Social worker: Dean Temple
Registration number: SW35823
Fitness to Practise
Final Hearing

Dates of hearing: 24 March 2025 to 28 March 2025

Hearing venue: Remote hearing

Hearing outcome:
Fitness to practise impaired, conditions of practice order (12 months)

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

Introduction and attendees:

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

2. Mr Dean Temple did not attend and was not represented.

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

Adjudicators	**Role**
Manuela Grayson	Chair
Samuel Ana-Amdingo	Social worker adjudicator
Sally Underwood	Lay adjudicator

Hearings team/Legal adviser	**Role**
Andrew Brown	Hearings officer
Molly-Rose Brown	Hearings support officer
Esther Oladipo	Legal adviser

Service of notice:

4. The panel of adjudicators (hereafter "the panel") was informed by Mr Harris that notice of this hearing was sent to Mr Dean Temple (the social worker) by email and by next day special delivery to the address provided by the social worker. The notice was sent to Mr Temple's registered address as it appears on the Social Work England register. The notice of hearing was sent by next day special delivery on 21 February 2025, and a copy was also emailed to Mr Temple's registered email address on the same date. Mr Harris submitted that the notice of this hearing had been duly served.

5. The panel 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 21 February 2025, addressed to Mr Dean Temple at his email and postal address, which he had provided to Social Work England;

    - An extract from the Social Work England Register as of 21 February 2025, detailing Mr Temple's registered address;

    - A copy of a signed Statement of Service, dated 21 February 2025, on behalf of Social Work England, confirming that the Notice of Hearing and related documents were sent by next day special delivery and email to Mr Temple at his registered address and email address;

    - A copy of the Royal Mail Track and Trace document indicating "signed for" delivery to Mr Temple's address at 12:03 pm on 22 February 2025.

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

7. Having had regard to Rule 44 of the Fitness to Practise Rules 2019 (as amended) and all of the information before it in relation to the service of notice, the panel was satisfied that notice of this hearing had been served on Mr Temple in accordance with the Rules.

Proceeding in the absence of the social worker:

8. 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 Mr Temple, and as such there was no guarantee that adjourning today's proceedings would secure his attendance. Mr Harris further submitted that Mr Temple had been given sufficient opportunity to engage with the proceedings, as evidenced by an email dated 4 February with his completed Response Forms dated 04 February 2025 which included written submission stating he does not intend to at the hearing. And further evidence by an email dated 12 March 2025, where Mr Temple confirmed he would not be attending the hearing as he could not afford to take time off work. This was reiterated in his further email dated 17 March 2025 with an updated Response Form and Submissions attached. This information is contained in the Social Worker Response Bundle and Additional Supplementary Bundle. Mr Harris therefore invited the panel to proceed in the interests of justice and the expeditious disposal of this hearing.

9. The panel accepted the advice of the legal adviser in relation to the factors it should take into account when considering this application. This included reference to Rule 43 of the Rules and the cases of *R v Jones [2002] UKHL 5*; *General Medical Council v Adeogba [2016] EWCA Civ 162*. The panel also took into account Social Work England guidance 'Service of notices and proceeding in the absence of the social worker'.

10. 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 considered that Mr Temple had been sent notice of today's hearing in accordance with the Rules, and the panel was satisfied he was aware of today's hearing. The panel also considered that Mr Temple had provided written submissions for the panel's consideration and had explicitly confirmed that he would not be attending as he could not take time off work. The panel noted that there was no power to compel Mr Temple to attend the hearing and was satisfied that he had voluntarily absented himself.

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

Allegations:

12. *Whilst employed as a Social Worker and Registered Manager for the Agency you did not take appropriate action to safeguard children following concerns raised about standards of foster care, in that you:*

    1. *Did not undertake or oversee completion of, an adequate standards of care review as recommended by the Independent Fostering Review Officer and/or required by the Agency Decision Maker, to properly explore concerns raised about Foster Carer 1 and Foster Carer 2 in their annual review in or around November 2018.*
    2. *You did not implement, or ensure the implementation of further training and support for Foster Carer 1 and Foster Carer 2 regarding managing the behaviour of Service User 1.*
    3. *You did not provide adequate management oversight and/or did not ensure that the recommendations of the Independent Fostering Review Officer and/or Agency Decision Maker regarding no further placements with Foster Carer 1 and Foster Carer 2 to be allowed were followed, resulting in the placements listed at Schedule A;*
    4. *You did not provide adequate management oversight and/or did not ensure that the Quality of Care Report in or around July 2019 adequately reviewed/assessed:*
        a. *Safeguarding concerns pertaining to foster care provided by Foster Carer 1 and Foster Carer 2 between January 2019 and May 2019;*
        b. *The capacity and skills of Foster Carer 1 and Foster Carer 2 to meet the needs and provide appropriate and safe care for Looked After Children who were placed with them.*
    5. *You did not provide adequate management direction and/or did not ensure that Foster Carer 1 and Foster Carer 2 were taken back to panel within the timeframe referred to by the Independent Fostering Review Officer and/or Agency Decision Maker.*
    6. *Following an allegation made by Service User 2 against Service User 3 on or around 1 July 2019:*
        1. *You did not immediately update and/or ensure that risk assessments were updated immediately*
        2. *You did not update and/ or ensure that Service User 2's safe care plan was updated immediately*
        3. *You did not notify OFSTED*
        4. *You did not inform the Agency's safeguarding committee*

5. *You did not record and/or ensure that all the actions taken or conclusions made were recorded*

Social Work England's Case:

13. On 5 February 2020, Social Work England received a referral concerning Mr Dean Temple, a registered social worker who had been the Registered Manager of Foundation Fostering, an independent fostering agency. Mr Temple joined the agency as Fostering Manager in July 2016 and was formally registered with Ofsted as the Registered Manager from December 2017. In this legal role, he held overarching responsibility for safeguarding, compliance with the Fostering Services (England) Regulations 2011, the National Minimum Standards (NMS), and general operational leadership.

14. As Registered Manager, Mr Temple's responsibilities included oversight of foster carer reviews, training implementation, policy adherence, management of standards of care investigations, and the monitoring of foster placements and safeguarding concerns. While he was permitted to delegate tasks, he retained ultimate accountability for their completion.

15. Concerns arose during his management of Foster Carers 1 and 2, whose approval dated back to 2016. Following multiple allegations and safeguarding issues linked to these carers between 2016 and 2019, the Independent Fostering Reviewing Officer (IFRO) and the Agency Decision Maker (ADM) made several recommendations in late 2018 and early 2019. These included suspending further placements with the carers until a thorough Standards of Care (SOC) review was completed and presented to the fostering panel.

16. Despite these instructions, further placements were made with the carers, and the SOC report prepared by Mr Temple in February 2019 was found to be inadequate, lacking detail, critical analysis, and appropriate safeguarding oversight. Additionally, following a separate safeguarding incident in July 2019 involving children placed with the same carers, there were further failures to update risk assessments, notify Ofsted, or inform the fostering agency's safeguarding committee. These incidents culminated in an Ofsted inspection in December 2019 that rated the fostering agency as 'inadequate'. Mr Temple's resigned on 15 December 2019.

Admissions:

17. Rule 32c(i)(aa) Fitness to Practise Rules 2019 (as amended) (the 'Rules') states:

    Where facts have been admitted by the social worker, the adjudicators or regulator shall find those facts proved.

18. Following the reading of the allegations, the panel Chair noted that although Mr Dean Temple was not in attendance at the hearing, he had in advance of the hearing provided

two formal response forms; the first dated 4 February 2025, and an updated version dated 4 March 2025, in which he admitted the alleged facts in their entirety. Mr Temple also confirmed that he accepted the contents of the statements of all the witnesses called by Social Work England and did not require the attendance of any of them at the hearing. Mr Temple also submitted a series of written submissions via email for the panel's consideration.

19. In his response form and accompanying submissions, Mr Temple:

    - Admitted the facts alleged at paragraphs 1, 2, 3, 4, 5 and 6 concerning his failure to take appropriate action to safeguard children following concerns raised about standards of foster care while employed as a Social Worker and Registered Manager at a Fostering Agency.

    - Confirmed that he accepted the content of the witness statements relied upon by Social Work England.

    - Confirmed that he did not require any of the witnesses to attend the hearing for cross-examination.

20. The panel heard and accepted the advice of the legal advisor which stated that where facts have been admitted by the social worker the panel must find those facts proved in line with Rule 32c(i)(aa) of the Rules.

21. The panel therefore found the facts alleged at paragraphs 1, 2, 3, 4, 5 and 6, including all sub-paragraphs, proved by way of Mr Temple's admissions.

Summary of evidence:

22. The panel was provided with a written statement of case dated 10 February 2025 which set out the allegations and evidence upon which Social Work England relied. The supporting evidence was presented with the following documents entitled Hearing timetable, Statement of Case, Statements Bundle, Exhibits Bundles, Social Workers Response Bundle, Final Service and Supplementary Bundle and Additional Supplementary Bundle.

23. Social Work England relied upon the written statements of five witnesses, as these were uncontested by the Social Worker.

    - Mr Nick Eadon who was Founder and Responsible Individual at Foundation Fostering, who provided extensive background on the Agency's structure, safeguarding practices, and Mr Temple's duties and failings.

    - Mr Thomas Gormley who was the Agency Decision Maker at the time, who endorsed critical safeguarding decisions and recommendations made following the annual review of foster carers.

- Ms Sharon Pitt who was a Supervising Social Worker at the Agency, who had involvement with the foster carers and service users relevant to the allegations.
- Ms Christy Wannop who was the Ofsted Inspector who undertook the December 2019 inspection and identified failures in safeguarding and record-keeping.
- Ms Naomi Ebanks-Simpson who is the current Operations Director and Responsible Individual at the Agency, who submitted case file evidence but was not directly involved during the time of the allegations.

24. The panel asked Mr Eadon to attend in order to clarify some points within his evidence.

25. In November 2018, following the annual review of Foster Carers 1 and 2 (FC1 and FC2), the Independent Fostering Reviewing Officer (IFRO), Ms Kay Vincent, recommended that a thorough Standards of Care (SOC) report be completed by the end of February 2019, in response to a series of historical safeguarding concerns and allegations. These included claims of physical chastisement, failure to disclose unlicensed driving, and misuse of Disability Living Allowance. The Agency Decision Maker (ADM), Mr Thomas Gormley, adopted this recommendation on 18 January 2019 and imposed a moratorium on further placements pending completion of the SOC and review by panel.

26. The evidence showed that Mr Temple, as Registered Manager, prepared an SOC report dated 14 February 2019. Mr Nick Eadon and Mr Gormley, described the report as lacking in depth, failing to analyse the safeguarding concerns, omitting details of a significant incident reported on 4 January 2019, and failing to assess the carers' capacity to provide safe care. It was said that the SOC did not evaluate the carers' understanding of behaviour management, nor did it identify appropriate training or supervision. Mr Temple concluded in his SOC that FC1 and FC2 should continue fostering.

27. Mr Temple in his response to regulatory concerns dated 9 December 2020 stated: "I accept that the Standard of Care Report was not completed in line with the recommendations. I did complete a Review of Care Report on 14 February 2020,[sic] however on reflection this could have been a more comprehensive report." He accepted that the report should have been presented to the fostering panel and that this omission was an oversight. [The panel assumed there was a typo and that the intended date was 14 February 2019].

28. The IFRO and ADM both directed that specific training be provided to FC1 and FC2 on preparing looked after children for independence and understanding the impact of autism on transitions. This recommendation arose from concerns related to Service User 1 and the foster carers' expressed difficulties in managing his behaviour. The evidence confirmed that whilst first aid training was completed in December 2018 and January 2019, the recommended training around autism and preparation for independence was not delivered. Mr Eadon and Mr Gormley stated that the Registered Manager had overall responsibility for ensuring carers' Personal Development Plans were updated and for coordinating training in line with NMS Standards 20 and 21.

29. There was no evidence to confirm that such training took place, nor was there a record of updated Personal Development Plans to reflect the recommendations. Exhibit NE/44 indicated training was allocated but not completed. The failure to ensure timely and targeted training would have left the carers unsupported in their role and undermined their ability to safely meet the needs of children in their care.

30. Mr Temple accepted that further training and support should have been arranged for Foster Carer 1 and Foster Carer 2 in relation to managing the behaviour of Service User 1. However, he stated he no longer had access to records to confirm what, if any, training was offered or completed.

31. The IFRO's recommendations included:

> *'It must be noted that the concerning events brought to this review all occurred some months ago and the agency and LASW were and are in agreement that the current placement should continue. [Service User 1], too, says he wants to stay with this family. However, due to the combination and serious nature of the concerns during this review period, the concerns for the future raised by the LASW, and the challenges [FC1 and FC2] have articulated during the meeting, I am unable to offer an unqualified recommendation for continued approval to foster...*
>
> *I strongly recommend that the agency undertakes a Standards of Care review to ensure that the matters raised and considered at this meeting are thoroughly explored against the carers' capacity to meet all national minimum standards fully and consistently, as well as ensuring that they are able to develop and adapt to meet the challenges they are currently seeking to manage.*
>
> *Action Points:*
> - ***The current approval status will continue throughout the Standards of Care review, which should be completed by end February 2019 and presented to the next Fostering Panel or to the ADM as necessary.***
> - ***No further placement to be made until after Standard of Care review has been shared with ADM.***
> - *Outstanding first aid training to be undertaken asap.*
> - *Agency to identify date for this by end December 2018.*
> - *PDP [Personal Development Plan] to be updated and include possible training on preparation for independence and the impact of autism on transitions. End January 2019'*

32. The ADM, Thomas Gormley's decision on 18 January 2019 states: '*Approved for a further six months, two children, either gender, aged 0-18 years on a short term, long term and respite basis'*, which is a reference to FC1's and FC2's approval status being continued for a further six months. Mr Gormley agreed that *'no additional placements should be made'*. The ADM decision also stated: '*Couple to be presented to Fostering Panel in six months' time'*.

33. The evidence showed that Mr Temple, as Registered Manager, allowed four placements between March and May 2019. These included the respite placement of Service User 4 on two occasions, and the placement of siblings Service User 2 and 3 between 25–27 May 2019.

34. The placement records (Exhibit NE/45 and NE/49) confirmed these dates. The evidence from Mr Eadon and Mr Gormley established that Mr Temple, as Registered Manager, held overall authority for placement decisions and Matching Reports, and he was expected to be aware of and enforce ADM decisions. The IFRO's recommendation became binding following the ADM's decision on 18 January 2019.

35. As set out above, it was alleged by Social Work England that Mr Temple placed additional children with the foster carers despite the ADM's recommendation that no further placements should occur until the SOC was completed and the matter reviewed by panel. Mr Temple having made formal admissions, maintained throughout that the placements were made in good faith and described the failure to follow the recommendation as an oversight.

36. In response to a serious safeguarding incident during the May 2019 respite placement of Service Users 2 and 3 with FC1 and FC2, where allegations included a physical assault by the carers' son and obstructing a child's attempt to contact Childline, Mr Temple completed a Quality of Care Report dated 1 July 2019.

37. The evidence of Mr Eadon and the GAPs analysis (Exhibit NE/52) was that this report also failed to engage meaningfully with the safeguarding concerns. It was said that the Quality of Care Report did not reference the previous IFRO and ADM recommendations, omitted earlier allegations (including those from January 2019), and failed to evaluate the carers' capacity or readiness to resume placements. There was no critical analysis of risk, no consideration of pattern or escalation, and no safeguarding learning. The conclusion of Mr Eadon and GAP analysis was that Mr Temple's recommendation for further training and continuation of placements was inconsistent with the totality of concerns.

38. Mr Temple accepted that the Quality of Care Report he completed in July 2019 was not sufficiently comprehensive and did not adequately review the safeguarding concerns or assess the carers' capacity to meet the needs of children placed with them.

39. The evidence showed that despite a recommendation to return FC1 and FC2 to the fostering panel within six months of the ADM's January 2019 decision, Mr Temple did not do so. The case was eventually scheduled for a panel in August 2019 but was withdrawn by Mr Temple on the basis that the Local Authority and the Local Authority Designated Officer (LADO) were satisfied with the situation, comments that were inaccurate and not supported by records.

40. On 1 July 2019, Service User 2 made a serious allegation of sexual abuse by her brother, Service User 3. The panel accepted evidence that initial safeguarding steps, such as alerting the LADO, informing the Local Authority, and removing Service User 3, were

taken promptly. However, the evidence also demonstrated that Mr Temple failed to update the risk assessment or Service User 2’s care plan in a timely manner; the risk assessment was not updated until 15 July 2019.

41. In relation to the concerns regarding Service User’s 2 and 3, the minutes of the Agency’s Safeguarding Committee meeting on 2 August 2019 noted Mr Temple’s decision to withdraw the matter from panel. Social Work England’s case was that this contravened the ADM's direction and bypassed scrutiny of the unresolved safeguarding issues. It was said that the failure delayed the carers’ review and allowed further placements without appropriate oversight.

42. Mr Temple accepted that he failed to ensure Foster Carer 1 and Foster Carer 2 were returned to panel within the timeframe set by the IFRO and ADM. He acknowledged this was a regrettable oversight.

43. Furthermore, there was no record of the concern being reported to OFSTED despite this being required within 24 hours. Nor was there any record of the concern being reported to the Agency’s Safeguarding Committee. Ms Wannop’s Ofsted report and Ms Pitt’s evidence corroborated this failure. Mr Temple’s inaction and omissions exposed the agency to regulatory criticism including that there was a failure to ensure robust protective measures for vulnerable children.

44. While Mr Temple denied failing to take action following the allegation made on 1 July 2019 by Service User 2, he accepted that he did not notify Ofsted or the Agency’s Safeguarding Committee as required. He also accepted that the risk assessments and care plans were not updated immediately but maintained that safeguarding measures were implemented, and other key stakeholders were informed.

<u>Evidence of Mr Nick Eadon</u>

45. Following the panel’s request Mr Nick Eadon gave oral evidence. Under oath he confirmed that he had his 65-page witness statement in front of him, signed and dated 16 December 2024. Mr Eadon stated that the contents of his statement were true to the best of his knowledge and belief, and he was content for it to stand as his evidence in chief.

46. In response to a question about his own role, Mr Eadon confirmed he was the Responsible Individual for the agency.

47. In response to the panel’s questions, Mr Eadon acknowledged that part of writing his statement was to reflect on his own role and shortcomings. He accepted that, in hindsight, he was not always sufficiently firm when situations required stronger managerial oversight.

48. Mr Eadon explained that while Mr Temple exhibited a tendency to rush tasks, this was not attributable to being overworked. He stated that the agency was a small independent fostering organisation, and staff, including Mr Temple, were not overwhelmed by excessive workloads. In Mr Temple’s case, although he sometimes

worked long hours and over weekends, the workload itself was manageable. Mr Temple was responsible for a relatively small number of families, foster carers, and children.

49. Mr Eadon and Mr Temple shared an office, and Mr Eadon confirmed that they had frequent informal conversations about workload and other matters. However, these discussions were not recorded and did not amount to formal supervision. He told the panel that in hindsight he should have conducted more formal supervision sessions with Mr Temple and formally recorded the informal discussions.

50. Mr Eadon explained that there was no regulatory requirement for an independent fostering agency to have a safeguarding committee. He had personally introduced the committee as an additional safeguard and oversight mechanism. Its purpose was to act as a filter to ensure nothing was missed. Typically, the Responsible Manager would prepare a report for the Safeguarding Committee, which could then make recommendations. These recommendations did not override those of the LADO but could be considered alongside them.

51. When asked whether the Responsible Manager could place a child without involving the Responsible Individual, Mr Eadon confirmed that while the Responsible Manager was authorised to make such decisions, they could, and often did, consult the Responsible Individual. In relation to Service Users 2 and 3, he could recall that Mr Temple consulted him prior to making placement decisions. He did not recall discussing the placement of Service User 4.

52. Regarding documentation, Mr Eadon confirmed that a Standard of Care (SOC) report and a Carer Review Report were distinct, despite the report dated 14 February 2019 having been referred by both names and including overlapping content. A Carer Review Report was prepared annually for foster carers, while a SOC report was triggered by concerns about the standard of care provided. He stated that the SOC report dated 14 February 2019 was inadequate because it lacked the analytical depth and structured recommendations typically expected, it read more as a narrative with opinions rather than a formal indepth assessment.

53. When asked whether he usually had sight of reports prepared for the Agency Decision Maker (ADM) or the Independent Fostering Reviewing Officer (IFRO), Mr Eadon confirmed that he generally did, although he would often rely on the Registered Manager to address any concerns arising from such reports. In respect of foster carers FC1 and FC2, Mr Eadon stated that had he seen the relevant recommendations. He agreed to a short respite placement. He would have supported Mr Temple's judgment, trusting him as the Registered Manager to implement decisions aligned with agency strategy. He clarified that his role focused on setting strategic direction, while the Registered Manager handled day-to-day operations.

54. Regarding Mr Temple's qualifications, Mr Eadon confirmed that there was a requirement for Mr Temple to have a management qualification when starting the role of Registered Manager or obtain one within six months. He further confirmed that Mr Temple had enrolled on a Level 5 management course within 6 months of starting the

role which enabled him to comply with requirement. He could not recall when Mr Temple started the course. He thought that Mr Temple did not complete the course because Mr Temple had resigned. Mr Eadon stated that the course needed to be completed within three years, but it was typically completed within two.

55. Mr Eadon was asked about a missing supervision report from February 2019 and explained that while regular supervision was important, there was no requirement for it to be conducted every calendar month. The January 2019 supervision had taken place at the end of the month, and the next session occurred in March 2019, which he considered reasonable given February is a shorter month.

56. Regarding the concerns made in 2019 involving Service User 3 and Service User 2, Mr Eadon stated that the Safeguarding Committee would typically have picked up on such concerns and issued appropriate recommendations. While he believed Mr Temple had acted correctly in addressing the safeguarding concerns, he stated that the issue was that Mr Temple had not formally recorded the actions taken, which was a documentation failing.

57. Mr Harris also asked about a report that Mr Eadon had referred to as a "Review of Care" report. Mr Eadon confirmed that this was the same report previously referenced as the inadequate SOC report prepared by Mr Temple. There was no second report.

Submissions

58. Mr Harris made closing submissions on behalf of Social Work England. He submitted that the live evidence of Mr Eadon did not undermine the reliability or weight of the evidence already before the panel, nor did it impact the admissions made by Mr Temple. Mr Harris reminded the panel that Mr Temple had admitted all of the factual allegations and accepted personal responsibility for his failings.

59. He emphasised that the seriousness of the admitted conduct was not diminished by the suggestion that others within the fostering agency may have also held some responsibility. Regardless of any shared involvement, Mr Temple, as the Registered Manager, held central responsibility for his systemic failings and the safeguarding deficiencies identified. Mr Harris submitted that Mr Temple's role carried overarching responsibility, including oversight of staff, monitoring compliance, and ensuring the safety and welfare of children in placement, duties which he failed to fulfil.

60. Mr Harris further submitted that Mr Temple had not attempted to deflect blame or shift culpability onto any other individual. He acknowledged his failings, and those admissions must, in accordance with Rule 32(c)(a)(ii) of the Fitness to Practise Rules, be treated as facts found proved.

61. Mr Harris concluded by submitting that the panel had a clear evidential basis for finding the allegations proven, based both on Mr Temple's formal admissions and the uncontested documentary and witness evidence presented by Social Work England.

62. Although Mr Temple had not attended the hearing he had provided written submissions in advance for the panel's consideration in the hearing. Mr Temple admitted the allegations and confirmed that he accepted the content of the witness statements, in his formal response dated 4 February 2025 and updated response form dated 4 March 2025 which were consistent with his earlier written submissions.

Finding and reasons on grounds

63. The panel considered the submissions made by Mr Harris, in relation to whether the facts found proved amount to misconduct. Mr Harris submitted that the panel could find that Mr Temple's conduct amounted to misconduct.

64. Mr Harris reminded the panel of Social Work England's overarching objective, which is to protect the public. This includes:

    - Protecting, promoting and maintaining the health, safety and wellbeing of the public;
    - Promoting and maintaining public confidence in social workers in England; and
    - Promoting and maintaining proper professional standards for social workers in England.

65. Mr Harris referred the panel to the definition of misconduct in *Roylance v GMC* (No.2) [2000] 1 AC 311, which describes misconduct as a serious departure from the standards expected of a professional. He also referred to the applicable professional standards in force at the time which were the HCPC Standards of Proficiency (2017) and The HCPC Standards of Conduct, Performance and Ethics (2016).

66. Mr Harris submitted that Mr Temple was an experienced social worker holding a senior leadership position with overall responsibility for safeguarding and operational oversight. His actions, or in many instances, inaction, placed vulnerable children at risk of harm. Mr Harris further submitted that while there may have been some shared responsibility among others within the fostering agency, this did not diminish Mr Temple's personal responsibility as the Registered Manager. The misconduct found proved breached fundamental tenets of the profession and was sufficiently serious to amount to misconduct under the statutory framework.

67. Mr Harris also submitted that none of Mr Temple's failings were trivial or inconsequential. He drew attention to the fact that although there was no regulatory requirement for the agency to have a safeguarding committee, the existence of such a committee added an additional layer of oversight, and Mr Temple's failure to refer serious concerns to this committee further demonstrated a serious disregard for safeguarding obligations.

68. The panel accepted the legal advice provided by the Legal Adviser who advised that in accordance with Regulation 25(2) of The Social Workers Regulations 2018, the panel is required to determine whether the facts found proved amount to a statutory ground. In this case, the relevant statutory ground is misconduct.

69. The panel should apply a two-stage test, as established in *Cheatle v GMC* [2009] EWHC 645 (Admin). First, the panel must determine whether the facts amount to misconduct. If so, then the panel may proceed to consider whether the social worker's fitness to practise is currently impaired.

70. The panel was reminded of the definition of misconduct in *Roylance v GMC* (No.2) [2000] 1 AC 311, which refers to conduct that falls short of what would be proper in the circumstances. Not all breaches of professional standards will amount to misconduct unless they are serious, as clarified in *Nandi v GMC* [2004] EWHC 2317 (Admin). Further, *Remedy UK Ltd v GMC* [2010] EWHC 1245 (Admin) made clear that misconduct may arise from failings in professional or personal conduct, if sufficiently serious.

71. The panel appreciated and took into account that the documents referred to in particulars 1 and 4, were according to Mr Eadon, all expected to be holistic reviews of the standard of care provided by FC1 and FC2. However they were referred to by a number of different names overtime. These included, 'Standards of Care Review', 'Standards of Care Report', 'Review of Care Report' and 'Quality of Care Report'. The panel noted in particular that Mr Temple's response in relation to particular 1 was that he accepted that "the recommended Standard of Care Report was not completed in line with the recommendations of the carers review". He stated however the following: "I did complete a Review of Care Report in... following the review to consider the issues raised." There may have been confusion over time about the nature and intentions of the reports.

72. The panel also noted that the ADM's report of 18 January 2019 appears to have been written on the assumption that Service User 1 was still in the care of FC1 and FC2 however he had left on 4 January 2019.

73. The panel took these matters into account when assessing grounds and impairment.

74. The panel first considered whether Mr Temple's conduct, found proved, breached any of the HCPC professional standards in force at the relevant time.

75. The panel found that Mr Temple's conduct breached the following obligations in force at the time:

HCPC Standards of Proficiency (2017):

1 – Be able to practise safely and effectively within their scope of practice

1.3 – Be able to undertake assessments of risk, need and capacity and respond appropriately

1.4 – be able to recognise and respond appropriately to unexpected situations and manage uncertainty

2.2 – understand the need to promote the best interests of service users and carers at all times.

4 – be able to practise as an autonomous professional, exercising their own professional judgment

4.3– recognise that they are personally responsible for, and must be able to justify, their decisions and recommendations.

10 - be able to maintain records appropriately

10.1 – be able to keep accurate, comprehensive and comprehensible records in accordance with the applicable legislation, protocols and guidelines

10.2 – recognise the need to manage records and all other information in accordance with applicable legislation, protocols and guidelines

12 - be able to assure the quality of their practice

12.3 be able to engage in evidence-informed practice, evaluate practice systematically and participate in audit procedures

HCPC Standards of Conduct, Performance and Ethics (2016):

10.1 - You must keep full clear and accurate records for everyone you care for, treat, or provide other services to.

<u>Particular 1</u>

76. Mr Temple failed to undertake or ensure completion of an adequate Standards of Care (SOC) review despite the recommendations made by the Independent Fostering Review Officer (IFRO) and Agency Decision Maker (ADM). The SOC review was completed on 14 February 2019 by Mr Temple, but lacked critical safeguarding analysis, omitted details of key incidents, and failed to review matching decisions or carers' understanding of behaviour management.

77. The document prepared by Mr Temple, which he entitled “Record of Care Report” should have evaluated each concern raised by the IFRO, assessed the foster carers’ abilities, and made structured recommendations. Instead, it was a narrative lacking depth and clarity. As Registered Manager, Mr Temple had a statutory duty to act on safeguarding recommendations. His failure to comply with those responsibilities placed children at risk and constituted a serious departure from professional standards. This represented a serious failure in safeguarding leadership. The panel considered that these failures were serious enough to amount to misconduct.

<u>Particular 2</u>

78. The panel accepted that although Mr Temple failed to ensure that FC1 and FC2 undertook training regarding managing Service User 1's behaviour, given the recommendation for the training was made in November 2018 and the timing of Service User 1 moving from the placement in January 2019, there was limited ability to fulfil the ADM's recommendation. While this failure reflected poor planning, the panel did not find it sufficiently serious, in isolation, to amount to misconduct.

Particular 3

79. Mr Temple failed to ensure that the recommendations of the IFRO and ADM prohibiting further placements with FC1 and FC2 were followed. Between March and May 2019, four placements were made, including Service Users 2 and 3 who later raised safeguarding concerns. Mr Temple accepted that he authorised the placements. The ADM's decision of 18 January 2019 was explicit in prohibiting further placements pending the SOC and fostering panel review. Mr Temple's breach of that direction undermined child safety and represented a serious failure of managerial and safeguarding responsibility. This breached direct safeguarding instructions and created a risk of harm to vulnerable children. The panel found this conduct amounted to misconduct.

Particular 4

80. The Quality of Care Report dated 1 July 2019 failed to address earlier safeguarding concerns raised in the November 2018 annual review and January 2019 ADM decision or assess risk appropriately. It did not analyse patterns of behaviour, assess carers' capacity, or identify training needs. The panel heard evidence that the fostering agency's 'GAP' analysis concluded that the report lacked critical analysis and did not meet expected standards. The Quality of Care report addressed some concerns but failed to integrate prior information including the January 2019 incident and prior recommendations and provide a comprehensive safeguarding analysis severely compromised the report and placed children at further risk. The panel found this amounted to misconduct.

Particular 5

81. The panel found that the timing of the fostering panel meeting did not align with the ADM's timeframe. Although the ADM directed that FC1 and FC2 be returned to the fostering panel in six months of the January 2019 decision, the panel noted that there was no panel in June 2019 and that the next available panel was in August 2019. Mr Temple arranged for the matter to be considered at this panel. However, the safeguarding committee advised that FC1 and FC2 should not be taken to the August panel following the incident which occurred in July between Service User 2 and Service User 3 that were still being dealt with. Mr Eadon told the panel that Mr Temple had acted promptly to safeguard Service User 2 by removing Service User 3 and notifying the LADO. However, his lack of recording his actions had let him down. While the delay in returning the case to panel may indicate a lack of urgency, the panel did not find this failure to be sufficiently serious to amount to misconduct.

Particular 6

82. Mr Temple failed to take all of the necessary safeguarding actions following the allegation made by Service User 2 against Service User 3 on or around 1 July 2019. Although some actions were taken, such as contacting the local authority social worker (LASW) and the LADO and removing Service User 3, the panel found:

    - He did not update and/or ensure that risk assessments were updated until 15 July 2019;
    - He did not update or ensure that Service User 2's safe care plan was updated immediately;
    - There was no record of OFSTED being notified within 24 hours;
    - The Agency's safeguarding committee was not informed;
    - Actions and decisions were inadequately recorded.

83. Mr Temple admitted that these were oversights. However, the panel considered the cumulative failure to document or report safeguarding concerns as a serious departure from expected standards. These responsibilities are fundamental to safeguarding children, and the panel found the failings amounted to misconduct.

84. Mr Temple's failures occurred while he was in a senior leadership role with clear safeguarding responsibilities. His actions were not isolated or inadvertent, but rather directly failed to comply with key safeguarding processes. While the panel acknowledged Mr Temple's admissions and written insight, the breaches were serious and created a risk to vulnerable children. Mr Temple's conduct involved serious departures from the standards expected of a social worker and posed a risk of harm to children in care. The conduct fell far short of what was expected of an experienced Social Worker in the position of a Registered Manager entrusted with safeguarding responsibilities.

85. The panel therefore found that particulars 1, 3, 4 and 6 amounted to misconduct.

Finding and reasons on current impairment

86. Mr Harris, on behalf of Social Work England, submitted that Mr Temple's fitness to practise is currently impaired on both the personal and public components. Mr Harris submitted that a finding of impairment is necessary in light of the risk of repetition, the need to uphold proper professional standards, and to maintain public confidence in the profession.

87. Mr Harris submitted that while Mr Temple has admitted the factual allegations and has shown some insight by expressing remorse and not seeking to deflect blame, there remains a lack of objective evidence of full insight or remediation. Mr Harris emphasised that Mr Temple has not demonstrated a clear understanding of what went

wrong, why it occurred, or how he would act differently in the future. He has not provided recent professional testimonials, undertaken relevant training, or evidenced learning in safeguarding, risk assessment or record keeping.

88. Mr Harris further submitted that a reasonable member of the public would be concerned if, in light of the proved allegations and lack of remediation, the panel were to find that Mr Temple's fitness to practise was not impaired. Mr Harris submitted that a finding of impairment is necessary in order to maintain public confidence in the profession and to uphold professional standards.

89. The panel accepted the advice of the legal adviser in relation to its approach to determining current impairment. The Legal Adviser advised the panel to consider both the personal and public elements of impairment, with reference to relevant case law, including *Cohen v GMC [2008] EWHC 581 (Admin)* and *Council for Healthcare Regulatory Excellence v Nursing and Midwifery Council & Grant [2011] EWHC 927 (Admin)*, which emphasises the importance of insight, remediation, and risk of repetition in determining impairment. The Legal Adviser reminded the panel that public confidence in the profession must be considered, and that certain conduct may be so serious that a finding of impairment is required even where the risk of repetition is low. The panel was also directed to Social Work England's "Impairment and Sanctions Guidance" and advised to consider factors including risk of harm, insight, remediation, and the need to maintain public confidence in the profession.

90. The panel considered whether Mr Temple is currently able to practise safely and effectively. The panel decided that while there was no evidence of actual harm caused to service users in this case, Mr Temple's failure to implement safeguarding measures and his failures in record keeping exposed vulnerable children to unwarranted risk of harm. As Registered Manager of Foundation Fostering, he failed to implement safeguarding measures that had been explicitly recommended by the Independent Fostering Reviewing Officer (IFRO) and adopted by the Agency Decision Maker (ADM).

91. These failures occurred in a safeguarding context involving children in care and therefore exposed vulnerable children to potential harm, in breach of safeguarding responsibilities which are fundamental tenets of social work practice.

92. The panel was of the view that Mr Temple's misconduct was capable of remediation. The panel next considered whether Mr Temple had in fact remediated his misconduct. The panel noted that there was no evidence that similar conduct has occurred since the events in question and Mr Temple has expressed remorse. The panel also acknowledged that Mr Temple admitted the allegations at an early stage and did not seek to deflect blame. However, the panel noted that he has not provided any objective evidence of remediation, such as training certificates, continuing professional development (CPD) records, or evidence of professional development in safeguarding, risk management, or leadership. The Panel had sight of a CV provided by Mr Temple and considered that despite working in a social care context since 2021, he has not supplied any recent testimonials from his current or recent employment covering the

period from 2021 to 2025. He has not supplied any detailed reflective statement demonstrating learning from his conduct. The panel was of the view that Mr Temple has not demonstrated a full understanding of what went wrong, nor has he provided a clear explanation of how he would prevent recurrence. The panel considered that his limited insight and failure to demonstrate learning indicate a lack of proactive steps to address the failings and increased the risk that similar issues may arise in future.

93. While the panel acknowledged that Mr Temple has not been working as a registered social worker, the absence of recent references or evidence of safe practice raises concerns about whether he has effectively addressed the issues identified. The panel considered that steps such as undertaking training, engaging in voluntary work, obtaining character references, or preparing a comprehensive reflective piece would have been realistic and proportionate expectations to demonstrate remediation.

94. The panel considered that Mr Temple has breached a number of the fundamental tenets of the profession, including the duty to safeguard vulnerable children, provide competent management oversight, and maintain accurate and timely records. While there is no suggestion of dishonesty, these failings are serious and indicate a significant departure from accepted professional standards.

95. Taking all the above into account the panel concluded that there was a risk of repetition.

96. The panel next considered whether a finding of impairment was necessary in the public interest, to maintain public confidence in the social work profession and uphold proper professional standards.

97. The panel was of the view that the nature and seriousness of the misconduct and Mr Temple's failure to act in accordance with professional and regulatory standards in the capacity as a Registered Manager would seriously undermine public confidence if a finding of impairment was not found. The failings occurred in the context of a leadership role where Mr Temple was entrusted with ensuring the safety and well-being of looked-after children. His failure to follow recommendations from the Independent Fostering Reviewing Officer and the Agency Decision Maker undermines the regulatory framework and trust placed in such positions of responsibility.

98. The panel considered that a reasonable and informed member of the public would be concerned if no finding of impairment were made in the circumstances of this case, particularly given the absence of demonstrable remediation and the ongoing risk to the public.

99. Therefore, the panel concluded that a finding of impairment on the public component is necessary to uphold public confidence in the social work profession and to promote and maintain proper professional standards for the social workers.

100. Having considered all of the evidence before it, including the submissions of Social Work England, Mr Temple's admissions and responses, and the guidance

provided, the panel concluded that Mr Temple's fitness to practise is currently impaired on both the personal and public components.

Decision and reasons on sanction

101. The panel heard submissions from Mr Harris on behalf of Social Work England, regarding the appropriate sanction in this case. Mr Harris submitted that a suspension order for a period of 12 months would be the proportionate and necessary response to the regulatory concerns arising from Mr Temple's conduct. He submitted that a sanction was required to prevent repetition, protect the public, and uphold public confidence in the social work profession. Mr Harris stated that there was some potential for remediation but emphasised that there remained a risk of repetition, and that the evidence of remediation presented by Mr Temple was limited. He submitted that conditions of practice were unlikely to be appropriate or workable given the seriousness of the concerns and the lack of tested compliance. He further submitted that the conditions required might be too onerous to implement effectively and would not sufficiently address the public interest in maintaining standards and trust in the profession. He stated that the seriousness of the failings, coupled with the limited evidence of meaningful remediation, warranted a suspension order as the most appropriate sanction.

102. The panel accepted the advice of the Legal Adviser who outlined the principles relevant to the imposition of sanctions. The Legal Adviser reminded the panel that it should consider the least restrictive sanction necessary to protect the public and maintain public confidence in the profession. The panel was advised to consider each sanction in ascending order of severity, providing clear reasons for its decision. The panel should also identify any aggravating and mitigating factors in the case when deliberating on sanction. The Legal Adviser referred to the Social Work England Impairment and Sanctions Guidance, emphasising that sanctions should be fair, proportionate, and appropriate to the circumstances of the case.

103. In reaching its decision on sanction, the panel had careful regard to Social Work England's "Impairment and Sanctions Guidance", the overarching objective of public protection, and the need to maintain confidence in the profession and uphold proper standards. The panel followed the structured approach set out in the guidance by considering the available sanctions in ascending order of seriousness and selecting the least restrictive outcome necessary to protect the public and satisfy the public interest. The panel also considered the relevant aggravating and mitigating factors, as well as its earlier findings of impairment on both personal and public grounds.

104. The panel took into account the following aggravating and mitigating factors in determining the appropriate sanction.

105. The panel identified the following mitigating factors:

- Early admission of the factual allegations in full.
- Remorse expressed by Mr Temple in his written submissions.
- Some level of engagement with the fitness to practise process, including provision of written submissions.
- Mr Temple did not seek to deflect blame or minimise the seriousness of the concerns.
- A positive testimonial provided from 2021.
- Inconsistencies in the titles of the documents used within the fostering agency which may have contributed to some confusion or misunderstanding about the nature and intentions of the reports.

106. The panel identified the following aggravating factors:

- A lack of objective evidence of remediation to date.
- The risk of harm to vulnerable children resulting from Mr Temple's actions and omissions.
- Mr Temple's conduct occurred in the context of a senior leadership role, carrying significant safeguarding responsibilities.

107. The panel first considered whether to take no further action. Given the seriousness of the misconduct, the potential risk of repetition, and the panel's findings that Mr Temple's fitness to practise is currently impaired, it concluded that such an outcome would be wholly inappropriate. Taking no further action would fail to protect the public and would undermine public confidence in the profession.

108. The panel then considered whether to issue advice or a warning. However, the panel concluded that neither outcome would be sufficient to reflect the gravity of the concerns and the risk of repetition. While advice or a warning may serve as a reminder of a social worker's professional obligations, they would not address the panel's concerns about Mr Temple's limited insight and lack of objective evidence of remediation. Nor would they provide adequate protection for the public or uphold the reputation of the profession. The panel noted that Mr Temple had not fully demonstrated an understanding of the broader impact of his conduct or shown sufficient reflection on how to avoid similar issues in future. For these reasons, advice or a warning would be inadequate.

109. The panel next considered whether a conditions of practice order would be sufficient and proportionate. In considering whether to impose a conditions of practice order, the panel had regard to the early admissions made by Mr Temple, his acceptance of responsibility, and his engagement with the regulatory process. The panel was

satisfied that Mr Temple's conduct, although serious, was capable of remediation, and that he had taken some steps to engage with the regulatory process. He had been in contact with Social Work England and had made attempts to obtain social work employment in line with the interim conditions previously imposed. The panel acknowledged that Mr Temple had demonstrated some insight into his failings and a willingness to comply with regulatory requirements. Furthermore, the panel was satisfied that there are appropriate, proportionate and workable conditions that could be formulated to address the concerns, and that Mr Temple is willing and able to comply with such conditions.

110. In assessing public protection, the panel concluded that Mr Temple does not pose a risk of harm to the public while practising under appropriate restrictions. It found that public protection could be achieved through a limited conditions on practice. The panel was also mindful of the Sanctions Guidance, which states that it is in the public interest to support a trained and skilled social worker to return to practice if this can be achieved safely. The panel was satisfied that this could be achieved in Mr Temple's case. It therefore concluded that a conditions of practice order would adequately protect the public, allow Mr Temple to take steps to remediate his practice, and promote his safe return to the profession.

111. For completeness, the panel also considered whether a suspension order would be more appropriate. It considered that the regulatory concerns were serious, but it was not satisfied that suspension was necessary in light of Mr Temple's current level of insight, willingness to engage, and capacity to practise safely under restricted conditions. The panel concluded that suspension would be a disproportionate response and would unnecessarily delay the opportunity for Mr Temple to remediate his practice and return to safe and effective work within the profession. A suspension order would also fail to reflect the guidance encouraging the profession's rehabilitation where appropriate. The panel was satisfied that the public interest does not require a suspension order in this case.

112. For all these reasons, the panel determined that the appropriate and proportionate sanction in this case is a Conditions of Practice Order. The order will operate for a period of 12 months, and the conditions have been carefully formulated to ensure public protection while supporting Mr Temple in addressing the deficiencies in his practice. The panel was satisfied that this sanction achieves a fair balance between the need for public protection, the seriousness of the misconduct, the public interest in upholding confidence in the profession, and Mr Temple's own interest in returning to safe practice.

113. Although the panel did not consider it necessary to include as a formal condition within the conditions of practice order, the panel noted that it would be helpful for any future reviewing panel if Mr Temple were to provide a reflective document. This document should address the root causes of the regulatory concerns and demonstrate how he would act differently in future to prevent similar failings. It would be helpful if this document demonstrated full and meaningful insight into the

reasons behind his conduct, with a clear explanation of the steps he would take to avoid recurrence.

114. The panel therefore decided that the appropriate and proportionate order is a 12 month conditions of practice order as follows:

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

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

3) a. At any time you are providing social work services, which require you to be registered with Social Work England, you must agree to the appointment of a reporter nominated by you and approved by Social Work England. The reporter must be on Social Work England's register. b. You must not start or continue to work until these arrangements have been approved by Social Work England.

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

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

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

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

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

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

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

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

11) You must formulate a personal development plan, specifically designed to address the shortfalls in the following areas of your practice:

- Safeguarding
- Decision making
- Record keeping
- Ability to appropriately follow instructions

Your personal development plan must be signed off by your employer.

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

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

14) You must not be responsible for either the administration or management of any independent or local authority social work practice /establishment.

15) You must provide a written copy of your conditions, within 7 days from the date these conditions take effect, to the following parties confirming that your registration is subject to the conditions listed at 1 to 13, above:

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

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

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

d. Any organisation, agency or employer where you are using your social work qualification/knowledge/skills in a non-qualified social work role, whether paid or voluntary. You must forward written evidence of your compliance with this condition to Social Work England within 14 days from the date these conditions take effect.

16) You must permit Social Work England to disclose the above conditions 1 to 15, to any person requesting information about your registration status.

Interim order:

115. In light of its findings on sanction, the panel next considered an application by Mr Harris for an interim order to cover the appeal period before the final order becomes effective.

116. 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 order was not imposed to cover that period in order to protect the public.

117. Accordingly, the panel concluded that an interim conditions of practice order of 18 months is necessary for the protection of the public. When the appeal period expires, this interim order will come to an end unless an appeal has been filed with the High Court. If there is no appeal, the final order of conditions of practice shall take effect when the appeal period expires.

Right of appeal

118. 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:

- 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.
- the decision of the regulator on review of an interim order, or a final order, other than a decision to revoke the order.

119. 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.

120. 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.

121. 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:

122. Under Paragraph 15(1), 15(2) and 15(3) of Schedule 2 of the regulations:

123. 15(1) The regulator must review a suspension order or a conditions of practice order, before its expiry

124. 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

125. 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

126. 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:

127. 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.