Ms Banks told Service User 12 's spouse to "*have a look on the letter whenever she have time*" instead of advising her to liaise with the financial team to have them talk through the letter, contrary to advise she gave the spouse a month earlier.

h. According to the notes, it seems Ms Banks and the Duty Occupational Therapist ("OT") Officer were relying on each other to follow up with the Assistive Technology ("AT") team to do the work that needed to be done as soon as possible, as the service user was at risk of wandering. There was no evidence of any follow up about whether a tracker had been put in place or any follow up with the AT team. Even if the agreement had been for the Duty OT Officer to follow up, as Ms Banks was holding the case, BG would have expected Ms Banks to follow up with AT to check their discussion and what was happening about follow up. The seriousness of the above steps not being carried out is that this was potentially serious for someone quite vulnerable, at risk of going out and possibly not being dressed appropriately.

i. BG has noted that in relation to Service User 11 , BG sent the overview assessment back to Ms Banks eight times between the 22 April to the 5 June before it was authorised. An overview assessment is the old name for a Care Act Assessment. This is a lot of returns which is quite significant for an ASYE of Ms Banks' experience; BG would expect to return assessments 2 or 3 times at the most.

j. Because the managers do not like to return documents to social workers, all social workers were informed to proof read reports, especially around Care Act assessments and reviews.

k. BG said that she was not motivated to fail Ms Banks on the ASYE in order to avenge LH. BG does not believe that Ms Banks was victimised by herself or SM. Ms Banks' work was not systematically delayed to create an impression that Ms Banks did not know what she was doing. BG considers that Ms Banks was supported at all times.

l. BG said that Ms Banks came across stressed in emails. On occasions, Ms Banks even mentioned to BG that she was stressed.

MC

23. MC provided the following evidence:

a. MC was aware that Ms Banks' ASYE portfolio had already been moderated, that Ms Banks had failed her portfolio and that she had appealed the decision, and that Oxfordshire County Council ("OCC") were looking for external moderation. Prior to moderation, MC never met Ms Banks.

b. When MC carried out the assessment, she used the Skills for Care Supporting Guidance, which could be downloaded from the second page of the moderation report template. The Skills for Care template document also has guidance and MC followed that guidance for her review. MC's approach was to:

i. Obtain a general overview;

ii. Ensure that the assessor's assessment is fair;

iii. Look at the assessor's assessment and the documents that back that up;

iv. Look at the mid-point and final reviews in particular to see how the Social Worker has developed; and

v. Look for supporting evidence of how the Social Worker met the elements.

c. MC noted that Ms Banks had had two assessors and additional sign offs from others and it was clear that there were challenges and a difficult relationship between assessor and worker. MC's could see that Ms Banks could identify the theories but MC struggled to find evidence of how Ms Banks applied this in practice.

MA

24. MA provided the following evidence:

a. Ms Banks started work with West Northamptonshire Council ("WNC") in April 2021. When Ms Banks joined the WNC, she had a different line manager but then it changed to MA. MA was Ms Banks' line manager for a period of four months. Ms Banks told MA that she had failed her ASYE due to a change of assessor. MA was made aware by Ms Banks that Ms Banks was under a Social Work England investigation in the first or second month of employment at WNC.

b. Ms Banks' role was to complete reviews, Care Act assessments, and MCAs, to assess service user needs, provide advice and cover duty. Ms Banks was also required to prepare cases for Independent Oversight Meetings ("IOMs"), and attend all meetings and training.

c. Ms Banks already had some experience. MA expected that someone with Ms Banks' experience would have more knowledge than she presented with.

d. Ms Banks had a standard induction plan and everything was on the system. Induction is two weeks and Ms Banks would have been provided with a hard copy of the induction booklet and a copy of "*How to Guides*" explaining WNC's processes. Booklets are also available online and there are more hard copies in the office. The following were mandatory training: data protection, health and safety, Care Act training, Eclipse training. MA is "*99% sure*" that Ms Banks received hard copies of the induction booklet as Ms Banks did not initially have access to emails, so MA gave her an induction booklet as something to read and focus on.

e. At the Council, supervision was usually undertaken once a month, however MA did supervision more often and this was because Ms Banks needed more support. Ms Banks was also provided with a lot of verbal feedback. MA and Ms Banks had a lot of informal meetings and they discussed cases in detail in "*On Track Chats*" which they usually had every two weeks. This was for all the workers and they could give each other advice.

f. MA did not want to be negative from the beginning and MA was trying to concentrate on strengths. In MA's supervisions with Ms Banks, Ms Banks' struggles were not entirely recorded. MA tried to build Ms Banks up with positive feedback and concentrate on what she was able to do other than what she was not able to do and MA would give her a plan. MA did not write concerns on Ms Banks' supervision notes, although these were orally discussed.

g. *[PRIVATE]* MA discussed her concerns with Ms Banks about her wellbeing and this is why there were regular supervision meetings. MA considers that this situation was affecting Ms Banks a lot, and MA raised it with her line manager. For this reason, MA did not record all the performance issues with Ms Banks. Once when MA recorded something, Ms Banks got really angry with MA and asked MA to change it. It was not related to work, but it was in relation to home and Ms Banks

could not agree that she was struggling. MA did change this as requested. When MA tried to help, Ms Banks got angry and aggressive, but Ms Banks did not see that she was being aggressive towards MA. Ms Banks shouted at MA on a few occasions and her body language indicated that she was distressed and angry. MA told Ms Banks at least twice that it may be best for her to be supervised by a different principal social worker but Ms Banks said she was not angry and did not want a different line manager. Ms Banks said she was happy with MA. However, any guidelines and any suggestions MA was giving Ms Banks regarding her cases or her wellbeing met with a negative response from Ms Banks.

h. Ms Banks' performance fluctuated. She would have a poor performance, then improve, but this would not be maintained.

i. The only concern Ms Banks sometimes raised during supervision with MA was about Eclipse, the case management system.

j. MA had general concerns about Ms Banks not being proactive enough with her caseloads, for example not approaching different teams involved in her cases such as brokerage, PBSS (Personal Budget Support Service), the Safeguarding Team. MA had concerns about Ms Banks not recognising when the Care Act was needed when reviewing cases and not recognising when an MCA was needed. MA also had concerns about Ms Banks asking the same questions many times about processes and Eclipse, therefore not retaining information, and about her inability to work on her own initiative.

k. None of MA's workers needed as much supervision and guidance as Ms Banks did. Ms Banks' MCAs were very basic. Ms Banks did not show any initiative. When MA tried to advise Ms Banks, it was always taken as she did not need it or knew it. Colleagues complained that Ms Banks approached them all the time with the same questions.

l. Ms Banks was struggling on the duty rota. This was discussed and led to the decision by the Duty Manager and Team Manager to remove Ms Banks from duty but that was a decision that was made after LC took over from MA.

m. Ms Banks was slowly building up her case load. She had two, then four and then slowly the cases were building up. The quality of Ms Banks' work was not too good either in terms of recording, duty, and communication and she also needed help with each case. Ms Banks needed guidelines about the smallest tasks, it was not sticking with her that it was the same process every time. Ms Banks would not show initiative or professional curiosity and she had to be told about the smallest thing and be given everything "*on a plate*".

n. During lockdown, MA heard that when Ms Banks was on the phone to the service users, she was not really able to advocate for the service users as a result of her language skills, lack of knowledge and lack of confidence sometimes.

o. Service User 6 was a case involving a lady who was looking after 3 grandchildren that really escalated because the communication between Service User 6 and Ms Banks was not very good. Service User 6 was really struggling and it escalated really badly and it went to the team manager. Ms Banks did not have an ability to recognise that she could come across as aggressive and angry over the phone, although MA does not believe it was Ms Banks' intention to come across as aggressive and angry. MA does not think Ms Banks had the ability to manage conflict or difficult conversations.

p. MA stated that the three-month review is to check whether a member of staff is on track. MA had Ms Banks' three-month review planned, but then due to sickness, either MA or Ms Banks, the three-month review was postponed and not rearranged due to work pressures at the time.

q. Ms Banks had a six-month probationary period which was extended.

r. MA was of the opinion that Ms Banks had a person-centred approach and that she knows the main domains of how an MCA is completed.

LC

25. LC provided the following evidence:

a. LC was Ms Banks' line manager from the end of October 2021 until Ms Banks left WNC in March 2023. There was no one else supervising Ms Banks at the same time as LC. LC cannot remember if she had a verbal handover from MA. LC would have had Ms Banks' previous supervisory notes from WNC. LC said that, initially, Ms Banks engaged positively with her.

b. Ms Banks's role was to complete Care Act assessments, complete safeguarding enquiries, complete MCAs, complete depravation of liberty assessments for the courts, support planning, present funding requests to senior management, manage a caseload based on risk and need, liaise with other professionals, be on the duty rota and participate in duty days once a week or so.

c. At their introductory meeting on 26 October 2021, Ms Banks told LC that there was an ongoing Social Work England investigation.

d. *[PRIVATE].* LC did not know of any of Ms Banks' health conditions and so she could not support Ms Banks.

e. By November 2021, LC had concerns about Ms Banks' performance, but due to the volume of concerns, LC wanted to raise these with Ms Banks in person rather than over Microsoft Teams. LC considered that she approached Ms Banks' competency issues in a non-biased way and based on the evidence presented. LC felt that Ms Banks lacked autonomy and the ability to make a decision.

f. Ms Banks' caseload was low for a qualified social worker. The normal caseload would have been 20 to 25 cases dependent upon complexity. It was unusually low within the team as there was more concern about her management of risk.

g. A principal or manager emailed LC on 10 November 2021 about safeguarding not being followed up. The duty manager had asked Ms Banks to make a call in relation to safeguarding but when they looked 2 weeks later, she had not made the call and they had to chase her.

h. Service User 14 lived with her brother, the place was neglected, there was hoarding and it was not very clean. Service User 14 was allocated to Ms Banks. Ms Banks presented a very good form at an IOM to ask for a package of care. When LC read some of the form, she thought it was really quite good and well written and was really pleased that Ms Banks had made progress. LC asked "*Did you write this yourself?*" It was not meant to be offensive, but the form was so different to Ms Banks' writing style and I thought she might have had training. However, Ms Banks took offence and reported LC to Social Work England and copied in BASW. It transpired that Ms Banks had taken some of the previous report (compiled by someone else two years previously) and copied it word for word. Although LC considered that it could be the case that the recommendation could be the same as two-years previously, it was unlikely that the description and details of the visit would have been exactly the same and had the same wording.

i. Service User 5 is an individual with high level of needs and has autism. At the point his matter was allocated to Ms Banks, he was living in a supported living environment and he had no tenancy in place. LC was invited to a meeting in November 2021 with the commissioning team and the care provider and they both wanted to raise concerns regarding Ms Banks' understanding of the situation without raising a formal complaint. They wanted to stop things from deteriorating and they asked for a new worker. The meeting was not recorded as it was an informal meeting before any complaints came in. An eviction notice had been served by the landlord for Service User 5's accommodation but not in relation to Service User 5's support package. Ms Banks had misunderstood and started the process to get new support and had not communicated this to Service User 5's family. It was already a complex family situation and the support provider did not become aware until the new provider started making contact. Ms Banks had got really confused. The situation caused a lot of confusion with Service User 5's support. It disrupted his care and caused real issues with family, which were complex anyway, namely the family not being involved in planning for Service User 5's accommodation and support. Ms Banks should have made sure that the family were involved every step of the way. Failure to do so risked a further breakdown of communication between WNC and the family, and it placed Service User 5's care at further risk. LC said that Ms Banks did not want to communicate with family as they were difficult.

j. Service User 6 is a young lady who lives at home with her grandmother and has a high level of needs. Her grandmother is the primary carer for two of Service User 6's younger siblings with care needs as well. Service User 6's case was allocated to Ms Banks on 7 July 2021. Service User 6's grandmother asked the Council to provide transport. Ms Banks should have completed a transport assessment which would go to the managers to consider, but she did not. Ms Banks' manager did not inform her that she needed to complete a transport assessment, and there were three other social workers involved in this matter who also shared responsibility in this matter. Service User 6's grandmother raised a complaint that she felt she was being bullied and asked for Service User 6's case to be reallocated.

k. Service User 15 had shared lives carers, which is when somebody with a learning disability lives in a family home with paid carers. Service User 15 had a high level of need for that scheme. Ms Banks' role was to look at his mental capacity and then consider what was in his best interest in terms of managing his finances. Ms Banks asked LC to come along to the MCA. Ms Banks was proactive and LC went along with Ms Banks and at that meeting it became quite clear Service User 15's case was quite unique and it was in his best interest for his carers to be his appointees as they needed quick access to his funds because of his needs. However, when Ms Banks sent the MCA to LC to quality assess, it was completely different to what had been discussed. LC's main concerns were firstly that the assessment was not reflective of the discussion on the day. It did not reflect what had happened and it was not what was agreed. Secondly, LC was concerned about the quality of the assessment, as it was poorly written and jumbled. LC started to quality assess this document but she became so concerned that she did not finish assessing it and sought advice from the then lead social worker who has now retired. LC forwarded the lead social worker the MCA and spoke to her over the telephone. She advised that another worker should be allocated as the content of the MCA was concerning. The terminology of the MCA was not appropriate. LC had serious concerns Ms Banks' professional judgment and ability to work independently as the MCA for Service User 15 was not reflective of the meeting. Ms Banks' handling of this matter could have been problematic as it could have impacted Service User 15's finances and led to a decision which was not in Service User 15's best interests. Further, there were concerns about how Ms Banks presented Service User 15's case at the IOM. Ms Banks only spoke about what the carers wanted and not what Service User 15 wanted. The wording and presentation of the IOM form were not meeting the required standard, the level of quality assurance was way beyond what the service expected and we do not really want to be editing things and they should pretty much good to go. LC left in the parts that were copied word for word.

l. Service User 16 was allocated to Ms Banks from 28 April 2021 to 7 December 2021. There was a concern about arranged or enforced marriage and part of Ms Banks' role was to assess Service User 16's mental capability. When LC received the MCA form completed by Ms Banks, she was concerned in the way it was

written as it was jumbled and confused. However, the biggest concern was that it went on to recommend that a best interest decision was made. That is a concern because that would not be legal. You cannot legally make a best interest decision in terms of enforced marriage, so if that had continued, the Council would have made an illegal decision. In the section titled "*Practicable Steps*", Ms Banks made a conclusion about Service User 16's mental capacity, but this should not be done until everything had been considered. In section titled "*The Decision*", there was a decision made about Service User 16's mental capacity and it should not be made there. That section should just be about the decision and why capacity is being assessed. The form reads as though Ms Banks has made the decision before considering all aspects of the assessment and before it began. It is expected that a social worker has knowledge of the MCA. There was a lot of MCA guidance on the Council's website. Ms Banks did not complete the mental capacity assessment in line with Council guidance. The number of revisions required for Ms Banks' MCAs were unusual. There appeared to be a lack of understanding of the legal framework which everyone was working in.

m. Ms Banks failed her probation at WNC in October 2021.

JH

26. JH provided the following evidence:

a. When JH commenced her role, she wanted to explore what was happening within the team, as when she first started, she noted that the team were in a very bad place as a whole. A lot of people had left and the numbers were low. JH met with each individual team member and put in 30-minute meetings with all of them. JH noticed that there was a theme coming up and people were mentioning Ms Banks to JH but they wanted to fix the team and it was not a culture of trying to cause trouble or being inappropriate. JH does not have a record of these meetings as they were informal discussions.

b. MA made JH aware that there was a Social Work England investigation into Ms Banks.

c. JH was made aware that Ms Banks' three-month review had not taken place. JH considered that Ms Banks may have felt that due process had not been properly followed.

d. JH spoke with HR advisors around an extension of Ms Banks' probation as JH was not happy for her probation to be signed off because concerns had been raised. HR stated that when concerns are raised towards the end of the probation period, it can extend it for a further three months. Ms Banks said she was not aware of concerns raised by MA, that they were not recorded in her supervision records, and that her three-month probation did not take place. Ms Banks did not feel that MA understood the cases she had and was only aware of issues raised in one case

concerning a transport issue that had not been properly organised and the service user was quite angry.

e. JH said that MA did not have anything written in supervision records to back up the concerns she had raised concerning Ms Banks. JH said that MA said this was because Ms Banks did not want anything negative written on her records.

f. Ms Banks missed the three-month probation meeting where concerns would normally be addressed as Ms Banks *[PRIVATE]* and it did not get rearranged.

g. JH made a decision to change the line manager for Ms Banks because she felt a fresh start for the extended three-month probation period would be better. JH considered that Ms Banks was receiving regular supervision from LC.

h. In the case of Service User 9, Ms Banks did not explore further the actual situation of the family. Although there were two other social workers on Service User 9's case as well. JH would expect a social worker to listen to the person's point of view and take that into account. It appeared to JH that Ms Banks just applied the transport rigidly and did not see the situation in a person-centred way in relation to supporting the person and their carers. JH cannot solely blame Ms Banks because she did not have the right support.

i. JH felt that Ms Banks did not have professional curiosity, empathy and problem-solving skills, and was unable to think differently about things. It was very rigid and she needed other people to support her with decision-making, she could not make judgments herself. JH did not think that Ms Banks understood the impact of her actions on Service Users, her colleagues and the Council. JH said that people in the team thought that Ms Banks had just commenced her social work career when in fact this was not the case.

j. JH was concerned that Ms Banks did not know that the issues surrounding Service User 16 could go to court. JH considers that Ms Banks could have made some serious legal errors in this case, causing the Council to act illegally. JH was very concerned that Ms Banks made a best interests decision on the document, which was the incorrect process. JH would have expected Ms Banks to discuss this case with her line manager. However, it is not for the line manager to do the work for them. The manager is there to guide, support and audit. JH would expect Ms Banks to be open and honest and acknowledge her own areas of learning.

<u>Ms Banks</u>

27. Ms Banks provided the following evidence:

a. Prior to becoming a social worker, Ms Banks worked in a care home with people with dementia and also worked in an NHS inpatient ward as a support worker.

b. Ms Banks completed a BA in Social Care and Management in 2010, and completed an MA in social work "*ten years later*".

c. When she started at OCC, Ms Banks was motivated. She knew there was going to be a lot of learning and took it as a challenge.

d. Ms Banks was aware of the Health and Care Professions Council ("HCPC") standards which she agreed to abide by. She was also aware of the ASYE support document which requires newly qualified social workers to be proactive in maintaining their development.

e. During her first week at OCC, Ms Banks completed mandatory training online. Ms Banks did not have a proper induction as her supervisor was on annual leave.

f. During her second week at OCC, Ms Banks was given two service users and allocations on what to do. Ms Banks went on a joint visit, took notes and was an observer on how to do a Care Act Assessment. Ms Banks was asked to write up the visit and was told by a colleague to look at a previous visit write up as a guide.

g. Ms Banks completed on line training and face to face training when learning to complete an MCA.

h. Ms Banks started her ASYE training on 18 March 2019. She was keen to undertake training opportunities to assist her progress. She attended monthly workshops.

i. Ms Banks agreed a supervision contract with her supervisor. For the first six months of her ASYE, Ms Banks' supervisor was supportive and there was open communication. After six months, Ms Banks felt that things changed as her supervisor said "*your work is going down*" to which Ms Banks replied, "*I've been on annual leave, where is the work that is going down?*" Ms Banks admitted that at this meeting she lost her temper and did not control herself.

j. Ms Banks' supervisor said that she was concerned about Ms Banks completing MCAs, and therefore Ms Banks was no longer going to get cases concerning mental capacity. However, Ms Banks said that her supervisor did not set out specific concerns and Ms Banks was keen to obtain more experience in mental capacity.

k. Ms Banks said that she had attended MCA training but had no opportunity for shadowing an MCA assessment. When she went to WNC, Ms Banks completed further MCA training. At WNC, Ms Banks said that she was co-working with another social worker on a case regarding a mental capacity assessment. Ms Banks said that the co-worker gave no guidelines, but just told Ms Banks to shadow her. Ms Banks said that she had access to training and support for MCAs both at OCC and WNC. Ms Banks said that she still needed more knowledge concerning MCAs as it is a huge area.

l. After six months in her ASYE, Ms Banks felt seriously impacted and demoralised. She felt she was being victimised and that she was involved in office politics which SM was too scared to confront. Ms Banks was not told by her supervisor the areas where she had to improve and she was not provided with an action plan going

forward. When she asked her supervisor what was wrong with her practice, Ms Banks was told to speak to colleagues; Ms Banks' colleagues told her to speak to her supervisor for areas of improvement.

m. Ms Banks considered that her ASYE was extended to cover the times that she was absent from work. Ms Banks thought that GW considered that Ms Banks did not need extra time to meet the standards for the ASYE, and therefore Ms Banks rejected that her ASYE be extended to August 2020.

n. Ms Banks was distraught when she was told that she failed her ASYE. Ms Banks tried to regain herself, look for new roles and continue her training through reading.

o. During her interview at WNC, Ms Banks did not immediately disclose that she failed the ASYE as she felt a sense of shame. Once she did disclose this to WNC, Ms Banks was told not to worry and that she would receive some training.

p. Ms Banks did not receive an induction at WNC as she joined during COVID. It took Ms Banks nearly two months before Ms Banks could get access to WNC's IT system. During these two months, Ms Banks would go into the office so she could meet people, get used to the environment and get used to the IT system. When she was in the office, someone would log into the IT system for Ms Banks and she could then access the training. Once Ms Banks obtained her laptop, she was able to complete the mandatory training.

q. At WNC, Ms Banks was not given the opportunity to shadow as most of the team had departed following COVID and a council restructure. Ms Banks was told by her supervisor that she had joined during a chaotic time.

r. WNC started having problems with Ms Banks following Social Work England's visit to WNC concerning Ms Banks' investigation. Following the visit of Social Work England, Ms Banks was told that she had to change teams. Ms Banks was told by WNC that what it had noticed about her performance was similar to the concerns of Social Work England. This was the first time that Ms Banks knew that WNC had any concerns surrounding her performance.

s. Ms Banks was aware that not all her work met the required standards and, through demonstrating this insight, was of the view that this demonstrates learning.

t. Ms Banks considered that if OCC and WNC had raised their concerns earlier, she would have used the feedback to improve herself.

u. Ms Banks said that if she was facing personal or practice difficulties in the future, she would go to her manager and supervisor and seek support in the areas where she is struggling. If there is specific training to improve her performance, Ms Banks would ask to go on it. Supervision is important for communication between

the manager and the supervisee to discuss what is important and areas for improvement.

v. *[PRIVATE]*.

w. Service User 3: Service User 3's assessment was first sent for approval on 19 June 2019 and approved on 3 July 2019. It was reviewed by two different reviewers and re-written by Ms Banks on five occasions. Ms Banks said that she made the corrections as requested by the reviewers and she put the service users' needs in the assessment. Ms Banks said that she corrected what GW wanted and then SM reviewed the assessment and identified other problems. In his review, SM asks Ms Banks to add a mental health diagnosis and to add more information on how Service User 3 was presenting on a day-to-day basis. Ms Banks said that SM looked at something different to what GW looked at. Ms Banks said that the assessment was up to standard, but different reviewers had different views, and that the assessment went "*back and forth*" between reviewers.

x. Service User 1: Service User 1's assessment was first sent for approval on 26 September 2019 and approved on 2 October 2019. It was reviewed by two different reviewers and re-written by Ms Banks on three occasions. Ms Banks said that the assessment could have been corrected in one go, rather than it being sent back to her three times. Ms Banks said that LH did not go through her assessments line by line. Ms Banks said that she did proof-read her work and then corrected it. Ms Banks said that other social workers with 20 years' experience were having their work returned too. Ms Banks said that this was an opportunity to learn and that she was learning from her mistakes.

y. Service User 8: Service User 8's assessment was first sent for approval on 3 December 2019 and approved on 12 March 2020. It was reviewed by two different reviewers and re-written by Ms Banks on six occasions. LH observed that Ms Banks stood over Service User 8's bed when listening to her. Ms Banks said that she was standing by Service User 8's bedside, and bent down to Service User 8's bed when wanted to hear something. Ms Banks said that the room was small, so she may have had to bend over Service User 8 to hear her. In hindsight, Ms Banks said that she should have asked Service User 8 if she could sit on her bed. LH said that Service User 8's husband left the room because he was not being heard; Ms Banks disagreed. Ms Banks said that she was concentrating on Service User 8's answer. LH said that Ms Banks was not listening to Service User 8's answers but just going through a checklist of questions; Ms Banks disagreed.

z. Service User 9: Service User 9's assessment was first sent for approval on 10 March 2020 and approved on 24 June 2020. It was reviewed by two different reviewers and re-written by Ms Banks on seven occasions. Service User 9 required a care plan review. GW spoke to Ms Banks about the review of Service User 9's assessment. In his review, SM sent Ms Banks a detailed email providing comments, including that Service User 9's name is incorrectly spelt in places and

whether Service User 9 wished to go home. Ms Banks said that Service User 9 puts too much pressure on her husband and he could not cope with it. SM said that Ms Banks had not provided sufficient evidence in her assessment, to which Ms Banks responded that she was not sure what further information/analysis SM wanted. Ms Banks said that she wrote down the risks of Service User 9 leaving the care home. Ms Banks admits that there may be problems with spelling, but that she was still learning. In the review by SM on 1 June 2020, he still highlighted that there was not enough evidence that Service User 9's concerns were being met, there were still grammatical errors, and there is still lack of clarity on what medication is required. Ms Banks said that she was still learning.

aa. Service User 10: Ms Banks reviewed Service User 10 on 10 March 2020, but did not submit the assessment for review until 30 March 2020. Following Ms Banks submitting the assessment for review, it was reviewed on five occasions by GW until it was approved on 14 April 2020. GW rejected the assessment because Ms Banks had not completed part of the assessment and there was missing information; Ms Banks cannot remember if this was the case. Ms Banks said that she was learning, therefore the assessment may need to be corrected. Ms Banks said that she put down the information that she got from Service User 10.

bb. Service User 11: Service User 11's assessment was first sent for approval on 22 April 2020 and approved on 5 June 2020. It was reviewed by two different reviewers and re-written by Ms Banks on eight occasions. Service User 11's assessment was rejected due to spelling and grammar issues, a lack of consistency (concerning care needed and medication), and a lack of detail concerning the support Service User 11 was given and the behaviours Service User 11 was exhibiting. Ms Banks said that she put what Service User 11 needed. Ms Banks said that she did not know what the standard required of her was because the feedback she received was inconsistent. Ms Banks said that whatever the reviewer wants to put there, they will put. Ms Banks does not consider that the review was not up to standard.

cc. Service User 4: Service User 4's assessment was first sent for approval on 28 May 2020 and approved on 17 June 2020. It was reviewed by BG and re-written by Ms Banks on five occasions. Ms Banks said that BG only concentrated on one paragraph. Ms Banks said that she did what BG asked of her: Ms Banks put the information in the assessment that she was given by the service user. Ms Banks said that because she was new, the reviewers made her feel like she did not know what she was doing. Ms Banks disagrees that work not up to standard.

dd. Service User 12: Service User 12's Domiciliary Care form was started on 14 May 2020, re-assigned to OAMHSWT authorisations tray on 8 June 2020, and approved on 29 June 2020. It was reviewed and re-written by Ms Banks on four occasions. Ms Banks agreed that she finalised the authorisation form without a signature, but Ms Banks said that everyone made the same mistake. Ms Banks said that she filled in the form from the information received from Service User 12. Ms Banks

said she was being discriminated against as she was the only social worker getting feedback through case notes. Ms Banks considers that BG was "*trying to destroy*" her.

ee. Service User 13: BG and LH told Ms Banks to proof read documents and to read assessments out loud to check for errors. Ms Banks said that all social workers need to proof their work as everyone can make an error. Ms Banks said that challenging behaviour can take different formats, which BG was unaware of. Ms Banks wanted to see the original assessment to see if it was up to standard.

ff. Service User 14: Ms Banks admitted that her assessment of Service User 14 was not an adequate review. Ms Banks accepted that she copied parts of previous social worker's report. Ms Banks said that she should have completed her own assessment based on her own visit. But in this case, Ms Banks said that it was coincidental that she had the same recommendation as previously.

gg. Service User 1: Service User 1 was where Ms Banks was describing service payments over the phone. Ms Banks denied that she had the paying for care booklet from OCC. Ms Banks cannot remember when Service User 1 was allocated to her. Ms Banks said that she did ask LH to take the phone call. Ms Banks said that Service User 1's daughter was screaming at her on the phone. Ms Banks said that she put the phone down for LH to pick it up. Ms Banks said that she did not disengage with Service User 1's daughter, but gave Service User 1's daughter what she needed as she was the one who followed up with Service User 1's daughter, not LH.

hh. Service User 3: Service User 3 concerned Ms Banks' communication with Service User 3's family regarding respite. Ms Banks said that staff called in August 2019 to book respite in December 2019. The respite was arranged and booked, but Ms Banks said that she was surprised to hear that it was not communicated to Service User 3's family. Ms Banks said that she tried to book transport and communicate with Service User 3's grandson (by text and email) that respite has been booked in December 2019. Ms Banks said that SM is lying that that it is not in the case notes that Ms Banks communicated to Service User 3's grandson. Ms Banks said that if Service User 3's family did not know about the December 2019 respite, then she is not clear how did Service User 3's grandson "*made the most of it*". Ms Banks said that the issue concerning respite related to the one in October 2019, not the one booked for December 2019. Ms Banks did not book any respite in October 2019 as she was on annual leave.

ii. Service User 2: Ms Banks told other professionals that they needed to speak to Service User 2's husband about domestic abuse, despite Service User 2's husband being believed to be the perpetrator. Ms Banks said that the following day, Service User 2's bruise became apparent. Ms Banks carried out two visits. Ms Banks explained to the other social workers what Service User 2's husband told her about how Service User 2 received the bruise. Ms Banks denied that her notes

were inviting other professionals to explore further whether Service User 2's husband was the perpetrator, but that she was not going to do anything further. Ms Banks disagreed that she said that safeguarding should not be raised. Ms Banks cannot remember why there are no notes to indicate why she did not visit between 3 and 15 July 2019. Ms Banks considers that both she and the hospital were safeguarding. As Ms Banks was not there when the assault took place, she said that she could not tell if Service User 2's husband was the perpetrator.

jj. Service User 4: Service User 4 wandered outside her home during the night and it was contemplated whether an electronic tracker be put in place. Ms Banks identified on 12 June 2020 that assistive technology was required. On 18 June 2020, Ms Banks made a call about the referral for tracker. On 23 June 2020, Ms Banks called a team administrator to say that Service User 4 is a wanderer, so a tracker is required as soon as possible. On 23 June 2020, Ms Banks was provided with the details needed to obtain the tracker by the assistive technology team. There were no further entries from Ms Banks until 29 June 2020. Ms Banks said that she identified that a tracker was needed and followed it up, but she kept being referred to different departments. Ms Banks also said that her focus during this period was the ASYE. When asked if taking no action between 12-18 June 2020 was a failure to take timely action, Ms Banks replied that she cannot answer this. Ms Banks said that she tried to follow up the issue of the tracker, but there were other things on her mind at the time.

kk. Service User 5: LC said that Service User 5 has autism and a high level of needs. Service User 5 was living in supported living with no tenancy in place. LC attended a meeting in November 2021 where concerns were raised about Ms Banks without receiving a formal complaint. LC said that Ms Banks started the process to get new support for Service User 5 without informing Service User 5's family. Ms Banks said that Service User 5's mother had blocked emails, and only the finance manager could contact Service User 5's mother. Although there is no evidence that Ms Banks spoke to Service User 5's family in the case notes, Ms Banks said that she was not trying to escape communicating to the family. Ms Banks said that Service User 5's family were trying to cause confusion. Ms Banks was looking for new provider, rather than searching for other options from same provider. Ms Banks said that she took this decision to the panel. Ms Banks said that she was concerned about the care costs of Service User 5's supported living, however, in communications, there is no reference there for a new provider due to higher care costs.

ll. Service User 6: Service User 6 concerned the availability of transport for Service User 6's grandmother. Ms Banks was given advice by WNC which she then gave to Service User 6's grandmother that she cannot have an additional form of transport in addition to her mobility car. On 15 September 2021, DM called Ms Banks to let her know that Service User 6's grandmother missed two diabetic appointments because of a lack of transport. Ms Banks said that she followed the

instructions given by WNC. Service User 6's grandmother called WNC to let them know that she is getting tired and she cannot do the school runs and look after herself properly. On 22 September 2021, a community nurse sent Ms Banks an email requesting that transport decision be reviewed again. Ms Banks said that she followed the advice given from WNC that Service User 6's grandmother is not entitled to further transport when she has a mobility car. On 6 October 2021, another social worker emailed Ms Banks to let her know that, as a result of the transport situation, Service User 6's grandmother "*sounds distressed*". Ms Banks does not consider that she would have been able to do anything more than she did, and that she did raise this issue with senior managers.

mm. Service User 7: Service User 7 concerned a safeguarding issue which was not followed up. Ms Banks said that she had already contacted Service User 7's family about the safeguarding issue, despite Service User 7's email having another reference number. Despite the notes saying that Ms Banks did not respond to Service User 7 for 12 days, Ms Banks said that she spoke to Service User 7. LC became aware of the safeguarding issue when Service User 7 made her aware.

Finding and reasons on facts:

28. 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. Hearsay evidence must be treated with caution and consideration given to the weight that could be afforded to it. Any admissibility issues, reliability issues or veracity of the evidence will be set out below.

29. The panel considered that all witnesses strove to be helpful to the panel. 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.

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

31. At the outset, the panel finds that neither OCC nor WNC were acting against Ms Banks or in any discriminatory way against Ms Banks. The only evidence of this comes from Ms Banks without any further evidence corroborating this. OCC and WNC staff questioned during the final hearing deny acting against Ms Banks or in any discriminatory way against Ms Banks. The panel has seen evidence – such as thorough reviews of assessments – of OCC and WNC staff members attempting to assist Ms Banks. The panel considers it contrary to the aims of either OCC and WNC for members of its staff to work against the interest of a social worker, which would ultimately reflect badly on the entire council.

Allegation 1(1) – In relation to Service User 3, you failed to undertake reviews and/or assessments adequately on one or more occasions – PROVED

32. Ms Banks was allocated Service User 3 on 5 June 2019 for completion of a Care Act Eligibility Assessment. Ms Banks first submitted an assessment for authorisation on 19 June 2019, but the assessment was returned to Ms Banks on five occasions by reviewers before authorisation was granted on 3 July 2019. Although the panel was hampered in its considerations by not having the various iterations of the assessment, on a balance of probabilities, it considers that Ms Banks failed to undertake an adequate assessment in relation to Service User 3 for the following reasons:

    a. The panel considers five reviews of a Care Act Eligibility Assessment to be excessive. BG said that she would expect to return assessments 2 or 3 times at the most.

    b. On two occasions, Ms Banks received thorough review comments from SM. SM provided feedback to Ms Banks in an email he sent to her on 25 June 2019 (as there was not enough space for electronic comments in case notes). The panel considers that Ms Banks received clear instructions on what was needed. On 25 June 2019, SM asked Ms Banks to provide further information regarding a number of areas of the assessment, and in particular, SM asks Ms Banks to explain why she has stated that Service User 3 requires 1:1 support. In his subsequent review on 27 June 2019, SM comments that he is still not clear why Service User 3 requires 1:1 support.

    c. There were contradictions within the assessment. As an example, SM notes that Ms Banks has answered "*none available*" in relation to "*Details of support provided by family/friends with social activities*", but that elsewhere she has written "*Needs contact with friends and family*".

    d. The assessment lacked relevant detail. SM commented that in the section titled, "*Is there likely to be a significant impact on well-being if these outcomes are not achieved?*", what Ms Banks wrote was "*so minimal and basic*". SM also said that the review was lacking a mental health diagnosis and needed more information on how Service User 3 was presenting on a day-to-day basis.

    e. Ms Banks considers that she made the corrections as requested by the reviewers, the assessment went "*back and forth*" between reviewers, and that her assessment was adequate. As set out at paragraph 31, the panel considers that the comments from the reviewers were there to assist Ms Banks rather than to work against her. Consequently, the panel accept SM's evidence that the Care Act has mandatory aspects which needed to be fulfilled. Even if different managers had different criteria to meet, the assessment would have been rejected as Ms Banks' assessment lacked these mandatory criteria. The panel noted that the assessment was reviewed by GW once and SM on four occasions. The panel deemed this was not "*back and forth*" as described by Ms Banks.

<u>Allegation 1(2) – In relation to Service User 1, you failed to undertake reviews and/or assessments adequately on one or more occasions – PROVED</u>

33. Ms Banks first submitted an assessment for authorisation for Service User 1 on 26 September 2019, but the assessment was returned to Ms Banks on three occasions by reviewers GW and SM before authorisation was granted on 2 October 2019. Although the panel was hampered in its considerations by not having the various iterations of the assessment, on a balance of probabilities, it considers that Ms Banks failed to undertake an adequate assessment in relation to Service User 1 for the following reasons:

    a. There were basic errors within the assessment. SM sets out that that "[t]*his overview was rejected three times due to significant spelling errors and irrelevant information that did not encapsulate Service User 1 's current position and the support they required*."

    b. The assessment was incomplete. Ms Banks failed to select options from the drop-down menus concerning support required for taking medication, dressing/undressing, and personal hygiene.

    c. There were contradictions within the assessment. As an example, SM notes that Ms Banks has put down in the summary that Service User 1 needs assistance in relation to maintaining her home, but in the body of the assessment it is written that Service User 1 can meet this need.

    d. Ms Banks considers that she made the corrections as requested by the reviewers, and that her assessment was adequate. Ms Banks also sets out that she considers the assessment could have been reviewed in one go. Ms Banks said that this was an opportunity to learn and that she was learning from her mistakes. As set out at paragraph 31, the panel considers that the comments from the reviewers were there to assist Ms Banks rather than to work against her. The panel notes that it was only following input from LH that the assessment was finally approved, demonstrating that Ms Banks' assessment was inadequate. Although the panel accepts that Ms Banks was on her ASYE and was learning, it considers that the issues raised in (a)-(c) indicate little progression during the ASYE process.

<u>Allegation 1(3) – In relation to Service User 8, you failed to undertake reviews and/or assessments adequately on one or more occasions – PROVED</u>

34. Ms Banks first submitted an assessment for authorisation for Service User 8 on 3 December 2019, but the assessment was returned to Ms Banks on six occasions by reviewers before authorisation was granted on 12 March 2020. Although the panel was hampered in its considerations by not having the various iterations of the assessment, on a balance of probabilities, it considers that Ms Banks failed to undertake an adequate assessment in relation to Service User 8 for the following reasons:

    a. The panel considers six reviews of an assessment to be excessive. BG said that she would expect to return assessments 2 or 3 times at the most.

    b. The assessment did not reflect the visit undertaken by Ms Banks. LH accompanied Ms Banks to this visit and noted that the assessment "*Include[ed] a statement*

about suicidal ideation, which wasn't said by the person but copied from another professional's notes."

c. The assessment was incomplete. SM provided extensive feedback to Ms Banks in an email he sent to her on 30 December 2019 (as there was not enough space for electronic comments in case notes), in which SM comments that "*the eligibility assessment still has significant gaps and errors*."

d. Ms Banks considers that that "*[GW] and [SM] seemed to find different reasons for rejecting the work resulting to 6 rejections on multiple occasions.*" As set out at paragraph 31, the panel considers that the comments from the reviewers were there to assist Ms Banks rather than to work against her. The panel noted that medication, risk assessment, proof reading, were all raised three times by the reviewers. Also, Ms Banks discussed the guidance on the completion of the Care Plan review with GW during personal supervision of 16 April 2020.

<u>Allegation 1(4) – In relation to Service User 9, you failed to undertake reviews and/or assessments adequately on one or more occasions – PROVED</u>

35. Ms Banks first submitted an assessment for authorisation for Service User 9 on 10 March 2020, but the assessment was returned to Ms Banks on seven occasions by reviewers before authorisation was granted on 24 June 2020. Although the panel was hampered in its considerations by not having the various iterations of the assessment, on a balance of probabilities, it considers that Ms Banks failed to undertake an adequate assessment in relation to Service User 9 for the following reasons:

a. The panel considers seven reviews of an assessment to be excessive. BG said that she would expect to return assessments 2 or 3 times at the most.

b. The assessment did not identify a change in needs of Service User 9. Although Ms Banks reported that there were no changes in Service User 9's needs, GW identified that there were changes in Service User 9's needs "*such as changes in medication and how Service User 9 was behaving*". SM highlighted "*the concerns surrounded [Ms Banks]' failure to follow the correct process and to capture the adequate information for an appropriate assessment*."

c. The assessment was unclear and/or contradictory. In an email to Ms Banks dated 18 May 2020, SM commented that "[t]*he information you provided and your analysis of risk and challenging behaviour are contradictory analysis in this review document*." Again, on 1 June 2020 and 24 June 2020, SM asked Ms Banks to correct or clarify parts of her assessment, including concerning points previously raised.

d. The assessment was incomplete as it missed important information. SM explained that Ms Banks "*was repeating the same information as to how Service User 9 presented or simply stating Service User 9's needs rather than addressing how they were being met.*"

e. The assessment contained basic errors. SM identified that Ms Banks misspelled Service User 9's name and that there were grammatical errors.

f. Ms Banks considers that the assessment was adequate, she wrote down the needs of Service User 9, and that although there may be problems with spelling, she was still learning. As set out at paragraph 31, the panel considers that the comments from the reviewers were there to assist Ms Banks rather than to work against her. Although the panel finds that Ms Banks wrote down the needs of Service User 9, she did not assess how those needs were to be met. Although the panel accepts that Ms Banks was on her ASYE and was learning, it considers that the issues raised in (a)-(e) indicate little progression during the ASYE process.

<u>Allegation 1(5) – In relation to Service User 10, you failed to undertake reviews and/or assessments adequately on one or more occasions – PROVED</u>

36. Ms Banks first submitted an assessment for authorisation for Service User 10 on 10 March 2020, but the assessment was returned to Ms Banks on five occasions by reviewers before authorisation was granted on 14 April 2020. Although the panel was hampered in its considerations by not having the various iterations of the assessment, on a balance of probabilities, it considers that Ms Banks failed to undertake an adequate assessment in relation to Service User 10 for the following reasons:

a. The panel considers five reviews of an assessment to be excessive. BG said that she would expect to return assessments 2 or 3 times at the most.

b. There was a delay in completing the assessment. The assessment was due to be completed on 16 March 2020, and was eventually completed on 14 April 2020.

c. The assessment did not complete mandatory questions and had missing information. This was highlighted in the evidence of SM.

d. The assessment was contradictory and failed to understand the needs of Service User 10. For example, SM noted to Ms Banks that "[y]*ou record that she has a daily wash but elsewhere you write that the care home cannot wash her due to her inability to stand*", and "[y]*ou record that she cannot respond to emergencies but you also say that she can use the call bell, if she needs support*".

e. Ms Banks considers that she wrote down the information received from Service User 10, the review comments were inconsistent between reviewers, and that she was still learning. As set out at paragraph 31, the panel considers that the comments from the reviewers were there to assist Ms Banks rather than to work against her. Although the panel finds that Ms Banks wrote down information provided by Service User 10, she did not assess how Service User 10's needs were to be met. Although the panel accepts that Ms Banks was on her ASYE and was learning, it considers that the issues raised in (a)-(d) indicate little progression during the ASYE process. Although Ms Banks set out that the review comments were inconsistent between reviewers, the panel noted that only GW reviewed this assessment.

Allegation 1(6) – In relation to Service User 11, you failed to undertake reviews and/or assessments adequately on one or more occasions – PROVED

37. Ms Banks first submitted an assessment for authorisation for Service User 11 on 22 April 2020, but the assessment was returned to Ms Banks on eight occasions by reviewers before authorisation was granted on 5 June 2020. Although the panel was hampered in its considerations by not having the various iterations of the assessment, on a balance of probabilities, it considers that Ms Banks failed to undertake an adequate assessment in relation to Service User 11 for the following reasons:

    a. The panel considers eight reviews of an assessment to be excessive. BG said that she would expect to return assessments 2 or 3 times at the most.

    b. The assessment contained basic errors. GW identified spelling and grammatical errors.

    c. The assessment lacked clarity. On 22 April 2020, GW asked Ms Banks whether Service User 11 "*needs a 24 hour placement or package of care*". The lack of clarity continued and evolved into contradictions. On 24 April 2020, GW told Ms Banks that "[t]*here appears to be a contradiction in what she needs – Formal or informal package of care*". Further, on 11 May 2020 GW noted to Ms Banks that "[i]*n the support section, you record that Service User 11 always needs someone present within the home and someone present all night. You record that this is unsustainable, as soon as the son returns to work. How will a care package of 3 visits support these needs? These are the questions I raised on 07 May.*"

    d. Ms Banks considers that the assessment was adequate, that she wrote down Service User 11's needs, and that she put what Service User 11 needed. Ms Banks said that she did not know what the standard required of her was because the feedback she received was inconsistent. Ms Banks considered that the actions of GW and BG were "*a deliberate act to disorganise and demotivate me*." As set out at paragraph 31, the panel considers that the comments from the reviewers were there to assist Ms Banks rather than to work against her. Although the panel finds that Ms Banks wrote down Service User 11's needs, she did not assess how Service User 11's needs were to be met.

Allegation 1(7) – In relation to Service User 4, you failed to undertake reviews and/or assessments adequately on one or more occasions – PROVED

38. Ms Banks first submitted an assessment for authorisation for Service User 4 on 28 May 2020, but the assessment was returned to Ms Banks on five occasions by reviewers before authorisation was granted on 17 June 2020. Although the panel was hampered in its considerations by not having the various iterations of the assessment, on a balance of probabilities, it considers that Ms Banks failed to undertake an adequate assessment in relation to Service User 4 for the following reasons:

    a. The panel considers five reviews of an assessment to be excessive. BG said that she would expect to return assessments 2 or 3 times at the most.

b. The assessment did not fully consider the needs of Service User 4. GW commented to Ms Banks in her ASYE report that there were "*some gaps in* [Ms Banks'] *information gathering effectiveness*."

c. Ms Banks considers that the assessment was adequate, that she wrote down Service User 4's needs, and that she put what Service User 4 needed. Ms Banks said that because she was new, the reviewers made her feel like she did not know what she was doing. As set out at paragraph 31, the panel considers that the comments from the reviewers were there to assist Ms Banks rather than to work against her. Although the panel finds that Ms Banks wrote down Service User 4's needs, she did not assess how Service User 4's needs were to be met.

Allegation 1(8) – In relation to Service User 12, you failed to undertake reviews and/or assessments adequately on one or more occasions – PROVED

39. Ms Banks first submitted a Domiciliary Care form for authorisation for Service User 12 on 14 May 2020, but the assessment was returned to Ms Banks on four occasions by reviewers before authorisation was granted on 29 June 2020. Although the panel was hampered in its considerations by not having the various iterations of the assessment, on a balance of probabilities, it considers that Ms Banks failed to undertake an adequate assessment in relation to Service User 12 for the following reasons:

a. The panel considers four reviews of an assessment to be excessive. BG said that she would expect to return assessments 2 or 3 times at the most. BG said in a feedback email to Ms Banks that some of her previous comments have not been addressed, for example whether Service User 12 is aware of the referral, and in relation to a discrepancy identified between the information contained within the funding authorisation form.

b. The assessment was submitted without an authorisation signature instead of being re-assigned to HSPO in order for care sourcing to be started. This delayed the service users' needs being met.

c. The assessment was inconsistent. Ms Banks had marked "*no*" in the section dealing with "*Mental Capacity/Advocacy – Considerations for Mental Capacity/DoLs*", despite BG noting that "*a MCA and BID has been completed*".

d. Ms Banks considers that the assessment was adequate, that everyone finalised the authorisation form without a signature, and that she filled in the form from the information received from Service User 12. Ms Banks said she was being discriminated against as she was the only social worker getting feedback through case notes. Ms Banks considers that BG was "*trying to destroy*" her. As set out at paragraph 31, the panel considers that the comments from the reviewers were there to assist Ms Banks rather than to work against her. Although the panel finds that Ms Banks filled in the form from the information received from Service User 12, she did not assess how Service User 12's needs were to be met.

Allegation 1(9) – In relation to Service User 13, you failed to undertake reviews and/or assessments adequately on one or more occasions – PROVED

40. Ms Banks first submitted an assessment for authorisation for Service User 13 on 1 July 2020, but the assessment was returned to Ms Banks on four occasions by reviewers before authorisation was granted on 24 July 2020. Although the panel was hampered in its considerations by not having the various iterations of the assessment, on a balance of probabilities, it considers that Ms Banks failed to undertake an adequate assessment in relation to Service User 13 for the following reasons:

    a. The panel considers four reviews of an assessment to be excessive. BG said that she would expect to return assessments 2 or 3 times at the most.

    b. The assessment did not provide complete information. On 9 July 2020, BG asked Ms Banks to provide more information about what has been described as "*challenging behaviour*", commenting that "[i]*t is noted that he can become breathless in the mornings when he is not busy. Please provide more information as to how this is challenging behaviour*". On 22 July 2020, Ms Banks confirmed that she had reviewed this section. However, on 24 July 2020, BG asked Ms Banks to review the section again due to unclear and conflicting information.

    c. Ms Banks said that challenging behaviour can take different formats, which BG was unaware of. Ms Banks considers that all social workers need to review their work as anyone can make an error, and that she wrote down the information provided by Service User 13. As set out at paragraph 31, the panel considers that the comments from the reviewers were there to assist Ms Banks rather than to work against her. Although the panel finds that Ms Banks wrote down information provided by Service User 13, she did not assess how Service User 13's needs were to be met. The panel considers that, although challenging behaviour can take different formats, BG was asking for clarification from Ms Banks as to how being "*breathless in the mornings*" resulted in challenging behaviour.

Allegation 3(a) – You failed to take appropriate and/or timely action to meet the needs of one or more service users and/or their families, namely Service User 1 – PROVED

41. The panel considers there to be two failures from Ms Banks under this allegation. The first is that the delay with which Ms Banks completed Service User 1's assessment, as set out in Allegation 1(2), demonstrates that Ms Banks failed to take timely action to meet the needs of Service User 1.

42. The facts surrounding the second failure are in relation to when Ms Banks was describing direct payments to Service User 1's daughter over the telephone. LH was sat next to Ms Banks during this telephone conversation. LH said that Ms Banks "*did not understand what she was saying (lack of knowledge) and [Service User 1's] daughter could not either*". LH says that Ms Banks tried to pass the phone to her, and then put the phone down and refused to pick it up. Ms Banks said that Service User 1's daughter was screaming at her on the phone. Ms Banks said that she did ask LH to take the phone call. Ms Banks said that she put the phone down

for LH to pick it up. Ms Banks said that she did not disengage with Service User 1's daughter, but gave Service User 1's daughter what she needed as she was the one who followed up with Service User 1's daughter, not LH.

43. The panel considers that Ms Banks failed to take appropriate action to meet the needs of Service User 1's daughter, in that Ms Banks put the phone down on Service User 1's daughter, for the following reasons:

    a. It is not appropriate to put the phone down on a service user and/or their family when they are trying to obtain information.

    b. LH did not confirm to Ms Banks that she would take over the phone call with Service User 1's daughter, but instead mouthed "*you deal with it*" to Ms Banks. Yet, Ms Banks put the phone down.

    c. The situation could have been avoided had Ms Banks been aware of OCC's direct payments policy. There is evidence within the bundle which shows, according to the Manager Supervision Record dated 12 April 2019, that Ms Banks was sent the OCC paying for care booklet by email from LH. LH further explained that she had "*explained Direct Payments to* [Ms Banks] *before she called the daughter*."

<u>Allegation 3(b) – You failed to take appropriate and/or timely action to meet the needs of one or more service users and/or their families, namely Service User 2 – PROVED</u>

44. The facts surrounding this allegation are in relation to when an individual from the safeguarding team called Ms Banks to confirm whether there was any abuse she had witnessed of Service User 2. Ms Banks asked the individual from the safeguarding team to speak to Service User 2's husband, who was considered to be the perpetrator. Ms Banks had spoken to the husband on 1 July 2019. Ms Banks denied that her notes were inviting other professionals to explore further whether Service User 2's husband was the perpetrator, but that she was not going to do anything further. Ms Banks cannot remember why there are no notes to indicate why she did not visit between 3 and 15 July 2019. Ms Banks considers that both she and the hospital were both responsible for safeguarding. As Ms Banks was not there when the assault took place, she said that she could not tell if Service User 2's husband was the perpetrator.

45. The panel considers that Ms Banks failed to take appropriate action to meet the needs of Service User 2, in that Ms Banks failed to properly safeguard Service User 2, for the following reasons:

    a. Ms Banks failed to use her professional judgement to ascertain the safety of Service User 2. There is no evidence demonstrating that Ms Banks asked Service User 2 how her injury occurred. There is no evidence demonstrating that Ms Banks considered the safety of Service User 2 in the situation that she was in.

    b. Despite there being a safeguarding risk that was known to Ms Banks on 1 July 2019, she failed to visit Service User 2 until 3 July 2019, and then failed to visit Service User 2 until 15 July 2019.

Allegation 3(c) – You failed to take appropriate and/or timely action to meet the needs of one or more service users and/or their families, namely Service User 3 – PROVED

46. The panel considers there to be two failures from Ms Banks under this allegation. The first is that the delay with which Ms Banks completed Service User 3's assessment, as set out in Allegation 1(1), demonstrates that Ms Banks failed to take timely action to meet the needs of Service User 3.

47. The facts surrounding the second failure are in relation to when in August Ms Banks booked in a period of respite for Service User 3 in December when the informal carer (Service User 3's grandson) was to go on holiday, but there is no evidence to suggest this booking was communicated to Service User 3's family who did not know what was happening. Ms Banks said that Service User 3's family did know of her December respite. Further, Ms Banks said that the issue concerning respite was the one in October 2019, not December 2019. Ms Banks did not book any respite in October 2019 as she was on annual leave. Ms Banks said that on 2 December 2019 she had informed Service User 3's grandson of the booked respite for December 2019.

48. The panel considers that Ms Banks failed to take timely action to meet the needs of Service User 3's family, in that Ms Banks did not inform them of the booked respite in December 2019 until December 2019, for the following reasons:

    a. There is no contemporaneous evidence suggesting that Ms Banks had booked the December 2019 respite and communicated this to Service User 3's family before 2 December 2019. The panel considers that such information would be important to note in Service User 3's case notes.

    b. Concerns over respite in October 2019 can be found from SM's statement which sets out: "*on one morning on 22 October 2019, Service User 3's informal carer left the house and the team's duty system, who works on the case when the Social Worker is not around, had to organise an urgent respite to support the person and the family*." This indicates that Ms Banks went on annual leave without informing Service User 3's family.

    c. Failure to inform Service User 3's family in a timely manner regarding both the December 2019 respite and the October 2019 leave has the effect of making the family felt as though they are not supported in their caring role and can providing a caring gap if no alternative care is found to fill the gap.

Allegation 3(d) – You failed to take appropriate and/or timely action to meet the needs of one or more service users and/or their families, namely Service User 4 – PROVED

49. The panel considers there to be two failures from Ms Banks under this allegation. The first is that the delay with which Ms Banks completed Service User 3's assessment, as set out in Allegation 1(7), demonstrates that Ms Banks failed to take timely action to meet the needs of Service User 4.

50. The facts surrounding the second failure are in relation to when Service User 4 wandered outside her home on the night of 11 June 2020 in inappropriate clothing, and there was a plan for assistive technology/tracker to be put in place. Ms Banks identified on 12 June 2020 that assistive technology was required. On 18 June 2020, Ms Banks made a call about the referral for tracker. On 23 June 2020, Ms Banks called a team administrator to say that Service User 4 is a wanderer, so a tracker is required as soon as possible. On 23 June 2020, Ms Banks was provided with the details needed to obtain the tracker by the assisted technology team. There were no further entries from Ms Banks until 29 June 2020. Ms Banks said that she identified that a tracker was needed and followed it up, but she kept being referred to different departments. Ms Banks also said that her focus during this period was the ASYE.

51. The panel considers that Ms Banks failed to take timely action to meet the needs of Service User 4, in that Ms Banks did not obtain assistive technology/tracker for Service User 4 as a matter of emergency, for the following reasons:

    a. Although Ms Banks identified on 12 June 2020 that assistive technology was required, she did not follow this up until 18 June 2020. Further, when Ms Banks was provided with the details required on 23 June 2020 to obtain the assistive technology, she did not follow up until 29 June 2020. The panel does not consider these actions to be timely for a service user who is at risk because of wandering behaviour.

    b. Even if Ms Banks was distracted at the time by her ASYE, this should not have distracted Ms Banks from her primary purpose as a social worker to protect her service users. Service User 4 was at risk of significant harm because of her wandering behaviour.

Allegation 3(e) – You failed to take appropriate and/or timely action to meet the needs of one or more service users and/or their families, namely Service User 5 – PROVED

52. The facts surrounding this allegation are in relation to Service User 5 who is an individual with a high level of needs and has autism, who was living in a supported living environment without a tenancy in place. Service User 5 had an eviction notice served by the landlord for his accommodation but not in relation to his care support. LC said that Ms Banks started the process to get new care support without informing family. Ms Banks said that Service User 5's mother had blocked emails, and only the finance manager could contact Service User 5's mother. Although there is no evidence in the case notes that Ms Banks spoke to Service User 5's family, Ms Banks said that she was not trying to escape communicating to the family. Ms Banks was looking for a new provider, rather than searching for other options from same provider.

53. The panel considers that Ms Banks failed to take appropriate action to meet the needs of Service User 5, in that Ms Banks took several inappropriate steps in attempting to obtain accommodation for Service User 5, for the following reasons:

    a. Ms Banks appears to have got confused regarding the provider of support and provider of accommodation. Ms Banks attempted to obtain new support for

Service User 5 (which was not needed), rather than new accommodation (which was needed).

b. There is no evidence that Ms Banks spoke to Service User 5's family about what she was doing. This would have left Service User 5's family without knowledge as to what is happening with Service User 5.

c. Ms Banks said that she was concerned about the care costs of Service User 5's supported living, however, in communications, there is no reference there for a new provider due to higher care costs. This was also done with a backdrop of Service User 5 not having a tenancy, where obtaining a further tenancy should have been the priority. In the end, SM had to step in to bring down Service User 5's rehousing time from 4 weeks to 2 weeks, otherwise this lack of understanding of the difference between a housing provider and a care provider and appropriate action could have resulted in Service User 5 being made homeless.

<u>Allegation 3(f) – You failed to take appropriate and/or timely action to meet the needs of one or more service users and/or their families, namely Service User 6 – PROVED</u>

54. The facts surrounding this allegation are in relation to Service User 6's accessibility to transport. Ms Banks was given advice by WNC which she then gave to Service User 6's grandmother that she cannot have transport for Service User 6 to attend appointments whilst Service User 6's grandmother has a mobility car. On 15 September 2021, DM called Ms Banks to let her know that Service User 6's grandmother missed two diabetic appointments because of a lack of transport. Ms Banks said that she followed the instructions given by WNC. Service User 6's grandmother called WNC to let them know that she is getting tired and she cannot do the school runs and look after herself properly. On 22 September 2021, a community nurse sent Ms Banks an email requesting that transport decision be reviewed again. Ms Banks said that she followed the advice given from WNC that Service User 6's grandmother is not entitled to further transport when she has a mobility car. On 6 October 2021, another social worker emailed Ms Banks to let her know that, as a result of the transport situation, Service User 6's grandmother "*sounds distressed*".

55. The panel considers that Ms Banks failed to take appropriate action to meet the needs of Service User 6's grandmother, in that Ms Banks failed to attempt to obtain transportation for Service User 6, for the following reasons:

a. Ms Banks failed to understand the changing needs of Service User 6's grandmother, which should have prompted Ms Banks to make a further application to WNC for further transport. The changing needs included that Service User 6's grandmother missed two diabetic appointments; Service User 6's grandmother was getting tired and she cannot do the school runs, transport Service User 6, and look after herself properly; concern from a community nurse; and Service User 6's grandmother sounding "*distressed*".

b. Ms Banks was not fully familiar with WNC's transport policy. As set out by JH, it "*does not say if you have a mobility car, you are not allowed transport*", but rather

explains that it "*asks workers to explore various options before they confirm transport, so you check all those things because you have to be careful about the Council's budget*".

Allegation 3(g) – You failed to take appropriate and/or timely action to meet the needs of one or more service users and/or their families, namely Service User 7 – PROVED

56. The facts surrounding this allegation are that on 28 October 2021, a duty manager, TD, had asked Ms Banks to make a call in relation to safeguarding but when they looked 2 weeks later, she had not made the call and they had to chase her. Ms Banks respond by email on 10 November 2021 in which she states that "*[t]he reference of this person has no case notes*". However, the name of the person was in the email chain. Ms Banks said that the referral had no name, no initial, no date of birth, and no address to assist her in locating the records. Ms Banks states that MA was not available for supervisory guidance and that TD said that he was very busy and she should wait for her supervisor to return.

57. The panel considers that Ms Banks failed to take appropriate action to meet the needs of Service User 7, in that Ms Banks failed call Service User 7 in relation to safeguarding, for the following reasons:

    a. Safeguarding is priority for social workers and the panel consider it to be inappropriate that Ms Banks waited two weeks to follow up a safeguarding referral to her.

    b. Ms Banks should have been able to find out the details of Service User 7 given the information provided in the email chain sent to her, or take proactive action rather than leave the allocated case un-progressed.

58. At this stage, the hearing was adjourned until 07 May 2024.

Finding and reasons on grounds:

59. The hearing resumed on 07 May 2024 with both parties making submissions on grounds.

60. Ms Banks provided the following evidence in relation to the grounds of lack of competence and capability and current impairment:

    a. She submitted a written account previously given orally at fact finding stage of the hearing in November 2023. Ms Banks submitted that nothing has changed in her position since then.

    b. She has been tormented for four years as a result of the allegations and subsequent proceedings. Ms Banks just wants this matter to be over.

    c. She has undertaken training since the facts were proved in November 2023. This is part of her reflection. The training considered the mental capacity of service users and the relevant questions to ask a service user when undertaking an assessment. Ms Banks considered this training to be helpful to assist her in

undertaking an assessment of a service user. The training was online and consisted of courses which ranged between 2-3 hours.

d. Prior to the final hearing, Ms Banks was under an interim conditions of practice order. She found the restrictions to be very tight and impacted on her ability to work as a social worker. She was unable to work due to the restrictive nature of the conditions, even though she has applied for a number of jobs and went through agencies.

61. On behalf of Social Work England, Ms Atkins submitted that:

a. The proven facts demonstrate that Ms Banks lacked competence and capability. It is not disputed by Ms Banks that the proven facts amount to the statutory ground of lack of competence and capability.

b. Ms Banks held a lower-than-average caseload, in terms of both volume and complexity.

c. Ms Banks did not make any significant progress in developing her social work knowledge and skills, and continued to require an extensive degree of support and supervision in order to complete the core tasks required in her role.

d. Ms Banks was not discriminated against as alleged during her testimony on the factual allegations.

62. On behalf of Ms Banks, Mr Dingley submitted that whether Ms Banks lacked competence and capability was a matter for the panel.

63. 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 lack of competence or capability. Neither party bears the burden of proof. Lack of competence can be equated with deficient professional performance, which, as set out in *Calhaem v General Medical Council* 2007 EWHC 2601: "*connotes a standard of professional performance which is unacceptably low and which (save in exceptional circumstances) has been demonstrated by reference to a fair sample of the [social worker's] work.*"

Allegation 1

64. The panel considered that, in relation to allegation 1, Ms Banks' professional performance fell to a standard which was unacceptably low. This has been demonstrated by reference to a fair sample of ten cases of Ms Banks' work. The following themes were prevalent in Ms Banks' work:

a. Reviews by supervisors were required to bring the review/assessment to a standard which would result in the documents being of assistance to the service users and professionals. The reviews required were deemed more extensive and well above the average number required by a social worker with similar experience;

b. A lack of consistency in the reviews/assessments as a result of contradictions and a lack of clarity within them;

c. A lack of relevant detail, including missing mandatory information;

d. Basic errors in the reviews/assessments, including spelling and grammatical errors;

e. Incomplete reviews/assessments;

f. The reviews/assessments did not reflect the visits undertaken;

g. The reviews/assessments did not fully consider the needs of the service users; and

h. The reviews/assessments were delayed on occasion.

65. The panel considers that Ms Banks' actions in relation to allegation 1 amounts to the statutory ground of lack of competence or capability.

Allegation 2

66. The panel considered that, in relation to allegation 2, Ms Banks' professional performance fell to a standard which was unacceptably low. This has been demonstrated by reference to a fair sample of five cases of Ms Banks' work. The following themes were prevalent in Ms Banks' work:

a. An inability to understand the mental health capacity assessment framework;

b. Reliance on third party information, rather than undertaking a Mental Capacity Assessment;

c. Sending a funding authorisation form through before a Mental Capacity Assessment had been completed;

d. A failure to adequately complete a Mental Capacity Assessment, or complete one to the requisite standard; and

e. A failure to identify the need for a formal Mental Capacity Assessment.

67. The panel considers that Ms Banks' actions in relation to allegation 2 amounts to the statutory ground of lack of competence or capability.

Allegation 3

68. The panel considered that, in relation to allegation 3, Ms Banks' professional performance fell to a standard which was unacceptably low. This has been demonstrated by reference to a fair sample of seven cases of Ms Banks' work. The following themes were prevalent in Ms Banks' work:

a. A failure to pass relevant information to service users' families;

b. Avoiding service users' families;

c. A failure to understand Council policies;

d. A failure to use professional judgement to ascertain safety;

e. Delayed visits when there was a known safeguarding concern;

f. A failure to act on information in a timely manner;

g. A failure to understand the facts of a situation, including the needs in a changing situation; and

h. A failure to act proactively to ascertain information.

69. The panel considers that Ms Banks' actions in relation to allegation 3 amounts to the statutory ground of lack of competence or capability.

Allegation 4

70. The panel considered that, in relation to allegation 4, Ms Banks' professional performance fell to a standard which was unacceptably low. Ms Banks' professional performance is set to a backdrop of having a lower-than-average caseload at both OCC and WNC, in terms of both volume and complexity. Throughout the period at both OCC and WNC, Ms Banks did not make any significant progress in developing her social work knowledge and skills, requiring an extensive degree of support and supervision in order to complete core tasks. Although there were some issues with the support provided to Ms Banks, she did receive a lot of support and each supervisor provided similar feedback.

71. The panel considers that Ms Banks' actions in relation to allegation 4 amounts to the statutory ground of lack of competence or capability.

72. Consequently, taken cumulatively, the panel found that the proven facts at allegations 1 to 4 demonstrate that Ms Banks' conduct amount to the statutory ground of lack of competence or capability.

Finding and reasons on current impairment:

73. On behalf of Social Work England, Ms Atkins submitted that Ms Banks was currently impaired on the basis that:

a. Ms Banks' responses fail to recognise her own responsibility as a social worker to be accountable for the quality of her practice. She placed service users at risk of harm, which is as serious as actual harm caused. For example, Ms Banks failed to implement a tracker for Service User 4 despite their risk of wandering. Ms Banks waited two weeks to action a safeguarding concern in relation to Service User 21.

b. Ms Banks has demonstrated a repeated pattern of failing to meet fundamental tenets of social work. She has not met the needs of service users or their families.

c. The proven/admitted facts demonstrate that the allegations were a series of avoidable failures, but that Ms Banks' inability to develop her social work skills resulted in these failures.

d. Ms Banks has not sufficiently reflected on the serious nature of the concerns, and the potential risks to service users resulting from them.

e. Ms Banks continues to lack insight. She continues to believe that she was inadequately supported, yet the findings are that her colleagues tried their best to support her. She has failed to understand her own responsibilities as a social worker. Ms Banks' position has not changed despite the facts being proved.

f. A lack of previous fitness to practice regulatory concerns does not mitigate a finding of impairment. The proven/admitted facts took place during the start of Ms Banks' career and persisted over two employing councils.

g. Ms Banks does not appear to have undertaken work as a social worker since leaving WNC, and has not otherwise provided sufficient evidence to demonstrate that the concerns have been successfully remediated. Despite undertaking training, it is not clear what Ms Banks has learned from the training and how this will remediate any faults in her practice.

h. Ms Banks' testimonials have not been updated since the findings of fact in November 2023.

i. Taking into account the lack of evidence to demonstrate that Ms Banks has insight and/or has successfully remediated the concerns, Social Work England consider that there remains a risk of repetition (including a risk of actual harm) and that Ms Banks' fitness to practise remains impaired.

j. Given the serious nature of the failings identified, a finding of current impairment should be made to maintain public confidence in the profession and to promote and maintain proper professional standards for social workers in England.

74. On behalf of Ms Banks, Mr Dingley submitted that Ms Banks is no longer impaired on the basis that:

a. At no point did Ms Bank cause actual harm to any of her service users.

b. These are the first allegations that Ms Banks has faced. Placed in context, these were avoidable failures from a social worker at the start of her career. The panel needs to take into account that mistakes are made at the start of a career.

c. Although there has been repetition of errors, there will be no further repetition in the future as Ms Banks has recognised her failings and completed training.

d. Ms Banks has become a social worker from the goodness of her heart and is trying to contribute to society.

e. It has been difficult for Ms Banks to prove that her practice has improved as she has not been able to obtain further employment as a social worker.

f. The training that Ms Banks has completed, both before and after the final hearing, demonstrate that she is willing to learn and remedy her deficits. She undertook

the training as she recognised the errors that she made and she wants to continue as a social worker.

g. She admitted a number of facts at an early stage. Ms Banks' acceptance of these facts demonstrates understanding and insight of the nature and level of remediation necessary.

75. The panel accepted the advice of the legal adviser that when considering impairment, the panel should consider whether Ms Banks is currently impaired in relation to the lack of competence or capability found. The panel was asked by the legal adviser to consider:

a. whether Ms Banks 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 Banks has in the past and/or is liable in the future to bring the social work profession into disrepute;

c. whether Ms Banks 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 Banks has in the past acted dishonestly and/or is liable to act dishonestly in the future.

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

Whether Ms Banks 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

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

a. Several reviews by supervisors, as well as significant support and intervention, over and above what would be considered required of a social of Ms Banks' experience, were required to bring her review/assessments to a standard which would result in the documents being of assistance to the service users and professionals;

b. There was a lack of consistency in her reviews/assessments as a result of contradictions and a lack of clarity within them;

c. There was a lack of relevant detail in her reviews/assessment, including missing mandatory information;

d. There were basic errors in her reviews/assessments, including spelling and grammatical errors;

e. Her reviews/assessments were incomplete;

f. Her reviews/assessments did not reflect the visits undertaken;

g. Her reviews/assessments did not fully consider the needs of the service users;

h. Her reviews/assessments were delayed on occasion;

i. She failed to understand the mental health capacity assessment framework;

j. She relied on third party information, rather than undertaking a Mental Capacity Assessment;

k. She sent a funding authorisation form through before a Mental Capacity Assessment had been completed;

l. She failed to adequately complete a Mental Capacity Assessment, or complete one to the requisite standard;

m. She failed to identify the need for a formal Mental Capacity Assessment;

n. She failed to pass relevant information to service users' families;

o. She avoided service users' families;

p. She failed to understand Council policies;

q. She failed to use professional judgement to ascertain safety;

r. She delayed visits when there was a known safeguarding concern;

s. She failed to act on information in a timely manner;

t. She failed to understand the facts of a situation, including needs in a changing situation; and

u. She failed to act proactively to ascertain information.

78. Ms Banks has expressed some insight into her failures by admitting some of the allegations at an early stage. 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. In particular, the panel considers Ms Banks' limited insight to be self-focused:

a. Ms Banks still continues to deny the facts found proved.

b. Ms Banks has been given opportunities to explain the level of insight she possesses, but still considers that any failings were due to a lack of support and not her fault.

c. Ms Banks has failed to understand, and appeared to be detached, from the risk of harm that her actions placed on service users (for example, waiting two weeks to respond to a safeguarding concern; and telling another social worker to speak to the husband of a potential domestic abuse victim). She has not apologised for her actions or shown any remorse. Her only reflection is that that if she cannot practice as a social worker, then her time and money spent training and obtaining her degree has been wasted.

79. The panel considers that Ms Banks has not undertaken sufficient remediation so as not to place service users at unwarranted risk of harm in the future. Although Ms Banks has

undertaken training, it is not clear how the training has helped remediate her practice. The panel did not see any evidence of the aims and objectives of the training; whether the training required an assessment at the end of it; and Ms Banks could not say what she learned from the training and how she would do things differently.

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

80. For the reasons set out in paragraph 77, the panel considers that Ms Banks has in the past brought the social work profession into disrepute.

81. For the reasons set out in paragraphs 78 and 79, the panel does not consider that Ms Banks has gained sufficient insight or undertaken sufficient remediation so as not to bring the social work profession into disrepute in the future.

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

82. The panel considers that Ms Banks has breached a fundamental tenet of the social work profession, namely placing the safety and wellbeing of service users at risk.

83. For the reasons set out in paragraphs 78 and 79, the panel does not consider that Ms Banks has gained sufficient insight or undertaken sufficient remediation so as not to breach a fundamental tenet of the social work profession in the future.

Whether Ms Banks has in the past acted dishonestly and/or is liable to act dishonestly in the future

84. The panel considered dishonesty was not alleged and therefore not considered to be a factor in this matter.

Panel's conclusion on impairment

85. In light of the above, the panel considers Ms Banks' practice to be impaired on the personal element.

86. 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:

87. On behalf of Social Work England, Ms Atkin submitted that a suspension order for no less than 12 months is an appropriate and proportionate sanction. She submitted that:

    a. The allegations that Ms Banks has admitted to or that have been found proved relate to fundamental skills required by a social worker.

    b. Ms Banks' current level of insight and remediation is not sufficient so as not to put service users at risk of harm. The panel found that:

        i. her insight is self-focused;

ii. appeared to be detached from the risk of harm that her actions placed on service users; and

iii. she did not have sufficient remediation.

c. There is a risk of repetition given that Ms Banks has not been able to demonstrate the implications of the failures in her practice. Further, the deficiencies in her practice were mainly as a result of failures by others.

d. No further action, advice or a warning are not appropriate or proportionate for the circumstances of this case given the findings of the panel at paragraph 77 of this Decision. No further action, advice or a warning would not reflect the seriousness of the admitted/proven failings and would not reflect the findings concerning Ms Banks' ability.

e. Conditions attached to her practice would be insufficient to protect the public due to:

i. Ms Banks' low level of insight and remediation;

ii. It not being possible to identify appropriate, proportionate and workable conditions;

iii. Ms Banks' failures are not capable of being remedied;

iv. It being a significant time since Ms Banks has practiced as a social worker; and

v. When Ms Banks practiced as a social worker, it was on an ASYE, where she would have been afforded close supervision. Ms Banks' previous conduct demonstrates that there is no guarantee that close supervision would protect the public from risk of harm.

f. A suspension order is appropriate as the admitted/proven allegations and impairment demonstrate wide-ranging concerns and a serious breach of professional standards.

g. A suspension period of not less than 12-months is requested so that Ms Banks has sufficient time to meaningfully demonstrate insight and remediation prior to any review.

h. A suspension order in this matter will send a message to the wider public that Social Work England has identified that Ms Banks has capability issues and that these are being addressed. A suspension order will assist Social Work England to achieve its overriding objective to maintain confidence in the profession and provide the time for Ms Banks to develop her skills in social work.

i. In the alternative, should the panel be minded to issue conditions of practice, Ms Atkin provided the panel with Social Work England's proposed conditions which include:

i. close supervision of Ms Banks' practice;

ii. that a Personal Development Plan be formulated to address shortfalls in Ms Banks' practice;

iii. Ms Banks' practice is limited in accordance with advice of her supervisor;

iv. Ms Banks' is not able to supervise others;

v. Ms Banks cannot practice as an independent social worker; and

vi. a reflective piece to demonstrate her insight.

88. On behalf of Ms Banks, Mr Dingley submitted that a warning order is appropriate and proportionate. He submitted that:

a. A suspension order would be wholly disproportionate. At no stage during these proceedings has Banks been subject to an interim suspension order; only interim conditions of practice. A suspension order is not appropriate where a social worker has failed to demonstrate some insight or remediation. Ms Banks has:

i. demonstrated some insight through early admission of facts. Ms Banks understands that there are issues to resolve in her practice;

ii. understands what needs to be remedied in her practice; and

iii. undertaken training which demonstrates a willingness and ability to resolve issues which have arisen during the course of her practice.

b. Ms Banks has been unable to demonstrate improvement in her practice as the interim conditions imposed on her meant that she could not return to work as a social worker.

c. Ms Banks has provided testimonials prior to the November 2023 start date.

d. Ms Banks is facing considerable hardship and financial difficulties by being unable to work.

e. Ms Banks has no previous fitness to practise history.

f. At the time of the concerns, Ms Banks was at an early stage of her career. She was operating at a level that was lower than an experienced social worker who would have had a better understanding of situations. The concerns in her practice occurred due to a lack of supervision and mentorship.

g. In light of the above, a warning order is appropriate and proportionate given that:

i. Ms Banks' failures were isolated and limited;

ii. There is a low risk of repetition given that Ms Banks' failures had been identified at an early stage of her career; and

iii. Ms Banks has demonstrated some insight.

h. In the alternative, should the panel be minded to issue conditions of practice, Mr Dingley submitted that conditions 3 (the appointment of a reporter) and 4 (providing reports from the reporter to Social Work England every three months) of Social Work England's draft conditions should not be included so that it is easier for Ms Banks to secure employment.

89. 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.

90. The panel considered the following factors to be mitigating:

a. Ms Banks provided early admissions to some of the allegations;

b. At the time of the concerns, Ms Banks was at an early stage of her career;

c. There is some evidence to suggest that the supervision and mentorship Ms Banks received at OCC and WNC was not of the highest quality;

d. At the time of some of the concerns, Ms Banks was under stressful personal circumstances *[PRIVATE]*;

e. Ms Banks is of previous good character; and

f. The panel understand the financial impact these proceedings have had on Ms Banks.

91. The panel considered the following factors to be aggravating:

a. Ms Banks put service users at risk of harm;

b. The failures in Ms Banks' practice were wide-ranging and repeated, despite significant assistance and multiple reviews of her work;

c. Ms Banks has limited insight into her failings, which is self-focused. In particular, Ms Banks has failed to identify, understand, take ownership and appeared to be detached, from the risk of harm that the concerns place on service users;

d. Ms Banks has not apologised for her actions or shown remorse; and

e. Ms Banks has undertaken limited remediation. Although she has completed some training, she has not demonstrated what impact the training had on her or shown any reflection following the training.

92. In light of the seriousness of its findings in relation to Ms Banks' lack of competence and capability and current impairment, the panel finds that taking no action or issuing advice would not adequately protect the public because her practice would not be restricted so as to mitigate the risk of harm. In addition, these sanctions would not adequately meet the wider

public interest of maintaining public confidence in the profession and declaring and upholding proper standards of conduct and behaviour.

93. The panel then considered whether issuing Ms Banks a warning. Paragraph 108 of the Sanction Guidance states that:

> "*A warning order is likely to be appropriate where (all of the following):*
>
> - *the fitness to practise issue is isolated or limited*
> - *there is a low risk of repetition*
> - *the social worker has demonstrated insight*"

94. As set out above, the panel finds that Ms Banks does not meet any of these criteria:

    a. The concerns were not isolated or limited. The failures in Ms Banks' practice were wide-ranging and repeated;

    b. For the reasons provided in the "*finding and reasons on current impairment*" section above, the panel finds that there is not a low risk of repetition; and

    c. Although Ms Banks has demonstrated limited insight, it is self-focused. In particular, Ms Banks has failed to identify, understand, take ownership and appeared to be detached, from the risk of harm that her practice shortfalls place on service users.

95. Furthermore, a warning order would not adequately meet the wider public interest of maintaining public confidence in the profession and declaring and upholding proper standards of conduct and behaviour.

96. The panel then considered whether a conditions of practice order would be proportionate and appropriate in the circumstances. The panel gave extensive thought to a conditions of practice order. However, given:

    a. the wide-ranging allegations admitted/proven in Ms Banks' practice;

    b. the panel's findings that Ms Banks has put service users at unwarranted risk of harm;

    c. the high risk of repetition of conduct similar to that of the failures found in Ms Banks' practice;

    d. Ms Banks would have been under close supervision during her ASYE year, yet significant concerns surrounding her practice existed;

    e. the continuing limited insight from Ms Banks in relation to her failures, which has been exacerbated by:

        i. Ms Banks' continued belief that failures in her practice were solely due to inadequate supervision and mentorship;

ii. Ms Banks' belief that a warning order would suffice to protect the public;

iii. Ms Banks' only apparent concern, should conditions be imposed, is her ability to obtain employment (rather than the protection of the public); and

f. Ms Banks has failed to understand, and appeared to be detached, from the risk of harm that her actions placed on service users,

the panel found that it could not formulate conditions which were proportionate or workable, or which were not so restrictive that they would be tantamount to suspension, in order to protect the public.

97. The panel next considered whether it was appropriate to impose a suspension order. For the following reasons, it considered a suspension order to be appropriate and proportionate to protect the public and the wider public interest:

a. The admitted/proven allegations demonstrate failures in fundamental aspects of social work practice. The panel consider these to be a serious breach of the professional standards;

b. Ms Banks has demonstrated limited insight and undertaken limited remediation. A suspension order will provide her with the time to reflect on the findings, and obtain insight and remediate her practice; and

c. Ms Banks has, through Counsel, indicated a willingness to resolve failings in her social work practice. The panel is keen for Ms Banks' willingness to be demonstrated and has provided some recommendations to her below at paragraph 102.

98. The panel noted that under paragraph 150 of the Social Work England Sanctions Guidance, a removal order is not available to it in the current situation.

99. The panel also took into account the importance of publicly declaring the standards of conduct and behaviour expected of a registered social worker and maintaining public trust and confidence in the profession. The panel noted that there is a public interest in permitting a social worker to continue to practise their profession for the public good, if it is safe to do so, provided that it is not inconsistent with the wider public interest objectives which must take priority. The panel concluded that permitting Ms Banks to return to practice immediately and her professional and personal interests were outweighed by the panel's duty to uphold the wider public interest. Therefore, a Suspension Order would satisfy the public interest aspects of the case.

100. The panel had regard to the paragraph 142 of the Sanctions Guidance:

"*Suspension up to one year may be appropriate if the suspension's primary[…] aim is (one or both of the following):*

- *maintaining confidence in the profession*
- *ensuring the professional standards are observed*"

101. Having balanced the factors outlined above, and upon considering all of the circumstances of the case, the panel found that a 12-month suspension order would be a sufficient period for Ms Banks to develop full insight and remediate her practice. The panel is further satisfied, for all of the reasons outlined above, that this is a sufficient period of time to protect the public and to maintain public confidence in the profession. Ms Banks has indicated her wish to return to social work practice; it is in the public interest to support a trained and skilled social worker to return to practice. Further, a period of in excess of 12 months risks Ms Banks becoming deskilled and the risk of deskilling is a public interest consideration.

102. The suspension order will be subject to review before expiry, during which a separate panel of adjudicators will consider whether Ms Banks' fitness to practise remains impaired and, if so, what, if any, sanction should be imposed. Ms Banks will only be permitted to practice, under restrictions or otherwise, if she demonstrates full insight and if the review panel is satisfied that there no longer remains a risk to the public and that allowing her to practice maintains public confidence in the profession. The reviewing panel would benefit from:

    a. Ms Banks' continued engagement with Social Work England;

    b. Ms Banks undertaking work comparable to social work practice to develop her skills as a practicing social worker. Further, a future reviewing panel would be assisted with samples of Ms Banks' written work which is comparable to written social work;

    c. Training undertaken by Ms Banks which covers:

        i. following management instructions;

        ii. maintaining case file records;

        iii. producing assessments to the standards expected;

        iv. time management;

        v. safeguard service users;

        vi. general social work, given Ms Banks' absence from social work for an extended period;

        vii. reflection on her training to set out what she learned and how her practice has improved; and

    d. A written reflective piece from Ms Banks:

        i. addressing the panel's findings;

        ii. demonstrating full insight and complete remediation; and

        iii. setting out why she would not commit the same practice failings should she return to social work practice unrestricted.

Interim order:

103. In light of its findings on sanction, the panel next considered an application by Ms Atkin for an interim suspension order for 18 months to cover the appeal period before the final order becomes effective. On behalf of Ms Banks, Mr Dingley did not make submissions on whether the panel should impose an interim order.

104. 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 imposition of a suspension 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.

105. Accordingly, the panel concluded that an interim suspension order is necessary for the protection of the public 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 an appeal has been filed with the High Court. If there is no appeal, the final order of 09 May 2024 shall take effect when the appeal period expires.

106. Ms Banks waived her right to notice to review her existing interim order under section 8, Schedule 2 of the Social Workers Regulations 2018. Consequently, the panel revoked the interim order made under section 8, Schedule 2 of the Social Workers Regulations 2018, as it is now replaced be an interim order made under section 11, Schedule 2 of the Social Workers Regulations 2018.

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.