

**Social worker: Frances
Robertson
Registration number: SW80973
Fitness to Practise
Final Hearing**

Dates of hearing: 17 March 2025 to 25 March 2025

Hearing venue: Remote hearing

Hearing outcome: Fitness to practise impaired, removal order

Interim order: Interim suspension order (18 months)

Introduction and attendees:

1. This is a hearing held under Part 5 of The Social Workers Regulations 2018 (as amended) (“the regulations”).
2. Ms Robertson did not attend and was not represented.
3. Social Work England was represented by Mr Khan instructed by Capsticks LLP.

Adjudicators	Role
Eileen Carr	Chair
Glenys Ozanne-Turk	Social worker adjudicator
John Brookes	Lay adjudicator

Hearings team/Legal adviser	Role
Titlee Pandey	Hearings officer
Lauryn Green	Hearings support officer
Zill-e Huma	Legal adviser

Service of notice:

4. The panel of adjudicators (hereafter “the panel”) was informed by Mr Khan that notice of this hearing was sent to Ms Robertson by email and next day delivery service to an address provided by the social worker (namely her registered address as it appears on the Social Work England register). Mr Khan 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 13 February 2025 and addressed to Ms Robertson at her email and postal address which she provided to Social Work England.
 - An extract from the Social Work England Register detailing Ms Robertson’s registered address.
 - A copy of a signed statement of service, on behalf of Social Work England, confirming that on 13 February 2025 the writer sent by email and next day special delivery service to Ms Robertson at the address referred to above.

- A copy of the Royal Mail Track and Trace Document indicating “signed for” delivery to Ms Robertson’s address at 09.43am on 18 February 2025.
6. The panel accepted the advice of the legal adviser in relation to service of notice.
 7. Having had regard to Rules 14 and 15 of the Fitness to Practise Rules 2019 (as amended) (“the 2019 Rules”) 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 Ms Nicholson in accordance with Rules 44 and 45 of the 2019 Rules.

Proceeding in the absence of the social worker:

8. The panel heard the submissions of Mr Khan on behalf of Social Work England. Mr Khan submitted that notice of this hearing had been duly served, no application for an adjournment had been made by Ms Robertson and as such there was no guarantee that adjourning today’s proceedings would secure her attendance.
9. Mr Khan further submitted that on 17 May 2022, Ms Robertson replied to an email from Social Work England. She amended the subject line of the email, so it read *“Re: SWE Reg - 'you do you', because you are so good at it (not), or I'm going to contact my solicitor as I know it's amounting to demanding money for your failing organisation with manaces”*. Her reply read:
 - “I do not accept the last email you sent to me, here is my reply.
 - I want SWE to take note as I do not want you or other employees of your organisation to ever contact me again.
 - I have cancelled my registration from the Social Work register with Social Work England as I am no longer employed as a Social Worker following the outcome of a capability dismissal meeting in March 2022 **[PRIVATE]**
 - I no longer want to be registered as a Social Worker with Social Work England, as I have left the profession, and have no intention of returning to it, and this is why I have completed the removal process.
 - If Social Work England want to proceed with an investigation in my absence, then that is up to them.
 - I cancelled the direct debit to Social Work England at the same time as completing the removal process.

- I will treat any further communication from Social Work England requesting money from me as harassment and will take appropriate action.
 - **[PRIVATE]**
 - Do not contact me again in your efforts in undertaking the dirty work of corrupt Councils.”
10. Mr Khan therefore invited the panel to proceed in the interests of justice and the expeditious disposal of this hearing.
 11. The panel accepted the advice of the legal adviser in relation to the factors it should take into account when considering whether it was appropriate to conduct the hearing in the absence of Ms Robertson. This included reference to the cases of *R v Jones [2002] UKHL 5*; *General Medical Council v Adeogba [2016] EWCA Civ 162*. The panel also took into account Social Work England guidance ‘Service of notices and proceeding in the absence of the social worker’.
 12. The panel considered all of the information before it, together with the submissions made by Mr Khan on behalf of Social Work England. The panel noted that Ms Robertson had been sent notice of today’s hearing, and the panel was satisfied that she was or should be aware of today’s hearing.
 13. The panel therefore concluded that Ms Robertson had chosen voluntarily to absent herself. The panel had no reason to believe that an adjournment would result in Ms Robertson’s attendance. The panel thoroughly considered the matter and decided to proceed in Ms Robertson’s absence. It emphasised that postponing the Final Hearing without a compelling reason would undermine Social Work England’s ability to fulfil its overarching objective of public protection. It is crucial to resolve matters expeditiously, and it would cause inconvenience to witnesses and the regulator. Having weighed the interests of Ms Robertson in regard to her 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 Ms Robertson’s absence.

Preliminary matters:

Application to amend the allegations

14. Mr Khan on behalf of Social Work England made an application to amend a typographical error in allegation 1,2, and 3 which currently reads “*one more cases*”

and should read “*one or more cases*”. He submitted that the amendment was minor in nature and related to a typographical error. It was further submitted by him that there was no prejudice caused to Ms Robertson by the amendment as it is simply a typographical error that would have been clear from the face of the papers.

15. The panel received legal advice from the legal adviser. The Rules provide the panel with discretion to regulate its own procedure and conduct the hearing in a fair manner, as outlined in Rule 32.
16. The panel considered the prejudice to Mrs Robertson in respect of this late amendment but tempered that with the duty to ensure that cases are not under-prosecuted. Given the fact that the amendments were minor in nature and related to a typographical error. The panel considered that it was fair to amend.
17. Accordingly, the panel granted the application to amend the allegation to be read “*one or more cases*”.
18. Furthermore, the panel received the following updated documents in addition to the existing bundle of documents.

a) Statements Bundle {Redacted} – 73 pages

b) Exhibit Bundle {Redacted} - 798 pages

Application for the hearing to be heard partly in private

19. Mr Khan made an application under Rule 38(b), for parts of the hearing to be heard in private, namely those parts of the hearing when the health and related matters concerning Ms Robertson were considered.
20. The panel accepted the advice of the legal adviser in relation to the factors it should take into account when considering this application. The panel was reminded of its discretionary power to hear part of the hearing in private where appropriate, having due regard to any of the parties’ welfare. The panel was reminded of the need to balance the protection of any affected party’s welfare with the public interest in open justice.
21. The panel decided that it was appropriate to exercise its discretion given that some of the evidence related to issues of the health and personal circumstances of Ms Robertson.

22. Accordingly, the panel directed that the following parts of the hearing were to be held in private:
- Those parts of the hearing when health and related personal matters concerning Ms Robertson are mentioned.

Allegations:

“The allegations arising out of the regulatory concerns referred by the Case Examiners on 21 April 2023 are:

Whilst employed by Cumbria County Council between approximately 1 February 2021 and 22 March 2022:

1. Failed to adequately assess the support needs of service users, in respect of one or more cases, namely:

a. Service user SU1

b. Service user SU2

c. Service user SU3

d. Service user SU6

e. Service user SU8

f. Service user SU10

g. Service user SU14

2. Failed to adequately assess the mental capacity of service users, in respect of one or more cases, namely:

a. Service user SU7

b. Service user SU11

3. Failed to adequately and/or promptly assess and manage the risks to service users, in respect of one or more cases, namely:

a. Service user SU12

b. Service user SU3

c. Service user SU13

d. Service user SU4

e. Service user SU6

4. On 1 April 2022, you declared to Social Work England that you were unaware of any current allegation, investigation, proceedings, or order which may result in action being taken against you, when this declaration was:

a. false; and/or

b. intended to mislead

5. Failed to cooperate with Social Work England's fitness to practise investigation between May 2022 and January 2023.

6. Your actions at paragraph 4 above were dishonest.

Your conduct set out at paragraphs 1-3 above amounts to the statutory ground of misconduct or lack of competence/capability.

Your conduct set out at paragraphs 4-6 above amounts to the statutory ground of misconduct.

Your fitness to practise is impaired because of your misconduct or competence/capability."

23. The panel noted that Ms Robertson had not complied with the Case Management Directions ("directions") which were issued on the 15 November 2024 and required Ms Robertson to indicate, by 20 January 2025 which parts of the statement of case are admitted and which remain in dispute, including on the question of whether her fitness to practise is currently impaired.

24. The panel heard submissions from Mr Khan who invited the panel to find the allegations proved on balance of probabilities.

25. The panel accepted the advice of the Legal Adviser with regards to the burden and standard of proof and dishonesty. In relation to the allegations of dishonesty, the panel was referred to the test set out in *Ivey v Genting Casinos (UK) Ltd* [2017] UKSC 67. It recognised that the burden of proving each allegation rested with Social Work England and that the standard of proof required was the balance of probabilities.
26. In line with Rule 32c(i)(a) of the Rules, the panel then went on to consider the evidence and determine the disputed facts.

Background:

27. On 13 April 2022, Social Work England received a referral from Ms Stoica on behalf of Cumbria County Council regarding Ms Robertson, a social worker employed by the Council. Ms Robertson worked as part of the Mental Health Team, which was responsible for conducting Care Act assessments, safeguarding enquiries, and assessments of service users. The team also worked closely with mental health hospitals, as many service users were discharged from hospital and required ongoing care.
28. Ms Robertson's primary role was to assess the social care needs of individuals with functional mental health issues, determining eligibility for aftercare services and arranging necessary care if eligible. Additionally, she was tasked with safeguarding duties under the Care Act 2014 and completing capacity assessments. The team had three levels of social workers, with Ms Robertson positioned in the middle level.
29. During her employment, Ms Robertson received several training courses relevant to her role, including those related to safeguarding, the Care Act, and report writing. One of her line managers, Mr Ashworth, confirmed that she received all the necessary training to perform her duties.
30. Despite this, Ms Robertson was subject to capability procedures during her time at the Council. Mr Ashworth, who managed the Mental Health Team, observed issues with her performance, particularly regarding the depth and clarity of her assessments. She struggled to understand basic social work principles and frequently provided contradictory information. While her performance improved under Mr Ashworth's close supervision, he noted that this was due to 'micromanagement', and the same issues arose once the direct supervision ended.
31. In 2018, Ms Robertson was moved to the West Team under Mr Ashworth's supervision, where an informal capability procedure was initiated. This included monitoring her case progress, response times, and case recording. Despite the support provided, an investigation led to a formal capability procedure. Ms

Robertson raised a grievance against Mr Ashworth, which was not upheld after investigation. The grievance process ended in 2019, and the capability process resumed.

32. In late 2019, Ms Sibbald, another manager, took over the capability management and began preparing a new capability plan for Ms Robertson. **[PRIVATE]**
33. Ms Stoica, who was the Mental Health Service Manager at Cumberland Council, took over Ms Robertson's sickness absence management in November 2020. Ms Stoica continued the formal capability process, providing frequent feedback through structured supervisions and emails. Despite this support, Ms Robertson's assessments continued to show deficiencies. Many of her assessments were rejected due to a lack of depth, and the feedback given was often not acted upon. Ms Stoica made efforts to meet with Ms Robertson more frequently, especially towards the end of her employment, but significant issues remained unresolved.
34. Throughout this period, Ms Robertson continued to receive regular feedback and supervision, yet her performance issues persisted, with many of her case assessments needing significant revision. Her failure to adequately address these concerns led to the ongoing capability processes and eventually leading to her dismissal and referral to Social Work England.
35. On 13 April 2022, Social Work England received a referral from Ms Stoica with details of concerns about Mr Robertson's practice. The matter was assigned to a Social Work England investigator before being reassigned to Mr Taylor, who was an investigator for Social Work England. Mr Taylor was responsible for completing the investigation and collecting outstanding evidence.
36. On 1 April 2022, Ms Robertson had completed a Voluntary Removal Initial Application and expressed an interest to be removed voluntarily from the Social Work England register. A Voluntary Removal case was opened by Social Work England on 1 April 2022 but closed on 12 May 2022 as the rules provided at the time that a Social Worker may not voluntarily remove themselves from the register if there was an open fitness to practise investigation.
37. As part of the declarations required when Ms Robertson completed the application on 1 April 2022, she confirmed that *"I am unaware of any current allegation, investigation, proceedings, or order which may result in action being taken against me"*
38. However, Ms Robertson was already aware of the Capability Dismissal Meeting being convened as she had responded to the scheduling of it through her

representative and was aware of the outcome of it by virtue of the letter dated 23 March 2022. That letter had specifically referred to a referral being made to Social Work England. Her last day of employment was to be in May 2022.

Finding and reasons on facts:

Whilst employed by Cumbria County Council between approximately 1 February 2021 and 22 March 2022:

1. Failed to adequately assess the support needs of service users, in respect of one or more cases, namely:

Service user SU1

Service user SU2

Service user SU3

Service user SU6

Service user SU8

Service user SU10

Service user SU14

39. The panel carefully considered all the evidence and submissions including what the assessment process should focus on as per the Care Act (*“The assessment process is one of the most important elements of the care and support system. It starts when local authorities begin to collect information about the person. The objective is to place the individual in control of the assessment process and enable them to lead as fully in the process as they wish to. The Care Act states that the focus of assessment should be: •To identify what needs a person may have •The impact of those needs on the person’s wellbeing •What is available to meet the needs – including their own strengths and capability and their informal network •The outcomes the person needs – asking people about outcomes in an assessment helps to keep information-gathering focused on the purpose.”*)

40. In relation to the assessment of Service User (SU) 1,2,3,6,8,10,and 14 conducted by Ms Robertson, after a thorough and detailed review of all the evidence, the panel concluded, on the balance of probabilities, that Ms Robertson failed to adequately assess the support needs of SU1,2,3,6,8,10, and 14. The decision is based on a careful assessment of all the evidence, including Ms Stoica's oral evidence, which was compelling, clear, reliable, consistent and corroborated with the other evidence.
41. The panel found that the evidence provided by Ms Stoica, (who supervised Ms Robertson's sick leave from November 2020, then Capability Supervision from June 2021) corroborated by the evidence of Mr Ashworth, (who held the position of Team Manager for the West Division Mental Health Team at Cumbria Council from 2016 before being promoted to Service Manager in November 2019). His evidence was significant in demonstrating the background of Ms Robertson's previous performance issues, which were addressed through capability processes prior to the concerns arising in 2021.
42. The panel determined that Mr Ashworth's evidence detailed the consistent themes that emerged during his supervision of Ms Robertson, particularly the lack of depth and cogency in her assessments. He noted that her assessments often contained contradictory information, and he observed that Ms Robertson seemed to struggle with the basic expectations of her role, particularly in terms of analysis and clarity. This was consistent with Ms Stoica's evidence, which identified similar issues with Ms Robertson's failure to adequately assess and analyse the service users' needs.
43. The panel concluded that Ms Stoica's oral evidence, corroborated by Mr Ashworth's evidence, highlighted that despite the formal and informal support plans put in place over the years, Ms Robertson's performance failed to demonstrate sustained improvement. Ms Stoica described Ms Robertson as having "*no professional curiosity*" in her work, a sentiment that underscored the lack of proactive investigation and analysis when assessing service users' needs. Mr Ashworth explained that although Ms Robertson's performance improved during the formal capability process in 2017, this improvement was due to his direct supervision and 'micromanagement'. He further noted that once this close oversight ended, the same issues resurfaced, which was consistent with the shortcomings identified by Ms Stoica.
44. The panel noted that Mr Ashworth's evidence also outlined that in 2018, following a period of leave, an informal capability procedure was implemented for Ms Robertson, targeting similar performance issues such as timely case progression and accurate case recording, all of which echoed the areas of concern identified by Ms Stoica in her evidence regarding Ms Robertson's lack of clarity and analysis in her assessments. The consistency of these issues, as reflected in both Ms Stoica's

and Mr Ashworth's evidence, further reinforced the panel's conclusion that Ms Robertson failed to meet the required professional standards in assessing the service users' needs.

45. The panel also heard evidence from Ms Clark, who was a Senior Adviser with HR with The Council at the time. She started this role in January 2016 and concluded her tenure in April 2023. Her responsibilities involved providing advice and guidance to the Council's management on complex HR matters, including conduct, capability, absence, grievance, and bullying and harassment cases. Ms Clark first became involved with Ms Robertson in late 2018, during the capability process. She informed the panel that on 7th December 2021, the final formal capability meeting for Ms Robertson was held, at which Ms Clark was also present.
46. In her evidence, Ms Clark stated that it is highly unusual for someone to be dismissed on the grounds of capability. However, she explained that numerous concerns had been raised by multiple individuals, and several line managers had highlighted ongoing issues with Ms Robertson's practice over the years. Ms Clark further informed the panel that the capability process for Ms Robertson involved some of the most significant conflict she had witnessed between a social worker and other parties in her role.
47. The panel found Ms Clark's evidence to be professional, factual, and honest.

Service User 1

48. The panel identified a primary issue in Ms Robertson's failure to adequately analyse the information regarding SU1's needs. On the balance of probabilities, the panel concluded that Ms Robertson did not provide sufficient analysis of how SU1's mental health issues, specifically her personality disorder and depression, impacted her ability to meet her daily needs. Ms Stoica's oral evidence, supported by her written statement, was particularly persuasive in explaining this failure. She detailed how Ms Robertson did not adequately explore the impact of SU1's mental health on her daily life.
49. The panel noted for example, in relation to SU1's toileting needs, the assessment included a quote supposedly from SU1 that stated, *"I manage ok when feeling well physically and mentally but, I'm not maintaining my needs in this domain as I think I require support to reengage in daily living skills to remain independent in her own home."* Ms Stoica explained that this quote was unclear and nonsensical, failing to establish whether SU1's difficulties were due to her physical or mental health issues, or both. The panel accepted Ms Stoica's assertion that this lack of clarity

showed Ms Robertson's failure to properly assess the nature of SU1's needs and, ultimately, to determine whether they warranted support.

50. In addition to the failure to analyse information properly, the panel found that the assessment contained numerous inconsistencies and contradictions, which raised serious doubts about its reliability. Based on the balance of probabilities, the panel concluded that these inconsistencies were not the result of simple errors but were indicative of a deeper failure in the assessment process. Ms Stoica's oral evidence was crucial in identifying these contradictions. She provided specific examples where the assessment described SU1 as "independent" in certain areas, yet other sections suggested she was struggling with physical health issues. For instance, in one part of the assessment, SU1 was said to struggle at home, while in another, she was described as independent, despite having some physical health problems.
51. The panel concluded, on the balance of probabilities, that these contradictions were significant enough to undermine the overall reliability of the assessment and the conclusions drawn from it. Ms Stoica's written statement pointed out these conflicting entries, for example, where the Social Worker *"described without detail that SU1 struggled at home, but also indicated SU1 was independent."*
52. Another key issue was the failure to adequately assess certain aspects of SU1's needs, such as her ability to manage personal care, nutrition, and community access. On the balance of probabilities, the panel concluded that Ms Robertson did not sufficiently address these needs. Ms Stoica's oral testimony was compelling in explaining how the assessment lacked a coherent rationale for determining whether certain needs were eligible for support. For example, while the assessment noted that SU1 could manage her personal care *"independently but with difficulty,"* it identified this as an eligible need despite the fact that the difficulty did not meet the threshold for significant support. Similarly, SU1's nutritional needs were identified as eligible, despite the assessment noting that she could manage her nutrition independently, albeit with some difficulty.
53. The panel concluded, on the balance of probabilities, that these inconsistencies and the lack of rationale for identifying these needs as eligible were indicative of a failure to properly assess SU1's situation and determine whether support was required. Ms Stoica also pointed out in her written statement that *"nutritional needs were identified as eligible despite an entry that SU1 is able to manage independently with difficulties and later wrote that SU1 was able to manage her nutritional needs."*
54. The panel noted the inclusion of irrelevant and outdated information in the assessment, which again raised concerns about the quality of the process. Ms Stoica's oral evidence was particularly persuasive in pointing out that the assessment included case notes from 2015 that were irrelevant to the current

situation. She explained that these outdated case notes were not reflective of SU1's present circumstances and, therefore, should not have been included in the assessment.

55. On the balance of probabilities, the panel concluded that the inclusion of such irrelevant information further undermined the adequacy, quality and accuracy of the assessment. Ms Stoica's written statement highlighted this concern by mentioning that the Social Worker had included case notes from 2015 in the assessment, which were "*not relevant to the issue*" at hand.
56. The panel considered the revisions made to the assessment after Ms Stoica's rejection of the assessment and suggested revisions. Despite receiving clear and detailed feedback from Ms Stoica, the third draft of the assessment still failed to address the core issues identified. On the balance of probabilities, the panel concluded that Ms Robertson's revisions did not meet the necessary standards for a thorough and accurate assessment. Ms Stoica's oral evidence was particularly persuasive in explaining why the revisions were insufficient. She pointed out that the assessment continued to lack the necessary clarity, consistency, and rationale, despite her detailed guidance.
57. The panel found that this failure to revise the assessment adequately indicated that Ms Robertson did not exercise the required professional judgment or skill in revising her work. Ms Stoica noted in her written statement that "*the Social Worker had failed to analyse the relevant information*" and had included irrelevant details, such as "*answering a question about communication issues by stating that SU1 uses electronic communications and posts regularly on social media,*" which was not relevant to the question asked.
58. The panel concluded, on the balance of probabilities, that Ms Robertson failed to adequately assess the support needs of Service User 1. The assessment was marked by inconsistencies, a lack of clear analysis, and the inclusion of irrelevant and outdated information. Key areas of SU1's needs were not properly addressed, and the rationale for determining eligibility for support was unclear and unsupported. The oral evidence provided by Ms Stoica was crucial in identifying these deficiencies. On the balance of probabilities, the panel concluded that Ms Robertson did not meet the professional standards required for conducting an adequate assessment, and as such, the panel found that Ms Robertson's assessment of SU1 was inadequate and failed to provide an accurate understanding of SU1's support needs.

Service User 2

59. The panel carefully considered the evidence in relation to the Assessment of Needs completed by Ms Robertson for Service User 2 (SU2), who had a diagnosis of Autism and Anxiety and had requested an assessment due to difficulties and stress caused by maintaining his employment. The panel found, on the balance of probabilities, that Ms Robertson's assessment of SU2 was inadequate. In particular, the panel identified significant deficiencies in how Ms Robertson conducted the assessment and the rationale she provided for her conclusions about SU2's eligible needs.
60. The panel noted that Ms Robertson's assessment referred to a telephone assessment conducted on 16 September 2021, described as the 'first visit'. However, the panel found that a significant portion of the content within the Assessment of Needs was copied from case notes previously written by Ms Stoica. These case notes described a visit when SU2 came to the office in a distressed state and subsequently had a home visit from Ms Stoica.
61. The panel concluded, on the balance of probabilities, that Ms Robertson relied too heavily on these pre-existing case notes, which were not appropriately integrated into the assessment. While case notes can provide useful background information, the panel found that Ms Robertson failed to analyse and apply this information effectively to SU2's current situation. Ms Robertson did not demonstrate a clear rationale for why this historical information was relevant or how it influenced her conclusions regarding SU2's eligibility for support.
62. The panel found that a large amount of the assessment content was copied verbatim from the case notes, specifically under the section seeking the 'Views of significant other'. In this section, Ms Robertson included information from a case note written by Ms Stoica on 9 September 2021. The panel found this approach to be inadequate, as the information from case notes was simply pasted into the assessment without any attempt to analyse or provide context.
63. The panel concluded that this approach was insufficient to properly address the specific needs of SU2. The panel emphasised that while case notes may serve as supporting material, they must be used alongside analysis that directly answers the questions posed in the assessment. In this instance, the lack of analysis resulted in a failure to demonstrate why the case note information was relevant to SU2's needs and how it contributed to determining his eligibility for care and support.
64. The panel considered the oral and written evidence of Ms Stoica, which was clear, consistent, and compelling in highlighting the shortcomings in Ms Robertson's assessment. Ms Stoica provided a detailed explanation of how the assessment lacked the necessary depth and analysis, particularly in the use of case notes and the failure to adequately assess SU2's needs. The panel found Ms Stoica's evidence

to be reliable and informative in confirming that Ms Robertson's assessment did not meet the required standards for a comprehensive and adequate needs assessment.

65. The panel considered the overall quality of the assessment and found that it lacked the necessary depth and clarity required for an accurate and adequate understanding of SU2's needs. Ms Robertson's failure to analyse the information adequately and provide a clear rationale for her decisions left the assessment incomplete and unsubstantiated. The panel concluded that, on the balance of probabilities, the assessment was not of an acceptable standard, and Ms Robertson had failed to meet the expected professional standards in conducting a thorough and effective needs assessment for SU2. As such, the panel found that Ms Robertson's assessment of Service User 2 was inadequate.

Service User 3

66. The panel carefully reviewed the evidence concerning the Assessment of Needs conducted by Ms Robertson for Service User 3 (SU3), who had been diagnosed with Emotionally Unstable Personality Disorder and suffered from seizures. The assessment was tasked with determining SU3's care and support needs, and the panel found, on the balance of probabilities, that Ms Robertson's assessment of SU3 was inadequate. The primary issue identified by the panel was the lack of clarity, consistency, and a coherent rationale in Ms Robertson's assessment, which ultimately failed to provide a proper analysis of SU3's needs.
67. The panel noted that Ms Robertson initially concluded that SU3 did not have eligible needs, despite the fact that SU3's mother was providing all necessary support. Ms Robertson's rationale for this conclusion was that SU3's needs were being met by their mother. However, the panel found that Ms Robertson could not adequately explain why she planned to remain involved in SU3's case after this conclusion, as the assessment lacked sufficient justification for her continued involvement. The panel determined, on the balance of probabilities, that this initial conclusion was flawed and lacked the necessary depth of analysis that would support such a decision.
68. The panel further considered the oral and written evidence provided by Ms Stoica, which identified several significant issues with Ms Robertson's assessment. Ms Stoica's evidence was clear, detailed, and compelling, and the panel found it to be crucial in identifying the failings in Ms Robertson's approach. Ms Stoica pointed out contradictions in the assessment, such as references to SU3's needs being long-term, while later attributing the need for support to neurological and mental health problems. Furthermore, there were discrepancies in the assessment that described SU3 as being independent at one point but later stating that support was required.

The panel found that such contradictions undermined the overall accuracy and reliability of the assessment.

69. In addition to these contradictions, the panel also found that Ms Robertson's assessment lacked specific rationale to explain why certain needs were deemed eligible for support. Ms Stoica's evidence highlighted the absence of sufficient detail regarding what SU3 could or could not do and the level of support that was required. The panel concluded, on the balance of probabilities, that Ms Robertson's failure to provide clear and specific information regarding SU3's capabilities and the support needed contributed to the inadequacy of the assessment. There was also a lack of explanation as to the frequency of the support required, which is crucial in determining the level of care and intervention that SU3 needed.
70. The panel found that Ms Robertson's assessment was incomplete in terms of providing a clear understanding of SU3's needs and the appropriate interventions that would be required to support them. Ms Stoica's evidence reinforced this, noting that a comprehensive and detailed assessment should have provided specific, actionable information that would have allowed for a proper determination of SU3's eligibility for care and support. Ms Stoica's evidence was consistent, detailed, and corroborated the panel's findings that the assessment failed to meet the required standards of thoroughness and clarity.
71. The panel concluded on the balance of probabilities, that Ms Robertson's assessment of SU3 was inadequate. The assessment lacked sufficient analysis, contained contradictions, and failed to provide a clear rationale for the decisions made regarding SU3's eligibility for support. The panel found that Ms Robertson did not adequately assess SU3's needs, and the assessment was ultimately inadequate.

Service user 6

72. The panel carefully considered the evidence concerning the Assessment of Needs conducted by Ms Robertson for Service User 6 (SU6), who had been diagnosed with bipolar disorder. The assessment was tasked with determining the care and support needs of SU6. On the balance of probabilities, the panel found that Ms Robertson's assessment of SU6 was inadequate. The panel's decision was based on multiple issues, including Ms Robertson's failure to properly link SU6's mental health condition with their ability to complete daily tasks independently, a lack of a clear rationale in the conclusions drawn, and delays in completing the assessment in a timely manner.

73. Ms Stoica's written and oral evidence provided crucial insights into the failings of the assessment. Ms Stoica specifically highlighted that the assessment failed to demonstrate a clear link between SU6's mental health and physical condition and their inability to complete tasks independently. This was a critical issue, as it is necessary to establish such links in order to identify eligible needs under the Care Act. Ms Stoica's evidence also identified contradictions in the assessment, particularly in the section on nutritional needs, where the information was not presented in a coherent manner. Additionally, Ms Robertson failed to provide sufficient details in the 'Home Environment' section and inaccurately described the role of SU6's carers. The panel found that the lack of a clear rationale regarding the eligibility of needs, as pointed out by Ms Stoica, significantly undermined the quality and completeness of the assessment.
74. The panel considered the timeline for completing the assessment, which was a point raised by Ms Stoica during her supervision sessions with Ms Robertson. The assessment remained incomplete and in draft form as of 9 November 2021, despite being initiated on 5 August 2021. Although Ms Robertson stated she was waiting for information from the care coordinator, the panel found that this was an unreasonable delay, particularly since Ms Robertson already had access to a significant amount of relevant information through SU6's existing care agency support.
75. The panel concluded that the failure to complete the assessment in a timely manner could have potentially delayed the provision of necessary services for SU6. According to the Council's guidelines and the Care Act itself, assessments must be conducted in a timely and proportionate manner, and this was not the case in Ms Robertson's handling of the assessment.
76. The panel considered the evidence provided by Ms Stoica, reinforced these points. Ms Stoica explained that Ms Robertson failed to demonstrate the required knowledge of the Care Act and incorrectly identified which needs were eligible for care under the Act. In particular, Ms Stoica pointed out that Ms Robertson had concluded that SU6 only had one eligible need, despite the requirement for at least two needs to justify a care package. Additionally, the assessment was contradictory in its discussion of personal care, stating that SU6 had an eligible need because of a '*mental impairment somewhere*,' but later claiming that the need was not linked to mental health. These contradictions, as highlighted by Ms Stoica, further indicated a lack of clear analysis and justification in Ms Robertson's assessment.
77. The panel noted that by 19 November 2021, when Ms Robertson was still making amendments to the assessment, it was evident that the assessment remained incomplete, contained irrelevant information, and lacked a proper rationale when identifying eligible needs. The assessment was unclear as to whether SU6 could not

complete certain tasks, chose not to do them, or relied on others to do them for her. The panel found that Ms Robertson had also made an error in identifying SU6's eleven-year-old grandson as her carer, which further demonstrated a lack of attention to detail in the assessment process. The panel accepted Ms Stoica's evidence that if a need is assessed as having a significant impact on a service user's well-being, it should be considered an eligible need. Ms Robertson's failure to identify such needs correctly further contributed to the inadequacy of the assessment.

78. The panel concluded, on the balance of probabilities, that Ms Robertson's assessment of SU6 was inadequate. The assessment lacked the necessary analysis to establish clear links between SU6's conditions and their care needs, was completed after an unreasonable delay, and contained numerous contradictions and errors. The panel found that Ms Robertson's failure to apply the required professional standards and her inability to justify her conclusions resulted in an assessment that was inadequate.

Service User 8

79. The panel carefully considered the evidence regarding the Assessment of Needs conducted by Ms Robertson for Service User 8 (SU8), who was a woman in hospital and did not wish to engage with the assessment process. The assessment was intended to evaluate SU8's needs, including her ability to maintain her home environment and manage personal relationships. On the balance of probabilities, the panel found that Ms Robertson's assessment was inadequate due to multiple deficiencies, including a lack of comprehensive analysis, failure to properly assess SU8's needs, and a misunderstanding of her role and the Care Act process.
80. The panel considered that Ms Stoica's written and oral evidence played a crucial role in identifying these deficiencies. In particular, Ms Stoica's evidence highlighted that Ms Robertson failed to consider key aspects of SU8's situation. Despite the fact that the Service User was in hospital and reluctant to engage, Ms Stoica noted that the Social Worker did not effectively utilize other sources of information to complete the assessment. Ms Stoica provided clear guidance on how the assessment could have been more thorough, signposting to other avenues of information that should have been explored. This was indicative of Ms Robertson's failure to demonstrate the necessary initiative and understanding to properly complete an assessment in such a situation.
81. The panel found that Ms Stoica's evidence indicated that Ms Robertson's assessment lacked crucial details, particularly concerning SU8's ability to maintain her home environment. The Social Worker's assessment did not address this area at all, and her response to Ms Stoica's feedback demonstrated a lack of

understanding about the importance of including such information. The panel considered that Ms Robertson's failure to explore SU8's home environment undermined the thoroughness of the assessment, and her inability to identify necessary information to draw appropriate conclusions pointed to significant deficiencies in her practice.

82. The panel also found that Ms Robertson's conclusions regarding SU8's eligible needs were flawed. In particular, Ms Robertson's deemed needs related to maintaining the home environment and developing family and personal relationships as non-eligible, solely on the basis that SU8 did not want to return home. However, Ms Stoica's evidence stressed that this was an overly simplistic approach, and the panel agreed that it did not constitute sufficient reasoning for determining eligibility. At the same time, Ms Robertson deemed other needs as eligible without providing a clear rationale for those conclusions. This inconsistency in the assessment demonstrated a lack of careful analysis and professional judgment, further contributing to the assessment's inadequacy.
83. One of the most significant issues identified by the panel was Ms Robertson's failure to properly assess and understand the joint responsibility under Section 117 of the Mental Health Act, which mandates that care following discharge from a mental health hospital requires a collaborative effort between social care and health services. Ms Stoica's written and oral evidence emphasised that the Social Worker did not fully grasp this joint responsibility and was unclear on how aftercare services should be arranged.
84. The panel found that Ms Robertson's assessment was contradictory in this regard, as she appeared to suggest that SU8 could return home with support from the Care Coordinator, yet the application to the Supported Living Service was made by the Care Coordinator, not the Social Worker. The panel also found that Ms Robertson did not adequately inquire into or understand the nature of the supported living placement being considered for SU8, specifically the Peel Tower facility, which required joint funding from both the NHS and the Council. This lack of understanding and failure to engage with the multidisciplinary team was a significant oversight in the assessment process.
85. The panel considered that Ms Robertson made recommendations that lacked sufficient consideration of the broader context. For example, she suggested that SU8 rent a different property without addressing important factors such as SU8's existing financial commitments, including a mortgage with her husband. The panel accepted Ms Stoica's evidence that this recommendation was unrealistic and did not take into account SU8's family dynamics or financial situation.

86. The panel found that Ms Robertson's assessment of SU8 was inadequate. The assessment lacked the necessary depth, coherence, and professional analysis to identify SU8's eligible needs accurately. Furthermore, the Social Worker's failure to follow proper procedures under Section 117, as well as her failure to engage with relevant professionals and consider important factors in SU8's life, led the panel to conclude that the assessment was not conducted in accordance with the expected standards. The panel found Ms Stoica's evidence to be clear, consistent, and persuasive, and relied upon it in making its decision. On the balance of probabilities, the panel determined that Ms Robertson did not meet the required standard in conducting the Care Act assessment for Service User 8.

Service User 10

87. The panel thoroughly reviewed the evidence for The Care Act assessment completed by Ms Robertson for Service User 10 (SU10). Ms Robertson began her assessment on 12 August 2021 and submitted a version prior to 11 November 2021, with a later version dated 17 November 2021. The panel found several critical issues with the assessment process, which led to the conclusion that Ms Robertson's assessment of SU10 was inadequate. The panel applied the balance of probabilities' test and found that the assessment lacked clarity, consistency, and adequate rationale, particularly in relation to identifying SU10's eligible needs.
88. The panel considered that Ms Stoica's written and oral evidence was pivotal in demonstrating the significant flaws in Ms Robertson's assessment. In her written feedback to Ms Robertson dated 11 November 2021, Ms Stoica highlighted contradictions in the assessment, pointing out areas where the Social Worker stated that SU10 was independent in most aspects of life, while simultaneously using SU10's need for support as a justification for eligibility. Ms Stoica's evidence was clear that these contradictions were detrimental to the overall accuracy and reliability of the assessment. The panel found that Ms Stoica's evidence was thorough and provided compelling reasons why the assessment lacked coherence, particularly regarding the identification of SU10's needs and eligibility.
89. The panel found that during a supervision meeting on 16 November 2021, Ms Stoica again provided feedback to Ms Robertson on the assessment, pointing out omissions and inconsistencies. She noted that relevant information, such as the fact that SU10's father provided most of his care, was omitted from the assessment, while irrelevant details were included. Ms Stoica also observed that there was a lack of explanation for the rationale behind various decisions made in the assessment.
90. The contradictions in the assessment were a central issue in the panel's decision. Ms Robertson's failure to adequately reconcile her assessment of SU10's

independence with the identification of his needs for support undermined the validity of the assessment. The panel concluded that these contradictions reflected poorly on Ms Robertson's ability to analyse the situation thoroughly and provide a clear rationale for her conclusions. The panel noted that the lack of a contingency plan in the event that SU10's primary carer could not provide support, indicated a failure to adequately consider the potential risks and challenges faced by SU10.

91. The panel determined that the absence of a finalised draft of the assessment further compounded the issue. Ms Stoica confirmed that the assessment was never approved, and as a result, a different practitioner was allocated to complete the work. This final decision to cancel the assessment, coupled with the lack of a finalised document available for review, indicated that Ms Robertson's work was ultimately deemed inadequate for further processing. The panel found this to be a significant factor in its overall conclusion that Ms Robertson did not meet the professional standards expected in completing a Care Act assessment.
92. The panel concluded on the balance of probabilities that Ms Robertson's assessment of SU10 was inadequate. The panel found Ms Stoica's written and oral evidence to be reliable, consistent, and credible in highlighting the serious flaws in the assessment. The contradictions, omissions, and lack of a coherent rationale for the conclusions drawn led the panel to determine that Ms Robertson failed to meet the expected professional standards for completing an adequate Assessment of Needs for SU10.

Service User 14

93. The panel carefully considered the evidence for the Care Act assessment completed by Ms Robertson for Service User 14 (SU14), which raised significant concerns about its quality and completeness. The panel applied the balance of probabilities test and concluded that the assessment was inadequate due to various key deficiencies, as identified in the evidence provided by Ms Stoica.
94. One of the central issues identified by the panel was that Ms Robertson's assessment included summaries of case notes without making it clear who had authored these notes or whether the information was current. Ms Robertson failed to provide sufficient context or relevance for the information she had included, which made it difficult to understand the rationale behind her conclusions. Ms Stoica's written and oral evidence highlighted these deficiencies, pointing out that the failure to clarify the source and relevance of the information undermined the assessment's overall integrity. Ms Stoica's evidence was clear and compelling in explaining why this lack of clarity was problematic for both the assessment process and the outcome for SU14.

95. The panel found, in the section of the assessment related to 'Personal Care' that Ms Robertson had failed to provide a rationale for her statements, leaving the section insufficiently detailed and lacking necessary analysis. There was no clear link established between SU14's mental health difficulties and their inability to manage their personal care needs. Ms Stoica's evidence further corroborated this, as she indicated that the assessment lacked depth in connecting the Service User's mental health condition to their care requirements. Ms Stoica's written evidence also emphasised the importance of detailing such links to ensure that the assessment met the Care Act's requirements, and her oral evidence confirmed that this omission was a significant shortcoming.
96. The panel noted that in the 'Managing Toilet Needs' section, Ms Robertson referenced SU14's alcohol consumption, which was irrelevant to the issue at hand. The inclusion of this information without context or explanation diluted the focus of the assessment and made it unclear whether this was a contributing factor to SU14's difficulties. Ms Stoica's evidence further underscored this error, pointing out that such details were unnecessary and did not directly relate to SU14's needs in the context of the assessment. The panel determined that this inclusion was a clear deviation from the standards expected of a Care Act assessment.
97. The panel found that in the 'Maintaining a Comfortable Home' section, Ms Robertson again failed to provide sufficient relevant information or rationale for why SU14 was unable to maintain a home environment. This section lacked the depth and clarity needed to properly assess SU14's needs, and the panel found that the failure to adequately address this aspect of the assessment was another significant flaw. Ms Stoica's evidence, both written and oral, supported this conclusion, as she emphasised that the assessment should have provided a clear explanation of how SU14's circumstances prevented them from maintaining their home and what specific support was needed.
98. The panel determined that in the 'Accessing the Community' section, Ms Robertson inconsistently described SU14 as both 'independent' and needing support, without explaining this contradiction. The assessment failed to clarify what support SU14 required and why it was necessary. The panel found that this inconsistency reflected poorly on the quality of the assessment and Ms Robertson's ability to provide a clear and coherent rationale for her conclusions. Ms Stoica's evidence highlighted this inconsistency and confirmed that it undermined the validity of the assessment.
99. The panel concluded on the balance of probabilities, Ms Robertson's assessment of SU14 was inadequate. The assessment lacked sufficient detail, clear rationale, and consistency, which were necessary to demonstrate a proper understanding of

SU14's needs and eligibility for support. Ms Stoica's evidence was instrumental in identifying these deficiencies.

2. Failed to adequately assess the mental capacity of service users, in respect of one more cases, namely:

Service user SU7

Service user SU11

100. The panel carefully considered all the evidence and submissions in relation to the assessment of Service User (SU) 7 and Service User (SU) 11 conducted by Ms Robertson. After a thorough and detailed review of all the evidence, the panel concluded, on the balance of probabilities, that Ms Robertson failed to adequately assess the mental capacity of SU7 and SU11. The decision is based on a careful assessment of all the evidence, including Ms Stoica's oral evidence, which was compelling, clear, reliable, consistent, and corroborated with the other evidence.

Service User 7

101. The panel carefully considered all the evidence regarding the assessment of the mental capacity of Service User 7 (SU7) conducted by Ms Robertson. After a thorough review of the available documentation and all other evidence including oral evidence, the panel concluded, on the balance of probabilities, that Ms Robertson failed to adequately assess the mental capacity of SU7.
102. The panel noted that, during a supervision session on 9-10 November 2021, a plan was made for Ms Robertson to assess SU7's care, social needs, and capacity. The plan stated that SU7's capacity to engage with her care and support needs would need to be assessed by Ms Robertson. However, the panel found that Ms Robertson's approach to the capacity assessment was flawed.
103. The panel considered that Ms Robertson completed a Mental Capacity Assessment for SU7 on 15 November 2021, prior to conducting the Care Act assessment. The panel concluded that this sequencing was inappropriate. Capacity assessments should follow the identification of eligible needs through a Care Act assessment. The Care Act assessment is meant to identify a Service User's needs, and it is only after that that a capacity assessment can properly be carried out to determine whether the individual is able to make decisions about those needs. The panel found that Ms Robertson had not gathered sufficient information about SU7's needs

to assess her capacity accurately. Consequently, the Capacity Assessment could not properly consider SU7's capacity to engage with the plans, as her needs and the plans to address them had not yet been fully explored.

104. The panel found that Ms Robertson did not adequately address concerns raised by SU7's family and other professionals regarding her desire to move home rather than go into residential care. The assessment failed to consult key people or discuss their concerns with SU7. This was a significant oversight, as it was essential for Ms Robertson to assess whether SU7 understood the risks and benefits of moving home and whether she was capable of making an informed decision. The lack of consideration of the concerns raised by those around SU7 prevented Ms Robertson from properly testing her ability to understand and weigh the information needed to make a decision about her care.
105. The panel found that during the capacity assessment, Ms Robertson did not engage with other health and social care professionals involved with SU7's case. The panel found that this was a key failure, as input from other professionals would have provided a more comprehensive understanding of SU7's situation, particularly given her history of failed attempts to live at home. Ms Robertson did not seek to assess SU7's understanding of the risks surrounding her wish to move back home, nor did she test her ability to understand and use the information in making such a decision.
106. The panel noted that Ms Stoica, in her written evidence, provided clear feedback to Ms Robertson regarding these issues. Ms Stoica in her evidence expressed concerns that Ms Robertson had not sufficiently addressed the risks associated with SU7's discharge and the potential for harm if she returned home. Despite this feedback, Ms Robertson did not appear to adequately reflect on or address these concerns in her subsequent assessments. While Ms Stoica did allow Ms Robertson the opportunity to reassess the situation and repeat the capacity assessment, the second version of the capacity assessment, completed on 23 November 2021, still failed to address the critical issues raised by professionals and informal carers involved with SU7. The second assessment continued to overlook the concerns about SU7 returning home and did not demonstrate that Ms Robertson had tested SU7's ability to understand the risks involved.
107. The panel on balance of probabilities concluded that Ms Robertson's failure to properly assess SU7's mental capacity was a significant oversight. The lack of a thorough Care Act assessment prior to conducting the capacity assessment, the failure to address concerns raised by others, and the inadequate consideration of SU7's ability to understand and make decisions led the panel to conclude that Ms Robertson had not met the required standards in assessing SU7's mental capacity. The panel determined that Ms Robertson's assessment of SU7 was inadequate.

Service User 11

108. The panel carefully reviewed all the evidence and submissions concerning the Mental Capacity Assessment of Service User (SU) 11, which was conducted by Ms Robertson. After a detailed analysis of all the evidence, the panel concluded, on the balance of probabilities, that Ms Robertson failed to adequately assess the mental capacity of SU11, particularly in relation to his decision about whether to give his mother £5000 for a roof repair.
109. The panel noted that the assessment, dated 7 October 2021, involved evaluating SU11's capacity to make a decision about a significant financial transaction, as the Council was managing his money. While Ms Robertson acknowledged that SU11 had the ability to make decisions about small financial gifts, she did not adequately assess his capacity to handle a larger sum, such as £5000.
110. The panel found that Ms Robertson failed to provide or obtain sufficient information for SU11 to make an informed decision. Specifically, there was no evidence that she discussed with SU11 how much money he actually had or explained the financial implications of the decision. Ms Robertson did not ensure that SU11 understood the options available to him, nor did she adequately assess the risks and benefits of the decision.
111. The panel considered that Ms Robertson incorrectly assessed SU11 as having the capacity to decide not to give the £5000 to his mother. While SU11 ultimately chose not to give the money, the core issue was that the decision regarding his capacity was flawed. The panel concluded that Ms Robertson did not properly assess whether SU11 had the capacity to understand the consequences of such a decision, particularly given the potential implications of the local authority controlling his wider finances. The failure to assess his capacity appropriately meant that the potential impact on SU11's ability to manage his finances around making this large gift was not properly considered.
112. The panel noted that Ms Stoica discussed this matter during a supervision session on 19 November 2021, where the shortcomings in the capacity assessment were addressed. The panel found that the concerns raised by Ms Stoica were valid and well-founded. Following this, the capacity assessment was reallocated to a different professional, who concluded that SU11 lacked capacity to make the decision about the £5000, further reinforcing the panel's finding that Ms Robertson's assessment was inadequate.
113. The panel determined on the balance of probabilities that Ms Robertson failed to adequately assess the mental capacity of SU11. Her assessment lacked the

necessary depth, clarity, and consideration of relevant information, which ultimately led to an incorrect conclusion about SU11's capacity. This failure to properly assess capacity was a significant oversight in her duties, and the panel found, on the balance of probabilities, that Ms Robertson did not meet the required professional standards in this instance.

3.Failed to adequately and/or promptly assess and manage the risks to service users, in respect of one or more cases, namely:

Service user SU12

Service user SU3

Service user SU13

Service user SU4

Service user SU6

114. The panel carefully considered all the evidence and submissions in relation to the assessment of Service Users (SU) 12, 3, 13, 4, and 6, conducted by Ms Robertson. After a thorough and detailed review of all the evidence, the panel concluded, on the balance of probabilities, that Ms Robertson failed to adequately and promptly assess and manage the risks to these service users. The decision is based on a careful assessment of all the evidence, including Ms Stoica's oral evidence, which was compelling, clear, reliable, consistent, and corroborated with the other evidence.

Service User 12

115. The panel carefully reviewed all the evidence in relation to the assessment of Service User 12 (SU12) conducted by Ms Robertson. After a thorough analysis of the all the evidence before it, the panel concluded, on the balance of probabilities, that Ms Robertson failed to adequately and promptly assess and manage the risks to SU12 and found the assessment to be inadequate.
116. The panel noted that SU12 was known to services as a vulnerable individual, diagnosed with Emotionally Unstable Personality Disorder (EUPD), and had previously been referred to Adult Social Care twice due to safeguarding concerns.

On 9 July 2021, Ms Robertson was tasked with conducting an assessment for SU12. The assessment process was crucial in determining whether the referral should progress to a strategy meeting and in developing an initial risk management plan. However, the record progression audit for SU12 revealed that Ms Robertson's assessment submissions were rejected twice after initial reviews, and it was only on 9 August 2021 that a final version of the assessment was successfully submitted.

117. The panel found that during the supervision process, Ms Stoica provided clear and constructive feedback regarding Ms Robertson's assessment. In an email dated 11 July 2021, Ms Stoica pointed out that she could not approve Ms Robertson's work because the assessment had failed to address several important safeguarding concerns reported by Adult Social Care, most notably the allegation that SU12 had been forced to drink an unknown substance. This allegation, which was a central concern in the case, was not adequately addressed, and no risk management plan was provided to reduce the likelihood of similar incidents reoccurring.
118. The panel noted despite this information, Ms Robertson's assessment did not give sufficient weight to the severity of these concerns, particularly regarding the nature of the abuse, which was incorrectly identified by Ms Robertson. Instead of recognising the primary issue as potential physical abuse related to poisoning, she mistakenly added other inappropriate types of abuse and failed to prioritise the key safeguarding concern.
119. The panel concluded in addition to misidentifying the nature of the abuse, Ms Robertson's risk assessment failed to provide adequate justification for the conclusions drawn. She stated that four out of the five types of abuse identified were unlikely to reoccur, but she did not provide any rationale for this conclusion. Moreover, she failed to obtain SU12's views on the safeguarding concerns, nor did she assess the impact of the alleged abuse on SU12. This lack of engagement with SU12 and the failure to properly and promptly evaluate the potential risks further undermined the adequacy of the assessment.
120. The panel found that Ms Stoica's oral evidence, along with the written feedback provided in her written evidence, highlighted the significant gaps in Ms Robertson's approach to assessing and managing the risks for SU12. Her feedback was consistent and clear, identifying that key safeguarding issues had been overlooked, and the risk management plan was insufficient. The panel determined that Ms Robertson's failure to adequately address these issues, as well as the lack of proper justification and consideration in her assessment, demonstrated that she did not meet the required professional standards in safeguarding and risk management.
121. The panel concluded that Ms Robertson's assessment of SU12 was inadequate, and that she failed to assess and manage the risks to SU12 in a timely and effective

manner. The evidence provided by Ms Stoica, both in writing and orally, corroborated this conclusion, highlighting the deficiencies in Ms Robertson's approach to the case.

Service User 3

122. The panel carefully considered all the evidence in relation to the assessment of Service User 3 (SU3) conducted by Ms Robertson. After a thorough and detailed review of the available information, the panel concluded, on the balance of probabilities, that Ms Robertson failed to adequately and promptly assess and manage the risks to SU3 and found the assessment to be inadequate.
123. The panel noted SU3 had a diagnosis of Emotionally Unstable Personality Disorder (EUPD), and during the assessment process, she disclosed information that raised safeguarding concerns. Specifically, SU3 mentioned that her boyfriend had taken her to speak with his neighbour to explain that the emergency service's visit to his address was due to her self-harm, rather than any involvement of her boyfriend. This disclosure prompted Ms Robertson to identify potential risks, including emotional abuse, domestic abuse, disability hate crime, and discrimination. These concerns were serious and required careful investigation to ensure SU3's safety and well-being.
124. However, the panel found that the record progression audit for SU3 revealed significant shortcomings in Ms Robertson's assessment. Ms Robertson submitted her initial assessment on 8 July 2021, but this was rejected after review by Ms Stoica. In feedback dated 11 July 2021, Ms Stoica identified critical issues in the assessment, particularly the lack of rationale regarding the nature of the abuse. Specifically, there was no clear explanation provided by Ms Robertson for why the incident might constitute disability hate crime or discrimination, and no evidence or rationale was given as to whether the alleged perpetrator intended to cause harm. Moreover, Ms Robertson had highlighted a potential risk from SU3's boyfriend's neighbour, but again, failed to provide further justification or analysis regarding this concern.
125. The panel noted Ms Robertson's assessment lacked essential information. There was no evidence that she had considered previous safeguarding concerns, and crucially, there was no evidence that she had discussed with SU3 what her desired outcome was in relation to the safeguarding concerns. Despite indicating that a strategy meeting was not necessary, Ms Robertson contradicted this conclusion by noting that the safeguarding team had advised that it should proceed. The panel concluded that this inconsistency further undermined the reliability of her assessment. Additionally, the risk management plan was absent or poorly

developed, and SU3's views were not incorporated into the assessment, nor was there any clear evidence of discussion on how the risks would be mitigated.

126. The panel considered that Ms Stoica's evidence further highlighted the inadequacies in Ms Robertson's approach. She pointed out that the lack of rationale, the failure to incorporate SU3's views, and the insufficient development of a risk management plan were all significant failings that compromised the quality of the assessment. Ms Stoica's feedback was clear, consistent, and constructive, providing Ms Robertson with an opportunity to reassess and improve the assessment. However, despite these opportunities for improvement, the second submission, dated 23 July 2021, did not address these issues adequately and was deemed to have been insufficient.
127. The panel found that on the balance of probabilities Ms Robertson failed to adequately and promptly assess and manage the risks to SU3. The assessment was incomplete and lacked critical elements such as a thorough evaluation of the safeguarding concerns, appropriate rationale for identifying specific types of abuse, and a comprehensive risk management plan. The evidence provided by Ms Stoica, both in writing and orally, reinforced these findings and highlighted significant gaps in Ms Robertson's professional practice. The panel therefore concluded that Ms Robertson's assessment of SU3 was inadequate.

Service User 13

128. The panel carefully considered all the evidence in relation to the assessment of Service User 13 (SU13) conducted by Ms Robertson. After a thorough and detailed review of all of the evidence, the panel concluded, on the balance of probabilities, that Ms Robertson failed to adequately and promptly assess and manage the risks to SU13 and found the assessment to be inadequate.
129. The panel noted that SU13 had a diagnosis of Paranoid Schizophrenia and expressed concerns that her ex-partner had misused her bank account, benefit payments, and neglected her flat and pets while she was in a mental health hospital for three months. Ms Robertson was tasked with assessing these concerns and gathering the necessary information to determine the appropriate care and risk management plan for SU13.
130. The panel found that the record audit for SU13 revealed multiple failures in Ms Robertson's approach. She made three attempts to submit an Information Gathering Form for review by Ms Stoica, on 17, 19, and 23 March 2021, but each submission was rejected. Ms Stoica's evidence, highlighted that the form lacked relevant information and did not meet the expected standard for approval. In her

email dated 19 March 2021, Ms Stoica emphasised the need for professional judgment to be included in the risk management plan, stating that Ms Robertson should have provided her view on the risk of recurrence and specific actions taken to manage the risk, such as cancelling the bank card or breaking up with the alleged perpetrator. This feedback was clear and detailed, offering Ms Robertson an opportunity to amend her assessment and provide a more thorough evaluation of the risks involved.

131. The panel determined that despite this feedback, Ms Robertson failed to incorporate the required information into the revised submissions. In her email on 17 March 2021, Ms Stoica explicitly asked Ms Robertson to speak with SU13 to explain the safeguarding process and gather her views on what she wanted or did not want. Ms Stoica also emphasised the importance of completing the risk management plan and considering whether the case should proceed to a strategy meeting. However, Ms Robertson's response suggested that she had not engaged sufficiently with SU13 to discuss these critical aspects, nor had she provided a clear rationale for her conclusions or the risk management strategies in place.
132. The panel noted that in her further feedback on 17 March 2021, Ms Stoica reiterated that Ms Robertson needed to assess SU13's capacity to make decisions regarding the safeguarding concern, and to include SU13's views on whether or not she wanted police involvement. Despite these clear instructions, Ms Robertson did not adequately address these elements in the assessment. Ms Stoica's evidence confirmed that SU13's views were not fully incorporated, and the risk management plan was incomplete and lacked necessary details. Additionally, Ms Stoica's written and oral evidence highlighted that there was insufficient consideration of the information already available from the mental health consultants and coordinators, which should have informed the risk assessment process. The lack of relevant information in the risk assessment prevented a proper decision from being made about the care and safeguarding needs of SU13.
133. The panel found that Ms Robertson's failure to adequately assess the risks to SU13, her failure to engage with the service user effectively, and her inability to provide a comprehensive and professional assessment were significant shortcomings. The assessment was incomplete, lacked critical information, and did not include the necessary professional judgment or risk management strategies. This resulted in an inadequate assessment that failed to protect SU13's well-being and safeguard her from potential harm.
134. The panel determined on the balance of probabilities that Ms Robertson failed to adequately and promptly assess and manage the risks to SU13. Ms Stoica's evidence provided a clear and consistent account of the issues with the assessment, which reinforced the panel's findings. The panel concluded that the

assessment of SU13 was inadequate and did not meet the required professional standards.

Service User 4

135. The panel carefully considered all the evidence in relation to the assessment of Service User 4 (SU4) conducted by Ms Robertson. After a thorough review of all the available evidence, the panel concluded, on the balance of probabilities, that Ms Robertson failed to adequately and promptly assess and manage the risks to SU4 and found the assessment to be inadequate.
136. The panel considered that SU4, who had a diagnosis of Personality Disorder, was referred for assessment under the Care Act following a safeguarding referral, which indicated that SU4 may have been a victim of sexual abuse. On 17 June 2021, Ms Robertson was allocated to assess SU4's care and support needs. However, the evidence presented to the panel indicated significant failures in Ms Robertson's handling of the case.
137. The panel found that Ms Stoica's evidence made it clear that Ms Robertson had visited SU4 but had left the safeguarding forms in draft. There was no indication that Ms Robertson had followed up on the safeguarding referral or made any arrangements to address the matter with her senior colleagues. Instead, Ms Robertson went on annual leave without completing the necessary steps for the case. Ms Stoica discovered the safeguarding referral in Ms Robertson's electronic tray when she was looking to identify any cases requiring reallocation, after Ms Robertson requested an extension to her leave.
138. The panel noted that the record for SU4 included an annotation by Ms Stoica, which stated: *"Significant delay due to practitioner going on leave before the decision was made. The contact was re-loaded as Safeguarding enquiry 21603 and dealt with by a different practitioner"*. This annotation made it clear that Ms Robertson's failure to progress the case in a timely manner and failing to alert her manager that the assessment was unfinished before going on leave, led to unnecessary delays in addressing the safeguarding concerns for SU4. The case was eventually reallocated to another practitioner, who then took over the safeguarding inquiry.
139. The panel determined that Ms Stoica's evidence further corroborated the lack of urgency and attention to this case. Ms Stoica in her written evidence confirmed that the case was not managed promptly and that the failure to complete the safeguarding forms or consult with senior colleagues was a serious oversight. Ms Stoica highlighted that this delay meant that SU4's safeguarding concerns were not addressed in a timely manner, potentially putting SU4 at further risk of harm.

140. The panel found that Ms Robertson's failure to assess and manage the risks to SU4 in a timely manner was a clear lapse in professional duty. The safeguarding referral was not adequately acted upon before Ms Robertson's leave, which caused a significant delay in addressing the potential risks to SU4. The subsequent reallocation of the case to another practitioner underscores the inadequacy of Ms Robertson's handling of the matter.
141. The panel concluded that the delay in the assessment and lack of prompt action were critical failings in Ms Robertson's handling of the case. The failure to consult with senior colleagues, leaving the safeguarding forms incomplete, and the decision to go on leave without ensuring the safeguarding referral was identified as unfinished to her manager all contributed to an inadequate response to SU4's situation.
142. The panel concluded on the balance of probabilities that Ms Robertson failed to adequately and promptly assess and manage the risks to SU4. Ms Stoica's evidence provided compelling support for this finding, emphasising the significant delay and failure to act on the safeguarding concerns in a timely manner. The panel determined that the assessment was inadequate and did not meet the professional standards required to protect SU4.

Service User 6

143. The panel carefully considered all the evidence in relation to the assessment of Service User 6 (SU6) conducted by Ms Robertson. After a thorough review of all the evidence before it, the panel concluded, on the balance of probabilities, that Ms Robertson failed to adequately and promptly assess and manage the risks to SU6 and found the assessment to be inadequate.
144. The panel considered that SU6, who had a diagnosis of bipolar disorder, was referred for an assessment of needs, which was carried out by Ms Robertson. During her assessment, Ms Robertson noted that SU6's relationship with her husband was not good and provided some examples of issues within the relationship. These concerns were discussed further in a supervision session on 16 November 2021. However, despite identifying some difficulties in the relationship, Ms Robertson did not recognise the potential safeguarding issues, emotional abuse, or domestic abuse that might be present in SU6's situation.
145. The panel noted that Ms Stoica's evidence was crucial in highlighting the significant gaps in Ms Robertson's assessment. Ms Stoica in her evidence explained that while Ms Robertson had acknowledged the relationship difficulties, she had failed to identify the serious safeguarding concerns that were apparent. Specifically, Ms

Stoica emphasised that there was no indication in Ms Robertson's assessment that she had considered the possibility of domestic abuse or emotional abuse, despite the clear signs of an unhealthy and potentially harmful relationship. This failure to recognise and respond to potential abuse was a key omission in the assessment.

146. The panel found that when the case was later reallocated to a different practitioner, the safeguarding concerns were immediately identified. The new practitioner recognised the signs of emotional and domestic abuse, which should have been picked up during Ms Robertson's initial assessment. Ms Stoica's evidence made it clear that the failure to assess the potential risks of emotional and domestic abuse in SU6's relationship was a significant lapse in Ms Robertson's professional judgment.
147. The panel determined that Ms Stoica's evidence highlighted that a failure to adequately assess safeguarding concerns is a critical issue, particularly in cases where there is a history of vulnerability and mental health challenges, as was the case with SU6. She emphasised that safeguarding should have been a priority during the assessment, and the lack of attention to this raised serious concerns about the adequacy of Ms Robertson's practice.
148. The panel found that Ms Robertson's failure to recognise the safeguarding risks to SU6 and her inability to identify potential emotional and domestic abuse was a clear breach of professional responsibility. The fact that the issue was only identified after the case was reallocated further underlined the inadequacy of Ms Robertson's initial assessment.
149. The panel concluded on balance of probabilities that Ms Robertson failed to adequately and promptly assess and manage the risks to SU6. Ms Stoica's evidence was compelling in demonstrating that the safeguarding concerns were not appropriately addressed by Ms Robertson, and the failure to recognise the potential risks to SU6's safety and well-being was a significant oversight. The panel determined that the assessment was inadequate, failing to meet the required professional standards for safeguarding vulnerable individuals.

4. On 1 April 2022, you declared to Social Work England that you were unaware of any current allegation, investigation, proceedings, or order which may result in action being taken against you, when this declaration was:

false; and/or

intended to mislead

151. The panel carefully considered all the evidence before it in relation to the declaration made by Ms Robertson to Social Work England on 1 April 2022 on a voluntary removal application. Specifically, the panel assessed whether the declaration made by Ms Robertson that she was unaware of any current allegation, investigation, proceedings, or order which may result in action being taken against her was false, and whether it was intended to mislead.
152. After a thorough review of all the available evidence, including the oral evidence provided by Mr. Taylor, the panel concluded, on the balance of probabilities, that the declaration made by Ms Robertson on 1 April 2022 was indeed false and intended to mislead Social Work England.
153. The panel considered that the key issue in this matter was the fact that Ms Robertson was fully aware of the ongoing investigation into her fitness to practice at the time she submitted her Voluntary Removal application. The evidence presented to the panel showed that Ms Robertson was aware of the Capability Dismissal Meeting that had been convened by her employer, the Council. She had been informed of this through correspondence and was involved in responding to the scheduling of this meeting through her representative. Furthermore, the 23 March 2022 letter she received explicitly referred to the referral being made to Social Work England. Ms Robertson's last day of employment was set for May 2022, and the letter indicated that a referral to Social Work England was imminent.
154. The panel determined that despite being fully aware of the ongoing investigation and the imminent referral, Ms Robertson made the declaration to Social Work England on 1 April 2022 that she was unaware of any current allegation or proceedings that could lead to action being taken against her. This declaration was clearly false, as she had knowledge of both the investigation and the decision to refer her to Social Work England.
155. The panel found Mr. Taylor's oral evidence to be professional, credible, factual, and honest. Mr. Taylor provided a clear and detailed account of the process, including the timeline of events surrounding Ms Robertson's Voluntary Removal application. He explained that Ms Robertson was aware of the referral to Social Work England and the ongoing investigation. His evidence was pivotal in establishing that Ms Robertson's declaration was false, and it was clear from his testimony that the intention behind the false declaration was to mislead Social Work England into processing her application for Voluntary Removal, potentially to avoid any fitness to practice investigation or action being taken against her.

156. The panel further considered the submissions from Social Work England, which outlined that the Social Worker was aware of the investigation and the outcome of the Council's dismissal process. Ms Robertson's declaration to Social Work England that she was unaware of any current allegations or proceedings was clearly intended to mislead, as the nature of the ongoing investigation was such that a referral to Social Work England was inevitable. The panel noted that this application for Voluntary Removal appeared to have been made promptly to avoid any action by Social Work England, which could impact her fitness to practice.
157. The panel also took into account the fact that Ms Robertson's application for Voluntary Removal had been made on 1 April 2022, after the final outcome of the Council's investigation had concluded but before her final day at work. The timing of the application, combined with her false declaration, led the panel to conclude that Ms Robertson sought to avoid any potential consequences of the ongoing fitness to practice proceedings by misleading Social Work England.
158. In conclusion, the panel found, on the balance of probabilities, that the declaration made by Ms Robertson to Social Work England on 1 April 2022 was false and intended to mislead. Mr. Taylor's oral evidence was instrumental in demonstrating the falsity of the declaration, and the panel determined that Ms Robertson's actions were intended to avoid the potential impact of a fitness to practice investigation.

6. Your actions at paragraph 4 above were dishonest.

159. The panel has carefully considered the issue of dishonesty in relation to Ms Robertson's declaration to Social Work England on 1 April 2022. In light of the legal test established in *Ivey v Genting Casinos* [2017] UKSC 67, the panel applied the two-stage approach required to assess whether Ms Robertson acted dishonestly.
160. The first stage in the test required the panel to ascertain Ms Robertson's actual knowledge or belief as to the facts. In this case, the panel reviewed the evidence in full, including Ms Robertson's involvement in the Capability Dismissal Meeting, the communication she received on 23 March 2022 regarding the referral to Social Work England, and the fact that she was fully aware of the ongoing investigation into her fitness to practice.
161. The panel found that Ms Robertson had knowledge that the investigation was ongoing, she was aware of the Council's decision to refer her to Social Work England, and she was fully informed of the circumstances that led to this referral. Furthermore, her last day of employment had been set for May 2022, and she had already been involved in the process leading up to the referral. The panel was satisfied that, at the time of completing the Voluntary Removal application, Ms

Robertson was fully aware of the ongoing investigation, the nature of the allegations, and the referral to Social Work England. Thus, it was clear that Ms Robertson had the subjective belief that her declaration was false because she was aware of the facts surrounding her fitness to practice investigation and the referral to Social Work England.

162. The second stage of the test required the panel to apply the objective standards of ordinary decent people to determine whether her conduct was dishonest. The panel concluded that ordinary decent people would inevitably view Ms Robertson's conduct as dishonest. Ms Robertson's deliberate omission of the ongoing investigation and referral to Social Work England from her Voluntary Removal application was an attempt to conceal relevant facts from Social Work England. In doing so, she sought to gain an advantage by avoiding the scrutiny and potential consequences of a fitness to practice investigation.
163. The panel considered that ordinary, decent people would expect a professional social worker to be transparent and truthful when interacting with a regulatory body. In this case, Ms Robertson knew that Social Work England was likely to scrutinise her professional conduct, and by making a false declaration, she was attempting to manipulate the process for her own benefit. This conduct is inconsistent with the standards expected of a professional social worker, who is required to act with integrity and honesty, especially when engaging with a regulatory body.
164. The panel determined that ordinary, decent people would regard Ms Robertson's actions as dishonest because she deliberately misrepresented her awareness of the ongoing investigation and referral. Her intention was to mislead Social Work England into processing her application for Voluntary Removal, potentially to avoid any consequences that might result from the fitness to practice proceedings.
165. Having applied the subjective and objective tests outlined in *Ivey v Genting Casinos*, the panel found, on the balance of probabilities, that Ms Robertson acted dishonestly in making the false declaration to Social Work England on 1 April 2022. She was aware that the declaration was false, and ordinary decent people would regard her conduct as dishonest because she deliberately concealed the ongoing investigation and referral to avoid potential consequences.
166. The panel concluded that Ms Robertson's actions were dishonest and not in keeping with the professional standards expected of a social worker.

5. Failed to cooperate with Social Work England's fitness to practise investigation between May 2022 and January 2023

167. The panel carefully considered the evidence regarding Ms Robertson's failure to cooperate with Social Work England's fitness to practise investigation between May 2022 and January 2023. The relevant facts were reviewed, including Ms Robertson's communications and lack of engagement with the investigation. The panel applied the balance of probabilities test and determined that Ms Robertson did indeed fail to cooperate with the investigation.
168. The panel noted that Standard 6.7 of the Social Work England Professional Standards 2019 clearly states that a social worker must cooperate with any investigations by their employer, Social Work England, or another agency into their fitness to practise or the fitness to practise of others. This standard is crucial in maintaining the integrity of the regulatory process and ensuring public protection. Although there was some discussion as to whether Ms Robertson had renewed her registration at the appropriate time in 2021, she would have been aware of the requirement to cooperate with investigations since Social Work England assumed the regulation of social workers in December 2019.
169. The panel found that, despite these obligations, Ms Robertson failed to cooperate with the investigation. On 17 May 2022, Ms Robertson sent an email to Social Work England stating that she no longer wanted to be contacted. She informed Social Work England that she had cancelled her registration, was no longer employed as a social worker, and had no intention of returning to the profession. In her email, Ms Robertson also stated that she would treat any further communication from Social Work England as harassment and would take legal action if necessary. This communication was clear in its intention to halt engagement with the investigation entirely.
170. The panel determined that as a result of Ms Robertson's communication, the investigator, Mr. Taylor, had limited contact with her, he was only making contact, when necessary, under the rules. Ms Robertson's refusal to cooperate hindered the investigation, as no additional context or information was provided by her to address the concerns raised. Without this input, the investigation lacked a complete understanding of the situation, which may have affected the decisions made during the process.
171. The panel noted that cooperation from a social worker during an investigation is not only beneficial to the regulator but also to the social worker, as it allows for any relevant context or insight to be considered, potentially reducing the severity of the concerns. Ms Robertson's refusal to cooperate meant that the investigation proceeded without this input, making it more difficult to assess the full extent of the issues at hand. Moreover, her actions went beyond simply not cooperating; by attempting to end all communication and accusing Social Work England of

harassment, she obstructed the investigation and failed to meet her professional responsibility to engage with the process transparently.

172. On the balance of probabilities, the panel found that Ms Robertson failed to cooperate with the fitness to practise investigation. She actively chose not to engage with the process, as evidenced by her email, which indicated a deliberate attempt to cease all contact with Social Work England. This failure to cooperate constitutes a breach of Standard 6.7 of the Social Work England Professional Standards 2019, which obliges social workers to cooperate with investigations. The panel concluded that Ms Robertson's actions were contrary to the professional standards expected of a social worker and that her failure to cooperate undermined the regulatory process. The panel found Mr Taylor's oral evidence to be professional, honest, factual and reliable which played a vital role in its decision-making process.

Findings and decision on grounds

173. Mr Khan in his submissions invited the panel to find that the factual findings it had made amounted to misconduct on the part of Ms Robertson. He referred the panel to *Roylance v GMC [2000] 1 AC 311*, *Holton v General Medical Council [2006] EWHC 2960 (Admin)*, *Calhaem v General Medical Council [2007] EWHC 2606 (Admin)* and to those parts of Social Work England's Professional Standards which, he submitted, had been contravened. In particular:

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

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

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

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

3.3 Apply my knowledge and skills to address the social care needs of individuals and their families commonly arising from physical and mental ill health, disability, substance misuse, abuse or neglect, to enhance quality of life and wellbeing.

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

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

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

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

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

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

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

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

6.7 Cooperate with any investigations by my employer, Social Work England, or another agency, into my fitness to practise or the fitness to practise of others.

174. The panel heard and accepted the legal adviser's advice on misconduct and lack of competence. The panel understood from that advice that: -

- Whether facts proved or admitted amount to misconduct is a matter of judgment for the panel rather than a matter of proof. [*Council for the Regulation of Health Care Professionals v GMC and Biswas* [2006] EWHC 464].
- Misconduct is, in essence, a serious departure from the standards of conduct expected of social workers as professionals and what would be proper in the circumstances of the case. [*Roylance v General Medical Council (No.2)* [2000] 1AC]

- Whether a breach of professional rules should be treated as professional misconduct depended on whether it would be regarded as serious and reprehensible by competent and responsible [registrants] and on the degree of culpability. [*Solicitors Regulatory Authority v Day & ors* [2018] EWHC 2726 (Admin)].
- There is a high threshold of gravity for misconduct. Behaviour which is trivial, inconsequential, a mere temporary lapse or something otherwise excusable or forgivable does not constitute misconduct. [*Khan v Bar Standards Board* [2018] EWHC 2184(Admin)]
- The question of misconduct was a matter for its judgment and that appropriate standards of conduct should be judged with reference to Social Work England's Professional Standards. Not every departure from those Standards would necessarily amount to misconduct. The departure had to be sufficiently serious; whether any particular departure was sufficiently serious to be categorised as misconduct was a matter for the judgement of the panel. The panel had regard to Social Work England's Professional Standards.
- Lack of competence or capability is a separate and distinct category of impairment from misconduct. Lack of competence or capability suggests a standard of professional performance which is unacceptably low. It demonstrates that the social worker may lack the knowledge and skills to carry out their role in a safe and effective manner.
- Usually, Social Work England must demonstrate lack of competence or capability over a fair sample of a social worker's work. There is no set definition of 'fair sample'. It suggests a sample sufficient to show the social worker's usual standard of work over a period of time.

175. The panel conducted a thorough assessment of the allegations against Ms Robertson, evaluating each allegation found proved for lack of competence and/or misconduct and subsequent impairment of fitness to practice. In considering lack of competence, the panel considered that the number of cases before it amounted to a fair sample of Ms Robertson's work.

Allegation 1

176. After finding Allegation 1 proved, the panel considered the overall conduct and performance of Ms. Robertson, particularly in relation to her repeated failures in her role as a social worker. The panel carefully reviewed all the evidence, including the oral and written statements provided by witnesses, particularly Ms. Stoica and Mr. Ashworth. The panel concluded that Ms. Robertson's conduct in allegation 1, as

evidenced in her assessments of service users, clearly fell below the professional standards set by Social Work England. This persistent failure to meet these standards amounted to lack of competence.

177. The panel first considered Ms. Robertson's repeated failures to adequately assess the needs of service users, as evidenced in the cases of Service Users 1, 2, 3, 6, 8, 10, and 14. The panel found that her assessments were consistently incomplete, inaccurate, and contradictory. In many cases, Ms. Robertson failed to identify key needs, such as the impact of mental health on daily living and failed to make reliable recommendations for care and support. In the case of SU1, for example, her failure to identify the correct needs of the service user, including mental health support, alongside contradictions between findings of independence and the need for support, demonstrated an unreliable and inaccurate assessment. These failings showed a clear lack of professional judgment and an inability to apply the necessary frameworks and tools to assess service users effectively. The panel concluded that such conduct, where assessments are not completed to a professional standard, amounted to lack of competence.
178. The panel also took into account Ms. Robertson's failure to engage with feedback and guidance provided by her supervisor, Ms. Stoica. Despite receiving clear and constructive feedback on her assessments, Ms. Robertson repeatedly failed to take on board the feedback or make the necessary improvements. This demonstrated a lack of reflection and professional development, which are fundamental expectations in social work practice. The panel considered that Ms. Robertson's inability to apply feedback or show sustained improvement in her practice despite supervision and support indicated a lack of professional competence and a failure to take responsibility for her development. This disregard for professional feedback and her failure to improve her practice amounted to lack of competence.
179. Additionally, the panel considered Ms. Robertson's failure to complete her assessments in a timely manner. The panel found that her delay in completing the assessment for SU6 for several weeks resulted in unnecessary delays in providing the necessary care and support. Timeliness in completing assessments is crucial, particularly when service users are vulnerable and in need of immediate assistance. By failing to meet the required timelines, Ms. Robertson breached the professional standards set by Social Work England, specifically Standard 3.12, which mandates that social workers practice in a timely manner. The panel concluded that Ms. Robertson's delay in completing assessments and providing timely support for service users was a serious failure and amounted to lack of competence.
180. The panel further considered Ms. Robertson's lack of attention to detail in her assessments. For example, in the case of SU14, Ms. Robertson inaccurately identified a family member as a carer without properly investigating the situation.

This oversight, along with other instances of similar errors, highlighted Ms. Robertson's failure to demonstrate the necessary professional judgment and attention to detail required of a social worker. The inability to properly assess and identify key aspects of care needs, such as the role of carers, undermines the reliability of her assessments and poses potential risks to the well-being of service users. The panel found that this lack of attention to detail was a clear reflection of her inadequate professional competence and amounted to lack of competence.

181. The panel also considered Ms. Robertson's failure to meet several other Professional Standards outlined by Social Work England, including working in partnership with service users and their families (Standard 1.3), demonstrating empathy and professional confidence (Standard 2.4), and applying professional authority in line with legal and ethical frameworks (Standard 3.1). Ms. Robertson's continued failure to work effectively within the multidisciplinary team, her disregard for supervision, and her inability to engage with feedback all contributed to her failure to meet the core expectations of a social worker. These breaches of professional standards, along with her failure to demonstrate professional competence, were significant and amounted to lack of competence.
182. In conclusion, the panel found that Ms. Robertson's conduct and performance consistently failed to meet the professional standards required by Social Work England. Her repeated failure to adequately assess service users' needs, her disregard for feedback and supervision, her failure to complete assessments in a timely manner, and her lack of attention to detail all demonstrated significant deficiencies in her professional competence. These failings, when taken together, were found to amount to lack of competence.

Allegation 2

183. The panel carefully considered the evidence and its findings in relation to Allegation 2, which involved Ms. Robertson's failure to adequately assess the mental capacity of Service Users 7 (SU7) and 11 (SU11). The panel thoroughly examined all relevant documents, oral evidence, and submissions and concluded that Ms. Robertson's actions and omissions amounted to lack of competence, in breach of several Social Work England Professional Standards.
184. The panel first considered the case of Service User 7. Ms. Robertson was tasked with assessing SU7's mental capacity, but her approach was fundamentally flawed. She conducted a Mental Capacity Assessment on 15 November 2021 before completing a proper Care Act assessment, which is required to identify a service user's needs before any capacity assessment can be properly undertaken (Standard 3.1: Work within legal and ethical frameworks, using professional authority and judgement appropriately). This sequencing was inappropriate, as it

meant that Ms. Robertson did not have a full understanding of SU7's needs when assessing her capacity to make decisions about her care. The failure to follow this established process and gather sufficient information before conducting the capacity assessment demonstrated a lack of professional judgement, which is a significant breach of the standards expected of a social worker (Standard 2.4: Practice in ways that demonstrate empathy, perseverance, authority, professional confidence, and capability). This oversight amounted to lack of competence.

185. Additionally, the panel noted that Ms. Robertson did not engage with key individuals involved in SU7's care, including her family members and other professionals. These individuals had raised concerns about SU7's desire to return home instead of moving into residential care. Ms. Robertson failed to adequately assess whether SU7 understood the risks and benefits of this decision, nor did she test her ability to make an informed choice (Standard 1.3: Work in partnership with people to promote their well-being and achieve the best outcomes, recognising them as experts in their own lives). The failure to consult with others and consider the concerns raised about SU7's mental capacity to make this important decision was a significant oversight (Standard 3.2: Use information from a range of appropriate sources, including supervision, to inform assessments, analyse risk, and make professional decisions). This conduct reflects a failure to demonstrate professional curiosity and attention to the wider context, undermining the quality of the assessment and failing to safeguard the well-being of the service user, which is a breach of the professional standards expected (Standard 3.4: Recognise the risk indicators of different forms of abuse and neglect and their impact on people, their families and their support networks). Consequently, this failure amounted to lack of competence.
186. The panel considered that Ms. Robertson was given an opportunity to reassess SU7's capacity after receiving feedback from her supervisor, Ms. Stoica. Despite this, Ms. Robertson's second assessment, completed on 23 November 2021, still failed to address the concerns raised about SU7's ability to understand the risks associated with her decision to return home (Standard 4.2: Use supervision and feedback to critically reflect on, and identify my learning needs, including how I use research and evidence to inform my practice). This lack of improvement after feedback demonstrated a lack of responsibility for improving her practice, which is a fundamental expectation for professionals in the field (Standard 5.2: Behave in a way that would bring into question my suitability to work as a social worker). The continued failure to correct the issues raised indicated a disregard for the supervisory process and a lack of commitment to professional development, which further compounded the lack of competence.
187. Turning to Service User 11, the panel found that Ms. Robertson's assessment of his mental capacity was similarly inadequate. Ms. Robertson was tasked with

assessing SU11's capacity to make a significant financial decision, specifically whether to give £5000 to his mother for a roof repair. The panel noted that while Ms. Robertson assessed SU11's ability to make decisions about smaller gifts, she failed to adequately assess his capacity in relation to a much larger financial transaction. The panel found that Ms. Robertson did not explore the full financial context with SU11, including whether he understood the implications of making such a significant gift and the potential consequences for his wider financial management (Standard 3.3: Apply my knowledge and skills to address the social care needs of individuals and their families). This lack of thoroughness meant that the assessment of SU11's capacity was incomplete and flawed (Standard 3.1: Work within legal and ethical frameworks). By failing to fully explore these issues, Ms. Robertson did not meet the required professional standards, and this failure amounted to lack of competence.

188. The panel found that Ms. Robertson did not take sufficient steps to ensure that SU11 was provided with all the information necessary to make an informed decision. There was no evidence to suggest that Ms. Robertson discussed with SU11 how much money he had, nor did she explain the financial implications of his decision (Standard 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). This failure to ensure that SU11 understood his options and the risks involved in the decision was a significant oversight in her assessment process (Standard 2.4: Practice in ways that demonstrate empathy, perseverance, authority, professional confidence and capability). Her approach was lacking in depth and clarity, leading to an incorrect conclusion about SU11's capacity. The panel found that this failure to properly assess SU11's mental capacity reflected a lack of professional competence and attention to detail (Standard 3.11: Maintain clear, accurate, legible and up-to-date records, documenting how I arrive at my decisions), which amounted to lack of competence.
189. The panel considered that after receiving feedback from her supervisor, Ms. Stoica, regarding the shortcomings of the capacity assessment, Ms. Robertson did not properly reflect on or act upon the concerns raised (Standard 4.2: Use supervision and feedback to critically reflect on, and identify my learning needs, including how I use research and evidence to inform my practice). Despite the feedback, Ms. Robertson did not reassess SU11's capacity adequately, and the assessment was ultimately reallocated to another professional, who concluded that SU11 lacked the capacity to make the financial decision in question (Standard 3.12: Use my assessment skills to respond quickly to dangerous situations and take any necessary protective action). This further reinforced the panel's finding that Ms. Robertson had failed to meet the necessary professional standards in her initial assessment. Her failure to engage with supervision and take appropriate corrective action demonstrated a lack of responsibility and professional judgement (Standard

3.12: Use my assessment skills to respond quickly to dangerous situations and take any necessary protective action), amounting to lack of competence.

190. In conclusion, the panel determined that Ms. Robertson's conduct in Allegation 2 in relation to both Service User 7 and Service User 11 amounted to lack of competence. Her failure to conduct thorough, well-informed, and professional capacity assessments for both individuals, coupled with her failure to address feedback or reflect on her shortcomings, demonstrated a significant breach of the professional standards expected of a social worker. The panel concluded that Ms. Robertson's conduct in Allegation 2, specifically her inadequate assessment of the mental capacity of Service Users 7 and 11, amounted to lack of competence, in breach of the relevant Social Work England Professional Standards outlined above.

Allegation 3

191. The panel concluded that Ms Robertson's conduct in relation to allegation 3 amounted to lack of competence due to significant and repeated failures to meet professional standards, which compromised the safety and well-being of the service users SU12, SU3, SU13, SU4, and SU6.
192. The panel found that for SU12, Ms Robertson failed to conduct a thorough safeguarding assessment despite clear risks of abuse, such as the allegation that SU12 had been forced to drink an unknown substance. She did not adequately address the severity of the abuse or provide an appropriate risk management plan. This failure is in direct violation of Professional Standard 3.4, which requires social workers to recognise risk indicators of abuse and neglect and their impact. Additionally, her failure to prioritise this concern and offer a proper justification for her conclusions breaches Professional Standard 3.2, which requires social workers to use information from a range of appropriate sources, including supervision, to inform assessments and make professional decisions. This lack of timely and thorough assessment, along with her failure to take action, demonstrates a clear breach of the professional duty and amounts to lack of competence.
193. The panel determined that for SU3, Ms Robertson did not adequately address emotional and domestic abuse concerns despite disclosures that raised significant safeguarding issues. She failed to incorporate SU3's views, did not provide an adequate rationale for the concerns she raised, and did not develop a comprehensive risk management plan. This failure breaches Professional Standard 2.4, which requires social workers to practise with empathy, professionalism, and confidence, ensuring that the service user is involved in discussions and decision-making. Additionally, her failure to incorporate supervision and feedback to improve the assessment process breaches Professional Standard 3.2, as Ms Robertson did not use available information effectively to assess the risks and safeguard SU3. The

lack of a thorough evaluation of safeguarding risks and failure to incorporate SU3's views or develop an adequate plan of action amounts to lack of competence.

194. The panel concluded for SU13, Ms Robertson's assessment was incomplete, missing key information, and she did not adequately assess the risks or engage with the service user in a meaningful way. She did not consider SU13's capacity to make decisions, nor did she ensure that SU13's views were incorporated into the process, which directly breached Professional Standard 2.4, to work with people to enable full participation and discussion in decision making. Her failure to complete a thorough risk assessment, including considering previous safeguarding concerns and relevant information from other professionals, breached Professional Standard 3.1, which requires working within legal and ethical frameworks to make professional judgments. This failure to protect SU13 through a thorough assessment and subsequent action amounted to lack of competence.
195. The panel considered that in the case of SU4, Ms Robertson's failure to act promptly on the safeguarding referral, leaving crucial documents in draft and failing to follow up on the case, resulted in significant delays in addressing safeguarding concerns. This is a direct breach of Professional Standard 3.12, which requires social workers to respond swiftly to dangerous situations and take necessary protective actions. Moreover, her failure to notify her supervisor of the unfinished referral before going on leave, which led to the case being reallocated, further breached Professional Standard 3.9, as she failed to inform relevant colleagues of the risks in a timely manner. The lack of prompt action, proper follow-up, and the absence of appropriate communication within the team amounted to lack of competence.
196. The panel found that for SU6, Ms Robertson did not identify emotional or domestic abuse despite clear signs of relationship difficulties that she documented during the assessment. This failure to recognise and address safeguarding concerns breached Professional Standard 3.4, which emphasises the importance of identifying risk indicators of abuse and neglect. Furthermore, her failure to apply the knowledge and skills necessary to address safeguarding concerns, despite having the information available to do so, demonstrated a breach of Professional Standard 3.3, which requires social workers to apply their knowledge to address the care and safeguarding needs of individuals. The inability to adequately assess the potential risks to SU6's safety and well-being, despite being in a position to do so, amounted to lack of competence.
197. The panel concluded that in all these cases, Ms Robertson's repeated failure to meet the required professional standards, her inadequate assessments, lack of proper engagement with service users, and failure to take timely protective actions undermined her duty to safeguard vulnerable individuals. These failings show a pattern of poor practice and a consistent inability to meet the fundamental

responsibilities of a social worker. The panel concluded that these breaches of professional standards amounted to lack of competence, as they directly impacted the safety and well-being of the service users involved.

Allegation 4 and 6

198. The panel carefully considered the evidence and its findings relating to Ms Robertson's conduct and her declaration to Social Work England on 1 April 2022 in allegation 4. The panel concluded that Ms Robertson's conduct in making this false declaration amounted to misconduct. Social workers are expected to act with honesty and integrity, particularly when engaging with regulatory bodies such as Social Work England. Ms Robertson's failure to disclose the ongoing investigation, despite being fully aware of it, was a deliberate attempt to avoid scrutiny and the potential consequences of a fitness to practise investigation. This conduct was inconsistent with the ethical standards required of a social worker, and her actions were seen as an attempt to manipulate the process to her own benefit. Such behaviour is clearly in breach of the expectation that a social worker should act transparently and truthfully when interacting with regulatory bodies.
199. The panel considered the issue of dishonesty in relation to Ms Robertson's actions. Her deliberate omission of crucial information in her Voluntary Removal application was intended to deceive Social Work England and avoid the potential consequences of a fitness to practise investigation. It was clear that she sought to conceal the ongoing investigation in order to gain an advantage by having her application processed without the necessary scrutiny.
200. The panel further considered that social workers must uphold the highest standards of professionalism and integrity. Ms Robertson's attempt to mislead Social Work England about her awareness of the ongoing investigation undermines the public trust in the social work profession. Social workers are required to behave in a way that does not bring their suitability to practise into question, and Ms Robertson's dishonesty in this case clearly breaches this standard. Her conduct was not only misleading but also reflects a serious lack of transparency, which is incompatible with the responsibilities of a professional social worker and therefore amounted to misconduct.
201. The panel found that Ms Robertson's actions amounted to misconduct as they breached several core professional standards, including the requirement to behave honestly and transparently, and to act in a way that does not bring the profession into disrepute. Her dishonest behaviour was a serious failure to uphold the integrity expected of a social worker. As such, the panel determined that Ms Robertson's actions in allegation 4 in making the false declaration to Social Work England on 1

April 2022 constituted misconduct, a deliberate attempt to mislead, and was dishonest.

Allegation 5

202. The panel carefully examined all the evidence and its findings regarding Ms Robertson's failure to cooperate with Social Work England's fitness to practise investigation between May 2022 and January 2023. The key issue for consideration was whether Ms Robertson's conduct in this period of failure to engage meaningfully with the investigation amounted to misconduct. The panel reviewed Ms Robertson's communications with Social Work England, particularly her email dated 17 May 2022, in which she explicitly refused to cooperate, stating she no longer wished to be contacted and accusing Social Work England of harassment. The panel found that this email demonstrated a clear and deliberate attempt to halt any further engagement with the investigation, thereby failing to cooperate in the process. This failure to engage constitutes misconduct, as it directly obstructed the regulatory process and ignored her professional obligations.
203. The panel considered the facts, and the relevant standards outlined in the Social Work England Professional Standards. Standard 6.7 clearly states that a social worker must cooperate with any investigations into their fitness to practise or the fitness to practise of others, whether by their employer, Social Work England, or any other relevant agency. This standard is fundamental to ensuring the integrity of the regulatory process and safeguarding public trust in the profession. The panel noted that Ms Robertson would have been aware of her obligations under these standards, having been regulated by Social Work England over a significant period of time. Regardless of her employment status or registration status at the time, she was still subject to the regulatory requirements. Her failure to comply with this standard amounts to misconduct, as it represents a clear breach of professional conduct expected of social workers.
204. The panel concluded that Ms Robertson's refusal to cooperate with the investigation was a direct violation of this professional standard. By sending an email stating that she would treat further contact as harassment and would take legal action, if necessary, Ms Robertson effectively obstructed the investigation. This failure to engage with Social Work England's fitness to practise investigation prevented the regulator from obtaining any additional context or information that could have been vital in assessing the concerns raised. The panel recognised that cooperation in such investigations is essential not only for the regulator but also for the social worker, as it allows for the full range of circumstances to be considered, potentially mitigating the severity of any concerns. This deliberate obstruction of the investigation process constitutes misconduct, as it demonstrates a deliberate refusal to fulfil her professional responsibilities.

205. The panel found that Ms Robertson's refusal to cooperate went beyond a simple failure to engage as it was an active attempt to cease all communication and avoid participation in the process. Her actions in refusing to provide any further information or clarification on the concerns raised in the investigation hindered Social Work England's ability to conduct a comprehensive assessment of her fitness to practise. The panel considered that such behaviour undermined the regulatory process and reflected a disregard for the responsibilities expected of a professional social worker. Ms Robertson's failure to cooperate with the investigation amounts to misconduct, as it demonstrates an intentional disregard for the obligations set out in the professional standards.
206. The panel found that Ms Robertson's behaviour demonstrated a lack of professional responsibility and a failure to adhere to the standards expected of a social worker, especially with regard to cooperation with regulatory investigations. Her conduct amounted to misconduct as it hindered the proper functioning of the regulatory process and violated the professional obligations outlined in the Social Work England Professional Standards.
207. In conclusion, the panel determined that Ms Robertson's conduct in allegation 5 in failing to cooperate with Social Work England's fitness to practise investigation between May 2022 and January 2023 constituted misconduct. Her deliberate refusal to engage with the investigation, as evidenced by her communication on 17 May 2022, was a clear violation of Standard 6.7 of the Social Work England Professional Standards, which obliges social workers to cooperate with investigations. The panel found that her actions undermined the regulatory process and were not in keeping with the professional standards expected of a social worker, consequently, amounted to misconduct.
208. The panel found that in relation to allegations 1,2 and 3, that Ms Robertson's actions amounted to a lack of competence. In relation to allegations 4 and 5 the panel found that Ms Robertson's behaviour amounted to misconduct.

Finding and reasons on current impairment

209. Mr. Khan referred the panel to Social Work England's guidance on Impairment and invited the panel to make a finding of current impairment of fitness to practise by reason of misconduct. He emphasised that Ms Robertson's level of insight appeared to be poor, as she failed to acknowledge her personal responsibility. He further asserted that Ms Robertson demonstrated a notable lack of insight, as she consistently failed to recognise and accept her own personal responsibility in the matter at hand. Mr. Khan also submitted that the public interest required a finding of impairment to be made if the reputation of the profession and proper standards of

behaviour were to be upheld. He referred to the cases of *Cohen v General Medical Council*, *Council for Healthcare Regulatory Excellence v Nursing and Midwifery Council*, and *Grant*.

- The panel heard and accepted the advice of the legal adviser on impairment. That advice included reference to Social Work England's Impairment Guidance as well as the following points:
- The existence of impairment is a matter for the panel's own independent judgment or assessment and, in considering whether Ms Robertson's fitness to practise was impaired, the panel should take account of Social Work England's Impairment and Sanctions Guidance.
- According to the Impairment Guidance, a social worker is fit to practise when they have the skills, knowledge, character and health to practise their profession safely and effectively without restriction. If a panel decides that a social worker's fitness to practise is impaired, this means that it has serious concerns about the social worker's ability to practise safely, effectively, or professionally.
- As stated in *Meadow v General Medical Council [2006] EWCA Civ 1390*, the purpose of fitness to practise proceedings is not to punish the practitioner for past misdoings but to protect the public against the acts and omissions of those who are not fit to practise.
- The test for impairment, as set out by the court in *Council for Health and Regulatory Excellence v Nursing and Midwifery Council and Grant [2011] EWHC 927 (Admin)*, is whether the panel's finding of misconduct in respect of Ms Robertson indicated that her fitness to practise is impaired in the sense that she had in the past (a) put service users at unwarranted risk of harm; (b) brought the social work profession into disrepute; (c) breached one of the fundamental tenets of that profession; in each case, was liable to do so in the future.
- As stated in *Cohen v General Medical Council [2008] EWHC 581 (Admin)*, at the impairment stage the tribunal should take account of evidence and submissions that the conduct (a) is easily remediable, (b) has already been remedied and (c) is highly unlikely to be repeated.
- When assessing whether a finding of impairment is required in order to protect the health, safety and well-being of the public, the panel should consider the extent to which the social worker's conduct gave rise to harm, or a risk of harm and the likelihood of that conduct being repeated. Assessment of the risk of repetition involves consideration of (i) the social worker's previous history and their conduct since the concerns about their conduct arose and (iii) the extent to which they have

developed insight into their misconduct and (iii) the extent to which they have taken steps to remedy any failings on their part which led to that misconduct.

- A finding of personal impairment is usually not needed if (a) the social worker has understood the causes of, and learnt from, any mistakes or misjudgements; and (b) there is no risk of repetition. However, the panel should also consider whether a finding of impairment is required in order to maintain public confidence and proper professional standards (the so-called public component of impairment). Depending on the circumstances, a finding of impairment on these grounds can be necessary even where the social worker poses no current risk to the public.
- The legal adviser reminded the panel that impairment was to be judged at the present date and that the personal component of impairment involved a careful assessment of the risks of repetition of the misconduct. Regardless of this, however, the panel was also obliged to consider whether the public interest required a finding of impairment to be made on the basis that the absence of such a finding would undermine the reputation of the profession in the eyes of a reasonable and fully informed member of the public.

210. Having determined that the proved facts amount to lack of competence and misconduct, the panel considered whether Ms Robertson's fitness to practise is currently impaired. When considering the question of impairment, the panel took into account Social Work England's 'Impairment guidance'. The panel had regard to the questions posed by Dame Janet Smith in her fifth Shipman report endorsed in the case of *Council for Healthcare Regulatory Excellence v Nursing and Midwifery Council and Grant [2011] EWHC 927 Admin*. In light of its findings on misconduct the panel concluded that Ms Robertson had, in the past: a). acted so as to put a member of the public at unwarranted risk of harm; b). brought the profession of social work into disrepute; c). breached fundamental tenets of the social work profession (in relation to safeguarding the vulnerable).

Allegation 1

211. The panel, having found allegation 1 proved and considering the lack of competence identified, determined that Ms. Robertson's fitness to practice was and remains impaired, as her conduct raises serious concerns about her ability to practise safely, effectively, and professionally.
212. In making this determination, the panel took into account the nature and extent of Ms. Robertson's failures in her assessments. The panel found that her assessments were consistently incomplete, inaccurate, and contradictory. Her failure to identify key service user needs, including the impact of mental health on daily living, and her failure to make reliable recommendations for care and support, demonstrated a clear lack of professional judgement and competence. These failings placed service

users at unwarranted risk of harm by failing to provide accurate assessments and proper care recommendations, thus undermining the safe and effective delivery of social work services. As a result, the panel concluded that Ms. Robertson's fitness to practise was and is currently impaired. Furthermore, the panel noted Ms. Robertson's failure to engage constructively with feedback and guidance provided by her supervisor, Ms. Stoica. Despite receiving clear and constructive feedback on her work, she failed to revise her assessments or demonstrate any significant improvement. This lack of engagement with professional development and failure to take responsibility for her shortcomings pointed to a lack of insight and ongoing incompetence in her practice. The panel was concerned that Ms. Robertson's disregard for professional guidance and her failure to learn from her mistakes suggested that her fitness to practise is currently impaired.

213. The panel also took into account Ms. Robertson's failure to complete assessments in a timely manner, particularly in the case of SU6, where unnecessary delays were caused in providing essential support to the service user. Timeliness is a critical aspect of social work practice, particularly when vulnerable individuals are involved. By failing to meet the necessary deadlines, Ms. Robertson's actions delayed the provision of care and support to those in need, breaching the professional standards of Social Work England and demonstrating serious deficiencies in her practice. This failure to act promptly and responsibly contributed further to the panel's finding of impairment.
214. Additionally, the panel noted Ms. Robertson's lack of attention to detail in her assessments, which was evident in the case of SU14, where she inaccurately identified a family member as a carer without proper investigation. This oversight, along with other similar errors, reflected Ms. Robertson's failure to exercise the necessary professional judgement and attention to detail required of a social worker. The panel found that this lack of attention to detail undermined the reliability of her assessments and posed a risk to the well-being of service users.
215. The panel further considered that Ms. Robertson's conduct demonstrated a consistent failure to meet several core professional standards outlined by Social Work England. Her repeated inability to work effectively with service users, collaborate with multidisciplinary teams, and demonstrate empathy and professional confidence indicated a pattern of professional deficiencies. These failures, which were not limited to isolated incidents, signified a breach of fundamental social work standards and reflected a lack of the necessary skills, knowledge, and professional competence to practise safely and effectively.
216. In assessing whether Ms. Robertson's fitness to practise is impaired, the panel considered the guidance set out in *Cohen v General Medical Council* [2008] EWHC 581 (Admin), which requires the panel to determine whether the lack of competence

poses a risk of harm to service users, brings the profession into disrepute, or undermines the fundamental tenets of the profession. The panel found that Ms. Robertson's conduct clearly placed service users at risk of harm due to her inadequate assessments and failure to act in a timely manner. Moreover, her failure to demonstrate the requisite professional judgement and competence brought the reputation of the social work profession into question. These failings also breached the core values of the profession, including working in partnership with service users, demonstrating empathy and professional authority, and maintaining competence through ongoing development.

217. The panel also considered whether Ms. Robertson's failings were remediable, as set out in the *Cohen* case. While it acknowledged that some of her failings could be addressed with further training and development, the panel was concerned that Ms. Robertson had demonstrated a lack of insight into the severity of her actions and had failed to take appropriate steps to address her shortcomings. Given her failure to engage with feedback and her lack of sustained improvement, the panel was not satisfied that the risk of repetition was low. Therefore, the panel concluded that her fitness to practise is impaired.
218. The panel considered the public interest in making a finding of impairment. It noted that the public expects social workers to adhere to high professional standards and to act in the best interests of service users. The panel found that, in Ms. Robertson's case, a finding of impairment was necessary to protect the public and uphold the reputation of the profession. Ms Robertson's repeated failures and lack of insight meant that public confidence in the profession would be undermined if no impairment were found.
219. In conclusion, the panel determined that Ms. Robertson's fitness to practise is currently impaired due to her lack of competence. The panel found that her conduct had put service users at risk of harm, brought the profession into disrepute, and breached fundamental professional standards. The panel also found that Ms. Robertson's lack of insight and failure to address her shortcomings suggested that there was a risk of repetition. Consequently, the panel concluded that Ms. Robertson's fitness to practise is impaired, both to protect the public and to maintain public confidence in the social work profession.

Allegation 2

220. The panel, having carefully considered all the evidence, its findings, and the relevant law, concluded that Ms. Robertson's fitness to practise as a social worker is impaired. This decision is based on her lack of competence related to Allegation 2 concerning her failure to adequately assess the mental capacity of Service Users 7 (SU7) and 11 (SU11).

221. In determining whether Ms. Robertson's fitness to practise is impaired, the panel applied the guidance set out in Social Work England's Impairment and Sanctions Guidance. The panel considered whether Ms. Robertson's lack of competence in relation to her assessments put service users at risk of harm, brought the profession into disrepute, or breached fundamental tenets of the profession, and whether there is a risk of repetition of the lack of competence in the future.
222. The panel concluded that Ms. Robertson's lack of competence in this case, particularly her failure to perform thorough and accurate mental capacity assessments, put service users at risk of harm by not ensuring that their decision-making abilities were properly assessed, which could have resulted in inappropriate decisions being made about their care and well-being. This lack of competence also brought the profession into disrepute and breached fundamental professional standards relating to competence, judgment, and responsibility.
223. The panel took into account the risk of repetition of Ms. Robertson's lack of competence. The panel considered that while she had received feedback and supervision, she failed to demonstrate the necessary insight into her shortcomings or to take adequate corrective actions. The continued failure to improve her practice despite clear feedback indicated a risk that similar issues may recur in the future. The panel concluded that Ms Robertson's fitness to practise is impaired due to her failure to develop insight and make improvements.
224. The panel also considered whether a finding of impairment was required to protect the public and maintain public confidence in the profession. The public interest in upholding professional standards and ensuring that social workers practise competently and safely outweighed any individual mitigating factors. A finding of impairment was necessary to maintain the reputation of the profession and ensure that future harm was prevented.
225. The panel concluded that Ms. Robertson's fitness to practise is currently impaired. Her lack of competence, including her failure to adequately assess mental capacity, failure to engage with supervision, and lack of professional development, raised serious concerns about her ability to practise safely, effectively, and professionally. The panel found that her actions put service users at risk of harm and undermined public confidence in the profession. Therefore, the panel decided that Ms. Robertson's fitness to practise is impaired.

Allegation 3

226. The panel considered Ms. Robertson's lack of competence in allegation 3 and found that due to her repeated failures to meet professional standards, which

compromised the safety and well-being of service users, her fitness to practice is impaired.

227. Considering Service User 12 (SU12), the panel found that Ms. Robertson failed to conduct a thorough safeguarding assessment despite clear signs of abuse, such as an allegation that SU12 had been forced to drink an unknown substance. Her failure to appropriately assess and manage the risks, coupled with her lack of engagement with relevant information and supervision, resulted in a breach of the professional standards. This conduct demonstrates a lack of professional judgment and decision-making ability, which is a serious concern regarding her ability to practise safely and effectively. According to the case of *Council for Health and Regulatory Excellence v Nursing and Midwifery Council and Grant* [2011] EWHC 927 (Admin), the test for impairment involves assessing whether the social worker's conduct in the past has placed service users at unwarranted risk of harm. The panel found that Ms. Robertson's failure to safeguard SU12 reflects a lack of competence, raising significant concerns about her ability to practice safely. Therefore, the panel concluded that Ms. Robertson's fitness to practise is impaired due to concerns about her competence and decision-making.
228. The panel determined that for Service User 3 (SU3), Ms. Robertson failed to adequately assess emotional and domestic abuse concerns despite disclosures raising safeguarding issues. Her failure to incorporate SU3's views, the lack of proper assessment of risks, and the absence of an adequate risk management plan, directly breached the professional standards expected of a social worker. The failure to act appropriately when faced with emotional and domestic abuse concerns is a significant lapse in her duty of care. In line with *Cohen v General Medical Council* [2008] EWHC 581 (Admin), the panel considered whether the conduct was easily remediable or had been addressed. Given the ongoing nature of her failures and her lack of meaningful engagement with supervision to address these issues, the panel found that Ms. Robertson's lack of competence indicates a serious and persistent risk of harm. Therefore, her fitness to practise is impaired due to concerns regarding her failure to act effectively and her lack of remediation in response to feedback.
229. The panel found in relation to Service User 13 (SU13), Ms. Robertson's incomplete assessment, failure to engage with the service user, and lack of consideration for SU13's capacity to make decisions resulted in a breach of key professional standards. Her failure to apply her knowledge and skills appropriately and to consider relevant information regarding safeguarding concerns further demonstrated a lack of professional competence. This failure to assess risks adequately has the potential to place service users at risk of harm, which is why the panel concluded that Ms. Robertson's fitness to practise is impaired. As discussed in *Meadow v General Medical Council* [2006] EWCA Civ 1390, the purpose of fitness

to practise proceedings is to protect the public and ensure the social worker's actions do not put service users at risk. The panel found that her failures show a lack of personal accountability and judgment, raising concerns about her ability to provide safe and effective care in the future.

230. The panel considered that with regard to Service User 4 (SU4), Ms. Robertson's failure to act promptly on a safeguarding referral, leaving key documents incomplete, and her failure to inform relevant colleagues about the risks, breached the professional standards expected of her. This lack of timely action and poor communication resulted in significant delays in addressing safeguarding concerns. Such behaviour is not only a breach of professional standards but also demonstrates a lack of urgency and responsibility in safeguarding vulnerable individuals. According to the test for impairment in *Council for Health and Regulatory Excellence v Nursing and Midwifery Council and Grant [2011] EWHC 927 (Admin)*, the panel assessed whether the conduct demonstrated a risk to service users. The panel concluded that her failure to act swiftly and ensure proper follow-up undermined her fitness to practise, indicating concerns about her ability to respond appropriately in high-stakes situations. Consequently, the panel found Ms. Robertson's fitness to practise is impaired based on her inability to manage risk effectively and safely.
231. The panel found that for Service User 6 (SU6), Ms. Robertson failed to recognise emotional or domestic abuse despite clear signs during her assessment. Her inability to identify these safeguarding concerns directly breached professional standards that require social workers to apply their knowledge and skills to safeguard vulnerable individuals. The panel found that this was a fundamental failure in her professional practice, raising concerns about her competence and attention to the welfare of service users. As stated in *Council for Health and Regulatory Excellence v Nursing and Midwifery Council and Grant [2011] EWHC 927 (Admin)*, the panel must consider whether such failures would pose a risk of harm in the future. Given Ms. Robertson's failure to identify safeguarding concerns despite being in a position to do so, the panel concluded that her fitness to practise is impaired due to concerns about her ability to meet the professional standards required of her.
232. The panel also considered the public element of impairment, which is concerned with whether Ms. Robertson's continued ability to practise could undermine public confidence in the social work profession. The repeated and significant failures to meet professional standards, including inadequate safeguarding assessments and a lack of timely action to protect service users, demonstrate a pattern of poor practice that could seriously erode public trust in social workers. The public has an expectation that social workers will act in a professional, competent, and safe manner when safeguarding vulnerable individuals, and Ms. Robertson's conduct

undermines this expectation. The panel determined that a finding of impairment is necessary to maintain public confidence in the social work profession.

233. The panel concluded that Ms. Robertson's fitness to practise is impaired due to both personal and public concerns. Her repeated failures to meet professional standards and her lack of effective action in safeguarding vulnerable service users demonstrate a pattern of behaviour that calls into question her ability to practise safely and effectively. The panel determined that her actions not only placed service users at risk but also undermined public confidence in the profession. In line with the guidance from *Council for Health and Regulatory Excellence v Nursing and Midwifery Council and Grant [2011] EWHC 927 (Admin)*, the panel concluded that her fitness to practise is impaired, and that this finding is necessary to protect the public and uphold the reputation of the social work profession.

Allegation 4

234. The panel considered all the evidence and its findings regarding Ms. Robertson's conduct in relation to the false declaration made to Social Work England on 1 April 2022, as outlined in allegation 4. Ms. Robertson's actions in failing to disclose the ongoing investigation, despite being fully aware of it, were a deliberate attempt to avoid scrutiny and potential consequences. Social workers are required to act with honesty and integrity when engaging with regulatory bodies such as Social Work England. Her omission of critical information from her Voluntary Removal application was intended to manipulate the process for personal benefit. This deliberate attempt to mislead the regulatory body represents a clear breach of the professional standards set for social workers, which demand transparency and truthfulness. Given the severity of this misconduct, the panel concluded that Ms. Robertson's fitness to practise is impaired.
235. In examining the issue of dishonesty, the panel found that Ms. Robertson's actions demonstrated a serious failure to maintain the integrity expected of a social worker. By deliberately omitting important information, she sought to conceal the ongoing investigation and gain an advantage by avoiding the scrutiny that would come with a fitness to practise investigation. This conduct undermines the public trust in the social work profession, which relies on professionals acting transparently and truthfully in all dealings. As her actions were inconsistent with the ethical and professional standards required of a social worker, the panel determined that Ms. Robertson's fitness to practise is impaired.
236. The panel also considered the implications of Ms. Robertson's dishonest conduct in relation to the test for impairment set out in *Council for Health and Regulatory Excellence v Nursing and Midwifery Council and Grant [2011] EWHC 927 (Admin)*. The test for impairment involves assessing whether Ms. Robertson's misconduct

has put service users at unwarranted risk, brought the profession into disrepute, or breached fundamental tenets of the profession. Although her actions did not directly harm service users, they clearly brought the social work profession into disrepute and breached one of the fundamental tenets—acting with honesty and integrity. Her conduct was incompatible with the responsibilities of a social worker, and therefore, the panel concluded that Ms. Robertson’s fitness to practise is impaired.

237. The panel considered the personal component of impairment as set out in *Cohen v General Medical Council [2008] EWHC 581 (Admin)*. The panel reviewed whether Ms. Robertson’s misconduct was easily remediable, had been remedied, or was unlikely to be repeated. The panel found no evidence that Ms. Robertson had demonstrated sufficient insight into the seriousness of her actions or taken any meaningful steps to remedy her dishonest conduct. Acts of dishonesty are difficult to remediate as they indicate an attitudinal issue. Her failure to acknowledge the gravity of her actions and to take appropriate steps to prevent their recurrence led the panel to conclude that her fitness to practise is impaired. This lack of insight and remediation indicates that the risk of repetition remains, further supporting the panel’s decision.
238. The panel considered the public interest element of impairment. It is important to maintain public confidence in the social work profession, as the public expects social workers to act with the utmost integrity and transparency. The panel concluded that allowing Ms. Robertson to continue practising without a finding of impairment would undermine the public’s trust in the profession. Even in the absence of a direct risk to service users, Ms. Robertson’s dishonesty was a serious breach that could erode the reputation of the social work profession. Therefore, the panel determined that a finding of impairment was necessary to protect public confidence in the profession and maintain the ethical standards required of all social workers.
239. The panel assessed all the factors outlined above, including Ms. Robertson’s dishonesty, lack of insight, and failure to take corrective action. As her actions breached fundamental professional standards, brought the profession into disrepute, and have not been remedied, the panel determined that Ms. Robertson’s fitness to practise is impaired. This decision was made not only to protect the public but also to ensure that the social work profession maintains its reputation for professionalism and integrity. Consequently, the panel concluded that Ms. Robertson’s fitness to practise is impaired.

Allegation 5

240. The panel carefully reviewed all the evidence and its findings regarding Ms. Robertson's failure to cooperate with Social Work England's fitness to practise investigation between May 2022 and January 2023. In her email dated 17 May 2022, Ms. Robertson explicitly refused to cooperate, stating that she no longer wished to be contacted and accusing Social Work England of harassment. The panel found that this email demonstrated a deliberate attempt to halt any further engagement with the investigation, constituting a failure to cooperate. Given her professional obligations, this misconduct was an obstruction of the regulatory process and a clear violation of her duties as a social worker. Consequently, the panel concluded that Ms. Robertson's fitness to practise is impaired.
241. In reaching this decision, the panel applied the test for impairment outlined in *Council for Health and Regulatory Excellence v Nursing and Midwifery Council and Grant [2011] EWHC 927 (Admin)*. This test requires the panel to assess whether Ms. Robertson's conduct in failing to cooperate with the investigation has put service users at unwarranted risk of harm, brought the profession into disrepute, or breached fundamental tenets of the profession. While her actions did not directly harm service users, they did bring the social work profession into disrepute by obstructing the regulatory process. Her failure to cooperate with the investigation also constituted a breach of a fundamental tenet of the profession and cooperation with regulatory bodies. Given the nature of the misconduct and its potential to undermine the regulatory process, the panel concluded that Ms. Robertson's fitness to practise is impaired.
242. The panel also considered the personal component of impairment, in line with the principles established in *Cohen v General Medical Council [2008] EWHC 581 (Admin)*. This requires the panel to evaluate whether Ms. Robertson's misconduct is remediable, whether she has taken steps to remedy it, and whether the risk of repetition is low. The panel noted that there was no evidence to suggest that Ms. Robertson had shown insight into her misconduct or taken any steps to rectify her actions. Her failure to engage with the investigation and her refusal to cooperate remained unresolved, and there was no indication that she had taken meaningful steps to address the underlying issues. The panel therefore found that the risk of repetition remained, and this further supported the conclusion that Ms. Robertson's fitness to practise is impaired.
243. The panel also considered the public interest component of impairment. In this case, Ms. Robertson's misconduct undermined the regulatory process and violated key professional standards. If allowed to continue without consequence, her actions could erode public trust in the profession. Therefore, the panel concluded that a finding of impairment was necessary not only to protect the public but also to maintain the reputation of the social work profession.

244. The panel determined that Ms. Robertson's conduct in failing to cooperate with Social Work England's fitness to practise investigation between May 2022 and January 2023 was detrimental to the integrity of the profession, consequently, the panel found that Ms. Robertson's fitness to practise is impaired. This decision was made to protect the public, maintain public confidence, and uphold the professional standards required of social workers.
245. In conclusion, the panel was satisfied that a finding of current impaired fitness to practise, based on all allegations in their entirety, was necessary to protect the public. It considered that reasonable and well-informed members of the public would be shocked by Ms Robertson's inappropriate conduct. The misconduct and lack of competence involved breaches of fundamental tenets of social work, and the panel concluded that professional standards would not be promoted or maintained unless there was a finding that Ms Robertson's fitness to practise is currently impaired. This conclusion was particularly pertinent when considering the panel's assessment of her lack of insight and the absence of any meaningful remediation.
246. The seriousness and repeated nature of her misconduct and lack of competence, which included dishonesty and a failure to assess adequately and progress a significant volume of safeguarding work for which she had been unable to provide a coherent explanation, posed a considerable risk to vulnerable individuals. Furthermore, it undermined the integrity of the social work profession. The lack of insight into her dishonesty, failure to cooperate with the investigation by Social Work England coupled with the risk of repetition, led the panel to conclude that Ms Robertson's fitness to practise is currently impaired.
247. The panel found that this determination was necessary not only to protect the public but also to maintain public confidence in the profession and uphold the standards expected of social workers. Therefore, the panel concluded that, due to Ms Robertson's misconduct, a finding of current impairment of fitness to practise was required to protect the public, promote and maintain public confidence in the social work profession, and uphold the proper standards of conduct and behaviour.

Decision and reasons on sanction

248. Mr. Khan made submissions on sanction. He submitted to the panel that, in determining the appropriate sanction, it was important to consider both the aggravating and mitigating factors, and then to assess the range of available sanctions, starting with the least severe and escalating only if warranted.

249. In relation to the aggravating features, Mr. Khan submitted that there was a clear pattern of behaviour exhibited by Ms Robertson over a period of at least 12 months, involving multiple vulnerable service users. Despite the high level of support and supervision provided to Ms Robertson, this pattern persisted. He further highlighted that there was no evidence to suggest any insight on the part of Ms Robertson regarding her actions, nor any indication of remorse. In fact, during her early interactions with Social Work England, Ms Robertson appeared to blame the regulator for the circumstances in which she now finds herself.
250. Mr. Khan also drew attention to Ms Robertson's failure to engage meaningfully with the proceedings. She had provided no evidence of remediation, or any steps taken to address her failings. This disengagement, compounded by her attempts to deflect blame onto the regulator and her supervisors, demonstrated a profound lack of accountability and a failure to recognise the harm her actions may have caused. As a result, Mr. Khan submitted that the risk of harm remained significant. He further submitted that there were no mitigating circumstances in this case.
251. In considering the available sanctions, Mr. Khan submitted that taking no further action, issuing advice, or imposing a warning would be entirely inappropriate, given the seriousness of the conduct and the risk to the public should Ms Robertson be allowed to continue to practise without restriction. Ms Robertson had expressly stated in her correspondence with Social Work England that she no longer wished to practise as a social worker and had shown no inclination to cooperate with the regulator. Therefore, he argued, it was highly unlikely that she would comply with any conditions that the panel might impose. Whilst suspension could have been an option, Mr. Khan argued that there was no evidence to suggest that Ms Robertson had gained any insight into her actions or was willing to remedy her failings. Consequently, suspension was not a suitable course of action.
252. Mr. Khan submitted that the only appropriate and proportionate sanction given Ms Robertson's significant failings, lack of insight, and failure to engage with the regulator in this case was a removal order. Ms Robertson's conduct and performance had consistently failed to meet the requisite standards, and her actions had demonstrated significant deficiencies in professional competence. Furthermore, her dishonesty in omitting crucial information from her voluntary removal application was indicative of the gravity of her misconduct. As dishonesty is considered one of the most serious forms of misconduct, Mr. Khan submitted that the only viable sanction in this case was removal from the register. Such a sanction, he argued, was necessary to protect the public and maintain the integrity of the social work profession.
253. The panel accepted the advice of the legal adviser, who reminded the panel that its role was not to punish Ms. Robertson but to determine a proportionate outcome,

considering its responsibility to protect the public and uphold proper standards of conduct. The relevant principles were outlined in Social Work England's Impairment and Sanctions Advice. The panel was advised to identify both aggravating and mitigating factors to ensure a fair and proportionate approach. Any sanction imposed should be the minimum necessary to achieve these objectives and must be consistent with the panel's decision regarding impairment. The social worker's personal circumstances should generally not influence the assessment of an appropriate and proportionate sanction. The purpose of a sanction is not to punish but to protect the public and serve the broader public interest. The panel should consider sanctions in ascending order, starting with the least restrictive option.

254. The panel considered the matter of sanction, taking into account both the aggravating and mitigating factors before reviewing the specific sanctions available. The panel first addressed the aggravating and mitigating circumstances, followed by an evaluation of the sanctions in ascending order of severity, beginning with the least serious.

255. The panel found the following aggravating factors in this case:

- There was a clear pattern of behaviour over a period of at least 12 months, involving multiple vulnerable service users. This conduct continued despite the high level of supervision and support provided to Ms Robertson.
- The panel found no evidence of insight by Ms Robertson into her actions, and she has failed to take responsibility for her conduct or acknowledge the harm her actions may have caused.
- The panel found no evidence of remorse. During her early interactions with Social Work England, Ms Robertson sought to blame the regulator for the situation, rather than accepting responsibility for her own actions.
- The panel noted that Ms Robertson has failed to provide any evidence of remediation or efforts to address her deficiencies. Her failure to demonstrate attempts at improvement was seen as concerning.
- Ms Robertson disengaged early from the proceedings, criticised the regulator, and sought to shift the blame to others, including her supervisors. This behaviour further compounded the seriousness of her actions.
- The panel noted that Ms Robertson failed to demonstrate any understanding that her actions could have caused significant harm to vulnerable service users.

- Ms Robertson’s conduct and performance consistently failed to meet professional standards, demonstrating significant deficiencies in her competence.
- The panel found that Ms Robertson deliberately falsified critical information in her voluntary removal application, intending to deceive Social Work England. This intentional dishonesty with the intention to deceive her regulator was deemed a serious aggravating factor.
- Furthermore, as the investigation unfolded, Ms Robertson sought to criticise the regulator, further highlighting her unwillingness to cooperate or accept responsibility.

256. The panel considered potential mitigating factors. However, it found no evidence to suggest that there were any mitigating circumstances that could explain the seriousness of Ms Robertson’s actions. **[PRIVATE]** Consequently, the panel did not find any mitigating factors in this case.

257. The panel then examined the available sanctions, considering them in ascending order of severity, and assessed their appropriateness and proportionality in the context of this case, taking into account the aggravating factors.

No Further Action

258. The panel considered whether to take no further action. Given the serious nature of the findings against Ms Robertson, including her dishonesty and lack of competence, the panel concluded that this option was entirely inappropriate. No evidence had been presented to suggest that Ms Robertson was fit to practise, and taking no action would fail to protect the public or maintain professional standards.

Advice or Warning

259. The panel determined that a warning or advice would also be wholly inadequate. The seriousness of the misconduct, including the deliberate dishonesty and consistent disengagement, meant that such a sanction would not be sufficient. The panel found that a warning or advice would not effectively protect the public or restore confidence in the social work profession.

Conditions of Practice

260. The panel considered whether conditions of practice could be imposed. Whilst the panel had found lack of competence which could be considered remediable, it noted that Ms Robertson had not shown any willingness or ability to remedy her failings. There was no evidence to suggest she would comply with conditions. The panel noted that Ms Robertson has not worked as a social worker for a significant period of time and has been clear that she does not wish to return to the profession. Given her lack of engagement, insight, and willingness to cooperate, the panel concluded that conditions of practice would not be appropriate in this case. Further, having made a finding of dishonesty the panel also considered that conditions of practice could not be formulated that would address the serious nature of the dishonesty.

Suspension

261. The panel then considered suspension as a potential sanction. Suspension is appropriate in cases where the misconduct is serious but not irreparable. However, the panel found that Ms Robertson's lack of insight and failure to recognise her dishonesty or remediate her deficiencies made suspension an insufficient response. Furthermore, the dishonesty involving her regulator meant that suspension would not adequately address the seriousness of the issue or maintain public confidence in the profession. The panel determined that suspension was not an appropriate sanction.

Removal from the Register

262. The panel concluded that the only appropriate and proportionate sanction was removal from the register. Ms Robertson's conduct had consistently failed to meet professional standards, and she had demonstrated serious deficiencies in her competence. The panel found that Ms Robertson's fitness to practise was impaired on the grounds of both lack of competence and misconduct. In particular, the panel considered that the deliberate dishonesty involving a regulator is a significant and aggravating factor, which compounded the severity of her failings. Her dishonest actions, including the falsification of crucial information to deceive Social Work England, demonstrated a deliberate attempt to obstruct the regulatory process and undermine the integrity of the profession.
263. Further, the panel have seen no evidence of an intention on the part of Ms Robertson to take any steps to resolve or remediate her conduct. Her lack of insight, failure to remediate her deficiencies, deliberate dishonesty and failure to engage

with the regulatory process further demonstrated that she was unwilling or unable to remedy her failings.

264. The panel considered paragraph 148 of the Impairment and Sanctions Guidance, which states: “*. A removal order must be made where the decision makers conclude that no other outcome would be enough to (do one or more of the following):*

- *protect the public*
- *maintain confidence in the profession*
- *maintain proper professional standards for social workers in England”*

265. Given these factors, the panel found that removal from the register was the only appropriate and proportionate response. It was necessary to protect the public, maintain confidence in the social work profession, and uphold the integrity of the regulatory system.

266. Therefore, the panel decided that Ms Robertson should be removed from the register.

Interim order

267. The panel next considered an application by Mr Khan for an interim suspension order for 18 months to cover the appeal period before the final order becomes effective. Mr Khan submitted that an order is necessary to protect the public and would be consistent with the panel’s finding and decision on sanction.

268. The panel heard and accepted the advice of the legal adviser on its power to make an interim order under paragraph 11(1)(b) of Schedule 2 of the Social Workers Regulations 2018.

269. The panel was mindful of its earlier findings and decided that it would be wholly incompatible with those findings not to impose an interim order. The panel considered paragraph 207 of the impairment and sanctions guidance which highlighted that “*an interim order may be necessary where the adjudicators have decided that a final order is required, which restricts or removes the ability for the social worker to practise...without an interim order, the social worker will be able to practise unrestricted until the order takes effect. This goes against our overarching objective of public protection*”. The panel had identified that service users would be

put at serious risk of harm due to there being a high risk of repetition if Ms Robertson was permitted to practise without restriction.

270. The panel concluded that an interim suspension order was necessary to ensure the protection of the public. Accordingly, the panel concluded that an 18-month interim suspension order is necessary. When the appeal period expires, this interim order will come to an end unless an appeal has been filed with the High Court. If there is no appeal, the final order of removal shall take effect when the appeal period expires.

Right of appeal

271. 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.

272. 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.

273. 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.

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

The Professional Standards Authority

275. 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>.