Social worker: Sophie Henderson
Registration number: SW95226
Fitness to Practise
Final Hearing

Dates of hearing: 17 June 2024 to 25 June 2024
10 September to 11 September 2024

Hearing venue: Remote hearing

Hearing Outcome: Removal Order

Interim Order: Interim Suspension Order – 18 months

Introduction and attendees:

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

2. Ms Henderson did not attend and was not represented.

3. Social Work England was represented by Mr Adrian Harris case presenter from Capsticks LLP.

4. The panel of adjudicators ("the panel") conducting this hearing and other people involved in it were as follows:

Adjudicators	**Role**
Gill Mullen	Chair
Natalie Pickles	Social worker adjudicator

Wallis Crump	Hearings officer
Khadija Rafiq/ Jo Cooper	Hearings support officer
Natalie Amey-Smith	Legal adviser

Service of notice:

5. Ms Henderson did not attend and was not represented. The panel was informed by Mr Harris that notice of this hearing was sent to Ms Henderson by email to the electronic mail address provided by Ms Henderson. Mr Harris referenced the Social Work England (Fitness to Practise) Rules 2019 (as amended) ("the rules") and drew the panel's attention to the relevant rules. Mr Harris submitted that the notice of this hearing had been duly served.

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

   - A copy of the notice of the final hearing dated 15 May 2024 and addressed to Ms Henderson at her email and postal addresses which she provided to Social Work England.
   - An extract from the Social Work England Register ("the register") as of 15 May 2024 detailing Ms Henderson's registered email and postal 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 electronic mail to Ms Henderson at the address referred to above, the notice of hearing and relevant documents. On 16 May 2024, the writer also sent the notice and relevant documents by special next-day delivery to Ms Henderson at her postal address as detailed on the register.

- A copy of the Royal Mail Track and Trace Document indicating "signed for" delivery to Ms Henderson's address at 09:27am on 18 May 2024.

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

8. Having had regard to the rules and all the information before it in relation to the service of notice, the panel was satisfied that notice of this hearing had been served on Ms Henderson in accordance with rules 14, 15, 44 and 45.

Application to proceed in private:

9. Mr Harris told the panel that some of the evidence provided in the bundles relates to Ms Henderson's health matters. He asked for the 'application to proceed in private' to be heard in private so that he could mention Ms Henderson's health matters in more detail to support his application.

10. The panel agreed to hear the 'application to proceed in private' in private to enable it to hear the full details of the application without undermining Ms Henderson's right to a private life concerning her health.

11. Mr Harris submitted that in accordance with the rules, any submissions or evidence relating to Ms Henderson's health matters must be heard in private. Mr Harris submitted that this was not a health case but that the evidence does contain *[Private]*.

12. The panel heard and accepted the advice of the legal adviser and had regard to rules 37 and 38 of the Rules.

13. The panel agreed with Mr Harris that matters relating to Ms Henderson's health shall be held in private session in accordance with rule 38. The panel concluded that all other parts of the hearing shall be held in public, in accordance with rule 37.

Proceeding in the absence of Ms Henderson:

14. The panel heard the submissions of Mr Harris on behalf of Social Work England. Mr Harris submitted that notice of this hearing had been duly served, no application for an adjournment had been made by Ms Henderson and as such there was no guarantee that adjourning today's proceedings would secure her attendance. Mr Harris referred the panel to the Social Work Response Bundle and in particular Ms Henderson's typed submissions dated 6 May 2024. In part the submissions state:

'As previously, mentioned in my emails and telephone discussions to social work England , ...and other individuals. I have been thinking it through for several weeks now that it is with regret that I wont be in actual attendance to the final hearing. This is due to several personal factors which I have outlined in emails and telephone calls. Most recently with ... This is due to several personal factors; for instance, as identified I do not have the financial or personal means of having any support or representation at this hearing, after leaving social work in April 2021 and surrending [sic] my membership and registration to social work England and [Private], I could not afford this after leaving social work and certainly can not afford it now. I have no one who I could ask to attend

this process and support me. I can't not cope with this ten day lengthy process on my own either or feel able to represent myself. [Private]. Furthermore, I am currently working as a carer in day centre, while this is an unqualified and non social work related role (to which social work England are aware of, my service manager is also aware of the sw England processes) I do not have the annual leave sufficient to take this amount of time off . I also can not financially afford to take this time as sick or unpaid. However, I would like to make it clear, However that I will make myself available on a day to dial in if the fitness to practice investigation wishes to speak to me in person and will abide/ accept any decision the panel makes regarding my fitness to practice as a social worker/ whether my fitness is impaired.'

15. Mr Harris also drew the panel's attention to an email sent by the Hearings support officer to Ms Henderson on 7 June 2024. In part the email states:

    '*We have received information from Capsticks indicating that you do not wish to attend the hearing in person but are willing to be available by phone should the panel have any questions. Could you please confirm if this is still correct?*

    Additionally, we would appreciate it if you could provide us with your availability throughout the week. Specifically, please let us know the best times for you to be contacted by phone.

    We will liaise with the panel to determine if they have any questions for you. We aim to update you by Monday, 17th with any further information regarding the panel's inquiries.'

16. Mr Harris drew the panel's attention to the email response (sent as a reply to the Hearings support officer and including the text of the original email) from Ms Henderson dated 10 June 2024. The email states:

    ' *Thank you fir [sic] your email. The information you have is correct. I am available after 4 pm wednesday, friday and Thursday should the panel wish to talk to me. Thanks Sophie*.'

17. Mr Harris submitted that Ms Henderson's stance in relation to her non-attendance was a settled view. He submitted that whilst she had engaged to a limited degree the panel could conclude that Ms Henderson's actions amounted to a deliberate waiver of her right to attend.

18. Mr Harris reminded the panel that unlike in criminal law, it has no powers to compel Ms Henderson's attendance. He submitted that:

    - There was a strong public interest in conducting the hearing without delay.
    - That the witnesses are on notice and available to give evidence.
    - That any delay might negatively impact on the quality of evidence.

- That whilst there would be some disadvantage to Ms Henderosn in not attending the hearing, she had provided written submissions, which the panel could take into account in reaching its decisions.

19. In relation to Ms Henderson's offer to be available after 4pm on Wednesday, Thursday, or Friday, if the panel had any questions, Mr Harris submitted that it was a matter for the panel. However, he submitted that it would not be appropriate to slow down the hearing to allow for that and that if a decision is made to proceed in absence, then the case should proceed without adjournments.

20. The panel heard and accepted the advice of the legal adviser in relation to the factors it should take into account when considering this application. This included reference to rule 43 of the rules and the cases of *R v Hayward [2001] EWCA Crim. 168, General Medical Council v Adeogba [2016] EWCA Civ 162* and the factors endorsed in *Sanusi v GMC [2019] EWCA Civ 1172*. The panel's attention was drawn to the '*Service of notices and proceeding in the absence of the social worker'* guidance dated 16 December 2022 which is available on the Social Work England website.

21. The panel considered all of the information before it, together with the submissions made by Mr Harris on behalf of Social Work England. The panel took into account its early decision on service of notice and was satisfied that Ms Henderson was aware of the hearing and of her right to attend.

22. The panel took into account that Ms Henderson has been engaging with Social Work England in relation to the final hearing. In doing so she has been consistent in stating on several occasions, (some of which are set out above), that she has no intention of attending at the final hearing. It noted that Ms Henderson has provided various written submissions which contain her views on the regulatory concerns, and which it will take into account when reaching its decisions. The panel took into account that Social Work England has three witnesses on notice to give evidence at this hearing and that the allegation dates back to 2020.

23. The panel concluded that Ms Henderson had chosen voluntarily to absent herself from these proceedings and had made her feelings clear in her emails. The panel had no reason to believe that an adjournment would result in Ms Henderson's attendance nor that it would secure her future engagement. Having weighed the interests of Ms Henderson, with those of Social Work England, and the public interest in an expeditious disposal of the hearing, the panel determined that it is in the interests of justice to proceed in Ms Henderson's absence.

24. Having made the decision to proceed in absence the panel did not find it fair or necessary to slow the pace of the hearing to enable Ms Henderson to be telephoned at 4pm on Wednesday, Thursday or Friday. In reaching its decision, the panel took into account that Ms Henderson is not actively asking to be telephoned to enable her to participate, she is simply stating that she will be available at those times/days should the panel have any questions. The panel considered that it would be disruptive and inappropriate for the hearing to be paused at an exact point as to enable Ms Henderson

to be telephoned in accordance with her availability and could risk the hearing going part heard.

25. Despite the decision to proceed in absence, the panel was aware that there was still opportunity for Ms Henderson to re-engage should she wish to do so as the hearing progresses. The panel decided that it would be fair, in light of Ms Henderson's offer of availability, to send her the decision at facts stage, and each and every subsequent stage (if reached), to enable her to read the decision and choose whether she wishes to engage. However, for the reasons already stated, the panel decided it would not pause the hearing once the decision had been sent to allow Ms Henderson further time, it would continue in accordance with the timetable.

Allegations:

1. *The allegation arising out of the regulatory concerns referred by the Case Examiners on 13 October 2022 is:*

   Whilst registered as a social worker:

   1. *Between 1 July 2020 and 28 February 2021, you failed to safeguard others, in that you:*

      a. *Did not adequately assess and /or respond to risk in a timely manner for one or more service users identified in Schedule 1*

      b. *Did not complete workflows appropriately and/or without excessive delay for one or more service users identified in Schedule 2*

   2. *Between 1 July 2020 and 28 February 2021, you failed to safeguard others, in that you:*

      a. *Did not accurately record information within case notes for one or more service users identified in Schedule 3*

      b. *Did not record information within case notes in a timely manner for one or more service users identified in Schedule 4*

   3. *On 3 November 2022, you made assertions to Social Work England in that you:*

      a. *told Social Work England by email that you had previously sent an email accepting an offer of Accepted Disposal;*

      b. *Sent what you asserted was a forwarded email in which you had previously accepted an offer of Accepted Disposal*

   4. *Your conduct at paragraph 3 above was false and/or carried out with the intention of misleading employee/s of Social Work England into believing you had attempted to accept the offer of Accepted Disposal.*

5. *Your conduct at paragraph 3 and 4 above was dishonest.*

Your conduct at paragraphs 1-2 above amounts to lack of competence or capability, and/or misconduct.

Your conduct at paragraphs 3-5 above amounts to misconduct.

By reason of your lack of competence or capability, and/ or your misconduct, your fitness to practise as a social worker is impaired.

Schedule 1 – Did not adequately assess and /or respond to risk in a timely manner

Service User	**Failure to assess risk**	**Failure to respond to risk in a timely manner**
i. *Service User 1*	Did not complete a Care Needs Assessment under the Care Act 2014 with sufficient detail	Referral received on 7 August 2020, sufficient initial call not completed until 23 November 2020.
ii. *Service User 10*	IC referred on 30 July 2020 to request assessment for a care package. Did not establish contact within reasonable time frame	Did not follow up with nurses and on lack of contact and closed the case
iii. *Service User 23*		When on duty, did not follow up concerns raised about bruising.
iv. *Service User 22*	Referred to Council on 6 January 2021 for review of care package. SC went into hospital on 27 January 2021 and the Social Worker had not made contact.	Same reasons
v. *Service User 3*	Asked to make contact in April 2020 re increase in care. Delay in establishing contact.	Notified of safeguarding concerns on 20 July 2020. Did not take any action until September 2020
vi. *Service User 24*	Assessment of care needs requested 3 July 2020, contact with family not made until 24 November 2020.	
vii. *Service User 8*	Concern raised 8 July 2020 regarding self-neglect. Did not visit until 21 October 2020.	Took three months to make contact in a case regarding

Service User	Failure to assess risk	Failure to respond to risk in a timely manner
		concerns over self-neglect.
viii. *Service User 15*	Allocated on 18 May 2020 to assess long term care needs. Arranged a care package but did not contact MS or carer to assess care needs by 16 September 2020.	Two to three week delay in responding to carer breakdown.
ix. *Service User 14*		Delay of several weeks in establishing urgency and nature of risks and needs
x. *Service User 17*	Allocation 14 September 2020. Contact to complete assessment had not taken place by 16 October 2020	Delay as set out
xi. *Service User 20*	Allocated 17 September 2020 to review RF's care package. Support not arranged until end of October 2020.	Same reasons
xii. *Service User 21*	Allocated 24 July 2020 to make contact with relative and arrange assessment if required. Did not speak to RH's family until 6 October 2020.	Same reasons
xiii. *Service User 9*	Allocated 18 August 2020 to assess HJ's needs. Did not. Made only one attempt to contact Mental Health team same day. No further action taken until 16 September 2020.	Same reasons
xiv. *Service User 6*	Allocated 9 July 2020 – urgent referral, Social Worker required to assess care needs and arrange support. Another social worker was asked to visit on 21 August 2020 because of the lack of information on the case record.	Same reasons

Service User	Failure to assess risk	Failure to respond to risk in a timely manner
xv. *Service User 7*		Allocated 16 July 2020 for care needs assessment. Telephone assessment completed 27 July 2020 but no support put in place. Had not been written up by 21 August 2020.

Schedule 2 – Did not complete workflows appropriately and/or without excessive delay

Service User	Did not complete workflows appropriately	Did not complete workflows without excessive delay
i. *Service User 12*		The Social Worker did not complete the care plan when asked in May 2020 which restricted KB's direct payment. This was not resolved until December 2020.
ii. *Service User 4*	Completed home visit on 2 March 2020 but did not complete the Continuing Health Care checklist or review of care package.	Allocated on 10 February 2020. Continuing Health Care checklist not completed until 6 January 2021 and care package review not completed until 15 January 2021.
iii. *Service User 2*	Received information required for annual review of direct payments but did not complete the review.	Allocated on 25 June 2019 to complete annual review of direct payments and audit direct payment account. Social Worker first made contact with AC on 15 April 2020.
iv. *Service User 1*	Did not complete a Care Needs Assessment under the Care Act 2014 with sufficient detail	Referral received on 7 August 2020, sufficient initial call not completed until 23 November 2020.
v. *Service User 10*	Failed to seek advice before closing case	IC referred on 30 July 2020 to request assessment for a care package. Did not

Service User	Did not complete workflows appropriately	Did not complete workflows without excessive delay
		establish contact within reasonable time frame
vi. *Service User 25*		Failed to refer for a carer's assessment. First discussed in August 2020 but not done until 25 November 2020
vii. *Service User 23*	Failed to pass on safeguarding concerns about bruising to duty manager or allocated social worker	
viii. *Service User 13*	Did not have conversation with Service User 13 at correct stage and should have been done earlier.	Service User 13 self-referred for assistive technology in December 2020. Initial contact with Service User 13 not made until 28 January 2021. Did not complete Conversation 1 document until 14 April 2021.
ix. *Service User 19*	Conversation completed by email rather than telephone.	
x. *Service User 22*		Referred to Council on 6 January 2021 for review of care package. Service User 22 went into hospital on 27 January 2021 and the Social Worker had not made contact.
xi. *Service User 18*	Social Worker was advised to meet Service User 18 face to face as he was better at communicating. Social Worker did not do this. No outcome for Service User 18 until the Social Worker left the team in April 2021.	
xii. *Service User 3*	Social Worker was required to purchase additional care for Service User 3 when discharged. Failed to arrange	Notified of safeguarding concerns on 20 July 2020. Did not

Service User	Did not complete workflows appropriately	Did not complete workflows without excessive delay
	and bring forward care package review	take any action until September 2020. Did not address concerns regarding Service User 3's husband struggling as a carer from July 2020 to October 2020.
xiii. *Service User 24*	Social Worker did not establish urgency and contact SW early enough to establish they had savings and care could not be provided.	Assessment of care needs requested 3 July 2020, contact with family not made until 24 November 2020.
xiv. *Service User 8*	Did not arrange joint visit with housing provider on receipt of referral	Took three months to make contact in a case regarding concerns over self-neglect
xv. *Service User 5*	The Social Worker received call on duty on 11 June 2020, she did not include sufficient information in assessment for authorisation for additional nursing care. Did not make correct arrangements.	Took three weeks to amend assessment and did not arrange for needs to be met by 16 September 2020.
xvi. *Service User 11*	Did not make correct arrangements for care package purchase	Delay of two months in purchasing care.
xvii. *Service User 15*		Two to three week delay in responding to carer breakdown.
xviii. *Service User 14*	Did not make initial contact with Service User 14 to enquire about the change in needs.	Delay in completing full assessment. Referral on 4 September 2020, assessment had not been done by 7 October 2020.
xix. *Service User 17*	Did not complete initial call with sufficient detail regarding extra care and did not follow up.	Referral received on 14 September 2020, contact had not taken place by 16 October 2020.
xx. *Service User 20*		Referral received on 4 September 2020. Support not arranged until end of October 2020.

Service User	Did not complete workflows appropriately	Did not complete workflows without excessive delay
xxi. *Service User 21*		Delay in progressing referral received on 24 July 2020. Did not speak to family until 6 October 2020.
xxii. *Service User 9*	Did not take any action to assess needs save for one attempt to contact Mental Health Team.	Allocated on 18 August 2020 but no action taken by 16 September 2020 so case reallocated.

Schedule 3 – did not accurately record information within case notes

Service User
i. Service User 12
ii. Service User 3
iii. Service User 6
iv. Service User 16

Schedule 4 – did not record information within case notes in a timely manner

Service User
i. Service User 12
ii. Service User 4
iii. Service User 3
iv. Service User 24
v. Service User 6
vi. Service User 5
vii. Service User 16
viii. Service User 21
ix. Service User 7

Background (taken from the Statement of Case):

26. On 4 December 2020, Social Work England received a referral from a Team manager at Worcestershire County Council, regarding the respondent social worker, Sophie Henderson.

27. At the time of the referral, Ms Henderson was employed by Worcestershire County Council ("the Council") as a social worker.

28. Ms Henderson first registered as a social worker on 21 October 2013.

Summary of evidence:

Social Work England

29. Social Work England relied upon three witnesses:

    - JK - Advanced Social Work Practitioner at Worcestershire County Council. Ms Henderson's manager from October 2018 to 07 October 2020.
    - SWY - Advanced Social Work Practitioner at Worcestershire County Council. Ms Henderson's manager from October 2020 to April 2021 (when Ms Henderson left the role).
    - FE - Case Operations Manager at Social Work England.

30. Mr Harris called JK, SWY and FE to give evidence. The three witnesses gave evidence under affirmation and adopted the contents of their witness statements.

31. As Ms Henderson was not present, the witnesses were not cross examined but the panel was mindful that in the absence of Ms Henderson it should play an inquisitorial role and explore any apparent weaknesses there might be in Social Work England's case. The panel therefore asked questions of clarification as it deemed appropriate.

JK's evidence

32. The panel had a written statement from JK dated 25 September 2023. The statement attached numerous exhibits including supervision records, a performance Improvement Action Plan ("PIAP"), *[Private]*, the Council's recording policy and case records for multiple service users. The statement also sets out details about specific service users and Ms Henderson's involvement with their cases.

33. In summary JK's statement sets out:

    - Ms Henderson's role included assessing service users and following the guidance in the Care Act 2014 to assess their care needs. The team works with adults who are over 18 years old and gets referrals from the public and other professionals for people with care needs and safeguarding support needs. This ranges from people with autism, physical disabilities, vulnerable adults and adults who are self-neglecting.
    - Ms Henderson was responsible for attending to referrals, to determine whether the service user was eligible for care and support, or if not to safeguard them and support them to access services elsewhere if needed. Safeguarding is a big part of the social worker role, and individuals have to learn to look for concerns and issues. The priority is to make sure that the individual is protected and to take the necessary steps to ensure their wellbeing.

- Ms Henderson started with monthly supervision and then when concerns started to be raised regarding her work, this increased to fortnightly and weekly supervisions when her cases were not progressing to make sure that the service users were safe.
- Within the team, the caseload of social workers differed depending on what types of cases each person held. The normal amount expected for someone to hold was between 20 and 25 cases. Ms Henderson's caseload varied from month to month and was recorded in supervision records as follows: a. July: 20 cases, b. August: 22 cases, c. September: 27 cases, and d. October: 20 cases.
- Ms Henderson was on an informal performance plan and given the opportunity to improve her practice before going through a formal process.
- Ms Henderson was invited to a performance assessment meeting on 9 July 2020 and the outcome was that a Performance Improvement Action Plan ("PIAP") was agreed. The PIAP was aimed at addressing the following areas: case recording; professional responsibility and responding to calls; responding to situations in a timely manner; and following legal processes and department protocols.
- As part of the job, everyone is on a rota to take part in duty function. This is where all the calls come from the public and staff get their work from. If a worker did not have capacity, then they would not pick up cases while on duty. Due to lack of progress with cases, Ms Henderson was taken off the duty rota for four months, and then her duty days were reduced further following this. Ms Hendeson was also taken off duty rota during the PIAP. This was done to help her to have time to deal with her outstanding caseload.
- When concerns started being raised regarding Ms Henderson, she raised some health concerns. *[Private]*.

SWY's evidence

34. The panel had a written statement from SWY dated 13 September 2023. The statement attached numerous exhibits including case records for various service users, *[Private]*, and supervision notes. The statement also sets out details about specific service users and Ms Henderson's involvement with their cases.

In summary SWY's statement sets out:

- SWY was asked to step in and support Ms Henderson when JK had to take long term leave. Ms Henderson was in the midst of a performance review and so SWY did a handover supervision session with JK and then had weekly supervision meetings with Ms Henderson.
- As per the recommendations, Ms Henderson was taken off the duty rota prior to 16 October 2020 as she had some difficulties with this.

- The number of cases carried by Ms Henderson is recorded in each supervision note and was as follows: a. November 2020: 16 cases, b. December 2020: 15 cases, c. January 2021: 18 cases, and d. February 2021: 10 cases.
- Ms Henderson's assessments and support plans were generally good and thorough, however SWY had some concerns on some assessments where Ms Henderson included what the wife or partner had asked for.
- Ms Henderson would have several weeks where there were no case notes, or there would be a call to the duty worker where a service user would say Ms Henderson had been to visit, but there would be nothing in the case records to say that the visit had ever happened.

FE's evidence

35. The panel had a written statement from FE dated 20 April 2023. The statement attached numerous exhibits primarily providing copies of email correspondence between Ms Henderson and Social Work England.

36. In summary FE's statement sets out:

- Following investigation of the initial Regulatory Concerns, the case was sent to the Case Examiners. On 9 August 2022, the Case Examiners made a preliminary decision, proposing an Accepted Disposal of an 18-month Conditions of Practice Order. This was sent to Ms Henderson by email on 9 August 2022.
- As no response was received, JH (Case Examiner Operations Officer) sent email messages to Ms Henderson on 7 September 2022 and 9 September 2022, asking for a response to the Accepted Disposal proposal.
- FE attempted an unsuccessful telephone call to Ms Henderson on 11 October 2022 to discuss the Accepted Disposal proposal.
- On 17 October 2022, the Case Examiners referred Ms Henderson to a hearing and notified her by email, also notifying her that an interim order may be necessary.
- The hearings team sent an email to Ms Henderson on 24 October 2022 regarding an interim suspension order hearing in which Social Work England was proposing to apply for an interim suspension order.
- FE become involved in Ms Henderson's case as she emailed the Case Examiners Operations team inbox on 31 October 2022 expressing confusion and concerns regarding the outcome of the Case Examiners decision. FE replied by email.
- Ms Henderson responded to FE's email on 3 November 2022 to request a call from FE, as she had replied via email that she accepted the suspension.
- FE spoke with Ms Henderson on 3 November to try and understand the confusion. FE explained that the case had been referred to a hearing due to her

nonresponse to the Accepted Disposal. Ms Henderson told him about already having responded prior to the call and that she had agreed to the Accepted Disposal.

- Although the Case Examiners team had not received any correspondence from Ms Henderson it was not out of the question that she had sent it to a wrong email address as this has happened with other cases held by Social Work England.
- FE explained the possibilities of what could happen to Ms Henderson which included the Case Examiners reconsidering their position if there was evidence of Ms Henderson having responded in time. FE asked Ms Henderson to send the evidence that she had responded in time and that he would send it to the Case Examiners who would then decide whether to reconsider.
- Ms Henderson sent an email to the Case Examiners inbox at 15:45 on 3 November 2022. This email appeared to forward a previous email which was addressed to a clearly incorrect email address. FE took this at face value and did not look at the date and time stamp of the forwarded email. The date of the email forwarded was 3 November 2022 and the time was 15:40.
- During the process of reviewing the case FE noticed that this purportedly forwarded email had been sent on 3 November 2022 at 15:40 which was about five minutes before the email forwarding this to the Case Examiner Operations team.
- Therefore, on 16 December 2022 FE wrote to Ms Henderson explaining that the response to the proposed disposal was outside of the deadline set for a response, and the decision to refer the case to a hearing still stood.
- FE did not ask Ms Henderson about this email to clarify why she had sent this as the decision had already been made to refer the incident to Social Work England's Triage team. FE considered that any involvement from him would constitute investigation of the concerns and was not appropriate. Therefore, FE did not have any conversations with Ms Henderson about her intentions with the email or what may have occurred.

Ms Henderson

37. Although Ms Henderson was not present the panel had been provided with a bundle containing various responses from Ms Henderson throughout the investigation period and copies of telephone attendance notes from conversations Ms Henderson had with Social Work England staff.

38. In summary Ms Henderson states:

- In respect of Paragraph 1 of the Allegation, she 'partially' admitted this. She indicated her view that '*during [the] time period I did try to fulfil my duty to safeguard and respond and act appropriately to risk in a timely manner*', adding

that on several cases this was done in line with Council guidance, completing assessments and supports wherever possible within the 28-day guidance.

- That '*wherever possible on duty I completed actioned emergency work…as soon as possible*'.
- She acknowledged that were '*areas for improvement'* within her practice and things she could have done better, particularly in respect of sensitive work on duty and complex processes such as COP (Court of Protection).
- She connected this to her feeling that her effectiveness was '*greatly hindered by the dynamics, running and expectations of the team*' and that social workers were given excessive caseloads plus expected to clear duty every time too, with management not addressing this when it was raised with them until she was at the point of being *[Private]*.
- In respect Paragraph 2 of the Allegation, she 'partially' admitted this. She wrote that '*Upon reflection due to the level of work, amount and complexity of cases and duty work that was expected there were times that I fell behind with some aspects of my recording. This was by far not a general theme as suggested and several times in supervision particularly laterally with was discussed that my case notes were detailed and contained a lot of information. When concerns were raised I addressed these and arranged to attended Record keeping and record keeping training organised by the council and undertook CPD through BASW with the aim of improving my practice in this area.'*
- That she thought that with more support initially, she felt that she may not have fallen behind.
- The employment environment at the time had been unsupportive to begin with and had '*considerably high caseloads'*.
- She described her working relationship with her line manager as '*virtually non-existent'*, improving only latterly when SWY took over as her line manager.
- Support had been provided, but only after '*many months of asking'*, in respect of *[Private]*.
- She accepted she did '*not always do enough to ensure [her] practice was effective as it could have been' [sic] and with hindsight, she should have left the team, taken a 'step down' taking further training, sought extra support or found a different role as it was apparent from early on that her practice was impaired in that team*.
- She accepted there were times that her case recording fell behind, although she said this was in the context of excessive calls/email and *[Private]*.
- She accepted fault in respect of case recordings but wrote that there was some context.

- She states that she did not deliberately attempt to mislead Social Work England in respect of her response (re: the Accepted Disposal) and that her fault was in not reading the documents well enough of checking to where she sent her response.
- She states that she did not alter an email message.

Legal Advice

39. 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. The legal adviser provided advice on the issues of credibility and reliability, as per the guidance in R (Dutta) v GMC [2020] EWHC 1974 (Admin) and guidance on hearsay evidence and the weight to attach to such evidence. Advice was also given in relation to Ms Henderson being a person of good character who prior to this Allegation had no previous regulatory concerns raised against her. The legal adviser also provided advice on the specific wording of the Allegation, including the word 'failed', 'false' and 'intention to mislead'. The panel heard and accepted advice on the test to be applied when considering a charge of dishonesty which is found in the guidance of the Supreme Court in *Ivey v Genting Casinos (UK) LTD t/a Crockfords [2017] UKSC 67* and referred to in the case of *R v Barton and another [2020] EWCA Crim 575*.

Finding and reasons on facts:

(1) Between 1 July 2020 and 28 February 2021, you failed to safeguard others, in that you:

(a)Did not adequately assess and /or respond to risk in a timely manner for one or more service users identified in Schedule 1. ***Found Proved on all apart from service users 6 and 22.***

40. The panel firstly considered the sub-section of the particular, before considering the stem of the particular. It did so by examining the evidence relating to each of the service users identified in Schedule 1 in turn, to establish for each of them, whether Ms Henderson had not adequately assessed and/or responded to risk in a timely manner.

41. In order to establish a base line for adequacy and timeliness of assessing/responding to risk, the panel relied on the documentation exhibited by JK in his witness statement. The panel felt confident in relying on the documentation provided by JK and placed significant weight on it. The panel took into account that the documentation was contemporaneous, was produced prior to the instigation of the Social Work England proceedings, and was documentation produced in the course of business. The panel also felt confident in accepting the evidence of JK as during his oral evidence he provided answers with reference to the contemporaneous documents exhibited to his statement.

42. JK exhibited a copy of Ms Henderson's job description to his witness statement. This notes the purpose of the job is:

'To carry out professional social work assessments/support plans in a timely and effective way.

To ensure that opportunities to prevent, delay or defer the need for on-going support by maximising opportunities for independent living are always considered and explored.

...'

43. The job description (in part) notes as the main activities & responsibilities the following:

'*To undertake comprehensive social work assessments/Support Plans, as allocated by the Triage process within designated timescales, taking into account eligibility factors, Continuing Health Care Checklists and assessment processes and ensuring the identification and minimisation of risk.*

...

To maintain accurate and timely records of actions and decisions and ensure documentation is completed accurately and clearly and issued to service users and carers in a timely manner. Ensure decision making and accountability is clearly evidenced.'

44. JK's evidence states that although Ms Henderson had conducted assessments on some service users, these had not been completed (recorded) on the system for a long period of time. This caused significant delays. JK's witness statement provides details of the impact that delays had on the service users/their families.

45. JK's evidence states that Council policy was that calls/contacts should be recorded on case notes within 24 hours and that reviews and assessments should be recorded within 48 hours. The panel had regard to the 'Council policy on recording' as exhibited by JK which the panel noted accords with his statement. The recording policy is that critical conversations and interventions should be recorded immediately or at least within 24 hours. For all other assessments (conversations) the policy does not give a specific time but states that they should be recorded as soon as they are completed.

46. The panel took into account that Ms Henderson was reminded of the timescales in relation to assessing and responding to service users in the supervision records. The panel placed significant weight on the supervision records, finding them to be detailed as to each case held by Ms Henderson, the previous actions/inactions taken, and the actions/tasks agreed during supervision. The panel took into account that the requirement to adhere to timescales was also set out in the PIAP, which Ms Henderson had been given on 20 July 2020, albeit she did not return the signed version until 25 August 2020. The panel had a copy of the PIAP and noted the following:

'*Sophie to contact referrer promptly and assess the urgency of the situation and establish what support is required.*

Sophie to ensure that contact with the referrer is not delayed more than 48 hours from case allocation.

Sophie to complete required documentation within 48 hours of gathering all the required information.'

47. The panel was therefore confident that Ms Henderson was aware of these timescales. The panel took into account that according to JK's statement, the timescale for completing an assessment depends on the individual circumstances and that it depends on the worker's professional judgement from the initial information gathering contact to determine how soon support is required. The panel took into account that this involves a worker making an initial call to assess how urgent the assessment is.

48. As stated at paragraph 34 above, the panel considered each service user listed in schedule 1 in turn, and in relation to each had regard to the statements of JK and SWY. The panel then cross referenced the statements with the primary source of information within the exhibits, namely the service user case records and the supervision notes. The panel felt confident in relying on the evidence of SWY for the same reasons as those set out in relation to JK.

Service user 1

49. In relation to service user 1, the panel took into account JK's statement and cross referenced it with the case notes and supervision notes provided. The panel noted from JK's statement that a referral was received for service user 1 on 7 August 2020 from an independent care provider for mental health and practical support as service user 1 had several health conditions and was struggling to manage as the family were no longer supporting them. The statement notes that the service user "*had several health conditions and was not sleeping, eating or taking medication efficiently*". JK states that the "*consequences for not providing this support were quite high as there was a risk of health deterioration and weight loss as the lack of support with shopping affected her nutrition. It is difficult to imagine what would have happened without urgent support*."

50. The panel noted that service user 1's case was allocated to Ms Henderson on 10 August 2020 and that she was required to complete a Care Needs Assessment under the Care Act 2014. The panel took into account that in accordance with the supervision records from 21 August 2020, Ms Henderson had not made any contact with service user 1 and she was reminded by JK of the Council's timescales for making initial contact and the potential consequences. The supervision record notes that Ms Henderson will respond to the referral by "next Monday and arrange an assessment".

51. The supervision record for 16 September 2020 notes that Ms Henderson had spoken with the service user on 8 October (this appears to be a typo given it postdates the supervision notes and should be 8 September) and that the case note of the

conversation "*doesn't clearly state what her care needs are. [Ms Henderson] was also unsure what her needs are*." The supervision record notes that JK asks Ms Henderson to speak to service user 1 again to complete an assessment and get clarity of what she needs. The panel cross checked the supervision record with the case note for service user 1 dated 8 September 2020 and noted that they corroborate in terms of Ms Henderson making a call on 8 September.

52. The supervision record from 7 October 2020 shows no record of any contact made with service user 1. JK again requests that Ms Henderson contacts the service user and completes the assessment.

53. JK states that Ms Henderson did not make the initial call to assess how urgent the assessment was until 23 November 2020, as the call on 8 September 2020 did not cover sufficient detail about what the Service User required. JK states that an emergency care package was put in place following an assessment on 23 November 2020, which started from 2 December 2020 and JK exhibits the assessment.

54. In relation to service user 1, Ms Henderson had not made the initial call to service user 1 satisfactorily until 23 November 2020, because the 8 September call which she made did not cover sufficient detail about what was required. The panel took into account JK's evidence in his statement that, "*since service user [1] had been left for a long period without any action we had to process this as an urgent package of care. If [Ms Henderson] had acted on time, then potentially the need for four visits a day could have been unlikely. As it had been four months since the referral, the service user's care needs may have changed in that time without the preventative support*."

55. Based on all the evidence before it, the panel found that Ms Henderson did not adequately assess and respond to risk in a timely manner for service user 1.

<u>Service user 10</u>

56. The panel relied on the statement of JK and cross referenced this with the case records and supervision notes exhibited.

57. JK states that service user 10 was referred to the Council by the nurses in the health team on 30 July 2020 to request an assessment for a care package. Ms Henderson was allocated to this case on 30 July 2020 and remained as the allocated social worker until 22 October 2020. Ms Henderson was required to assess the needs of service user 10 and arrange care if required.

58. JK states that the nature of service user 10's needs were unknown as the referral had very limited information. Ms Henderson was therefore required to contact the nurses in the health team to gather more information before arranging an assessment visit. Ms Henderson first contacted the service user's husband on 11 August 2020, and the service user's husband asked her to call back the next day. There is no record on the file of Ms Henderson following this up from this initial phone call.

59. In supervision on 21 August 2020, it is noted that Ms Henderson agreed to contact the service user on 24 August 2020 to make an appointment to complete the assessment. In supervision on 7 October 2020 there was still no contact made with the service user. This was a period of three months where the case was with Ms Henderson, but she had not taken any action on this.

60. JK states that this meant that Ms Henderson did not know how urgent the situation was, as she had not made the initial call to the service user to determine this. The nurses made the referral knowing that the service user was struggling with their care package and not acting quickly regarding this would have an impact on the individual.

61. Based on all the evidence before it, which is summarised above, the panel found that Ms Henderson did not adequately assess and respond to risk in a timely manner for service user 10.

Service user 23

62. The panel relied on the statement of SWY which exhibited service user 23's case records and correspondence with the care home.

63. SWY states that Ms Henderson was on duty and a call had come in from a care home as they had noticed bruising on service user 23, who had come into the home for respite. Ms Henderson took the call and said to the manager of the care home that she would get the service user's allocated worker to ring them back when they were next at work. The allocated worker was on leave for the whole week and service user 23 was due to go back home the next day. The care home was not sure where the bruising was from.

64. SWY states that Ms Henderson did not action anything in relation to this safeguarding concern and did not report this to the duty manager. SWY was not aware of this until the allocated worker came back from leave and raised this with SWY as service user 23 had been discharged home to an environment where there were potentially significant concerns for her safety.

65. SWY states that she spoke to the care home about what information they had provided to Ms Henderson, and what her responses had been, thereafter she spoke to Ms Henderson about this. SWY states that when she challenged Ms Henderson, she said that she had not said this, and if she did then she was sorry. There was no understanding of the risk that could have been as a safeguarding concern and that there could have been significant concerns about further injury or even death.

66. SWY states that it was ultimately found out that the bruises were from recent medical treatment, however it took over a week to discover this.

67. Whilst this case was already allocated a social worker, it was clear to the panel from the evidence it had read and heard that duty was an important and significant part of social work job within the team. Therefore, in accordance with the job description and

Council policy on recording, Ms Henderson should have adequately assessed the risk given the nature of the call and unavailability of the allocated worker.

68. Based on all the evidence before it, which is summarised above, the panel found that Ms Henderson did not adequately assess and respond to risk in a timely manner for service user 23.

Service user 22

69. The panel had regard to the statement of SWY who states that service user 22 was referred to the Council on 6 January 2021 for a review of his care package. SWY states that Ms Henderson was asked to do a review of the service user's care, but things changed quite dramatically as the service user went into hospital on 27 January 2021 and was incredibly unwell before being discharged home and passed away on 10 February 2021.

70. The panel noted that SWY states that there was a three-week period between Ms Henderson being allocated to complete the review, and the service user going into hospital. Within these three weeks, Ms Henderson had not made any contact with the service user.

71. Unlike with other service users, the panel found SWY's evidence in relation to service user 22 vague. SWY does not provide any contemporaneous documentation to show whether it was Ms Henderson who received the referral, whether it was Ms Henderson who took the referral call on duty, or if not, what date she was allocated the case.

72. Based on all the information before it, which is summarised above, the panel found that there was insufficient evidence to prove that Ms Henderson did not adequately assess and respond to risk in a timely manner for service user 22.

Service user 3

73. In relation to this service user the panel noted that some of the concerns identified in JK's statement pre-date the time period for the Allegation. Therefore, the panel only considered the evidence relevant to the time period in question.

74. The panel relied on the evidence of JK and cross referenced it with the supervision records and case records. The panel took into account that during supervision on 16 September 2020, Ms Henderson said that she had not taken any action as agreed previously, (which was to review before the next supervision). JK states that he advised Ms Henderson to arrange a visit by the next day. The case records show that Ms Henderson contacted the service user's husband on 17 September 2020, but by this time the service user was admitted into hospital. JK states that Ms Henderson had attempted to contact the service user's husband on 3 September 2020 and 11 September 2020, but that he would have expected Ms Henderson to make additional attempts to contact the service user between these dates.

75. JK states that the safeguarding concerns were raised on the 7 of August 2020 and Ms Henderson had not attempted to contact the service user until 3 September 2020.

Considering the delay and the concerns raised by the agency, it was important to contact the service user themselves to ensure their wellbeing and safety. Ms Henderson only contacted the service user after speaking to the agency, and by this time the service user had been admitted to hospital.

76. JK states that the review was initially requested on 20 July 2020 and Ms Henderson made first contact after two months on 17 September 2020. Safeguarding responses are expected to be on the same day, depending on the level of urgency. If someone is highly vulnerable, then immediate action is required irrespective of the day and time. If the individual is not at risk of danger and the referral is reporting some concerns, then a decision could be made in consultation with the manager to respond the next working day.

77. Based on all the evidence before it, which is summarised above, the panel found that Ms Henderson did not adequately assess and respond to risk in a timely manner for service user 3.

Service user 24

78. The panel relied on the evidence of JK which it cross referenced with the referral for this service user, the case records and the supervision records.

79. JK states that an assessment of service user 24's care needs was requested on 3 July 2020. The case was allocated to Ms Henderson on 3 July 2020, and she was required to complete an assessment of needs for the service user as the husband was struggling to manage her care needs and his own health needs. JK states that Ms Henderson was required to make contact to acknowledge the referral and to gather more information to establish the urgency and to plan a visit. In the supervision meeting on 21 August 2020 the records show that JK asked Ms Henderson to contact the service user and identify the urgency of the need and arrange a visit to complete the assessment after her annual leave. The supervision session records for 16 September show that Ms Henderson reported that she had not completed this and that she would contact them by 23 September. In the following supervision session records for 7 October 2020, it shows that Ms Henderson had not yet contacted the service user but had spoken to the Early Intervention Team on 6 October 2020. Ms Henderson had attempted to contact the service user on 6 October 2020 but did not follow up on this attempt.

80. JK states that this was a great concern since Ms Henderson did not contact them for three months and no further information was available to assess the urgency of the needs and the wellbeing of the person. In the worst-case scenario, the service user could have suddenly deteriorated between the referral and Ms Henderson making contact.

81. JK states that Ms Henderson only contacted the family on 24 November 2020 and that the delay in following up and not making any effort to ensure the wellbeing of this couple was unacceptable.

82. Based on all the evidence before it, which is summarised above, the panel found that Ms Henderson did not adequately assess and respond to risk in a timely manner for service user 24.

Service user 8

83. The panel relied on the statement of JK and cross referenced it with the case records for service user 8 and the supervision records.

84. A concern was raised regarding service user 8 by her housing provider on 8 July 2020. These concerns were around self-neglect as service user 8 was not looking after herself and was only eating cold food and not wearing clean clothes.

85. JK states that the case was referred to Ms Henderson on 8 July 2020, and that she was required to complete an assessment of needs. JK states that this required making initial contact with the referrer and with the service user to gather more information and to arrange a visit to assess service user 8's needs if appropriate.

86. JK states that Ms Henderson said in supervision that she had attempted to contact the service user but had not been able to speak to her, and no further contact had then been made for several months. The supervision records for 7 October 2020 note Ms Henderson reported that she had not taken any actions, and that JK advised her to arrange a joint visit with the housing provider.

87. JK states that this joint visit subsequently took place on 21 October 2020 following his management direction. JK states that Ms Henderson was expected to contact a service user within two or three days following an allocation to gather basic information and see how urgent the assessment was. This was agreed as a measurable outcome in the PIAP. Ms Henderson should then make a judgement on how soon a home visit should take place to complete the assessment. If she did not get through to the service user, she was expected to try again the next day and keep contacting them. The intention is to establish the urgency and the responsibility for doing this comes onto the social worker. If there was no response, then it would become a worry particularly when the concerns were centred around self-neglect.

88. JK states that in this case, Ms Henderson said that she had attempted to contact the service user, but no follow up contact was attempted to make an initial assessment on the urgency of the assessment and to see what the concerns were. It took Ms Henderson three months to do this home visit following the referral.

89. Based on all the evidence before it, which is summarised above, the panel found that Ms Henderson did not adequately assess and respond to risk in a timely manner for service user 8.

Service user 15

90. The panel relied on the statement of JK and cross referenced it with the case records for service user 15 and supervision records. The panel noted that the case was allocated to Ms Henderson in the timeframe prior to the dates in the Allegation but that further

issues developed in the case within the relevant timeframe. The panel only relied on the evidence relevant to the timeframe in question.

91. JK states that this case was allocated to Ms Henderson on 18 May 2020 to assess the service user's long term care needs. Ms Henderson arranged a care package following this request, however further concerns were raised by District Nurses on 20 August 2020 regarding potential carer breakdown due to the husband struggling to manage care in between carers visits.

92. The supervision records on 16 September 2020 show that Ms Henderson had not contacted the service user or carer to assess her care needs. The Supervision records note that Ms Henderson '*acknowledged that the delay in responding to a carer breakdown referral is unacceptable and goes against the objective in PIAP*.'

93. JK states that there was a two-to-three-week delay in responding to the carer breakdown faced by the husband and this went against the PIAP objectives of responding to contact in two days.

94. Based on all the evidence before it, which is summarised above, the panel found that Ms Henderson did not adequately assess and respond to risk in a timely manner for service user 15.

Service user 14

95. The panel relied on the evidence of JK which it cross referenced with the case records for this service user and with the supervision records.

96. JK states that service user 14 was referred to the Council as they had requested that they would like to move into a care home. Ms Henderson picked this case up as she was on duty on 4 September 2020. Ms Henderson was required to have an initial conversation with the service user to establish the reason for this request and to arrange a home visit to complete an assessment of needs if appropriate.

97. JK states that service user 14's daughter had contacted the Council on seeking support with the service user twice a week and was advised to arrange this privately considering the limited support required. Within three days of this contact, the service user contacted the Council seeking help to move into a care home. Ms Henderson needed to explore what had changed in those three days and what the service user's needs were.

98. JK states that Ms Henderson did not contact this service user following the referral within 24 hours of the contact as was required by the PIAP. In the supervision records on 7 October 2020, it notes that Ms Henderson said that she had spoken to the daughter on 28 September 2020 and had arranged to carry out a full assessment with the service user on 30 September 2020.

99. JK states that there was a period of six weeks where Ms Henderson had not contacted the service user to establish why they would like to move into long term care. Ms Henderson also had not sent the CCN form regarding funding to the Service User as agreed. JK states that the risk in delaying contacting service users when a referral

comes is that '*we do not know how urgent the concerns are and what led to the referral being made. As a result, we could potentially miss urgent action, and this could include life threatening concerns or safeguarding issues. It is an essential part of the job to get the details about concerns and assess how urgent these are*.'

100. Based on all the evidence before it, which is summarised above, the panel found that Ms Henderson did not adequately assess and respond to risk in a timely manner for service user 14.

Service user 17

101. The panel relied on the statement of JK and cross referenced it with the case records for service user 17 and the supervision records.

102. JK states that a referral for service user 17 to be assessed to move into long term care was made on 14 September 2020. This had come from the daughter who reported that her mother was struggling to walk, and that they wanted to move into a care home.

103. JK states that Ms Henderson was allocated to the case on 14 September 2020. Ms Henderson was required to complete an initial conversation with the service user's daughter to gather more details and arrange an assessment with the view to supporting the service user.

104. The supervision records for 7 October note Ms Henderson said that she had spoken to the service user on 24 September 2020 and had agreed to make contact again on 28 September to discuss more details on extra care, but no contact was made. The supervision records state the Ms Henderson was asked to contact the service user again by 16 October 2020.

105. Based on all the evidence before it, which is summarised above, the panel found that Ms Henderson did not adequately assess and respond to risk in a timely manner for service user 17.

Service user 20

106. The panel relied on the statement of JK and the case records and supervision records.

107. JK states that service user 20 was referred to the Council as he was requesting a review of his care package and two hours of replacement care. This referral came from the care agency on 4 September 2020 requesting support for his wife to have a break from her caring role. The care agency suggested two and a half hours of support to enable her to go out.

108. JK states that Ms Henderson was initially allocated this case on 17 September 2020. JK states that during supervision on 7 October 2020, Ms Henderson said that she had not contacted the wife but had approached the care agency to make some enquiries about whether they had capacity to make extra calls. The impact of the delay in arranging this support could have had significant impact on the wife's health and wellbeing.

109. The panel found that the evidence before it did not suggest that Ms Henderson did not adequately assess service user 20 as she was already aware from the referral what was required. However, there was then a period of inactivity by Ms Henderson where she did not respond to the risk in a timely manner. The panel therefore found this proved in relation to the inadequacy of the responding to risk in a timely manner only.

Service user 21

110. The panel relied on the evidence of JK and the case notes for service user 21 as well as the supervision records.

111. JK states that service user 21 was referred to the Council on 24 July 2020 when a relative requested support as they had been supporting him but could not sustain this. The case was allocated to Ms Henderson on 24 July 2020, and she was required to make initial contact with the relative to gather more information and to arrange an assessment if this was required.

112. JK states that there was a significant delay in Ms Henderson contacting the family to make this initial assessment. In supervision on 29 July 2020 Ms Henderson said that she would contact the family and arrange an assessment the next week. In the supervision meeting on 21 August 2020 there was no record of any contact made with the service user or his family. JK states that he asked Ms Henderson to make contact with the family by 25 August 2020.

113. The supervision records for 16 September 2020, note that Ms Henderson had not taken any action and that '*she will contact him on 23/09/2020*.' The supervision records note, '*reminded [Ms Henderson] that she is breaching the PIAP agreement by not making contacts and not following the direction*.'

114. JK states that the case notes show that Ms Henderson only spoke to the service user's family on 6 October 2020, after which she made a referral for Occupational Therapists for service user 21.

115. Based on all the evidence before it, which is summarised above, the panel found that Ms Henderson did not adequately assess and respond to risk in a timely manner for service user 21.

Service user 9

116. The panel relied on the statement of JK as well as the case notes for service user 9 and the supervision records.

117. JK states that service user 9 had a diagnosis of Alzheimer's and dementia, and there were concerns about the service user knocking on neighbours' doors and having frequent falls. The family had arranged care, but this was considered to be insufficient. There were also concerns regarding the management of the service user's finances by his Power of Attorney.

118. JK states that Ms Henderson was allocated to this case on 18 August 2020 and was required to assess needs and to look into the concerns that were raised, as set out above.

119. JK states that Ms Henderson did not take any action except one attempt to contact the Mental Health team on 18 August 2020.

120. The supervision records for 16 September 2020 note '*No action taken. [Ms Henderson] to follow this up urgently.'*

121. JK states that the Mental Health team contacted the Council again on 16 September 2020 raising their concerns and chasing up on the previous referral. The duty worker had to deal with this urgent contact and provide the family with support and guidance.

122. Based on all the evidence before it, which is summarised above, the panel found that Ms Henderson did not adequately assess and respond to risk in a timely manner for service user 9.

Service user 6

123. The panel had regard to the statement of JK and the relevant case records for the service user. Unlike with the evidence relating to other service user's, the panel found JK's evidence relating to service user 6 as vague. JK states that Ms Henderson was allocated the case on 9 July 2020, but also states that the referral to the Council was not made until 24 July 2020.

124. The case records show that Ms Henderson was taking some actions, and JK's statement does not reflect why despite taking those actions, it would be considered that she had failed to adequately assess or respond to risk in a timely manner. It was difficult for the panel to be clear on the evidence of JK, exactly what was expected, by when, and by whom.

125. The panel therefore found insufficient evidence to prove that Ms Henderson did not adequately assess and respond to risk in a timely manner for service user 6.

Service user 7

126. The panel relied on the evidence of JK together with the case notes for service user 7 and the supervision records.

127. JK states that Ms Henderson was allocated to the case on 16 July 2020 when the Health Visitor requested an assessment of care needs. Service user 7 was diagnosed with Alzheimer's and had other health conditions. His wife was his main carer and was struggling to manage his care needs, so she was requesting respite and care at home.

128. JK states that Ms Henderson was required to have an initial conversation with the service user to establish the situation and to complete an assessment of care needs. JK acknowledges that Ms Henderson had several conversations with the family, on 16 July, 23 July and then completed a telephone assessment on 27 July 2020. However, JK states that no support was put in place for the service user by Ms Henderson.

129. JK states that in supervision on 21 August 2020, Ms Henderson said that she had completed the assessment on 27 July 2020 and had identified replacement care and daily support for the service user but that she had not written this assessment up. JK states that he reminded her of the timescales for case records in the PIAP, and Ms Henderson said that she would contact the family the next week and also write up the assessment.

130. JK states that the service user's behaviour deteriorated during this period, and he became aggressive towards his wife. As a result, an urgent care home placement was required, which was put in place in September 2020. JK states that a planned intervention by Ms Henderson following the referral and assessment on 27 July 2020 could have potentially avoided the situation where an urgent placement was required.

131. Based on all the evidence before it, which is summarised above, the panel found that whilst Ms Henderson did carry out an adequate assessment, she did not write this up nor put in place the provision required as identified in her assessment. The panel therefore found that Ms Henderson did not adequately respond to risk in a timely manner for service user 7.

1. Between 1 July 2020 and 28 February 2021, you failed to safeguard others, in that you:

b. Did not complete workflows appropriately and/or without excessive delay for one or more service users identified in Schedule 2. **Found proved on all apart from service user 22.**

132. The panel firstly considered the sub-section of the particular, by examining the evidence relating to each of the service users identified in Schedule 2 in turn, to establish for each of them, whether Ms Henderson had not completed workflows appropriately and/or without excessive delay.

<u>Service user 12</u>

133. The panel relied on the statement of JK with the exhibited case records and supervision notes. JK's statement is corroborated by SWY's statement. The panel took into account that some of the evidence relates to a time period outside of the scope of the Allegation and therefore it only relied on the evidence within the scope of the Allegation.

134. JK states that Ms Henderson was allocated to service user 12 on 4 April 2018 and was the allocated worker until 14 December 2020. Service user 12 received direct payments from the Council to pay to attend day care services at Headway. The direct payment to the account is audited on a yearly basis. Concerns were raised by the Direct Payment Team about service user 12 using the direct payment inappropriately in April 2020, and the Direct Payment Team raised additional concerns in May 2020 about him not paying his contribution to the direct payment account.

135. JK states that Ms Henderson was asked to review the service user's care plan and audit his Direct Payment account urgently. In the meantime, the Direct Payment account was restricted to deposit only while the audit took place. However, this was not communicated by Ms Henderson to the service user, and he continued to believe that the Council Direct Payment was being paid in. He continued to attend day care and when the provider invoiced, he could not make payments to them as the account was restricted.

136. JK states that during supervision in May 2020 Ms Henderson was advised to contact the service user to explain that there had been concerns and the account had been suspended. This was necessary to resolve the issue as soon as possible, as there had been a huge delay with this case. This was also explained in the supervision on 22 June 2020 as this had not been progressed. JK states that during supervision on 31 July 2020, Ms Henderson reported that this was not completed and agreed to contact the service user to discuss and resolve the issues by 3rd August 2020.

137. SWY states that issues with this service user had been going on for quite a while before she supervised Ms Henderson. SWY states that there was also no purchasing on the system at all. Ms Henderson had been asked to speak to the provider to confirm their costs again in October 2020, but by 20 November supervision she had still not done this.

138. SWY states that by the supervision on 4 December, Ms Henderson said that she had sent the request to end all services and to backdate the funding. SWY states that it had taken Ms Henderson from October to December to do this which is not an acceptable timescale. The consequences of this not being resolved in a timely manner is that the service user was being invoiced directly for services that he was not having, which caused distress to him and his wife. The provider had not received the money for their services which was also having a knock-on effect on their business.

139. The panel found that whilst the initial delay (referred to by JK) is prior to the timeframe of the Allegation (and is included for context), the evidence of SWY does fall within the relevant timeframe. The panel found that Ms Henderson had not completed the workflow without excessive delay as she had not actioned the tasks identified in supervision on 7 October until December.

Service user 4

140. The panel relied on the evidence of JK plus his exhibited documentation which included case notes, supervision records and the completed checklist documents.

141. JK states that Ms Henderson was allocated to service user 4 on 10 February 2020. They had significantly high care needs and Ms Henderson was required to review the care package, audit the direct payments and check if this person would be eligible for Continuing Health Care Funding.

142. JK states that Ms Henderson carried out a home visit on 2 March 2020 to carry out the Continuing Health Care checklist, but only completed the Continuing Health Care checklist on 6 January 2021, and the review of the care package was completed on 15 January 2021.

143. JK states that this review was significantly delayed, which raised concerns about case management, prioritising skills and regarding Ms Henderson holding cases for unnecessarily long periods of time.

144. The supervision records for 31 July 2020 show that Ms Henderson is to prioritise this case, update the support plan, audit the direct payment and send for review. The records show that Ms Henderson was asked to 'set aside some time next week and complete this piece of work.' The supervision records for 21 August show that there was no progress and that Ms Henderson agreed to complete this by 18 September 2020. The supervision records for 7 October 2020, show that Ms Henderson had not completed the support plan or audited the direct payment. Ms Henderson was also unsure if the checklist is sent to Continuing Health Care team although in supervision on 6 May 2020, she had confirmed that the daughter agreed with checklist. The supervision records state that there is 'no record of sending CHC checklist to CHC team and this is not uploaded. [Ms Henderson] to check with CHC team if they have received the completed Checklist.'

145. The panel found that the evidence supports the fact that Ms Henderson did not complete workflows appropriately and without excessive delay as she did not undertake the tasks that were clearly identified to her in supervision on 31 July 2020 and by 7 October the tasks had still not been completed.

Service user 2

146. The panel relied on the statement of JK with the exhibited case notes and supervision records. It also relied on the statement of SWY which corroborated with the statement of JK. The panel noted that some of the evidence relates to a period of time outside of the scope of the Allegation and therefore this is mentioned only for contextual reasons and was not relied upon to prove the Allegation.

147. JK states that Ms Henderson was allocated to the case of service user 2 on 25 June 2019 to complete an annual review of the direct payments and audit of the direct payment account. Ms Henderson made first contact with the service user on 15 April 2020. Ms Henderson then received the required information on the revised costings required for the review on 23 April 2020.

148. JK states, and the records confirm, that during supervision on 31 July 2020, Ms Henderson acknowledged that she had not completed this review. Ms Henderson was asked to prioritise this and audit the direct payment before the next supervision. The supervision records for 21 August 2020 show that there had not been any progress made on this review. In supervision on 7 October 2020, Ms Henderson had not taken any action. Although Ms Henderson had received revised costings in April 2020 to

review the care package this had not been completed. Ms Henderson was advised what actions needed to be completed in relation to the change in direct payment and she agreed to review the audit by 16 October 2020.

149. SWY states that at the supervision on 4 December 2020, Ms Henderson had contacted the service user's mother and the care provider and had updated the case notes to reflect this. However, she had not carried out the audit, the review or any paperwork for this. Ms Henderson then completed the audit and review by the supervision meeting on 21 December 2020.

150. SWY states that this work took quite a period of time to complete (seven months), and she would expect this to be concluded within a four-week period.

151. The panel found that the evidence supports the fact that Ms Henderson did not complete workflows appropriately and without excessive delay as she did not complete the direct payment tasks despite having the necessary information and there was an excessive delay as outlined above.

Service user 1

152. The panel relied on the evidence and its findings set out at paragraphs to 49 to 55 of this decision. The panel found that these show that Ms Henderson did not complete workflows appropriately as she did not complete the Care Needs Assessment with sufficient detail. Further, she did not complete the workflows without excessive delay as there was a delay until 23 November in her completing the task.

Service user 10

153. The panel relied on the evidence and its findings set out at paragraphs 56 to 61 above. It also took into account the further evidence about this service user outlined in JK's witness statement.

154. JK states that on 15 October 2020 Ms Henderson contacted the service user's husband but there was no response to the phone number. Ms Henderson left a message for the neighbourhood team to return her call. The case was then closed without sending a closure letter. This is a letter that is sent when someone is not responding after several attempts, asking them to contact again if they still require support. There was no evidence that a letter was sent. Letters or any postal communication are uploaded onto the Document section of the Social Care IT system. JK states that he reviewed the Document section for service user 10 which shows that there are no documents uploaded to their case records. JK states that Ms Henderson was aware of this requirement as it was discussed at induction and was part of the practice in the Team. JK states that if Ms Henderson had been contacting the service user for a long time with no response, then she should seek advice from the manager.

155. The panel found that these show that Ms Henderson did not complete workflows appropriately as she failed to seek advice before closing the case and did not send a

closure letter. Further, she did not complete the workflows without excessive delay as there was a delay of at least three months.

Service user 25

156. The panel relied on the statement of JK and the statement of SWY.

157. JK states that this individual was the husband and carer of service user 24. He had requested a carer's assessment as he was providing care for service user 24. The carer's assessment is carried out by the carers' organisation but is commissioned by the Council, and so all Ms Henderson had to do was to make the referral. To make the referral Ms Henderson needed to know the level of care the individual had been providing by identifying the service user's care needs.

158. JK states that this was discussed in supervision on 21 August 2020, 16 September 2020, and on 7 October 2020, but Ms Henderson did not do this until 24 November 2020.

159. JK states that the husband had this extra pressure of providing this level of care until Ms Henderson provided guidance on how the stepdaughter could source care privately.

160. SWY states that it took Ms Henderson from July 2020 to the end of November 2020 to make this contact and have this discussion with the family. SWY states that this is something that could be dealt with in one day, or a few days if the daughter had wanted to discuss the information with the family before making a decision. At the most this should be done in a working week from the referral being received as the family were looking for support for looking for care and advice and guidance on this. They should not have to wait for four months for this.

161. The panel found that Ms Henderson did not complete the workflow without excessive delay as there was a delay of approximately four months.

Service user 23

162. The panel relied on the evidence and its findings as set out at paragraphs 62 to 68 of this decision.

163. The panel found that the evidence supports the fact that Ms Henderson did not complete workflows appropriately in that she did not pass on safeguarding concerns about bruising either to her own manager or the duty manager and given the nature of the concern this needed to be done without delay.

Service user 13

164. The panel relied on the evidence of SWY who states that this service user made a self-referral for assistive technology in December 2020, including a pendant alarm for assisting with falls. SWY states that Ms Henderson did not make any contact with the service user until 28 January 2021 and then did not complete the initial screening document until 14 April 2021. SWY states that Ms Henderson should have started the

initial screening document at the point of first contact in January as the Council are not able to purchase anything until the initial screening document has been done.

165. The panel found that Ms Henderson did not complete the workflow appropriately as she did not have a conversation with the service user at the correct stage as this should have been done much earlier. There was also excessive delay as the referral was made in December and the service user was not spoken to until 28 January with the initial screening document not being completed until April 2021.

Service user 19

166. The panel relied on the statement of SWY, and the case notes exhibited.

167. SWY states that Ms Henderson was allocated to this service user on 17 December 2020 as the family were requesting information about moving the service user from his home to Extra Care.

168. SWY states that the initial screening document was completed by Ms Henderson on the basis of email advice, 'which is not a good way of doing things.' This appears to have been because of Ms Henderson struggling to get hold of the family. SWY states that, as per the Council's guidance, if a worker is struggling to contact someone they can always send a text message to arrange a convenient time and date to make that contact. If this does not work, a letter should be sent with a two-week deadline for the service user to call to discuss this further. SWY states that there were a couple of things that could have been attempted to make contact with service user 19's family rather than attempting all communication by email as people may have issues with the internet.

169. The panel found that Ms Henderson did not complete the workflow appropriately as she completed the initial screening document from information within an email rather than by telephone, as was the expectation.

Service user 22

170. The panel considered the evidence of SWY in relation to service user 22. For the reasons already set out at paragraphs 69 to 72 panel were not satisfied on balance that the evidence was sufficient on the balance of probabilities to support the allegation that Ms Henderson did not complete the workflow without excessive delay.

Service user 18

171. The panel relied on the evidence of SWY and exhibited case notes.

172. SWY states that service user 18 was allocated to Ms Henderson in November 2020. SWY states that the service user was a lot better at communicating face to face, and so she suggested in supervision with Ms Henderson in January 2021 that Ms Henderson should write all of the information in a letter and take this to go and see the service user to discuss.

173. SWY states that Ms Henderson did not do this, and there was no outcome for the service user until Ms Henderson left the team in April 2021. SWY states that this was something simple about a package of care and direct payment so should not have been overly complicated, but it took the best part of four months to resolve. During this period of four months, the service user was left in quandary without answers.

174. The panel found that Ms Henderson did not complete workflows without excessive delay as she did not meet the service user as advised by SWY and it took almost four months to resolve.

Service user 3

175. The panel relied on the evidence and its findings as set out at 73 to 77 of this decision. It also took into account the further evidence about this service user set out in JK's statement.

176. JK states that the service user was admitted to hospital on 17 September 2020. The care package for this service user was increased before discharge as the hospital team had identified that this person required an increase to the care package. The hospital discharge team notified Ms Henderson to purchase this increase. She did not purchase this additional care despite being notified.

177. JK states that Ms Hendeson was reminded to purchase this additional care by the commissioning team on 29 September 2020. This was because the care agency was not getting paid, and they contacted the Commissioning Team to raise their concerns. Following hospital discharge, the care agency also reported concerns about disruption of care by the husband. These concerns were the same as the previous safeguarding concerns raised by the care agency but didn't receive a response from Ms Henderson about this since July 2020. Ms Henderson also did not arrange any reviews of the service user's care following hospital discharge. In normal circumstances, a review of the care package should have been completed within four weeks of hospital discharge. However, if the situation is unstable or there are concerns, then the review should be brought forward. The concerns about the service user's husband were raised in July and should have been addressed at that time but were repeated again following the hospital discharge. These safeguarding concerns were partially addressed by the duty worker while Ms Henderson was on leave to make the service user safe. This was then passed on to Ms Henderson to review and consider longer term solutions and further action to ensure the service user's safety. Ms Henderson stated in supervisions that she had spoken to the family, but there were no records of these conversations on the system.

178. The panel found that Ms Henderson did not complete workflows appropriately as she was required to purchase additional care for the service user when discharged but she did not do so, nor did she arrange and bring forward the care package review. The panel also found that Ms Henderson did not complete the workflows without excessive delay as there was a delay from the July to the September as outlined above.

Service user 24

179. The panel relied on the evidence and its findings as stated in paragraphs 78 to 82 of this decision.

180. The panel found that Ms Henderson did not complete workflows appropriately as she did not establish the urgency of the situation, as was required. The panel found that Ms Henderson did not complete the workflow without excessive delay as the assessment was requested in July and Ms Henderson only contacted the family on 24 November 2020.

Service user 8

181. The panel relied on the evidence and its findings as set out at paragraphs 83 – 89 of this decision.

182. The panel found that Ms Henderson did not complete workflows appropriately and without excessive delay, as she should have undertaken the assessment and arranged a joint visit with the housing provider on receipt of the referral, but it took her three months to make contact.

Service user 5

183. The panel relied on the statement of JK, and the contemporaneous documents exhibited to it.

184. JK states that service user 5's Parkinsons Nurse made a referral to the Council requesting a reassessment of their care needs on 11 June 2020. Ms Henderson took the case on duty and in due course sent JK an assessment for authorisation. JK returned the assessment to Ms Henderson as it needed more information included to justify Ms Henderson's recommendations. The panel noted that the email to Ms Henderson was sent by JK on 23 July 2020 and asked her to re-look at the assessment highlighting several points that needed resolving and including.

185. JK states that it took Ms Henderson three weeks to amend the assessment and send it to the relevant team to search for a care provider. On 11 August the relevant team retuned a selection of care home providers and Ms Henderson was required to liaise with the care home to make sure they assess the service user and confirm whether they could meet his needs. Ms Henderson only contacted the care home on 20 August 2020.

186. JK states that in the supervision meeting on 16 September it was identified that there was no progress made with this service user and he was still at home. Ms Henderson had identified in the assessment that the service user had 24-hour care needs and so there was no support in place at this time to meet those needs at night. There were also concerns whether the care home still had room available considering the delay in confirming the placement as they could have offered this to someone else.

187. JK states that Ms Henderson said that she had spoken to the service user's niece and confirmed that he was safe at home and had the correct level of care, however there was no record of this on the system.

188. The panel found that Ms Henderson did not complete workflows appropriately and without excessive delay, as she should have gained sufficient information at the outset to complete the assessment appropriately. Thereafter she should have made the correct arrangements with the care home. The panel found excessive delay as Ms Henderson took three weeks to amend the assessment and also delayed contacting the care home and making subsequent progress on the case.

Service user 11

189. The panel relied on the evidence of JK and the service user's case records as well as the supervision records.

190. JK states that there were concerns regarding the service user as the care agency had started to provide care, but this had not been purchased on the system. The case was allocated to Ms Henderson on 31 July 2020 following a referral received on 30 July 2020 from the care agency reporting a gap in the purchasing of care.

191. JK states that he asked the Social Worker to investigate the gap in the care purchased and to resolve this. In the supervision on 21 August 2020, it was confirmed that Ms Henderson had not taken any action on this. JK states he told Ms Henderson to resolve this before she went on leave. In supervision in September 2020, Ms Henderson reported that she had not taken any action. She was asked to amend the care purchased on the system to reflect the increase in the care package. The agency then contacted the Council again regarding not being paid for the care they were providing.

192. JK states that on 7 October 2020, the team manager asked Ms Henderson to purchase this care again, and this is referenced in the supervision record for October.

193. JK states that it was hard to track when Ms Henderson completed this as the care was purchased retrospectively, but this had not been completed when the team manager requested on 7th October 2020. The care was not purchased for around two months and the care agency did not get paid for the work that they were providing. This could have significantly affected the care provision as the care agency could have withdrawn and alternative care had to be arranged to provide this level of care. This was also a contractual issue as the Council agreed to pay the agency for the care provided.

194. The panel found that Ms Henderson did not complete workflows appropriately and without excessive delay, as she should have made correct arrangements for the care package purchase and should not have delayed in two months before purchasing the care.

Service user 15

195. The panel relied on the evidence and its findings as set out in paragraphs 90 to 94 of this decision.

196. The panel found that Ms Henderson did not complete workflows without excessive delay as there was a two-three-week delay in responding to a carer breakdown.

Service user 14

197. The panel relied on the evidence and its findings as set out in paragraphs 95 to 100 of this decision.

198. The panel found that Ms Henderson did not complete workflows appropriately and without excessive delay as there was a period of six weeks where she had not contacted the service user to establish why they would like to move into long term care. Ms Henderson also had not sent the CCN form regarding funding to the service user as agreed.

Service user 17

199. The panel relied on the evidence and its findings as set out in paragraphs 101 to 105 of this decision.

200. The panel found that Ms Henderson did not complete workflows appropriately and without excessive delay as she did not complete the initial call with sufficient detail and then did not follow this up between 14 September and 16 October 2020.

Service user 20

201. The panel relied on the evidence and its findings as set out in paragraphs 106 to 109 of this decision.

202. The panel found that Ms Henderson did not complete workflows without excessive delay as she did not arrange support until the end of October despite being allocated on 17 September 2020.

Service user 21

203. The panel relied on the evidence and its findings as set out in paragraphs 110 to 115 of this decision.

204. The panel found that Ms Henderson did not complete workflows without excessive delay as she did not progress the referral until 6 October despite being allocated on 24 July 2020.

Service user 9

205. The panel relied on the evidence and its findings as set out in paragraphs 116 to 122 of this decision.

206. The panel found that Ms Henderson did not complete workflows appropriately and without excessive delay as she did not take any action to assess needs, save for one attempt to contact the Mental Health Team. Ms Henderson was allocated on 18 August but had taken no action by 16 September 2020, so the case was reallocated.

Failing to safeguard others

207. Having considered and made findings in respect of some of the service users in schedule 1 and schedule 2, the panel then had regard to the stem of the charge and as to whether the findings amounted to a failure by Ms Henderson to safeguard others.

208. The panel found that Ms Henderson had failed to safeguard others. The panel relied on the job description, which is already referred to in this decision, as to establishing the duty and expectations on Ms Henderson. Not only does the job description set out the expectations but Ms Henderson was also provided with frequent supervision setting out tasks and actions to take on her cases. Further, she was subject to the PIAP which also set out in specific detail the requirements of Ms Hendeson within her social work role broken down into different areas of the role for clarity. The combination of these documents together with the Council recording policy clearly set out what Ms Henderson ought to have done on her cases.

209. The panel took into account Ms Henderson's submissions that she had not felt sufficiently supported and her other comments about the caseload, duty system, etc. The panel considered whether this was the situation, and if so, whether this would have impacted on Ms Henderson's opportunity to do what was expected of her.

210. The panel did not find that Ms Henderson was not adequately and sufficiently supported such that she could not carry out the expectations of the role. The panel relied on the evidence of JK and SWY, both written and oral. The panel read and heard evidence that Ms Henderson was properly supported. She was *[Private]*. The panel saw evidence of the regular supervisions, and of Ms Henderson being taken off duty when she was struggling with capacity. Her case load was decreased after September 2020, and she was given access not only to her own manager but also to the duty manager as and when required. The panel found the PIAP to be very detailed and supportive and the evidence showed that management responded properly and promptly to issues as they arose including allowing Ms Henderson to work from the office during Covid time if this would be better for her.

211. In finding Ms Henderson failed to safeguard others, not only did it have regard to each of the findings it had already made in relation to the individual service users but also to the summary paragraph of JK, which the panel thought appropriately captured the failure. JK states that Ms Henderson was responsible for attending to referrals, to determine whether the service user was eligible for care and support, or if not to safeguard them and support them to access services elsewhere if needed. Safeguarding is a big part of the social worker role, and individuals have to learn to look for concerns and issues. The priority is to make sure that the individual is protected and to take the necessary steps to ensure their wellbeing. The panel found that failing to adequately assess, respond to risk in a timely manner, failing to complete workflows appropriately, and without excessive delay, did amount to a failure to safeguard others.

> 2. *Between 1 July 2020 and 28 February 2021, you failed to safeguard others, in that you:*

a. *Did not accurately record information within case notes for one or more service users identified in Schedule 3* **Found proved on all apart from service users 2 and 16**

212. The panel firstly considered each of the service users in schedule 3 and considered whether Ms Henderson did not accurately record information within case notes.

Service User 12

213. In reaching its decision the panel had regard to the evidence relating to this service user as set out at paragraphs 133 to 139 of this decision. The panel also took into account further evidence about this service user set out in JK's statement.

214. JK states that during supervision on 21 August 2020, Ms Henderson said that she had contacted the family and Headway, and they were not sure why the money had not been paid. JK states that there were no case records of any contact with Ms Henderson and the family.

215. JK states that any conversations involving the service user should be recorded on the case records under the Council's Recording Policy. This policy also states that case notes should be updated the same day or within 24 hours to ensure that ongoing work is captured accurately, any meetings, calls and texts should be recorded within 48 working hours and case summaries should also be completed within 48 hours. If information is not recorded on the file, then no one else would know what conversations have been held, or whether Ms Henderson or the family agreed to do something. If Ms Henderson was not in work the next day and something occurred, the duty worker would not know what had been discussed. Additionally, if there was a complaint then there would be no evidence to show what had been agreed or if the family had been asked to do certain things or given certain guidance. There was also no continuity and out of date information being shared between departments.

216. The panel took into account that Ms Henderson had said that she had made the calls, and she would have been aware of the Council's recording policy and the expectations of recoding case notes as set out in the PIAP. JK states that there were no case records of contact with the family or Headway and therefore the panel found that Ms Henderson did not accurately record information within case notes as she should have recorded these conversations.

Service User 3

217. The panel took into account the evidence in relation to service user 3 as already set out earlier in this decision. The panel noted that the concerns in JK's statement about Ms Henderson not recording calls/attempted calls fall outside of the timeframe for the Allegation. Therefore, the panel could not rely on that information to find this particular proved.

218. The panel took into account that during supervision on 16 September 2020, Ms Henderson said that she had not taken any action as agreed previously and therefore

there would have been no information to record in the case notes as she had not done anything on the case to record.

219. The panel therefore did not find proved that Ms Henderson had not accurately recorded information within case notes for service user 3.

Service User 6

220. Although the panel had found the previous charge relating to service user 6 not proved, it reconsidered the evidence of JK noting that this charge is a different charge and there might be other evidence which is relevant.

221. The panel relied on the evidence of JK. He states that Ms Henderson was allocated to this case when the son of service user 6 contacted the Council requesting an assessment as he was struggling to provide care. Ms Henderson was required to assess needs and arrange support to minimise the risk of carer breakdown.

222. JK states that following the arrangement of care by a duty worker, Ms Henderson was required to review the care package and arrange for the CCN (Client Contribution) form to be signed by the service user. This is a form with information about financial assessment and contribution towards care is explained and where the service user acknowledges what they were signing up to. If the service user does not sign this form, then they could say that they did not agree to contribute towards this care and so could decline to pay client contribution.

223. JK states that Worcestershire Association of Carers (WAC) had also been trying to contact Ms Henderson for three weeks to raise concerns about the son not being able to provide care for the service user and being on the verge of a carer breakdown. JK states that in supervision Ms Henderson said that she had spoken to WAC several times. JK states that there was no record on case recording system of this. JK states that Ms Henderson had referenced in an email to WAC that she had spoken to them, but this was not recorded on the system. JK states that this should have been recorded on the same day as contact was made as per the recording policy and Ms Henderson's PIAP requirements. Due to the concerns raised, another social worker was asked to carry out a visit to the service user on 21 August 2020, because of concerns around the lack of information on the case record around what was happening. This was a safeguarding concern and should have been identified by Ms Henderson immediately.

224. The panel cross referenced the supervision record which note that Ms Henderson does state that she spoke to WAC several times, but that there is not record on the case recording system. The panel therefore found that Ms Henderson did not accurately record information within case notes as she should have recorded these conversations in accordance with the Council's recording policy and her PIAP.

Service User 16

225. The panel considered the evidence of JK in relation to service user 16. JK states that Ms Henderson ended a package of support for this service user whilst on duty.

226. The panel took into account that JK does not state that Ms Henderson did not accurately record information in case notes. He does not explain what the expectation of ending a package of support would be and whether it would be expected to be case noted or whether it would be a form in the documents section of the service user's records.

227. In the circumstances, the panel did not find sufficient evidence to support a finding that Ms Henderson had not accurately recorded information within case notes.

> *2.Between 1 July 2020 and 28 February 2021, you failed to safeguard others, in that you:*
>
> *b. Did not record information within case notes in a timely manner for one or more service users identified in Schedule 4.* **Found proved on all apart from service users 4, 3, 24, 5 and 16.**

228. The panel firstly considered each of the service users in schedule 4 and considered whether Ms Henderson did not record information within case notes in a timely manner.

Service user 12

229. The panel relied on the evidence and its findings set out at paragraphs 213 to 216 to find this particular proved. It is clear from the evidence that Ms Henderson did not record information within case notes for this service user in a timely manner.

Service user 4

230. The panel considered the evidence of JK and its previous findings in relation to this service user. Whilst there had been delay in relation to this case as per the earlier findings, there was nothing in the evidence specific to a failure to record information within case notes in a timely manner. On balance, the panel did not find sufficient evidence for Social Work England to prove that Ms Henderson did not record information within case notes for service user 4 in a timely manner.

Service user 3

231. The panel considered the evidence of JK in relation to service user 4. The panel took into account that whilst it did mention Ms Henderson contacting the service user or his family, then retrospectively entering case notes, these relate to a time frame outside of the Allegation.

232. The panel therefore did not find sufficient evidence for Social Work England to prove that Ms Henderson did not record information within case notes for service user 3 in a timely manner.

Service user 24

233. The panel took into account the evidence already set out in this decision relating to service user 24. It also took into account further information about this service user contained in JK statement.

234. JK states that Ms Henderson only contacted the family on 24 November 2020 although the referral was received on 3 July 2020. JK states that Ms Henderson retrospectively added case *notes* of attempted contact with the service user dated 6 July 2020, 10 July 2020, 30 July 2020 and 31 July 2020. These were all entered retrospectively one after another on 31 July 2020 and all of these were recorded as attempted contacts.

235. The panel took into account that unlike with other parts of JK's evidence, the case notes *for* July for this service user were not produced as an exhibit. The panel took into account the supervision notes from July to October. These state in the July that Ms Henderson said that she had attempted to contact but did not manage to speak to the service user. The supervision record does not provide details of dates of the alleged contact or how many times.

236. The panel found on balance that there was insufficient contemporaneous documentation to support the allegation that Ms Hendeson had not recorded information in case notes in a timely manner.

Service user 6

237. The panel took into account its earlier findings that Ms Henderson did not accurately record information within case notes as she should have recorded her conversations with WAC, in accordance with the Council's recording policy and her PIAP. The panel found that her failure to do so also amounted to a failure to record information within case notes in a timely manner.

Service user 5

238. The panel considered the evidence of JK.

239. JK states that Ms Henderson said that she had spoken to the service user's niece and confirmed that he was safe at home and had the correct level of care, however there was no record of this on the system.

240. The panel found that unlike with other service users, JK did not provide specific dates in relation to this alleged conversation with Ms Henderson, or the date which she had allegedly spoken to the niece.

241. The panel took into account that whilst the supervision notes for 16 September do record Ms Henderson as saying she spoke with the niece; they do not provide a date. The panel also took into account the case notes for which there are numerous entries in August and September of Ms Henderson speaking to the niece or attempting to speak to the nieces, which are recorded on the date of the call or within 24 hours.

242. The panel therefore found the charge in relation to service user 5 not proved. There was insufficient evidence to prove that Ms Henderson had not recorded information within case notes in a timely manner.

Service user 16

243. For the same reasons as identified at paragraphs 225 to 228, the panel found this charge in relation to service user 16 not proved.

Service user 21

244. The panel relied on the evidence of JK who states that Ms Henderson made retrospective case note recordings on 6 October 2020 stating that she had tried to contact the service user's family at different dates.

245. The panel relied on the case notes which had been provided as exhibits to JK's statement. The case notes show that on 6 October 2020, Ms Henderson entered a case record for an attempted call on 30 July 2020. The case notes also show:

- An entry on 6 October 2020 for a call made on 6 August 2020.
- An entry on 6 October 2020 for a call made on 2 October 2020.

246. The case notes show that Ms Henderson spoke to the service user's family on 6 October 2020 and the case recording for that conversation is inputted on the same date.

247. The panel relied on the contemporaneous case notes to find proved that Ms Henderson did not record information in case notes in a timely manner in relation to service user 21, as three of the entries were made outside of the expected 24-hour period.

Service user 7

248. The panel relied on the evidence of JK. He states that Ms Henderson completed a telephone assessment of the service user on 27 July 2020, however no support was put in place for service user 7. In supervision on 21 August 2020, Ms Henderson said that she had completed the assessment on 27 July 2020 and had identified replacement care and daily support for service user 7 but had not written this assessment up.

249. The panel cross referenced JK's statement with the supervision records and noted that they accurately reflect JK 's evidence.

250. The timescales for recording are set out elsewhere within this decision. Ms Henderson did not record the information within case notes for approximately one month which is outside the expected time frames. Therefore, the panel found proved that Ms Henderson did not record information within case notes in a timely manner in relation to service user 7.

Failing to safeguard others

251. Having considered and made findings in respect of some of the service users in schedule 3 and schedule 4, the panel then had regard to the stem of the charge and as to whether the findings amounted to a failure by Ms Henderson to safeguard others.

252. The panel found that Ms Henderson had failed to safeguard others. In finding this failure, the panel adopted its findings at paragraphs 207 to 211, which it considered applied equally to this part.

253. In relation to accurate and timely recording, this is specifically set out in the job description. It notes that social workers must maintain accurate and timely records of actions and decision. This expectation was also set out in the Council's recording policy and the PIAP.

254. JK explains the importance of accurate and timely recording in his statement which in summary includes:

- With no recording, there would be no evidence to say the Council had tried to be in contact and there would be no way to justify the delay in trying to contact a service user.
- Information should be recorded so that it is accessible for anyone else accessing the records.
- If information is not recorded on the file, then no one else would know what conversations have been held, or whether the social worker or family agreed to do something.
- If the social worker was not in work the next day and something occurred, the duty worker would not know what had been discussed.
- If there was a complaint, then there would be no evidence to show what had been agreed or if the family had been asked to do certain things or given certain guidance.
- Out of date information could be being shared between departments.

255. The panel accepted the evidence of JK in this regard and found that not accurately recording information within case notes and not recording information in case notes within a timely manner did amount to a failure to safeguard others.

3.-On 3 November 2022, you made assertions to Social Work England in that you:

a. told Social Work England by email that you had previously sent an email accepting an offer of Accepted Disposal; **Found proved**

b. Sent what you asserted was a forwarded email in which you had previously accepted an offer of Accepted Disposal **Found proved**

256. The panel took into consideration the statement of FE which exhibited emails between Social Work England and Ms Henderson dated 3 November 2022. The panel also took into consideration the information contained in Ms Henderson's submissions pertaining to this issue. Ms Henderson does not appear to dispute the fact that she made assertions in emails to Social Work England on 3 November 2022. It is the issue of falsity and intention to mislead which she disputes, and which is dealt with by a separate particular of the Allegation.

257. The panel relied on and placed significant weight on emails exhibited to FE's statement as they are contemporaneous and were created in the course of exchanges with Ms Hendeson prior to the concerns about dishonesty being raised.

258. The bundle contained an email from Ms Henderson dated 3 November 2022 at 09:54. In this email sent to FE, Ms Henderson states, '*...could please call me this afternoon... I have no voicemail and replied via email that I accepted the suspension but felt it was harsh in September.*'

259. The bundle contained a telephone attendance note of a conversation between FE and Ms Henderson on 3 November 2022. The telephone attendance note states the start time of the call to be 15:07 with the call ending at 15:24. Amongst other information, the telephone attendance note states that FE asked Ms Henderson to send him the evidence that she had sent the response to the case examines proposal.

260. The bundle contains a further email from 3 November 2022 from Ms Henderson to FE, sent at 15:45. This email states, '*This was email I sent back in reply to accepted disposal ans [sic] dismissal. I believe there was a typo in email address I replied to as it is different to one emailed today . Apologies for this error. Have forwarded message today to you as discussed with [FE].*' The email contains a forwarded email within the body of it, sent from Ms Henderson to caseexaminers@socialworkenglan.com at 15:40 on 3 November 2022. That email states, '*Hello to whom this may concern, I have read through documentation ans [sic] your decision for suspension. I am unhappy with the length of suspension and feel it is harsh, certainly given the time taken to make decision. However I accept this decision to suspend me and don't wish to challenge it. I would like to know if there is any thing more I can do rectify situation and help my return to practice after this date.*'

261. The panel found that the emails dated 3 November 2022, do show that Ms Henderson made assertions to Social Work England by email that she had previously sent an email accepting an offer of Accepted Disposal, and that she sent what she asserted was a forwarded email in which she had previously accepted an offer of Accepted Disposal.

> *4. Your conduct at paragraph 3 above was false and/or carried out with the intention of misleading employee/s of Social Work England into believing you had attempted to accept the offer of Accepted Disposal.* **Found proved**

262. The panel considered all the documentary evidence before it in relation to the circumstances surrounding the Accepted Disposal offer and subsequent

communications about it, as well as the communication relating to an interim order. The panel had regard to the facts, the history, and Ms Henderson's explanations including taking into account her good character.

263. The panel took into account that the Case Examiner's had proposed an 18 month Conditions of Practice Order and this has been communicated by email to Ms Henderson on 9 August 2022, asking her to, ' ... *take the time to thoroughly read and understand the accepted disposal guidance document before completing your response form'*, and stating that, '*there is a 28 day deadline to return your accepted disposal response form to Social Work England - which is no later than 06/09/2022*.'

264. The panel took into account that as no response was received from Ms Henderson, Social Work England sent further emails to her on 7 September and 9 September 2022, asking for a response. The emails reminded Ms Henderson of the deadline being 6 September 2022 but allowing to the end of 8 September and then 9 September 2022 for her to reply. The panel noted that both email messages reminded her that if there was no response, the case would automatically progress to a hearing.

265. On 17 October 2022, the Case Examiners' final decision to refer the case to a hearing was sent by email to Ms Henderson. The panel took into account that Ms Henderson had responded (directly) to that email on 31 October 2022 at 09:36. In part that email states, '*I am sure even after reading all documentation as to why this has gone to a hearing when decision letter already sent suggesting suspension for 18 months*.'

266. The panel took into account that FE had responded (by email) to Ms Henderson on 31 October 2022, confirming that the Case Examiners had decided to refer the case to a hearing as no response had been received from Ms Henderson to the Accepted Disposal. The panel noted that in his email FE refers to an 18-month suspension. In oral evidence, FE said that he mentioned suspension in error, and it should have been a Conditions of Practice which he referred to.

267. The panel took into account that the first mention of suspension arose on 24 October 2022, that being the date an email was sent to Ms Henderson, informing her of an interim order application hearing, because an interim suspension order was being sought.

268. Ms Henderson's submissions state:

> '*I will readily admit fault in the fact that I did not read the email and documents sent to me sufficiently when they were first sent through...I did not fully take on board and sufficiently read the documentation, its meaning or what was required of me and assumed an email in response would suffice. I also did not check where I was sending my response too (email address) and that I had a response to confirm this was ok...There was no deliberate attempt on my part to deliberately deceive social work England, I am not particularly good with or hot on technology and panicked when I saw what the outcome now was and the error I had made. Which had I paid due to diligence in the first place, would have either not been made or would have*

been rectified earlier, to this accept responsibility and any sanction decision you as a body impose. I didn't deliberately try to mislead or alter email to be deceitful as I have said I struggle with technology and thought I was forward on the email I had sent in reply to the conditions to practice and only edited as far as it was needed for me to be able to send it across.'

269. The panel found that the email which Ms Henderson asserted to be 'forwarded' does not demonstrate that the quoted message was in fact sent as an acceptance of the Agreed Disposal within any deadline, given that it is sent on 3 November 2022 at 15:40, which is just 5 minutes before Ms Henderson 'forwarded' it to the genuine address. The email was sent as an in-line email chain so is simply typed text in the body of the message, rather than as an enclosed message that could show it was genuinely sent at a particular time with that text within it.

270. The panel did not find Ms Henderson's assertion within the email to Social Work England on 3 November 2022 to make any sense. She states that her original reply was sent inadvertently to the wrong address, however the email chain suggests it was sent as a direct reply to the Case Examiner Operations email dated 9 August 2022 (providing the preliminary decision), in which case there would be no need to alter the recipient address and no reason to do so. Also, her email which she asserts she had previously sent to the Case Examiners in reply to the Accepted Disposal mentions her being unhappy with the length of the suspension. However, the Case Examiners had proposed a Condition of Practice Order and suspension was not mentioned in any correspondence with Ms Henderson until 24 October 2022, (when she was written to about the interim order). The panel therefore found that this message (which Ms Henderson said she had sent in September 2022) cannot have been a genuine reply within time to the proposal made to her, as the Accepted Disposal acceptance date was 9 September, which was prior to the time of any mention of suspension.

271. The panel took into account that Ms Henderson would have a motivation to persuade Social Work England that she had replied in timescales as she had been told by FE that if an incorrect email address had been used then the Case Examiners might reconsider its decision to send the case to a hearing and reinstate the offer of Accepted Disposal.

272. Based on the reasoning above, the panel found that Ms Henderson's assertions to Social Work England were false, and it inferred from the evidence that she made the assertion with the intention to mislead employee/s of Social Work England into believing she had attempted to accept the offer of Accepted Disposal.

Your conduct at paragraph 3 and 4 above was dishonest **Found proved**

273. Based on its finding (as set out above) that Ms Henderson's assertions were false and made with the intention to mislead, Ms Henderson knew that she had not accepted the Accepted Disposal, she then created a false email and provided a false narrative in order to try and secure the original Conditions of Practice order than risk going through a hearing process.

274. The panel concluded that taking into account Ms Henderson's understanding of the circumstances, as set out above, an ordinary decent person would find the conduct as dishonest. The Panel found that deliberately misrepresenting the true position regarding the failure to respond to the offer of Accepted Disposal, so as to seek a return to that offer, would be held to be dishonest upon an objective test.

Resuming hearing – 10 September 2024

Service of notice

275. Ms Henderson did not attend the resuming hearing and was not represented. The panel was informed by Mr Harris that notice of this resuming hearing was sent to Ms Henderson by email to the electronic mail address provided by Ms Henderson. Mr Harris submitted that the notice of this hearing had been duly served in accordance with the rules.

276. The panel had careful regard to the documents contained in the resuming hearing service bundle as follows:

- A copy of the notice of the resuming hearing dated 08 July 2024 and addressed to Ms Henderson at her email address which she provided to Social Work England;
- An extract from the Social Work England Register ("the register") detailing Ms Henderson's registered email address;
- A copy of a signed statement of service, on behalf of Social Work England, confirming that on 08 July 2024, the writer sent by electronic mail to Ms Henderson at the address referred to above, the notice of resuming hearing letter with enclosures.

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

278. Having had regard to the rules and all the information before it in relation to the service of notice, the panel was satisfied that notice of this resuming hearing had been served on Ms Henderson in accordance with rules 14, 15, 44 and 45.

Proceeding in the absence of Ms Henderson:

279. Mr Harris adopted the submissions he had made in relation to his previous application to proceed in absence. He referred the panel to a recent email from Ms Henderson confirming that she would like the panel to proceed in her absence. The email from Ms Henderson, is dated 08 July 2024, and is sent to Social Work England as a direct reply to the notice of resuming hearing email. It states:

> '*Thank you for this. Please continue in my absence. I look forward to hearing from you with your decision after this. Please let me know if you require any further information from myself.*'

280. The panel heard and accepted the advice of the legal adviser in relation to the factors it should take into account when considering this application. This included reference to rule 43 of the rules and the cases of *R v Hayward [2001] EWCA Crim. 168* and *General Medical Council v Adeogba [2016] EWCA Civ 162*. The panel's attention was drawn to the 'Service of notices and proceeding in the absence of the social worker' guidance dated 16 December 2022 which is available on the Social Work England website.

281. The panel considered all of the information before it, together with the submissions made by Mr Harris on behalf of Social Work England. The panel took into account its early decision on service of notice and was satisfied that Ms Henderson was aware of the resuming hearing and of her right to attend.

282. The panel took into account that Ms Henderson has been engaging with Social Work England in relation to the final hearing. In doing so she has been consistent in stating on several occasions, including 08 July 2024, that she has no intention of attending at the final hearing. It noted that the recent email from Ms Henderson states explicitly that she would like the hearing to proceed in her absence.

283. The panel concluded that Ms Henderson had chosen voluntarily to absent herself from these proceedings and has once again made her feelings clear in her email. The panel had no reason to believe that an adjournment would result in Ms Henderson's attendance or that it would secure her future engagement, given her previous nonattendance and her clear intention set out in the email 08 July 2024. Having weighed the interests of Ms Henderson, with those of Social Work England, and the public interest in an expeditious disposal of the hearing, the panel determined that it is in the interests of justice to proceed in Ms Henderson's absence.

Finding and reasons on grounds:

Submissions

284. The panel heard submissions from Mr Harris on the statutory grounds and the issue of impairment, but it decided on each stage separately and each stage is dealt with under separate headings below.

285. Mr Harris referred the panel to the 'Statement of Case' and submitted that whether the facts found proved (in relation to facts 1 and 2) amount to misconduct and/or lack of competence or capability is a matter of judgement for the panel, rather than a matter of proof. Mr Harris submitted that facts 4, 5 and 6, amount to the statutory ground of misconduct.

286. Mr Harris referred the panel to the cases of:

- *Roylance v General Medical Council (No 2) [2000] 1 AC 311*
- *Holton v General Medical Council [2006] EWHC 2960 (Admin)*

- *Calhaem v General Medical Council [2007] EWHC 2606*
- *Johnson and Maggs v Nursing and Midwifery Council [2013] EWHC 2140 (Admin)*
- *R (Remedy UK Ltd) v GMC [2010] EWHC 1245 (Admin)*
- *Khan v Bar Standards Board [2018] EWHC 2184 (Admin)*
- *Tait v The Royal College of Veterinary Surgeons [2003] UKPC 34*

287. Mr Harris submitted that Ms Henderson was in breach of Social Work England's Professional Standards ("Standards"), in particular:

'1.3 Work in partnership with people to promote their well-being and achieve best outcomes, recognising them as experts in their own lives.

2.4 Practise in ways that demonstrate empathy, perseverance, authority, professional confidence and capability, working with people to enable full participation in discussions and decision making.

3.1 Work within legal and ethical frameworks, using my professional authority and judgement appropriately.

3.2 Use information from a range of appropriate sources, including supervision, to inform assessments, to analyse risk, and to make a professional decision.

3.3 Apply my 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.

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

3.6 Draw on the knowledge and skills of workers from my own and other professions and work in collaboration, particularly in integrated teams, holding onto and promoting my social work identity.

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

3.11 Maintain clear, accurate, legible and up to date records, documenting how I arrive at my decisions.

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

3.13 Provide, or support people to access advice and services tailored to meet their needs, based on evidence, negotiating and challenging other professionals and organisations, as required.

4.2 Use supervision and feedback to critically reflect on, and identify my learning needs, including how I use research and evidence to inform my practice.

5.2 Behave in a way that would bring into question my suitability to work as a social worker while at work, or outside of work.'

288. Mr Harris submitted that in relation to facts 1 and 2, the evidence relied on by the panel in finding the facts proved, points more towards misconduct. He submitted that the panel might consider that the evidence shows that Ms Henderson was aware of policy and practice and that she was able to comply on occasions and undertake some good work. He submitted that if Ms Henderson did have the knowledge and capability, but then failed to adhere to what was expected of her, this would amount to misconduct rather than lack of competence.

289. Mr Harris submitted that Ms Henderson was an experienced worker and that the conduct/failings in facts 1 and 2 relate to fundamental elements of social work practice. He submitted that the conduct/failings created a consequential risk of harm to service users. He submitted that Ms Henderson's actions were repeated over a prolonged period and involved a large number of service users, despite the support she was receiving from her managers as set out within the PIAP.

290. Mr Harris submitted that the conduct/failings in relation to facts 1 and 2 were seriously aggravated by the second case against Ms Henderson as per facts 3, 4 and 5. He submitted this was serious misconduct, as Ms Henderson had lied to her regulator and was dishonest.

291. Ms Henderson was not present to make oral submissions, but the panel took into account the written submissions she had previously provided.

Legal Advice

292. The panel heard and accepted legal advice from the legal adviser on the issue of misconduct. The legal adviser referred to the 'Case Examiner Guidance' dated 16 December 2022, and the 'Impairment and Sanctions Guidance' dated 19 December 2022. Those documents provide guidance in relation to misconduct and lack of competence and the differences between the statutory grounds.

Decision

293. The panel at all times had in mind the overriding objective of Social Work England which includes its duty to protect the public, promote and maintain public confidence in social workers in England and to promote and maintain proper professional standards for social workers in England. The panel had regard to the 'Social Work England Impairment and Sanctions guidance'. It had regard to the Social Work England Professional Standards and bore in mind that a departure from the Standards does not necessarily constitute misconduct.

294. The panel carefully considered both the statutory grounds of lack of competence or capability and misconduct to decide which ground, if any, the behaviours of Ms Henderson fell into. It decided that the behaviours of Ms Henderson in relation to facts: 1,2,3,4 and 5 do amount to serious professional misconduct.

295. The panel concluded that Ms Henderson's conduct and behaviour fell far below the standards expected of a registered social worker. Her conduct amounts to failings of basic and fundamental tenets of the social work profession. The panel determined that Ms Henderson's conduct was in breach of multiple Standards, in particular Standards:

    1.3; 2.4; 3.1; 3.2; 3.3; 3.4; 3.6; 3.9; 3.11; 3.12; 3.13 and 5.2.

296. Based on the findings, the panel considered that the misconduct fell into two interlinked areas:

    i) failing to safeguard others; and
    ii) dishonesty to the regulator with regards to an Accepted Disposal which was offered as a resolution to the concerns relating to failing to safeguard others.

297. In relation to the failure to safeguard others, as set out in facts 1 and 2, the panel did consider whether those failings would more appropriately meet the statutory ground of lack of competence rather than misconduct. However, it took into account that whilst the standard of Ms Henderson's performance was unacceptably low at times, it was not consistently low across all elements of her practice. The evidence suggests that Ms Henderson did have the knowledge and skills to do her work in a safe and effective manner, and she did so on some occasions. SWY's evidence was that Ms Henderson's assessments and support plans were generally good and thorough and that she was capable.

298. The failing to safeguard others, at fact 1, included failing to adequately assess and respond to risk in a timely manner and not completing workflows appropriately and without excessive delay. The panel took into account that these failures had persisted across an eight-month period, despite Ms Henderson having adequate and sufficient support to enable her to meet the expectations of her role. The failures related to multiple service users and their families, and placed service users at risk of harm. Despite Ms Henderson showing some level of insight, during her management supervision, into tasks and actions which remained outstanding, she continued to repeat her failings and place service users at risk. The panel considered that

safeguarding is a key part of the social worker role, and the priority is to make sure that service users are protected and to take the necessary steps to ensure their wellbeing. The panel found that failing to adequately assess, respond to risk in a timely manner, failing to complete workflows appropriately, and without excessive delay, did amount to serious misconduct.

299. The failing to safeguard others, at fact 2, included not accurately recording information within case notes and not recording information within case notes in a timely manner. The panel took into account the evidence it had received, about the importance of accurate and timely recording. This included that a failure to adequately record means that other professionals involved, or who may have been required to pick cases up, would not be fully sighted on the service users' current situation. The panel had evidence of the recording expectations, and this guidance and policy was made clear to Ms Henderson in supervision and as part of her PIAP. However, her failings persisted across an eight-month period and related to multiple service users. The requirement to record is a basic and core social work duty which Ms Henderson did not fully adhere to.

300. Ms Henderson provided some written mitigation for why she thought the failings had arisen. However, as set out earlier in this decision, the panel found that Ms Henderson was adequately and sufficiently supported. The panel concluded that Ms Henderson had not provided any reasonable justification for consistently breaching the Standards. The conduct/failings at facts 1 and 2 were serious as they both relate to safeguarding and occurred on multiple occasions, across multiple months and impacted on multiple service users. The panel considered that the facts found proved would be seen as far below what is expected by fellow practitioners.

301. In relation to the dishonesty to the regulator with regards to an Accepted Disposal, the panel decided that this also amounted to serious misconduct. Ms Henderson is an experienced social worker who should have been aware of the importance of honesty and transparency when dealing with her regulator. Whilst her dishonesty relates to one day (3 November 2022), it is exacerbated as she firstly created a false narrative, and thereafter, provided a fabricated email to try and secure a favourable outcome for her own gain. The panel took into account that during the course of that day, there was an opportunity for Ms Henderson to be honest, but she was not, and instead she made the conscious decision to fabricate and send the email, purporting it to be one she had previously sent to the Case Examiners. Even now, three months post the panel's findings, which were handed down in June 2024 and sent to Ms Henderson, she has not provided evidence or submissions accepting that she behaved in a dishonest manner.

302. The panel considered this to be a serious departure from the Standards expected of social workers. Ms Henderson's dishonesty shows a failing of a most basic and fundamental tenet of the social work profession.

303. The panel considered that the facts found proved (1-5) would be seen as far below what is expected by fellow practitioners and concluded that individually and cumulatively, they amount to misconduct.

Finding and reasons on current impairment:

Submissions

304. Mr Harris submitted that a finding of impairment was a matter of judgement for the panel. He referred to the Statement of Case and to the following cases:

- *CHRE v (1) NMC & (2) Grant [2011] EWHC 927 (Admin)*
- *Cohen v GMC [2008] EWHC 581 [Admin]*
- *Kimmance v GMC [2016] EWHC 1808*
- *PSA v HCPC v Ghaffar*
- *Yeong v GMC*

305. Mr Harris submitted that Ms Henderson was impaired on the personal and public components. He submitted that in relation to facts 1 and 2, these relate to breaches of fundamental tenets of the profession and that these breaches resulted in consequential harm to service users. He submitted that Ms Henderson has, in her written submissions, expressed some remorse and shown limited insight. He submitted that the insight was limited as whilst she acknowledged understanding the deficiencies, she also sought to blame management due to her perceived lack of support.

306. Mr Harris submitted that Ms Henderson has not provided any evidence of remediation. She has not provided details of any training or work which she is undertaking.

307. Mr Harris submitted that in relation to facts 3,4 and 5, dishonesty is hard to remediate. He submitted that Ms Henderson had provided no evidence of insight and that the risk of repetition remains. He further submitted that Ms Henderson has not fully engaged with Social Work England and has provided little evidence of any reflection on matters.

308. Mr Harris reminded the panel of Ms Henderson's written submissions which indicate numerous times that she does not wish to return to social work practice. He submitted that given this intention, she may not wish to remediate or develop further insight.

309. Mr Harris submitted that given the serious findings, the public would be shocked if a finding of impairment were not made in this case.

310. Ms Henderson did not provide oral submissions, but the panel took into account her written submission.

Legal advice

311. The panel heard and accepted the advice of the legal adviser in relation to impairment. The panel heard advice on some of the cases already listed above and the cases of *Meadow v GMC [2007] 1 WB 462*, *General Medical Council v Armstrong [2021] EWHC 1658 (Admin)* and *Sawati v General Medical Council [2022] EWHC 283*.

312. The legal adviser directed the panel to have careful regard to the Social Work England 'Impairment and Sanctions' guidance updated 19 December 2022, which includes guidance on assessing impairment, including paragraphs relating to dishonesty.

Decision

313. The panel considered Ms Henderson's current fitness to practise firstly from the personal perspective and then from the wider public perspective. The panel also had regard to whether the conduct in this case is easily remediable, whether it has been remedied and whether it was likely to be repeated.

314. In deciding impairment, the panel considered whether:

1. Ms Henderson has in the past and/or is liable in the future to place service users at unwarranted risk of harm.
2. Ms Henderson has in the past brought and/or is liable in the future to bring the profession into disrepute.
3. Ms Henderson has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the profession.
4. Ms Henderson has in the past acted dishonestly and/or is liable to act dishonestly in the future.

315. In relation to the first question the panel determined that based on the evidence before it, Ms Henderson has in the past placed service users at unwarranted risk of harm. The panel considered that its findings on misconduct (paragraph 298 of this decision) show that Ms Henderson has acted in a way that could place service users at risk of harm. Ms Henderson's role was to carry out professional social work assessments/support plans in a timely and effective way and to prevent, delay, or defer the need for on-going support for service users by maximising opportunities for independent living. Her failings to accurately assess, respond in a timely manner, complete workflows appropriately without delay, record accurate information and case note within a timely manner, ultimately meant that service users were not always safeguarded, and consequently were placed at risk of harm.

316. In relation to the question of whether Ms Henderson has in the past brought the profession into disrepute, the panel determined she had. A significant aspect of public interest is upholding proper standards of behaviour so as not to bring the profession into disrepute. The panel took the view that members of the public would be extremely concerned to learn that a registered social worker had behaved in the manner found in Ms Henderson's case. The panel considered that the dishonest conduct towards the regulator was particularly serious because the purpose of the regulator is to protect the public and public confidence in the profession.

317. In finding that Ms Henderson did not conduct herself in such a way as to adhere to the Social Work England Professional Standards, the panel determined that she had breached fundamental tenets of the social work profession. The panel considered that

safeguarding vulnerable people, accurate and timely communication, and honesty, are fundamental tenets of social work and lie at the heart of social work practice.

318. In relation to the fourth component, the panel determined that Ms Henderson had in the past acted dishonestly and had done so on more than one occasion during her involvement with Social Work England on 3 November 2022.

319. The panel considered the extent to which the misconduct in this case can be, and has been remediated by Ms Henderson, and whether it is likely to be repeated.

320. The panel kept in mind that the facts found against Ms Henderson relate to both her professional social work practice, and to her lack of honesty. The panel considered that character concerns, such as dishonesty, are often harder to remediate because it is more difficult to produce objective evidence of reformed character. Nonetheless, the panel did consider that the misconduct found was capable of being remedied providing that sufficient insight, remediation and reflection could be evidenced.

321. The panel took into account the submissions provided by Ms Henderson about the circumstances at the time of the misconduct, and how events had materialised.

322. In relation to the safeguarding failures, the panel noted that whilst Ms Henderson had acknowledged some of her deficiencies, she had also sought to deflect blame onto the management and the work environment. The panel considered that Ms Henderson's written submissions do not offer meaningful reflections on her practice and how her failings resulted in risk to multiple service users over multiple months, or how her actions impacted on her colleagues and the profession.

323. The panel had no information before it from Ms Henderson relating to remediation. Whilst it accepted that she was not in a social work role, nonetheless it would have been possible to undertake training courses, and/or provide testimonials from her employer or colleagues.

324. The panel had no confidence that Ms Henderson recognises what went wrong, nor that she fully accepts her role and responsibility in relation to the failings. Whilst the panel acknowledged that Ms Henderson had to an extent engaged with Social Work England, it considered this to be limited and, it had included her being dishonest to the regulator on 3 November 2022.

325. In relation to the dishonesty, whilst Ms Henderson was entitled to deny the particulars of Allegation, the panel had rejected her defence. Since the findings were made, Ms Henderson has not taken the opportunity to reflect on the findings and provide insight as to how findings of dishonesty impact on public safety and confidence in the profession. The panel did not consider the dishonesty to represent a significant deep-seated attitudinal character trait, keeping in mind that during her supervision, she was open and transparent about her failure to take action on cases, despite this being to her detriment. The panel also took into account that she is of previous good character, and it considered that the dishonesty was situational rather than fundamentally part of her character. However, the dishonesty was serious, as it was to the regulator, it was

repeated during the date in question, and it was for personal gain. Honesty is key to good social work practice as social workers are routinely trusted with access to private spaces (such as people's homes), and highly sensitive and confidential information (such as case notes). Further, other agencies, including the regulator rely on social workers providing them with honest information to enable them to undertake their own roles and responsibilities. Ms Henderson has provided no evidence of insight or reflection into the dishonesty findings. She has not addressed how she might act or react differently if the same circumstances were to happen again (to avoid reoccurrence of similar concerns).

326. The panel considered whether the misconduct was likely to be repeated by Ms Henderson, taking into account all it had read and heard about the misconduct.

327. Due to the lack of insight, and lack of remediation, the panel concluded that a risk of repetition remains.

328. The panel determined that Ms Henderson's fitness to practise is currently personally impaired on the grounds of her misconduct.

329. The panel next considered whether a finding of current impairment was necessary in the public interest. The panel was mindful that the public interest encompassed not only public protection but also the declaring and upholding of proper standards of conduct and behaviour as well as the maintenance of public confidence in the profession. It took into account the guidance in the *NMC v Grant* case at paragraph 74:- '*In determining whether a practitioner's fitness to practise is impaired by reason of misconduct, the relevant panel should generally consider not only whether the practitioner continues to present a risk to members of the public in his or her current role, but also whether the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances*.'

330. The panel considered its findings in relation to misconduct including the findings of dishonesty. The panel took into account that social workers hold privileged positions of trust. It is essential to the effective delivery of social work that the public can trust social workers to practise in a safe manner and to be honest. The panel considered that members of the public, would be concerned if the regulator were not to mark the seriousness of Ms Henderson's misconduct with a finding of current impairment on public interest grounds. The panel considered that not to make a finding of current impairment of fitness to practise in relation to those matters, given the amount of breaches of the Standards, would undermine public trust and confidence in the profession and would fail to uphold and declare proper standards.

331. The panel therefore decided on the public interest element of impairment that Ms Henderson's fitness to practise is currently impaired.

Decision and reasons on sanction:

Submissions

332. Mr Harris submitted that the appropriate sanction is a removal order. He made reference to the case of *Law Society v Bolton [1994] 1 WLR 512*, and the judgement of Sir Thomas Bingham MR.

333. Mr Harris submitted that the central purposes in considering whether to impose a sanction are the protection of the public including the wider public interest of maintaining public confidence in the profession and upholding proper standards of conduct. He submitted that part of this is by preventing repetition. He told the panel that mitigation is a factor that will generally be of less significance given that the purpose of sanction is not punitive.

334. Mr Harris submitted that there is a need to maintain a well-founded confidence that social workers are persons of unquestionable honesty, integrity, and trustworthiness among members of the public.

335. Mr Harris submitted that the workplace failings relating to safeguarding were sufficiently serious alone to justify a significant sanction given that they relate to fundamental expectations of social work practice. Mr Harris drew the panel's attention to its findings in respect of Ms Henderson, in that it had found that she had fell far below standard and had placed service users at consequential risk of harm. This had occurred over an eight-month period across multiple cases and despite support the failures were ongoing. Mr Harris submitted that against that backdrop, the dishonesty findings seriously aggravate the misconduct.

336. Mr Harris submitted that whilst the panel had found the dishonesty to be driven by circumstance, it is nonetheless attitudinal. He submitted that Ms Henderson had every opportunity to come clean, but she chose to lie and then amplify the dishonesty by creating a false email to support her lie. She could have reflected after the initial lie, but instead she chose to continue it.

337. Mr Harris submitted that the dishonesty is serious because the target of the dishonesty was the regulator, and they rely on the honesty and integrity of those who they regulate.

338. Mr Harris drew the panel's attention to its decision in relation to the lack of insight, reflection and remediation.

339. Mr Harris referred to the *Social Work England Impairment and Sanctions guidance'* ("Sanctions guidance") dated 19 December 2022, noting that dishonesty is likely to threaten public confidence in the social work profession. Mr Harris submitted that if Ms Henderson wished to show that her dishonesty was not a long-standing character trait, she could have sought to provide evidence of insight and reformation of character, but she has not done so.

340. Mr Harris referred the panel to its decision on misconduct and impairment reminding it that the decision finds that this case involves serious dishonesty to the regulator and that there remains a risk of repetition.

341. Mr Harris submitted that given the seriousness of the conduct, lesser orders of no action, advice or warning would be wholly inappropriate in light of the panel's findings as to repetition and harm, as they do not restrict practise.

342. Mr Harris referenced the Sanctions guidance and submitted that Conditions of Practice are unlikely to be appropriate in such a case as this, where such attitudinal failings are involved.

343. Mr Harris drew the panel's attention to the relevant sections of the Sanctions guidance which reference suspension orders, removal orders and dishonesty. He submitted that suspension is likely to be unsuitable as Ms Henderson has not provided evidence that she is willing and able to resolve her failings, and despite the passage of time since the events she still has no insight into her dishonest conduct.

344. Mr Harris submitted that based on the Sanctions guidance and in all of the circumstances of this case a removal order is necessary for the protection of the public, including maintaining public confidence in the profession and upholding proper standards of conduct.

345. Mr Harris referred to passages from the following cases:

- *Law Society v Bolton [1994] 1 WLR 512.*
- *Professional Standards Authority v The Health and Care Professional Council & Mohammed Ghaffar [2014] EWHC 2723 (Admin).*
- *Abbas v GMC [2017] EWHC 51 (Admin).*
- *Parkinson v NMC [2010] EWHC 1898 (Admin).*

346. Mr Harris submitted that if the panel do not accept Social Work England's submission that the appropriate sanction is one of removal, then it should impose a suspension order which should be long to mark the seriousness. He submitted that sufficient time would be required to remediate something which is difficult to remediate, and which Ms Henderson has thus far been unwilling to do.

347. Mr Harris sought for the panel to make an interim order for eighteen months to cover the appeal period if it imposed a restrictive order or removal order. He submitted that an interim order is necessary to protect the public in light of the findings of misconduct and impairment made by the panel.

Legal advice

348. The panel heard and accepted the legal advice from the legal adviser on all the available options on sanction as set out in the Regulations. The panel was advised to consider the Sanctions guidance dated 19 December 2022. The panel was advised that the purpose of any fitness to practise sanction is to protect the public which includes maintaining confidence in the profession and upholding professional standards. The sanction imposed should be the minimum necessary to protect the public. The panel also heard and accepted the advice of the legal adviser in relation to the test for interim

orders at final hearing stage. To impose an interim order in the present circumstances it needed to be satisfied that such an order was necessary for the protection of the public which includes the public interest.

Decision

349. The panel applied the principle of proportionality by weighing Ms Henderson's interests with the public interest and by considering each available sanction in ascending order of severity. The panel considered the mitigating and aggravating factors in determining what sanction, if any, to impose.

350. The panel was unable to identify any mitigating factors.

351. The panel identified the following aggravating factors:

    a. Ms Henderson's conduct in relation to the safeguarding findings was a consistent theme across multiple cases and repeated over a number of months. Her conduct caused consequential risk of harm to multiple service users.
    b. Ms Henderson showed limited insight into the safeguarding failings.
    c. Ms Henderson showed no insight into the dishonesty.
    d. Ms Henderson provided no evidence of remediation.
    e. The dishonesty occurred on more than one occasion on 3 November 2022. Ms Henderson told a lie then attempted to conceal her lie by creating a false email, to support her lie, and for her own personal gain.
    f. Ms Henderson's dishonesty was targeted at the regulator.

352. Considering the serious nature of the findings of fact it had made, the panel decided that taking no further action, issuing advice or a warning, would not be appropriate as these sanctions would not restrict Ms Henderson's practice and would therefore not protect the public from the risks that have been identified.

353. The panel went on to consider whether a conditions of practice order would be appropriate. It is difficult to see how a conditions of practice order might address and safeguard members of the public from the risks of the dishonesty aspect of Ms Henderson's misconduct. The panel took into account that the dishonesty related to providing inaccurate information to the regulator. It reminded itself that it had found Ms Henderson had shown limited insight, had not remediated, and there was risk of repetition. With this in mind the panel considered that conditions of practice would not be sufficient to prevent the risk of repetition, nor would it be sufficient to satisfy the public interest element, as the public and other agencies including the regulator must be able to trust the accuracy of information provided by social workers.

354. The panel then considered whether a suspension order should be imposed to protect the public and the wider public interest. The panel took into account that a suspension order can be imposed for a period of up to three years. The panel had in mind that the

purpose of a suspension order is not to punish but to protect the public and public interest.

355. The panel asked itself whether this was a case which fell short of requiring removal, having regard to its findings on misconduct. It noted its decision that that the misconduct was capable of being remedied, providing that sufficient insight, remediation, and reflection could be evidenced.

356. The panel asked itself what a period of suspension would seek to achieve in Ms Henderson's case. A period of suspension would provide an opportunity for Ms Henderson to seek to address the misconduct findings made against her. However, she has provided written submissions stating that she does not wish to practise as a social worker. Therefore, the panel had no evidence to suggest an indication that Ms Henderson is willing or able to resolve or remediate her failings.

357. In relation to dishonesty, the panel noted that Ms Henderson has provided no acknowledgment of fault, no meaningful reflection, and has no insight into her conduct. The panel had no confidence that the conduct would not be repeated, particularly given the dishonest attempt by Ms Henderson to try and conceal the lie that she told to her regulator, by creating a false email to support what she had said.

358. The panel took into account that social workers hold positions of trust, and the role often requires them to engage with vulnerable people. Dishonesty is therefore likely to threaten public confidence in social workers. The public (which includes the regulator) must be able to trust the accuracy of information provided by social workers.

359. For the above reasons the panel determined that a suspension order was not sufficient to protect the public, public confidence in the profession, nor to mark the public interest in declaring and upholding proper standards of conduct and behaviour.

360. The panel took into account the Sanctions guidance which states that:

> 'A *removal order must be made where the decision makers conclude that no other outcome would be enough to (do one of more of the following):*
> - *protect the public*
> - *maintain confidence in the profession*
> - *maintain proper professional standards for social workers in England.'*

361. The panel considered that a removal order is a sanction of last resort and should be reserved for those categories of cases where there is no other means of protecting the public and the wider public interest. The panel decided that Ms Henderson's case falls into this category because of the nature of her dishonest conduct, the persistent lack of insight into the seriousness of her actions or consequences, and the indication that she is unwilling to remediate as she has stated on numerous occasions that she does not wish to practise as a social worker in the future. The panel was also satisfied that any lesser sanction would undermine public trust and confidence in the profession, in light of the lack of meaningful engagement, insight, remediation, and reflection.

362. The panel had regard to proportionality and balanced the public interest against Ms Henderson's interests. The panel considered the potential consequential personal, financial, and professional impact a removal order may have upon Ms Henderson but concluded that these considerations are significantly outweighed by the panel's duty to give priority to public protection and the wider public interest.

363. The panel concluded that the appropriate and proportionate order is a removal order.

Interim order

364. In light of its finding on sanction the panel next considered whether to impose an interim order. It was mindful of its earlier findings and decided that it would be wholly incompatible with those earlier findings if an interim suspension order was not made.

365. Accordingly, the panel concluded that an interim suspension order is necessary for the protection of the public, including the wider public interest. The panel decided that the appropriate length would be eighteen months to allow time for any potential appeal to be considered by the High Court.

366. 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

367. 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.

368. 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.

369. 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.

370. 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:

371. 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

372. 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:

373. 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.