Social worker: Nancy Dibo
Registration number: SW99368
Fitness to Practise
Final Hearing

Dates of hearing: 15 April 2024 to 24 April 2024

Hearing venue: Remote hearing

Hearing Outcome: Fitness to practise impaired, removal order

Interim order: Interim suspension order (12 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 Dibo attended and was represented by Mr Lloyd of Counsel.

3. Social Work England was represented by Ms Atkin, case presenter from Capsticks LLP.

Adjudicators	**Role**
Alexander Coleman	Chair
Glenys Ozanne-Turk	Social worker adjudicator
Melissa Forbes-Murison	Lay adjudicator

Wallis Crump	Hearings officer
Khadija Rafiq	Hearings support officer
Charlotte Mitchell-Dunn	Legal adviser

Preliminary matters:

Matters dealt with in private

4. The panel determined that the evidence in respect of Ms Dibo's health should be heard in private because it touched upon personal matters in her private life.

5. The panel had regard to rules 37 and 38 of the Rules which provide:

37. Subject to Rule 38, a hearing under these Rules shall be held in public.

38. (a) A hearing, or part of a hearing, shall be held in private where the proceedings are considering:

(i) whether to make or review an interim order; or

(ii) the physical or mental health of the registered social worker.

(b) The regulator, or adjudicators as the case may be, may determine to hold part or all of the proceedings in private where they consider that to do so would be appropriate having regard to:

(i) the vulnerability, interests or welfare of any participant in the proceedings; or

(ii) the public interest including in the effective pursuit of the regulator's over-arching objective.

6. The panel bore in mind the evidence that it had read and the need to hold as much of the hearing as possible in public. Both Ms Atkin and Mr Lloyd on Ms Dibo's behalf agreed that evidence in respect of Ms Dibo's ***[Private]*** should be heard in private because it touched upon personal matters in her private life.

7. Balancing all matters, the panel decided that it would hear parts of the evidence relating to the health of Ms Dibo in private.

Application to amend the Allegation

8. Ms Atkin on behalf of Social Work England made an application at the outset of the hearing to amend paragraph 1(a) (i) of the allegation. She applied to amend Paragraph 1(a) (i) to read "on or around 25 January 2019" instead of "25 January 2019".

9. Ms Atkin made this application on the basis that the amendment was minor in nature and reflected the fact that there was evidence to suggest that the matter may not have been completed until 27 January 2019. Ms Atkin submitted that the amendment reflected the evidence, and it was not prejudicial to Ms Dibo. Ms Atkin submitted the amendments were necessary to ensure that the matter was not under prosecuted. Mr Lloyd on Ms Dibo's behalf did not oppose the application and indicated that the amendment was not prejudicial to Ms Dibo.

10. The panel accepted advice from the legal adviser. The panel noted that it has a wide discretion as to the management of the hearing in accordance with paragraph 32(a) of the Social Work England (Fitness to Practise) Rules 2019 (as amended), provided that it ensures that the hearing is conducted fairly.

11. The panel noted that the amendment was minor in nature and reflected the evidence. The panel determined that in all the circumstances it was fair to amend the allegation. The panel concluded that there was no prejudice to Ms Dibo in amending the allegation, as it was a minor and insignificant amendment which only related to the specific date in question. The panel noted the representations of Mr Lloyd that the amendment was not prejudicial to Ms Dibo.

12. The panel therefore granted the application to amend the allegation.

Allegations:

13. The allegations arising out of the regulatory concerns referred by the Case Examiners on 24 August 2022 are:

1. Between July 2018 and July 2020, you failed to identify and/or respond to evidence of risk in an appropriate manner in that:

(a) In the case of Person 1 and Person 1's child, you:

(i) did not create a case for Person 1's child on or around 25 January 2019;
(ii) did not complete a Pre-Birth Assessment until 20 February 2019
(iii) did not convene a Safe Discharge Meeting prior to the baby's discharge from hospital.

(b) In the case of Person 2, you

(i) did not arrange a strategy meeting for Person 2 until 6 February 2019.

(c) In the case of Sibling 1 and Sibling 2, you

(i) On 23 July 2019, did not ensure that Sibling 1 and Sibling 2, who were in town unaccompanied at about 19:00, returned home safely and promptly in that you:

(aa) Did not take them home to their placement personally;

(bb) Did not inform the Council's on-call manager; and/or

(cc) Did not report the incident to the police

(d) In the case of Child 1 and Child 2, you:

(i) On 18 March 2020, whilst acting as the duty social worker to the Council's Child in Need Service, you did not inform your manager and/or discuss the need for further investigation of the concerns received from either:

(aa) The nursery of Child 1 and Child 2 that both children were presenting with injuries, including a bruise to Child 1's left ear;

(bb) Dr N that Child 1 had presented at his surgery with a bruise;

2. On 25 February 2022, you were barred from working with children and adults by the Disclosure and Barring Service.

The matters outlined at paragraph allegation 1 amount to the statutory ground of misconduct.

The matters outlined in paragraph 2 amount to the statutory ground of being included by the Disclosure and Barring Service in a barred list.

Your fitness to practise is impaired by reason of your misconduct and/ or your inclusion by the Disclosure and Barring Service in a barred list.

Admissions:

14. Rule 32c(i)(aa) of the 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.

15. Following the reading of the allegations the Panel Chair asked Mr Lloyd on Ms Dibo's behalf whether she admitted any of the allegations.

16. Mr Lloyd informed the panel that Ms Dibo admitted all of the allegations namely 1(a)(i)-(iii), 1 (b) (i), 1(c)(i) (aa)-(cc), 1(d) (i) (aa)-(bb) and 2.

17. The panel therefore found all of the allegations proved by way of Ms Dibo's admissions.

18. The panel noted that Ms Dibo disputed some contextual facts in respect of the allegations.

19. In line with Rule 32c(i)(a) of the Rules, the panel then went on to determine the disputed contextual facts. The panel noted that both counsel supported this approach.

Background

20. On 2 April 2020, Social Work England received a referral from CC, then ***[Private]*** at Leicester City Council ("the Council") regarding Ms Dibo.

21. The detail of the referral was in relation to a telephone call received by the Social Worker on 18 March 2020, from the Nursery of Child 1 and Child 2 reporting an injury, namely a bruise to Child 1's left ear. The concerns related to the Social Worker's failure to raise this report with management which led to a delayed safeguarding response.

22. The Council also referred further concerns about the Social Worker's practice in relation to her failure to identify risk and to safeguard a number of service users, including Person 1 and Person 1's child, Person 2 and Sibling 1 and Sibling 2.

23. The Council also referred concerns to the Disclosure and Barring Service who, on 25 February 2022, placed the Social Worker on the Adults' Barred list and Children's Barred list.

24. At the time of the referral, the Social Worker was a social worker in the Child in Need Service at the Council, where she had been employed since October 2016. At the time the referral was made, the Council was conducting an internal investigation following concerns in respect of the Social Worker's practice.

Summary of evidence:

25. Social Work England called live evidence from the following witnesses:

(a) NB, ***[Private]***;

(b) HS, ***[Private]***;

(c) CC, ***[Private]***;

(d) AT, ***[Private]***.

26. The panel read and took into account the witness statement of JK, ***[Private]***.

NB

27. NB was called to give evidence, she confirmed that the content of her witness statement was true to the best of her knowledge and belief.

28. NB was asked about the risk assessment scale, which ran from 0-10, 0 being unsafe and 10 being safe. She was asked about a score of 4 and 3 in respect of Person 1. NB confirmed that these scores were quite worrying, because they were low.

29. NB was asked questions in cross examination. She confirmed at the relevant time that she did not manage a caseload. In respect of the way in which teams were functioning at the Council, NB confirmed that she could only comment on her own team and stated that Leicester City Council was in a good position with regard to caseloads. She noted in her investigation that she focused on Ms Dibo's caseload and was not able to comment on the wider team that Ms Dibo was in. She confirmed a review of the working conditions did not form part of her investigation. In respect of Ms Dibo's capability during her Assessed and Supported Year of Employment (AYSE) NB stated this information was passed on to her by a predecessor, and she did not have a copy of the action plan, which was alleged to have been put in place. She noted in her investigation that she was focusing on the issues at the relevant time and did not take steps to obtain information about Ms Dibo's ASYE.

30. It was put to NB that Ms Dibo had five managers in her time at the Council. NB was unable to confirm this.

31. It was put to NB that she did not investigate the fact that Ms Dibo was overwhelmed. NB responded that matters in respect of Ms Dibo feeling overwhelmed were discussed with her manager, and there was evidence in the supervision notes about the seeking of support. ***[Private]***

32. NB confirmed that she did not access or obtain Ms Dibo's training records. She could not confirm whether Ms Dibo had attended training in respect of pre-birth assessments. NB confirmed that the deadline for completing such assessments was 45 days dependent on the circumstances of the case. She confirmed the assessment would need to be completed unless the case was closed.

33. NB was asked about the discharge process of a new-born baby, and she confirmed in respect of Person 1's child there was a clear need for strategic input with a multi-agency meeting involving all professionals. NB stated that the police confirmed that a further discharge meeting was not required.

34. NB was asked about Sibling 1 and Sibling 2, she was asked whether they were "Missing Children" as defined by the policy. She confirmed that she considered that they were missing, and it was concerning given their ages and the fact that a domestic violence incident had occurred between their parents the week before. She noted that the children were near a bus stop that would take them to their parents. She confirmed that the children were not technically missing when seen by Ms Dibo but stated that Ms Dibo did not know where they were going, so they would have been missing thereafter.

35. NB confirmed in respect of caseloads a newly qualified social worker should have up to 14 cases, and there should be 20 cases for a level 3. ***[Private]***

AT

36. AT was called to give evidence, he confirmed that the content of his witness statement was true to the best of his knowledge and belief.

37. AT was asked questions in cross examination. He confirmed that he was not Ms Dibo's manager at the time of her ASYE. AT was asked about the team at the time of the investigation. He confirmed there were approximately seven Social Workers, and he believed that they were all qualified, with the possibility of one ASYE Social Worker. He confirmed that the majority of the team were permanent members of staff. He stated that there was one agency Social Worker at the time. He confirmed that the caseload was manageable, and the ASYE workers had approximately 16 cases and full-time staff had approximately 22 or 23. He stated the team was stable, and he was mindful of the work that was provided to Ms Dibo.

38. In respect of support AT confirmed that Ms Dibo did not request support directly. ***[Private]***

39. ***[Private]***

40. AT confirmed that some of the supervision notes within the bundle were not his own. He could not confirm whether the supervision notes were his in respect of Person 1's child. He stated that an assessment would not necessarily be done if the case was to be closed. He confirmed there was a risk assessment outstanding and a delay of over a week was significant.

41. It was put to AT that there were other issues to address in the case including homelessness. He stated there was not just homelessness, there were other issues including the child being a young age, the mental health of the mother, drug use and a separation from a partner.

42. AT was asked about notetaking by Social Workers, and it was put to him that Ms Dibo may have been using a paper diary and paper notes. He confirmed that he kept his own electronic records, but it was commonplace at the time for people to take notes on paper and then type them up later.

43. AT was unable to recall a copy of the supervision records but confirmed it looked like a supervision had taken place in the time that he was involved in matters. He confirmed that he didn't recall the conversation recorded within the supervision note in respect of Person 1. He did not recall Person 1's case closing or asking for enquiries to be made.

44. AT was asked questions by the panel. He confirmed that he had concerns about Ms Dibo's practice within the first 6 months of managing her. In respect of the notes which demonstrated that he had asked for enquiries to be made about Person 1, he confirmed

that he didn't know why the conversation didn't continue. He stated it was however Ms Dibo's responsibility to make the enquiries. He was asked whether he expected social workers to say what the position was on every case, and he confirmed that this was correct.

HS

45. HS was called to give evidence, she confirmed that the content of her witness statement was true to the best of her knowledge and belief.

46. HS was asked questions in cross examination. She confirmed that Ms Dibo had failed parts of her ASYE assessment. She was asked questions about the consistency of management throughout Ms Dibo's course of employment. It was put to her that the Council was going through a difficult time and there was staff movement. HS confirmed at the time they had started to stabilise the workforce. It was put to HS that Ms Dibo had 5 managers. HS recalled two managers before AT. HS noted that Ms Dibo had consistency on her ASYE and had an advanced practitioner, who was the same person and was available throughout that time. HS noted that Ms Dibo also had lots of support in supervision.

47. HS stated that she believed that Ms Dibo had had 4 managers in 5 years. HS was asked why Ms Dibo was moved to CC's team and she confirmed that this was for a fresh start and because she was aware that the team was very settled and stable. She confirmed she wanted to give Ms Dibo the best opportunity in a stable team with very experienced workers. She was asked whether this was because stabilising factors were not present, and she stated that it was for the purpose of helping Ms Dibo. She stated she was concerned ***[Private]*** and wanted to give Ms Dibo the best opportunity in the best team.

48. HS was asked about what, if anything was done about Ms Dibo's case load ***[Private]***. She confirmed she did not know, and that it would have been AT's role to manage this. She recalled Ms Dibo needing to make sure the cases she needed to close were closed, as this would have reduced the number on her case load. She recalls this impacting the figure in respect of Ms Dibo's case load and noted that her case load was in fact lower.

49. HS was asked what was wrong with a low case load ***[Private]*** HS noted that the Council could not be in the position where there was unallocated work. HS confirmed that she did not know what AT did in respect of ***[Private]***

50. HS noted that Ms Dibo had 14 cases to close at one point and this would have artificially inflated the number of cases she was dealing with.

51. HS was asked about the purpose of supervision, and she described that this covered how a team was getting on and functioning, and to review matters in respect of the Social Worker but not in great detail. HS confirmed that she wanted Ms Dibo to be a level 2, because this would result in a pay increase. She confirmed the service would also benefit from another level 2. She stated that she wanted Ms Dibo to finish and prioritise her ASYE

assessment. She stated she didn't want her to miss another deadline, as most people had completed the course. She stated it was about helping Ms Dibo.

52. ***[Private]*** HS confirmed that Ms Dibo could approach her. She recalled laughing about the issue and saying, "*just go home and finish it*". She confirmed that this was a joke between herself and Ms Dibo.

53. HS was asked about the telephone call from the doctor in respect of Child 1 and Child 2. She was asked about any copies of the notes in respect of the discussions that took place with CC, and she confirmed that there would not be copies.

54. In respect of the procedures in place at the relevant time HS confirmed that she had not seen a copy of Ms Dibo's training records.

55. HS was asked questions in re-examination. ***[Private]***. She stated that Ms Dibo had come to her about a previous managers style, and she felt that Ms Dibo could talk to her. She said her comments about completing the ASYE where in Ms Dibo's best interests.

56. ***[Private]***

57. HS was asked about the content of the ASYE portfolio, and she explained the content and purpose.

<u>CC</u>

58. CC was called to give evidence, she confirmed that the content of her witness statement was true to the best of her knowledge and belief.

59. CC was asked to confirm whether, if an allocated social worker was on leave, the Social Worker covering the matter would be expected to read into the background of the case and have knowledge of it. CC confirmed that she would expect the social worker to at least have had sight of the case summary and know some details before going out to do a statutory visit. She confirmed that they would need to know the purpose of the visit.

60. CC was asked whether a social worker on the duty team would be receiving calls, and to what extent they would have access to case records. CC confirmed that there would be the expectation that if a call came in, a social worker would have the details of the case via access to the liquid logic identification for each child. Therefore, before making any decisions or comment the Social Worker would need to have read some level of detail of the case.

61. CC was asked questions in cross examination. She was asked what remote access facilities were available to social workers at the time if a social worker was on a visit and got a call. She was asked if the laptops had stored data. CC confirmed that they had stored data pre COVID, she stated Citrix enabled Social Workers to log on remotely. She confirmed that an internet connection was however required.

62. CC was asked what she was aware of in terms of the history of Ms Dibo's previous management and how many managers she had previously. She stated she couldn't remember the exact level of detail that was provided to her. She confirmed that she could not recall if there was any written handover. CC was asked about Ms Dibo's case load and whether it was between 18 and 21 cases. She stated she did not know but she believes the information could have been captured from Liquid Logic. She confirmed the typical expectation of a Level 2 or Level 3 social worker would have been between those numbers.

63. CC confirmed that there was nothing out of the ordinary in terms of how busy the department was. In terms of duty working, she confirmed that there was usually a duty backup. In respect of the decisions relating to the urgency of a case, CC confirmed if there was an issue in terms of the prioritisation of matters, the Social Worker would speak to the team manager.

64. In respect of 18 March 2020 CC was unable to recall who the duty back up was. CC confirmed that there was a department WhatsApp group if somebody was inundated with calls or things were unclear.

65. CC was asked about the nursery in respect of Child 1 and Child 2 being provided with her email address, and whether the email address was correct. She stated this was not the appropriate response by Ms Dibo.

66. CC was asked about Dr N not being able to get hold of the duty worker or the back up. She stated she did not know why Dr N not able to get through. CC confirmed that the matter should have been escalated, as injuries to a child always need management oversight.

67. CC was asked whether she was aware that an assessment with a medical professional was already booked on that day, she confirmed that she was not aware.

68. CC was asked whether her evidence was that Dr N spoke with Ms Dibo or another social worker that day. She confirmed she understood it to be Ms Dibo. She accepted that Dr N later escalated matters in order to receive a response.

69. CC was asked about time off in lieu (TOIL). CC was questioned about the number of hours accrued by Ms Dibo. She stated that this was not unusual and would have indicated an increased workload. CC was asked if this was reflective of the broader teams increase or whether that was specific to Ms Dibo. She stated she thought it was about Ms Dibo joining the team and reflected discussions in supervision. She believed at the time of the discussions Ms Dibo had 15 cases with 2 closures. CC was unable to recall conversations about duty work. She stated when Ms Dibo joined the team, she had a lower caseload there were no issues with her competence or her ability. She stated in the first three months Ms Dibo settled in well and there were no concerns. She had a positive relationship with the team.

70. CC was asked whether the HR process impacted Ms Dibo's mood. She stated it was difficult for her, with it "*hanging over her*". ***[Private]***

71. ***[Private]***

72. In re-examination CC was asked if Ms Dibo had raised any concerns with her about the other duty work she had undertaken on 18 March 2020, and whether this had meant she was too busy to deal with the concern. She said to the best of her recollection Ms Dibo had not. She stated that she felt the response to the concern was inappropriate, as no details had been given so that matters could be escalated to her. She stated Ms Dibo's response to the incident in respect of Child 1 and Child 2 did not align with social work values, in terms of the immediacy of that level of concern.

73. CC was asked about her conversation with Dr N and his recollection that he spoke with the duty social worker named Nancy, she stated that there were no other social workers named Nancy who might have picked up the call.

74. ***[Private]***

75. CC was asked about Ms Dibo's statutory visit to Child 1 and Child 2 on 6 March 2020. She confirmed she was not aware of whether Ms Dibo checked in with her after that visit on noting injuries.

<u>Ms Dibo</u>

76. Ms Dibo gave evidence. She confirmed that she is a qualified social worker but is currently working in customer services. She stated that when she worked as a Social Worker she enjoyed supporting families and children and making an impact on their life in a positive way. She confirmed this is why she started working as a Social Worker in 2016 at the Council.

77. She stated she joined the Council at a very difficult time period for them and unknown to her the department was going through quite a lot of issues. She confirmed that she started as a newly qualified social worker in October 2016, and she went through 5 managers in total in the time that she was at the Council. She said her experience was "*not that positive*". She recalled a period in her team when they were "*really struggling*" and had about 45 unallocated cases to manage. She described further cases due to her covering of duty matters and stated this impacted on her protected case load during her ASYE.

78. Ms Dibo described integrating in the team well, she said however that issues within the service impacted not just her but other members of the team. She stated the team was struggling in terms of staffing, so newly qualified social workers didn't have a gradual introduction. She stated on her ASYE she was expected to do visits and have input into other cases which were not on her caseload. She stated this had a severe impact on her

own caseload. Ms Dibo said people noticed she was struggling but stated "*the only reason why I was struggling is because I was made to do other people's cases*". She stated matters came to the attention of the service manager as staff were having breakdowns.

79. Ms Dibo stated she wished to make a correction and stated that she did not fail her ASYE. She stated that she didn't know where that information had come from, and it was surprising to hear. She said her ASYE completion was not late. She stated the issue that she had was the fact her case load was suffering. She stated that she did not need to resubmit her ASYE portfolio as she passed the Portfolio first time. She said HS wasn't chasing her to submit her portfolio, but she did step in to investigate why she was struggling with her personal caseload. She described that she had two managers in this period of time.

80. Ms Dibo confirmed that she is not a Level 3 Social Worker, and she does not know why anyone is saying she is a Level 3 Social Worker. She stated she immediately moved to Level 2 automatically when she passed her portfolio. She stated she did not recall the joking conversation with HS about submitting her portfolio. She recalled a conversation with HS however about focusing on her caseload, which she described as "helpful".

81. Ms Dibo described early 2019 and her day-to-day work life, she stated she had some very serious cases, she confirmed that the Team was busy, and she had some cases in court. She stated that in respect of a particularly serious case she had to tell her manager she was struggling. She confirmed that caseload varied, and some cases could be challenging. She described having three serious cases and asking her manager to take one over for her.

82. Ms Dibo was asked about the cases she had which were ready for closure. She described a complex case which she was dealing with and stated that she was working all the time, to make sure that the children on her caseload were safe.

83. ***[Private]***

84. ***[Private]***

85. ***[Private]***

86. ***[Private]***

87. In respect of the delay in creating a case for Person 1's child in the case of Person 1. Ms Dibo stated the only reason why she didn't create the case for Person 1's child was that the case was one that was to be closed. She stated the case was on her list for closure. She stated it was only after the incident that she was advised that it doesn't matter if the case is being closed, you would still need to open a case for the unborn child. She stated the reason she didn't open the case was because she was closing the family. She stated she had a column with an action plan of the things that she needed to do before the case

was closed. She stated everything was fine, so she had in her mind that the case was going to be closed.

88. Ms Dibo was asked what she would do differently today. She stated she would open Person 1's child's matter even if the case was going to be closed. She stated that the file needs to be opened because the unborn child is part of the family, "*they have to be known in the system*". She stated if the case was closed later down the line the service would know about the child.

89. Ms Dibo confirmed that the pre-birth assessment was not completed due to a delay on her part. She stated she has learnt about the consequences of delay, and the mother in this case was caused unnecessary stress and was not able to go home from hospital. She confirmed that she didn't share the outcome with the hospital and therefore the mother's return home was delayed causing distress. She stated this made her feel "*very bad*" and it was not something she wished to repeat. She confirmed her actions put the service in a negative light. She confirmed that the aim of the service was to protect vulnerable members of the public, build trust and keep people safe.

90. Ms Dibo stated if the situation were to occur again she would convene a meeting with the nurses to make sure everyone is informed. She stated this was to ensure everyone was working together to support the family.

91. In respect of Person 2, Ms Dibo explained that there were concerns about homelessness and these impacted her decision of when to schedule a meeting. She stated she went to the housing department, and they refused to provide suitable accommodation for the family because they stated the child's homelessness was due to the mother. She stated management had to get involved and it was not straightforward. She stated the responsibility rested with her to look for suitable accommodation and this was not supposed to be her responsibility.

92. In respect of Sibling 1 and Sibling 2, Ms Dibo stated she knew the children, and wanted to gain the trust of the older child who was 14. She stated it had been a challenge to get her to engage with the service. She didn't have a good relationship with the service due to the way in which the previous foster carers treated her and her sibling. She stated the stability of the foster placement relied heavily on the stability of the 14-year-old. She stated she was trying to build rapport and trust with the 14-year-old. She stated the 14-year-old was with a friend when they spoke and had said she wanted to go with this friend. Ms Dibo stated that she had said ok, but asked whether it was late for the little sibling who was 7. She asked to speak to her foster carer on the phone, so she gave her the phone and the foster carer was trying to convince her to come home and go tomorrow. The girl refused and because she had a 9pm curfew Ms Dibo advised it was ok if the children were home by 9pm. She stated it was agreed if the children didn't come home as promised the police would be informed.

93. Ms Dibo confirmed that she failed to inform her manager that this was what had happened. Ms Dibo stated she didn't report matters to the police because she trusted the girl, and she said this was an error on her part. She stated she should have phoned the duty team or informed the police.

94. Ms Dibo stated if she were to do things differently she would inform the duty team. She denied saying that she didn't call the police because she was outside of work, and it was not her problem. She stated she had a lot of trust and was "*rolling with the resistance*".

95. Ms Dibo described what it was like taking a five month break from Social Work. She confirmed she was supported on her return.

96. In respect of 18 March 2020 Ms Dibo confirmed that she received a phone call from the nursery of Child 1 and Child 2 in which they referred to the injuries including a bruise. She stated on that morning she received two messages which she considered as an emergency, one was a 15-year-old child who was alleging she was the victim of a historic rape and had made a disclosure of this at her school. She confirmed she didn't mention the nursery call in respect of Child 1 and Child 2 to her manager. She stated she didn't treat the call-in relation to Child 1 and Child 2 as an emergency because she was informed the children would have a health assessment that day. She confirmed that if she had escalated events, the same outcome would have occurred as the children would be seen by a paediatrician. She considered the children were in the right place.

97. She confirmed that she gave the nursery her managers email address. In respect of the call from Dr N she stated she did not receive any call from a doctor. She stated nobody spoke to her. She stated she was not in the office because she was doing a visit.

98. In respect of her practice Ms Dibo reflected that she relied on handwritten notes, and she stated that this caused her more work. She stated she had learnt through the negative experience and had time to think deeply about her practice. She confirmed if she were able to, that she would like to resume practice. She confirmed that it saddens her that she is not able to continue to help people as a social worker.

99. Ms Dibo was cross examined. In respect of the case of Person 1 it was put to Ms Dibo that there was a risk in terms of there being concerns about inconsistent parenting, a history of alcohol misuse and there were also concerns that Child 3, the first child of Person 1, had witnessed incidents of domestic violence, and as a result was aggressive towards his mother. Ms Dibo agreed this was correct. She agreed that the notes in respect of the case did not reflect that there was a discussion about the case being closed. Ms Dibo stated she wasn't sure and " *it's not every time that management gets things right*". Ms Dibo confirmed that the decision would have to be kept under review if new information came to light. Ms Dibo stated she had learnt from her mistake and knows

now that a case should have been opened in respect of the unborn child, and she would inform her manager if new information came to light.

100. Ms Dibo confirmed that the case was to be closed after the next Child in Need meeting and a social worker would need to reassess matters in light of any new information. She confirmed she should have opened the file sooner. It was put to Ms Dibo that the notes reflected the fact that the case should not have been closed because Person 1 was pregnant, and there was no plan at the end of January to close the case. Ms Dibo confirmed that there were outstanding assessments, and the service needed to make sure the new father was safe. She confirmed this was why the case was still open.

101. A note in the file was put to Ms Dibo which stated that a meeting had confirmed that the case would not be closing as agreed because Person 1 was pregnant, and it was unclear how she would cope with Child 3's behaviour once the baby arrives. It was put to Ms Dibo that there were further details within the file about Person 1 reporting that there was a level of risk and concern around the baby's arrival. Ms Dibo agreed. It was put to Ms Dibo that on the 18 January 2019 the notes reflect that the case was not appropriate for closure. Ms Dibo agreed that that this was reflected in the notes.

102. Ms Dibo confirmed that a number of assessments were outstanding in February 2019 prior to the pre-birth assessment being completed. Ms Dibo confirmed that the notes on the file indicated that there was a chance that Person 1 might deliver the baby early. It was put to Ms Dibo that the notes reflected that Person 1's child should be made the subject of a Child in Need plan, under the category of at risk of neglect, along with her sibling, whilst a further assessment was being carried out. Ms Dibo confirmed that the notes recorded on 25 February 2019 stated that the team manager still has significant concerns. It was put to Ms Dibo that there was no plan for closure of the case. Ms Dibo stated she had completed the assessments required, and she knew in her head the outcome of the Child in Need plan.

103. In respect of Person 2, it was put to Ms Dibo that there were concerns around the mother's drug use and the potential risk to the baby as a result. Ms Dibo agreed she had involvement in the case from at least October 2018. She confirmed there were suggestions in 2018 that the mother was homeless. Ms Dibo confirmed that the mother was found smoking weed about two weeks before she had given birth. She acknowledged that this information would have affected the outcome of her pre-birth assessment, as the mother had been using drugs and lying about it.

104. Ms Dibo confirmed that the mother was later served with an eviction notice and had been found using drugs again. Ms Dibo acknowledged that there were concerns about the conditions the baby was being kept in.

105. She acknowledged that there were concerns about the child overheating and further homelessness. Ms Dibo agreed from the notes it appeared that the mother's lifestyle choices were putting her daughter at risk. Ms Dibo was asked about the safety ratings of 4 and 3. Ms Dibo accepted that there were clear discussions about a strategy discussion being arranged and this was not actioned in a timely fashion.

106. It was put to Ms Dibo that there were concerns which were ongoing in respect of homelessness and an extension of accommodation had been agreed on 25 January 2019. Ms Dibo agreed. It was put to Ms Dibo that it was important to prioritise a strategy discussion. Ms Dibo stated that there was pressure to secure a semi-permanent placement which was suitable. Ms Dibo confirmed however that due to the delay there was not a safe sleeping arrangement in place to address the risks.

107. In respect of Sibling 1 and Sibling 2, Ms Dibo confirmed that they were looked after siblings, Sibling 2 was seven years old, and Sibling 1 was 14 years old at the relevant time. Ms Dibo confirmed that they were looked after because of concerns about alcohol misuse and mental health in respect of their parents. They had witnessed domestic violence between their parents and contact with the parents was supervised because of the concerns outlined.

108. Ms Dibo confirmed there was an incident a few weeks prior to the allegation in which Sibling 1 had gone missing and had not returned to her foster placement until the following day and had said she had been sleeping near the lakes with two boys. Ms Dibo conceded that there were further incidents of the child going missing and being found in the care of her father. There had also been reports of self-harm.

109. It was put to Ms Dibo that Sibling 2 was only seven years old, and it was obvious that the children were in a position of risk, vulnerable and there was no way of knowing whether the children would return. Ms Dibo agreed.

110. In respect of the case of Child 1 and Child 2 it was put to Ms Dibo that prior to the phone call from the nursery she had conducted a statutory visit to the family on the 6 March 2020. She agreed, she stated she "*popped her head in and out"* on the children, but she didn't have time to sit down and read the case.

111. Ms Dibo agreed the content of the call from the nursery in respect of Child 1 and Child 2. Ms Dibo agreed she gave the team manager's e-mail address and advised the nursery to continue to monitor the children. She agreed she was aware that the children were recently off sick from nursery. Ms Dibo maintained that the children had an initial health assessment that morning so she knew that they would be seen by a professional. She conceded that there was a level of concern and there were significant red flags. Ms Dibo conceded that she didn't inform her manager. She stated thinking about it now,

she was "*waiting to get a clearer picture of the situation*" because she "*didn't think it was serious*".

112. It was put to Ms Dibo that there was no guarantee that the children would attend the health assessment, or it might be rescheduled. Ms Dibo stated the assessment was important and the carer would have known they had to attend.

113. It was put to Ms Dibo that from the notes she was named and therefore it was likely that Dr N had spoken to her. She disputed this and stated she had a mobile phone and was not in the office. She stated when she received a call from her manager she was driving.

114. Ms Dibo agreed she didn't leave an action for anyone to follow up. It was put to Ms Dibo that the doctor hadn't been told about any concerns communicated by the nursery and there was nothing in place to ensure the safety of the children if the assessment was rescheduled. Ms Dibo agreed.

115. It was put to Ms Dibo that she prioritised the wrong concern. She conceded and stated, "*not all the decisions that you make as a social worker will turn out to be the right decision*".

116. She stated she prioritised the other case knowing the paediatrician would see the children. She noted she was in a very difficult place that morning.

117. Ms Dibo's investigation interview was put to her in which she stated, "*I didn't see it as a serious incident I took it at face value that they had scratches and in my opinion this was just a scratch, when a child was playing or is falling over or something*". She acknowledged that she had seen scratches on the children previously but stated "*the injury behind the ear …was something of concern*".

118. It was put to Ms Dibo that at the relevant time she didn't consider the information she had received raised any serious concerns. Ms Dibo stated she thought the information needed further clarification and the only reason she didn't inform her manager was due to the health assessment. She acknowledged it was not the right decision and led to delay.

119. It was put to Ms Dibo that she did not mention struggling ***[Private]*** in supervision and she stated "*I'm that type of person that I struggled alone. I don't tell people about it, that is one of one of my weakest points…I keep things to myself a lot."*

120. In response to the panels questions Ms Dibo was asked what the purpose of a safe discharge meeting was, and she stated it was so all "*professions were on the same page*". Ms Dibo was asked the purpose of the strategy meeting in respect of Person 2. She stated it was to step up the child's case to child protection because the child was homeless.

121. Ms Dibo accepted that Sibling 1 and Sibling 2's foster carer didn't know where they were until they spoke on the phone. She agreed she didn't know where the children were going, and she left them at the bus stop. Ms Dibo was asked whether it occurred to her that technically according to the protocol they were missing. Ms Dibo stated the foster carer was trying to stop the children from coming to town, but they still insisted, they wanted to see one of their friends and that they wanted to go to the other side of the town. She agreed that she trusted the child.

122. Ms Dibo was asked about the duty system. Ms Dibo confirmed that you may just be on the phone and answering phone calls concerning cases and then updating the system for the allocated social worker, she stated you may have tasks that you need to do for a particular case and when the allocated social worker returns they will continue with what needs to be completed. She said if you need to continue to do other things on the case because the person is away for a long period of time you would ask your manager.

123. Ms Dibo acknowledged that in the role of a social worker protecting the vulnerable and safeguarding was very important.

124. ***[Private]***

Finding and reasons on facts:

125. The panel accepted the advice from the legal adviser, which included the following:

a. Particulars 1 and 2 of the allegation have been proved in their entirety in line with Rule 32c(i)(aa) Fitness to Practise Rules 2019 (as amended);

b. It is for Social Work England to prove disputed facts on the balance of probabilities;

c. All the evidence should be considered before making findings of credibility, and when making such findings, the panel should not rely exclusively on demeanour;

d. The panel should have regard to the guidance in respect of drafting decisions.

<u>Contextual Facts</u>

126. The panel considered the evidence in detail and determined that the disputed contextual facts fell within four categories as follows;

i) ***[Private]***

ii) The position in respect of the Council, management and caseloads;

iii) Ms Dibo's ASYE years and the support provided;

iv) The circumstances surrounding the factual particulars and any mitigating factors.

127. The panel noted that all of the witnesses called on behalf of Social Work England sought to be helpful to the panel and despite the significant passage of time all witnesses endeavoured to provide clear and accurate evidence.

128. In respect of the evidence of Ms Dibo the panel noted that Ms Dibo considered her answers with care, however there were a number of inconsistencies in her recollection. Her evidence was hindered by the passage of time in this case.

[Private]

129. ***[Private]***

130. ***[Private]***

131. ***[Private]***

132. ***[Private]***

133. ***[Private]***

134. ***[Private]***

The position in respect of the Council, management and caseloads

135. The panel heard evidence in respect of the position of the Council at the relevant time and the management of Ms Dibo. The panel noted that Ms Dibo had stated that the department she was in was going through quite a lot of issues. She confirmed that she started as a newly qualified social worker in October 2016, and she went through 5 managers in total in the time that she was at the Council.

136. The panel noted the evidence of the witnesses called by Social Work England, none of whom accepted that there were any particular difficulties within the council, but all of whom acknowledge that Ms Dibo had a number of different managers. The panel considered the evidence of HS that she moved Ms Dibo into a more stable and established team.

137. The panel considered that while it is far from ideal to have numerous management changes, Ms Dibo did have access to experienced colleagues. The panel bore in mind its previous conclusions ***[Private]*** and considered this in regard to the mitigation she advanced about the position of the Council.

138. The panel had no doubt that the council was a busy environment and acknowledged that there must have been a clear reason that HS moved Ms Dibo to another team, however the panel did not consider that there was anything exceptional about the environment that Ms Dibo worked within which would have impacted on her performance.

139. In respect of Ms Dibo's caseload the panel noted that this was not excessive and considered the evidence provided by Social Work England's witnesses that Ms Dibo had a number of cases on her caseload which needed to be closed.

Ms Dibo's ASYE year and the support provided

140. The panel noted the evidence of Ms Dibo in respect of her ASYE year and her submission that she had not failed this year and did not recall the support offered by HS in respect of getting her portfolio completed on time.

141. The panel considered a supervision record within the hearing bundle dated 23 March 2018, this states "*Nancy – failed her portfolio, her report was meant to be in yesterday, not clear if she has done it*."

142. The panel also considered an email chain dated 23 April 2023 to HS entitled AYSE re-submission. The email states " *Nancy did have to resubmit her portfolio which she did and went on to pass her ASYE year*."

143. The panel considered that the evidence before it supported the conclusion that Ms Dibo initially failed her ASYE and went on to pass when she re-submitted her portfolio.

144. The panel therefore preferred the evidence of HS, that she had sought to assist Ms Dibo in getting her portfolio completed, in order that Ms Dibo could become fully qualified.

The circumstance surrounding the factual particulars and any mitigating factors

145. The panel considered the evidence of Ms Dibo in respect of Person 1's child. The panel noted that Ms Dibo had submitted that the case was due for closure, and this mitigated some of her failures in respect of the pre-birth assessment.

146. The panel considered the case notes in respect of Person 1 within the bundle. The panel considered that these do not suggest that the case was due for imminent closure. Further, the panel considered Ms Dibo's concession in cross examination in this regard.

147. The panel noted that Person 1 had a child who was already violent and was unable to engage with her. The panel considered that this would have placed the baby at a significant risk of harm. The panel considered Ms Dibo's answers in respect of the purpose of the safe discharge meeting to be vague. She stated the purpose was to ensure that professionals were all on the same page and her focus was upon the distress caused to Person 1 by the incident.

148. In respect of Person 2 the panel considered Ms Dibo's evidence that she was focusing on homelessness, and this was prioritised over the organisation of a strategy meeting. The panel considered that Ms Dibo prioritised what she considered a priority as opposed to what she was asked to do by management.

149. The panel considered that Ms Dibo's understanding of the purpose of the strategy meeting was incorrect and she failed to acknowledge that the purpose of this meeting was to see if any further actions could be taken to prevent a child from going on a child protection plan. Ms Dibo failed to acknowledge that the issues in respect of homelessness could have been addressed at such a meeting.

150. In respect of Sibling 1 and Sibling 2, Ms Dibo stated that she knew the children and wanted to gain the trust of the older child who was 14, as it had been a challenge to get her to engage with the service.

151. The panel considered that this was an unacceptable explanation for Ms Dibo's actions. The Panel noted that Ms Dibo did not fully acknowledge that the children were missing and acted inappropriately in all the circumstances.

152. The panel noted Ms Dibo's concessions in cross examination that there was an incident a few weeks prior to the allegation in which Sibling 1 had gone missing and had not returned to her foster placement until the following day, citing she had slept at a lake with two boys. Ms Dibo also conceded that there were further incidents of Sibling 1 going missing previously and being found in the care of her father. There had also been reports of self-harm in respect of Sibling 1. The panel considered that given the history of the case Ms Dibo's explanation that she had acted in order to build trust was significantly misguided.

153. In respect of Child 1 and Child 2, Ms Dibo submitted that she had two matters that day which she considered to be an emergency. She noted that she provided her manager's email address and submitted that she felt at the time her actions were mitigated by the fact that the children would be assessed at a health assessment.

154. The panel did not consider the matter raised by Ms Dibo in respect of a historic rape allegation to be an emergency. It considered that the providing of her managers email was an inappropriate and insufficient measure, which was not followed up with a call to her manager to explain the circumstances. The panel noted Ms Dibo's concessions in cross examination that there was nothing in place to ensure the safety of the children if the health assessment was rescheduled.

155. In all the circumstances, the panel considered the mitigation advanced by Ms Dibo in this regard to be insufficient.

Finding and reasons on grounds:

156. The panel accepted the advice of the legal adviser that it must pursue the overarching objectives when exercising its functions. It must consider whether the proved allegations amount to misconduct.

157. The panel noted the authority of Roylance v General Medical Council (No.2) [2000] 1 A.C. 311 which states:

> *"Misconduct is a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be found by reference to the rules and standards ordinarily required to be followed by a practitioner in the particular circumstances. The misconduct is qualified in two respects. First, it is qualified by the word 'professional' which links the conduct to the profession. Secondly, the misconduct is qualified by the word 'serious'. It is not any professional misconduct which will qualify. The professional misconduct must be serious …"*

158. The panel further noted that the adjective '*serious*' must be given its proper weight, and in other contexts there have been references to conduct which would be regarded as deplorable by fellow practitioners.

159. The panel noted Section 25 (2) (g) of the Social Workers Regulations 2018 and considered Ms Dibo's acceptance that she was included on the barred list by the Disclosure and Barring Service.

160. The panel considered that the proved facts of the allegation amounted to a breach of the following HCPC Standards of Conduct, Performance and Ethics:

> 6.1 You must take all reasonable steps to reduce the risk of harm to service users, carers and colleagues as far as possible.
>
> 7.1 You must report any concerns about the safety or well-being of service users promptly and appropriately.
>
> 7.2 You must support and encourage others to report concerns and not prevent anyone from raising concerns.
>
> 7.3 You must take appropriate action if you have concerns about the safety or wellbeing of children or vulnerable adults.
>
> 7.6 You must acknowledge and act on concerns raised to you, investigating, escalating or dealing with those concerns where it is appropriate for you to do so.
>
> 10.1 You must keep full, clear, and accurate records for everyone you care for, treat, or provide other services to

161. The panel also considered that the proved facts of the allegation amounted to a breach of the following Social Work England's Professional Standards (applicable from 2 December 2019):

3.4 Recognise the risk indicators of different forms of abuse and neglect and their impact on people, their families and their support networks.

3.9 Make sure that relevant colleagues and agencies are informed about identified risks and the outcomes and implications of assessments and decisions I make.

3.12 Use my assessment skills to respond quickly to dangerous situations and take any necessary protective action.

162. The panel acknowledged that Ms Dibo's breaches of the above standards occurred in circumstances where she was struggling with her work ***[Private].***

163. The panel considered that the allegation presented a pattern of a persistent lack of professional curiosity regarding the risks posed to children. The panel considered that Ms Dibo's actions showed a disregard for the safety of vulnerable children, with an incorrect focus on rapport building as opposed to risk management.

164. In respect of Person 1's child, the panel considered that Ms Dibo's action showed a failure to demonstrate an understanding and consideration of the risks posed to Person 1's child. The panel considered that even with the passage of time Ms Dibo understanding in this regard had not developed. The panel noted that Person 1's child was at risk due to both the actions of Person 1 and her other child.

165. In respect of Person 2, the panel considered that Ms Dibo's actions showed that she prioritised matters incorrectly and this in turn led to a risk of harm in respect of Person 2. The actions of Ms Dibo demonstrated a pattern of poor communication and failure to prioritise appropriately, including acting autonomously contrary to the directions of her manager and the best interests of service users. The panel noted that despite the fact that she was requested to organise a strategy meeting, she prioritised matters which she considered appropriate and failed to appreciate that the strategy meeting would be an appropriate forum for raising the issue of homelessness. The panel considered her actions in this regard demonstrated a lack of professional concern for the safety of this child.

166. In respect of Sibling 1 and Sibling 2, the panel considered the inaction of Ms Dibo to be extremely serious, given the history of the case and the risks present. The panel noted that Sibling 2 was only 7 years old and was out late in the evening. Ms Dibo also failed to appropriately report the concerns about the safety or well-being of Sibling 1 and Sibling 2. The panel noted its previous conclusion in respect of Ms Dibo's explanation in relation to building trust, and how misguided this was. The panel considered that Ms Dibo failed to protect the safety or wellbeing of Sibling 1 and Sibling 2 who were both vulnerable. This

was a further demonstration of Ms Dibo acting autonomously contrary to the best interests of service users.

167. Finally in respect of Child 1 and Child 2 Ms Dibo's failure to act could have led to a significant risk of harm. The panel noted its previous conclusions that there was nothing in place to ensure the safety of the children if the health assessment was rescheduled. The panel considered that Ms Dibo failed to recognise the risk indicators of abuse and neglect and their impact, and this in turn could have led to further harm. This is further evidence of poor communication and a failure to prioritise appropriately.

168. The safety of vulnerable children is paramount, and the panel determined that Ms Dibo's actions placed children at risk. The ability to assess and manage risk is a core requirement of a social worker's role, and Ms Dibo's actions demonstrated a fundamental failure in this obligation.

169. The panel was satisfied that members of the public and the profession would be shocked by Ms Dibo's conduct, particularly given the risks posed to vulnerable children. Her failure to safeguard vulnerable children, could impact on the public's confidence in the profession. Ms Dibo's actions demonstrated a disregard for procedures and policies which are in place to safeguard vulnerable service users and further demonstrates a failure to prioritise risk.

170. The panel was therefore satisfied that each of the proved allegations, both individually and cumulatively, amount to serious misconduct, and Ms Dibo's conduct would be regarded as deplorable by fellow practitioners.

171. The panel noted that Ms Dibo accepted that she was included on the barred list by the Disclosure and Barring Service. In line with section 25 (2) (g) of the Social Workers Regulations 2018, the panel found the statutory ground proved

Finding and reasons on impairment:

172. The panel considered all the evidence and the submissions. The panel accepted the advice of the legal adviser and was aware that:

i) The overriding objective of Social Work England is to protect the public, which includes maintaining public confidence in social workers and maintaining professional standards of social workers.

ii) Impairment was considered by Dame Janet Smith in the fifth Shipman Report. The test for impairment was then endorsed by the court in *Council for Health and Regulatory Excellence v Nursing and Midwifery Council and Grant [2011] EWHC 927 (Admin)* namely;

"whether the panel's findings in respect of the practitioner's competence and capability show that the practitioner's fitness to practise is impaired in the

sense that they have in the past and/or are liable in the future (a) to put service users at unwarranted risk of harm; (b) to bring the profession into disrepute; (c) to breach one of the fundamental tenets of the profession; (d) to act dishonestly and/or be is liable to act dishonestly in the future.

iii) At the impairment stage the panel should take account of the case of *Cohen v General Medical Council [2008] EWHC 581* which requires the panel to considered evidence and submissions that the misconduct found proved (i) is easily remediable, (ii) has already been remedied; and (iii) is highly unlikely to be repeated.

iv) The panel should also consider whether Ms Dibo's fitness to practise is impaired in the sense that a finding of impairment is required to maintain public confidence or proper professional standards. In line with the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Paula Grant [2011] EWHC 927* and *Yeong v GMC [2009] EWHC 1923.*

v) The panel should consider the guidance provided by Social Work England on the meaning of impairment, provided in its Impairment and Sanctions Guidance.

173. Having determined that the proved facts amount to misconduct and the statutory ground of being included on the disclosure and barring service barred list, the panel considered whether Ms Dibo's fitness to practise is currently impaired.

174. The panel had regard to the questions posed by Dame Janet Smith in her fifth Shipman report endorsed in the case of *Council for Healthcare Regulatory Excellence v Nursing and Midwifery Council and Grant [2011] EWHC 927 Admin*. In light of its findings of misconduct the panel concluded that Ms Dibo had, in the past:

i. acted so as to put a member of the public at unwarranted risk of harm;

ii. brought the profession of social work into disrepute;

iii. breached fundamental tenets of the social work profession (in relation to safeguarding the vulnerable).

175. The panel considered that Ms Dibo's misconduct in relation to paragraphs 1 and 2 of the allegation was difficult but not impossible to remediate.

176. While Ms Dibo has referenced within her evidence the difficulties she suffered at work, the panel considered Ms Dibo has not sufficiently acknowledged the potential harm caused to numerous vulnerable child service users by her conduct, nor has she sufficiently addressed the panel on any steps she has taken to prevent such failures re-occurring in the future.

177. While Ms Dibo engaged in the hearing process and was able to articulate certain things that she would do differently, were matters to arise again, the panel considered that both her

current responses to the allegations and her past actions demonstrate a failure to appropriately assess risk. Further, her responses demonstrate a fundamental failure to understand the basic tenets of the Social Work profession.

178. The allegations found proved demonstrate a failure by Ms Dibo to communicate with management and share information appropriately. This in turn led to numerous vulnerable child service users being exposed to a risk of harm. While Ms Dibo has shown remorse for her actions, the panel considered that she has failed to demonstrate within her evidence an appropriate level of insight into the seriousness of the allegations and the potential resulting risks to vulnerable children.

179. The allegations demonstrate a pattern of wrongly prioritising risk, and the panel considered that Ms Dibo perpetuated this pattern in her evidence before the panel. In particular the panel noted Ms Dibo's evidence in respect of building trust in the case of Sibling 1 and Sibling 2. The panel considered that trust building should never have taken precedent over the safety of two vulnerable children. Further, in respect of Person 2, the panel considered Ms Dibo's prioritisation of homelessness was inappropriate given her knowledge of the mother's drug use and lifestyle choices, which were putting her child at serious risk of harm.

180. The panel considered that Ms Dibo has not demonstrated developed insight into her misconduct. The panel considered that during Ms Dibo's evidence she demonstrated that her approach to certain risk assessments, continues to display a flawed understanding of the underlying principles of Social Work.

181. While the panel notes that there is potential for remediation in this case, the panel considered that Ms Dibo's flawed understanding of the underlying principles of Social Work, have hindered her ability to remediate.

182. Further, the panel concluded that Ms Dibo has not sufficiently evidenced remediation, for example a demonstration of any efforts on her part to retrain or address the failings in her practice.

183. The panel has partial information regarding Ms Dibo's previous work history and is aware of her previous good character, which the panel has taken into account. While the panel understands Ms Dibo is currently restricted from working in a social work capacity, the panel considered this did not prevent Ms Dibo from providing evidence to support the fact that has sought to undertake any relevant training or continuing professional development to address the concerns raised.

184. The panel considers that Ms Dibo has made some effort to reflect on her conduct and to some extent has partially acknowledged the impact of her actions. However, based on the above consideration the panel concluded that Ms Dibo has failed to appropriately reflect on the tangible impact of her actions.

185. The panel noted from Ms Dibo's evidence in respect of her reflections, this focused on the mother in respect of the case of Person 2, as opposed to the child. The panel also noted that within her evidence Ms Dibo's failed to acknowledge the real risks to the seven-year-old

child, in respect of the case of Sibling 1 and Sibling 2. Further, in respect of Child 1 and Child 2 the panel considered that there was inadequate acknowledgment by Ms Dibo of the potential harm to a very young child.

186. The panel therefore considered that Ms Dibo had not demonstrated sufficient remediation or insight. Ms Dibo's conduct placed vulnerable child service users at risk of harm. Her misconduct related to failings in her core obligations as a social worker. The panel considered that Ms Dibo's conduct amounted to a breach of a fundamental tenet of the profession. Due to these findings, together with an absence of evidenced remediation and limited insight, the panel concluded that there was a high risk of repetition of the misconduct.

187. The panel was satisfied that a finding of impaired fitness to practise was necessary to protect the public, particularly vulnerable service users. Further, the panel considered that reasonable, well informed, members of the public would be very concerned about Ms Dibo's conduct and the potential consequences of her failings. The panel therefore concluded that a finding of impaired fitness to practise was necessary to maintain and promote public confidence in the social work profession.

188. Given that Ms Dibo's misconduct related to breaches of fundamental tenets of social work, namely the safeguarding of vulnerable service users, the panel was satisfied that professional standards would not be promoted and maintained by a finding that Ms Dibo's fitness to practise is not currently impaired, particularly considering the panel's assessment of limited insight and remediation.

189. The panel therefore concluded that, because of Ms Dibo's misconduct, a finding of impaired fitness to practise was necessary to protect the public, promote and maintain public confidence in the social work profession and declare and uphold proper professional standards.

190. In respect of Ms Dibo's inclusion on the barred list by the Disclosure and Barring Service (DBS), the panel noted the conclusions reached by the DBS as follows;

> *"We understand you have worked/volunteered in a role considered to be "regulated activity" This was as a Social Worker with Leicester City Council. Based on the enclosed information, it appears, on the balance of probabilities, that:*
>
> *Between approximately December 2018 and March 2020, you failed to follow appropriate safeguarding and looked after procedures in relation to a number of children, and failed to communicate significant information to team manager and relevant agencies.*
> *(See Annex A)*
>
> *These initial findings are considered to be relevant conduct in relation to children and vulnerable adults.*

We have concerns about the risk you may pose to children and vulnerable adults in the future. Specifically it appears that you have demonstrated a pattern of irresponsible and reckless behaviour which has previously seen you placed on action plans and despite this, further incidents of failing to report and act on concerns within safeguarding protocols have occurred. It appears that you have failed to notify your Team Leader of concerns and issues, as well as delaying arranging safeguarding meetings which has ultimately resulted in children being left at risk of harm in unsuitable environments. Despite there being interventions including action plans, reduced workload and you being moved to work with an experienced Team Leader, these issues have still continued to arise.

It also appears that you have shown a lack of empathy towards children that you had a responsibility to safeguard. You were reported to appear 'quite blasé' when spoken to regarding a delayed report concerning a young child who had bruising, and you appear to have failed to prioritise this case over other cases you had which were not as time critical. It also appears that you failed to act after witnessing young children out late of an evening. Whilst it does not appear that you have always deliberately shown a lack of empathy whilst in your role, your behaviour has demonstrated that there are concerns regarding your actions in this regard. Whilst it is noted you stated you loved your job and expressed a willingness to undergo additional training, this has not appeared to have resolved the problems arising in the past. As such, it would appear that you fail to understand or consider the potential harm children were left in due to repeated delays and failures on your part.

***[Private]** If you were to work with children again in the future, based on your repeated behaviour over a significant amount of time, the DBS has concerns that there is a significant risk that you would repeat this behaviour which would result in children being left in situations which would leave them at continued risk of harm. As such, it is deemed appropriate for the DBS to consider including you in the Children's Barred List at this time.*

Should you work or volunteer with vulnerable adults at any time in the future, there is no evidence that your behaviour would not transfer to the adult workforce and the same concerns would therefore remain. As such, it is also considered appropriate for the DBS to consider including you in the Adults' Barred List. Consideration has been given to the impact on your human rights should you be barred from working or volunteering with children and vulnerable adults. It is accepted that you have worked as a Social Worker for a number of years and have undertaken a significant amount of training and education to achieve this. Your inclusion in the Barred Lists however would result in you not being able to earn in an area you have experience in, and would also restrict your volunteering with vulnerable groups including children. The safeguarding of children and vulnerable adults must also be considered however, and with the absence of any other safeguards in place to reduce the risk of your repeated behaviour, it is considered that your inclusion in the Children's Barred List and Adults' Barred List would be a proportionate measure to ensure the continued safeguarding of vulnerable groups. Although the incidents did not involve vulnerable adults, we are concerned you may pose a risk to them if you were to engage in regulated activity with them."

191. The panel concluded that whilst Ms Dibo was of previous good character with an unblemished career, it could not be said that her conduct was isolated. In this regard the panel noted its conclusion in respect of Ms Dibo's conduct in respect of multiple child service users, presenting a pattern of a persistent lack of professional curiosity, regarding the risks posed to children.

192. The panel agreed with the conclusions of the DBS that Ms Dibo's actions demonstrated a lack of empathy towards children that she had a responsibility to safeguard.

193. The panel noted its conclusions set out above in respect of risk of repetition and noted that Ms Dibo has demonstrated a fundamental failure to understanding of the basic tenets of the profession. The panel concluded that this in turn presented a risk of harm to members of the public.

194. The panel considered that reasonable, well informed, members of the public would be very concerned about the findings of the DBS in respect of Ms Dibo. The panel therefore concluded that a finding of impaired fitness to practise was necessary to maintain and promote public confidence in the social work profession.

195. Given that Ms Dibo's inclusion on the DBS barring list, the panel was satisfied that professional standards would not be promoted and maintained by a finding that Ms Dibo's fitness to practise in this regard is not currently impaired.

196. The panel therefore concluded that because of Ms Dibo's inclusion on the barring list by the DBS, a finding of impaired fitness to practise was necessary to protect the public, promote and maintain public confidence in the social work profession and declare and uphold proper professional standards.

197. In conclusion, for the above reasons the panel consider that Ms Dibo's fitness to practise is currently impaired on both the personal element and the wider public interest element.

Findings and reasons on sanction:

198. The panel accepted the advice of the legal adviser, that it must again pursue the overarching objective when exercising its functions. The panel must apply the principle of proportionality, balancing Ms Dibo's interests with the public interest. 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 sanctions first before considering more restrictive sanctions. The panel had regard to the Social Work England Impairment and Sanctions Guidance, published in December 2022, together with its determination of grounds and impairment.

199. The panel reminded itself that it had concluded that Ms Dibo's fitness to practise was found to be impaired, due to serious misconduct and due to her inclusion on the barring list by the DBS.

200. In relation to mitigating features, the panel noted that Ms Dibo was of previous good character. The panel also took into consideration that there was evidence at the time that Ms Dibo was ***[Private]***. The panel noted Ms Dibo's engagement with the regulatory process and took into consideration her admissions to the allegations at the outset of the hearing.

201. In respect of the aggravating features, the panel reminded itself of its finding in respect of the steps that Ms Dibo could have taken to seek support. The panel noted its conclusions that Ms Dibo has shown limited insight and remediation. The panel considered that Ms Dibo's remorse focused on the wrong individuals, including the mother in the case of Person 2 and Ms Dibo has not correctly reflected on the impact of her conduct on vulnerable child service users, who were exposed to a risk of harm. The panel noted that Ms Dibo has provided limited character references, testimonial or evidence of continuing professional development or reflection. The panel considered that Ms Dibo had not demonstrated that she had taken any steps to prevent her behaviour re-occurring. The panel considered its previous findings that Ms Dibo through her evidence to the panel has shown a failure to appropriately assess risk or understand the basic tenets of the Social Work profession. On the basis of these findings the panel concluded that Ms Dibo continues to pose a risk of harm to people who use social work services.

202. The panel noted that Ms Dibo's conduct, presented a pattern of a persistent lack of professional curiosity, regarding the risks posed to vulnerable children. This in turn demonstrated a lack of empathy towards children that she had a responsibility to safeguard. The panel considered its previous conclusions that Ms Dibo's evidence in respect of her reflections, failed to acknowledge the real risks to a newborn baby and young and vulnerable children. Throughout her evidence Ms Dibo continued to display a flawed understanding of the underlying principles of Social Work.

203. The panel considered that taking no action, or issuing advice or a warning, would not adequately reflect the serious nature of Ms Dibo's misconduct. These outcomes would not adequately protect the public, as they would not restrict Ms Dibo's practice. The panel has assessed there to be a high risk of repetition, and so considered that the public could not currently be adequately protected unless Ms Dibo's practice is restricted. Further, taking no action, or issuing advice or a warning, would not maintain public confidence in the profession or promote proper professional standards, considering the panel's finding that Ms Dibo exposed vulnerable child service users to a risk of harm.

204. The panel next considered whether a conditions of practice order would be sufficient to protect the public and the wider public interest. The panel, however, noted paragraph 114 of the Impairment and Sanctions Guidance, which states:

114. Conditions of practice may be appropriate in cases where (all of the following):

- *the social worker has demonstrated insight.*
- *the failure or deficiency in practice is capable of being remedied.*
- *appropriate, proportionate, and workable conditions can be put in place*

- *decision makers are confident the social worker can and will comply with the conditions*
- *the social worker does not pose a risk of harm to the public by being in restricted practice*

205. The panel noted the submissions of Mr Lloyd on behalf of Ms Dibo, however in light of the panel's findings in respect of risk of harm and insight the panel considered that conditions of practice were not appropriate.

206. The panel noted that conditions of practice must be appropriate, proportionate, and workable. The panel considered that given the risks identified and the panels conclusions in respect of Ms Dibo's flawed understanding of the underlying principles of Social Work, the level of supervision required to ensure safe practice would be tantamount to a suspension.

207. The panel was satisfied that workable conditions could not be formulated to adequately protect the public. Further, considering the serious misconduct, the panel was satisfied that conditions would not be sufficient to maintain public confidence, or to promote proper professional standards.

208. The panel therefore went on to consider making a suspension order. The panel noted the submissions made by Social Work England and Mr Lloyd in respect of the purpose of a suspension and it failing to secure the public interest. The panel also considered paragraphs 136-138 of the Impairment and Sanctions Guidance, which state as follows:

"136. Suspension is appropriate where (both of the following apply):

- *the decision makers cannot formulate workable conditions to protect the public or the wider public interest*
- *the case falls short of requiring removal from the register (or where removal is not an option)*

137. Suspension may be appropriate where (all of the following):

• the concerns represent a serious breach of the professional standards

• the social worker has demonstrated some insight

• there is evidence to suggest the social worker is willing and able to resolve or remediate their failings

138. Suspension is likely to be unsuitable in circumstances where (both of the following):

• the social worker has not demonstrated any insight and remediation

• there is limited evidence to suggest they are willing (or able) to resolve or remediate their failings"

209. The panel focused its considerations on the appropriateness of a suspension order by reviewing Ms Dibo's insight and ability to remediate.

210. The panel reminded itself of its conclusions that Ms Dibo had failed to demonstrate within her evidence an appropriate level of insight into the seriousness of the allegations and the potential resulting risks to vulnerable children. Further, the panel considered that Ms Dibo demonstrated that her approach to certain risk assessments, continues to display a flawed understanding of the underlying principles of Social Work.

211. The panel noted that limited evidence has been placed before it in respect of remediation. While it may be said that Ms Dibo's engagement suggests a willingness to remediate the panel considered its conclusions that Ms Dibo's flawed understanding of the underlying principles of Social Work, hindered her ability to remediate.

212. The panel considered that despite the passage of time in this case, the responses provided by Ms Dibo in her evidence to the panel demonstrate that she does not possess the requisite skills to be able to resolve or remediate her failings. Further, the panel concluded that given the support that was previously provided by colleagues and Ms Dibo's previous disregard for management instructions, Ms Dibo's failures in understanding the basic tenets of the Social Work profession are unlikely to be remedied.

213. The panel considered the serious misconduct, in which it had found Ms Dibo had placed vulnerable child service users at risk of harm. In particular, the panel considered its findings that Ms Dibo presented a pattern of a persistent lack of professional curiosity and failed to demonstrate empathy towards children that she had a responsibility to safeguard.

214. The panel considered paragraph 149 of the Impairment and Sanctions Guidance, which state as follows:

> *"149. A removal order may be appropriate in cases involving (any of the following):*
>
> *…*
>
> - *persistent lack of insight into the seriousness of their actions or consequences*
> - *social workers who are unwilling and/or unable to remediate (for example, where there is clear evidence that they do not wish to practise as a social worker in the future)"*

215. The panel concluded that Ms Dibo's misconduct in relation to vulnerable child service users was fundamentally incompatible with registration. Ms Dibo has failed to demonstrate appropriate insight in respect of her conduct, and further her evidence and reflections submitted indicate that she does not possess the ability to remediate such conduct.

216. The panel noted that its conclusions in respect of Ms Dibo's misconduct are in line with the findings of the DBS, particularly in respect of the risk of repetition and insight. While the panel is not bound or influenced by the decision of the DBS in respect of its own decision on sanction, this panel note that a Removal Order would be compatible with the decision of the DBS to include Ms Dibo on the Barring list.

217. The panel recognised the impact a removal order would have on Ms Dibo and took this into account. However, it considered the public interest outweighed Ms Dibo's interests. The panel therefore concluded that the only sanction which achieved the aim of public protection in all three limbs was a removal order, with no lesser sanction being sufficient.

Interim Order

218. In light of its findings on sanction, the panel next considered an application by Ms Atkin for an Interim Suspension Order to cover the appeal period before the final order becomes effective.

219. Ms Atkin submitted that, in view of the panel having made a removal order, an interim order would be appropriate to protect the public and the wider public interest. She submitted that an interim order was necessary because the panel had directed the removal of Ms Dibo's name from the register, and in the event that there might be an appeal. Due to the time any appeal might take to resolve, Ms Atkin submitted that the interim order should be imposed for 18 months.

220. Mr Lloyd opposed the application. He noted that the order was not necessary for the protection of the public, on the basis that Ms Dibo was already suspended by the DBS. He stated such an order would therefore only serve public interest. Mr Lloyd noted the case of SWE v Sobrany [2024] EWCA 67 (Admin) and referred to the need for scrutiny in respect of the proportionality of the length of the order sought.

221. Ms Atkin responded to Mr Lloyd and noted that the case of SWE v Sobrany [2024] EWCA 67 (Admin) related to an interim order imposed prior to a final hearing and did not relate to a case under paragraph 11(1)(b). In respect of necessity, she submitted that SWE have no control over the DBS barred list.

222. Ms Atkin noted that Ms Dibo was currently subject to an interim order under Schedule 2 8(1) of The Social Workers Regulations 2018. The order is due to expire in September 2024. Ms Atkin submitted that there was no reason for both orders to continue, and invited the panel to consider, subject to Ms Dibo's agreement, if she waived notice, to revoking that order.

223. Mr Lloyd noted that he made no criticism of Ms Atkin's application he submitted however that the vast majority of appeals are dealt within 6 months. He stated that directions could also be agreed to include an extension of an interim order. Mr Lloyd stated he was not prepared to waive notice, in the absence of instructions and he was not willing to seek such instructions. He therefore stated the panel could not revoke the Schedule 2 8 (1) interim order.

224. The panel was advised that it had power to make any interim order if it considered this necessary to protect the public, or in the best interests of the social worker. The panel was mindful of its earlier findings. The panel decided that it would be wholly incompatible with those earlier findings to not protect the public with an interim order to cover the appeal period, or the period until any appeal is resolved. Social Work England has no control over any decision made by the DBS and therefore the panel decided that its own interim order was necessary for the purposes of public protection.

225. The panel was mindful that it could make any interim order. It considered that, in light of its findings, it was necessary to make an Interim Suspension Order. Since any appeal, if made, might take some time to resolve, the panel decided to make the Interim Suspension Order for 12 months.

226. Accordingly, the panel concluded that an Interim Suspension Order is necessary for the protection of the public. When the appeal period expires, this interim order will come to an end unless an appeal has been filed with the High Court. If there is no appeal, the final order of a removal order shall take effect when the appeal period expires.

Right of appeal

227. 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.

228. 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.

229. 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.

230. This notice is served in accordance with Rules 44 and 45 of the Social Work England Fitness to Practise Rules 2019 (as amended).

Review of final orders:

231. 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

232. 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:

233. 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.