Social Worker: Ebinepre Olufunmilayo Adewale
Registration number: SW38204
Fitness to Practise

Final Hearing

Date of hearing: 17-21 February 2025

Hearing Venue: Remote hearing

Hearing outcome:

Fitness to practise impaired, suspension order – 6 months

Interim order:
Interim suspension order – 18 months

Introduction and attendees:

1. This was a hearing held under Part 5 of The Social Workers Regulations 2018.
2. Mrs Adewale attended and was represented by Mr Anyiam, counsel.
3. Social Work England was represented by Ms Sharpe of Capsticks LLP.

Adjudicators	**Role**
Rachel O'Connell	Lay Chair
Warren Dillon	Social Work Adjudicator
Richard Weydert-Jacquard	Lay Adjudicator

Tom Stoker (Mon-Thurs) and Paige Swallow (Fri), observed by Jo Cooper throughout	Hearings Officer
Lauryn Green, observed by Ruby Wade	Hearing Support Officer
Nathan Moxon	Legal Adviser

Allegations:

4. Mrs Adewale faced the following Allegation:

> "*While registered as a social worker, on or around 17 November 2020 in respect of a visit to Family A, you:*
>
> 1. *Did not prepare adequately for the visit;*
> 2. *Did not take appropriate safeguarding action to a safeguarding concern in that you:*
>
> *a. Did not immediately seek advice from your team manager;*
>
> *b. Did not request/gain consent for a Child Protection Medical Assessment for Child E and/or;*
>
> *c. Did not immediately request a strategy meeting and/or;*
>
> *d. Did not take safeguarding steps in relation to the other children of Family A, and/or;*
>
> *e. Did not take the lead in ensuring appropriate safeguarding action was undertaken.*

The matters set out at paragraphs 1 – 2 constitute misconduct.

By reason of your misconduct, your fitness to practise as a social worker is impaired.

Admissions:

5. At the outset of the hearing, Mrs Adewale admitted paragraphs 2b, c and d of the Allegation. Pursuant to rule 32(c)(i)(aa) of the Social Work England Fitness to Practise Rules 2019 (as amended ("the Rules"), the panel announced that those admitted parts of the Allegation were found proved.

Preliminary matters – public / private hearing

6. The panel was satisfied that, pursuant to rule 37 and 38 of the Social Work England Fitness to Practise Rules 2019, any aspect of the hearing in which the names of service users and their families are named should be in private. This was for only an extremely brief period as the service users and families related to the Allegation were anonymised throughout by use of the monikers: Family A and Child E.

Background:

7. Mrs Adewale commenced work for Thurrock Council ("the Council") via an agency as a locum senior practitioner on 2 November 2020. Her line manager was BO, who had commenced work for the Council at a similar time. Her service manager, and therefore BO's line manager, was DM.

8. Mrs Adewale's role was to manage a caseload and assess risk within families who were referred via the Multi-Agency Safeguarding Hub ("MASH").

9. On 17 November 2020 Mrs Adewale attended a joint visit at the home of Family A with RA, a health visitor. Family A consisted of Mother, Father and three children, aged around six months, 18 months and three years. There was a history of violence within the family and lack of cooperation with agencies. During the visit, a fourth child, aged about 18-24 months, was present "Child E". She was identified as the niece of Mother.

10. Mrs Adewale and RA both had concerns about the presentation of Child E. RA reported her concerns to the police, who attended later in the day and took Child E into police protection, before she was admitted to hospital for a child protection medical assessment. Mother and Father were subsequently arrested in relation to injuries to Child E.

11. A strategy meeting was undertaken on 18 November 2020 and Child E was placed into temporary foster care and the three children of Family A were removed from their parents and also placed into temporary foster care.

12. On that day, Mrs Adewale's and BO's contracts with the Council were terminated with immediate effect on account of the Council concluding that neither had taken appropriate safeguarding action.

13. On 30 November 2020 DM referred Mrs Adewale to Social Work England as a consequence of alleged failures of Mrs Adewale in relation to the meeting with Family A and her action upon encountering Child E.

Summary of Evidence – Facts:

14. Social Work England relied upon written statements and oral evidence from RA, DM and BO.

15. Social Work England relied on various documents, included within a 1,149-page exhibits bundle.

16. Social Work England also relied upon a statement of case, updated on 2 June 2023.

17. Mrs Adewale provided written and oral evidence before the panel.

18. Mrs Adewale relied upon various documents, included within an 86-page bundle and a 48-page bundle.

19. During the hearing the panel was also provided with photographs of Child E and an email from DM, dated 18 December 2021.

20. The panel considered all written and oral evidence, together with the submissions of the parties, with care. It is not intended that all the evidence be repeated within this document, but to simply make reference to the more pertinent points that assisted the panel in reaching its decisions.

Findings – Facts:

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

    a. The panel must always have regard to the overarching objective to protect the public and to promote and maintain public confidence in the social work profession and proper professional standards;

    b. It is for Social Work England to prove the allegations upon the balance of probabilities;

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

    d. The fact that Mrs Adewale was dismissed by the council is not evidence in support of the Allegation. The panel is solely responsible in these proceedings for making findings of fact.

22. Further, upon request by Mr Anyiam, the panel was given a direction pursuant to the case of *R v Lucas* [1981] QB 720, namely that, if the panel were to find that Mrs Adewale has lied about any aspect of her evidence, it does not automatically follow that her entire testimony is dishonest or that the allegations are proved solely due to that dishonesty. A person may lie to bolster an otherwise genuine defence.

23. RA had been involved with Family A since August / September 2020. There has been no dispute about her previous engagement with the family. She outlined, within her witness statement, dated 1st April 2023, that upon her first visit to the family home she was concerned for the three children as:

> "*…the house was full of cigarette smoke and the children were running riot. It took the Mother 15 minutes to let me into the house as she said that she forgot I was coming and shut the door. The youngest child had a heart murmur and the hospital had recommended a six week health check at a GP to make sure the baby was clinically well. At the six week visit the mother had not registered the baby at a GP surgery and none of the children had received any immunisations. The 18 month old boy was also presenting in peculiar ways as he was not interested in normal toys and liked breaking things. The back of the boy's head was flat which suggests that he was left in a cot. The eldest child was three years old at the time and did not know any animals or colours. The mother said that she was going to nursery but when I tried to confirm this with the nursery they said they had never heard of the child*."
>
> *I felt that the family was not being truthful with me as when I asked about their previous involvement with Social Services they said they had none, however I later discovered that the Mother was involved with Social Care as a child and when she had her first child there were concerns from Social Services about how she was going to keep her safe. I therefore made a detailed referral tor Social Services for the children*".

24. It is not in dispute that, prior to Mrs Adewale's employment at the Council, Family A was referred to another social worker who undertook a visit to the family home with RA. RA stated in oral evidence that the meeting took about three hours and was extremely detailed.

25. The initial social worker left the Council and the case was reallocated to Mrs Adewale.

26. Mrs Adewale and BO stated that there was a delay in them being given access to the Liquid Logic system, also known as LCS, used by the Council. Mrs Adewale stated in her oral evidence that she never received access to the system. That evidence was rejected by the panel. The panel noted the certificate produced by Mrs Adewale that she completed the requisite IT training on 12 November 2020. It noted the evidence from DM that social workers are given access to the system almost immediately upon completion of the training. Further, she stated in her witness statement and oral evidence that Mrs Adewale had access to the system as of 17 November 2020 as the family was allocated to her on the electronic system.

27. The panel also noted that within Mrs Adewale's response to the allegations, on 22nd January 2021, she stated that, after the conversation with RA on 17 November 2020 "*…I intended to log these series of events onto the system during this time, however I was scheduled to attend a third face-to-face visit with another family…*". Further, within the contents of an email sent by Mrs Adewale on 4 November 2021 she stated: "*I had my*

LCS Training on Thursday 12/11/21, prior to this I was not able to access the system…". The panel noted that reference to 2021 is in error and should read 2020 given the dates that Mrs Adewale worked for the Council and the fact that 12th November 2020 fell on a Thursday whereas 12th November 2021 fell on a Friday. Neither the initial written response to the allegations, nor the aforementioned email, state that Mrs Adewale was never given access to the system. That has only been subsequently argued by her.

28. As such, the panel was satisfied that Mrs Adewale had access to the system from 12 November 2020. In any event, the panel considered any access or otherwise to the system was a peripheral matter that did not assist it in determining whether the allegations were found proved.

29. RA's evidence was that the visit by Mrs Adewale on 17 November 2020 was Mrs Adewale's first visit with Family A, whereas Mrs Adewale contended that she had already undertaken an initial visit on 11 November 2020. The panel preferred Mrs Adewale's evidence in this regard and noted that she had always been consistent about having attended Family A on 11 November 2020; and an email by DM, dated 18 December 2021, states her understanding at that time that a visit had occurred on 11 November 2020.

30. Given access to the system was not provided until 12 November 2020, the previous visit on 11 November 2020 could not be recorded in a timely manner and was not recorded prior to Mrs Adewale's dismissal. The lack of a recorded visit does not therefore indicate that the visit did not occur.

31. The panel did not consider that RA sought to mislead. There would be no reason for her to seek to do so. The panel was satisfied that RA had genuinely, but nevertheless mistakenly, believed that the 17 November 2020 visit was Mrs Adewale's first with Family A.

32. The panel did not consider it necessary to make findings as to whether Mrs Adewale was reluctant to attend the 17 November 2020 with RA in person or whether she made derogatory comments about management, as such findings did not assist the panel in determining whether the allegations have been proved. In any event, any reluctance by Mrs Adewale to attend the 17 November 2020 visit in person would be mitigated by the fact that she had attended in person on 11 November 2020.

33. RA detailed in her witness statement that she was frustrated at having to lead the meeting with Family A on 17 November 2020 and stated in her oral evidence that Mrs Adewale's approach to the meeting was in stark contrast with the meeting that RA had attended between Family A and the previous social worker, which had lasted three hours and been extremely detailed. However, the panel was satisfied that RA's perception of Mrs Adewale's approach to the meeting, and the fact that "*…there was no depth to the assessment…*" was tainted by the fact that she mistakenly believed that it was Mrs Adewale's first visit to Family A. In fact, Mrs Adewale had visited only six days earlier. Her visit was not therefore to commence an assessment but to continue an assessment that had already started. Her attendance was primarily as a consequence

of RA asking her to join her, and RA accepts making that request. Mrs Adewale intended to use the opportunity to obtain signed consent from the parents, as supported by her diary which details a 10:30 visit with the family with the annotation "*sign papers*". This is what she said that she achieved, together with talking to the parents about rent and benefits issues. Given that Mrs Adewale had already visited the family, and was attending on 17 November 2020 at the request of RA, the panel was satisfied that it was not necessary for her to take the lead on all matters at the meeting, given that the primary purpose of her attendance was to support RA, or that any failure to do so betrayed a lack of preparation.

34. The panel was satisfied that Mrs Adewale's approach to the meeting would have been inappropriate had it been her first meeting with the family, as believed by RA, but that given she had visited a few days earlier, her actions and approach could be justified.

35. Whilst RA stated in her witness statement that Mrs Adewale did not have any documents with her at the meeting, she conceded during her oral evidence that she could not recall whether Mrs Adewale had a bag or what the contents were of any bag. Further, whilst stating in her witness statement that Mrs Adewale did not have any documents, she goes on to say that Mrs Adewale did have a document that she used with the eldest child of family A for that child "*...to show their point of view*".

36. Further, regardless of any access to Liquid Logic, the panel was satisfied that Mrs Adewale had been given a synopsis of the family and a copy of a printout of the MASH referral, as confirmed by BO, and there is no adequate evidence that she failed to consider that referral prior to the 17 November 2020 visit.

37. In all the circumstances, and whilst accepting that Mrs Adewale did have access to Liquid Logic by 12 November 2020 and therefore prior to the 17 November 2020 visit with Family A, the panel was not satisfied that she did not prepare adequately for the visit and that the judgment of RA to the contrary was significantly flawed upon the mistaken belief that it was Mrs Adewale's first meeting with Family A.

38. As such, paragraph 1 of the Allegation is not proved.

39. In relation to Child E, the panel was satisfied that Mrs Adewale first encountered Child E when entering Family A's property and notes that, within her witness statement, RA details how, when they arrived, Mrs Adewale "*...went down the corridor towards the back bedroom, but did not enter the room, and introduced herself to the Mother and asked the Mother if those were all her children, and I assumed that she was talking about the three children*".

40. The panel was satisfied that Mrs Adewale then went to the living room where she spoke to the parents before Mother left to take the youngest child to a medical appointment.

41. The panel was satisfied that, as RA and Mrs Adewale were leaving the property, they went to the children's room with Father where RA first encountered Child E.

42. There has been some dispute between RA and Mrs Adewale as to how Child E presented. RA has said throughout her accounts that Child E was covered in bruises, whereas Mrs Adewale has always stated that they were "*marks*" or "*blemishes*".

43. The panel had sight of photographs taken of Child E by the police on 17 November 2020 upon her being removed from Family A's home. Those photographs show Child E's face, neck and arms, all of which were visible to RA and Mrs Adewale at the time of their visit. The face, neck and arms are shown in the photographs showed extensive bruising and scratches. It is evident from even a cursory look at the photographs that Child E had numerous injuries upon the exposed areas of her body. They cannot have been missed by Mrs Adewale who saw Child E at the start and end of her visit to Family A on 17 November 2020. To describe the bruises as "*marks*" and "*blemishes*" significantly minimises Child E's physical presentation. The panel, having considered the photographs with care, had sympathy with RA's comment in her witness statement that "*The bruising to Child E was the worst thing I have ever seen as a Health Visitor*" and within her contemporaneous notes of the visit that "*I was absolutely taken aback by her face - her face was covered in small, circular bruises*".

44. The panel was satisfied that any reasonable person who encountered Child E as she physically presented on 17 November 2020 would be gravely concerned about her immediate wellbeing and safety. The panel was satisfied, having considered the photographs, that a person would not require social work training or experience to identify that there were significant safeguarding concerns when presented with a child as Child E presented.

45. Mrs Adewale's evidence was confusing and internally inconsistent. Whilst she stated that she believed Child E had marks that may have been a result of a skin condition, and suspected paediatric lupus, she accepted that she had been told by both Mother and Father that Child E had bashed her head and hit her face in imitation of one of Family A's children. Even if their account was accurate, it would confirm that Child E was presenting with physical injuries and not a skin condition. Further, their purported explanations could not have reasonably been accepted as a likely cause of the extensive visible injuries to Child E as shown within the photographs.

46. In light of RA's consistent written and oral account of Child E's presentation, together with the panel's findings that Mrs Adewale sought to minimise the physical presentation of Child E, the panel was satisfied that Child E presented emotionally as RA outlined. The panel was satisfied that Child E presented as outlined within RA's contemporaneous notes as "*…very timid and sad*"; in her initial, undated, witness statement as "*…very timid and reluctant to come towards us*"; and in her police witness statement, dated 22 January 2021, as looking "*..like a rabbit in caught in headlights, she was apprehensive and was extremely wary to come towards me, she looked very scared*".

47. The panel also took into account RA's witness statement in which she stated that "..Child *E…I had never seen a child look so petrified, her clothes were filthy and she was*

covered in bruising all over her face…The bruises on her face were all the same shape and were perfectly circular and similar in size. When I spoke to Child E she kept saying 'ow' and lifting her shirt up".

48. *She concluded: "The bruising to Child E was the worst thing I have ever seen as a health visitor*".

49. She detailed in her oral evidence: "*I remember her looking like a rabbit in headlights and had big wide eyes and looked frightened and meek and she looked bewildered and seemed so frightened*".

50. Given the fact that RA's evidence has been consistent within numerous accounts, together with being consistent with how Child E physically presented as covered in bruises, the panel preferred her account of Child E's emotional presentation to that of Mrs Adewale who had, as outlined above, sought to minimise Child E's physical presentation. The panel therefore rejected Mrs Adewale's evidence that Child E presented as happy, smiling, playing and demonstrated no sign of distress or pain.

51. The panel noted that, even if the child had presented as happy, the physical injuries alone should have caused immediate safeguarding action.

52. The panel was therefore satisfied that RA and Mrs Adewale, on 17 November 2020, were presented with a child under two years of age, showing numerous signs of physical injury and who also presented as timid and scared. This was at the address of a family within which, it is not disputed, there had been a history of domestic abuse concerns and un-cooperation with agencies, which had included an initial refusal of entry to RA on 17 November 2020, as Mrs Adewale accepts being told about upon her own arrival. The panel was unimpressed with Mrs Adewale's oral evidence that she was not concerned about the past violence as that had been between adults in the family. She was in a house containing adults with a history of violence and a young child displaying numerous injuries. That should have raised significant concern and triggered immediate action.

53. Further, within her oral evidence Mrs Adewale stated that Father "*shut down*" and was "*anxious and hostile*" when asked about Child E's presentation, which the panel considers should have been a further red flag. Upon being pressed about this in cross-examination, Mrs Adewale stated that she did not mean that he had "*shut down*", which the panel considered to be an example of Mrs Adewale seeking to change her evidence to downplay her failings during the situation.

54. The panel concluded that, in those circumstances, any reasonable person encountering Child E would, even in the absence of any relevant professional training or experience, realise that there was a significant safeguarding concern.

55. There is some dispute between RA and Mrs Adewale as to the explanation given by Mother and Father about Child E's presentation. RA stated that Father had said that it was as a result of Child E being constipated, which had caused her to bash her head on her high chair, whereas Mrs Adewale stated that both Mother and Father told her that it

was as a consequence of Child E imitating another child. The panel considered that it need not make findings on that dispute as, on either account, it was not disputed by the adults within Family A that Child E was presenting with physical injury.

56. The panel was satisfied from the evidence of DM and upon a common sense assessment of the scenario faced by Mrs Adewale, that she should have taken immediate safeguarding action to protect Child E. That conclusion is supported by the action taken by other agencies when the case was referred to them, namely she was removed by police from the care of Family A, medically examined and taken into temporary foster care. Whilst there has been some dispute as to whether Mrs Adewale was adequately inducted when she started her work with the Council, or whether she had access to local policy and guidance documents, the panel accepted without hesitation the evidence of DM that: "*This is basic safeguarding and I would expect any qualified social worker at any stage of career to take immediate safeguarding action… this is basic child protection and safeguarding and I would expect a social worker with any length of service to know*".

57. As such, the panel was satisfied that, whether or not Mrs Adewale was aware of the Southend, Essex and Thurrock (SET) Safeguarding and Child Protection Procedures or the other local policy and guidance documents, which have been provided within Social Work England's documents is a moot point. The situation faced by Mrs Adewale involved "*basic safeguarding*" which the panel was satisfied is a fundamental tenet of social work regardless of a social worker's employment status or level of experience. It reminded itself that Mrs Adewale was a senior practitioner of significant experience, regardless of being a locum who had recently commenced work with the Council, and so should have especially known that immediate safeguarding action was required.

58. Further, whilst there is dispute as to Mrs Adewale's caseload, the panel considered that, regardless, she would be required to take immediate appropriate action to safeguard children that she encounters on a visit to a family.

59. The panel was satisfied that Mrs Adewale should not have left Child E, or the other children, in the care of Family A. She should have taken action, whether inside the property or by stepping outside to do so without being overheard, to contact her manager and the police to arrange for the children to be removed to a place of safety. She should not have left the vicinity until they were safe. The panel was satisfied that leaving the property to return to her office, and leaving Child E and the other children in the care of Family A, was a significant failure of basic safeguarding.

60. The panel is satisfied that Mrs Adewale should have taken the action as outlined by DM within her witness statement, dated 16 March 2023:

> *"I … would expect immediate action to be taken including making enquiries about how the injury took place, discussing this with a manager and not leaving the child until arrangements had been made for a Child Protection Medical assessment. This Child Protection Medical assessment requires parental consent, and so if the parents did not consent then I would expect the social*

worker to seek advice from their manager and arrange a strategy meeting with the police to undertake appropriate safeguarding actions..... I would also have expected the Social Worker to undertake or consider safeguarding for the children of Family A as at that time we did not know how or when Child E had sustained the injuries. This meant the children in the home may have been left vulnerable. The Social Worker did not undertake any of these actions set out above, and instead left Child E and the other children in the home at the potential risk of ongoing significant harm."

61. It is not in dispute that Mrs Adewale left the area and understood that RA would make some enquiries.

62. This is detailed within Mrs Adewale's response to the allegations, dated 22 January 2021:

> *"After the visit had concluded, I spoke with [RA] outside of the property and expressed concern about the unidentified marks on CHILD [E]'s face. [RA] agreed that this was unusual. I advised [RA] that I would make a referral based on the unidentified marks on the face of CHILD [E] as I felt that it needed to be further investigated. [RA] told me that she was going directly to the office and would access the medical records of CHILD [E] to establish whether this had been reported previously. [RA] offered to make the referral after her findings. I accepted this and informed her to update me once the medical checks had been made and once the referral had been completed. My assessment was that there was no immediate risk of harm to CHILDREN [A] or CHILD [E] at that time. Further investigation into CHILD [E]'s medical history was required and I concluded that a referral was to be made. We both agreed the above action and left to conduct a further face-to-face visit with another family at South Ockendon."*

63. The panel was satisfied that this was an unreasonable and improper approach by Mrs Adewale. Firstly, the assessment that the children were in no immediate risk of harm was significantly flawed in all of the circumstances. Further, Mrs Adewale, as the social worker, should have taken control of safeguarding the child. The panel accepted the evidence of both DM and BO that it was not appropriate to delegate this to someone who was not a social worker.

64. All social workers ought to be aware of their statutory duty, pursuant to section 17(1)(a) of the Children Act 1989, to safeguard and promote the welfare of children within their area who are in need; and section 47(a)(b) that, where there is reasonable cause to suspect that a child who lives, or is found, in their area is suffering, or is likely to suffer, significant harm, the authority shall make, or cause to be made, such enquiries as they consider necessary to enable them to decide whether they should take any action to safeguard or promote the child's welfare.

65. Further, within the national document, of which all social workers should be familiar: 'Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children' it is stated, at page 36:

> "*Where there is a risk to the life of a child or a likelihood of serious immediate harm, local authority social workers, the police or NSPCC should use their statutory child protection powers to act immediately to secure the safety of the child… The local authority in whose area a child is found in circumstances that require emergency action (the first authority) is responsible for taking emergency action."*

66. At page 37 it states:

> *"Following acceptance of a referral by the local authority children's social care, a social worker should lead a multi-agency assessment under section 17 of the Children Act 1989"*.

67. Mrs Adewale accepted in her oral evidence that, despite Child E being believed to live in an area not covered by the Council, the fact that she was in the Council's area at the time meant that the Council was under a duty to safeguard.

68. The panel was satisfied that Mrs Adewale should have taken the lead on safeguarding by calling her manager and the police immediately and without leaving Child E and the other children in the care of Family A.

69. The panel rejected the submission by Mr Anyiam that Mrs Adewale's decision to wait for RA to make enquiries was appropriate as RA had volunteered to do so. Firstly, the panel considered that, regardless of any offers by a health visitor to make enquiries, the social worker, and therefore Mrs Adewale, had the primary responsibility for safeguarding. Further, the panel was satisfied that RA only stated that she would make enquiries as she was concerned that Mrs Adewale was not taking the matter sufficiently seriously, a reasonable conclusion to have made given that, on Mrs Adewale's own account, she told RA that she was going to another visit before considering what action to take.

70. The panel accepted the evidence of DM and agreed with her analysis, as detailed within her March 2023 witness statement:

> *"The Health Visitor appears to have taken on the role expected of the Social Worker due to her concerns that the Social Worker did not take safeguarding action. Child E and the other children should not have been left until a safety plan had been agreed and concerns escalated to management for oversight. The Social Worker had a duty to safeguard the children… The Social Worker should have led this response and taken immediate safeguarding action. The Social Worker should not have left the property or delegated her own responsibility….. Until there is an explanation of how the injury occurred, then this is an unassessed risk. If you do not get a clear account of how the injury occurred then you may leave a child at ongoing risk of harm. If a Child Protection Medical*

assessment later identifies that this was a non-accidental injury caused by someone then the child has suffered significant harm and by not getting an explanation for this you could leave a child at risk of ongoing harm."

71. During her evidence, DM was clear that, having spoken to Mrs Adewale after the joint visit, that her view as service manager was that Mrs Adewale still, at that point, lacked a full understanding of how high the risk of harm was to Child E and the other children in the home and that urgent safeguarding action was required. The panel was of the view that RA was clear in her evidence that she had to take the lead in the safeguarding action and it noted that it was RA that contacted the police, liaised with the North East London NHS Foundation Trust's ("NELFT's") safeguarding social worker. Furthermore, the police had spoken to RA as a point of contact immediately following her request for them to attend the property, and gave her the update as to Child E's full body assessment, including onward actions that would be taken. The panel considered that this was evidence that RA and not Mrs Adewale had taken the lead in safeguarding action.

72. Mrs Adewale's evidence during the hearing was that she returned directly to the office to speak to BO. The panel rejected that evidence. It notes RA's evidence that, upon leaving Family A's property, Mrs Adewale told her that she was going on another visit. Mrs Adewale accepts saying that but states that she changed her mind thereafter. She says that she returned to her office and spoke immediately to her manager. The panel was satisfied that Mrs Adewale did not return immediately to the office and found as a fact that, before doing so, she attended another visit with another family.

73. The panel took into account Mrs Adewale's diary which details that Mrs Adewale had a meeting with Family A arranged for 10:30 and then a visit at 12pm arranged with Family N. The panel noted that, within her initial response to the Social Work England referral, dated 22 January 2021, and therefore only two months after events, as outlined above, she detailed:

"*We both agreed the above action and left to conduct a further face-to-face visit with another family at South Ockendon."*

74. That written account continues (emphasis added):

*"**After completing my second face -to-face visit, I returned to the office** at about 1pm to brief my line manager of the case concerning my joint visit to FAMILY [A] with [RA]. I provided full feedback as to what had transpired, and I explained the safety and wellbeing concerns in relation to CHILD [E]. I informed her that a referral was to be made and that I was expecting further details / feedback from [RA] with regards to the outcome of her medical checks. I also informed my line manager that the referral was going to be made by [RA] to the Local Authority where CHILD [E] resides."*

75. The panel did not accept Mrs Adewale's explanation in her oral evidence that, since she submitted that initial written response to the regulatory concerns, she has reflected

and realised that she did not attend the visit with Family N. The panel noted that the first account given by Mrs Adewale that she had cancelled the visit with Family N was within her written response to the allegation, dated 30 May 2023, and therefore 2 ½ years after events. The panel considered it incredible that she would have initially stated that she had attended the visit, so soon after events, if that second visit had not occurred or that an account 2 ½ years later would a better recollection of events than an account given two months after events. Distress arising from being referred to her regulator does not provide an adequate explanation. The panel noted that the visit is detailed in Mrs Adewale's diary and had not been crossed out as being cancelled. She stated during the hearing, for the first time, that the visit to Family N was to be unannounced and did not require cancelling. Whilst Mrs Adewale stated that it could not have occurred as she did not detail next to the meeting the mileage accrued in travelling to it, she also stated that she would not have included the mileage had she attended on the family before and the panel noted from her diary that she had attended previously on 12 November 2020 and noted the mileage on that occasion. Further, BO told the panel that she was first notified of the safeguarding concerns by Mrs Adewale after the police had been notified by RA, which demonstrates that there was a delay in Mrs Adewale speaking to her manager.

76. The panel was therefore satisfied that Mrs Adewale failed to take appropriate and immediate safeguarding action, inappropriately delegated responsibility for making enquiries to RA and attended a visit with another family before going to the office to speak to her manager.

77. The panel reflected on those findings of fact when considering whether the allegations at paragraph two of the regulatory concerns are proved.

78. The panel was satisfied that Mrs Adewale did not take appropriate safeguarding action by immediately seeking advice from her team manager. The panel considered the ordinary use of the word "*immediately*" to mean straightaway and without delay. The panel considered that appropriate safeguarding action would have involved Mrs Adewale contacting her manager whilst present at Family A's property, or having stepped away briefly so as not to be overheard, and that this should have been done there and then: straightway, immediately. She failed to appropriately safeguard Child E by delaying contacting her manager until after she undertook another visit and upon her return to the office. Even if Mrs Adewale's account was accepted at its highest, which it is not, namely that she returned to the office directly from Family A's property, where she sought advice from BO, that itself would not have been immediate and would have involved the delay in travelling to the office.

79. Mrs Adewale admitted, and the panel found proved, that she failed to take appropriate safeguarding action by not requesting or gaining consent for a child protection medical assessment for Child E; by not immediately requesting a strategy meeting; and by not taking safeguarding steps in relation to the children of Family A. As outlined above, Mrs Adewale should have taken immediate action, including contacting the police, to safeguard all children in that property.

80. As outlined above, the panel found that it was incumbent on Mrs Adewale, as the social worker, to take the lead to ensure appropriate safeguarding action was taken and that she failed to do so by instead delaying any action for RA to make enquiries, resulting in RA being the person to contact the police.

Summary of findings of fact:

81. The Allegation was determined as follows:

> *"While registered as a social worker, on or around 17 November 2020 in respect of a visit to Family A, you:*
>
> 1. *Did not prepare adequately for the visit* ***NOT PROVED****;*
> 2. *Did not take appropriate safeguarding action to a safeguarding concern in that you:*
>
> *a. Did not immediately seek advice from your team manager* ***FOUND PROVED****;*
>
> *b. Did not request/gain consent for a Child Protection Medical Assessment for Child E and/or* ***ADMITTED AND FOUND PROVED****;*
>
> *c. Did not immediately request a strategy meeting and/or* ***ADMITTED AND FOUND PROVED****;*
>
> *d. Did not take safeguarding steps in relation to the other children of Family A, and/or* ***ADMITTED AND FOUND PROVED****;*
>
> *e. Did not take the lead in ensuring appropriate safeguarding action was undertaken* ***FOUND PROVED****.*
>
> *The matters outlined above amount to the statutory ground of misconduct.* ***TO BE DETERMINED***
>
> *Your fitness to practise is impaired by reason of misconduct.* ***TO BE DETERMINED****"*

Preliminary matters – Grounds and Impairment:

82. The facts determination was handed down at 1:30pm on day four of the five-day listed hearing. Upon consultation with the parties, it was agreed that the ground and impairment stage would commence at 2:15pm. Upon request from Mr Anyiam, further time was taken until 2:30pm.

83. When the hearing reconvened at 2:30pm, Mr Anyiam stated that Mrs Adewale was distressed by the findings of facts and he asked that proceedings be adjourned until the next day. He stated that he did not intend to call Mrs Adewale to give further evidence. The panel accepted the advice from the legal adviser that the central issue is one of fairness to all parties. The panel was reminded that the hearing, if adjourned part-heard, would not be continued until a future date when all parties could reconvene.

84. The panel was minded that it is not uncommon for a social worker to be distressed by an unfavourable finding and that there was no evidence before the panel that Mrs Adewale has any additional needs that would necessitate reasonable adjustments. She was not required to actively participate for the rest of the day's proceedings given that the grounds and impairment stage would proceed by way of submissions only. Furthermore, Mr Anyiam had not indicated that he was unable to obtain instructions.

85. Further, the panel had regard to timings. The hearing relates to an allegation arising from events that occurred over four years ago. Delay, such as that sought by Mr Anyiam, would potentially lead to the proceedings not being concluded within the allotted five-day hearing, which would result in further delay of a number of months before the panel could reconvene.

86. The panel therefore indicated that it would wish to proceed without delay and that, if she wished, Mrs Adewale could turn her camera off so that her image could not be seen. Mr Anyiam and Mrs Adewale was given further time to consider the matter.

87. The hearing recommenced at 2:55pm, upon which Mr Anyiam reiterated that Mrs Adewale would not be giving evidence. He confirmed that he had obtained her instructions and was ready to proceed with Mrs Adewale present but with her camera turned off.

88. The panel was satisfied that it was fair and pursuant to the overarching objective to proceed without delay and that doing so caused no prejudice to Mrs Adewale.

Summary of Evidence and Submissions – Grounds and Impairment:

89. On behalf of Social Work England, Ms Sharpe submitted that Mrs Adewale had breached parts of Social Work England's Professional Standards together with national and local guidance and policy documents that were available to her at the material time. She argued that safeguarding failures are inherently serious and go to the heart of social work practice. She argued that the breaches amount to serious misconduct.

90. Ms Sharpe submitted that failure to exercise good judgment is difficult to remediate. Whilst Mrs Adewale has provided evidence of training, she has not provided any reflection or evidence that the learning has been embedded into her practice. She submitted that Mrs Adewale provided no evidence of insight or reflection prior to her witness statement, dated 30 May 2023, which demonstrates some reflection and an acceptance that she should have acted differently. However, Mrs Adewale was inconsistent in her oral evidence as to whether Family A's children required urgent safeguarding action on 17 November 2020. Ms Sharpe invited the panel to take into account its findings of facts when determining the development of insight.

91. Ms Sharpe concluded that there remained a risk of repetition of the serious misconduct and that, as a consequence, it is necessary to find Mrs Adewale's fitness to practise is impaired in order to protect the public and wider public interest.

92. Mrs Adewale relied upon certificates of completed eLearning and classroom learning related to safeguarding, including learning on safeguarding children and undertaking necessary assessments. Many of the certificates are dated 2021 but there is also a certificate of completion of 'Safeguarding Children Complex (Level 4)', dated 23 January 2025.

93. She provided her CV which shows that she qualified as a social worker in 2009 and has worked as a social worker thereafter. Prior to that, since 1994, she had undertaken roles such as support worker, in which she worked with vulnerable people.

94. Mrs Adewale provided testimonials dating back to 2016, which speak positively about her work and character. She has been employed by the National Fostering Agency as a supervising social worker since August 2021 and has provided a positive testimonial from her manager at that employment, dated 5 February 2025 which details:

> "*Funmi continues to be a valued member of the agency. She has consistently provided good quality supervision and support to foster carers, to enhance the quality of care provided to the children and young people and to safeguard their welfare*.
>
> *Funmi has completed the required safeguarding training including Safeguarding Foundation Children's and Level 4 Safeguarding and she has been able to apply these in her work with foster carers, children and young people*.
>
> *In the agency's recent Ofsted inspection of September 2024, for which the agency was awarded 'Outstanding' with no recommendations or requirements, two of Funmi's cases were selected by Ofsted for case tracking, one of which was a parent (of whom five of her children had been removed from her care for serious safeguarding concerns) placed with her baby, with one of our agency's Parent & Child foster carers supervised by Funmi, for assessment of her parenting. The quality of Funmi's intervention and support for the foster carer and the mother placed, to improve the quality of parenting and to safeguard the welfare of the baby, including her engagement with the Local Authority Children's Services and other professionals was highlighted in the feedback from the Lead and supporting inspectors respectively*".

95. On behalf of Mrs Adewale, Mr Anyiam submitted that the proved regulatory concerns do not amount to misconduct as they consisted of a single omission, which has never been repeated. The incident arose out of an error of judgment rather than dishonesty.

96. He submitted that Mrs Adewale has accepted that she would act differently if a scenario, such as that in 17 November 2020, occurred and so there is between minimal and non-existent risk of repetition of the adverse regulatory findings. This is supported by the fact that Mrs Adewale does not have any previous adverse regulatory history and so has not shown a pattern of failing to adequately undertake her duties. He submitted that the incident on 17 November 2020 was a one-off and not representative of Mrs Adewale's practice.

97. Mr Anyiam directed the panel to the positive testimonials from people who have known Adewale professionally for a lengthy period of time, including from previous colleagues and her current and previous managers. He submitted that Mrs Adewale had made admissions to a number of the charges and had been open and honest with employers about the regulatory proceedings which, in itself, demonstrates insight.

98. Mr Anyiam concluded that there was not a risk of repetition and that a finding of impairment was not necessary to protect the public and wider public interest.

Determination and Reasons - Grounds and Impairment:

99. The panel accepted the advice of the legal adviser that it must again pursue the three overarching objectives when exercising its functions. It must consider whether Mrs Adewale's fitness to practise is currently impaired by reason of misconduct. To do so, it must first consider whether the proved allegations amounted to misconduct, whether that misconduct was serious and, if so, whether that leads to a finding of current impairment. Neither party bears the burden of proof. When considering impairment, the panel should consider whether the misconduct is remediable and, if so, whether it has been remedied and what insight has been demonstrated by Mrs Adewale. The panel must also determine whether the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of current impairment were not made.

100. The panel noted that "*misconduct*" in regulatory proceedings is defined as follows:

> "*....some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be found by reference to the rules and standards ordinarily required to be followed by a practitioner in the particular circumstances.*"

101. The panel was reminded to take into account the Impairment and Sanctions Guidance ("the Guidance"), published in December 2022 and that if it departs from the Guidance, it should give clear reasons for doing so.

102. The panel first considered whether the facts proved amount to misconduct. It was satisfied that Mrs Adewale failed to adhere to her statutory obligations as prescribed under the Children Act 1989; failed to follow the guidance within Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children'; and breached the following paragraphs of Social Work England's Professional Standards:

> **3.2** - Use information from a range of appropriate sources, including supervision, to inform assessments, to analyse risk, and to make a professional decision;
>
> **3.4** - Recognise the risk indicators of different forms of abuse and neglect and their impact on people, their families and their support networks.
>
> **3.8** - Clarify where the accountability lies for delegated work and fulfil that

responsibility when it lies with me.

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

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

103. The panel was therefore satisfied that the facts proved constitute misconduct, as they amount to a significant failure to adhere to the standards expected of someone in Mrs Adewale's position. The fact that it was a one-off, and a consequence of an error of judgment rather than dishonesty, does not minimise the significance of that failure.

104. Further, the panel was satisfied that the misconduct was serious as Mrs Adewale breached a fundamental tenet of social work in relation to safeguarding vulnerable children. Instead of undertaking appropriate safeguarding of vulnerable persons, she left four children, including an injured and visibly frightened child, in the care of people who may have posed a significant risk of serious harm.

105. The panel then considered whether Mrs Adewale's fitness to practise is currently impaired and, in doing so, reminded itself of paragraph 11 of the guidance:

> "*Not every case where the statutory ground has been found necessarily means that the social worker's fitness to practise is impaired. There are 2 elements to impairment; the personal element and the public element*."

106. The panel again reminded itself of the significant risk of potential harm that was faced by the children being left alone with the adults in Family A, together with the fact that one of those children had already received significant injury, albeit their causes have not been conclusively outlined to the panel.

107. The panel noted that Mrs Adewale has an otherwise faultless regulatory history. Her abilities and commitment to social work are detailed within numerous testimonials dating back to 2016. She has worked in her current role since August 2021 and there has been no concern as to her practice.

108. In relation to remediation, the panel noted that Mrs Adewale has undertaken some relevant safeguarding training, although these appear to have been short sessions, many of which are eLearning. Significantly, she has not provided adequate reflection of what she has learnt from the training and how she would put that learning into practice to ensure that she is adhering to the fundamental tenet of safeguarding vulnerable people. It therefore follows that it has not been adequately outlined what that training has taught Mrs Adewale over and above the training and experience she had already gained as a social worker of over a decade's experience at the time of events. Given that safeguarding is a fundamental tenet of social work, it is unclear why she did not already demonstrate a full understanding on 17 November 2020, or what the further training achieved.

109. Mrs Adewale admitted some of the regulatory concerns but denied others. Regarding remorse, the panel considered that Mrs Adewale, throughout her evidence during the facts stage, and in her brief written reflection, had sought to place blame on others and did not demonstrate material remorse for her failures and their impact and potential impact upon vulnerable children.

110. In relation to insight, the panel was satisfied that Mrs Adewale has shown a consistent and persistent pattern of minimisation and has given inconsistent and, at times, confusing evidence of what she did and what she should have done on 17 November 2020. Furthermore, the panel was of the view that the brief written reflections she provided did might contain evidence of what her reflection was on the impact on her failures upon the children involved, colleagues or the wider public confidence in the profession. As such, the panel considered Mrs Adewale's insight to be lacking depth.

111. DM detailed within her witness statement that when she spoke to Mrs Adewale on 17 November 2020, Mrs Adewale: "*...minimised the concerns and felt that she had taken appropriate action. The Social Workers' understanding was that the Health Visitor was going to deal with it. The Social Worker did not really see her role and responsibilities within this*."

112. On 28 November 2020 Mrs Adewale sent a WhatsApp message to BO showing images of children with paediatric lupus and said that this was similar to the marks that she observed, despite the presentation of the children in those images being significantly different from the presentation of Child E in the police photographs and despite the admission of the parents of Family A that Child E did present with injuries, albeit self-inflicted. The panel considered that this was further evidence of minimisation.

113. Within her initial response to the regulatory concerns, on 22 January 2021, Mrs Adewale denied the allegations and stated:

> "*When the health visitor and I both attended the property, the child was not at risk of harm, neither were there any safeguarding issues as per this visit on 17 November 2020. Although CHILD [E} presented as bubbly and happy and was not in any way distressed, as a precaution, a decision was taken to further investigate and subsequently initiate a referral based on the marks/spot on the child's face*."

114. Within an undated second response she stated:

> "*In hindsight, one may conclude that I should have personally conducted the referral, however I truly believed that despite meeting RA for the first time, I acknowledged her as a professional. Child protection necessarily involves collaborative work with all professionals involved in safeguarding children, namely, Teachers, Safeguarding Nurses, GPs, Police, Health Visitors etc. I cannot conclude that I failed to take action when the concerns were raised by myself, shared by the health visitor and the next cause of action agreed between the two of us. RA volunteered to contact the local authority and make the referral*

following investigations on the child's medical records. There was an element of mutual understanding and most importantly trust. Safeguarding is everyone's business and we should be working together. I am saddened that the facts of the case was misconstrued and based on lies and inconsistencies. On the other hand, there is a lesson to be learnt. This experience has formed part of my reflective practise and I have learned from this experience. Furthermore, I will ensure I receive supervision with my manager, as required. Upon reflection, I do not regret the relationship built with RA in such a short time frame as my role requires this, especially when dealing with safeguarding concerns. I will ensure that I am mindful that sudden situations can occur, even if the children are not assigned to my case, and I will continue to take the relevant steps to ensure their safety."

115. Within her witness statement, dated 30th May 2023, she stated:

> *"I was conscious of the fact that the marks / bruises observed on "Child E" during the home visit on 17th November 2020 were clearly very concerning, which required some form of urgent but tactful action. As an experienced social worker and a senior practitioner who has had the opportunity to give evidence and been cross examined in some vigorously contested care proceedings involving allegations of non-accidental injury to children, I was careful not to allow my emotional sentiments to overtake my sense of judgement.*

116. During her evidence, including her oral evidence, Mrs Adewale sought to minimise as to Child E's physical and emotional presentation.

117. Within her witness statement, dated 30 May 2023, she detailed that she had reflected and:

> "*I accept that in light of the visible marks and bruises on "Child E" the situation was such that I should have taken the lead and also acted immediately while I was still at the home of "Family A", rather than wait to get to the office to seek guidance from my line manager about the appropriate line of action.*
>
> *I take this as a learning process. In future, if I am confronted with a similar situation will act differently by contacting the police or if necessary seek guidance from my line manager immediately on what to do while at the home, rather than wait until I get to the office…*"

118. However, despite that apparent acceptance, she nevertheless maintained denials of paragraph 2(a) and (e), specifically that she did not take appropriate safeguarding action to a safeguarding concern in that she did not immediately seek advice from her team manager; and did not take the lead in ensuring appropriate safeguarding action was undertaken. The continued denial of those regulatory concerns led the panel to conclude that her purported reflection in May 2023 was not genuine or fulsome.

119. Within her oral evidence Mrs Adewale gave confusing evidence in relation to whether she believed that urgent action was required or not: on one hand stating that leaving the

children in the property was not inappropriate whilst she went to the office to speak to her manager, whereas also accepting that it was an urgent situation which was why she went to the office to speak to her manager immediately. She initially stated that urgent action was not necessary in relation to the children of Family A, but under cross-examination accepted otherwise, which demonstrated a changing account.

120. Within her oral evidence, Mrs Adewale repeatedly stated that she had erred on the side of caution in how she managed the situation. The panel considered that this failed to demonstrate an understanding that, where a safeguarding issue arises concerning a vulnerable person, the cautious approach is to ensure their safety. Furthermore, the panel agreed with RA's assessment that Mrs Adewale lacked a sufficient degree of professional curiosity in her approach to the safeguarding matter.

121. Within her written and oral evidence, Mrs Adewale referenced the lack of access to the Council's electronic system; lack of induction training, including locality familiarisation; her locum status; and the fact that she had a high caseload. The panel concluded that none of those features, if Mrs Adewale's account was to be accepted, would have been barriers to her undertaking appropriate immediate action to safeguard the children. Her reliance on those factors demonstrates efforts to minimise her wrongdoing and demonstrates a significant lack of development of insight of the need for professional accountability.

122. Throughout the four years and three months since the events that formed the regulatory concerns, Mrs Adewale has therefore failed to demonstrate an unambiguous and unequivocal acceptance that she should not have left the property and that she should instead have contacted her manager and / or the police immediately whilst at or within the vicinity of the property.

123. Throughout her evidence Mrs Adewale demonstrated a lack of insight into the fact that it was her responsibility to take the lead when the safeguarding issue arose and that it was not appropriate for RA to be left to make enquiries. She has not acknowledged her statutory obligations or the requirements as outlined in guidance within the Working Together to Safeguard Children document. She failed to demonstrate an unambiguous and unequivocal acceptance that it was her statutory and professional responsibility to take the lead.

124. Mrs Adewale has also failed to demonstrate adequate insight of the potential consequences of her failing to safeguard Child E and the children of Family A. She failed to acknowledge the risk of harm that could have arisen during the delay in adequate safeguarding action being taken, for example the fact that the children were left alone in the company of Father, who was believed to have a history of violence, prior to the police being contacted and arriving to the property.

125. Whilst Mrs Adewale accepted some of the regulatory concerns and admitted that, in hindsight, she should have acted differently, she failed to adequately acknowledge the risk posed to the children as a consequence of her safeguarding failure.

126. Mrs Adewale stated within her 30th May 2023 witness statement that "*I accept that my action which led to these proceedings raise issues of wider public interest, including the need to maintain public confidence in the profession.*" However, she did not provide any detailed insight as to how her actions would have undermined trust in the profession and why such trust and confidence is important.

127. The panel therefore noted that there has been limited insight into the regulatory concerns and the minimal insight demonstrated has continued some time after events. The panel reminded itself of paragraph 39 of the Impairment and Sanctions Guidance:

> "*39. Decision makers should be cautious about giving credit for insight that has only emerged after investigations and enquiries have been completed. Insight should be rooted in the social worker's personal reflection and assessment of how they have fallen short of the professional standards. This should ideally take place as soon as possible after the incident or events. Insight may carry less weight if it is led by or dependent on the conclusions and directions of others. Decision makers should assess insight in accordance with the individual circumstances of the case and social worker*.

128. Even having given weight to the extremely positive testimonials; Mrs Adewale's lengthy social work career; and the fact that there have been no adverse regulatory findings against her either before or after the events of 17 November 2020, the panel considered that, in light of the lack of evidence of sufficient remediation and insight, together with her persistent efforts to minimise events, there remains a real and present risk of repetition.

129. Mrs Adewale has failed to adequately demonstrate that she properly understands what she did wrong; what the consequences could have been; and how she would act differently in the future. The panel reminded itself of paragraph 31 of the Guidance that:

> "*There is a greater risk of repetition if the social worker fails to fully understand what they have done wrong (and why it is wrong)*."

130. A failure to safeguard vulnerable people results in those people being at risk of harm. As such, in light of the assessed risk of repetition of the serious misconduct, the panel was satisfied that a finding of current impairment was necessary to protect, promote and maintain the health, safety and well-being of the public.

131. Further, the panel considered that reasonable, well informed, members of the public and the social work profession would be appalled by the fact that Mrs Adewale left four children, particularly Child E who was displaying numerous injuries, in a property in which they were at risk of significant harm. The public require social workers to be able to identify and act upon safeguarding issues in order to protect vulnerable people. Even upon taking into account Mrs Adewale's lengthy social work history and lack of repetition of the safeguarding failures, the panel was satisfied that public confidence in the social work profession would be undermined upon a finding that Mrs Adewale's fitness to practise is not currently impaired. The panel was satisfied that this was all the

more likely given Mrs Adewale's lack of adequate remediation and insight, together with the panel's assessed risk of repetition.

132. Given that the serious misconduct related to a breach of a fundamental tenet of social work, to safeguard vulnerable people, the panel was satisfied that professional standards would not be promoted and maintained by a finding that Mrs Adewale's fitness to practise is not currently impaired.

133. The panel therefore concluded that, as a consequence of Mrs Adewale's serious misconduct, a finding of impaired fitness to practise is necessary to promote and maintain public confidence in the social work profession and proper professional standards.

Summary of Submissions – Sanction:

134. Ms Sharpe, on behalf of Social Work England, submitted that an appropriate sanction, given the assessed risk of repetition of the regulatory concerns, is an order of suspension.

135. She argued that imposing no sanction, or a sanction that does not restrict Mrs Adewale's practice, would be inconsistent with the findings of the panel during the facts and grounds and misconduct stages of the proceedings.

136. Ms Sharpe submitted that a conditions of practice order would restrict Mrs Adewale's practice and provide some protection to the public. However, she argued that conditions would not be appropriate given the finding that Mrs Adewale's insight is not fully developed and given the seriousness of the regulatory concerns proved.

137. Ms Sharpe argued that suspension was appropriate as the case falls short of requiring the removal of Mrs Adewale from the social work register. She noted that some, albeit limited, insight had been demonstrated, as had a willingness to remediate.

138. She invited the panel to impose a sanction of suspension and to make recommendations of actions to be taken by Mrs Adewale in preparation for a review hearing towards the end of the order.

139. Mr Anyiam, on behalf of Mrs Adewale, reminded the panel that it was required to impose the least onerous sanction necessary.

140. He directed the panel to the witness statement of Mrs Adewale, dated 4 February 2024, in which she detailed that the delay in the final hearing being commenced, which had resulted from the matter being adjourned in June 2023 through no fault of her own, had caused "..*enormous distress and anguish because I have been living in a state of uncertainty* ...".

141. Mr Anyiam relied upon the decision of *R (On the application of Johnson & Maggs) v NMC* (2013) EWHC 2140 (Admin), in which the High Court concluded that the delay in determining regulatory allegations in that case was unacceptable and amounted to a

breach of the right to a hearing within reasonable time under Article 6 of the European Convention on Human Rights.

142. My Anyiam submitted that the panel should take into account Mrs Adewale's age, as she is to turn 60 years of age this year, and the fact that she has undertaken relevant training and engaged fully with the regulatory proceedings. He reminded the panel of the lack of previous or subsequent adverse regulatory findings. Suspension would have a detrimental effect upon Mrs Adewale as it would impact future mortgage payments and family responsibilities.

143. He concluded that the most appropriate sanction was a warning, although clarified that Mrs Adewale would be willing to comply with conditions if they were imposed, including supervision.

Determination and reasons – Sanction:

144. The panel accepted the advice of the legal adviser that it must again pursue the overarching objective when exercising its functions. The panel must apply the principle of proportionality, balancing Mrs Adewale's interests with the public interest. The purpose of a sanction is not to be punitive, although a sanction imposed may have a punitive effect. The panel considered the least restrictive sanction first and then moved up the sanctions ladder as appropriate. The panel had regard to the Social Work England Impairment and Sanctions Guidance ("the Guidance"), published in December 2022, together with its findings at the facts, grounds and impairment stages of proceedings.

145. The panel reminded itself that it had concluded that Mrs Adewale's fitness to practise was impaired, due to serious misconduct, in order to maintain and promote the health, safety and well-being of the public; public confidence in social workers; and professional standards.

146. In relation to aggravating features, the panel had regard to paragraph 82 of the Guidance which provides that aggravating features include, but are not limited to: repetition of concerns or a pattern of behaviour; relevant previous history; lack of insight or remorse; lack of remediation; harm or risk of harm to people who use social work services.

147. The panel noted that there have been no previous or subsequent regulatory concerns and that the proved misconduct does not constitute a pattern of behaviour but relates to one particular incident. However, the concerns are significantly aggravated by the lack of remorse, adequate insight and remediation demonstrated, as outlined in the determination on grounds and impairment, particularly paragraphs 109 to 127, above, together with the persistent lack of recognition of her accountability for her failings and the potential consequences thereof. Further, the concerns are aggravated by the assessed risk of repetition, as outlined in paragraphs 128 and 129, above, and the fact that repetition could place vulnerable service users at risk of significant harm.

148. In relation to mitigating features, the panel had regard to paragraph 81 of the Guidance which provides that mitigating features include, but are not limited to:

- *evidence of the social worker's insight, remorse and understanding of the problem, and their attempts to address it. This may include (any of the following):*
  - *early admission of the facts*
  - *full engagement with investigations*
  - *apologies to anyone affected*
  - *any efforts to prevent behaviour recurring*
- *evidence that the social worker has done remediation which addresses the deficiencies that led to the concerns. This may include (any of the following):*
  - *the successful completion of education or training courses*
  - *satisfactory performance appraisals*
  - *other positive feedback in relation to their professional practice*
- *personal mitigation such as (either of the following):*
  - *periods of stress or illness*
  - *personal and financial hardship*
  - *absence of previous fitness to practise history*
- *evidence of good character in the form of character references and testimonials*
- *contextual factors which are relevant and material to the events that raised the concerns. For example (any of the following):*
  - *the level of experience of the social worker at the time*
  - *the level of support the social worker received (such as training and/or supervision at work)*
  - *evidence of wider or systematic issues in the workplace*

149. Mrs Adewale admitted some of the facts and has engaged fully with the regulatory proceedings. Whilst there is limited evidence of remediation, Mrs Adewale does benefit from having undertaken relevant training and from positive testimonials about her character and professional practice. The lack of previous or subsequent adverse regulatory findings, including during the four years and three months since the date of the regulatory concerns, was considered by the panel as personal mitigation, as was the fact that she has had a lengthy social work career in which she is evidently respected, as detailed within the aforementioned testimonials. The panel considered that there are no contextual matters of the type listed in paragraph 81 of the Guidance, as Mrs Adewale was an experienced social worker at the material time. The panel reminded itself of the comments by DM within her evidence, as outlined within the determination of facts, at paragraph 57, above.

150. The panel noted that the regulatory concerns all arise from a one-off incident, rather than being a pattern of behaviour.

151. The panel noted the passage of time since the date of the regularly concerns, which are now four years and three months ago. It noted that the delay has been through no fault of Mrs Adewale and that she had been ready to proceed at the first substantive hearing listed in June 2023. It accepted that the delay has caused significant distress.

152. The panel considered that Mrs Adewale's case could be readily distinguished from that of *Maggs and Johnson*. In that case, the regulatory concerns arose from incidents in 1998, which were not notified to the registrant until 2003, and which then did not progress to a final hearing until 2009, finishing in 2011. As such, proceedings did not end until over 13 years after the alleged failings. In Mrs Adewale's case, she was aware of the fact that it was alleged she had failed to adequately safeguard the children two days after the events, when she was dismissed from the Council. A referral to Social Work England was made less than two weeks later and Mrs Adewale gave a detailed response in January 2021. Whilst the delays in proceedings have been unsatisfactory, they are not to the extent of those in *Maggs and Johnson* and have not undermined the fairness of proceedings so as to breach Mrs Adewale's Article 6 rights. Mrs Adewale has not claimed that her memory of events has significantly deteriorated since events or that she is otherwise prejudiced by the delay. The panel noted that there was no preliminary submission at the outset of the substantive hearing that a fair hearing could not proceed. It considered that such submissions would not have merit in all of the circumstances.

153. The panel did note Mrs Adewale's age and the submission that she was towards the end of her career and so suspension may affect a significant proportion of her remaining work. It also noted that suspension may have a financial impact upon Mrs Adewale and her personal circumstances.

154. The panel considered paragraph 93 of the Guidance, in relation to whether to take no action or to issue advice or a warning which states:

> "*A finding of impairment will likely mean the social worker is not suitable to be registered without restriction. The exceptions to this are (the following outcomes after a finding of impairment):*
>
> - *no further action*
> - *advice or warning*
>
> *These outcomes do not restrict the social worker's practice. They may only be appropriate where there are mitigating factors, which show that a social worker can still practise without restriction*."

155. The panel considered that taking no action, or issuing advice or a warning, would not adequately reflect the serious nature of Mrs Adewale's misconduct. The panel assessed there to be a real and present risk of repetition, and so considered that the public cannot currently be adequately protected unless Mrs Adewale's practice is restricted.

156. Further, taking no action, or issuing advice or a warning, would not maintain public confidence in the profession or promote proper professional standards in light of the particularly serious nature of the misconduct; the lack of adequate insight and remediation; and the assessed risk of repetition.

157. The panel next considered whether a conditions of practice order would be sufficient to protect the public and wider public interest.

158. The panel noted paragraph 114 of the Guidance, which provides that conditions of practice may be appropriate in cases where the social worker has demonstrated insight; the failure is capable of being remedied; appropriate, proportionate and workable conditions can be put in place; there is confidence that the social worker can and will comply with the conditions; and the social worker does not pose a risk of harm to the public by being in restricted practice.

159. The panel also noted paragraph 118, which states that conditions of practice are less likely to be appropriate in cases of character, attitude or behavioural failings and that they may also not be appropriate in cases raising wider public interest issues.

160. The types of cases listed in paragraph 119 where conditions are unlikely to be suitable do not apply to Mrs Adewale.

161. Mrs Adewale's significant lack of insight, which has not adequately developed within the four years and three months since the regulatory concerns arose, is such that the panel was not satisfied that conditions of practice, even with direct supervision, would adequately protect the public. The panel reminded itself that Mrs Adewale failed to demonstrate sufficient accountability or remorse for her failings and instead sought to minimise the risk that Child E, in particular, faced and her responsibility for failing to adequately safeguard Child E and the three other children in the property (the panel reminded itself that at the time Mrs Adewale left the property, one of the children from Family A was no longer present as she had been taken to a medical appointment, but that the child was due to return that afternoon). Mrs Adewale has failed to demonstrate an understanding of the actual and potential impact of her actions upon vulnerable children and the wider public confidence in the social work profession.

162. Given the lack of accountability and understanding identified, the panel was not satisfied that Mrs Adewale was currently in a position to fully and appropriately engage with conditions upon her practice, notwithstanding her willingness to comply. Conditions are only workable if a social worker has developed sufficient insight into identified failings. As such, the panel was not satisfied that the public, particularly vulnerable children in need of prompt safeguarding action, would be adequately protected by a conditions of practice order.

163. Further, in light of the serious nature of the regulatory concerns, together with Mrs Adewale's lack of adequately developed insight, which has included a lack of accountability and efforts to minimise events, the panel was satisfied that conditions would not maintain public confidence in the profession or promote proper professional standards.

164. The panel noted paragraph 136 of the Guidance, which states that suspension is appropriate where workable conditions cannot be formulated to protect the public or

wider public interest; and where the case falls short of requiring removal from the social work register.

165. The panel also noted paragraph 137, which states that suspension may be appropriate where the concerns represent a serious breach of professional standards; the social worker has demonstrated some insight; and there is evidence to suggest the social worker is willing and able to resolve or remediate their failings.

166. The panel was satisfied that the regulatory concerns found proved fall short of requiring removal of Mrs Adewale from the social work register. The panel considered that suspension was appropriate and proportionate in light of the fact that, whilst Mrs Adewale has shown limited insight, there have nevertheless been green shoots of insight, as evidenced by her admissions to some of the regulatory concerns and an acceptance that, in hindsight, she should have acted differently on 17 November 2020. The panel was hopeful that Mrs Adewale will take the opportunity during a period of suspension to reflect upon her regulatory failings and to develop insight. The panel's confidence is in consequence of the fact that she has fully engaged with the regulatory proceeds and has enjoyed a lengthy social work career without any previous or subsequent adverse regulatory findings. Mrs Adewale has many strengths as a social worker, as outlined within the testimonials provided.

167. The panel was therefore satisfied that a short period of suspension would give Mrs Adewale time to reflect upon the regulatory findings and develop insight so as to reduce the risk of repetition of the regulatory concerns. If she takes the opportunity to do so, that may sufficiently reduce the risk of repetition so as to permit safe return to practice. She must appreciate that, if she does not take the opportunity, the review panel will have the opportunity to extend the suspension or order her removal from the social work register.

168. The panel was satisfied that a suspension was sufficient to maintain public confidence in the profession and promote proper professional standards. The panel considered that it was in the interests of the public to give social workers the opportunity to develop insight and remediate concerns so that they can utilise their skills and qualifications to serve the public. The panel was satisfied that public confidence and professional standards would be maintained by allowing Mrs Adewale that opportunity, given that she would be required to subsequently prove to a panel of adjudicators that she is fit to return to unrestricted practice before she will be permitted to do so.

169. When considering the length of the suspension, the panel had regard to paragraph 141 of the Guidance:

> "*It is in the public interest to support a trained and skilled social worker to return to practice (if this can be achieved safely). This means the risk of deskilling is a public interest consideration. However, decision makers should also take into account that suspension orders are automatically reviewed before expiry. If the suspension period is too short, this may not allow the social worker to meaningfully demonstrate their improvement prior to the review*."

170. Whilst the panel was concerned about the lack of developed remediation and insight, it was confident that, with careful reflection, adequate progress could be made by Mrs Adewale in a relatively short period of time. Whilst insufficient remediation and insight had been developed in the four years and three months since the regulatory concern, the panel was hopeful that the substantive hearing and the determinations of the panel, arising from the facts and the grounds and impairment stages, will provide guidance on how she could make progress. The panel was satisfied that Mrs Adewale, who has demonstrated a commitment to social work by her lengthy practice and full engagement with proceedings, is likely to utilise the time effectively.

171. The panel was therefore satisfied that the least onerous sanction that it could appropriately and proportionately impose was a suspension for a period of six months.

172. The panel acknowledged that suspension will prevent Mrs Adewale from working as a qualified social worker and, as a consequence, she may be caused financial and professional hardship, together with distress, which may in turn impact upon her personal circumstances. However, the panel determined that in all of the circumstances the need to protect the public and wider public interests outweighed Mrs Adewale's interests.

173. The suspension order will be reviewed before it is due to expire. The review panel may foreseeably be assisted by the following:

    a. A reflective statement by Mrs Adewale. She should reflect on the impact of her failures upon the children in Family A's home and what action she should have taken to adequately safeguard the children and what she would do in the future. She should reflect upon the consequences of breaching the fundamental tenet of social work to safeguard vulnerable people. She should reflect upon the consequences of her actions upon her colleagues and the wider public perception on the social work profession;

    b. Evidence of relevant training in addressing the failures found proved, specifically safeguarding, and detailed reflections of the benefit obtained from that learning and how this will be embedded into her social work practice;

    c. Updated testimonials from people who know of these regulatory findings and who have read, in full, this determination. Those testimonials should address Mrs Adewale's abilities and commitment to social work and should give detailed examples and opinions of her ability to adequately safeguard vulnerable people ;

    d. Evidence of continued professional development;

    e. Evidence that Mrs Adewale has maintained her skills and knowledge, by way of non-registered work and / or by training and learning; and

    f. Mrs Adewale's attendance at the review hearing.

Interim Order:

174. Ms Sharpe, on behalf of Social Work England, invited the panel to impose an 18-month interim order of suspension to cover any appeal period. She reminded the panel of its assessment of risk of repetition, its finding of impaired fitness to practise and its reasons for imposing the substantive order of suspension.

175. Mr Anyiam, on behalf of Mrs Adewale, opposed the application as it would have a draconian effect in that she would be unable to return to her employment with immediate effect.

176. The panel considered that it would be wholly incompatible with its earlier findings to conclude that no interim order, or alternatively an interim order of conditions, would sufficiently protect the public and wider public interest during the appeal period. It would be incompatible to find that an interim order of suspension is not necessary to protect the public and the wider public interest.

177. Accordingly, the panel concluded that an interim suspension order was necessary to protect the public and the wider public interest. It determined that it was appropriate that the interim suspension order be for a period of 18 months in the event that Mrs Adewale seeks to appeal. However, when the 28-day appeal period expires, the interim suspension order will come to an end unless there has been an application to appeal.

Right of appeal:

178. 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.

179. 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.

180. 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.

181. 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:

182. 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

183. 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:

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