Social worker: Antonio Carlos Alcario Valente
Registration number: SW36661
Fitness to Practise
Final Hearing

Dates of hearing: 29 August 2023 to 4 September 2023 and 15 July 2024 to 18 July 2024

Hearing venue: Remote hearing

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

Interim order: Interim conditions of practice order (18 months)

Introduction and attendees:

1. This is a hearing held under Part 5 of The Social Workers Regulations 2018 (as amended) ("the regulations").
2. Mr Valente attended the hearing and represented himself.
3. Social Work England was represented by Ms Taggart case presenter instructed by Capsticks LLP.

Adjudicators	**Role**
Lesley White	Chair
Christine Moody	Social worker adjudicator
Janice Beards	Lay adjudicator

Tom Stoker	Hearings officer
Jo Cooper/Andrew Brown	Hearings support officer
Helen Gower	Legal adviser

Allegation:

While registered as a social worker and employed by Lambeth London Borough Council:

1. ***Between 10 April 2018 and 18 April 2019 while allocated the case of Child R and Child J, you failed to recognise risk and/ or take the appropriate action necessary to safeguard Child R and/ or Child J in that you:***
   - ***a) Did not carry out regular Child in Need visits within the required timescales;***
   - ***b) Did not investigate safeguarding concerns as required and/ or as instructed promptly, or at all, when:***
     - ***i) On 20 September 2018, Person A was admitted to hospital due to her deteriorating health and self-discharged the following day without treatment.***
     - ***ii) In October 2018, it was reported that Person A had disclosed that she had been the victim of domestic abuse perpetrated by Person B.***
2. ***On or around 13 January 2020 you failed to recognise risk and/ or take the appropriate action necessary to safeguard Child R and/ or Child J in that you failed to identify who was in charge of Child R and/ or Child J and/or failed to assess Person A's fitness to care for Child R and/ or Child J by:***

a) **Leaving the family home without ensuring that there was an appropriate adult to care for Child R; and/ or**

b) **Not taking action to gain access to the family home when Person A refused to come to the door and refused access;**

3. ***You failed to complete relevant assessments as required and/ or as instructed, on the following occasions:***
    a. ***On or around 11 March 2019, when you did not complete a Child and Family assessment in relation to Child R and/ or Child J.***
    b. ***On or around 30 December 2019, when you did not complete a Child and Family assessment in relation to Child R and/ or Child J.***

Your conduct at paragraphs 1 and/ or 2 and/ or 3 amounts to the statutory grounds of misconduct and/ or lack of competence or capability.

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

Admissions:

4. 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.

5. Following the reading of the allegations the panel Chair asked Mr Valente whether he admitted any of the allegations. Mr Valente stated that he did not make any admissions.

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

Background

7. On 31 January 2020, Social Work England received a self-referral from Mr Valente following his suspension from work on 20 January 2020.

8. Mr Valente was employed in the Family Support and Child Protection team as a social worker by The London Borough of Lambeth Council ("the Council"). Mr Valente initially began working for the Council in 2007 as a social worker before moving to a Family Support Worker role in 2010. Around 2013/2014 Mr Valente returned to his role as a social worker.

9. On 20 January 2020 Mr Valente was suspended from work pending full investigation into allegations that on more than one occasion, he was negligent in the course of his duty regarding children R and J ('the Family')

10. Mr Valente was allocated the Family on or around 10 April 2018. The Family consisted of two children, Child R, a 4 year old girl and Child J, a 13 year old girl who was the cousin of Child R. The children lived with Child R's mother ('Person A') and father ('Person B').

11. When the case was allocated to Mr Valente, the Family was supported under a Child in Need ('CIN') plan due to concerns surrounding Person A. The concerns related to Person A's alcohol misuse which led to safeguarding issues in respect of Child R in particular. The case was closed on 18 April 2019. The case was then reopened on 17 July 2019 following a referral from Child R's school.

12. The school for Child R reported further concerns about Child R's wellbeing on 10 January 2020. The Social Worker carried out a visit to the family home on 13 January 2020, and he saw Child R, who was 5 years old at the time, at the front door. Person A was said by Child R to be upstairs and was refusing to come down to the door. Mr Valente handed a letter to Child R and left the property.

13. Social Work England alleges that the Social Worker failed to recognise the risk and failed to take appropriate action to safeguard the Family during the time in which the Family were allocated to the Social Worker.

14. The investigation by the Council related to the incident arising from 13 January 2020, however further concerns were raised by the Social Worker's manager, Audrey Barrett, about the Social Worker's visits and the frequency of the same. Since the referral to Social Work England, further issues had come to light in that Mr Valente allegedly failed on two occasions to complete Child and Family assessments as required. Mr Valente also allegedly failed to follow up on safeguarding issues that arose in autumn 2018, namely Person A's medical treatment and disclosures regarding domestic violence.

Summary of evidence:

Social Work England

15. Social Work England relied on the evidence of Mr Luma together with the exhibits contained in the exhibits bundle. Social Work England also relied on the statement of Ms Heritage. A decision had been made by a different panel of adjudicators to admit Ms Heritage's statement as hearsay evidence. Ms Heritage was Mr Valente's line manager from June 2017 until an unknown date after March 2019. Ms Heritage exhibited the supervision records included in the bundle, but stated that she has no recollection of those discussions.

16. At the time of Mr Luma's involvement in Mr Valente's case, his role at the Council was the Fostering and Permanency Service Manager. Mr Luma conducted an investigation into the events that led to Mr Valente's suspension. Those events were Mr Valente's

attempted visit to the Family on 13 January 2020. Mr Luma's investigation did not extend to the concerns in particulars 1 or 3 of the Allegation. He did not carry out any investigation into Mr Valente's caseload such as the type, complexity or number of cases Mr Valente held either at the time of the incident in January 2020, or at any other time. Mr Luma's evidence relating to events outside the scope of his investigation was based on his review and opinion based on the documentary evidence. He was unable to comment on the level of management support provided to Mr Valente.

17. In answer to cross-examination questions from Mr Valente, Mr Luma agreed that the Council's child protection procedures included a requirement for Child in Need review meetings every three months and that records of the meetings should be on the Council's recording system. Mr Luma also agreed that the Child in Need Reviews would be an important source of information for an investigation. There would also usually be a written record of a review with other professionals carried out prior to a decision to close a case. Mr Luma also agreed with Mr Valente that there are procedures within the Council to address capability issues and this might include social workers who are behind in carrying out visits to service users. He stated that issues relating to Mr Valente's performance would be contained in the records of personal supervision, which differ from the records of case supervision which are contained in the service users' files, none of which he had seen.

18. In his oral evidence Mr Luma described that in his opinion the risks relating to the Family were high and that there had been missed opportunities to escalate the case. He highlighted incidents where the mother had passed out on the pavement, a fire incident in the home where Child R and her mother were admitted to hospital, and concerns about domestic violence. The process of escalating the case to a Child Protection Plan would involve a strategy discussion and Section 47 investigation, leading to a Child Protection case conference.

19. In cross-examination Mr Valente challenged Mr Luma's description that there was a fire incident, suggesting that the house had filled with smoke because Person A had fallen asleep when cooking. In response Mr Luma referred to Mr Valente's record of his visit to the Family after the incident. Mr Valente recorded that Person A "*nearly caused a fire in the house due to being intoxicated*" and that "*London Fire Brigade went into the small living room opposite the kitchen, they found child's mother and she and the Child R laying on the sofa and that she seemed oblivious that the flat was filled with smoke with the fire alarm still going off. The London Fire Brigade explained that they had concerns as child's mother appeared very drunk, oblivious to what was happening."* Mr Luma acknowledged that there was no blaze, but there was clearly smoke, and his interpretation was that there was a fire.

20. Mr Valente also challenged Mr Luma's description that Person A collapsed several times. He suggested that there was only one occasion when Person A collapsed when she was found by a member of the public on the floor outside a block of flats in September 2019. In response Mr Luma referred to a record of another incident on 4 December 2019 when a report was received from school stating that Person A had

collapsed around the corner from the school. Mr Valente referred Mr Luma to a police report dated 3 February 2020 , which described in relation to the 4 December 2019 incident that Person A was "*sitting in the middle of the road*". In response Mr Luma explained that the relevant concern was that Person A was due to be collecting her five year old daughter, but was intoxicated and not in a fit state to be looking after a child. In his references to Person A having "collapsed" Mr Luma told the panel he was intending to indicate that Person A was in a drunken state.

21. In respect of visits Mr Luma described the minimum requirement to visit was at least every six weeks, but more frequent visits may be required depending on the presenting risks. Mr Luma was referred to documents in the bundle and he explained the Mosaic system for recording visits and the workflow system.

22. In respect of the incident on 13 January 2020 when Child R answered the door to Mr Valente, Mr Luma described the context. He said that concerns had been raised by Child R's school on 10 January 2020 that the mother's partner was travelling abroad and that Child J may be left in charge of Child R and Child R was not in school. There were concerns about Person A's misuse of alcohol as there was information that Person A had previously consumed alcohol to the point that she collapsed or had not been alert, and there had also been the incident of a potential fire in the family home. There was information to indicate that Child R could be subject to harm as a result of lack of parental supervision or parental supervision impaired by alcohol intoxication. Child R opened the door and said that Person A was upstairs. Mr Valente asked Child R to speak to Person A and ask her to come down. Child R then informed Mr Valente that her mother did not want to come down.

23. In Mr Luma's opinion it was not sufficient from a social work perspective for Mr Valente to give a letter to Child R and leave the house without establishing Person A's state of mind or presence. Mr Luma could not understand Mr Valente's thinking or judgment in his decision to leave the house. If Mr Valente thought that he did not have the power to enter the house he could have asked for police assistance, contacted his manager, or telephoned the out of hours team for advice. In Mr Luma's opinion Mr Valente did not exercise care and attention and failed to safeguard Child R. In Mr Luma's opinion it was "*lucky*" that there was no harm to Child R, and that it could have been catastrophic.

24. Mr Luma described the scope of a Child and Family Assessment. Such assessments would include an assessment of the parenting capacity, information from partner agencies, and information from visits. The assessment would inform the plan for the child and the level of intervention required. The timescale for completing a Child and Family Assessment is a maximum of 45 working days from the contact that prompted the requirement for an assessment. In Mr Luma's opinion he would have expected that Mr Valente would have been able to complete an assessment in less than 45 working days given the history of the case and Mr Valente's knowledge of the family.

Mr Valente

25. The Panel permitted Mr Valente to rely on two additional documents a police case conference report dated 3 February 2020, and a record of a "*ten day review*" dated 30 December 2019 which recorded that Mr Valente's manager instructed him to continue with the Child and Family assessment for the Family.

26. Mr Valente gave evidence to the panel. He described the background that he was allocated the case of the Family in April 2018. He stated that Person A did not neglect or abuse the children while he was the allocated social worker. The children were well-cared for by both parents and were happy and content. In cross-examination Mr Valente agreed that in the past, prior to his involvement, Person A had been convicted of child neglect. He also accepted that there were occasions when Person A was not taking the children to school, that Child R had been admitted to hospital for smoke inhalation, and that if Person A was intoxicated she posed a risk to the children. When pressed in cross-examination, Mr Valente agreed that the incident when Child R was admitted for smoke inhalation was very serious, but he was unable to comment on whether Child R could have died or been seriously injured because he is not a health professional.

27. There were some suggestions that domestic violence had occurred which Mr Valente said he investigated and found no evidence to support. His view was that the central concern was Person A's drinking problem, which might cause an accident or injury to the children. Mr Valente described that there were protective factors which reduced the risks, including the influence of Child R's father, school staff, and Person A's probation officer. Following incidents on 4 October 2018 when Person A was found drunk on the street and on 25 November 2018 when the Fire Brigade attended the smoke incident, safety measures were put in place. In February 2019 a case review took place with other professionals, and there was agreement that there were at that time no concerns about the children's safety and wellbeing. A decision was therefore made to close the case, with the agreement of the team manager and head of services.

28. Mr Valente agreed that Child in Need visits should take place at least every six weeks. He admitted that there were gaps in the home visits he had carried out to the Family. However, he said that he had carried out visits to the best of his ability. He had not failed to recognise the risks, but there were other reasons for the delay. He had prioritised other cases in his case load, particularly six demanding Child Protection cases, which he assessed as higher risks. He said that he had classified the Family's case as medium risk, and that his manager had agreed with this assessment. If the risk had been high, it would have been escalated to a Child Protection case. There were, Mr Valente acknowledged, some delays in home visits for some of his Child in Need cases. For the Family there were also some cancellations of visits and the family travelled abroad on two occasions. In Mr Valente's opinion, his home visits had no influence on the issue of Person A drinking and the consequent potential risks to the children. In his view, it was the involvement of social services with the Family that was a controlling

influence. He did consider that it was important that visits should be up to date for various reasons, including to enable the children to feel safe.

29. Mr Valente told the panel that his manager knew the reason for the delays in his visits. He said that he spoke to her on many occasions in supervision. His manager was aware of all the cases and his difficulties. He said that he also spoke to the Service Manager about his caseload and requested that he should not be allocated more complex youth justice cases.

30. In cross-examination Mr Valente accepted that there was a discussion with his manager on 1 August 2019 and that he was advised "*Social worker to ensure future visits are booked to ensure that there is no gap.".* Mr Valente stated that he did book visits, but that sometimes the plan had to change because of other priorities. Mr Valente was asked about a gap between a visit on 8 August 2018 and 9 October 2018, despite incidents that had occurred, as documented in the records, on 20 September 2018 and 4 October 2018.

31. In relation to safeguarding concerns arising from Person A's admission to hospital on 20 September 2018 and her decision to discharge herself without treatment, Mr Valente said that he decided that it was most appropriate to monitor the situation rather than to escalate the case or start a new assessment. He spoke to Person A on 9 October 2018 who informed him that she had been to see the GP and had been prescribed iron tablets.

32. In relation to the concerns about domestic violence, Mr Valente said that he did follow up this concern which arose from an incident on 4 October 2018 when Person A had been taken to hospital by an ambulance crew. He spoke to Person A, who denied that she had been subject to any form of abuse, and he also spoke to a worker from GAIA, a domestic violence support agency. Mr Valente also explained that although the documents suggested that there was a second referral by the Independent Domestic Violence Advisor (IDVA), he had identified that this referral, one month later, arose from the incident on 4 October 2018.

33. Mr Valente explained that in respect of visits following the Fire Brigade incident in November 2018 he had made his own record on 14 December 2018 that as part of the safety plan more frequent visits should be carried out until the police investigation had been completed. However, there was no timeframe, and having reviewed the case with his manager, it was agreed that it was safe to revert back to the standard requirement for home visits.

34. Looking back now at the events on 13 January 2020, Mr Valente accepted that when he attempted to visit the Family he should not have left the home without taking further action, and that he would now do things differently. He said that he had accepted the criticism of his actions and referred himself to Social Work England. However, he denied that he failed to recognise risk, or failed to identify who was in charge of the children. Child J was at school and he had inferred that Person A was present and that she was alert from Child R's behaviour. Mr Valente noted that Child R seemed well and

happy and therefore felt that there was no requirement to contact the police or the office. He said that his rationale at the time of the events was his assessment that the children's safety was not compromised.

35. In cross-examination Mr Valente accepted that when he attended at the house on 13 January 2020 Person A was probably drunk and that consequently Child R was not safe. He said that he was completely "*blanked out*" and that at the time of his visit he had no recollection of the issues of alcohol abuse and the history of incidents involving the Family. On that day he said that he also had no recollection of the referral that had prompted his visit which involved a report that Child J had told her friends that Person A drinks excessively that that Child R's father was going away on 12 January 2020, leaving Child J in charge of caring for Child R.

36. In respect of the alleged failure to complete a Child and Family Assessment on or around 11 March 2019, Mr Valente stated that he was asked to update the Child and Family Assessment on 11 March 2019. He believed that he did complete the assessment and that if he had not done so, it would have been raised as a performance issue.

37. In cross-examination Mr Valente said that he remembered that he had started the assessment, but that if the work was not on the system this was because he was instructed to delete incomplete assessments because an inspection was coming up. He said that he sat down with a list of cases with a colleague and deleted various outstanding work tasks, as instructed by senior management.

38. Mr Valente agreed that he had not completed the Child and Family Assessment that was required after the referral on 4 December 2019, but that this was because he was suspended on 20 January 2020. He drew the attention of the panel to a document completed by his manager on 30 December 2019 in which he was instructed to continue the assessment to demonstrate that he was in the process of carrying it out.

Finding and reasons on facts:

39. The Panel heard submissions from Ms Taggart on behalf of Social Work England and from Mr Valente.

40. The Panel heard and accepted the advice of the legal adviser in respect of the approach to take in determining findings of facts and the burden and standard of proof. The burden of proof rests on Social Work England and it is for Social Work England to prove the Allegation.

41. The panel's assessment of the evidence was nuanced. It gave weight to the contemporaneous documentary records, but it also noted the limited material available which recorded Mr Valente's interactions with his managers. For example, there were no records of personal supervision meetings. There was also no documentation in relation to any assessment, or Child in Need meeting prior the closure of the Family's case in April 2019, despite documentation indicating that a Child in Need meeting had been arranged.

42. The panel considered what weight it should give to Ms Heritage's statement. It decided that it could be given very little weight as Ms Heritage was not present to allow her evidence to be challenged. In any event, Ms Heritage said in her written statement that she had no independent recollection of the details of the discussions in supervision.

43. The panel considered carefully the weight that it should give to Mr Luma's opinion evidence noting that it was not the opinion of an expert witness. The Panel gave the opinion evidence some weight, but it bore in mind that Mr Luma's involvement was limited to the investigation of the incident on 13 January 2020. His other comments and opinion were based on a review of the documents as part of his witness statement prepared for this case.

44. The panel noted that there was no evidence that any performance issues were raised with Mr Valente prior to the incident on 13 January 2020 by his line managers.

Particular 1(a)

Between 10 April 2018 and 18 April 2019 while allocated the case of Child R and Child J, you failed to recognise risk and/ or take the appropriate action necessary to safeguard Child R and/ or Child J in that you:

Did not carry out regular Child in Need visits within the required timescales;

45. The required timescale for Mr Valente to carry out visits to the Family was a minimum of every six weeks. This was agreed as the minimum requirement by Mr Valente in his evidence. His understanding was that visits were required every 4-6 weeks.

46. The documents record the following chronology in respect of Mr Valente's visits to the Family:

- Family allocated to Mr Valente 10 April 2018
- Case discussion with previous Social Worker 1 May 2018
- Visit 1 June 2018
- Visit 8 August 2018
- Visit 9 October 2018
- Visit 26 November 2018
- Visit 28 November 2018
- Visit 6 December 2018
- Visit 14 December 2018
- Visit 15 February 2019
- Visit 4 April 2019

47. Mr Valente did not visit the Family every six weeks, and there was one gap of more than 9 weeks, and two of more than 8 weeks. Mr Valente agreed that he had not carried out the visits within the required timescales.

48. Mr Valente described the case as one of medium risk although Mr Luma said he would have regarded the case as possibly requiring escalation to the higher intervention of Child Protection.

49. Child R and Child J were vulnerable to neglect due to the risk that Person A might not be able to care for them when intoxicated. In cross-examination Mr Valente agreed that there had been instances of neglect, such as the incident when the Fire Brigade were called to the home. The panel decided there was a responsibility on Mr Valente to take appropriate steps to safeguard Child R and Child J, which included taking the minimum steps required for visiting a child in need. The responsibility applied even if Mr Valente believed that visiting the Family would not be effective in reducing the risk that Person A would consume alcohol to excess.

50. The panel therefore found that Mr Valente had not taken appropriate action to safeguard Child R and Child J.

51. In respect of the recognition of risk, the panel accepted the evidence of Mr Valente that he had recognised risks for the Family, and that his failure to visit did not indicate that he had not recognised risks. Mr Luma's investigation had not included Mr Valente's visits to the family during the period relating to this particular of the allegation and there was no information available about Mr Valente's workload between April 2018 and April 2019, other than Mr Valente's evidence. There was also no information from Mr Valente's line manager about the relative risks of the other cases in his caseload, or whether there were any discussions about prioritisation. Other than one supervision note, which advised Mr Valente to ensure that the visits were booked, there were no relevant supervision notes. Documents showed that the Family's case was closed by a practice manager on 18 April 2019 and there was no evidence of any concerns about the inadequacy of visits.

52. Although Mr Luma's opinion was that the risks were high to the extent that the case should have been escalated to a higher level of intervention, there was evidence to support Mr Valente's assessment of the risk as "medium". For example, Mr Valente's records of his visits generally described the Family in a stable situation with appropriate care being given to the children. It was clear, based on the decision of the manager on 18 April 2019 that the risks had reduced to a level where the case could be closed. The possibility of closing the case had been flagged in earlier supervision discussions.

53. The panel accepted Mr Valente's evidence that he had considered the risk, but decided to give higher priority to other cases in his caseload. He described that he was responsible for six complex Child Protection cases and that consequently there were delays in visits in some of his Child in Need cases. He said in his written response to the allegation "*I had six child protection cases that were extremely demanding. These cases were about young people selling drugs on the streets. Three of those young*

people were victims of knife crime, and two others were offenders themselves. I also had two other demanding cases about two girls who were repeatedly going missing from home." He said that his line manager was aware that he was not compliant with the required timescales for all the cases in his caseload and had not asked him to adjust his priorities. Despite the repeated failure to meet the requirement for visits, Mr Valente's manager did not address this issue through the capability or conduct process.

54. The panel noted that Mr Valente had responded to new information which increased the level of risk. Following the incident on 25 November 2018 when the Fire Brigade were called to the house Mr Valente increased the frequency of his visits, until he was satisfied that the risks had been reduced. Although Mr Valente did not describe the risks for Family A in the same way as Mr Luma, the panel found that he had recognised that there were risks.

55. The panel therefore found particular 1(a) partly proved. Mr Valente had failed to take the appropriate action to safeguard Child R and Child J because he did not carry out visits within the required timescales.

Particular 1(b)(i)

1. Between 10 April 2018 and 18 April 2019 while allocated the case of Child R and Child J, you failed to recognise risk and/ or take the appropriate action necessary to safeguard Child R and/ or Child J in that you:

b. Did not investigate safeguarding concerns as required and/ or as instructed promptly, or at all, when:

(i) On 20 September 2018, Person A was admitted to hospital due to her deteriorating health and self-discharged the following day without treatment.

56. The documentation in the bundle included a note of a telephone call from a staff nurse on 21 September 2018 with a message that Person A had presented at hospital the previous day in a confused state. Following investigations, it had been identified that Person A required a blood transfusion, but Person A had discharged herself from hospital on 21 September 2018. The message included the following: "*there is a strong possibility of [Person A] collapsing again if she does not return to hospital"*. The panel decided that the risk Person A might collapse again was a safeguarding concern that required investigation. The panel drew an inference that this notification came to Mr Valente's attention soon after the note was made because he was the responsible social worker for the Family and there was no suggestion that he was not attending to his duties at the relevant time.

57. On 3 October 2018 a note of a supervision discussion between Mr Valente and Ms Heritage noted the incident when Person A had attended the hospital and identified the

risk of a relapse in Person A's health. Mr Valente was instructed to follow up if Person A had received treatment.

58. On 9 October 2018 Mr Valente visited the Family home and spoke to Person A. The discussion included Person A's admission to hospital. Person A stated that she had been diagnosed as anaemic and told that she would need a blood transfusion, but until that happened she had been prescribed iron supplements and vitamins by her GP.

59. The panel found that by making the enquiries on 9 October 2018 Mr Valente had investigated the safeguarding concerns and had acted on his manager's instruction promptly. He had arranged and completed the visit within a week.

60. However, the investigation carried out by Mr Valente was not "as required". The panel found that the delay of approximately twenty days between the notification on 21 September 2018 and the visit on 9 October 2018 was too long, given the nature of the concern, and the information that there was a strong possibility that Person A could collapse again. The panel found that Mr Valente had visited Person A and spoken to her about her health in response to the management instruction, rather than in response to the information from the hospital.

61. The urgency was apparent from the nature of the concern, given the information that Person A could "*collapse again*". There was no explanation from Mr Valente for the delay, and the panel found that he had failed to recognise the risk and take appropriate action.

62. Ms Taggart referred the panel to another management instruction in a supervision discussion on 11 March 2019. This included the following task "*Sw to follow up if [Person A] has received treatment – NOT COMPLETE, SW needs to check with the hospital*"

63. The panel noted that this instruction was approximately five months after the incident in question. There was no evidence from Ms Heritage to explain this instruction, its relevance, or the extent to which this remained an outstanding safeguarding concern at that date and the case was closed soon after. Social Work England has not proved that any failure to comply with this instruction amounted to a failure by Mr Valente to recognise risk or take appropriate action.

64. The panel therefore found particular b(i) proved on the basis that Mr Valente failed to recognise risk and take the appropriate actions necessary to safeguard Child R and Child J. He did investigate the safeguarding concern *"as instructed"*, but he did not investigate the concern "*as required"* because of the extent of the delay between 21 September 2018 and 9 October 2018.

Particular 1(b)(ii)

1. ***Between 10 April 2018 and 18 April 2019 while allocated the case of Child R and Child J, you failed to recognise risk and/ or take the appropriate action necessary to safeguard Child R and/ or Child J in that you:***

b. Did not investigate safeguarding concerns as required and/ or as instructed promptly, or at all, when:

ii) In October 2018, it was reported that Person A had disclosed that she had been the victim of domestic abuse perpetrated by Person B.

65. The panel noted the content of the case record made by Mr Valente on 26 October 2018:

"On 4/10/18 [Person A] was taken to hospital. She was intoxicated. She reported to the ambulance crew that [Person B] had assaulted her. The Sw spoke to her about this. She indicated that she did not remember said this [sic] to the ambulance crew. She said that there is no violence from [Person B]. She admitted to being drunk. She indicated that she is anaemic and she was too weak when she drunk [sic] that she passed out. [Person A] will need a blood transfusion.

[Person A] denied that Dv [sic] happened. We have no evidence at present to suggest that this is happening. However, it is possible that [Person A] was not being completely honest. The member of the network will remain vigilant and will share any concerns.

Analysis:

Based on my discussions with the children, with the members of the network, the possibility of a relapse from [Person A] is still a concern. [Person A] has not disclosed any DV incidents perpetrated against her from [Person B], but I am not sure if she is being honest about this. So I'm worried that DV could be happening but Person A does not disclose it. For now, the members of the network will remain vigilant and report any concerns."

66. Mr Valente had investigated the report of domestic abuse, and had found no evidence to support it. He had made a written record of his action and his reflections, which included the need to remain vigilant, and he had involved other members of the network, including the children's schools. In his oral evidence Mr Luma was invited to review this written record made by Mr Valente, and he agreed that Mr Valente's approach was appropriate.

67. In her submissions Ms Taggart suggested that Mr Valente might have taken further investigative steps such as contacting neighbours. In his evidence Mr Valente explained that he had no previous contact with Person A's neighbours and that it would be inappropriate to contact them. There was no evidence that Ms Heritage suggested that Mr Valente should speak to neighbours.

68. The panel noted that the police had also investigated the indirect report of domestic violence and had similarly found no evidence to support it.

69. On 30 October 2018, Ms Heritage recorded that new information had been received from the Independent Domestic Violence Advisor (IDVA), and described this as a "*second referral*". She instructed Mr Valente to follow this up.

70. Mr Valente told the panel that he had promptly followed up this instruction and had spoken to the GAIA worker. When he did so it became apparent that the information reported to the IDVA was the same information he had already investigated arising from the incident on 4 October 2018. There was therefore nothing new to investigate. There was no further management instruction from Ms Heritage, which indicates that the matter had been resolved. The panel accepted Mr Valente's evidence.

71. The panel found particular 1(b)(ii) not proved.

Particular 2

2. On or around 13 January 2020 you failed to recognise risk and/ or take the appropriate action necessary to safeguard Child R and/ or Child J in that you failed to identify who was in charge of Child R and/ or Child J and/or failed to assess Person A's fitness to care for Child R and/ or Child J by:

a) Leaving the family home without ensuring that there was an appropriate adult to care for Child R; and/ or

b) Not taking action to gain access to the family home when Person A refused to come to the door and refused access;

72. It is agreed that Person A refused Mr Valente's request that she should come to the door and, as the only responsible adult in the house, implicitly she refused access to the home. Child R was in the family home. Child J was at school, but was shortly due to return to the home after school. Mr Valente knew that Person B was abroad. Therefore, Person A would be the carer for Child J on their return from school.

73. Mr Valente accepts that he did not take action to gain access to the family home and that he left the home without taking further action that day other than leaving a letter with Child R to be handed to Person A. Mr Valente also agreed in his oral evidence that Person A may have been intoxicated and if so, she was not an appropriate adult to care for a five year old child, Child R.

74. Mr Valente inferred that Person A was in the home and responsible for Child R from Child R's behaviour. However, given his knowledge of Person A's history, he could not have been confident that Person A was well enough to do so. He did not see Person A and had insufficient information to assess whether or not she was fit to care for Child R or Child J when they returned from school.

75. Mr Valente stated that he identified that Person A was in charge of Child R and that Child J was at school. However, in respect of Child R, this was a presumption, based on his interaction with Child R. He said he concentrated his assessment of Child R as

being well-dressed, clean and happy. The panel decided that on his own evidence, his mind was "*blanked out"* and he gave no thought to the history of the family, or the risks that might arise if Person A were to be intoxicated. He was not in a position to make any assessment of Person A's fitness to care for Child R because he did not see Person A.

76. Although Mr Valente disputed that there was any risk to the children, the panel preferred the opinion of Mr Luma that there were clearly identifiable risks. Child R was a five year old child who was not at an age where she could care for herself. If Person A was intoxicated, there was a risk of neglect and the risk that the childrens' safety could be compromised. The risk is exemplified by the incident on 25 November 2018 when the fire brigade were called to the family home.

77. The panel found particular 2(a) proved. Mr Valente left the home without ensuring that there was an appropriate adult to care for Child R. In doing so he failed to identify who was in charge of Child R and failed to assess Person A's fitness to care for Child R and Child J.

78. The panel found particular 2(b) proved. Mr Valente did not take action when Person A refused to come to the door and refused access. Mr Valente failed to identify who was in charge of Child R and failed to assess Person A's fitness to care for Child R and Child J.

79. For both particulars 2a and 2b the panel found that Mr Valente failed to recognise risk and take the appropriate action to safeguard Child R and Child J.

Particular 3(a)

3. You failed to complete relevant assessments as required and/ or as instructed, on the following occasions:

a. On or around 11 March 2019, when you did not complete a Child and Family assessment in relation to Child R and/ or Child J.

80. On 11 March 2019 Mr Valente was given an instruction by his manager, Ms Heritage, that he should *"urgently update C & F assessment within 2 weeks."*. However, the case was closed in April 2019, but when it was subsequently reviewed the most recent Child and Family Assessment was 2018.

81. Mr Valente's written response to Social Work England included the following response to this allegation: "*I am not sure about this one. I think that then I had not completed the assessment when the senior management decided to close the case. The episode for assessment was subsequently deleted. I will see if I have the emails instructions for case closure and I will forward them over to you*".

82. In oral evidence Mr Valente gave a detailed account explaining why he thought that he had carried out work, but that it was deleted on the instructions of senior management in connection with a forthcoming inspection.

83. The panel decided that even if work had been deleted, it was more likely than not that this was ongoing or outstanding work, and Mr Valente had not completed the assessment. The completion of the assessment would have required his manager's signature and Mr Valente did not suggest that this had taken place.

84. The panel noted that a decision was made by a manager to close the Family's case without the completed assessment and that there is no evidence that Ms Heritage or another manager took any action in relation to the outstanding task.

85. The panel therefore found particular 3(a) proved.

3. You failed to complete relevant assessments as required and/ or as instructed, on the following occasions:

b. On or around 30 December 2019, when you did not complete a Child and Family assessment in relation to Child R and/ or Child J.

86. The relevant referral which prompted the need for a Child and Family assessment was dated 6 December 2019 and the required timescale was that the assessment should be completed in 45 working days from that date.

87. Mr Valente had not completed the assessment by the date he was suspended on 20 January. However, at that date the 45 working days had not expired. More than ten working days remained for Mr Valente to complete the assessment.

88. Mr Valente was given an instruction by his manager to complete the assessment on or around 30 December 2019. However, this instruction did not change the timescale within which Mr Valente was to complete the assessment.

89. The panel therefore found particular 3(b) not proved

Notice of reconvened hearing:

90. Ms Taggart referred the panel to documents in the service bundle for the reconvened hearing and submitted that good service of the notice of hearing had been effected.

91. The panel of adjudicators had careful regard to the documents contained in the service bundle as follows:

- A copy of the notice of the reconvened final hearing dated 31 October 2023 and addressed to Mr Valente at his email address which he provided to Social Work England;

- A copy of a signed statement of service, on behalf of Social Work England, confirming that on 31 October 2023 the writer sent the notice of hearing and related documents by ordinary email to Mr Valente at the address referred to above.

92. The panel accepted the advice of the legal adviser in relation to service of notice.

93. Having had regard to all of the information before it in relation to the service of notice, the panel was satisfied that notice of this hearing had been served on Mr Valente in accordance with Rules 14, 44 and 45 of Social Work England (Fitness to Practise) Rules (as amended) ("the Rules").

Proceeding in the absence of Mr Valente:

94. Ms Taggart submitted that the panel should proceed with the hearing in Mr Valente's absence. She referred to recent correspondence with Mr Valente and submitted that it would be fair and appropriate to proceed with the hearing and conclude the case expeditiously.

95. The panel received no information to suggest that Mr Valente had responded to the notice of hearing sent on 31 October 2023, but he had responded to more recent correspondence relating to the hearing as follows:

- On 28 June 2024 Mr Valente responded to an e-mail sent by the hearings support office and advised that he would be working on the days listed for the hearing unless he could arrange for someone to cover him. Mr Valente was provided with guidance on making a written application for a postponement of the hearing.
- On 1 July 2024 Mr Valente sent a further email stating that he needed to work for financial reasons and asked what his options were if the hearing proceeded without him. Mr Valente was advised that at the hearing he would have the opportunity to give evidence and make submissions on the issues which were yet to be decided and he was asked whether he had any availability between 15 July 2024 and 18 July 2024.
- Mr Valente sent a further e-mail on 9 July 2024 stating that there was a shortage of staff in the school where he worked and that he could provide certificates of training courses he had undertaken.
- On 11 July 2024 Mr Valente was asked whether he was content for the hearing to proceed in his absence or whether he would be applying for an adjournment.
- On 11 July 2024 Mr Valente sent an e-mail stating "I'm happy for the hearing to proceed in my absence".

96. The panel accepted the advice of the legal adviser in relation to the factors it should take into account when considering whether it was fair and appropriate to proceed with the hearing in Mr Valente's absence. This included reference to the cases of *R v Jones [2002] UKHL 5*; *General Medical Council v Adeogba [2016] EWCA Civ 162*. The panel also took into account Social Work England's guidance 'Service of notices and proceeding in the absence of the social worker'.

97. The panel was satisfied that Social Work England had taken reasonable steps to inform Mr Valente of the hearing and to enable him to participate. Having reviewed Mr Valente's correspondence, the panel concluded that he was aware of the hearing and has voluntarily chosen not to participate. Mr Valente has been advised of the process for applying for an adjournment, but has decided not to take that step and the panel concluded that an adjournment was not likely to secure his attendance.

98. The panel was of the view that in this case it was likely that there would be a disadvantage to Mr Valente in not attending the hearing to present his evidence and submissions, but it was also of the view that it would not be in the interests of Mr Valente or in the public interest for there to be a delay in the conclusion of the case. The findings of fact date back to the period 2018- January 2020 and the panel's decision on the facts was provided to the parties on 23 October 2023. The panel considered that there was a strong public interest in the expeditious conclusion of the case.

99. The panel concluded that it would be fair and appropriate to proceed with the hearing in Mr Valente's absence.

Panel directions:

100. The panel noted Mr Valente's recent engagement with the hearings team and that he does not have the benefit of legal representation. The panel was minded to proceed and decide the question of whether the statutory ground of misconduct or capability was made out in Mr Valente's absence, and to make directions to communicate the panel's views on the relevance and importance of Mr Valente's attendance for part of the hearing should the panel reach the stage of considering current impairment. The panel invited any comments from Ms Taggart before it made its directions. She had no instructions on the matter, but did not put forward an objection to the panel's proposal.

101. The panel directed that Mr Valente should be contacted and invited to provide evidence of relevant testimonials and that he should also be advised that the panel would appreciate the opportunity to hear from him on the question of current impairment, should the panel reach that stage.

102. In accordance with this direction an e-mail was sent to Mr Valente by the Hearings Officer.

Finding and reasons on grounds:

103. The panel took into account Ms Taggart's submissions. She invited the panel to conclude that the findings of fact amounted to misconduct and a lack of capability. The panel also took into account the documents in the Social Worker Response Bundle and the oral evidence given by Mr Valente on the facts.

104. The panel heard and accepted the advice of the legal adviser. She advised that the question of misconduct or a lack of capability was a matter for the panel's judgment.

105. In relation to a lack of capability the legal adviser referred the panel to the case of Calhaem v General Medical Council [2007] EWHC 2606 and advised that the panel should consider whether the standard of Mr Valente's work was unacceptably low, whether this is due to lack of knowledge and skill, and whether the lack of capability has been demonstrated by reference to a fair sample of Mr Valente's work.

106. In relation to misconduct the legal adviser referred the panel to the guidance in the case of Roylance v GMC that "*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".* A breach of standards is not determinative, and the conduct must be serious for the panel to conclude that it amounts to misconduct.

107. The legal adviser also referred the panel to the case of *Ahmedsowida v General Medical Council* [2021] EWHC 3466 and advised that generally it would not be appropriate to consider an allegation which the panel has concluded is not sufficiently serious to amount to misconduct cumulatively with other allegations, unless it is clear from the formulation of the allegation that the matters should be considered together.

108. The panel first considered whether any or all the proven findings of fact amounted to the statutory ground of lack of capability. The panel did not consider that the findings of fact represented a fair sample of Mr Valente's work. All the findings related to a single family, and there was no evidence of concerns relating to the remainder of Mr Valente's caseload. There was no evidence before the panel that any performance or capability issues were raised with Mr Valente by the Council. There was very little evidence before the panel relating to the supervision of Mr Valente, and no evidence of management concerns about Mr Valente's knowledge or skills.

109. In the panel's judgment none of the findings of fact amounted to the statutory ground of lack of capability.

110. The panel next considered whether each of its findings of fact amounted to the statutory ground of misconduct. In respect of allegation 1(a), the failure to conduct visits within the required timescales, the applicable standards were the HCPC

Standards of conduct, performance and ethics (2016). The panel considered that Mr Valente's conduct was a breach of the following standard:

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

111. In the panel's judgement the context was relevant to the assessment of the seriousness of Mr Valente's conduct. In particular:

- Mr Valente had assessed the risks and made a decision to give higher priority to six other cases which in his view involved higher risks;
- Mr Valente had responded to increased risk after the incident when the fire brigade was called to the house by increasing the frequency of his visits;
- Mr Valente had assessed the case as one of medium risk, not of high risk, as reflected by the management decision to close the case;
- The delays in visits were apparent from Mr Valente's records, but managerial action was limited, he was not asked to change his priorities, and the case was closed by his manager with no disciplinary or capability action;

112. The panel does not condone Mr Valente's failure to visit the family in accordance with the required timescales, with the consequent failure in safeguarding. Mr Valente should have done more to highlight to his manager that he was unable to comply with the statutory visiting requirements. In the panel's judgment Mr Valente's failure fell below the required standards for social workers and was poor practice. Nevertheless, the panel had in mind the requirement that misconduct must be serious. In the panel's judgment, the contextual factors reduced the degree of Mr Valente's culpability. The panel concluded that Mr Valente's conduct in particular 1(a) was not sufficiently serious to amount to misconduct.

113. In respect of allegation 1(b)(i), the failure to investigate safeguarding concerns following Person A's hospital admission, the applicable standards were the HCPC Standards of conduct, performance and ethics (2016). The panel considered that Mr Valente's conduct was a breach of the following standards:

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

114. The panel considered that Mr Valente's culpability was significant because he was aware of the circumstances, but failed to recognise the risk and failed to act, when he should have known that Child R and Child J were potentially at risk of harm. The risks were self-evident and it should not have been necessary for Mr Valente's manager to raise the issue with him as she did in the supervision session on 3 October 2018. There

was a potential risk of serious harm to Child R and Child J if Person A was unable to care for them due to her ill-health.

115. In the panel's judgment Mr Valente's conduct in particular 1(b)(i) fell far below the professional standards for social workers and was sufficiently serious to amount to misconduct.

116. In respect of allegation 2(a) and (b), which relate to the incident on 13 January 2020, the applicable standards were Social Work England's Professional Standards (2019). The panel considered that Ms Valente's conduct was a breach of the following standards:

- 3.2 Use information from a range of appropriate resources, including supervision, to inform assessments, to analyse risk, and to make a professional decision;
- 3.3 Apply knowledge and skills to address the social care needs of individuals and their families commonly arising from physical and mental ill health, disability, substance misuse, abuse or neglect, to enhance quality of life and wellbeing;
- 3.6 Recognise the risk indicators of different forms of abuse and neglect and their impact on people their families and their support networks;
- 3.12 Use assessment skills to respond quickly to dangerous situations and take any necessary protective action

117. As explained in its decision on facts the panel concluded that there was a clear risk to the children, particularly child R who was five years old because Person A may have been under the influence of alcohol and unable to care for Child R and Child J. Mr Valente's decision to leave the house without taking any action, other than leaving a letter with Child R, is inexplicable for a social worker, given that his role was to safeguard the children. The risks are not difficult to understand and they should have been obvious to a social worker. In Mr Valente's evidence he struggled to explain his actions and it appears that he gave no consideration to the implications and ramifications of his decision to leave the house without seeing Person A, calling the police, or taking advice from his manager. Mr Valente's conduct exposed the Child R and Child J to the risk of serious harm.

118. In the panel's judgment Mr Valente's conduct in particulars 2(a) and 2(b) fell far below the professional standards for social workers and was sufficiently serious to amount to misconduct.

119. The panel next considered particular 3(a), the failure to complete the Child and Family Assessment in March 2019. The applicable standards were Social Work England's Professional Standards (2019). The panel considered that Ms Valente's conduct was a breach of the following standard:

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

120. The panel considered that while Mr Valente's conduct fell below the professional standards and was poor practice, it was not sufficiently serious to amount to misconduct. The panel took into account the context that Mr Valente's manager subsequently closed the case without requiring the completion of the assessment and there is no evidence that the issue was raised with Mr Valente as a performance concern at the time the assessment should have been completed.

121. In summary, the panel found that allegations 1(b)(i), 2(a) and 2(b), were sufficiently serious to amount to the statutory ground of misconduct.

Finding and reasons on current impairment :

122. Mr Valente provided the panel with evidence that he had completed the following training:

- 11 July 2023 Safeguarding Children Practice Level 3
- 28 November 2023 Preventing Radicalisation
- 20 March 2024 Understand Your role within Safeguarding and Child Protection
- 20 March 2024 Understanding and Minimising Child on Child Abuse

123. Mr Valente gave oral evidence to the panel. He told the panel that he had remained employed by the Council following his suspension returning to work as a social worker in January 2021. He was then suspended for an unrelated matter in August 2021 and dismissed by the Council in December 2022. Mr Valente was then unemployed until he obtained a position as a teaching assistant in a special school in May 2024. Mr Valente said that he would like to return to work as a social worker in a year or so and that he liked working with children and young people.

124. Mr Valente was asked about his reflections about what went wrong. He said that he had reflected on the events on 13 January 2020 and that he should have acted differently and that it was a serious mistake. He acknowledged that he did not act well on that day and that going forward his first priority would be to make sure that the children are safe. He had reflected that his judgment was poor and that in future in a similar situation he would ask for help from his manager and insist on such help. Mr Valente stated that he took responsibility for his actions.

125. In cross-examination Mr Valente was asked about some of his earlier statements and responses to Social Work England. He agreed that following the decision of the panel on the facts he had questioned his assumptions and had further reflected on his past actions. He has considered the different perspectives that might be taken about his past conduct. When prompted Mr Valente was able to speak about some of the potential risks for Child R and Child J, the negative impact of his behaviour on the Council, and he also spoke about the way in which his misconduct would affect the image and credibility of social workers.

126. Ms Taggart submitted that Mr Valente's fitness to practise is currently impaired on both the personal element and the public element. She referred the panel to Mr Valente's previous statements and previous oral evidence and invited the panel to consider the transcripts of the hearing. Ms Taggart submitted that there was insufficient evidence of remediation and that Mr Valente had demonstrated very limited insight.

127. The panel reviewed and took into account all the documents provided by Mr Valente, including the certificates of completion of training, and those included in the Social Worker's Response bundle and the supplementary bundle. It also took into account Mr Valente's oral evidence.

128. The panel heard and accepted the advice of the legal adviser. Her advice included reference to case law including *Meadow v GMC* [2006] EWCA 1360*, Cohen v GMC* [2008] EWHC 581*,* and *CHRE v NMC and Grant* [2011] EWHC 927.When considering the question of impairment, the panel took into account Social Work England's 'Impairment and sanctions guidance' (the 'Guidance').

129. The panel considered first whether the misconduct is remediable. The misconduct relates to the basic requirement for a social worker to recognise risk and take the appropriate action. Given the nature of the misconduct the panel was of the view that the misconduct is potentially remediable, but that remediation would depend on Mr Valente demonstrating a sufficient level of insight.

130. In relation to the incident on 13 January 2020, Mr Valente made an early acknowledgement of wrongdoing. Notes from his investigation meeting dated 28 April 2020 report that he stated:

> "*if he was to do the visit again he would do things differently. He would contact his manager to ask for advice and contact the police….He acknowledged that there were risks for R for not being supervised by a parent. Mum could have passed out, the child could have an accident in the house and injury herself, she could have opened the door to a stranger, who may have harmed her. ….He has reflected on his practice and he does not want to pose a risk to people.*"

131. In his initial comments to Social Work England dated 8 November 2020 he stated:

"*I have reflected about my decision on that evening and have concluded that my judgement was poor. The mother's ability supervise, monitor the girl is reduced/impaired by the alcohol.....I have talked about this issue with colleagues and have read about alcohol and the impact of alcohol on parenting capability. I have consulted the custodyminefield site. I have also brushed up on risk assessments. As I have indicated above, I consider that my judgement was poor on that day. I should have contacted the manager to discuss this instead of leaving the premises.*"

132. Mr Valente told the panel that he had realised the error in his judgment when the duty social worker had visited Person A on 15 January 2020 and had found Child R and Child J with Person A who was in a state of intoxication.

133. The panel noted that in some of his subsequent written submissions Mr Valente had not been self-critical and had appeared to minimise the seriousness of his conduct, criticising his manager's analysis of the risks. In his oral evidence at the fact stage he stated on two occasions that he had reflected on his actions and that he would do things differently, but he also denied that he had failed to recognise risk and failed to identify who was in charge of the children.

134. In his oral evidence for this hearing Mr Valente outlined the potential risks for Child R and Child J, but the panel was concerned that he did not fully understand the seriousness of the potential harm to the children. Mr Valente also spoke about how he might better manage the stresses of working as a social worker, and stated that he would act differently if faced with a similar scenario, but did not give any examples. The panel was concerned that despite the passage of time Mr Valente has not fully addressed the reasons why he failed to recognise the risks for Child R and Child J on 13 January 2020. There was no evidence before the panel that Mr Valente has reflected on the danger of placing reliance on the appearance of a child when the nature of the concern was such that the risk might be concealed or hidden, or why he did not give a higher priority to this case.

135. The panel considered that Mr Valente has reflected to some extent on the findings of fact made by the panel and he was willing to engage and consider all the questions he was asked. However, Mr Valente had not prepared a reflective statement, and his current thinking about the panel's findings of fact emerged in response to prompts from the panel and cross-examination questions.

136. In relation to the misconduct in 1(b)(i), Mr Valente had consistently denied any wrongdoing prior to the panel's findings of fact. Mr Valente did not deny the primary facts, but in his defence of this allegation he had not agreed that there was a failure on his part in not acting more promptly after receiving the message from the hospital. Given the nature of Mr Valente's defence, the panel was of the view that it would be possible for him to demonstrate insight, notwithstanding his denial of allegation 1(b)(i).

137. In his oral evidence to the panel at the impairment stage Mr Valente accepted the panel's finding and his responsibility for the delay in the response to the message from the hospital. He acknowledged that the delay might have put Child R and Child J at risk of harm, if Person A were to have collapsed and not been able to care for them. The panel again noted the absence of a written reflective statement from Mr Valente and that Mr Valente appeared to have given little consideration to the underlying reasons for his misconduct. The panel was not persuaded that Mr Valente had fully reflected on why he did not recognise the risks and take action before his manager prompted him to act.

138. The panel's assessment was that Mr Valente's level of insight is developing, but is currently insufficient. Given that the misconduct relates to the core task for a social worker of recognising and responding to risk, the panel was not persuaded that Mr Valente has fully appreciated the seriousness of the findings of fact found by the panel. Mr Valente spoke about the reading he has undertaken of serious review cases such as Baby P. This did not sufficiently assist the panel, because the focus of Mr Valente's reflections should be on why he acted as he did, the potential consequences of his actions, and the steps he would take to ensure that there would be no repetition.

139. The panel considered that there was little evidence of remedial steps taken by Mr Valente. The panel acknowledged that Mr Valente has had little opportunity to demonstrate remediation because he has not worked as a social worker since August 2021 and that he has only very recently obtained employment as a teaching assistant. Mr Valente was unable to provide the panel with objective evidence of remediation such as appraisals or testimonials.

140. The panel noted the evidence provided by Mr Valente that he has completed training courses, but gave it little weight. Some of the training courses (preventing radicalisation, child on child abuse), although relevant to Mr Valente's role as a social worker, were not directly relevant to the misconduct in this case. Mr Valente did not provide written reflections or oral evidence relating to his learning from the courses to demonstrate how his learning is relevant to his past conduct relating to the safeguarding of Child R and Child J.

141. Having considered the level of Mr Valente's insight and the absence of sufficient evidence of remediation, the panel concluded that there is a risk of repetition and that there is currently a risk of harm to service users. The panel therefore concluded that Mr Valente's fitness to practise is impaired on the basis of the risk of harm to members of the public.

142. The panel next considered the wider public interest including the need to maintain public confidence in the profession and to uphold and maintain standards for social workers. The panel has concluded that Mr Valente's misconduct involves breaches of the professional standards for social workers. The misconduct also involves a breach of the fundamental tenet of the profession requiring social workers to recognise risk and

safeguard vulnerable service users. A finding of current impairment is therefore required to reaffirm clear standards of professional conduct.

143. The panel considered that an informed and reasonable member of the public would be very concerned by the panel's findings. They would expect that appropriate regulatory action should be taken to mark the seriousness of Mr Valente's misconduct, particularly as there is a risk that it might be repeated. The panel therefore decided that a finding that Mr Valente's fitness to practise is impaired is required to maintain public confidence in the profession.

144. The panel concluded that the following aspects of the test for fitness to practise were met.

- Mr Valente has in the past and is liable in the future to act so as to put service users at unwarranted risk of harm
- Mr Valente has in the past brought and is liable in the future to bring the profession into disrepute
- Mr Valente has in the past breached and is liable in the future to breach one of the fundamental tenets of the profession

145. The panel concluded that Mr Valente's fitness to practise is currently impaired.

Decision and reasons on sanction:

146. The panel heard submissions from Ms Taggart on sanction. Her submissions included reference to aggravating and mitigating features and to the Guidance. She invited the panel to impose a suspension order.

147. The panel accepted the advice of the legal adviser. She reminded the panel that the purpose of a sanction is not to punish Mr Valente, but to protect the public and the wider public interest. She advised that the panel should take into account the Guidance. She advised the panel to consider each available sanction in ascending order of severity and to apply the principle of proportionality, carefully balancing Mr Valente's interests and the public interest.

148. Although Ms Taggart submitted that Mr Valente had not demonstrated remorse, the panel considered that remorse can be expressed in different ways. Mr Valente does not have the benefit of legal representation, and the panel was of the view that he had expressed his regret that he had not acted to keep Child R and J safe.

149. The panel identified the following mitigating features:

- Early admissions and a degree of insight during the Council's disciplinary investigation;

- Expression of remorse and developing insight, co-operation with Social Work England over an extended period of time and engagement with the panel
- Limited support and supervision.

150. Mr Valente said that he had received limited support and supervision, which the panel accepted, and took the view that it was a mitigating factor which carried some weight. There was little information provided to the panel relating to Mr Valente's supervision and Mr Luma said that he questioned where the managers were at the time.

151. The panel identified the following aggravating features:

- The absence of any written reflective piece following the panel's findings of fact
- Risk of harm to Child R and Child J

No action, advice or warning

152. The panel considered that the misconduct in this case was serious, for the reasons set out earlier in this decision, and there were no exceptional reasons to merit taking no action. The option of giving advice to Mr Valente or imposing a warning would not be sufficient to protect the public because these options do not restrict practice and are not appropriate where there is a risk of repetition and an ongoing risk to the public.

Conditions of practice

153. The panel considered the Guidance at paragraph 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 that 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"*

154. The panel was of the view that Mr Valente had demonstrated a sufficient level of insight for conditions to be appropriate. In its decision on current impairment the panel concluded that the insight he had demonstrated was insufficient for the panel to

conclude that he would not pose a risk of harm in unrestricted practice. However, as set out in its decision on current impairment, the panel considered that Mr Valente's insight is developing.

155. Mr Valente was asked whether he would comply with any order made by the panel and without hesitation he said that he would. Mr Valente's case has been outstanding for a long period of time, but he has continued to engage with Social Work England and the panel. The panel considered that Mr Valente has demonstrated his commitment, and the panel was confident that he could and would comply with the conditions of practice.

156. In its decision on impairment the panel decided that the misconduct is remediable. It was of the view that appropriate, proportionate, and workable conditions could be put in place to address the deficiency in Mr Valente's practice. The conditions would ensure that Mr Valente is appropriately supervised and that there is a focus in his management on ensuring that he appropriately recognises and manages risk. The panel bore in mind that the deficiency in Mr Valente's practice was limited to a single family and did not extend to widespread failures to recognise and manage risks. It also bore in mind that Mr Valente had returned to practice as a social worker from January to August 2021, and there was no evidence before the panel of any further fitness to practice concerns.

157. The panel considered that when working under the conditions of practice it has formulated, Mr Valente would not present a risk of harm to the public.

158. The panel noted that Mr Valente indicated that he did not intend to work as a social worker within the next year. The panel considered that this did not have the consequence that a conditions of practice order would be inappropriate or unworkable. Many of the conditions of practice would only take effect if Mr Valente obtained employment as a social worker.

159. The panel considered the option of a suspension order as proposed by Social Work England. The guidance states that a suspension order is appropriate where the decision makers cannot formulate workable conditions to protect the public or the wider public interest. In this case the panel was able to formulate workable conditions to protect the public. The panel did not consider that a more restrictive sanction than a conditions of practice order was required to maintain public confidence in the profession and to uphold standards. The imposition of a conditions of practice order is a serious sanction. It incorporates a clear message to members of the profession and members of the public that misconduct of this nature will be dealt with seriously by the regulator.

160. The panel considered the potential consequences and impact if it were to impose a suspension order on Mr Valente. Mr Valente has not worked as a social worker since August 2021 and a period of suspension would result in further deskilling. The panel also took into account the public interest in the rehabilitation of a skilled social worker to public service. In the circumstances, and having regard to the mitigating factors, the

panel decided that a suspension order would be disproportionate. The less restrictive option of a conditions of practice order would be sufficient to protect the public.

161. The panel next considered the length of the conditions of practice order. It took into account Mr Valente's circumstances and his current intentions. As explained in paragraph 120 of the guidance the order should be long enough for Mr Valente to complete any necessary remediation. Given Mr Valente's intentions not to seek work as a social worker for about a year, the panel decided that a two year order was appropriate. This would allow sufficient time for Mr Valente to obtain employment as a social worker, and for there to be sufficient reports from his workplace supervisor to demonstrate that he has completed remediation and that it is embedded in his practice. If Mr Valente's intentions and circumstances change, it would be open to him to make an application for an early review of the conditions of practice order.

162. The imposition of a conditions of practice order may have a negative impact on Mr Valente's financial and reputational interests, but the panel decided that his interests were outweighed by the need to protect the public and the wider public interest.

163. The panel therefore decided that the appropriate and proportionate order is a two year conditions of practice order as follows:

1. You must notify Social Work England within 7 days of any professional appointment you accept or are currently undertaking and provide the contact details of your employer, agency or any organisation with which you have a contract or arrangement to provide social work services, whether paid or voluntary.

2. You must allow Social Work England to exchange information with your employer, agency or any organisation with which you have a contract or arrangement to provide social work or educational services, and any reporter or workplace supervisor referred to in these conditions.

3. a. At any time you are providing social work services, which require you to be registered with Social Work England, you must agree to the appointment of a reporter nominated by you and approved by Social Work England. The reporter must be on Social Work England's register.

b. You must not start or continue to work until these arrangements have been approved by Social Work England.

4. You must provide reports from your reporter every 3 months and at least 14 days prior to any review and Social Work England will make these reports available to any workplace supervisor referred to in these conditions on request.

5. You must inform Social Work England within 7 days of receiving notice of any formal disciplinary proceedings taken against you from the date these conditions take effect.

6. You must inform Social Work England within 7 days of receiving notice of any investigations or complaints made against you from the date these conditions take effect.

7. You must inform Social Work England if you apply for social work employment/self-employment (paid or voluntary) outside England within 7 days of the date of application.

8. You must inform Social Work England if you are registered or subsequently apply for registration with any other UK regulator, overseas regulator or relevant authority within 7 days of the date of application [for future registration] or 7 days from the date these conditions take effect [for existing registration].

9. a. At any time you are employed, or providing social work services, which require you to be registered with Social Work England; you must place yourself and remain under the supervision of a workplace supervisor nominated by you and agreed by Social Work England. The workplace supervisor must be on Social Work England's register. The workplace supervisor may be the same person as the reporter.

b. You must not start or continue to work until these arrangements have been approved by Social Work England.

10. You must provide reports from your workplace supervisor to Social Work England every 3 months and at least 14 days prior to any review, and Social Work England will make these reports available to any reporter referred to in these conditions on request.

11. You must work with your workplace supervisor and/or reporter, to formulate a personal development plan, specifically designed to address the shortfalls in the following area of your practice:

- assessment and management of risk

12. You must provide a copy of your personal development plan to Social Work England within 6 weeks from the date these conditions take effect, and an updated copy 4 weeks prior to any review.

13. You must keep your professional commitments under review and limit your social work practice in accordance with your workplace supervisor's advice.

14. You must not supervise the work of any other social worker or student social worker.

15. You must not be responsible for the work of any other social worker or student social worker.

16. You must not work as an independent social worker and must only work as a social worker at premises where other social workers are employed.

17. You must not be responsible for the administration or management of any independent social work practice.

18. You must read Social Work England's 'Professional Standards' (July 2019), and provide a written reflection 3 months after these conditions take effect, focusing on how your conduct, for matters relating to this case, assessing and managing risk, was below the accepted standard of a social worker, outlining what you would have done differently, with reference to the following standards:

- 3.2 Use information from a range of appropriate resources, including supervision, to inform assessments, to analyse risk, and to make a professional decision;
- 3.3 Apply knowledge and skills to address the social care needs of individuals and their families commonly arising from physical and mental ill health, disability, substance misuse, abuse or neglect, to enhance quality of life and wellbeing;
- 3.6 Recognise the risk indicators of different forms of abuse and neglect and their impact on people their families and their support networks;

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

19. You must provide a written copy of your conditions, within 7 days from the date these conditions take effect, to the following parties confirming that your registration is subject to the conditions listed at 1-18, above:

- Any organisation or person employing or contracting with you to undertake social work services whether paid or voluntary.

- Any locum, agency or out-of-hours service you are registered with or apply to be registered with in order to secure employment or contracts to undertake social work services whether paid or unpaid (at the time of application)

- Any prospective employer who would be employing or contracting with you to undertake social work services whether paid or voluntary (at the time of application).

- Any organisation, agency or employer where you are using your social work qualification/knowledge/skills in a non-qualified social work role, whether paid or voluntary.

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

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

Interim order:

164. In light of its findings on sanction, the panel next considered an application by Ms Taggart for an interim conditions of practice order to cover the appeal period before the final order becomes effective.

165. The panel accepted the advice of the legal adviser.

166. The panel considered whether to impose an interim order. It was mindful of its earlier findings and decided that it would be wholly incompatible with those findings if there

were to be no restriction on Mr Valente's practice during the appeal period. The panel considered that it was appropriate to impose an interim conditions of practice order in the same terms as the substantive order to ensure the necessary protection for the public. The panel considered Mr Valente's interests, but decided that they were outweighed by the need to protect the public and the wider public interest. The panel decided to impose the order for eighteen months to cover the appeal period and the time that it might take for any appeal to be concluded.

167. Accordingly, the panel concluded that an interim conditions of practice 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 removal shall take effect when the appeal period expires.

Right of appeal:

168. 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.

169. 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.

170. 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.

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

The Professional Standards Authority:

172. 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.