

Social worker: Gareth Andrew
McWha

Registration number: SW134614

Fitness to Practise
Final Hearing

Dates of hearing: 22 September 2025 to 26 September 2025

Hearing venue: Remote hearing

Hearing outcome:

Fitness to practise impaired, suspension order (2 years 6 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. Mr McWha did not attend and was not represented.
3. Social Work England was represented by Ms Louisa Atkin instructed by Capsticks LLP.

Adjudicators	Role
Rachel O'Connell	Chair
Natalie Pickles	Social worker adjudicator
Bridget Makins	Lay adjudicator

Hearings team/Legal adviser	Role
Andrew Brown/Paige Swallow / Poppy Muffett	Hearings officer
Chiugo Eze	Hearings support officer
Andrew Lewis	Legal adviser

Service of notice:

4. The panel of adjudicators (hereafter “the panel”) was informed by Ms Atkin that notice of this hearing was sent to Mr McWha by email to an address provided by the social worker (namely their registered address as it appears on the Social Work England register). Ms Atkin 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 15.08.2025 and addressed to Mr McWha at the email address which he provided to Social Work England. The notice of hearing set out the dates of the hearing from 22 September 2025 to 29 September 2025 and contained all the information required by the Rules;
 - An extract from the Social Work England Register as of 15.08.2025 detailing Mr McWha’s registered address and email address;
 - A copy of a signed statement of service, on behalf of Social Work England, confirming that on 15/08/2025 the writer sent by email to Mr McWha at the address referred to above: notice of hearing and related documents;
6. The panel accepted the advice of the legal adviser in relation to service of notice.
7. Having had regard to Rules 14, 15, 43, 44, and 45 and all of the information before it in relation to the service of notice, the panel was satisfied that notice of this hearing in the correct form had been served on Mr McWha in accordance with the Rules.

Proceeding in the absence of the social worker:

8. The panel heard the submissions of Ms Atkin on behalf of Social Work England and had regard to the following documents:
 - a. An email and letter dated 03/04/2025 addressed to Mr McWha at the same email address to which the notice of hearing was sent “enclosing” the disclosure of Social Work England’s case;
 - b. An email and letter dated 23/04/2025 addressed to Mr McWha at the same email address enclosing directions made at a case management hearing. The letter and email set out that the hearing would be “Between Saturday 20 September 2025 (sic) and Tuesday 30 September 2025 (7 days)”. The enclosed directions stated that that, “The final hearing will take place between Monday 22 September 2025 and Tuesday 30 September 2025. The current time estimate for the hearing is 7 days.”
 - c. An email from Mr McWha dated 24/04/2025 sent from the same at the same email address to which the notice of hearing was sent, in which he stated “*A 7 day hearing, is that excessive? In any event, I’m not taking any part in it. I would have liked to have just revoked my membership, as you had earlier mentioned.*”
 - d. A 30 page bundle of material from Mr McWha setting out his comments on the concern raised by Social Work England including:
 - i. A statement dated 2 November 2022;
 - ii. “Observations” dated 8 August 2023;
 - iii. A statement dated 29 March 2024;
9. The panel observed that Mr McWha responded in the documents listed at paragraph 8(d) above, to the regulatory concerns that were raised by Social Work England and which gave rise to the allegations at this hearing.
10. With regard to the matters that are covered by allegations 1 and 2, he broadly admitted that he had made errors. With regard to allegation 3 and the allegation of dishonesty he denied allegation 3 and any dishonesty.
11. Ms Atkin set out the relevant guidance and law which the panel refers to in its decision set out below.
12. Ms Atkin submitted that it was clear from the correspondence that Mr McWha knew about the hearing and the allegations against him and had decided not to attend. She reminded the panel that Mr McWha had not asked for the hearing to be adjourned and submitted that there was no reason to believe that he would attend on a later date. She acknowledged that there was a potential disadvantage to Mr McWha in not attending but submitted that this was mitigated to a significant extent by the written statements he had made. She submitted that any disadvantage had to be balanced against the

public interest in this matter, which was already between three and four years old, being decided without further delay. She also reminded the panel that there were witnesses who had given up time to give evidence who would be disadvantaged if they had to return on another occasion.

13. The panel received and accepted the advice of the legal adviser, which it followed in its decision set out below.
14. The panel had regard to Rule 43 which provides “*Where the registered social worker does not attend a hearing and is not represented, the regulator or adjudicators, as the case may be, may proceed to determine the matter, including in circumstances where the registered social worker has previously indicated they wished to attend, if they are satisfied that the registered social worker has been served or all reasonable efforts have been made to serve the registered social worker with notice of the hearing in accordance with these Rules.*”
15. The panel also had regard to the Social Work England guidance, “Service of Notices and Proceeding in the Absence of the Social Worker, last updated 5 December 2019”, the decision of the *House of Lords in R v Jones [2002] UKHL 5* and the further guidance given to panels by the Court of Appeal in *GMC v Adeogba [2016] EWCA Civ 162*. These include the following:
 - The discretion to continue in the absence of the social worker should be exercised with great caution and with close regard to the fairness of the proceedings;
 - The decision about whether or not to proceed must be guided by Social Work England’s primary objective of protecting the public;
 - Fairness to the social worker is very important, but so is fairness to Social Work England and the public;
 - Whether all reasonable efforts have been taken to serve the social worker with notice;
 - The panel should consider the nature of the social worker’s absence and in particular whether it was voluntary;
 - Whether there is any reason to believe the social worker would attend or make submissions at a subsequent hearing;
 - Whether the social worker wishes to be represented;
 - Any disadvantage to the social worker in not attending the hearing;
 - The duty of professionals to engage with their regulator;
 - There must be an end to the “adjournment culture”.

16. The panel had regard to the direction given by the Court of Appeal in *Adeogba* (above) *“Where there is good reason not to proceed, the case should be adjourned; where there is not, however, it is only right that it should proceed.”*
17. Having regard to the material set out above, the panel was satisfied that all reasonable efforts have been made to serve Mr McWha with notice of the proceedings and was satisfied that he was aware of this hearing and had made a clear statement that he would not attend the hearing. The panel concluded that Mr McWha had waived his right to attend by voluntarily absenting himself.
18. The panel considered whether an adjournment was likely to result in Mr McWha attending on a subsequent hearing date. It concluded that it was not likely, in light of his clear statement that he would not attend and his subsequent lack of response to the correspondence from Social Work England.
19. The panel bore in mind that Social Work England had secured the attendance of witnesses who had made themselves available. A further delay was likely to have an adverse impact on them and the quality of their evidence.
20. The panel acknowledged that Mr McWha was likely to suffer a disadvantage by not attending the hearing. Nevertheless, it reminded itself of Mr McWha’s professional obligation to engage with his regulator and concluded that any disadvantage to him was mitigated by the detailed response he had made to the original regulatory concerns and had to be balanced against the public interest in this matter being resolved without further delay.
21. Accordingly, the panel decided to proceed in Mr McWha’s absence.

Allegation

The Allegation arising out of the regulatory concerns referred by the Case Examiners on 18 December 2023 is:

- 1. Whilst employed as a social worker at Wigan County Council;**
 - a. In relation to Child A, you;**
 - i. did not complete a visit on 5 February 2021;**
 - ii. did not complete a ‘bottom line’ with Child A’s father on 5 February 2021;**
 - iii. did not check Child A’s reported injury when visiting on 8 February 2021;**
 - iv. left Child A at school, following the visit on 8 February 2021, in circumstances where Child A had disclosed to you that her father had hit her;**

- v. *did not speak to a Manager or colleague prior to leaving Child A at school following the visit on 8 February 2021.*
- b. *In relation to Child B, you did not;*
 - i. *obtain a signed statement of expectations from Child B's father during a visit on 27 October 2021;*
 - ii. *identify and/or escalate concerns to your Manager following the visit on 27 October 2021, either promptly or at all.*
- 2. *Your actions at paragraph;*
 - a. *1a failed to safeguard Child A;*
 - b. *1b failed to safeguard Child B.*
- 3. *In or around September 2022, you informed a recruitment agency that you had completed your Assessed and Supported Year in Employment ('ASYE') when that was not the case.*
- 4. *Your conduct at 3 above was dishonest, in that you knew you had not completed your ASYE.*

The matters outlined at paragraphs 1 – 2 above amount to the statutory ground of misconduct and/or lack of competence or capability.

The matters outlined at paragraphs 3 – 4 above amount to the statutory ground of misconduct.

Your fitness to practise is impaired by reason of your misconduct and/or lack of competence or capability.

Preliminary Matters:

- 22. The panel observed that Mr McWha had responded to the original regulatory concerns and made a number of admissions to them. Nevertheless, he had not responded directly to the allegations now before the panel.
- 23. Ms Atkin submitted that the panel should not treat Mr McWha's admissions in respect of the regulatory concerns as admissions to the allegations for the purposes of Rule 32c(i)(aa) but should take them into account when deciding each of the allegations.
- 24. The panel heard and accepted the advice of the legal adviser which it followed in its decision set out below.
- 25. The panel reminded itself of Rule 32c(i)(aa) Fitness to Practise Rules 2019 (as amended) (the 'Rules') which states:

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

26. The panel was satisfied that Ms Atkin’s approach was correct and treated each of the allegations as contested while bearing in mind that Mr McWha’s written submissions, including his admissions, should be taken into account by the panel when deciding each allegation.

Background

27. Mr McWha completed the ‘Front-Line Programme’ as a student social worker at Wigan Council (the Council) between September 2019 and September 2020. This was a one-year course involving both study and practical experience. At the end of that course Mr McWha qualified as a social worker.
28. Mr McWha was then employed by the Council from 1 September 2020 until 1 November 2020 as a Child, Young Person and Family Worker (a non-social work role). In this role, he worked alongside a social worker providing direct intervention to children, young people and families.
29. On 2 November 2020 Mr McWha started work as a Child and Family Social Worker in the Duty Team. He was assigned to Duty Team C where he undertook an Assessed and Supported Year in Employment (“ASYE”) within the Duty Team at the Council. This is a period during which a social worker works under supervision before working independently.
30. Mr McWha was suspended from work on 10 February 2021. He returned to work following a disciplinary hearing on 12 May 2021, subject to an Action Plan, to improve his performance.
31. From 25 April 2022 until 5 October Mr McWha worked for the Council as Family Group Conference (FGC) and Mediation Co-Ordinator. This was not a social work role and on 4 March 2022 Mr McWha sent an email to the ASYE co-ordinator confirming that he was taking a post in the family group conferencing team (part-time) [PRIVATE], so would no longer be completing the ASYE.
32. At a date which is not recorded but is at some time in September 2022, Mr McWha approached a social work recruitment agency called Pertemps.
33. Allegations 1 and 2 arise from Mr McWha’s work as a Social Worker during his ASYE year. Allegations 3 and 4 arise from Mr McWha’s contact with the recruitment agency, Pertemps.

Summary of evidence:

34. The panel heard and read the evidence of the witnesses upon whom Social Work England relied. The panel deals with the relevant detail of their evidence under its findings in respect of each allegation. Nevertheless, the panel sets out here the witnesses whose evidence it took into account so that their roles are clear:
- a. Laura Farrell, is Social Worker and was an Advanced Practitioner in Duty Team C in 2021. She was Mr McWha’s ASYE assessor and had been “buddied” with him

by the Team manager to give him support during his ASYE year. She gave evidence relating to allegations 1a and 2a, in relation to Child A, in February 2021.

- b. Shareen Denman is a Social Worker and was Interim Team Manager of Duty Team C from January 2021 until around March or April 2021. She gave evidence about the events of February 2021, including allegations 1a and 1b, and the significant personal and professional difficulties faced by Mr McWha at that time.
- c. Paula Latham is a Social Worker and was Team Manager of Duty Team C from 14 June 2021 until April 2022. She gave evidence of the supervision she gave Mr McWha and events that give rise to allegations 1b and 2b (in October 2021). She also gave evidence of what had been reported to her in October 2022 about the matters giving rise to allegations 3 and 4;
- d. Liam Salt is now a university student and was a Recruitment Coordinator with Pertemps Social Care Recruitment from April to September 2022. He gave evidence about his contact with Mr McWha and the Council in relation to allegations 3 and 4;
- e. Rebecca Sutton is a Social Worker Service Lead and the Council's Single Point of Contact for Social Work England. She did not give evidence directly related to any of the allegations but provided helpful information about his background, training and dates relating to Mr McWha's employment with the Council.

35. The panel also received a number of documents, including but not limited to the following:

- a. Case Notes for Child A, 4 February 2021,
- b. Text Messages between Mr McWha and Ms Farrell, 5 February 2021,
- c. An email from Ms Denman recording the events of 5 and 8 February 2021, including her contact with Mr McWha, 8 February,
- d. The records of what Ms Farrell, Ms Denman, and Mr McWha said in investigatory interviews carried out on 24 February, 25 February and 18 March 2021,
- e. Email correspondence between Ms Farrell, Social Work England and Mr Salt in October 2022,
- f. Mr McWha's responses to the regulatory concerns on various dates from September 2021 until 29/03/2024.

36. The panel heard submissions from Ms Atkin. She reminded the panel of the relevant law, including the burden and standard of proof and the directions given to panels by the High Court to recognise the limits of memory and to base decisions, wherever possible, upon contemporaneous records. She also reminded the panel of the law regarding dishonesty.

37. The panel accepted these submissions on the law and referred to the relevant law in its decisions set out below.
38. With regard to allegations 1 and 2, Ms Atkins submitted that there was effectively no dispute about what had happened on 5 and 8 February 2021, apart from the efforts that Mr McWha had made to speak to other social workers. She reminded the panel about the extensive admissions that Mr McWha had made during the initial investigation in the Council and his own written responses, in which Mr McWha said that “he had made a judgement call and got it wrong” and admitted other errors.
39. Ms. Atkin submitted that the position was the same with regard to the events of 27 October 2021 where Ms Latham’s Account was not challenged and Mr McWha had acknowledged in his written statement that he had not recognised the risks to child B at the time.
40. Turning to allegation 2. Ms Atkin submitted that it was clear that Mr McWha, as a social worker, had a duty to protect Child A and Child B and he had failed to do so in both cases by leaving the children at risk of harm.
41. Turning to allegations 3 and 4, Ms Atkin acknowledged that the evidence of what Mr McWha had told the recruitment agency was not as strong or clear as it was with regard to allegations 1 and 2. Nevertheless, she submitted that the panel could reject Mr McWha’s written submission that the agency was acting to cover up its own bad practices and that the evidence was sufficient to prove the allegations on the balance of probabilities. Ms Atkin submitted that Mr McWha would have been perfectly aware that he had not completed his ASYE year and ordinary decent people would have no doubt that he would have been dishonest if he had told the agency that he had.
42. The panel received and accepted the advice of the legal adviser which it has followed in its approach to the allegations set out below.

The panel’s approach

43. The panel accepted and bore in mind all the following matters.
44. The panel considered each allegation separately and reminded itself that the burden of proving each allegation rested upon Social Work England and Mr McWha did not have to prove anything. It reminded itself that the standard of proof is the balance of probabilities, that is to say an event is more likely to have occurred as Social Work England alleged.
45. Where an allegation alleged that Mr McWha failed to do something it asked first whether he had a duty to do so and then whether he had not fulfilled that duty.
46. The panel did not draw any adverse inference from Mr McWha not being present to give evidence and took account of the written responses he had supplied to Social Work

England, bearing in mind that they were not contained in sworn evidence that had been tested by cross-examination.

47. It remembered that it must not speculate but can draw inferences from proven facts.
48. It assessed the evidence of each witness and assessed its reliability, remembering that a witness may be completely honest but nonetheless an unreliable source of evidence because of the passage of time, in particular if there are no contemporaneous notes or records of the matter that the witness deals with.
49. In this context, the panel followed the guidance given by the High Court in a number of cases, including *Roach v GMC* [2024 EWHC 1114 and in particular that “The credibility of witnesses must take account of the unreliability of memory and should be considered and tested by reference to objective facts, and in particular as shown in contemporaneous documents. Where possible, factual findings should be based on objective facts as shown by contemporaneous documents.”
50. The panel acknowledged that it should not have excessive regard to a witness’s demeanour and that a witness’s confidence is not a good indicator of accuracy.
51. The panel bore in mind that Mr McWha is a man of good character, that is to say there have been no criminal or regulatory matters proved against him. The panel acknowledged that this was of particular importance when assessing dishonesty because it made it less likely that he would be dishonest and added weight to the material he had put before the panel. The panel reminded itself that good character is not a defence.
52. With regard to dishonesty the panel followed the test set out in *Ivey v Genting Casinos (UK) Ltd* 2017 UKSC 67
53. “When dishonesty is in question the fact-finding tribunal must first ascertain-
54. (subjectively) the actual state of the individual’s knowledge or belief as to the facts.
55. The reasonableness or otherwise of his belief is a matter of evidence (often in practice determinative) going to whether he held the belief, but it is not an additional requirement that his belief must be reasonable; the question is whether it is genuinely held.
56. When once his actual state of mind as to knowledge or belief as to facts is established, the question whether his conduct was honest or dishonest is to be determined by the fact-finder by applying the (objective) standards of ordinary decent people. There is no requirement that the defendant must appreciate that what he has done is, by those standards, dishonest.”

[Allegation 1 a \(in relation to Child A\)](#)

57. The panel heard and accepted the evidence of Ms Farrell that, on 4 February 2021, she had allocated Mr McWha a priority visit to child A to explore concerns that child A was being, among other concerns, “dragged to her room” by her father.
58. The panel saw a printout of the computer system entry on which the referral was made. That document outlines the background to the allocation, including concerns that Child A was being dragged in the way described and that there are significant concerns regarding parental conflict, inconsistent contact with Child A’s mother, mental health concerns about Child A’s father and concerns about the state of the child’s home.
59. Under the heading “actions”, the document contains the following instructions

Actions:

- Covid risk assessment to be completed prior to initial visit - 05/02/2021.
 - Priority visit to be undertaken 05/02/2021.
 - Social worker to speak with Child A alone in initial visit to gain her views on the current situation and then feedback to AP/TM [advanced practitioner/team manager] for next steps.
 - Social worker to complete a bottom line with dad - he must not be dragging Child A to her bedroom.
60. For the avoidance of doubt, the panel heard and accepted evidence that a “bottom line” is an agreement which a parent can be asked to sign and adhere to in a situation such as this and sets out certain minimum standards that the parent should observe when caring for a child.
 61. The panel is satisfied that Mr McWha received this instruction because it has seen a copy of the text messages between Mr McWha and Ms Denman.
 - a. GM: 9.42 “did you say I was getting a case that required a visit this morning?”
 - b. SD: 9.43 “just in a meeting. It’s the (Child A) case. Read it and ring Startwell worker to see if she will visit with you today she’s put the referral in.”
 - c. GM: 9.43. “Thanks.”
 - d. SD: 11.37 “just spoken to Startwell worker... who states that she is unwell today so can’t do joint visit. (Child A) is in school, so is the emphasis to see child, see dad, or both (obviously need to speak to dad first about meeting (Child A) in school.)”
 - e. GM: 11.38 “speak to Shareen whilst I’m doing marac. Don’t know how long I’ll be.x”

f. SD: 11.38 “Ok thanks”

62. The panel accepted that “Shareen” is Ms Denman, the interim team manager of Team C at that time.
63. Ms Denman gave written and oral evidence that was in accordance with the contents of her Council internal investigatory interview on 25 February 2021.
64. In her written and oral evidence, she said that she was engaged in an urgent case on 5 February 2021 and so “wasn’t able to provide support” although she had no record of Mr McWha contacting her or a colleague.
65. Her evidence was that she telephoned Mr McWha on Monday 8 February 2021, to find out what had happened on 5 February 2021 and it was only then that she discovered that he had not carried out the visit. He explained to her that he had not visited because he had not been able to contact child A’s father. He then told Ms Denman that he had been informed that further concerns had been received from Child A’s school that morning, that Child A had been assaulted over the weekend and suffered an injury.
66. Ms Denmans’ evidence is that she told Mr McWha to stop whatever he was doing, visit child A at school and telephone her before he left the school. When Ms Denman had not heard back from Mr McWha by Monday afternoon she instructed Ms Farrell to call him.
67. Ms Farrell told the panel that when she called Mr McWha he had already left the school and was [PRIVATE] Mr McWha informed Ms Farrell that Child A had reported that her father had been dragging her on the previous evening and had some injuries which the school had witnessed. He had not seen the injuries himself and had left Child A at school to return home while he [PRIVATE].
68. The panel read the account given by Mr McWha in a Council investigatory interview on 18 March 2021. With regard to the events of Friday 5 February 2021 he acknowledged that he had been allocated a “priority visit” and needed to go on 5 February 2021. He explained that he tried to contact Child A’s father but could not get through. He had tried to ring his managers but could not get through to them because they were dealing with a serious case. He had spoken to the Startwell worker who didn’t feel the child was at high risk but the father needed to be spoken to. He said, “I made a judgement call and it was the wrong one.”
69. With regard to Monday 8 February 2021, he acknowledged that he had spoken to Ms Denman and visited Child A at school. He said that he had spoken to Child A but did not see her injury because he understood it to be a bruise on her lower back and he felt that by looking at it he would be placing either Child A or himself in a compromising position. He explained that he had rung Ms Farrell at 2.55 before he left the school, but she didn’t answer. She rang him back at 15.30, by which time he had left to [PRIVATE].
70. The panel also read the account given by Mr McWha at the investigatory hearing which took place on 12 May 2021. The panel observed that Mr McWha gave the same account

as he had before, but gave more detail about his conversation with Child A. He explained that Child A had told him that she had had “a bit of a meltdown” and her father had “grabbed her and smacked her, not hard but just to stop her being upset... I asked her where the bruise was, she said lower back, I didn’t ask to see the bruise”.

71. In light of this evidence, the panel concluded that there is no dispute that Mr McWha did not complete a visit to Child A on 5 February and as a result did not complete “a bottom line” because he did not meet Child A’s father. On 8 February, all the evidence, including Mr McWha’s own evidence to the Council investigation, shows that Mr McWha did not see Child A’s injury, left Child A at school after she told him she had been hit by her father and did not speak to a manager until after he left the school.
72. Accordingly, the panel found paragraph 1a proved in its entirety.

Paragraph 2a (in relation to Child A).

73. In accordance with its approach set out above, the panel first asked whether Mr McWha had a duty to protect Child A at the time. The panel concluded that he did because he was the duty social worker who had been allocated to safeguard Child A in circumstances where he had been made aware both by his initial instructions and the subsequent disclosures made by Child A at school, that she was at significant risk of harm.
74. The panel concluded that by not carrying out a visit on 5 February 2021 and by not ascertaining the extent of Child A’s injury for himself on 8 February and in particular by not contacting a manager or colleague before he left Child A at school, at risk of returning home where she was vulnerable to further injury, Mr McWha had failed to safeguard her.
75. Accordingly, the panel found paragraph 2a proved.

Paragraph 1b (in relation to Child B)

76. This paragraph of the allegation arises from what occurred when Mr McWha was instructed to carry out an urgent visit on 28 October 2021, to Child B, who was judged to be at risk of harm.
77. The panel observed that this paragraph of the allegation was based upon the evidence of Ms Latham whose account was supported by some contemporaneous documentation and subsequent statements Mr McWha had submitted to Social Work England.
78. Ms Latham gave evidence that she took over as manager of Team C in June 2021. She gave evidence that she had taken over the supervision of Mr McWha and ensured the implementation of a support or action plan which had been developed in November 2020 but was not made available to either her or him until September 2021.

79. Nevertheless, she told the panel in both written and oral evidence, that she had given Mr McWha the supervision which she felt he had not received before, including taking him with her to carry out assessments of 11 children. She observed that, until the matters giving rise to this allegation, he had been “doing really well. He always checked in with me and was not providing me with any concerns.”
80. She told the panel that on 27 October 2021 she had instructed Mr McWha to carry out an urgent visit to the home of Child B’s paternal grandparents the following morning. In her evidence, she set out, the concerns regarding Child B.
- a. Child B normally lived with her mother and had supervised contact with her father.
 - b. Child B had initially been assessed because of concerns about domestic violence involving Child B’s father and an agreement was in place for Child B’s father to have contact with Child B with the supervision and support of Child B’s paternal grandmother.
 - c. The case had been reopened following Child B’s paternal grandmother disclosing ongoing domestic abuse (mainly emotional) from Child B’s father towards her. The Council’s concern was that Child B was potentially exposed to this abusive relationship when spending time with her father. A child in need plan was implemented to work with Child B’s mother and father to ensure Child B was safe during contact.
 - d. Urgent concerns had been identified because Child B’s grandmother had been admitted to hospital following a fall in the kitchen and Child B’s mother had told social services on 26 October 2021, that she was going the following day to Ireland because her own father was gravely ill. Child B, who normally lived with her, would be staying in the home of her paternal grandparents.
81. Ms Latham gave evidence that she instructed Mr McWha to speak to Child B’s father and get him to sign a “Statement of Expectations”.
82. Ms Latham explained to the panel that this is a document which sets out the Council’s concerns and what they expect a family to do to deal with these concerns. She said that the “Statement of Expectations” to be signed and agreed by Child B’s father would have set out that if there were any tensions Child B’s father was to leave the home to calm down.
83. Ms Latham gave evidence that she did not hear further from Mr McWha on 27 October 2021. However, whilst working late that evening she was alerted to Mr McWha making an entry in the Council’s computer records. This entry set out that he had visited Child B’s grandparent’s home and been greeted by Child B’s grandmother home from hospital in a neck brace. He had not seen Child B. He had heard Child B’s father

speaking loudly in the house but had not spoken to him because he was informed by Child B's grandmother that he would not come to speak to him. He had then left the "Statement of Expectations" with Child B's grandmother for Child B's father to sign.

84. Ms Latham described how she telephoned Mr McWha, knowing that he was on leave the following day, and expressed her concerns to him, which she described as "red flags". She told the panel that these were that Child B's paternal grandmother was at home when she was supposed to be in hospital. Child B's father was not engaging. Child B had not been seen when there was a potential that she could be exposed to domestic violence. Leaving the statement of expectations with the paternal grandmother was problematic because the grandmother had made a complaint of domestic abuse to her by Child B's father.
85. Ms Latham explained that she was particularly concerned that Mr McWha had not telephoned her as a matter of urgency to explain how the situation had changed and was potentially problematic. She was also concerned that even when she went through the concerns with Mr McWha he did not understand that there was a problem.
86. She told the panel that she recorded her concerns and the panel has seen that this was done at the time in the records.
87. The panel also read Mr McWha's statement to Social Work England dated 2 November 2022, in which he states that the visit unfolded as set out in his record. He explained that Child B's father had refused to come to the door and he chose not to press this for fear of escalating matters. He said that the grandmother said she was more than happy to hand the letter to the father. He acknowledged that he had an agreement with his manager (Ms Latham) to call her if there were any issues but felt at the time that there were none. Therefore, he did not make any call.
88. He went on to explain that when he discussed things with his manager after his visit she raised concerns which at the time he simply could not see. However, he said that upon reflection it was fair to say that he could see why there was a concern and would raise it with a manager if a similar situation arose in the future.
89. Taking this evidence together, the panel is satisfied that Mr McWha did not obtain a signed statement of expectation from Child B's father because he never met him on 27 October 2021. There is also no dispute that he did not identify or escalate concerns to his manager because, on his account and hers, he did not identify any concerns.
90. Accordingly, the panel found Paragraph 1b proved.

Paragraph 2b (In relation to child B)

91. The panel again asked whether Mr McWha was under a duty to safeguard Child B and was satisfied that he did because he was the social worker allocated to visit child B and ensure she was safe in circumstances where significant risks had been identified.

92. The panel concluded that by not obtaining a signed Statement of Expectations and in particular by not recognising and escalating concerns to Ms Latham, he had failed to safeguard Child B.
93. Accordingly, the panel found Paragraph 2b proved.

Paragraph 3

94. The allegation that Mr McWha informed a recruitment agency (Pertemps) that he had completed his ASYE arose initially because Ms Latham received a request for a reference in October 2021. She became aware that the agency appeared to think that Mr McWha had completed his ASYE and she was concerned because this was not the case, for the reasons set out above.
95. The panel observed that the matter was reported to Social Work England, who conducted enquiries with the agency and took a statement from Mr Salt on 30 September 2024. In that statement, he revealed that he had been a recruitment coordinator at Pertemps and was Mr McWha's point of contact. However, through no fault of his own, he did not have any records of discussions between him and Mr McWha. He explained that the company did not routinely record phone calls, but brief notes could be made on its system.
96. The result of this was that he did not know when Mr McWha had approached the agency nor when he had spoken to Mr McWha. He did not know how he had spoken to Mr McWha or how often. He did not know if anyone else had spoken to Mr McWha.
97. Mr Salt gave evidence to the panel and was, in the panel's view, open and frank with the panel about having no recollection of events beyond what was in his statement. The panel has read representations by Mr McWha and noted his concerns that the allegation that he told Pertemps that he had completed his ASYE was part of an attempt to cover up Pertemps' lax practices.
98. The panel found no evidence of such a cover-up and was satisfied that Mr Salt was an honest and straightforward witness who was open about his lack of recollection and the absence of any records of what Mr McWha told Pertemps either when he first engaged with them or subsequently.
99. The panel observed that Mr Salt was also asked what he understood by ASYE and said that he believed it was an additional qualification to qualify a social worker to work with children.
100. The panel observed that Mr Salt's statement contains no recollection that Mr McWha told him he had completed his ASYE only that "it was the usual process to ask a Social Worker during registration process whether they have completed their ASYE and checked throughout the process of on boarding and gathering information."
101. The panel saw an email from Mr Salt to Social Work England dated 22 October 2022 in which he said that "Gareth said he completed his ASYE". However, the panel saw that

there was no record of Mr Salt's source of this information. It also saw the email from Mr Salt to Social Work England dated 11 November 2022 in which Mr Salt confirmed, "I would not be able to provide proof/ documents as we do not record out (sic) phone calls. I apologise I cannot help further.

102. The panel also saw an attendance note made by a Social Work England investigator recording that on 22 October 2022, Mr Salt had told him that a "hiring manager" had asked Mr McWha about his ASYE on the telephone and been told he had completed it. Mr Salt told the panel he had no recollection of anything not in his statement but thought it likely that he was the hiring manager referred to. He added that he had been dealing with a large number of applicants at that time, which added to his difficulty in remembering any individual case.
103. Again the panel observed that Mr Salt had not had access to any records and it was surprising that he should refer to himself in the third person as the hiring manager, when he is referred to as LS throughout the note of the conversation.
104. The panel also revisited Mr McWha's written statements and noted that he had strongly denied telling Pertemps that he had completed his ASYE but only told them that he had completed six months of it. The panel observed that these denials were made in the context of documents in which Mr McWha made full admissions of his mistakes and difficulties as a social worker. The panel also reminded itself that Mr McWha is a man of good character.
105. The panel considered this allegation with particular care because dishonesty is a serious matter and the panel was mindful of its duty to protect the public. Nevertheless, it also had regard to the clear directions given to panels by the High Court to be wary of relying upon memories unsupported by contemporaneous records. The panel observed that this is particularly important where one would expect such records to exist and a witness is trying to remember something as unmemorable as asking someone about his qualifications, in circumstances where he is dealing with many applicants.
106. The panel also reminded itself that the burden of proving this allegation rests upon Social Work England.
107. Taking all those matters together, the panel concluded that there was not enough evidence to persuade it, even on the balance of probabilities, that Mr McWha told Pertemps that he had completed his ASYE. The panel is satisfied that there is at least an equal chance that somebody at Pertemps misunderstood what Mr McWha told them in circumstances where he said he had completed 6 months, in particular when Mr Salt did not understand the nature of the ASYE and what he would have been enquiring or hearing about.
108. Accordingly, the panel found paragraph 3 not proved.
109. In those circumstances the issue of dishonesty raised in paragraph 4 did not arise and the panel found Paragraph 4 not proved

110. That completes the decision on facts.
111. Grounds and impairment
112. Having found proved paragraphs 1 and 2 of the Allegation as set out above, the panel considered whether Mr McWha's fitness to practise is impaired by reason of misconduct or lack of competence or capability.
113. Ms Atkin called no further evidence and relied upon the evidence called at the facts stage.

Submissions on grounds

114. In written and oral submissions. Ms Atkin set out the legal principles relevant to both grounds and impairment and the panel followed those in its approach set out below. She reminded the panel that the questions of grounds and impairment were both matters for the panel's own judgment and there was no question of applying a burden or standard of proof.
115. Ms Atkin submitted that the facts found proved amounted to either misconduct or lack of competence or capability and acknowledged that the choice that the panel must make is not entirely straightforward.
116. Ms Atkin submitted that the distinction could usually be characterised in this way: lack of competence arises when a social worker cannot do what is required of them whilst misconduct arises when a social worker has not done what is required of them despite having the ability to do so.
117. Ms Atkin submitted that there were aspects of Mr McWha's conduct that could properly be characterised as misconduct because the panel had found that Mr McWha had:
 - i. acted contrary to, and despite, clear management instructions;
 - ii. did not keep managers updated with respect to his actions;
 - iii. did not act on clear indications of risk and/or make any significant efforts to obtain support from colleagues / managers.
118. Ms Atkin submitted that Mr McWha's failure to telephone Ms Latham after his unsuccessful visit to see Child B was properly characterised as misconduct because he disobeyed a direct instruction.
119. She acknowledged Mr McWha's relative inexperience, but submitted that this was not sufficient to lessen his culpability for his conduct.
120. Ms Atkin drew the panels attention to the following provisions of Social Work England's professional standards (the Standards), which she submitted Mr McWha had breached by reason of the matters found proved:

Being accountable for the quality of my practice and the decisions I make

3.1 Work within legal and ethical frameworks, using 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.

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

3.8 Clarify where the accountability lies for delegated work and fulfil that responsibility when it lies with me.

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

3.11 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.

121. Ms Atkin submitted that there were factors that pointed to lack of competence or capability including:

- a. the Social Worker has acknowledged, when reflecting on the concerns in his written statements to Social Work England, that “*my knowledge and practice as a social worker is not enough to allow me to get up to speed, in terms of my practice, awareness, and it would require a significant amount of training and support for that to change*”, and he accepted that “*my skill level as a social worker would not meet a requirement that would be fit for purpose*”;
- b. both the incidents involving Child A and Child B raise concerns about the Social Worker’s ability to fulfil basic and core elements of his role, including in terms of his ability to assess risk, and to identify when matters fall outside of the scope of his knowledge and experience;
- c. whilst the incidents involving Child A and Child B do not necessarily represent a fair sample of the Social Worker’s work across the duration of his ASYE, both suggest a lack of competence in a fundamental aspect of social work, and occurred when the Social Worker was not paired with a more experienced social worker.

122. Ms Atkin reminded the panel that if, but only if it found one of the grounds proved, it should go onto consider whether Mr McWha’s fitness to practice is currently impaired.

Submissions on impairment

123. Ms Atkin set out the general principles of impairment of fitness to practise, and the panel refers to these in its decisions below.

124. Ms Atkins drew the panels to the test for impairment set out in the case of Council for Healthcare Regulatory Excellence v Nursing and Midwifery Council, Paula Grant [2011] EWHC 927 (Admin) “Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her fitness to practise is impaired in the sense that s/he:
- i. *has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*
 - ii. *has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*
 - iii. *has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*
 - iv. *has in the past acted dishonestly and/or is liable to act dishonestly in the future.”*
125. Ms Atkin submitted that it followed from the panel’s decision on facts that Mr McWha had put two children at risk of serious harm, had brought the profession into disrepute by failing to safeguard two children when he was under a duty to do so, and breached a fundamental tenet of the profession.
126. Ms Atkin submitted that Mr McWha was liable to do so again because his insight was limited and there was no evidence that he had taken steps to remediate or improve his practice.
127. Ms Atkin acknowledged that Mr McWha had demonstrated some insight in his written submissions by indicating that he understood his actions in relation to child A “were not enough as expected of a social worker”, and that on reflection he could “see why there was a concern” with regards to his actions in relation to Child B.
128. Nevertheless, she submitted that this was not sufficient insight to reduce the risk of repetition because he had not demonstrated understanding of how to avoid such incident in the future. She submitted that this was important because both incidents arose from similar failings.
129. With regard to remediation, Ms Atkin submitted that there was no evidence before the panel that Mr McWha had undertaken any remediation and he had acknowledged in his written submissions that his “skill level as a social worker would not meet a requirement that would be fit for purpose”.
130. Ms Atkin submitted that a finding of impairment was also necessary to promote and maintain public confidence in the profession of social workers and to uphold proper standards conduct for the profession.
131. The panel heard and accepted the advice of the legal adviser, which did not differ from the submissions on the law made by Ms Atkin, and followed that advice in its decisions on grounds and impairment.

The panel's approach

132. The panel accepted and reminded itself of the matters set out below.
133. This stage of its proceedings is itself a two-stage process. The panel must ask first whether the matters it has found proved amount to serious misconduct or lack of competence or capability. If, but only if it does, it should then go on to consider whether Mr McWha's fitness to practise is impaired.
134. Both the grounds and impairment are a matter for the panels own judgement. There is no burden or standard of proof applicable to these questions.

The panel's approach to grounds

135. With regard to misconduct, cases going back to *Roylance v General Medical Council (No.2)* [2000] 1 AC 311 establish that "Misconduct" is a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be found by reference to the rules and standards ordinarily required to be followed by a medical practitioner in the particular circumstances."
136. To make a finding of impairment because of misconduct, the panel must be satisfied that the misconduct is serious.
137. The Panel had regard to the decision of the High Court in *Solicitors Regulation Authority v. Day and others* [2018] EWHC 2726 (Admin) which gave the following guidance to panels: *"We do not, we emphasise, say that there is a set standard of seriousness or culpability for the purposes of assessing breaches of the core principles in tribunal proceedings. It is a question of fact and degree in each case. Whether the default in question is sufficiently serious and culpable thus will depend on the particular core principle in issue and on the evaluation of the circumstances of the particular case as applied to that principle."*
138. With regard to lack of competence and lack of competence, the Panel had regard to the Social Work England Impairment and sanctions guidance (the Guidance), paragraphs 151 to 153:

151. Lack of competence or capability is a separate and distinct category of impairment from misconduct. [28] 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.

152. 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.

153. Single episodes or incidents do not normally suggest a social worker lacks the knowledge or skills to be competent. In exceptional circumstances, a single episode or incident can happen because of a lack of knowledge or competence in a fundamental aspect of social work. This may raise a wider issue of concern for public safety. However, the single episode or incident would need to be very serious. In such cases, a decision maker may make a finding of impairment and decide to place a sanction on the social worker’s practice and registration.

139. The panel accepted that this guidance properly summarised the case of *Calhaem v GMC* [2007] EWHC 2606 (Admin)

(3) ‘Deficient professional performance’ within the meaning of 35C(2)(b) is conceptually separate both from negligence and from misconduct. It connotes a standard of professional performance which is unacceptably low and which (save in exceptional circumstances) has been demonstrated by reference to a fair sample of the doctor’s work.

(4) A single instance of negligent treatment, unless very serious indeed, would be unlikely to constitute ‘deficient professional performance’.

The panel’s decision on grounds

140. The panel first decided whether Mr McWha’s conduct amounted to either misconduct or lack of competence or capability.
141. The panel was satisfied that Mr McWha’s conduct was very serious because on three occasions (5 and 8 February 2021 and 27 October 2021) he put two vulnerable children at risk of harm in circumstances where that risk should have been obvious to a qualified social worker in light of the instructions he was given to visit both children.
142. The panel found that the question it had to ask itself is whether the reason that Mr McWha conducted himself as it has found was that he was culpable for his actions/in actions or because he lacked the competence or capability to act as he should have done.
143. The panel had regard to the following matters relating to his period of practice from the end of his training in 2020 until October 2021.
144. The panel observed that at the end of his training his assessment indicated that (Mr McWha) “*will need support to develop his knowledge, understanding and competence in attending to the range of responsibilities inherent in this role.*” The report observed that he had struggled more than most to work remotely during the Covid-19 pandemic.

145. The panel also had regard to the observation of Ms Farrell, who had assigned Mr McWha the first visit to see Child A on 5 February 2021: *“The Social Worker was three months into his ASYE when he was sent on this visit alone. I was asked to allocate the case to the Social Worker by Ms Denman but on reflection, I probably would not have done this as he was only at the start of his career.”*
146. The panel also had regard to the observations of Ms Denham, regarding the events of 5 and 8 February 2021, in which she was closely involved as team manager: *“The concerns could have been managed by additional training and more supervision. I do not think that the Social Worker was negligent, but we should have supported him more as a local authority. It was a learning curve for the Social Worker himself, but we all play a part in that.”*
147. The panel also observed that Mr McWha was made the subject of action plans before Ms Latham became his manager in June 2021 but Ms Latham was unable to locate an action plan until September 2021 and it was apparent to her that Mr McWha had not seen a copy of a plan, much less been supported to complete it, until September 2021.
148. The panel observed that there was very little evidence that Mr McWha was formally supervised, certainly before June 2021 when Ms Latham became his line manager. Ms Latham recognised his limitations and put in place a program of close supervision, an action plan and a reduced caseload.
149. The panel also reminded itself of Miss Latham’s evidence about the events of 27 October 2021, in relation to Child B. The panel accepted that she had gone through with Mr McWha all the concerns she had about him not seeing Child B or her father and not reporting back to her about the risks that he should have observed. The panel also accepted her evidence that Mr McWha, to her dismay, had simply not understood the concerns and the risks, even when they were pointed out to him.
150. The panel had regard to Mr McWha’s written statement of 2 November 2022 in which he acknowledged that he had not understood the concerns about Child B at the time, although he said he could now *“upon reflection I think it’s fair to say that I can see why there was a concern, and so were this to occur again I would ensure that I raise it with my manager, AP or peers for advice.”*
151. The panel observed that there were significant similarities between what occurred in February 2021 and October 2021. On both occasions, Mr McWha put a child at risk of harm because he did not act to address the risks that they faced. The panel found that these were serious failings.
152. The panel considered whether its findings should be characterised as misconduct in light of their seriousness. The panel considered the reasons why Mr McWha acted as he did. It observed that there was no suggestion that Mr McWha had intended to put children at risk and acknowledged that he worked with Ms Latham in accordance with the action plan to improve his practice.

153. Taking all the evidence together, the panel concluded that the reason that Mr McWha acted as he did was that he was unable to assess or even appreciate risk, rather than having the ability to do so and choosing not to, which would have lent itself to a finding of misconduct. The panel examined Mr McWha's failures to report to his managers on more than one occasion and concluded, in light of the pattern of events outlined above, that this arose because he could not appreciate that he had something to report.
154. The panel was satisfied that recognising risk is a fundamental competence and capability required of a social worker, which Mr McWha never fully acquired over the period from November 2020 to October 2021 and he demonstrated this by a pattern of behaviour over several months.
155. For these reasons, the panel concluded that the matters found proved demonstrated a lack of competence or capability.

The panel's approach to impairment

156. Having found that the matters found proved demonstrated a lack of competence or capability, the panel went on to consider whether Mr McWha's fitness to practise is currently impaired. The panel reminded itself of the matters set out below.
157. Not every finding of lack of competence will lead to a finding of impairment and this too is a matter for the panels own judgement.
158. The panel is concerned with current impairment, now some four years after the events giving rise to the panel's findings.
159. There is no statutory definition of impairment but the panel followed the approach endorsed by the High Court in *CHRE v NMC and P Grant* [2011] EWHC 927 (Admin): *"Do our findings of fact in respect of the (registrant's) misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her fitness to practise is impaired in the sense that s/he:*
- a) has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*
 - b) has in the past brought and/or is liable in the future to bring theprofession into disrepute; and/or*
 - c) has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*
 - d) has in the past acted dishonestly and/or is liable to act dishonestly in the future."*
160. The Guidance, reminds panels that it must have regard to what it describes as personal impairment and public impairment. Personal impairment arises from the risk that a social worker will repeat his misconduct or lack of competence. Public impairment

arises from the need to promote and maintain public confidence in the profession of social work and uphold proper standards for the profession.

161. When considering personal impairment, the panel should ask whether Mr McWha's lack of competence or capability is remediable, whether Mr McWha has taken steps to remediate and whether it is likely to be repeated.
162. A decision on impairment must not lose sight of the importance of promoting and maintaining public confidence in the profession and upholding standards of conduct.

The panel's decision on impairment

163. Before turning to the questions set out in Grant (above), the panel considered the risk that Mr McWha would repeat his lack of competence if he returned to unrestricted practice.
164. The panel acknowledged that Mr McWha had demonstrated in his written statements that he understood that his performance had fallen below that required of a social worker and that he lacked the competence and skills to practise safely. The panel accepted that this demonstrated that he had developed some insight.
165. Nevertheless, it observed that he had not understood the nature of his failings or why they had occurred, apart from his statement that he had received inadequate supervision until Ms Latham became his manager. The panel observed in particular, that Mr McWha had not demonstrated an understanding of what he would need to do to acquire the skills and competence necessary to practise safely. In his last statement, Mr McWha stated *"I had not intended to engage with this process, following my decision to walk away from social work due to the poor experience during my brief period to date."*
166. The panel found that remediation would not be easy because the competence that Mr McWha lacked was fundamental. The panel concluded that remediation would require a great deal of learning and reflection.
167. The panel found that, probably in light of his lack of understanding and decision to leave social work, Mr McWha has not taken any steps to improve his competence or reduce the risk of repetition.
168. For those reasons, the panel concluded that the risk of repetition is high.
169. The panel then turned to the question set out in the Grant case (above). In fairness to Mr McWha and for the sake of completeness, the panel records that there is no question regarding his honesty in this case.
170. Nevertheless, the panel concluded that:
 - a. by failing to safeguard vulnerable children, Mr McWha put service users at unwarranted risk of serious harm; and

- b. Mr McWha brought the profession into disrepute by failing to carry out one of the core duties of a social worker in his position;
- c. The panel observed that the Standards set out one of the fundamental tenets of the profession was to “promote the rights, strengths, and well-being of people, families and communities. The panel was satisfied that Mr McWha breached that tenet by failing to protect vulnerable children.

- 171. The panel then went on to consider whether he was liable to do these things in the future and concluded that he was in light of it finding that the risk of repetition is high.
- 172. The panel concluded that a finding of current impairment is necessary under the head of personal impairment.
- 173. The panel then considered whether a finding of impairment is necessary under the public component. The panel concluded that it was because public confidence in the profession would be seriously undermined if a social worker were able to return to unrestricted practice after demonstrating that he lacked the competence to carry out a core duty to protect vulnerable children and in particular while the risk of repetition remains because there is no evidence that he has subsequently acquired that competence.
- 174. Accordingly, the panel found Mr McWha’s fitness to practise impaired under both the personal and public components.

Decision on sanction

- 175. Having found Mr McWha’s fitness to practise impaired, for the reasons set out above, the panel considered what, if any, sanction it should impose upon his registration.

Submissions and advice

- 176. The panel heard submissions from Ms Atkin. She reminded the panel that the purpose of a sanction is not to punish a social worker but to protect the public, including the wider public interest in maintaining confidence in the profession and upholding standards of conduct for the profession.
- 177. Ms Atkin referred the panel to the Guidance and reminded the panel of the established approach to sanctions, starting with the least restrictive sanction and continuing until it found the least restrictive sanction that is sufficient to protect the public. She submitted that the panel should impose a sanction that is proportionate to the risk to the public the panel has identified.
- 178. Ms Atkin referred the panel to the Guidance and reminded the panel of its findings that Mr McWha had put vulnerable service users at risk and that there remained a risk that he would do so in the future. She submitted that, in those circumstances, taking no action, advice and warning were not appropriate sanctions, because they would not protect the public by restricting Mr McWha’s practice.

179. Ms Atkin drew the panel's attention to the relevant paragraphs of the Guidance and submitted that conditions would be neither appropriate nor workable in this case.
180. Ms Atkin reminded the panel that removal was not available to the panel because it had found impairment on the ground of lack of competence and, in those circumstances, a panel could not remove Mr McWha from the register until he had been the subject of a substantive order for two years.
181. Accordingly, she submitted that the appropriate sanction in this case was suspension. She submitted that the appropriate length was two years.
182. The panel also accepted the advice of the Legal Adviser which it has followed in this decision.

The panel's approach

183. The panel was aware that the purpose of sanction is not to be punitive but to protect the public and the wider public interest, which includes promoting and maintaining public confidence in the profession and promoting and maintaining proper standards for social workers.
184. The panel also bore in mind the principle of proportionality and balanced the panel's duty to protect the public against the rights of Mr McWha to practise his profession. The panel reminded itself that it should consider each sanction in turn and impose the least restrictive sanction necessary to protect the public, including the wider public interest.
185. The panel had regard to the Guidance when making its decision.

The panel's decision

186. The panel first identified the following aggravating and mitigating factors, having regard to the examples given at paragraphs 81 and 82 of the Guidance.
187. The panel identified the following aggravating factors, based upon the findings it has already made:
 - a. Mr McWha by failing to safeguard Child A and Child B placed two children at risk of harm;
 - b. Mr McWha has only limited insight and there is no evidence that he has undertaken remediation or is willing to do so;
 - c. Mr McWha failed to demonstrate the necessary competence or capability despite increased support and supervision, and failed to learn from his failings in February 2021;
188. The panel also identified the following mitigating factors:
 - a. Mr McWha was inexperienced;

- b. Mr McWha's progress had been affected by Covid, remote working and several changes of line manager during the first six months of his ASYE year;
- c. Mr McWha was recognised by his managers to have significant personal difficulties.

189. The panel balanced the aggravating and mitigating factors and concluded that the aggravating factors significantly outweigh the mitigating factors because Mr McWha's lack of competence related to skills that are fundamental to his work as a social worker and had put service users at risk. In addition, he had insufficient insight and was not willing to remediate.
190. Before turning to consider each sanction in term, the panel reminded itself that it had found that Mr McWha was at significant risk of practising with a lack of competence or capability in the future and of putting members of the public at risk of harm.
191. The panel first considered whether it was appropriate to take no further action. The panel had regard to paragraph 94 of the Guidance and was satisfied that there were no exceptional circumstances which would justify taking this course.
192. The panel then considered whether it should issue advice or a warning to Mr McWha. It had regard to paragraphs 107 to 112 of the Guidance and found that neither issuing advice or a warning was sufficiently restrictive to protect the public from the identified risk of repetition nor to uphold the wider public interest, in light of the seriousness of Mr McWha's failings.
193. The panel then considered whether it could protect the public by the imposition of a conditions of practice order. The panel had regard to paragraphs 114 and 117 of the Guidance, which provide

114. Conditions of practice may be appropriate in cases where (all of the following):

- *the social worker has demonstrated insight*
- *the failure or deficiency in practice is capable of being remedied*
- *appropriate, proportionate, and workable conditions can be put in place*
- *decision makers are confident the social worker can and will comply with the conditions*
- *the social worker does not pose a risk of harm to the public by being in restricted practice*

115. Decision makers commonly apply conditions of practice in cases of lack of competence or ill health. Conditions of practice may be appropriate where (both of the following apply):

- *public protection can be delivered by some restriction of practice*

- *it is not necessary for public protection (or public confidence in the profession) to suspend the social worker's registration*

116. When considering public protection, decision makers must fully assess insight and the social workers past engagement with the regulator and any employer. This should help to determine whether the social worker can comply with conditions of practice.

117. Decision makers must also be satisfied that the social worker is willing to (and capable of) complying with the conditions.

194. The panel acknowledged that “decision-makers commonly apply conditions to practice in cases of lack of competence...”. However, in this case, the panel could not be satisfied that the factors set out at paragraph 114 applied for the following reasons.

- d. The panel has already found that Mr McWha has demonstrated only limited insight;
- e. Mr McWha has shown that he cannot practise safely, even when receiving regular supervision after June 2021 and with a restricted work load;
- f. Mr McWha's failings are so fundamental and persistent that the panel cannot envisage conditions sufficient to remedy Mr McWha's failings before he has undertaken significant retraining and reflection;
- g. The panel has found that Mr McWha has put Child B at risk despite receiving regular supervision at that time;

195. For these reasons, the panel concluded that it could not draft workable conditions, that would address the risk to the public in this case, and which did not effectively result in Mr McWha being suspended from practice.

196. The panel also found that conditions of practice would not be sufficient to promote and maintain public confidence in the profession because it was satisfied that an informed member of the public would not have confidence in the profession if someone who had demonstrated a failure to acquire basic skills was allowed to return to practice, even subject to conditions, without demonstrating that he had first acquired those skills.

197. The panel has also observed that Mr McWha has indicated that he does not wish to return to social work and in those circumstances the panel can have no confidence that he would comply with any conditions.

198. The panel therefore concluded that the only sanction available to it which would protect the public and the wider public interest is a suspension order. The panel was reassured in this view by Paragraph 136 of the Guidance, which provides:

136. Suspension is appropriate where (both of the following apply):

- *the decision makers cannot formulate workable conditions to protect the public or the wider public interest*

- *the case falls short of requiring removal from the register (or where removal is not an option)*

199. The panel then considered the appropriate length of a suspension order. The panel reminded itself that the maximum length of suspension that it can impose is three years. The panel reminded itself of the following:
- a. The panel has already found that Mr McWha would require a significant amount of retraining in circumstances where there is no evidence that he has started that process;
 - b. Mr McWha has indicated that he does not intend to return to practise as a social worker and has not engaged with the hearing process;
 - c. If Mr McWha changes his mind and wishes to demonstrate that he has developed sufficient insight and undertaken sufficient training to return to (at least restricted) practice, the Regulations allow a social worker to apply for an early review;
 - d. If Mr McWha wishes to leave social work and cannot do so while these proceedings continue, he is not assisted by frequent reviews and a future review panel cannot remove him from the register until two years have elapsed from the making of the final order in this case.
200. Taking all those matters into consideration, including giving Mr McWha time to retrain if he wishes, and facilitating his removal from the register if he does not, the panel concluded that the correct period of suspension is 2 years and 6 months.
201. Accordingly, the Panel directs that Mr McWha's registration be suspended for two years and six months.
202. This order will be reviewed shortly before it expires. The Panel accepts that it cannot bind a future reviewing Panel. The panel has not noted that Mr McWha does not currently wish to return to practise as social worker and this panel cannot bind a future review panel, whether at an early review or shortly before this order expires.
203. At a final review hearing it will be open to the panel to order Mr McWha's removal from the register.
204. Nevertheless, in case Mr McWha changes his mind, and in order to give him some assistance, the panel points out that a review panel is likely to be assisted by the following:
- a. Mr McWha's attendance at the review hearing;
 - b. a written reflective piece containing Mr McWha's reflection on his lack of competence, the impact it had and what he needs to do to remedy his failings;

- c. evidence that Mr McWha has taken steps to address his failings through study, appropriate courses, or any work that does not require registration as a social worker or any other means;
- d. testimonials from any work, paid or unpaid that Mr McWha has undertaken
- e. evidence of up-to-date CPD to demonstrate that Mr McWha has attempted to keep his knowledge and skills up-to-date.

Interim order

- 205. Following its findings on sanction, the panel considered an application by Ms Atkin for an Interim Suspension Order to cover the appeal period before the sanction becomes operative.
- 206. Ms Atkin submitted that an order is necessary in light of the risk the Panel has already identified that Mr McWha would put members of the public at risk of harm if allowed to practise at this time.
- 207. She submitted that an interim conditions order would not be sufficient to protect the public for the same reasons that the panel found that a substantive conditions order would not be sufficient to protect the public.
- 208. The panel accepted the advice of the legal adviser which it has followed in this decision.
- 209. The panel reminded itself that it can only impose an interim order (under paragraph 11(1)(b) of the Regulations) if satisfied that it is necessary for the protection of the public, including the wider public interest, or in the interests of the social worker.
- 210. The panel also reminded itself that it had already found that Mr McWha posed a risk to service users and that public confidence in the profession would be undermined if he were free to practise at this time.
- 211. It noted that if no order is made, Mr McWha would be free to practise until the appeal period expires, 28 days after service of the order, or any appeal is dealt with. Accordingly, the panel was satisfied that an interim order was necessary for the protection of the public for the same reason that the substantive sanction is necessary.
- 212. The panel next considered whether it would be sufficient to impose an interim conditions of practice order. It was mindful of its earlier findings and decided that an interim conditions order would not be sufficient for the same reason that a conditions order would be insufficient as a final sanction.
- 213. Accordingly, the panel imposed an Interim Suspension Order to protect the public including the wider public interest.
- 214. It determined that it is appropriate that the Interim Suspension Order be imposed for a period of 18 months to cover the appeal period. When the appeal period expires, this Interim Order will come to an end unless there has been an application to appeal. In that case, it will expire when the appeal has been dealt with.

215. The panel was informed that there is an interim suspension order in place in respect of Mr McWha, which will expire on 19 November 2025. However, the panel accepted that it has no power to revoke that order without giving separate notice to Mr McWha. Accordingly, the panel decided to allow that order to run its course, unless revoked by an interim order panel.
216. That concludes this hearing.

Right of appeal

217. 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.
218. 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.
219. 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.
220. 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:

221. 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

222. 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:

223. 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>.