Social worker: Julia M MacKay
Registration number: SW91797
Fitness to Practise
Final Hearing

Dates of hearing: 08 September 2025 to 12 September 2025

Hearing venue: Remote hearing

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

Interim order:
Interim suspension order (18 months)

Introduction and attendees:

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

2. Ms Julia MacKay attended and was not represented.

3. Social Work England was represented by Ms Atkin, case presenter from Capsticks LLP.

Adjudicators	Role
Jayne Wheat	Chair
Jacqueline Telfer	Social worker adjudicator
Louise Wallace	Lay adjudicator

Hearings team/Legal adviser	Role
Tom Stoker/Poppy Muffett	Hearings officer
Ruby Wade	Hearings support officer
Gemma Gillet	Legal adviser

Preliminary matters:

4. Ms MacKay confirmed that she had received copies of the bundles including the statement of case, witness statements and exhibits by email in advance of the hearing and that she had read these documents. She explained that she was attending the virtual hearing using her mobile phone and did not have access to an additional device to allow her to look at the documents at the same time as attending the hearing. Ms MacKay informed the panel that she was content to start the hearing and was not asking for an adjournment or delay.

5. Ms Atkin advised the panel that efforts were being made to get hard copies of the documents sent to Ms MacKay by courier but could not confirm when these would arrive. The panel took note of the fact that Ms MacKay was not asking to adjourn the hearing and was mindful of the public interest in considering the allegations expeditiously and the limited time available. The panel was satisfied that Ms MacKay could fully participate in the hearing without the hard copy papers and confirmed that regular breaks would be taken to allow Ms MacKay to look at the relevant documents. Ms MacKay received hard copies of the documents at the end of day one of the hearing.

Allegations

The allegations arising out of the regulatory concerns referred by the Case Examiners on 13 May 2022 are:

Whilst registered as a social worker:

1. *You failed to safeguard children A-D, as set out in Schedule A.*

2. *You failed to record at all and/ or in a timely manner the home visits on 4 and 6 June and/ or the incident of 6 June 2019.*

3. *After visiting the home on 6 June 2019, you may have put yourself and/ or your multi-agency colleagues at risk by failing to work in a multi-disciplinary manner and/ or communicate effectively, as set out in Schedule B.*

SCHEDULE A

1. *By not arranging a safety plan for children A-D after 3 June 2019; and/or*
2. *By not escalating safeguarding concerns relating to children A-D in a timely way following a home visit on 4 June 2019; and/or*
3. *By not escalating safeguarding concerns relating to children A-D in a timely way following a home visit on 6 June 2019; and/or*
4. *By not informing your managers of the incident of 6 June 2019 in a timely way and/or following up with the police about the incident of 6 June 2019 in a timely way;*
5. *By not organising a strategy meeting prior to 20 June 2019.*

SCHEDULE B

1. *By not communicating to colleagues and or other multi-agency professionals about the increased risk of visiting children A-D at their home following the incidents of 3 June 2019; and/or*
2. *By not communicating to colleagues and or other multi-agency professionals about the increased risk of visiting children A-D at their home following the incident of 6 June 2019; and or*
3. *By not informing your managers of the incident of 6 June 2019 in a timely way and/or not following up with the police about the incident of 6 June 2019 in a timely way.*

The matters set out above amount to the statutory ground of misconduct.

Your fitness to practise is impaired by reason of your misconduct.

Admissions:

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

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

7. Following the reading of the allegations the panel Chair asked Ms MacKay whether she admits any of the allegations.

8. Ms MacKay informed the panel that she denied the allegations.

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

10. After the close of the case for Social Work England the parties were invited to make submissions in relation to the apparent omission of "and/or" from the drafted allegations in Schedule A between point 4 and 5. Ms Atkin submitted that this was a typographical error and that the panel should "read in" the additional words or amend if it felt it was necessary. She submitted that Ms MacKay had been able to understand the case against her and prepare her defence and would not be prejudiced by this approach. The panel should not be restricted in its ability to properly consider the issues in the allegations by reason of a technicality, so long as this does not result in unfairness to the social worker. Ms MacKay told the panel she did not have anything to say about the issue. The panel was referred to the cases of *Ganga v GMC* and PSA v *HCPC and Doree* and was reminded of Social Work England's overarching objective to uphold the standards of the profession and protect the public.

11. The panel accepted the advice of the legal advisor and decided that it was clear from the overall drafting of the allegations and the statement of case that each of the factual points in Schedule A should be considered individually and that the overarching allegation (allegation 1) should not fall away if one of the points in the schedule were to be found not proved. The panel found that it was obvious from the questions Ms MacKay had asked the witnesses that she understood the way in which the case had been put by Social Work England and that she would not be unduly prejudiced by the panel "reading in" the words "and/or".

Summary of evidence:

12. In accordance with the directions given at the Case Management Meetings which took place on 13 August 2025 and 21 August 2025, the following witness' statements were adduced as hearsay:

    - Lee Perry; Police Constable of Devon and Cornwall Police;
    - Catherine Attfield; Area Manager for Devon County council ("the council");
    - Clare Martini, Social Work Team Resource Officer at the council.

13. On behalf of Social Work England, Ms Atkin called Louise Turner (previously a team manager at the council) and Kim Baynham-Richards (previously an assistant team manager at the council) to give evidence. Both witnesses confirmed the truth of the contents of their signed witness statements and adopted the contents as part of their evidence for these proceedings

14. Ms Atkin, on behalf of Social Work England, opened the case on the following basis:

- Ms MacKay was employed via an agency to work in the Locality Children and Families Team at Devon County Council and had worked in this role since approximately May 2015. At the time of the concerns arising in June 2019, she was working as an experienced social worker.

- On 23 May 2019, an initial Child Protection Conference was held in relation to Children A – D, which determined that the children should be placed on Child Protection Plans. The notes of the conference stated that there was "*a long history of concerns regarding the family, with both parents of the children previously being involved in drug dealing, having both served custodial sentences and concerns regarding the impact on the children*". It was further noted that "*2 weeks ago police carried out a drugs raid at the family home*" and "*removed what are thought to be cannabis and amphetamine, a sawn-off shot gun, knives and hand-held imitation firearm – BB guns*". Ms MacKay was in attendance at the conference, and the case was allocated to her.

- On 3 June 2019, Ms MacKay was made aware that the children's father and his partner had been arrested for possession of a Class A substance, and that the children were being cared for by a family friend. On the following day, further information was added to the electronic recording system about the circumstances of the arrests, which noted that "[a]*s police entered a large quantity of controlled drugs were thrown from the rear window, believed to be Cocaine and Cannabis. There was also a large amount of cash thrown from the window*[. . .] *Also within the bedroom was further quantity of drugs and evidence of intravenous drug abuse*". It was noted that drugs and weapons had been seized from the address.

- On 5 June 2019, Ms MacKay responded to emails from a Senior Social Worker, Laura Costello, and Michelle White, an Independent Safeguarding Reviewing Officer, which confirmed that she was aware of the latest information provided by the police, and had visited the children on 4 June 2019. Ms White expressed concerns about the children's safety in light of the children's father and his

partner's recent arrest. Ms Mackay responded by email on 6 June 2019 confirming that she was the allocated social worker, and noted that she had visited the children on 4 June 2019, but had been unable to record her visit due to "*system difficulties*". Ms Mackay went on to say that the father and his partner had been released from custody on 3 June 2019, and suggested that the children had returned to the family home on 5 June 2019.

- On 6 June 2019, Ms MacKay attempted a further visit to the family home. She subsequently reported that, on her way to the property, a man who she believed to be the father of the children, had jumped out at her and held what she believed to be a gun to her face. On 7 June 2019, the Social Worker mentioned the incident to one of the administrators in the team, Clare Martini, but did not inform a manager.
- On 10 June 2019, Ms MacKay mentioned the incident of 6 June 2019 to Ms Turner, who in turn reported matters to her Manager, Ms Catherine Attfield. Ms MacKay was asked to arrange a Strategy Meeting, but this did not take place until 20 June 2019. Ms Turner and Ms Baynham provide evidence to the effect that this was ultimately organised by Ms Baynham, as Ms Mackay had failed to do what was necessary to arrange it.
- Within a referral completed by Ms Attfield on behalf of the Council, she raised concerns that Ms Mackay had not escalated safeguarding concerns in relation to the children in a timely way and did not alert anybody to the increased risk to the children or to staff.

15. Ms Turner informed the panel that at the relevant time she had been Ms MacKay's manager. She said that following the information provided by the police regarding the arrest of the children's father, she would have expected Ms MacKay to seek advice from a manager about arranging a strategy meeting, and in particular after she learned that the children were staying with a family friend but then returning to the family home. Ms Turner accepted that she had been on leave on 4 June 2019 and said that in those circumstances Ms MacKay should have sought advice from the duty manager or the assistant team manager, Ms Baynham-Richards. She confirmed that this had not been done.

16. Ms Turner said that she was not informed about the incident on 6 June 2019 until 10 June 2019. She would have expected Ms MacKay to inform a manager and call the police as soon as possible given the serious nature of the incident and the potential safeguarding issues. She accepted that she was still on leave on 6 June but said that if Ms MacKay had been unable to find another manager, she should have phoned the duty

number who would have located one for her. There was no evidence this had been done.

17. Ms Turner said that on 10 June 2019 she told Ms MacKay that she must set up a strategy meeting. She told the panel that her expectation would have been that a strategy meeting should have been requested within 24 hours of the incident and should take place as soon as the parties are available. On 13 June 2019, Ms Turner realised that there was no note on the system to show that the meeting had been requested. She chased Ms MacKay again on 17 June 2019 and then asked that Ms Baynham set one up. The strategy meeting eventually took place on 20 June 2019.

18. Ms Turner said that she did not recall Ms MacKay giving any explanation to her at the time for why the strategy meeting had not been arranged. She accepted that the meeting notes confirmed that a paper application had been sent to the police by Ms MacKay on 10 June 2019. She would have expected Ms MacKay to chase this. Ms Turner told the panel that a Public Law Outline meeting ("PLO") would not have been a suitable alternative to a strategy meeting in the particular circumstances.

19. Ms Turner told the panel that the email included in the case notes which outlined Ms MacKay's visit to children A-D on 4 June 2019 did not record the relevant issues so would not be sufficient as a "visit record". Ms Turner confirmed that there were no other records of the visit on 4 June 2019 or the incident on 6 June 2019 on the case file until she added a short note on 13 June 2019 on Ms Mackay's behalf.

20. Ms Baynham-Richards told the panel that to the best of her recollection she was the duty manager on the 6 June 2019 but was not aware of the incident until the next week. She recalled being asked to arrange the strategy meeting for the children as this had not been done by Ms MacKay. She told the panel that it was necessary to get a manager to sign off a strategy meeting request and that the administrators would organise the meeting after a request had been sent by the social worker in the case. It was the administrator's role to schedule the meeting and the social worker would be responsible for chasing managers to ensure it was set up.

21. Ms MacKay gave evidence under oath:

    - Ms MacKay said that at the relevant time she had a very heavy caseload with limited support and assistance. In addition to her own caseload, she was also asked to oversee many other cases. She was often working more than 12 hours a day to ensure she completed all the visits necessary. At times she had been the only social worker in the team.

    - Ms MacKay said that she repeatedly raised concerns in relation to her workload, that issues weren't being signed off by management. She also recalled that the computer system they had to work on would crash multiple times on a daily basis and that work was often lost as a result.

- Ms MacKay said that she was informed on 4 June 2019, by the duty team, that the father had been arrested the day before. She immediately contacted the police and the school to find out where the children were staying. Ms MacKay visited the children at a family friends' house and had some concerns about whether this was a suitable place for them to stay. She asked a manager from another team to consider an emergency placement for the children but was told that one was not available and that the children did not meet the threshold. She also discussed the need for a strategy meeting with a social work manager but was told it would not bring any new information to the table so would be better to consider a Public Law Outline meeting ("PLO"). She therefore submitted a paper request for a PLO. She does not know where this document is.
- Ms MacKay said that when she was told the father had been released, she made a number of requests of the police to attend a joint visit to the family. Ms MacKay understood that other professionals did not undertake visits alone due to weapons at the house. She attended a core group meeting on 6 June 2019 at the school, which the father attended and went well. She was able to arrange a joint visit with the police on the same day. Unfortunately, there was a "horrible incident" which prevented this from taking place. Following the incident, she called the duty line, but the duty worker was unable to locate the duty manager. She recalls that there was evidence of this call at the time.
- Ms MacKay said that her employer had omitted information about conversations she had with colleagues about the family. As soon as a manager was available Ms MacKay alerted them about the incident. When she had been asked to complete a request for a strategy meeting the computer system had not been working. The police confirmed that they would accept a paper referral. A manager signed off the request and then sent it to an administrator to action.
- After the incident on 6 June 2019, Ms MacKay told her manager that she did not feel comfortable visiting the family alone. She was informed that someone else would undertake the visit, after which, she felt that she was kept out of the loop in relation to the family.
- Ms MacKay explained that she was spending time ensuring that the recording on her cases was up to date as she recognised that this was an issue. She accepted that she had been asked by her manager why she had not completed a strategy meeting form and was confident she had explained that she had, but that it was in a paper format. She accepted that she had been asked by her manager to

complete the online strategy request form and case notes and that she did so, but the managers asked for numerous amendments to her wording which Ms MacKay did not feel comfortable with.

- Ms MacKay has never been sure who the perpetrator of the incident on 6 June 2019 was as they had their face covered. She suspected it was the father but was not sure. She said she had not been deliberately inconsistent.
- Ms MacKay described being "floored" when she was asked not to return to the local authority following the strategy meeting. She had worked there for 4 years without any issues with her work. She took an 8-month career break but cooperated with any meetings about this incident during this time. She has since worked for two other local authorities. She said that Ms Attfield had offered to have her return to the council, but she had been confused by this. Her work with the other local authorities had re-affirmed her confidence in her professional abilities.
- Ms MacKay said that since she left the council, she has undertaken training in relation to safeguarding, drug abuse, mental health, recording and professional fatigue. She found the professional fatigue training incredibly eye-opening in understanding what she had been experiencing at the time.

22. In cross examination Ms MacKay was taken to a statement she had provided to the police in June 2019 and a record of police interviews in July 2019 and January 2020. Ms MacKay accepted that her recollection would have been "fresher" at this time and she would have been careful to give an accurate account to the police. Ms MacKay was taken to contemporaneous evidence from the children's school about their concerns regarding the children's presentation which had been communicated to the social worker and the overall concerns in relation to the father and his girlfriend's drug use and involvement. Ms Atkin explored the information that was available to Ms McKay at the time and she agreed that she was aware that the father and/or his partner were continuing to put the children at risk by their behaviour, including by bringing the children back to the family home after his arrest, and the possibility that the father had pulled a gun on Ms MacKay on 6 June 2019.

23. Ms MacKay accepted that during her interviews with the police on 11 July 2019 and 9 January 2019, she had said that she did not report the concerns following the visits on 4 June 2019 or 6 June 2019 to a manager. Ms MacKay maintained that she now recalls that she had spoken to managers but could not explain why she said otherwise during the interview.

24. Ms MacKay was taken to a record of her meeting with Ms Attfield on 6 August 2019. Ms Atkin suggested that this record does not mention that Ms MacKay had given any

consideration for the need for a strategy meeting or that she had spoken to managers at the time. Ms MacKay accepted that it was not in these notes but reiterated that she had done so. Ms MacKay denied that she had failed to escalate the issues because she had formed the opinion that the children were doing well. Ms MacKay reiterated that she was concerned about the children's safety.

25. Ms Atkin suggested that Ms MacKay's view of the risk to the children should have escalated at the point she believed that the father had pointed a gun at her. Ms MacKay agreed. Ms MacKay said it had already been her intention to organise a strategy meeting after 5 June 2019, but that another team manager told her a PLO meeting would be a better way forward.

26. Ms MacKay accepted she had not reported the incident on 6 June 2019 to a manager. She was asked why she had said in a meeting on 6 August 2019 that she felt she "*had let the children down and left the children in danger*". Ms MacKay said that this was probably in relation to having not reported the incident, she recalls that at the time she was in shock.

27. Ms MacKay said that she had spoken to "*anyone who would listen*" about the incident on 6 June 2019 the next day, this included a manager for a different team and the administrator who was the only member of her team who was in the office. She said that Ms Attfield, the senior manager, had a reputation for not being approachable so did not consider contacting her. Ms MacKay denied that at the time she did not believe the matter required escalation. She accepted that there was no record of the conversation with this other manager and that this had not been mentioned in her previous accounts.

28. It was suggested to Ms MacKay that she had put colleagues and other professionals at risk by not recording the incident on 6 June 2019, Ms MacKay accepted this. Ms MacKay agreed that she had not checked that the man who approached her after the incidents was in fact a police officer, she had assumed that he was the officer she had arranged to meet. She accepted that she should have followed up with the police but was waiting for them to contact her.

29. Ms MacKay was taken to the evidence of Ms Turner in which she said Ms MacKay told her about the incident of 6 June 2019 on 10 June 2019 and that she had asked Ms MacKay to set up a strategy meeting at the same time. Ms MacKay said that she thought she had sent the paper request for the strategy meeting on 10 June not 13 June, as suggested in the police interview. This may have been because of a delay due to the need to get authority from a manager. Ms MacKay accepted that she had a role in chasing and ensuring that the strategy meeting took place as soon as possible, but she had been asked to prioritise writing up her notes. Ms MacKay agreed that the delay in conducting the strategy meeting may have increased the risk to the children.

30. Ms MacKay was taking to the HCPC standards which were applicable to social workers at the time of the allegations, including the standards in relation to record keeping. She explained that the climate in the office made this difficult and that she prioritised visits. Ms MacKay accepted that a proper visit record for 4 June 2019 cannot be seen on the

case system and that the available email record is not sufficient. Ms MacKay said that she did complete a record of the visit but was unable to say where this was.

31. Ms MacKay said that she had created a record about the incident on the 6 June 2019 but had been asked to amend the record on a number of occasions, in particular in relation to there not being a manager around to discuss the matter with at the time and the fact she had been unsure if it had been the father who had approached her.

32. Ms MacKay said that looking back at the situation she should have;

    - refused to take the case without assistance,
    - sought further advice following the discussion with the duty manager about organising a PLO meeting rather than a strategy meeting,
    - refused to take extra work to allow her to catch up with notes,
    - contacted senior managers to alert them that there were no managers available to support social workers in the team with decision making in-order to keep children safe.

33. Ms MacKay agreed that the purpose of a strategy meeting is to ensure that decisions are taken collaboratively and do not rest with one individual. Ms MacKay accepted that she had not mentioned discussions about a strategy meeting in her previous responses but did not agree that this is because she is mistaken in her recollection now.

34. In response to questions from the panel, Ms MacKay said that following the incident on 6 June 2019 the man she assumed to be a police officer could see that she was shaken and said that she should go home and that he would speak to the local authority duty team. She said that the next day there wasn't really anyone in the office. She recalled speaking to a male and female manager separately about the incident but she could not recall if it was the next day or the following day. She was certain she had spoken to these other managers before her line manager returned from annual leave.

35. Ms MacKay reiterated that she had made case notes on the system about the visits on 4 and 6 June 2019, so was very surprised when she saw there was an allegation that they were missing. She said that the system was unstable which often led to work being lost and that if a document was left in draft form, it could be edited by others. Ms MacKay explained that there were separate "pages" on the system for visit notes and meetings, which would not be included in the case notes page within the exhibit bundle. She suggested that the notes she made may have been saved on to one of those other pages.

36. Ms MacKay was asked about her understanding of what would constitute a safety plan for children. She said that it would depend on the circumstances but that she would consider a PLO to constitute one. Ms MacKay could not recall to whom she sent the PLO request for sign off, but assumed it would have been her manager as this would have been a necessary step before being sent on to the legal team.

Finding and reasons on facts:

37. The panel heard and carefully considered the submissions made by Ms Atkin and Ms MacKay. The panel took into account the advice of the legal adviser which included guidance on considering the credibility of individuals who had given evidence, hearsay and good character. The panel considered each of the allegations separately. Where the allegation included reference to a schedule, the panel considered each factual point of the schedule separately before considering whether the stem of the allegation had been proved in relation to each of those points.

> *Allegation 1. You failed to safeguard children A-D, as set out in Schedule A.*
>
> *1. By not arranging a safety plan for children A-D after 3 June 2019; and/or*

38. The panel noted that there had been a safety plan in place for children A-D following an initial Child Protection Conference on 23 May 2019. New information had been shared by the police following their raid on 3 June 2019. This included information relating to drugs being found at the family home and evidence of drug use. Multiple knives were discovered. There was information that at a previous raid in May, a firearm had been seized. The panel found that this new information was a clear escalation of the situation with the family and necessitated the allocated social worker, Ms MacKay, to arrange a new safety plan for the children to take this into account. This was necessary to properly assess the changing situation and safeguard the children.

39. The panel found that there was no evidence of a new safety plan until the strategy meeting on 20 June 2019, which was 17 days later. The panel was not persuaded by Ms MacKay's response during her evidence that a PLO meeting would have constituted a safety plan and preferred the evidence from Ms Turner who said that this would not have been an appropriate step in these circumstances. The panel also noted that there was no contemporaneous evidence to support Ms MacKay's assertion that she had made the PLO meeting request following advice from a manager. The panel considered the numerous accounts Ms MacKay had given closer to the time of the incident, including her interviews with the police and her initial response to Social Work England and found that she had not mentioned discussing the new information with a manager nor being advised to arrange a PLO meeting in any of those accounts.

40. The panel decided that Ms MacKay had not arranged a safety plan for the children after 3 June 2019 and that by failing to do so she had failed to safeguard children A-D. Therefore, this allegation was found proved.

Allegation 1. You failed to safeguard children A-D, as set out in Schedule A.

2. By not escalating safeguarding concerns relating to children A-D in a timely way following a home visit on 4 June 2019; and/or

41. The panel considered that following the police raid on the 3 June 2019 and Ms MacKay's subsequent visit to children A-D on 4 June, there had been a clear change in circumstances which increased the risk to the children. In addition to the reasons given above regarding the raid on 3 June 2019, the visit on 4 June 2019 had led Ms MacKay to observe that the temporary accommodation with the family friend was "*not an ideal situation given [...] has 4 children of her own and there is a history of fragile mental health*". She was also aware that the father had been released from the police station and had taken the children back to the family home to sleep. The panel found that the increased risk necessitated an escalation of safeguarding concerns as soon as possible.

42. The panel considered Ms MacKay's oral evidence that after the visit on 4 June 2019, she had asked the manager called Andrew to consider emergency placement for the children but was told that one was not available and that the children did not meet the threshold. She said that she had also discussed with the manager the need for a strategy meeting but was told it would not bring any new information to the table so it would be better to consider a PLO. The panel considered carefully the contemporaneous records and the numerous accounts Ms MacKay had given to the police, her employer and in writing to Social Work England and could not find any evidence to support Ms MacKay's oral testimony. The panel noted that during Ms MacKay's interviews with police, she had said that following her visit on 4 June 2019, she did not speak to a manager as no one had been available.

43. The panel considered the evidence it had heard regarding the availability of managers at the time. The panel accepted the evidence of Ms Turner who confirmed that she was on leave. However, Ms Baynham-Richards' evidence was that "*there is always a manager on duty*".

44. The panel carefully considered the email from Ms MacKay to the safeguarding officer on 6 June 2019 and decided that this had not escalated the concerns. Rather, the email provided re-assurance about the presentation of the children, "*they presented as calm, happy and content in father and [...] care*". The panel found that this email does not cover the obvious increase in risk following the police raid and Ms MacKay's visit and that the tone of the email suggests Ms MacKay may not have recognised the safeguarding concerns and/or the need to escalate. The evidence of concerns was such that the situation should have been dealt with immediately, and yet there was no evidence of positive action by Ms MacKay until 10 June at the earliest.

45. The panel decided that Ms MacKay had not escalated safeguarding concerns relating to children A-D in a timely way following a home visit on 4 June 2019 and that by failing to

do so she had failed to safeguard children A-D. Therefore, this allegation was found proved.

> *Allegation 1. You failed to safeguard children A-D, as set out in Schedule A.*
>
> *3. By not escalating safeguarding concerns relating to children A-D in a timely way following a home visit on 6 June 2019; and/or*

46. For the reasons set out above the panel concluded that there was a clear need for Ms MacKay to escalate safeguarding concerns relating to children A-D following the home visit on 4 June 2019 as soon as possible. The incident on 6 June 2019 involved a threat with a firearm in the vicinity of the children's home. Ms MacKay was not sure, but believed the perpetrator was the father of the children. Following this incident the panel found that Ms MacKay must have recognised, as a matter of common sense as well as being an experienced social worker, that this seriously increased the risk to the children and necessitated an immediate escalation of safeguarding concerns to both her managers and the police.

47. Ms McKay accepted in cross examination that she had not contacted a manager to escalate the safeguarding concerns immediately after the incident. She told the panel that she had been in shock and went home. The panel considered Ms MacKay's police statement dated 24 June 2019. The panel concluded that this account was made shortly after the incident, when the incident was likely to be fresh in Ms MacKay's mind. The panel also considered that given the circumstances, Ms MacKay would have ensured her account was full and accurate. The panel noted that in the statement Ms MacKay said that she spoke to a colleague the following day but hadn't spoken to a manager until about a week later. The panel also noted that during her interview with the police she said that the longer it went on the more difficult it became to report the issue as she "felt like she was being a drama queen".

48. The panel considered Ms MacKay's evidence that the man she believed to be a police officer who attended shortly after the incident had told her to go home and that he would "take it from here" and she would need to "ring it in". Although the panel recognised that this would have been a very difficult situation for Ms MacKay, it found that it was Ms MacKay's professional responsibility to escalate the increased risk to the children in a timely manner within her team. There is no evidence that Ms MacKay did this until 10 June 2019 at the earliest, when she spoke to Ms Turner about the incident. The panel found that given the serious nature of the incident, this could not be described as "in a timely manner".

49. The panel considered Ms MacKay's evidence during the hearing that she now recalled speaking to a male and female manager separately about the incident the next day or the following day. The panel found that there was no evidence or record of these conversations and that it was contradicted by the other accounts Ms MacKay had given about her actions.

50. The panel decided that Ms MacKay had not escalated safeguarding concerns relating to children A-D in a timely way following the visit on 6 June 2019 and that by failing to do so she had failed to safeguard children A-D. Therefore, this allegation was found proved.

> *Allegation 1. You failed to safeguard children A-D, as set out in Schedule A.*
>
> *4. By not informing your managers of the incident of 6 June 2019 in a timely way and/or following up with the police about the incident of 6 June 2019 in a timely way;*

51. For the reasons set out above the panel found that Ms MacKay had a professional duty to inform her managers of the incident on 6 June in a timely manner and failed to do so.

52. The panel considered the evidence Ms MacKay had given about her belief in the identity of the individual who attended the scene shortly after the incident on 6 June 2019. The panel noted that the police were unable to identify this individual or confirm that a police officer had attended the scene. The panel found that it was not necessary to make any finding in relation to this issue.

53. The panel found that regardless of Ms MacKay's belief that a police officer would "take it from here" she was under a professional responsibility to inform her managers and to ensure that the relevant police officers were aware of and acting on the information in order to safeguard children A-D. When Ms MacKay had not heard from the police immediately after the incident and had not been informed of any immediate action taken as a result, she should have followed up with the police to check that the information had been shared.

54. The panel noted that the police reported during the strategy meeting on 20 June 2019 that nothing regarding the alleged incident had been reported to the police. The panel found that the serious nature of the incident warranted an immediate response from Ms MacKay.

55. The panel decided that Ms MacKay had not informed her managers of the incident of 6 June 2019 in a timely way and had not followed up with the police about the incident in a timely way and that by failing to do so she had failed to safeguard children A-D. Therefore, this allegation was found proved.

> *Allegation 1. You failed to safeguard children A-D, as set out in Schedule A.*
>
> *5. By not organising a strategy meeting prior to 20 June 2019.*

56. The panel carefully considered the chronology of events that led to the strategy meeting on 20 June 2019. As detailed above, the panel found that there had been an escalation of safeguarding concerns relating to children A-D following the police raid on 3 June

2019, the visit on 4 June 2019 and the incident on 6 June 2019. The panel concluded that Ms MacKay, as the allocated social worker, had a professional responsibility to organise a strategy meeting as soon as possible to allow for a full discussion of the concerns and arrange a new safety plan for the children.

57. The panel accepted the evidence of Ms Turner, that Ms MacKay had made some steps towards organising a strategy meeting by making a paper meeting request on 10 June 2019. The panel also accepted the evidence from Ms Turner and Ms Baynham-Richards, that other individuals would have been involved in organising the meeting after the request had been made. However, the panel found, and Ms MacKay accepted that she had responsibility to make sure the meeting took place in a timely manner and chase the relevant individuals if necessary. It was accepted that the strategy meeting did not in fact take place until 20 June 2019, and that this meeting was organised by Ms Baynham-Richards.

58. The panel found that by failing to organise a strategy meeting for over two weeks after the incident on the 3 June 2019, Ms MacKay had failed to safeguard children A-D. Therefore, this allegation was found proved.

Allegation 2. You failed to record at all and/ or in a timely manner the home visits on 4 and 6 June and/ or the incident of 6 June 2019

59. The panel accepted the evidence from Ms Attfield that Ms MacKay should have made a record of the visit on 4 June 2019 and the incident on 6 June in a timely manner or at least within 48 hours. The panel decided that given the serious nature of the incidents it may have been necessary for Ms MacKay to make a clear record even sooner.

60. The panel considered the email dated 6 June 2019, which was copied into the case notes on the digital file. The panel found that the email did not contain sufficient detail about the visit on 4 June 2019. The panel accepted the evidence of Ms Turner and Ms MacKay's admission that this does not constitute a record of the visit.

61. The panel accepted the evidence from Ms Turner that after she had been informed on 10 June 2019 by Ms MacKay of the incident on 6 June 2019, she checked on the system but was unable to find a record. The panel accepted the evidence from Ms Turner that she was concerned enough about the lack of recording that she wrote the note herself on 13 June 2019.

62. The panel noted that Ms MacKay accepted her recording was an issue and was often the last thing she would do as she prioritised visiting the children. The panel considered Ms MacKay's oral evidence during the hearing that she now recalls making the records and speculated that they may have gone missing due to issues with the system or have been saved onto a part of the digital file which has not been included in the exhibits. The panel did not find that this account was consistent with the responses Ms MacKay had given on previous occasions.

63. The panel found that Ms MacKay failed to record at all and/ or in a timely manner the home visits on 4 and 6 June and/ or the incident of 6 June 2019. Therefore, this allegation was found proved.

> *Allegation 3. After visiting the home on 6 June 2019, you may have put yourself and/ or your multi-agency colleagues at risk by failing to work in a multi-disciplinary manner and/ or communicate effectively, as set out in Schedule B.*
>
> 1. *By not communicating to colleagues and or other multi-agency professionals about the increased risk of visiting children A-D at their home following the incidents of 3 June 2019; and/or*

64. The panel had regard to the stem of this allegation, which clearly states *after* visiting the home on 6 June 2019. The sub particular relates back to *before* the 6 June 2019 to the incidents of 3 June 2019. The panel considered that this was not well constructed or easy to understand, as it wasn't clear which failing was being alleged and when. The panel considered it lacked specificity. The panel has already made findings in relation to safeguarding the children after the incident on 3 June 2019 and the incident on 6 June 2019, and considered that there was evidence of an overall failure to communicate, but that proper consideration of those failings in light of the stem of 3, would be at Schedule B 2 and 3. Therefore, this allegation was not found proved.

> *Allegation 3. After visiting the home on 6 June 2019, you may have put yourself and/ or your multi-agency colleagues at risk by failing to work in a multi-disciplinary manner and/ or communicate effectively, as set out in Schedule B.*
>
> 2. *By not communicating to colleagues and or other multi-agency professionals about the increased risk of visiting children A-D at their home following the incident of 6 June 2019; and or*
> 3. *By not informing your managers of the incident of 6 June 2019 in a timely way and/or not following up with the police about the incident of 6 June 2019 in a timely way*

65. For the reasons set out above the panel found that Ms MacKay had failed to communicate with colleagues, managers, and other professionals by not arranging a safety plan after the 3 June 2019 and not escalating safety concerns following the home visit of 4 June 2019. It also found that following the incident on 6 June 2019, managers and the police were not informed in a timely way and that appropriate records were not kept during this time. The panel accepted that Ms MacKay spoke to an administrator the

following day, but Ms MacKay's own evidence was that she would not have expected her to act on the information or to pass the details to others.

66. The panel found that the following the incident of 6 June 2019, which had involved a threat with a possible firearm, there was undoubtedly an increased risk to professionals visiting children A-D at their home. Other colleagues, for example professionals at the children's school, health visiting or the police, may have had cause to visit the family and would not have been aware of this increased risk. The panel noted that, during her evidence, Ms MacKay had accepted that she had put colleagues and other professionals at risk by not communicating or recording the incident on 6 June 2019.

67. The panel found that a timely strategy meeting was necessary for decisions to be made in a multi-disciplinary manner in the best interests of children A-D and to pass on the relevant information to all professionals involved. Had the strategy meeting taken place in a timely manner, Ms MacKay's colleagues and other professionals would have been made aware of the increased risk.

68. The panel also found that by failing to communicate with colleagues, Ms MacKay did not receive the support and protection that she might have required from her employer following the incident.

69. The panel decided that by not communicating with colleagues, managers, other professionals and/or the police, Ms MacKay may have put herself and others at risk. Therefore, this allegation was found proved.

Finding and reasons on grounds:

70. The panel heard submissions from Ms Atkin on behalf of Social Work England. Ms Atkin made submissions in relation to misconduct and impairment and referred the panel to the relevant law and professional standards. The panel was told that the relevant professional standards were the HCPC Standards of Proficiency 2017 (4.1, 8.2, 10.1, 15.1) and the HCPC Standards of Conduct, Performance and Ethics 2016 (2.6, 6.1, 6.2, 7.1, 7.3, 10.2).

71. Ms MacKay provided the panel with the following written submissions;

I have shared some of the barriers I was experiencing during the months leading up to the matters before you, I will not repeat them here and wanted to assure you that whilst I may have presented at times that these were my focus, or as suggested, that my intention was to deposit blame on others, I would like to reassure you this was never my intention but instead wished to provide you with an insight into the very difficult environment I was working in.

I fully understand that my failure to complete a safety plan heightened the risk for children A-D and despite the professional barriers I was experiencing, I should have been more proactive and taken greater professional responsibility for managing the

safety of the children. Visits with the children and conversations with inter and multi agency professional were not enough to safeguard these children from the horrors of their parents behaviour and actions. I should have alerted a senior manager despite my anxiety around this and ensured records were written and completed immediately and over other commitments. I should have raised concern when I had not received a response regarding the arranging of a strategy meeting and escalated this to a higher authority.

72. In additional Ms MacKay submitted that her continued training since the incident has allowed her to recognise the symptoms and issues around professional fatigue and how she should have reacted when she found herself experiencing this. She told the panel that this may have included stepping away from the role rather than putting families and colleagues at risk. Ms MacKay explained that she understood the importance of keeping her safeguarding training up to date, and that she fully understood the principles of safeguarding. She also told the panel that she had read articles about whistleblowing and the challenges that creates, but that she recognised that you have to stick to the principles of why whistleblowing is necessary.

73. Ms MacKay submitted that she is now able to recognise the importance of record keeping and the mantra that "if it is not written down it did not happen". She submitted that she now recognises that making timely records and follow up actions must take priority over accepting additional work and/or visits. Ms MacKay told the panel that she is currently fostering and working with vulnerable women.

74. The panel accepted the advice of the legal adviser and noted that the decision on misconduct was a matter of judgement for the panel and that there was no burden or standard of proof.

75. The panel determined that the facts found proved amounted to a serious breach of the following standards:

HCPC Standards of Proficiency 2017

1.2 Recognise the need to manage their own workload and resources effectively and be able to practise accordingly

4.1 Be able to assess a situation, determine the nature and severity of the problem and call upon the required knowledge and experience to deal with it.

8.2 Be able to demonstrate effective and appropriate skills in communicating advice, instruction, information and professional opinion to colleagues, service users and carers.

10.1 Be able to keep accurate, comprehensive and comprehensible records in accordance with applicable legislation, protocols and guidelines.

15.1 Understand the need to maintain the safety of service users, carers and colleagues.

HCPC Standards of Conduct, Performance and Ethics 2016

2.5 You must work in partnership with colleagues, sharing your skills, knowledge and experience where appropriate, for the benefit of service users and carers

2.6 You must share relevant information, where appropriate, with colleagues involved in the care, treatment to other services provided to a service user.

6.1 You must take all reasonable steps to reduce the risk of harm to service users, carers and colleagues as far as possible.

6.2 You must not do anything, or allow someone else to do anything, which could put the health or safety of a service user, carer or colleague at unacceptable risk.

7.1 You must report any concerns about the safety or well-being of services users promptly and appropriately.

7.3 You must take appropriate action if you have concerns about the safety or wellbeing of children or vulnerable adults.

7.6 You must acknowledge and act on concerns raised to you, investigating, escalating, or dealing with those concerns where it is appropriate for you to so.

10.2 You must complete all records promptly and as soon as possible after providing care, treatment or other services.

76. The panel was mindful that not every falling short of the standards amounts to the statutory ground of misconduct. However, the panel concluded that the allegations found proved amounted to serious transgressions of the applicable standards which put children A-D and colleagues at risk of harm.

77. Over a period of 17 days, Ms MacKay had failed to take appropriate action to the obvious escalating safeguarding risks to children A-D. During that period the children were potentially left in an environment which may have contained drugs and/or firearms. She also failed to record and share information which had the ability to seriously impact risk to colleagues and other professionals.

Finding and reasons on current impairment:

78. When considering the question of impairment, the panel took into account Social Work England's 'Impairment and sanctions guidance'. The panel was mindful of the advice in Cohen v GMC [2008] EWHC 581 (Admin), quoted with approval in Grant, which states

> *The panel must be highly relevant in determining if a doctor's fitness to practice is impaired that first his or her conduct which led to the charge is easily*

remediable, second that it has been remedied and third that it is highly unlikely to be repeated."

79. The panel considered insight and remediation and was mindful of the guidance in the Grant case and the relevant tests it identified:

> *"Do the findings show that fitness to practise is impaired in the sense that:*
>
> *a) Has the Registrant in the past acted and/or is liable in the future to act in a way so as to put service users at unwarranted risk of harm;*
>
> *b) Has the Registrant in the past brought and/or is liable in the future to bring the profession into disrepute;*
>
> *c) Has the Registrant in the past breached and/or is liable in the future to breach one of the fundamental tenets of the profession;...*

80. In considering whether Ms MacKay's fitness to practise is currently impaired the panel consider the following two elements separately, namely:

- The personal element, established via an assessment of the risk of repetition
- The public element, established through consideration of whether a finding of impairment might be required to maintain public confidence in the social work profession, or in the maintenance of proper standards for social workers.

81. The panel found that Ms MacKay has in the past acted in a way that put service users and colleagues at unwarranted risk of harm, for the reasons set out in detail elsewhere in the judgement and that by doing so Ms MacKay had brought the profession into disrepute. The panel found that by failing to safeguard children A-D, Ms MacKay had breached one of the fundamental tenets of the profession.

82. The panel found that this conduct was not the result of an attitudinal issue and is therefore remediable. The panel noted that Ms MacKay has worked successfully in the social work profession for many years. The panel had regard to the statement of Ms Attfield in which she commented:

> *"The Social Worker did complete complex work. It is fair to say that the Social Worker was a good team player and the team was not always fully staffed. The Social Worker would often help bridge gaps in duty if someone was off sick and would support her team members. It is likely that this impacted upon her management of her own work."*

83. The panel accepted that there were factors in Ms MacKay's working environment at the time which may have impacted her judgment and behaviour. However, the panel observed that Ms MacKay had appeared defensive in her earlier responses to investigations and focussed too heavily on those external factors to explain her actions

rather than reflecting on her own professional responsibilities and the impact on the children and colleagues.

84. The panel was encouraged by Ms MacKay's level of engagement during the hearing and that her written submission at this stage demonstrated developing insight. It took into account that Ms MacKay accepted some of the failings in her oral evidence at the facts stage. The panel was encouraged by Ms MacKay's oral testimony that she has continued to undertake training but noted that no evidence had been provided in support. The panel was mindful that it had not received any documentary evidence in the form of updated testimonials about how Ms MacKay had been able to put her developing insight and the lessons learned from the training she has undertaken into practice as protective factors against repetition.

85. The panel considered the testimonials provided by Ms MacKay but found them to be of limited assistance to the issue of impairment as they related to the period of time before the allegations.

86. The panel concluded that due to the late development of insight which remains in its early stages and the lack of evidence provided in relation to remediation there remains a risk of repetition and therefore Ms MacKay's fitness to practice is currently impaired.

87. The panel went on to consider whether a finding of current impairment was required to maintain public confidence in the social work profession, or in the maintenance of proper standards for social workers. The panel concluded that the findings related to leaving vulnerable children in a potentially dangerous situation in the presence of drugs and/or firearms for an extended period of time is likely to be viewed as serious by members of the public. Public confidence would be undermined if a finding of impairment was not made.

Decision and reasons on sanction:

88. Ms Atkin made submissions on sanction and referred the panel to Social Work England's 'Impairment and sanctions guidance'. She reminded the panel that they must make the least restrictive sanction necessary to maintain public confidence in the profession.

89. Ms Atkin invited the panel, given their findings on misconduct and impairment, to impose a suspension order for a period of 12 months to reflect the gravity of the findings, protect the public and allow sufficient time for Ms MacKay to demonstrate insight.

90. Ms MacKay told the panel that although she is not currently working as a social worker, she hopes to return to the profession in the future when her personal commitments allow.

91. The panel accepted the advice of the legal adviser who reminded it that the purpose of a sanction was not to punish Ms MacKay but to protect the public and the wider public interest. The panel was reminded of the sanctions available and of the need to consider any aggravating and mitigating factors it sees fit. The panel was also asked to ensure that when considering sanctions, it begins with the lowest sanction and moves through all the available sanctions in ascending order of seriousness, before identifying the sanction it agrees is sufficient to protect the public and maintain confidence in the profession and uphold professional standards.

92. The panel had regard to the 'Impairment and sanctions guidance'. In reaching its decision on sanction, the panel took into account its previous findings, in particular at the misconduct and impairment stage which included Ms MacKay's limited insight and remediation at this stage. The panel identified and weighed the following aggravating and mitigating factors:

Aggravating factors:

- Risk of significant harm to service users and other professionals

Mitigating factors:

- Developing insight
- The concerns related to a single case
- Good character
- Engagement with the hearing
- Contextual factors including staffing issues, high caseload and the workplace environment as accepted by senior management.

93. The panel considered each available sanction in ascending order of seriousness.

94. It determined that taking no further action, or issuing an advice or warning would not be adequate in circumstances involving such a serious breach of the standards. Nor would it be appropriate given the panel's findings in relation to the limited insight and remediation.

95. The panel then considered whether a conditions of practice order could be imposed. The panel agreed with Ms Atkin's submission that the case involved behavioural failings on behalf of Ms MacKay which made a conditions of practice order less likely to be appropriate. The panel was concerned that Ms Mackay remains at an early stage of developing full insight. The panel also took into account Ms MacKay's current circumstances and her desire to return to social work when possible. It decided that it was unable to formulate appropriate, proportionate and workable conditions at this stage. Ms MacKay is not currently in practice and there is no prospect of her immediate return.

96. The panel went on to consider whether to impose a suspension order. The panel considered the sanctions guidance and in particular paragraph 137 which states that suspension may be appropriate where:

- the concerns represent a serious breach of the professional standards
- the social worker has demonstrated some insight
- there is evidence to suggest the social worker is willing and able to resolve or remediate their failings

97. The panel was satisfied that this case met each of the descriptions above and in the circumstances of this case falls short of removal. None of the indicators for removal at paragraph 148 were present. The panel found that Ms MacKay is willing and able to resolve and remediate her failings.

98. The panel went on to consider the necessary length of the suspension order. It recognised that there is a public interest to support a trained and skilled social worker to return to practice (if this can be achieved safely). This means the risk of deskilling is a public interest consideration. The panel noted that the sanction guidance states that suspension up to one year may be appropriate if the suspension's aim is (one or both of the following):

- maintaining confidence in the profession
- ensuring the professional standards are observed

99. The panel therefore concluded that a suspension order for a period of 12 months is sufficient to protect the public and maintain confidence in the profession and uphold professional standards

100. The panel considered that adjudicators reviewing this order may be assisted by evidence of developments in Ms MacKay's insight and remediation at the next review. The panel suggests that on the occasion of the next review Ms MacKay provides the following:

- A detailed reflection statement, to include:
    - what she has learned from the panel's findings
    - reflection on training undertaken and how it may be incorporated into practice
    - the work she has undertaken in a non-social work capacity
- targeted evidence of relevant training and development to address the findings of the panel
- up to date character references and testimonials

- evidence of keeping skills and knowledge up to date.

Interim order:

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

102. It was mindful of its earlier findings and decided that it would be wholly incompatible with those earlier findings not to impose an interim suspension order.

103. Accordingly, the panel concluded that an interim suspension order is necessary for the protection of the public and imposed an interim order for a period of 18 months to cover any time if an appeal is lodged. 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 suspension for a period of 12 months shall take effect when the appeal period expires.

Right of appeal

104. Under Paragraph 16(1)(a) of Schedule 2 of the regulations, the social worker may appeal to the High Court against the decision of adjudicators:

    - the decision of adjudicators:
        i. to make an interim order, other than an interim order made at the same time as a final order under Paragraph 11(1)(b),
        ii. not to revoke or vary such an order,
        iii. to make a final order.
    - the decision of the regulator on review of an interim order, or a final order, other than a decision to revoke the order.

105. 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.

106. 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.

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

Review of final orders:

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

- 15(1) The regulator must review a suspension order or a conditions of practice order, before its expiry
- 15(2) The regulator may review a final order where new evidence relevant to the order has become available after the making of the order, or when requested to do so by the social worker
- 15(3) A request by the social worker under sub-paragraph (2) must be made within such period as the regulator determines in rules made under Regulation 25(5), and a final order does not have effect until after the expiry of that period

109. Under Rule 16(aa) of the rules a social worker requesting a review of a final order under Paragraph 15 of Schedule 2 must make the request within 28 days of the day on which they are notified of the order.

The Professional Standards Authority:

110. 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.