Social worker: Odesanmi Akinpeluola Odoginyon
Registration number: SW132166
Fitness to Practise
Final Hearing

Dates of hearing: 17 to 21 June 2024; 29 to 30 August 2024

Hearing venue: Remote hearing

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

Interim order: Interim suspension order (18 months)

Introduction and attendees:

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

2. Mr Odoginyon did not attend and was not represented.

3. Social Work England was represented by Ms Sophie Sharpe, of counsel, instructed by Capsticks LLP as the case presenter.

Adjudicators	**Role**
Barry Greene	Chair
Rosemary Chapman	Social worker adjudicator
Lorna Taylor	Lay adjudicator

Robyn Watts; James Dunstan; Simone Ferris (17-21 June 2024) Hannah Granger (29-30 August 2024)	Hearings officer
Jo Cooper	Hearings support officer
Gerard Coll	Legal adviser

Service of notice:

4. Mr Odoginyon did not attend and was not represented. The panel of adjudicators (the panel) was informed by Ms Sharpe that notice of this hearing was sent on 15 May 2024 to Mr Odoginyon by special delivery post and by email to the respective addresses provided by Mr Odoginyon (the registered postal and email addresses as they appear on the Social Work England register). Ms Sharpe submitted that the notice of this hearing had been duly served. Ms Sharpe reminded the panel that proof of delivery or actual delivery into Mr Odoginyon's hands was not necessary in order for Social Work England to fully comply with the rules in respect of service.

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

    - A copy of the notice of the final hearing dated 15 May 2024 and addressed to Mr Odoginyon's registered postal and email addresses which they provided to Social Work England;

    - An extract from the Social Work England Register as of 15 May 2024 detailing Mr Odoginyon's registered postal and email addresses;

    - A copy of a signed statement of service, on behalf of Social Work England, confirming that on 15 May 2024 the writer sent by email to Mr Odoginyon at the address referred to above: notice of hearing and related documents;

    - A copy of the track and trace record from the post office showing return of the served documents on 12 June 2024.

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

7. 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 Odoginyon in accordance with rules 14, 15 and 44 of the Fitness to Practise Rules 2019 (as amended) (the rules). The panel understood that the postal delivery had been ineffective in that the package had not been handed to Mr Odoginyon, nor did he pick up the package from the post office. However, actual delivery is not required by the rules. It is sufficient that the addresses provided by Mr Odoginyon, precisely for the purpose of receiving such notice, had been effected.

29 August 2024

8. On 29 August 2024, the panel resumed in open session and heard submissions from Ms Sharpe that:

   - As proved by the signed statement of service of notice dated 25 June 2024 and
   - Supported by copies of the email to Mr Odoginyon dated 25 June 2024 containing notice of the resumed hearing today with accompanying papers.

   Accordingly, she submitted that service of notice of the resumed hearing had been effected in accordance with the rules.

9. The panel accepted the legal adviser's advice and having been satisfied that the rules in relation to service of notice were again met, were satisfied that notice of this resumed hearing had been served on Mr Odoginyon.

Proceeding in the absence of the social worker:

10. Ms Sharpe submitted that:

    - notice of this hearing had been duly served, that
    - no application for an adjournment had been made by Mr Odoginyon and, as such
    - there was no realistic prospect that adjourning today's proceedings would secure their attendance.

11. Ms Sharpe further submitted that Mr Odoginyon had not engaged with the process after the point that the Case Examiner's report was published on 28 April 2022.

12. Ms Sharpe therefore invited the panel to proceed in the interests of justice and the expeditious disposal of this hearing.

13. The panel accepted the advice of the legal adviser in relation to the factors it should take into account when considering this application. This included reference to rule 43 and to the cases of:

- *R v Jones* [2002] UKHL 5
- *General Medical Council v Adeogba* [2016] EWCA Civ 162.

14. The panel also took into account Social Work England guidance 'Service of notices and proceeding in the absence of the social worker.'

15. The panel considered all of the information before it, together with the submissions made by Ms Sharpe on behalf of Social Work England. The panel considered that Mr Odoginyon had consciously and voluntarily waived his rights to participate in the hearing. The panel noted that Mr Odoginyon had been sent an email on 14 June 2024 providing him with the necessary links to the Teams service to allow him to participate in this hearing if he wished to do so. The panel was satisfied that they were or should be aware of today's hearing.

16. The panel therefore concluded that Mr Odoginyon had chosen voluntarily to absent themselves. The panel had no reason to believe that an adjournment would result in Mr Odoginyon's attendance. Having weighed the interests of Mr Odoginyon in regard to their attendance at the hearing with those of Social Work England and the public interest in an expeditious disposal of this hearing, the panel determined to proceed in Mr Odoginyon's absence.

29 August 2024

17. The panel heard further submissions from Ms Sharpe inviting the panel to resume consideration of the case in Mr Odoginyon's absence. There had been no response by him to the email sent on 25 June 2024.

18. The panel accepted the legal adviser's advice. It recognised the need to proceed with care bearing in mind the importance of fairness to Mr Odoginyin. However, for the same reasons as above, the panel concluded that Mr Odoginyon had voluntarily absented himself and decided to proceed in his absence.

Preliminary matters

Decision to proceed partly in private

19. The panel was made aware by Ms Sharpe that Mr Odoginyon had a history of health concerns which may be relevant to part of the case, despite his absence today. Ms Sharpe invited the panel to proceed partly in private when any matter touching on the health or private life of Mr Odoginyon was being discussed with a witness or was being considered in the hearing. Ms Sharpe reminded the panel that it had the power to make this decision of its own will.

20. The panel accepted the legal adviser's advice. It reminded itself that the power to proceed partly in private was provided for in rule 38 which states:

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

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

21. The panel, acting in accordance with the mandatory nature of the provision under rule 38(a) and having regard to Mr Odoginyon's interests and welfare determined to hold part of the hearing in private where any issue relating to Mr Odoginyon's health was being discussed.

Amendment of allegations

22. Ms Sharpe reminded the panel that it had power to amend the drafting of any of the allegations where it was necessary to do so in order to avoid an allegation being artificially lost due to a correctable technicality. The panel accepted the legal adviser's advice. The panel reminded itself that rule 38 gave it wide powers to conduct the hearing fairly. The rule read:

38 (a) Subject to Rule 32(c), the adjudicators or the regulator may regulate their own procedures and must conduct the hearing or meeting in the manner they consider or it considers fair.

23. The panel recognised that it had an obligation to fully protect the public and to support the public's trust and confidence in the profession and its regulator by approaching fact-finding in a purposeful and unbureaucratic way, provided always that the hearing remained fair.

24. The panel decided that if it became necessary, it would apply this process in the public interest, prior to concluding any discussion on the relevant facts and with fairness to Mr Odoginyon at the heart of its decision making.

Allegations

25. The allegations arising out of the regulatory concerns in relation to Mr Odoginyon referred by the Case Examiners on 28 April 2022 are as amended:

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

1) In relation to Service User 1:

a) On or after 8 January 2021, you did not visit Service User 1 on learning their grandfather was terminally ill.

b) On or after 8 January 2021, you did not put a plan in place for contact between Service User 1 and his grandfather.

c) *On or around 21 March 2021, did not prepare an adequate risk assessment for Service User 1 in that:*
   i) *You did not obtain multiagency insight and/or feedback and/ or;*
   ii) *You did not obtain Service User 1's views on the plan;*

d) *Did not take appropriate safeguarding action after becoming aware of Service User 1's suicide attempt on or around 13 April 2021 in that you:*
   i) *Did not visit Service User 1 and/ or;*
   ii) *Did not contact medical professionals and/ or;*
   iii) *Did not ascertain the trigger for Service User 1's actions and/ or;*
   iv) *Did not call a timely strategy meeting.*

2) *In relation to Service User 2:*

a) *Between around January 2021 and around May 2021, you did not familiarise yourself with the case notes of Service User 2 such that you were not sufficiently aware of his vulnerabilities and existing safeguarding concerns.*

b) *On becoming aware that Service User 2 had on or around 8 March 2021, been in a volatile state and in need of calming down, you:*
   i) *Did not make a welfare call to Service User 2 and/ or;*
   ii) *Did not contact Service User 2 to ascertain what support he needed.*

c) *Between around 23 March 2021 and around May 2021, you did not take appropriate safeguarding action after becoming aware that Service User 2 was engaged in sexual communications online with other service users in that you:*
   i) *Did not inform the Team Manager of the incident and/ or;*
   ii) *Did not undertake sexual exploitation work with Service User 2 and/ or;*
   iii) *Did not complete a multiagency risk assessment.*

d) *Between January 2021 and around 6 April 2021, you:*
   i) *Did not ensure a risk assessment was completed prior to Service User 2 having unsupervised contact with his parents and/or;*
   ii) *Did not ensure Service User 2's parents were aware of the restrictions*

imposed on Service User 2 by way of a Sexual Harm Prevention Order ("SHPO") and/or;

iii) Failed to action a home visit in a timely manner.

e) You did not take appropriate safeguarding action upon being made aware that Service User 2 was being bullied on or around 6 April 2021, in that you:

i) Did not discuss these concerns with the placement staff and/ or;

ii) Did not visit Service User 2 and/ or;

iii) Did not update Service User 2's Care Plan in a timely manner and/ or;

iv) Did not complete a safety plan and/ or;

v) Did not call a multiagency meeting.

3) In relation to Service User 3:

a) In around December 2020, on learning that Service User 3 was having unsupervised overnight contact with his parents, you did not raise this concern with your Team Manager;

b) On or around 26 January 2021, you prepared a risk assessment in relation to Service User 3 which was inadequate in that:

i) It incorrectly assessed Service User 3's health risk level as "low" where it should have been "high" and/ or;

ii) It did not include details about Service User 3's general health and/ or;

iii) It did not contain adequate detail on how risk factors could be reduced and/ or;

iv) It did not address Service User 3's use of cannabis.

c) You did not take appropriate safeguarding actions upon becoming aware between around February 2021 and around March 2021 that Service User 3 was accessing extremist content online, in that you:

i) Did not promptly report concerns to your Team Manager and/ or;

ii) Did not take steps to gather information without prompting and/ or;

iii) Did not gather relevant information prior to meeting with police.

d) During a ~~Looked After Child review~~ Contact Management meeting on 3 February 2021, you did not manage the expectations of Service User 3 in relation to contact with his family.

4) On or around 8 January 2021, on becoming aware from a foster carer of a video depicting an unknown child being sexually abused, you did not respond adequately, in that you:

a) Did not contact the foster carer to obtain further information and/ or;

b) Did not inform your Team Manager and/ or;

c) Did not notify the police.

The matters outlined at paragraphs 1 - 4 amount to the statutory ground of lack of competence or capability.

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

Admissions

26. Mr Odoginyon denied all of the factual matters in the allegations as they were formulated prior to the Case Examiner's decision and afterwards in two online responses provided by him on 7 February 2022 and 24 May 2022.

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

Background

28. On 2 June 2021, Social Work England received a referral from Katie Holmes, an HR Consultant, on behalf of Southend Borough Council (the council) regarding the social worker, Mr Odesanmi Odoginyon.

29. Mr Odoginyon first became registered with Social Work England on 13 August 2020. He commenced employment on 7 September 2020 with the Care Management 16+ team (CM16+) at Southend Borough Council. As a qualifying social worker, he was completing the Assessed and Supported Year in Employment (ASYE) programme. Mr Odoginyon was allocated a limited number of cases in common with other trainees at the council. He was thereafter responsible for those cases in line with the Social Work England Professional Standards 2019.

30. Due, allegedly, to Mr Odoginyon's failure to progress as expected throughout the ASYE, he managed a reduced caseload and was then responsible for the cases of six service users.

31. The case against Mr Odoginyon is that despite being provided with very significant guidance and assistance throughout his career, concerns arose. Mr Odoginyon was failing to carry out tasks for which he was responsible in relation to a number of his cases, including but not limited to his:

    - not reading the case files,
    - not knowing the history of the children to whom he was allocated, and
    - not responding adequately to safeguarding concerns.

32. Concerns continued and deepened in relation to his lack of progress and conduct of his cases. The social worker was placed on a capability plan from 2 October 2020. He was subject to probationary reviews in respect of his practice on 22 January 2021 and 5 March 2021. Mr Odoginyon resigned from Southend Borough Council on 5 May 2021.

33. [PRIVATE]

34. [PRIVATE]

Summary of the evidence

35. The documents in the case consisted of:

    - Statement of case bundle of 20 pages
    - Timetable of 4 pages
    - Identification key of 2 pages
    - Statements bundle of 62 pages
    - Exhibits bundle of 1142 pages
    - Social worker response bundle of 83 pages
    - Service and supplementary bundle of 14 pages
    - Links reminder bundle
    - Reference notes for panel of 6 pages
    - On 29 August 2024, the panel had a resuming service bundle of 15 pages.

36. The documents included copies of papers in relation to other young persons who were part of Mr Odoginyon's caseload at the relevant time. Ms Sharpe explained that these

documents were not going to be spoken to by any witness. They were relevant only to the extent that they support Mr Odoginyon's assertions in writing of his good practice in conformity with the expected Standards of both Social Work England and the British Association of Social Workers (BASW).

Social Work England

37. Ms Sharpe explained that there were 4 witnesses on behalf of Social Work England. These were:

    1. Binesh Kappan, Team Manager in the CM16+ team at the council at the time of the allegations. Mr Kappan was the social worker's Line Manager at the time and would give evidence regarding his involvement in the social worker's cases.

    2. Diane Bowden, Advanced Practitioner in Assessment and Intervention Team 3 at the council, a Practice Educator and an ASYE Assessor at the time of the allegations. Ms Bowden was responsible for ensuring that the social worker was managing his caseload, recording the correct information, and identifying risk.

    3. Lara Fry, Advanced Practitioner and ASYE Co-ordinator and lead in The Practice Unit at the council at the time of the allegations. Ms Fry prepared a report on the social worker's progress in his ASYE, dated 19 January 2020.

    4. Simbarashe Moyo, Senior Social Worker in the CM16+ team at the council at the time of the allegations. Mr Moyo was responsible for ensuring the social workers in his team were carrying out their roles as required.

Mr Odoginyon

38. There were no witnesses called by or on behalf of Mr Odoginyon. The panel fully took into account both of the written responses made by Mr Odoginyon in 2022.

39. Mr Odoginyon's written representations stated in summary that:

    - There were challenges in starting the role during the coronavirus pandemic, and that his age, language, and cultural differences played a part in this. He has made mistakes but has reflected on them and learned from them.

    - His Line Manager Mr Kappan had failed to provide him with equipment required to complete his work due to his disability, thus increasing the time required to complete reports and case notes.

    - He was unsupported by his Line Manager in completing Pathway Plans.

    - He was advised by managers that asking for support was not acceptable.

    - In respect of his caseload, the reduction of his caseload amounted to removing one case only, and in any event it was a complex case which should not have been allocated to him as an ASYE.

- He believes he was discriminated against under the Equality Act 2010. Occupational Health reported that he was fit to work with reasonable adjustments.
- He felt that he was bullied and harassed by his manager, and that he reported this to the Head of Service and asked to move teams. His request was declined.
- He was unsupported and that his manager had a premeditated intention from the start to frustrate his practice and prevent him from working as a social worker.

40. Mr Odoginyon had not submitted any statement or written reflections, Occupational Health, or other reports in support of his written observations. The panel accorded what weight it could to the submissions. However, none of the submissions by Mr Odoginyon directly challenged or attempted to refute the factual bases for any of the allegations, with the exception of a brief submission in relation to Allegation 4.

41. The allegations in this matter relate to 3 separate service users who were part of Mr Odoginyon's caseload and one other young person. All of these separate service users were placed with the council in specialist placements in an attempt to address the complex needs and vulnerabilities.

42. The panel accepted the advice of the legal adviser. He reminded the panel that the burden of proof rested always with Social Work England and that the standard of proof is the civil standard of the balance of probabilities. The panel must be satisfied that the contemporary documents relied on by Social Work England were accurate and reliable.

Finding and reasons on facts

43. The panel first considered the documents made available by Social Work England. The panel accepted that these were contemporary documents which were authentic and uncontaminated. The dates and times of case management entries being made were controlled by the Liquid Logic system and were a reliable indicator of the date when entries were made and the time spent on that task. Meeting notes were documented as having been completed soon after the events and marked for distribution to relevant parties. This promoted the panel's confidence that the meeting notes were likely to have been accurately captured since they were open to challenge by attendees. Equally, the notes of supervision meetings and guidance with Mr Odoginyon that had been produced were detailed and unambiguous. Their contents had not been challenged by Mr Odoginyon, whose answer to the allegations focussed on a lack of support and reasonable adjustments for his disability.

44. The panel considered that the witnesses who had given evidence were credible and reliable witnesses who did their best to assist the panel. They could not all recall the events that they were asked about given the passage of time and the fact that two of the witnesses, Mr Kappan and Mr Moyo have moved post since the time of these events. All of the witnesses were satisfied that the statements made by them close to the time of the events and signed and dated by them were true and accurate statements. The panel

was satisfied that the contemporary statements were clear and dealt with the issues thoroughly. However, the statements were made after the events and the panel recognised that their contents may have been inadvertently shaped by the passage of time and the numerous internal discussions and reports regarding Mr Odoginyon's capability and competence. The panel was careful to assess the extent to which the statements accorded or diverged from the contemporary records.

45. The panel carefully considered the proposition from Mr Odoginyon, although not supported by any evidence provided by him that his competence and capability was not adequately supported by reasonable measure in the workplace to support his professional development. That, while important, was not a structured challenge to the authenticity of the contemporary records.

46. Mr Odoginyon said in 2022 that he did not accept the factual allegations. However he did not take up the opportunity to challenge and correct the evidence against him.

47. Mr Odoginyon did not attempt to meet the central criticisms made by some witnesses in respect of his lack of progress or capability. Some witnesses were broadly supportive of his open and caring approach. He was complimented on the good relationships which he had established with many of the challenging young people in his caseload.

Allegation 1

1 a)

48. The panel was satisfied that this limb was not proved.

49. The panel heard evidence in detail from Mr Kappan and Mr Moyo in relation to the particular vulnerabilities and difficulties faced by service user 1. Service user 1's grandfather was the special focus of the service user's familial attachment. Although the grandfather had a family history which may have raised concerns regarding contact with him, he was the person that the service user most closely identified with.

50. The service user's grandfather had been diagnosed with a terminal health condition. He was resident at a home, some distance from the service user's placement. The child had expressed on a number of occasions that he was a child carer for his grandfather, although this was incorrect. It did however illustrate the measure of connection felt by the service user towards his grandfather.

51. The panel heard evidence that medications were stored at the home, creating a risk that the service user might have unregulated and irregular access to them. The service user had a known history of self-harm and, regrettably, the panel understood that the service user and his girlfriend attempted serious self-harm with these medications at the home in the grandfather's absence in a hospice. The service user, after this incident was investigated, admitted that he had earlier attempted serious self-harm with the same medications, alone and unsupervised, although he had fortunately survived.

52. The panel heard that a resident of service user 1's home had tested positive for Covid and service user 1 had taken a Covid test and was awaiting the result. The panel had

sight of case notes from 8 January 2021 which indicated that the social worker attempted to carry out a statutory visit by way of two video calls at 09:45 and 13:10. Mr Moyo, in his oral evidence, accepted that a video call at this stage of the Covid pandemic could be regarded as a visit. Accordingly this limb of the allegation is not proved.

1 b)

53. The panel was satisfied that this limb was proved.

54. The panel was satisfied that the need for a plan for contact with the service user and his grandfather had to be put in place at this time. The panel was satisfied with the evidence from Mr Kappan and Mr Moyo supported by the accompanying documentation, that the service user was at that time making his own way to his grandfather's home a considerable distance without supervision. The placement was unaware that the service user was doing so, and considered for a time, that the young person may be untraced. The service user was plainly emotionally attached and vulnerable to dysregulation in these distressing circumstances. Despite the prompts and guidance available to Mr Odoginyon he did not make the appropriate plan.

1 c) i and ii

55. The panel was satisfied that this subhead was proved in both limbs.

56. Mr Kappan explained to the panel that the risk assessment completed by Mr Odoginyon on 21 March 2021 was inadequate because the social worker had not obtained multiagency insight and feedback and further, the social worker had not obtained service user 1's views on the plan that had been prepared.

57. Mr Kappan said in his evidence that had other professionals been consulted there would be an email chain or other documentary record which would trace this contact. Further, it would be expected that these contacts would be entered on the child's notes but there was no such record. Mr Kappan told the panel how important it was that the insights of other professionals were gathered and fed into the risk assessment, so that a full and adequate plan was available to safeguard the service user. Further, details which were too sensitive to be shared outside of the Department could be recorded internally but marked 'not for distribution'.

58. Mr Kappan also explained to the panel the need for Mr Odoginyon to obtain and record the service user's views on the plan. The service user may not have agreed, or he may have proposed modifications which would have supported him. In the absence of such views, the panel was satisfied that the plan was inadequate.

59. For the reasons above, the panel found both limbs of the subhead proved.

1 d) i, ii, iii and iv

60. The panel was satisfied that all limbs of this subhead were proved.

61. The panel was satisfied from the oral evidence and the supporting documents that service user 1 had attempted suicide on or around 10 April 2021. At this time, Mr Odoginyon was directly responsible as case holder for this highly vulnerable young person. The evidence supported that at the latest on 15 April 2021, Mr Odoginyon was told about the event in which the service user consumed highly toxic drugs prescribed for his grandfather, who was terminally ill, in a direct attempt to end his own life. There was evidence that he had been sent an email by the responsible looked after child nurse on 12 April 2021 explaining what had occurred.

62. The panel was satisfied that the evidence supported that Mr Odoginyon should have made the earliest possible attempt to contact the service user. He did not meet with the service user to discuss this situation. There was evidence that the service user had discharged himself from medical care without being fully medically assessed. Despite the seriousness of the situation, all of the oral evidence from Mr Kappan and Mr Moyo and the supporting papers confirmed that Mr Odoginyon had not taken an opportunity to visit the service user, in particular to ascertain what was the trigger for the service user's attempted suicide. Indeed, Mr Odoginyon, when asked by Mr Moyo whether he had visited service user 1, stated that he had not.

63. Further, Mr Odoginyon had not, the evidence confirmed, made contact with any of the health professionals who had dealt with the matter in order to understand the seriousness of the suicide attempt and its potential aftermath both physically and emotionally. The social worker should have done all of these things in an attempt to understand what safeguarding network was in place, if any, and to address the matter immediately and personally. Mr Odoginyon appears to have made only limited attempts to contact other professionals.

64. The panel was satisfied from the evidence of Mr Moyo and others that it would be important to call a strategy meeting involving other professionals, including the police and healthcare professionals at the earliest opportunity of learning of these events. The panel was satisfied from the evidence that this could be done within a day if the relevant professionals were available, but certainly within three days, given the circumstances. There was evidence in the papers that other strategy meetings had been conducted within this short timeframe.

65. The panel was satisfied that a strategy meeting ought to have been a matter of some importance and immediacy to Mr Odoginyon. Mr Moyo said in evidence that he had emailed Mr Odoginyon on learning the strategy meeting had not taken place and urging him to take action. The panel observed that there were no emails or other records in the papers made available to it, suggesting that Mr Odoginyon had immediately acted on this advice. Attempts appear to have been made by Mr Odoginyon to arrange a strategy meeting for 26 April 2021. This event was purposeless because not all of the relevant parties, including the police had been invited. Further, the parties who had attended were unaware of the purpose of the strategy meeting or the background circumstances. Following this, an effective strategy meeting was convened on 29 April 2021 which, the panel observed, reinforced the potential for such a meeting to be convened quickly

despite the challenges of other professionals' diary commitments. However, the index event, which prompted the strategy meeting was now at least two weeks in the past.

66. In all of the circumstances, the panel had no difficulty in finding all of the facts proved in relation to this subhead of allegation.

Allegation 2

2 a)

67. The panel found this subhead proved.

68. Mr Moyo noted in his evidence that:

On 18 February 2021 I held a supervision session with the social worker. I believe this was the first supervision session I held with the social worker for the case of the service user. At the session it became clear that the social worker had not read the file or the minutes for the previous looked after child reviews. I therefore identified this as an action for the social worker to complete. I instructed the social worker to undertake tasks, including:

- *read assessments by* SB
- *read the risk assessments from* [the service user's] *placement,*
- *update the CM16+ risk assessment and prepare for the Looked After Child (LAC) review.*

It was essential for the social worker to read the previous psychological assessment completed by SB. *This would have told the social worker what* [service user 2's] *needs were. The social worker would have known to do this as he would have been told to do so when the case was transferred over to him.*

69. Mr Moyo was clear in his evidence that Mr Odoginyon repeatedly did not familiarise himself with the necessary case notes in relation to this highly vulnerable young person. The panel understood that a SHPO had been put in place for this young person, partly as a result of their having perpetrated sexual abuse against children in the past, and partly because the young person was highly vulnerable to sexual exploitation. The panel was satisfied that in the circumstances, it was essential that Mr Odoginyon actively familiarised himself with this young person's case notes at the earliest opportunity. However, it was clear to the panel that Mr Odoginyon was repeatedly prompted to take these actions having not done so.

2 b) i and ii

70. The panel found this subhead proved in both limbs. The panel was satisfied with the uncontested evidence of Mr Moyo that the service user had been in a volatile state on 8 March 2021. The panel was satisfied with Mr Moyo's evidence that the circumstances required a welfare call by Mr Odoginyon to the service user directly and also contact

made in order to establish what support was necessary at this difficult time. Mr Moyo explained to the panel that these things had not been done. The panel's own survey of the case records did not disclose any such welfare call or contact.

2 c) i, ii and iii

71. Mr Kappan's evidence and the supporting documents satisfied the panel that this subhead of allegation in all three limbs was proved.

72. The evidence supported that on 23 March 2021 the service user's placement had made a disclosure that the young person had been in communication with two older service users who had been placed in this residential unit, although both had since moved on. This communication was of a sexual nature. The panel was satisfied that this was an important and troubling development for the service user. He had a particular history which made him highly vulnerable to sexual exploitation and also to becoming entrenched in exploitative behaviour patterns. Unless addressed, there was a clear risk that this would lead the service user into risks of serious harm and potentially becoming the focus of a police enquiry. The panel was satisfied that the evidence fully supported that there ought to have been an attempt by Mr Odoginyon to discuss the risks with his team manager at the earliest opportunity. In tandem with that, Mr Odoginyon should, the panel was satisfied, have conducted a risk assessment and planned for a multiagency safety plan, given the risks posed by the young person to himself and to others. Mr Moyo told the panel in evidence that "we social workers do not try to hold all of these risks by ourselves." There was a clear safeguarding obligation created not only to the service user, but to the other young persons who were in communication with him.

2 d) i, ii, and iii

73. The panel was satisfied that this subhead was proved in limbs i and iii, but not limb ii.

74. Mr Moyo explained to the panel that the young person had somehow found access to the internet despite his ability to do so being restricted as much as possible in order to protect him. He had income of only £5 per week, made available in equal amounts in order to limit his ability to purchase online credit. However, there was evidence of inappropriate and harmful access to the internet, despite these limitations.

75. The panel understood that the situation was exacerbated by the service user's family who facilitated and were seemingly untroubled by the service user's unauthorised and unsupervised access to the internet.

76. The service user's family did not recognise and accept that these limitations were required. The service user's father appeared to suggest that the service user had free access to a smart phone during contact and was free to use it in any way the service user wished.

77. There was nothing on record to suggest that Mr Odoginyon had attempted to challenge this attitude or to explore the risks with him for the service user. These were all

circumstances which mandated that the required actions be taken at the earliest opportunity. This included a risk assessment specifically addressing unsupervised contact with his parents and also a timely home visit to assess the situation and assist the service user. The panel was satisfied from the evidence that Mr Odoginyon had not done this.

78. In regard to limb ii, the panel did not see the SHPO and there were no other contemporary document references which identified when the order was in place and the scope of the restrictions. In these circumstances, it was not possible for the panel to be satisfied that Mr Odoginyon had the materials available to meet a requirement to make the family aware of the restrictions during the time frame specified in the limb.

2 e) i, ii, iii, iv, and v

79. The panel was satisfied that this subhead was proved in all of its limbs.

80. The panel accepted the uncontested evidence of Mr Kappan who explained to the panel:

On 6 April 2021, the Independent Reviewing Officer ("IRO") raised concerns that [service user 2] *was being bullied. Upon being informed of this, I would have expected the social worker to liaise with the child's carers at the accommodation and to see the child in person to understand their voice and experience of what had happened.*

The Social Worker would have known to do this through discussions in supervision, seeking guidance from colleagues and from speaking to his Team Manager and on-site supervisor about how to proceed.

The Social Worker had not raised this matter with me in supervision, however I was aware of it as I was copied into numerous emails.

The social worker had to be encouraged to go and visit the young people on his caseload, to engage with them and build relationships with them. The social worker was not proactive in asking what the next steps were on cases and visiting the young people to offer reassurance and to keep them informed.

The Social Worker would shift ownership onto others. For instance, in March 2021 the Social Worker requested that staff at the residential placement complete tasks that the Social Worker should have completed, including obtaining the voice of the child.

81. As explained above, the panel understood that this young person was highly vulnerable to exploitation. He had made remarks to another young person in the same residential placement who had responded by bullying him, directed at his perceived sexuality, and by threatening him with physical harm. The panel decided that the evidence supported that the safeguarding steps as outlined in the allegations were necessary. None of these steps had been taken despite the risks for the service user. The panel was satisfied, having considered all of the papers, that there was no evidence that Mr

Odoginyon had taken any of these obvious protective steps which he had been guided towards throughout his ASYE year.

Allegation 3

82. The panel considered each subhead of this allegation on their own respective merits.

3. a)

83. The panel found this subhead not proved.

84. The panel heard evidence that the service user was not to have unsupervised access with his parents due to their lack of engagement with social services, their known drug use and also concerns regarding domestic violence.

85. The panel heard that this case was a legacy matter transferred to the social worker in early December 2020. Mr Moyo appeared to be taking the lead in this matter, and acknowledged in emails to partners that the social worker was still familiarising himself with the case. He copied Mr Kappan, team manager, into these emails. Mr Kappan was also copied into other emails from partners. The panel concluded that the manager was already aware of the case and the concerns.

3. b) i, ii, iii, and iv

86. The panel found this subhead of allegation proved in respect of i, ii and iii but not in respect of iv.

87. The panel considered carefully the oral evidence from Mr Kappan, which was uncontested. Mr Kappan pointed out the deficiencies in the risk assessment which are reflected in the limbs of the subhead. The panel also took care to consider for itself the risk assessment dated 26 January 2021 completed by Mr Odoginyon which had been exhibited. This highlighted the concerns raised by Mr Kappan and in the panel's view, fully supported a finding of proved. As an example, details of the service user's current mental and physical health included that placement staff had expressed concerns and he had been placed on a waiting list for treatment. Further, specialist staff from Emotional Wellbeing and Mental Health Services (EWMHS) contacted the service user weekly to check on his welfare. Despite this, Mr Odoginyon had assessed the service user's health risk as "low." Furthermore, the panel could not find within the risk assessment adequate detail on how the risk factors could be reduced.

88. In respect of iv, the allegations suggests that the social worker did not address service user 3's use of cannabis. The panel noted that the risk assessment makes reference to the use of marijuana and the need for the residential support staff to help the service user to understand the risks of substance misuse. The panel observed that this may not have been a wholly satisfactory response but it did address the matter.

3. c) i, ii and iii

89. The panel found this head of allegation proved in all limbs.

90. The panel observed that among other contemporary documents, a risk assessment dated 12 March 2021 noted that the service user had been actively pursuing dangerous internet materials, focussed on:

- Terror group ideology and propaganda
- Explosives construction
- Homophobia
- Anti-woman agenda extremism.

91. The police were aware of these issues through their own resources and had contacted the service user's placement in February 2021. Mr Kappan and Mr Moyo explained in their respective evidence that despite the alarming online content actively being sought out and pursued by the service user, Mr Odoginyon had not promptly reported what were obvious concerns to his team manager. The panel considered that there was a self-evident risk of the young service user being radicalised by malign outside actors. This had been identified by the police as a risk. Despite this, Mr Odoginyon's response had been troublingly passive.

92. Mr Kappan enlarged on these issues in his unchallenged statement. The panel considered one excerpt among many available illustrated the basis for finding this head of allegation proved, in which Mr Kappan said:

> '*I instructed the social worker to visit service user 3 to find out more information and then to make a plan with the placement and service user 3's key worker to determine how the issue could be addressed. The issue could have been addressed through sessions with the key worker to teach service user 3 about online safety. The social worker would have to instruct key workers to complete key working sessions on online safety and request copies of the sessions evidence the direct work is taking place. Then review the progress during statutory 6-weekly meetings*.
>
> *I instructed the social worker to call a meeting with the police. I told the social worker that he should gather information so that he could present it at the meeting with the police. The social worker was expected to meet with service user 3 and the placement staff before that meeting so that by the time the meeting took place we would have all the necessary information and we could share that with the police.*
>
> *I cannot recall when the meeting with the police was held. We did not have the relevant information at the meeting as the social worker had failed to take the actions identified. As a result the police were not able to progress the matter and service user 3 was put at even higher risk of being radicalised*.'

93. The panel had no difficulty in finding this head of allegation proved. Mr Moyo gave evidence that despite closely guiding Mr Odoginyon on the steps that he required to take in this matter, Mr Odoginyon had failed to do what he had been instructed to do.

3. d)

94. The panel decided to amend the wording of subhead 3. d) to delete '*...Looked After Child review*' and to substitute '*Contact Management Meeting*' since the evidence and the documents supported that this was the actual designation of the meeting. The panel considered that making this amendment had no material impact on the fairness of the hearing and would not cause prejudice to either party.

95. The panel found this limb of the subhead not proved.

96. The panel observed that the evidence for this subhead came from Ms Bowden's oral evidence and her signed statement dated 27 October 2023, which provided:

'During the placement meeting, the Social Worker told service user 3 things that were not
achievable, given the risks identified. During the meeting, the Social Worker congratulated service user 3/his family member as they had passed a DBS check. This led to service user 3 thinking that plans were going ahead but these expectations were not realistic. Service user 3's behaviour then escalated because of this and he became aggressive. The feedback I provided is attached...'.

97. The panel also observed that Ms Bowden wrongly identified the meeting of 3 February 2021 as a pre-Looked After Child (pre-LAC) review, although in fact it was a Contact Management Meeting. The notes of the meeting were made on 9 February 2021 and did not include reference to Mr Odoginyon making the remarks which are attributed to him. The panel considered that the only reference to remarks made which may not have managed the service user's expectations regarding contact with their family appeared to be linked to the team manager, not Mr Odoginyon. The remarks were; he will '*...ensure that all the relevant police checks are completed before contact decisions are made, but it all seems positive and there are no concerns*.'

98. In the circumstances, the panel preferred the meeting notes to the much later 2023 statement and oral evidence in 2024. The panel considered that had such an observation been made by Mr Odoginyon, it would have been captured in the contemporaneous meeting notes.

Allegation 4. a), b) and c)

99. The panel considered that all three limbs of this subhead could be taken together.

100. The panel found that this subhead was proved.

101. The panel accepted the evidence of Mr Moyo that on 8 January 2021 a child service user shared a video that they had been sent showing a 4-year-old child being sexually abused by an older child. The panel accepted that the social worker was required to

respond to this urgently, informing the relevant parties without delay and ensuring that the information was not overlooked. The video had been shared on a social media platform which had a 24-hour expiry window meaning that the evidence of the video would be lost unless action was taken by an appropriate person or body to secure it. The panel considered that the significance of the video and the need for an urgent response could not be understated. Despite this, the panel was satisfied that Mr Odoginyon had not acted as he was required to act.

102. Mr Moyo said:

'*I would have expected the social worker to share the information with me, Binesh Kappan, and the police. I would also have expected the social worker to have telephoned the foster carer to gather more information in terms of where the video came from and how the child got hold of it. I would then have expected the social worker to share this information with myself, Binesh and the police*.'

103. '*We had concerns around the Social Worker's understanding of what procedures were to be followed and why he did not report the disclosure. It was also concerning that the Social Worker showed no urgency to share the disclosure or gather more details. When I spoke with the Social Worker about these concerns he told me that he did not feel that the information had to be shared because the children involved were not known to the team*.'

104. Despite Mr Odoginyon suggesting in his written submission that he had not been copied into the initial email from the foster carer reporting the incident, the panel saw that he in fact had been, and also copied into subsequent emails. There was no evidence to suggest that Mr Odoginyon had acted to contact the necessary persons and take the appropriate action arising out of this alarming disclosure.

Finding and reasons on grounds

Submissions by Social Work England

105. Ms Sharpe invited the panel to find that as a consequence of its findings of fact, it should find that the grounds of impairment in Mr Odoginyon's case, a lack of competence or capability in terms of regulation 25.-(2)(b), were established. This was a matter for the panel exercising its own professional judgement and not something to be limited to matters of evidence.

106. Ms Sharpe reminded the panel that the impairment and sanctions guidance last updated 19 December 2022 states that decisions should be fair and consistent. A finding that the statutory grounds were established would be consistent with the panel's findings above that Mr Odoginyon had failed to demonstrate the competence necessary to practise safely and effectively as judged by a fair sample of his work over a sufficiently long period of time. Ms Sharpe said that Mr Odoginyon had been subject to

an interim order of suspension for some time. Accordingly he would find it very difficult to demonstrate improved competence or capability in these circumstances.

107. Ms Sharpe submitted that the High Court had provided important guidance in this matter in the cases of *Holton v GMC* [2006] EWHC 2960 (Admin) and *Calhaem v General Medical Council* [2007] EWHC 2601. A lack of competence can be equated with deficient professional performance, which connotes a standard of professional performance which is unacceptably low and which (save in exceptional circumstances) has been demonstrated by reference to a fair sample of professional work. The standard to apply was that applicable to the post to which Mr Odoginyon had been appointed and was carrying out, namely a newly qualified social worker undertaking the ASYE.

Mr Odoginyon

108. Mr Odoginyon had not made any submissions in relation to grounds. His responses to the Case Presenters had referred to examples of good work where he was positively commended by his ASYE lead and other colleagues. He said that he had been able to learn from acknowledged errors and outlined how he would act differently in the future.

109. There were not any up-to-date testimonials, examples of professional practice in an associated employment capacity or reflections and evidence of further training since that point in time.

110. The panel accepted the legal adviser's advice and recognised that its decision on the grounds was one based on current circumstances. The Professional Standards in place at the time were the Social Work England Standards 2019. The Standards apply whether or not the relevant social worker is a fully qualified social worker, or whether they are an ASYE social worker.

111. The panel considered that the Standards which were engaged in this case were:

- *2.3 Maintain professional relationships with people and ensure that they understand the role of a social worker in their lives.*
- *2.4 Practice in ways that demonstrate empathy, perseverance, authority, professional competence, and capability, working with people to enable full participation in discussions and decision making.*
- *2.5 Actively listen to understand people, using a range of appropriate communication methods to build relationships.*
- *3.2 Use information from a range of appropriate sources, including supervision, to inform assessments, to analyse risk, and to make a professional decision.*
- *3.4 Recognising the risk indicators of difference forms of abuse and neglect and their impact on people, their families, and their support networks.*

- *3.11 Maintain clear, accurate, legible, and up to date records documenting how decisions were arrived at.*
- *3.12 Using skills to respond quickly to dangerous situations and take any necessary protective action.*

112. The panel concluded that the proved allegations demonstrated a lack of capability across a substantial range of basic social work skills. Mr Odoginyon was appointed to the ASYE post having initially satisfied his employer that he had the skills and training necessary to act in a demanding role. He had, however, been unable to demonstrate the necessary skills of building rapport and trust with the service users in his care and with professional colleagues in the social work profession and partners in other professions.

113. Mr Odoginyon had been employed for a period of 8 months. In that time he had been allocated a reduced caseload of service users and had been offered much more intensive supervision and support than would be anticipated of an ASYE social worker even in this demanding area of work. His varied and frequent failures across all of these Standards had placed vulnerable service users at risk. He had been unable to show consistent improvement in his level of capability.

114. The panel identified that Mr Odoginyon had failed to identify risks and safeguarding issues and to act accordingly. That amounted to a fundamental failure to observe the Standards of competence and capability identified by the panel.

115. The panel observed that in respect of a number of the service users in his care, Mr Odoginyon had failed to consider the case notes such that he was not in a position to identify safeguarding issues in advance of issues arising. He had failed to familiarise himself with the case notes and to get to know the service users concerned and their vulnerabilities, which was expected of any competent ASYE in his position. In respect of service user 2, Mr Odoginyon was not alert to the safeguarding issues presented by service user 2's contact with other service users. This was despite express requests that he familiarise himself with the risks in service user 2's case. Mr Odoginyon should have identified the risk prior to an incident arising, and therefore have been in a better position to safeguard all service users involved once it arose.

116. Mr Odoginyon's failure to utilise the necessary communication skills with service users affected his and also his colleagues ability to maintain reliable and meaningful contact with the service users. Communication and the nurture of relationships with service users is, the panel noted, a fundamental aspect of social work, particularly as the service users in this case were vulnerable adolescents.

117. Mr Odoginyon's failure to liaise with other agencies, such as the police in the case of service user 2 demonstrated that his practice was lacking in respect of communication with those who can assist ensuring the highest level of care for the service users. As the social worker acts as the voice of the service user when liaising with outside agencies, it is key that the social worker fulfils that responsibility. Furthermore, Mr Odoginyon had

demonstrated that he had not appreciated the importance of the roles and supports for service users offered by his professional colleagues such as police officers.

118. Mr Odoginyon had failed to maintain records and to complete necessary paperwork. This placed service users at risk through the potential for serious miscommunication with others involved in the care and safeguarding of the service users. Use of such recording mechanisms are, in the panel's judgement, essential in ensuring all relevant parties have a working knowledge and understanding of each individual case.

119. The panel concluded that Mr Odoginyon's conduct was in breach all of the above Standards of practice over a significant period of time during his 8-month employment. It was a fair sample of his work, even when judged against instances of good and effective safe practice as disclosed in the papers available to the panel. A substantial proportion of Mr Odoginyon's caseload was involved. The assistance provided to Mr Odoginyon by way of probationary reviews and guidance by supervisors was such, the panel considered, that he had been given adequate opportunities to grow and progress as would be expected of him within the Assessed and Supported Year in Employment (AYSE) programme.

120. Having had regard to all the circumstances, the panel determined that Mr Odoginyon had failed to apply the required Standards to his practice. The panel found that a finding of a lack of competence or capability had been made out.

Finding and reasons on current impairment

121. Having found lack of competence or capability, the panel went on to consider whether, as a result of that, Mr Odoginyon's fitness to practise is currently impaired.

Ms Sharpe on behalf of Social Work England

122. Ms Sharpe on behalf of Social Work England invited the panel to find that Mr Odoginyon's fitness to practise was impaired on grounds of protection of the public including the wider public interest element in order to maintain public confidence in the profession and to promote and maintain proper professional Standards for social workers.

123. Ms Sharpe referred the panel to the impairment and sanctions guidance provided by Social Work England last updated on 19 December 2022. The guidance notes that in the case of *Bolton v Law Society* [1994] 1 WLR 512 it was said that '*The reputation of the profession is more important than the fortunes of any individual member. Membership of a profession brings many benefits, but that is part of the price*.'

124. Ms Sharpe reminded the panel that impairment was again a matter of judgment for the panel and not a matter of evidence. There are two aspects of impairment, personal and public, which should be addressed separately.

Mr Odoginyon

125. There were no submissions in respect of current impairment by or on behalf of Mr Odoginyon.

126. The panel accepted the legal adviser's advice and recognised that the degree of insight and positive action taken by Mr Odoginyon, if any, was a central element in arriving at a judgement on current impairment.

127. The panel took into account the impairment and sanctions guidance last updated by Social Work England on 19 December 2022, in particular paragraphs 11 to 63 which outlined the factors to be taken into account when determining impairment.

Personal impairment

128. The panel considered the guidance provided in *Cohen v General Medical Council* [2008] EWHC 581 which invited panels to consider:

- whether the Registrant's conduct was easily remediable;
- whether it had been remedied; and
- whether it was highly unlikely to be repeated.

129. The panel concluded that Mr Odoginyon's lack of capability or competence was remediable, albeit with some difficulty. Mr Odoginyon had not, the panel understood, been able to continue in practice as a social worker since being subject to an interim suspension order. However, he had taken up work in a related though unqualified adviser capacity in which there was evidence of good practice dating back to 2022. The panel had nothing more recent. The certificates produced by Mr Odoginyon all predated his ASYE employment. There was no evidence of any targeted remediation such as courses of training or insight and reflection dealing with competence and capability. Mr Odoginyon emphasised the alleged failings of others as being instrumental in his inability to progress and demonstrate competence. He said that he had been set up to fail by being placed in a demanding job without adequate supervision or training. He did not acknowledge the measure of support provided to him including a very restricted caseload.

130. The panel considered that Mr Odoginyon had not been able to provide any practical evidence or any up-to-date reflections which addressed a relevant degree of insight into his lack of competence or capability.

131. Mr Odoginyon had wholly failed to engage meaningfully with the serious and substantial failings captured in the allegations. In particular, Mr Odoginyon had not expressed any real grasp of his personal responsibility for his failings, particularly in respect of his working collaboratively with partner colleagues, identifying and acting on alarming risks for service users, and his failures to build relationships with his professional colleagues and the service users in his caseload.

132. Mr Odoginyon said in his response to the Case Examiners that he had learned from his experience and he set out some things which he said he would do differently. However, these were superficial and were not accompanied by any measure of real ownership of his failings and any sense of remorse for the potential consequences of his lack of competence and capability. Instead, Mr Odoginyon couched his analysis in criticisms of Mr Kappan which he held to be the real cause of his difficulties. Mr Odoginyon said that he had been oppressed by the organisation that had employed him.

133. More significantly for the panel, Mr Odoginyon said that he had not posed a risk to any adult or child. The panel considered this to be an almost complete absence of insight on Mr Odoginyon's part.

134. There was no recognition by Mr Odoginyon of the impact that his actions had on vulnerable service users and others and the risks that his sustained lack of competence or capability had created. There was no fundamental engagement with the serious issues in this case. As a result, the panel could not be reassured that Mr Odoginyon would not repeat similar failings through an unaddressed lack of capability or competence.

135. The panel found that it could not conclude that it was highly unlikely that Mr Odoginyon's misconduct would be repeated.

136. The panel was disappointed not to have been provided with any real expression of remorse by Mr Odoginyon.

137. The panel concluded that Mr Odoginyon's fitness to practise is currently impaired by virtue of the personal component.

Public impairment

138. The panel paid close regard to the Social Work England guidance from paragraph 60 onwards. The panel also considered that Mr Odoginyon's actions engaged limbs (a), (b) and (c) of the test formulated in the High Court by Cox J in *Council for Healthcare Regulatory Excellence v Nursing and Midwifery Council and Grant* [2011] EWHC 927 (Admin) at paragraph 76:

'*Do our findings of fact in respect of* [Mr Odoginyon's] *misconduct, … show that his fitness to practise is impaired in the sense that* [he]:

a. *has in the past acted and/or is liable to act in the future so as to put a* [service user] *or at unwarranted risk of harm; and/or*

b. *has in the past brought and/or is liable in the future to bring the* [social work] *profession into disrepute; and/or*

c. *has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the* [social work] *profession; and/or*

d. *… '.*

139. The panel recognised that the risks of harm that Mr Odoginyon's inadequate and unimproved professional performance exposed vulnerable service users to were significant and unacceptable.

140. The panel was also satisfied that Mr Odoginyon's actions, even though conducted over a relatively short period of time and in relation only to one employer at an early stage in his career, did have the potential to bring the reputation of the profession into disrepute. Mr Odoginyon had failed to properly arrange important meetings with partner professionals on more than one occasion. That had attracted concern and criticism from his professional colleagues. In these circumstances, the well-informed member of the public would have little difficulty in understanding the loss of confidence in the profession that this might attract.

141. The panel was also satisfied that Mr Odoginyon had breached at least one of the fundamental tenets of the profession. Mr Odoginyon had failed to identify and act on clear and immediate risks for the service users in his caseload. He had not acted on information which pointed to a need for urgent protective steps to be taken. He had consistently demonstrated a lack of professional curiosity. He had failed to engage with fellow professionals both internally with his employer and externally in partner organisations including the police. Broader safeguarding matters had not been identified and dealt with. Mr Odoginyon's failures to build positive relationships with service users by responding to their needs was particularly concerning. Arising out of this Mr Odoginyon had not been an advocate for the service users and he had not prioritised their needs over his own. This ran contrary to the fundamental tenets of social work which Mr Odoginyon would, like all social workers, have been immersed in from the very beginning of his career.

142. The panel considered that the public would be concerned at Mr Odoginyon's unaddressed lack of capability and competence, unrecognised by him over an eight-month period of extensively supported ASYE practice. He had, in consequence of his unimproved competence placed at added risk a disadvantaged group of adolescent service users of being inadequately safeguarded.

143. In all of these circumstances, a finding of impairment was necessary in order to declare and uphold Standards for social workers and to maintain the trust and confidence of the public in the profession.

144. The panel, therefore, found Mr Odoginyon's fitness to practise to be impaired on the grounds of public protection and in the wider public interest.

Decision and reasons on sanction:

145. Ms Sharpe, on behalf of Social Work England, submitted that a suspension order was the appropriate and proportionate sanction. Ms Sharpe did not identify a time period which Social Work England considered was the correct one, but pointed out that Mr Odoginyon had not been in contact with Social Work England for more than two years. A

removal order would only be available to a reviewing panel after a substantive suspension order has been in place for two years.

146. She submitted that:

- Conditions of practice are often suitable and appropriate in cases of lack of competence or capability
- However Mr Odoginyon has not engaged in such a long time that the panel could not be confident that he would respond constructively to an opportunity of conditions of practice
- The allegations that have been found proved relate to fundamental skills required by a social worker
- Mr Odoginyon's current level of insight and remediation is not sufficient so as not to put service users at risk of harm
- The panel found that:
  - his insight is self-focused;
  - appeared to be detached from the risk of harm that his actions placed on service users; and
  - he did not have evidence of meaningful remediation.

147. Ms Sharpe submitted that there is a risk of repetition given that Mr Odoginyon has not been able to demonstrate the implications of the failures and inadequacies in his practice.

148. Further, he perceives the deficiencies in his practice were mainly attributable to failures by others.

149. Ms Sharpe invited the panel to be cautious in respect of possible double-counting of aggravating features which are already accounted for elsewhere in the guidance. In that regard, a lack of insight or engagement were not independent aggravating factors in themselves.

150. The panel accepted the legal adviser's advice. It recognised that the overarching objective is a central consideration when exercising its functions. The purpose of a sanction is not to be punitive although a sanction imposed may have an unintended punitive effect.

151. The panel considered the least restrictive sanction first and then moved up the sanctions in ascending order as appropriate. The panel had regard to the Social Work England Sanctions Guidance, updated on 16 December 2022.

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

- There were contextual factors which should be accounted for including the lockdown restrictions imposed under the Covid-19 public health measures which limited his

ability to access the office and colleagues. This was regrettable in the context of an ASYE employee.

- Mr Odoginyon had health issues at the point of his taking up ASYE employment. He said however that these factors were not significantly influential.
- Mr Odoginyon had acknowledged some failures in his practice although with incomplete insight and ownership.
- At the time of the concerns, Mr Odoginyon was at an early stage of his career.

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

- Mr Odoginyon had put service users at risk of harm;
- The failures in Mr Odoginyon's practice were wide-ranging across a broad canvas of professional competences and were repeated, despite significant additional assistance and multiple reviews of his work;
- Mr Odoginyon has limited insight into his failings, which is self-focused. In particular, Mr Odoginyon has failed to identify, understand, take ownership and appeared to be detached from the risk of harm that the concerns place on service users;
- Mr Odoginyon has not apologised for his failures or shown remorse; and
- Mr Odoginyon has not undertaken even limited remediation.

154. In light of the seriousness of its findings in relation to Mr Odoginyon's lack of competence and capability and current impairment, the panel found that taking no action or merely issuing advice would not adequately protect the public. Mr Odoginyon's practice would not be restricted so as to mitigate the risks of harm that stemmed from his deficiencies in competence and capability.

155. In addition, these sanctions would not adequately meet the wider public interest of maintaining public confidence in the profession and declaring and upholding proper standards of conduct and behaviour.

156. The panel then considered whether issuing Mr Odoginyon a warning. Paragraph 108 of the Sanction Guidance states that:

"*A warning order is likely to be appropriate where (all of the following):*

the fitness to practise issue is isolated or limited

there is a low risk of repetition

the social worker has demonstrated insight"

As set out above, the panel finds that Mr Odoginyon does not meet any of these criteria:

- The concerns were not isolated or limited. The failures in Mr Odoginyon' practice were wide-ranging and repeated;
- For the reasons provided in the "*finding and reasons on current impairment*" section above, the panel finds that there is not a low risk of repetition;
- Although Mr Odoginyon had demonstrated limited insight, it is self-focused. In particular, Mr Odoginyon has failed to identify, understand, take ownership for his own failings. He appeared to be detached from the risks of harm that his practice shortfalls placed on service users.

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

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

- the wide-ranging lack of competence or capability in Mr Odoginyon's practice;
- the panel's findings that Mr Odoginyon has put service users at unwarranted risk of harm;
- the high risk of repetition of conduct similar to that of the failures found in Mr Odoginyon's practice;
- Mr Odoginyon had been under close supervision during his ASYE year, yet significant concerns surrounding his practice existed;
- the continuing limited insight from Mr Odoginyon in relation to his failures, which has been exacerbated by Mr Odoginyon's continued belief that the failures in his practice were essentially due to inadequate supervision, management, and mentorship;

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

159. In any event, Mr Odoginyon has not engaged in over two years with his regulator or at all in this final hearing process. The panel could not have confidence that Mr Odoginyon would engage meaningfully with conditions of practice so that the public would be safe while he worked as a social worker under restrictions.

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

- The proved allegations demonstrate failures in fundamental aspects of social work practice. The panel consider these to be a serious breach of the professional standards;
- Mr Odoginyon has demonstrated only limited insight and has not undertaken remediation;
- A suspension order will provide him with the time to reflect on the findings, and to develop and broaden insight. It will allow scope for opportunities to demonstrate remediation of his competence and capability in his practice, albeit not as a social worker; and
- The panel noted that under paragraph 150 of the Social Work England Sanctions Guidance, a removal order is not available to it in the current situation.

161. The panel also took into account the importance of publicly declaring the standards of conduct and behaviour expected of a registered social worker and maintaining public trust and confidence in the profession.

162. The panel noted that there is a public interest in permitting a social worker to continue to practise their profession for the public good, if it is safe to do so, provided that it is not inconsistent with the wider public interest objectives which must take priority. The panel concluded that permitting Mr Odoginyon to return to practice immediately and his professional and personal interests were outweighed by the panel's duty to uphold the wider public interest. Therefore, a Suspension Order would satisfy the public interest aspects of the case.

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

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

maintaining confidence in the profession

ensuring the professional standards are observed"

In this case, there were real concerns for the safety of service users and the public which went beyond the public interest factors of the overarching objective. However, having balanced the factors outlined above, and upon considering all of the circumstances of the case, the panel found that a 12-month suspension order would be a sufficient period for Mr Odoginyon to develop full insight and to plan to remediate his practice if he wished to do so.

164. The panel decided that this was a sufficient period of time to protect the public and to maintain public confidence in the profession. Mr Odoginyon has not indicated a wish to return to social work practice. He might decide to do so having read this determination and considered the contents thoughtfully. The panel held in mind that it is in the public interest to support a trained and skilled social worker to return to practice. Further, a

period of in excess of 12 months risks Mr Odoginyon becoming deskilled and the risk of deskilling is a public interest consideration.

165. The suspension order will be subject to review before expiry, during which a separate panel of adjudicators will consider whether Mr Odoginyon's fitness to practise remains impaired and, if so, what, if any, sanction should be imposed. Mr Odoginyon will only be permitted to practise, under restrictions or otherwise, if he demonstrates sufficient insight and if the review panel is satisfied that his return to practise with or without a restriction would no longer pose a risk to the public and that allowing him to practise maintains public confidence in the profession. The reviewing panel would benefit from Mr Odoginyon's resumed engagement with Social Work England:

- Attendance at future hearings
- A reflective piece highlighting his past failings and the impact they had on the safety of service users, his colleagues, and on public trust and confidence in the profession.
- Mr Odoginyon may also wish to provide the reviewing panel with a history of his employment and training since the ending of his ASYE contract. That might include:
    - reflections on that work or training
    - how that has addressed and developed his competence and capability
    - explaining why he would not again be responsible for failings in practice related to a lack of competence or capability should he return to social work practice unrestricted.

Interim order:

166. In light of its findings on sanction, the panel next considered an application by Ms Sharpe for an interim suspension order for 18 months to cover the appeal period before the final order becomes effective.

167. The panel next considered whether to impose an interim order. It was mindful of its earlier findings. The panel decided that it would be wholly incompatible with those earlier findings and the imposition of a substantive suspension order not to conclude that an interim suspension order was necessary for the protection of the public or was otherwise in the public interest for the appeal period.

168. The panel was told by Ms Sharpe that an interim order of suspension had already been put in place prior to this hearing. However, the panel concluded that its duty was to protect the public in a positive way and not to rely on the potential effect of an order that was put in place for different reasons than an interim order related to a potential appeal period prior to the substantive order coming into effect.

169. Accordingly, the panel concluded that an interim suspension order is necessary for the protection of the public and public interest grounds. It determined that it is appropriate that the interim suspension order be imposed for a period of 18 months to cover the appeal period of 28 days and any subsequent time necessary to resolve the appeal up to 18 months. If there is no appeal, the interim order will no longer be effective on the coming into effect of the final order.

Right of appeal:

170. 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.

171. 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.

172. 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.

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

Review of final orders:

174. 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

175. 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:

176. 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.