Social worker: Sheela George
Registration number: SW52915
Fitness to Practise
Final Hearing

Dates of hearing: 20 January 2025 to 30 January 2025 (Final Hearing), 22 May to 23 May 2025 and 27 May – 30 May 2025 (Resuming Final Hearing), 30 June to 03 July (Resuming Final Hearing), 26 August – 27 August 2025 (Resuming Final Hearing) and 21 October 2025 (Resuming Final Hearing)

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. Sheela George ("Mrs George") attended throughout the Final Hearing and resumed Final Hearing and was not represented at either hearing.

3. Social Work England was represented by Ms Sophie Sharpe case presenter instructed by Capsticks LLP.

Adjudicators	**Role**
Miriam Karp	Chair
Beverley Blythe	Social worker adjudicator
Angela Brown	Lay adjudicator

Simone Ferris/Titlee Pandey	Hearings officer
Robyn Watts/Chiugo Eze/Lauryn Green/Kathryn Tinsley	Hearings support officer
Candice Manifold	Legal adviser

20 January 2025 to 30 January 2025 (Final Hearing)

Service of notice:

4. The panel of adjudicators (hereafter "the panel") was informed by Ms Sharpe that notice of this hearing was sent to Mrs George by email and next day special delivery service on 10 December 2024, to an email address and postal address provided by the social worker (the registered address as it appears on the Social Work England register).

5. The panel of adjudicators 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 10 December 2024 and addressed to Mrs George at her email address and postal address, which they provided to Social Work England;

    - An extract from the Social Work England Register detailing Mrs George's registered address;

    - A copy of a signed statement of service dated 09 January 2025, on behalf of Social Work England, confirming that on 10 December 2024 the writer sent by email and next day special delivery service 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 all of the information before it in relation to the service of notice, the panel was satisfied that notice of this hearing had been served on Mrs George in

accordance with Rules 44 and 45 of the 2019 Fitness to Practise Rules 2019 (as amended) (the "Rules").

20 January to 30 January 2025 (Final Hearing)

Preliminary matters:

8. Ms Sharpe on behalf of Social Work England confirmed that by way of preliminary matters:

   a. Social Work England sought to make an application for privacy in relation to health matters;

   b. That there was no application for admission of hearsay evidence, as the inclusion of the statements of the two witnesses not being called, had been considered and agreed at an earlier case management meeting.

Application for part of the hearing to proceed in private

9. Ms Sharpe made an application for those parts of the hearing that relate or refer to Mrs George's health or private life to be held in private.

10. The panel accepted the legal advice provided by the legal adviser, namely that pursuant to Rule 37, and subject to Rule 38 of the Rules, Fitness to Practice Hearings are to be conducted in public. Further, that Rule 38 provides that the panel must sit in private to consider matters of the social worker's physical or mental health and may sit in private where it is appropriate, having regard to Mrs George's vulnerability, interests, or welfare.

11. The panel decided that it would be proportionate and appropriate to allow the application for those parts of the hearing that refer or relate to Mrs George's health and/or private life to be held in private session. A redacted public version of the panel's determination will be produced for publication.

22 May to 23 May 2025, 27 May – 30 May 2025 (Resuming Final Hearing)

Preliminary matters:

12. At the resuming final hearing Mrs George made an application to rely on two pieces of further evidence. The first being a character statement from a family friend/colleague, and the second being the admission of the Fitness to Practise Case Investigation Report and reference to the Interim Order that had been imposed. Whilst there was no objection from Social Work England to the admission of the character statement, Social Work England did object to the disclosure of and inclusion of the Fitness to Practise

Case Investigation Report on the basis that the panel would not normally have knowledge of earlier decisions and in any event, this was not relevant to the facts that the panel were required to consider. Mrs George asked that the panel have sight of the Fitness to Practise Case Investigation Report, so that it could understand the application that she was making.

13. The panel accepted the advice of the legal adviser regarding the power to conduct FTP hearings as it considered fair and reasonable, and that this extended to the late admission of documents. The panel allowed the admission of the statement/character reference but did not allow the admission of the Fitness to Practise Case Investigation Report on the basis that the panel did not consider this relevant to the facts that it had to go on to decide at stage one.

Background:

14. On 21 December 2018, Social Work England received a referral from Mr David Hynes, Team Manager at Wirral Council regarding the Respondent social worker, Sheela George.

15. Mrs George had been employed by Wirral Metropolitan Borough Council ("Wirral Council") as a social worker from around October 2005. In 2017, Mrs George was working within the Assessment and Intervention Team 8, Children's Services at Wirral Council.

16. Between November 2017 and November 2018, concerns were raised about Mrs George's practice, in particular in relation to the timely completion of assessments and visits, and safeguarding failings including failing to assess known or reported risks.

17. The concerns were investigated by way of an internal investigation and disciplinary process which gathered and considered relevant evidence from a number of sources.

Allegations:

18. The Allegations were as follows:

Whilst registered as a social worker:

1. *Between approximately May 2018 and November 2018, you failed to appropriately act in the following cases:*

    a. *Service User 1 in that you:*

        i. *Did not take appropriate safeguarding action on or around 9 May 2018;*

        ii. *Did not respond to and/or follow up reported concerns;*

        iii. *Did not complete a Single Assessment within timescales.*

b. Service User 2 in that you:

i. Did not complete a Single Assessment within timescales;

ii. Did not adequately complete the Single Assessment in that it did not contain an adequate analysis of risk pertaining to Person A.

2. Between approximately November 2017 and November 2018, you failed to complete assessments within timescales in one or more of the following cases:

a. Service User 3 and/or Service User 4;

b. Service User 5;

c. Service User 9.

3. Between approximately November 2017 and November 2018, you failed to complete visits within timescales in one or more of the following cases:

a. Service User 3;

b. Service User 1.

The matters set out at paragraphs 1 – 3 constitute misconduct.

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

Admissions:

19. Case management directions issued on 01 November 2024 required Mrs George to indicate which parts of the statement of case were admitted and which remained in dispute. Mrs George did not comply with this Direction; however, she did provide a written response to one of the witness statements.

20. At the Case Management Meeting on 13 January 2025 Mrs George was given a further opportunity to respond and state her case, it being directed that she provides any additional responses by 5pm on 15 January 2025. Mrs George complied with this direction and lodged a completed response form and a response to the witness statement of Simone White.

21. Following the reading of the allegations the panel Chair asked Mrs George whether she admitted any of the allegations.

22. Mrs George informed the panel and as set out in her completed response dated 15 January 2025, that she did not admit all of the allegations, and that whilst she admitted

some of the allegations that she wished to provide context and/or provide valid reasons.

23. Ms Sharpe invited the panel to find the allegations admitted to by the social worker as proved in accordance with Rule 32 (c)(i) (aa) of the Rules.

24. The panel heard and accepted the advice of the legal adviser in respect of Rule 32 (c)(1) (aa) and the need to exercise caution in respect of the partial admissions made by Mrs George, which had each been qualified with context and/or rationale.

25. The panel noted that whilst Mrs George had made admissions in respect of allegations 1 a) i), 1a) ii) and 2b), in each instance, they were caveated with Mrs George wishing to provide context or further information. The panel decided that in light of this, there was no unequivocal admission on the part of Mrs George in respect of any of the aforementioned allegations, and that they would have to take the caveats as a denial. The panel reminded itself that Mrs George is not represented at the hearing and therefore may not necessarily fully understand the implications that admission to allegations and the panel finding them as proved would have. Consequently, the panel decided that it would be incorrect of it to proceed on the basis of having found those allegations proved.

26. The panel recorded therefore that Mrs George denied all the allegations. In line with Rule 32c(i)(a), the panel then went on to determine the disputed facts.

Legal advice on procedural fairness

27. During witness examination the panel was concerned about the timetable and the fact that Mrs George had indicated that she would still need significant time with the witnesses, so the panel sought legal advice.

28. The legal adviser informed the panel that Rule 32 of the Rules allowed the panel to regulate its own procedure and conduct the hearing or meeting in a manner it considers fair, and the panel was also reminded of Article 6 of the European Convention of Human Rights.

29. The panel was advised that it can ask questions of the witness and was referred to the case of *Gossalakal v General Medical Council* [2015] EWHC 2445 (admin) in which it was held that interventions from the Chair to obtain vital information from a witness were held not to amount to a procedural irregularity. Further, the panel was provided with advice in respect of the role of the legal adviser and the extent to which she was able to assist Mrs George. The panel was reminded that Mrs George had chosen not to exercise her right to be represented or appoint a McKenzie friend, and was advised that notwithstanding the difficulties it recognises Mrs George has, it should also be mindful of any potential for a suggestion of bias or the favouring of one party over another. The panel was reminded of the test for apparent bias of the fair-minded and informed observer.

30. The panel having heard and accepted the advice of the legal adviser, allowed Mrs George additional limited time to that which had been allocated on the hearing timetable.

Summary of evidence:

31. Social Work England chose not to call the following witnesses; it having been agreed between the parties that their statements could be admitted as hearsay evidence:

    a. Deborah Heaney and

    b. Charmaine Morrison

32. The panel first heard evidence from Ms Simone White, who was at the relevant time, the Deputy Director of Children, Families and Education at Wirral Council. Ms White confirmed that she had since retired and was no longer working for Wirral Council.

33. Ms White stated that she had had no involvement with Mrs George prior to the investigation in November 2018, that 07 November 2018 was the date that she formally wrote to Mrs George to confirm her suspension, but that she believed the suspension to have taken place before this. Ms White stated that the suspension was carried out by Mrs George's then Team Manager, David Hynes, and subsequently brought to her attention. Ms White explained her role as the Hearing Officer, and also the role of Ms Dawn Stanley-Smith who had been appointed as the Investigation Officer.

34. In respect of Liquid Logic, the case recording system used by the Council at the time, Ms White gave evidence to the panel that the system logs who the user is, the time that the file has been accessed and also records what has been accessed. Further, that this ensures that any record is only accessed appropriately by individuals who need to see it. In response to the suggestion by Mrs George that records had been deleted and whether that was in fact possible, Ms White confirmed that her understanding was that to delete records once they had been inputted onto Liquid Logic, that the request would have to be made via the IT service and that this is not something that an individual could do at the push of a button, and that it would require permission.

35. In respect of Mrs George not having followed up referrals due to her believing them to have been malicious, Ms White gave evidence to the panel that as a matter of general social work practice she would expect each concern or referral to have been responded to, and some follow up undertaken to ensure that children were safe and well. Ms White went on to say that if you were clear that an individual had been subject to a range of malicious concerns, that you would follow up as a minimum to check on the welfare and safety of the children. Further, Ms White went on to say that it would not be acceptable to rely on the fact that agencies had not contacted the social worker to raise concerns as the rationale for the social worker not making further enquiries.

36. With regards to visiting timescales, Ms White confirmed in evidence that visiting frequencies during assessment would be expected to be more frequent than those when a child is subject to a Child In Need (CIN) plan, as by the time that you had completed your assessment you would understand whether the child was still a child in need, what the concerns were and what support needed to be put in place. She explained that whilst completing an assessment, it would be good practice to visit regularly and how much or how regularly depended upon the nature of the concerns being investigated. Ms White stated that where there is a concern, you would want to complete that assessment as quickly as possible, to ascertain whether the mother was being open and honest, the children's lived experiences and drawing knowledge from those that know the family. Therefore, in order to do that the visiting frequency to complete an assessment quickly would need to be more frequent than that for a child that was subject to CIN.

37. With regards to timescales for assessment, Ms White stated that overall, an assessment needed to be completed within a maximum of 45 working days, but if you believed a child to be at risk of harm and potentially a child protection concern, you would want to be completing that assessment within a much quicker timescale. If a child was considered to be at risk of this significant harm, a strategy discussion would be convened to meet and discuss the concerns with other agencies. Further, that you would expect to hold the strategy discussion within 15 working days of the referral, so an assessment would need to be done speedily.

38. Ms White confirmed that whilst she understood that Mrs George stated that she went to seek advice from her line manager as quickly as possible, that the appropriate safeguarding action on 9th May 2018 in her very strong view and belief was that Mrs George should have called for help, either from her line manager or the police, and to have remained at the family home whilst doing so. She further stated that given that there were two children potentially at risk of harm, she would have expected the line manager to have ensured that either the social worker or the line manager himself would have made a record in the notes and ensured that it had been followed up. She went on to state that she could only assume that this was not done because the children had been located at nursery and were well or they had been seen in some way, that had not been recorded on the file. However, she would expect a line manager to make a record and ensure that the matter was followed up.

39. Ms White stated that she had considered evidence of a range of times where there had been discussions between Mrs George and her manager as to her support needs, and that if Mrs George did not feel satisfied with that she would have expected her to have raised this with her line manager's manager, the union or herself but that she did not do so.

40. In response to the suggestion that the investigating officer Dawn Stanley-Smith, assisted by Mr Hynes, had tried to get Mrs George into trouble or colluded, and /or that others including herself had treated Mrs George less favourably owing to her race or disabilities, this was not accepted, and Ms White stated that she could not think of any

reason why they would want to do that. With regards to alleged race and disability discrimination in particular, Ms White stated that as part of the investigation, she did consider these matters carefully and listened to Mrs George's concerns, and that she also took note of where Mrs George said that there was mitigation for tasks that had not been undertaken.

41. Ms White explained that we (social workers) do a difficult job and she herself has disabilities which require her to have reasonable adjustments, but that she has to make sure that once those reasonable adjustments are in place that she is keeping children safe and that if she has difficulty complying owing to her own disabilities, that she must make sure that the welfare of the children is prioritised. Ms White's accepted that Mrs George's disabilities and required reasonable adjustments may have impacted her ability to carry out the administrative tasks/functions of her role but did not accept that these would have impacted her ability to make appropriate safeguarding decisions and judgement.

42. In regard to caseload levels and what is considered reasonable, Ms White's evidence to the panel was that this model was not in fact used consistently and was ultimately discarded due to its complexity. She stated that it was difficult to define what was considered a reasonable caseload and this varied from social worker to social worker and from team to team depending on their focus. She acknowledged that caseloads may have been too high at Wirral Council. She told the panel that she had come in to assist Wirral Council due to Ofsted failures.

43. The panel went on to hear evidence from Mr David Hynes, who was at the relevant time, the Team Manager at Wirral Council and the line manager of Mrs George, Mr Hynes confirmed that he is now retired and is no longer registered as a social worker.

44. In respect of caseloads, Mr Hynes stated that the average caseload in the teams that he was responsible for over the years, was above 20 children, between 20 and 30, sometimes 35. He went on to explain that these cases often contained a mixture of CIN, new assessments, and Child Protection (CP), and care proceedings cases. He stated that Mrs George's caseload was significantly below this, throughout the period of time that he managed her. Mr Hynes stated that there were reasons for Mrs George's caseload being lower, some to do with her sickness and returning to work, but that throughout the whole time that he managed Mrs George that her caseload was between 10 and 20 cases/children. Further, that Mrs George never had any care proceedings cases, which is the most complex type of work. Most of Mrs George's cases were CIN, with some CP. His judgement was that Mrs George's caseload was lower than what would normally be expected, and he did not agree that Mrs George's caseload was high, or the cases were particularly complex.

45. Mr Hynes confirmed in evidence that he did not actively use the Council's workload management scheme in allocating to Mrs George or the other social workers nor that he utilised it in assessing their capacity to take new work.

46. In respect of timescales for the completion of assessments, he accepted the documentary evidence that quoted the Working Together to Safeguard Children 2018 guidance as being 45 working days and the Council's practice guidance which states the aim for Wirral to complete assessments within the national average of 26 days. Mr Hynes was unable to confirm which Council policy or Council document stipulated that a single assessment or assessment must be within a shorter abridged timescale of 15 days. He acknowledged that Mrs George had been allocated assessments to complete within 15 days and explained that this was his practice as a manager within the Council and that sometimes the concerns meant that there was a need for completion of an assessment within a shorter period of time. Mr Hynes gave the single assessment and risk assessment in respect of unborn/newborn C as an example, where it was directed that the assessment be completed within 15 days and so that it could then be considered at the conference for the half-siblings and the concerns for the family to be considered as a whole.

47. Mr Hynes was clear in his evidence as to the action that he asked Mrs George to take on 9 May 2018, which in the first instance was to contact the nursery to confirm whether the children had been taken to nursery that day, and if not, to undertake a further home visit straightaway and get support from another worker. Mr Hynes stated that on visiting the property that morning and not being able to get any answer from the mother, that if Mrs George was not able to gain entry herself, she should have called the police to gain entry. Mr Hynes did not accept the fact that her return to the office to seek assistance and guidance nor her speaking to the mother by phone later that day to be sufficient steps to safeguard the children.

48. Mr Hynes went on to articulate the risks of a 2 and 3 year old child being left alone or being found at home, possibly alone, or with a parent that is so incapacitated that they cannot meet their needs. That access needed to be gained. If the social worker or other professionals cannot gain access, then those with the legal power to force entry were the police. He stated personally, he would have let the children put the key through the letterbox and gained entry that way.

49. Mr Hynes confirmed that he did consider Mrs George's health challenges and reasonable adjustments, that he continued to monitor this and that he did ask Mrs George whether she felt that she could make clear decisions. He recalled that they had discussions about this. He stated that he was aware from her medical records that there was an ongoing issue with **[PRIVATE]**

50. Mr Hynes stated that he asked Mrs George if her health made any impact on the decisions that she had made and that in response, Mrs George did not put forward any specific mitigation in relation to health and her ability to make decisions. He went on to say that he did not believe that the delay in implementing some of the requested reasonable adjustments, would have had any impact upon Mrs George's decision making. He accepted however that without some of the equipment; she may have had some difficulty with administrative tasks such as her recording in a timely way.

51. In respect of alleged malicious allegations, Mr Hynes stated that if a social worker considers allegations to be malicious that this does not mean that they do not follow them up and that a social worker has a duty to make an assessment properly. He stated that he was concerned that whilst Mrs George had undertaken an initial visit, she had not followed up on the referrals and/or completed further visits to the children. He stated that to make a judgement, purely on your own feelings and without doing further visits or making further enquiries or completing the proper assessment, is poor practice. In addition, that a social worker cannot rely on the absence of concerns raised from other agencies as evidence of no concerns and that one of the key messages from all serious case reviews that have taken place over decades is that agencies do not always talk to each other and share information. He said that one cannot assume that other agencies will inform one of their concerns, one needs to be proactive.

52. As to the allegations of discrimination, collusion and/or deleting case recordings from the system, Mr Hynes denied each of these in their entirety.

53. The panel heard evidence from Mrs George.

54. The majority of Mrs George's evidence in chief centred around what she considered to be failures by her manager to provide support, guidance, and reasonable adjustments. In addition, she argued that the timescales for completing assessments and undertaking visits were unfair and unrealistic given the volume of work that she had to undertake in her role.

55. As to the events of 09 May 2025, Mrs George stated that on arrival at the home she was unable to get a response from the mother: that she knocked on the door, then made calls on her phone but that there was no response. Mrs George explained that she could see/hear the children watching television in the front room, and that they came to the door and placed the key through the letterbox, with the older child saying that her mum was sleeping. Mrs George stated that she returned the key through the box to the child and told her to go and get her mother.

56. Mrs George stated that she continued to make attempts to contact the mother by phone and that she also tried to contact her manager by phone, but that calls to Mr Hynes' phone were not connecting. Mrs George stated that she did not ring the duty number as in her view that would have taken longer, and she was concerned about the safety of the children so returned to the office as it was a short distance away (by taxi) and with the aim of seeking immediate assistance and help from her manager.

57. Mrs George stated that on return to the office she immediately went to speak with her line manager Mr Hynes. Further, that she approached him to speak to him about this case and her concerns that day, on at least 4 or 5 separate occasions. Mrs George was challenged about this in cross examination, and also about the fact that there were no case recordings to support this being the case. Mrs George did not consistently accept that the appropriate safeguarding response was to call the police and remain at the property, as asserted by Ms White and Mr Hynes in evidence, and also mentioned by the health visitor in a meeting involving the family the day after (on 10 May 2018).

58. In respect of the allegation concerning a failure to follow up and investigate referrals concerning Service User 1, Mrs George confirmed that part of the reason that she had not done so was because she had believed the referrals to have been malicious and from her own experience of the family, that the children were well taken care of. She also relied on the fact that no concerns had been raised by other agencies. Mrs George went on to explain that she had other reasons for the delay, namely the volume of other work tasks. Mrs George stated that she had to decide what she prioritised and chose not to prioritise this as she believed the referrals to be malicious. Mrs George pointed to the fact that the referrals were later found to be malicious as justification for her not investigating them initially.

59. Mrs George did not accept the case point allocation system, and how the allocations had been worked out relative to her caseload.

60. Mrs George alleged that she had been treated differently and discriminated against, and in summary stated that a number of the professionals at the Council – Ms White, Mr Hynes, the Independent Reviewing Officer (IRO) and the investigating officer had all both individually and collectively colluded to make a case, get her into trouble and cause her to be suspended.

61. Mrs George explained that there was a period at the end of 2017, start of 2018 where she took an extended period of leave and that on return, she was allocated a large number of new cases within a very short period and also found that no work or visits had been undertaken on any of the cases that she had been holding at the point that she went on leave. Mrs George explained that she was very busy on her return from leave, that this placed a lot of pressure on her, that she was not supported and that she felt this was not considered by her line manager.

62. When cross examined as to the extent that the required reasonable adjustments could have helped assist her safeguarding decision making or assisted her in deciding how to follow up referrals of concern, Mrs George was unable to confirm what impact, if any they would have had. When questioned as to the extent that the reasonable adjustments may have assisted with single assessments, Mrs George explained that there was little admin support in the team and that her disabilities impacted how quickly she could type, and despite requiring the dragon software, this had not worked correctly and as such she could not use it. Mrs George stated that she felt she had been treated less favourably than other members of staff who for example, received new monitors when she did not and/or who she feels would have received more support than she was provided.

63. Mrs George initially mentioned that she had submitted a form to her employer raising that she felt discriminated and named Mr Hynes. However, in cross examination she later stated that this form whilst submitted did not name Mr Hynes.

Social Work England's closing submissions on facts:

64. In opening, Ms Sharpe accepted that the burden of proving the disputed allegations rests with Social Work England and that the civil standard applies, that being the balance of probabilities. The panel was invited to consider all of the documentary evidence before it, together with the oral evidence heard of the witnesses and to adopt the statement of case.

65. In respect of caseload and Mrs George's assertion that she was given too many cases, with too much work, and insufficient support to discharge her duties, it was submitted by Social Work England that that the assertion is not supported by any available data, case records or the witness evidence of the manager.

66. In respect of the hearsay evidence contained in the bundle, the panel was reminded that the statements were before them by agreement, and that it is required to consider what weight should be given to the hearsay and whether the hearsay evidence is consistent with any other provable facts or evidence.

67. Ms Sharpe summarised Social Work England's case in respect of each of the allegations and invited the panel to find all of the allegations at 1 and 2 proved in their entirety.

Mrs George's closing submissions on facts:

68. In closing, Mrs George confirmed that she did not admit the allegations. Mrs George asked that the panel to consider the evidence that it had heard along with all of the documentary evidence that it had, focusing in particular, on the many factual inaccuracies she believed there to be and which she indicated had been highlighted in her written responses. Mrs George asked that the panel finds that the allegations are not proved.

69. Mrs George stated that her belief was that there had been collusion, and alleged both manipulation of and deletion of case recordings from Liquid Logic.

70. Mrs George also submitted that there had been a lack of support from her manager, alleged mismanagement, and failings of her manager, and that she had a high volume of work with timescales that she considered to be unreasonable and unrealistic. Mrs George also alleged that she had been discriminated against whilst working for the Council.

71. Mrs George concluded by stating that regarding:

    a. Allegation 2 a – Mrs George stated that she had undertaken two visits, had valid reasons for the delay in following up the referrals but that these were not taken into account, and she could have completed this task if given more days. She stated that there had been discriminatory treatment of her;

    b. Allegation 2 b – that she did not accept the allegation;

c. Allegation 2 c – that she had provided lots of support to this child and his mother, and that in alleging that she had not completed the assessment in timescales, that her manager failed to consider her workload. Mrs George directed the panel to the Working Together guidance 2018 in relation to required timescales, and directed the panel to consider the extent of the immediate and direct support she gave to the family, which she saw as the priority;

d. She asserted that her cases stagnated in her absence whilst on extended leave, in that her manager did not organise or attend relevant conferences or meetings.

e. Finally, she concluded that all the allegations are unsubstantiated;

Legal Advice:

72. The panel heard and accepted the advice of the legal adviser. It recognised in particular, that it was for Social Work England to prove each of the allegations on the balance of probabilities. The panel was aware that it should give such weight to the hearsay evidence as it considers appropriate, and notwithstanding the fact that Mrs George actively consented to the admission of this evidence as hearsay, the panel should:

(i) proceed with caution in the absence of cross examination of the witnesses;

(ii) review the absent witnesses' evidence to see if there is any inherent or other weaknesses in it;

(iii) ascertain if there is evidence supporting the untested evidence; and

(iv) make a fair assessment in all the circumstances.

Finding and reasons on facts:

73. The panel considered each of the allegations in turn, and in each instance, considered whether the particulars of each of the allegations were proved or not.

74. In respect of those allegations that relate to an alleged failure to complete assessments within timescales, the panel noted from the evidence given by the witnesses that there is disagreement as to what timescale ought to have applied, and whether it was reasonable to expect an assessment to have been completed within a shorter timescale of 15 days or 30 days when the 'Working Together to Safeguard Children 2018' national guidance states a maximum 45 days for an assessment. The panel was also aware of Wirral's practice guidance that states that 'the aim is to complete a single assessment within the national average of 26 days.' The panel

decided that in respect of each of the allegations concerning timescales for assessment, that it would in the first instance consider whether the timescale imposed was fair and reasonable.

75. The panel noted that Mrs George was formally suspended on 07 November 2018, however, the panel accepted her evidence that her last full working day was 02 November 2018. The panel noted that the two witnesses for Social Work England could not confirm Mrs George's last working day and Mr Hynes indicated it definitely preceded her formal suspension date. The panel noted his case recordings showed reallocation of Mrs George's cases prior to the 07 November 2018.

76. The panel noted the concerns raised by Mrs George with regards to some case recordings being linked and not standalone or specific to an individual child but also being linked to siblings. The panel noted that the case recordings did differ in detail and substance suggesting different types of records across the service users. Further, the panel noted Mrs George's belief that some case recordings had been deleted on her files so that there was no evidence of work that she had undertaken. As the panel was not provided with any factual evidence supporting this belief and it is not the panel's role to speculate, the panel concluded that it was unable to make this finding.

Allegation 1:

Between approximately May 2018 and November 2018, you failed to appropriately act in the following cases:

a. Service User 1 in that you:

i. Did not take appropriate safeguarding action on or around 9 May 2018;

77. The panel heard and accepted the evidence of Mr Hynes and Ms White as to what the appropriate safeguarding response would have been in that instance, which was to remain at the property and call the police. The panel also took into account the documentary evidence from the child in need meeting the following day (the 10 May 2018) that identified another professional indicating that the appropriate action in the circumstances faced by Mrs George on 09 May 2018, was to call the police. The panel did not accept the evidence of Mrs George that she had acted appropriately in safeguarding Service User 1 by returning to the office to seek the assistance of and guidance of her manager as to the appropriate next steps, and did not accept that it was reasonable for Mrs George to have relied upon past experience from eight years prior where in that scenario, she told the panel that she found children home alone and stated that she wanted to call the police but was told by her manager to return to the office for actions to be taken.

78. The panel also took into account Mrs George's comments regarding the children being obedient, and that she could see/hear them through the window, watching television,

and arguably in Mrs George's view, not at immediate risk of harm. The panel did not consider this to have been enough to protect the children. The panel did not consider this to be appropriate safeguarding action in the circumstances where the mother, the only adult in the house was allegedly not awake, unresponsive to any attempts to rouse her, and therefore not able to safeguard the two young children under the age of four.

79. Further, the panel did not accept there to be any evidence of Mrs George's agreed need for reasonable adjustments to have impacted upon her ability to take appropriate safeguarding action in this instance.

80. The panel concluded that it was reasonable to have expected Mrs George, an experienced social work professional, to have used her professional judgement and exercised a degree of autonomy to immediately safeguard the children. The panel was satisfied that the appropriate steps to immediately safeguard the children would have been for Mrs George to call the police, who would have been able to gain entry to the property and for Mrs George to remain on site where she could continue to engage the children to ensure their safety. The panel was satisfied that there was a failure to take appropriate safeguarding action by Mrs George. The panel therefore found this allegation proved.

ii. Did not respond to and/or follow up reported concerns;

81. The panel was satisfied that Mrs George did not respond to and/or follow up reported concerns in respect of Service User 1. This case was initially allocated to Mrs George on 09 November 2017, then later closed 31 July 2018 following a period of support. The case was reallocated to Mrs George on 30 August 2018, following a referral from an anonymous caller expressing concerns regarding inadequate supervision and adult alcohol/drug use. Mrs George was tasked with completing a home visit within 5 days and was also requested to complete a single assessment.

82. The panel noted that the case recordings show that Mrs George undertook a home visit to the family on 05 September 2018, and that this visit was within the required timescales.

83. The panel also noted that the case recordings show that further referrals were received throughout September and October 2018 regarding the safety of the children, including alleged smacking and shouting at children and expressing serious concerns regarding neglect and the safety of the children. There is no evidence of any follow up action or case recordings from Mrs George, following these referrals from September or October 2018, until explicit prompting by her manager in November 2018. The panel heard evidence from Mrs George that the reason for her not doing so was that she considered the allegations to have been malicious and unfounded, and also due to the fact that no other partner agencies had contacted her to raise concerns. The panel accepted the evidence of Ms White and Mr Hynes regarding the potential risks of not visiting and not

following up on these serious concerns. The panel therefore found this allegation proved.

iii. Did not complete a Single Assessment within timescales.

84. The panel was satisfied that Mrs George had failed to complete a Single Assessment in respect of Service User 1 within timescales.

85. The case was reallocated to Mrs George on 30 August 2018. The timescale for the single assessment was 15 days, which would have meant that the assessment needed to be completed no later than 20 September 2018. In the first instance, the panel considered the appropriateness of a shortened timescale for assessment and having done so, concluded that it had not heard sufficient justification from Mr Hynes and/or seen documentary evidence as to why a 15-day timescale had been applied in this instance. Accordingly, the panel went on to consider whether Mrs George had completed the assessment within 45 days.

86. The panel noted that there are case recordings throughout the months of September and October 2018, of ongoing concerns relating to the welfare and safety of the children. The panel also noted the absence of any visit having been carried out by Mrs George after the initial visit carried out on 05 September 2018, the absence of proactive partner agency contact by Mrs George in September and October 2018 and ultimately the absence of any completed single assessment.

87. As of 02 November 2018, the assessment stood at 47 working days and was not completed. The panel did not accept Mrs George's evidence that the assessment was 'nearly ready.' Mrs George had been directed by her manager to complete further actions and these actions, and the assessment remained outstanding. The panel was satisfied from the evidence before it that this assessment had not been completed within timescales and therefore found this allegation proved.

b. Service User 2 in that you:

i. Did not complete a Single Assessment within timescales;

88. The panel was satisfied that Mrs George did not complete a Single Assessment in respect of Service User 2 within timescales.

89. In the first instance, the panel considered the reasonableness of the 15-day timescale for the completion of the Single Assessment that had been given and went on to decide that this timescale was reasonable, proportionate and fair given the circumstances of this individual case and the reason for the assessment.

90. The case concerned an unborn baby whose half-siblings were subject to Child Protection Plans. The Single Assessment had been requested so as to assess the risk/s

to the then unborn/newborn child, so that consideration could be given to the family as a whole, the concerns could be looked at in the round at the next Child Protection Conference and tie in with decision making concerning the half-siblings. The panel decided that the shorter timescale for assessment was a targeted and logical approach.

91. Having decided that the 15 working day timescale was reasonable, the panel went on to consider whether the assessment had been completed by Mrs George within the timescales or not. The panel noted that the single assessment was allocated on 09 August 2018, and a 15 working day timescale for completion would have meant that the assessment needed to be completed by 30 August 2018. The panel accepted the clear evidence in this case that the assessment had not been completed within the 15 working day timescale that had been set, or the subsequent extension to 30 working days that had been granted after Mr Hynes reviewed the assessment that had been completed and considered it to have not considered the risks sufficiently. The panel also noted the concerns of the Independent Reviewing Officer ("IRO") at the Child Protection Review Conference regarding the absence of a single assessment and also the inadequacy of a risk assessment, which then led to the submission of an escalation form by the IRO on 09 October 2018. The panel noted that Service User 2 was born early on 07 September 2018, and therefore Mrs George prioritising completion of the assessment would be expected.

92. The panel did not accept Mrs George's evidence of the manager having delayed signing off or returning her assessment/s for trivial and unimportant reasons. The single assessment was not completed within reasonably directed timescales; therefore, the panel found this allegation proved.

> *ii. Did not adequately complete the Single Assessment in that it did not contain an adequate analysis of risk pertaining to Person A.*

93. The panel was satisfied that Mrs George did not adequately complete the Single Assessment in respect of Service User 2, in that it did not contain an adequate analysis of risk pertaining to Person A.

94. The panel accepted the evidence presented by Social Work England in respect of there having been insufficient analysis of risk in the assessment prepared by Mrs George. In particular, the panel noted the very clear recording from Mrs George's manager Mr Hynes that he did not agree with Mrs George's conclusion to step the case down and instead directed that a strategy discussion be convened and a full risk assessment be undertaken in respect of the risks pertaining to Person A. However, the panel also noted that despite this, the assessment had been ticked as authorised by Mr Hynes. The panel also noted the very clear concerns of the IRO and subsequent action taken, in lodging of the escalation form. The panel noted that the assessment that had been prepared by Mrs George lacked analysis. This assessment was dominated by narrative

built on self-reporting and unchallenged accounts/reports provided by the father. The panel therefore found this allegation proved.

Allegation 2

Between approximately November 2017 and November 2018, you failed to complete assessments within timescales in one or more of the following cases:

a. Service User 3 and/or Service User 4;

95. The panel did not conclude that Mrs George failed to complete the assessment regarding Service User 3 and/or Service User 4 within timescales.

96. In the first instance, the panel considered whether the timescale for completion which was directed at 15 days, was fair and reasonable. The panel did not hear sufficient evidence justifying why a timescale of 15 days was considered necessary in this instance. The panel reminded itself that whilst the Council's own practice standards for a single assessment indicate an aim to complete an assessment in an average of 26 days, the 'Working Together to Safeguard Children 2018' national guidance provides for a maximum timescale of 45 working days for the completion of a single assessment.

97. The allocation date was 06 September 2018, and therefore in this instance a timescale of 45 working days for completion of a single assessment would have been 08 November 2018. The case recordings evidence that Mrs George carried out the visit within the required timescales of 5 days from allocation. The timescale for completion of the assessment was extended at her supervision on 12 October 2018, to a new deadline of 17 October 2018.

98. Mrs George's last working day was on 02 November 2018, and she stated that but for her suspension, the assessment would have been completed within the timescale of 45 working days as it was nearly completed. The panel also considered the submissions made by Social Work England that it was unrealistic to consider that Mrs George would have completed the assessment regarding Service User 3 and/or Service User 4 within 45 working days, had she not been suspended.

99. The panel considered it clear from the evidence that whilst Mrs George had not completed some assessments within timescales, there is also evidence that she had completed some of her assessments within the timescales. The panel noted within case records that at the point of reallocation on 06 November 2018 Mr Hynes acknowledges the existence of a draft assessment by Mrs George. The panel felt it was unfair to speculate on whether Mrs George would or would not have completed the assessment had she not been suspended, as the panel had not been provided with the draft assessment that Mrs George was working on at the time of 02 November. The panel therefore found this allegation not proved.

b. Service User 5;

100. The panel considers that Mrs George failed to complete the assessment for Service User 5, within timescales. Mrs George was allocated this case on 24 July 2018 for the completion of a single assessment within 26 days or the maximum of 45 working days.

101. The panel accepted the evidence produced by Social Work England that Mrs George had been granted sufficient time, had received follow up requests and reminders from her manager regarding the outstanding assessment, and had also been provided with direction from her manager as to the gaps in the assessment and what further work/information was required. The panel did not accept the evidence of Mrs George that Mr Hynes had delayed signing off or returning her assessment/s for trivial and unimportant reasons. The panel noted from the documentary evidence that there were multiple areas of outstanding work identified by Mr Hynes through the history of this case's allocation to Mrs George. The panel was satisfied that there was no evidence that these were trivial matters.

102. The panel considered this to be a clear failure, as at the point of Mrs George's last working day on 02 November 2018, the assessment stood at 73 working days which is far outside the maximum period for an assessment of 45 working days. The panel therefore found this allegation proved.

c. Service User 9

103. The allocation date was 06 September 2018. The panel did not consider it had heard sufficient explanation or reasoning for a shorter abridged timescale applying in this instance and therefore went on to consider whether Mrs George had completed the assessment within 45 working days. A timescale for completion of this assessment within 45 working days would have been 08 November 2018.

104. The panel noted that by Mrs George's own admission, she had not completed the single assessment for this Service User before her last working day on 02 November 2018. The panel took into account that Mrs George had put in place immediate financial support, interpreters and had liaised with other professionals. There is also evidence in the case recordings of her visiting the family/Service User 9.

105. At the point that Mrs George was suspended on 02 November 2018, the assessment stood at 42 working days and was reallocated to another worker for amendments and completion. The panel noted in the documentary evidence an assessment authorised on 26 November 2018 which identifies Mrs George as a contributor/co-author. The panel considered it was unfair to speculate on whether Mrs George would or would not have completed the assessment within the 45 working days had she not been suspended, as the panel had not been provided with the draft assessment that Mrs George was working on at the time of 02 November. The panel therefore found this allegation not proved.

Allegation 3

Between approximately November 2017 and November 2018, you failed to complete visits within timescales in one or more of the following cases:

a. Service User 3;

106. The case was allocated to Mrs George on 06 September 2018. The panel noted that the case recordings for Service User 3 evidence that Mrs George carried out the initial visit on 7 September 2018 within the required 5 days from allocation. Then she undertook a further visit on 20 September 2018.

107. The panel carefully considered Ms White's evidence that it was good practice to visit regularly, sometimes more frequently, whilst undertaking an assessment. It accepted Ms White's evidence and concluded that despite Mrs George not being directed to undertake a further visit or visits, it would have been good practice to do so. The panel noted that Social Work England in closing submissions, having acknowledged responses by Mr Hynes in cross examination on this matter, conceded that the service user was not yet subject to a CIN or CP plan as the assessment regarding this service user was still in progress and therefore the statutory timescales for visits did not apply. Therefore, the panel considered that the timescales/requirements for visiting that would have applied if the service user were subject to such a plan, did not. Further, allegation 3a) alleges *"a failure to complete visits within timescales"* and in relation to Service User 3, there was no such failure as alleged, because the one required statutory required visit was completed within the timescale. This required visit was within 5 days on 07 September 2018, and there was a further visit on 20 September 2018. The panel therefore found this allegation not proved.

b. Service User 1.

108. The panel noted that the service user was made subject to a CIN plan following an assessment completed by Mrs George on 14 December 2017. Shortly after that, Mrs George took an extended period of annual leave. Social Work England's case is that despite her having returned from leave in January 2018, no visit had been completed until 05 February 2018 and that this is therefore outside of timescales. The panel does not accept that there had been a failure to complete a visit within required timescales in this instance, as it is quite clear that Mrs George could not have done so whilst on leave. The panel heard in evidence from Mr Hynes that no alternative arrangements had been put in place by him as he believed the level of risk could be managed until she returned. The panel took into account that Mrs George arranged for a visit shortly following her return from leave.

109. The case was re-referred to Mrs George in August 2018, and Social Work England accept that the case recordings show that Mrs George visited on 05 September 2018,

but state that a further visit was not completed and indicated a timescale requirement of 8 weeks. Documentary and oral evidence from Mr Hynes proved inconclusive in regard to the relevant timescales applicable. The panel noted Mr Hynes directed Mrs George to visit on 02 November 2018 and the case recordings show that she did attempt a second visit but that was unsuccessful. The panel therefore found this allegation not proved as there was no failure to complete visits within timescales.

30 June – 03 July (Resuming Final Hearing)

Preliminary matters:

110. At the resuming final hearing Mrs George made two separate applications to admit further evidence.

111. The first application was an application to have the panel consider her submissions in respect of and objections to the facts found. Having heard submissions on behalf of Social Work England, and having received and accepted legal advice, the panel went on to allow the admission of this document but in doing so made clear that it would not go behind the facts that had been determined. The application that related in part to minor amendments to address factual inaccuracies regarding job title, role etc were agreed and would be made, but a reconsideration of the facts decided would not.

112. The second application from Mrs George related to an application to admit and rely on late evidence towards remediation. This evidence was in the form of records of Mrs George's Continuing Professional Development records since the time of her suspension. On behalf of Social Work England, Ms Sharp stated that notwithstanding the lateness of the submission, there was no objection to these records being admitted. The panel heard and accepted legal advice and went on to allow the admission of the CPD records into evidence.

Summary of evidence and submissions from Mrs George in respect of grounds and impairment:

113. Mrs George gave evidence to the panel in respect of grounds and impairment. In summary, Mrs George stated that whilst she acknowledged the facts that had been found proved by the panel, she denied that those facts now found proved amounted to misconduct or impairment.

114. Mrs George referred to the fact that she had engaged throughout the process, appreciated the seriousness of the concerns, remains committed to upholding the standards and has engaged with required CPD and learning each year despite not currently practising as a social worker. Further, Mrs George highlighted her long career to date which she asserted evidenced her commitment to social work and safeguarding

others, and expressed her ongoing commitment to assisting children, families, and communities.

115. Mrs George submitted that the absence of timely leadership, lack of managerial support and a failure to put in place identified reasonable adjustments, alongside a high and unreasonable caseload, contributed to the delays and her finding herself in front of the regulator. Mrs George asked that the panel take all of the contextual issues into account when arriving at its decision.

116. Throughout, Mrs George asserted that she had acted in the best interests of the children and the families on her caseload and prioritised getting them the support required. She maintained that this reflected the complex realities of frontline practice. She further asserted that a finding of misconduct and/or impairment in respect of the allegations found proved, could risk setting a precedent that the broader body of work undertaken, which was consistent with safe and responsible practice, could also be viewed unfairly through a lens of misconduct. She stated that such an interpretation would not reflect frontline practice and professional decision making under pressure. Mrs George submitted that this would leave dedicated social workers unprotected and that it would frame active safeguarding as misconduct and would not serve to protect the public.

Social Work England's submissions on grounds and impairment:

117. Ms Sharpe submitted that all the facts found proved are serious enough to amount to misconduct.

118. In relation to Allegation 1a (i) on 09 May, Ms Sharpe submitted that Mrs George's conduct left two young children at unacceptable and immediate risk of harm and that this should have been clear to her. She stated that safeguarding and appropriate and immediate response to risk is at the heart of the profession and is self-evidently serious. She submitted that it was only by luck that there had been no harm to the children on this occasion.

119. In relation to Allegation 1a (ii) not responding to and following up reported concerns, Ms Sharpe submitted that this failure to investigate safeguarding concerns raised by others was similarly serious as these referrals had raised significant concerns including smacking, neglect and shouting at the children. She stated that it was essential for safeguarding concerns to be followed up to ensure the children were safe. Ms Sharpe submitted that the fact that these referrals were subsequently found to be unsubstantiated does not diminish the seriousness of the failure to follow up, visit and make enquiries.

120. In relation to Allegation 1b (i) completing assessments within timescales, she stated that these were serious failures, referring to David Hynes's evidence that good quality assessment of need and risk form the basis of good social work practice. She submitted that failures to complete assessments within the maximum timeframe of 45

days created a risk of delays in decisions about the children's care and that cases may not move to an appropriate level of formal support in a timely way. Ms Sharpe stated that assessments are neither a tick box nor an administrative exercise and reminded the panel that they are important enough for there to be national safeguarding guidance setting specified maximum timeframes.

121. In relation to Allegation 1b(ii), Ms Sharpe reminded the panel that the inadequacies of the risk assessment for the father had been identified by the IRO and other professionals. She submitted that the dangers of an inadequate risk assessment are clear especially where there are serious concerns about the family. She said that to suggest that the seriousness was mitigated because professionals could read a child's file did not reduce the seriousness, as it was not realistic to expect each individual professional to be able to review all the historical information such that a risk assessment was neither important nor necessary.

122. Concluding her misconduct submissions Ms Sharpe submitted that all the facts found proved fell seriously short of what was proper in the circumstances.

123. Ms Sharpe submitted that the panel may think that the conduct proved, the practice concerns, are capable of remediation, however questions of judgement of risk, she maintained are not easily remediated. She referred to Social Work England's Guidance on Impairment and Sanctions and the relevant case law and asked the panel to carefully assess Mrs George's remediation, insight, reflection, remorse, and risk of repetition.

124. She submitted that there is limited evidence today of remediation and no evidence of targeted remediation. In relation to the risk of harm, she submitted that the conduct proved demonstrated an unacceptable and avoidable risk to service users. She stated that an action that by luck did not cause harm, may risk harm if repeated and should therefore not be regarded as less serious. She submitted that this was very important when assessing impairment and the seriousness attached to the safeguarding matters in this case.

125. In addressing the relevant case law of *Grant*, Ms Sharpe submitted that the panel should have little difficulty in concluding that the facts found proved put service users at unwarranted risk of harm, that Mrs George brought the profession into disrepute through her actions or inactions and breached the fundamental tenets of the profession by failing to safeguard, assess need and risk and reduce the risk of harm.

126. Ms Sharpe reminded the panel to scrutinise the quality of the Social Worker's insight. She stated that an assertion by Mrs George that she acted wrongly is unlikely to be sufficient to demonstrate insight. She submitted that the panel should consider if Mrs George's evidence demonstrates that she recognises what went wrong, accepts her own role in these events and what she should have done differently and has addressed how she would act or react differently in the future.

127. Ms Sharpe asked the panel to carefully consider Mrs George's reliance on what she considers to be her poor treatment by the Council in relation to her high case load, as she described it, supervision, management support and the alleged conspiracy to suspend her. She submitted that the panel should consider if this is a social worker seeking to minimise her own responsibility or shift blame to others.

128. In relation to delay in the provision of reasonable adjustments, she asked the panel to assess the impact of any delay on the social worker's practice at the time of the proved concerns. She reminded the panel of their determination that the 9 May safeguarding incident related to a judgement matter not affected by timely provision of reasonable adjustments.

129. The panel should consider how Mrs George has struggled to acknowledge whether she could, or should have acted differently, why these matters were of concern to her former employer and Social Work England, or appreciate the risks attached to the conduct proved. The panel may consider that they have heard insufficient evidence that the risk of repetition has been adequately addressed to be satisfied that the concerns proved are highly unlikely to be repeated. Now over six years since these events, Mrs Sharpe submitted that Mrs George's insight is at best limited.

130. Turning to the public interest, Ms Sharpe submitted that Mrs George has not demonstrated an appreciation of why the public may be concerned about the failures proved or how the conduct proved may undermine public confidence in the profession. She stated that a finding of impairment is required to uphold proper standards and public confidence in the profession and the Regulator.

131. Mrs Sharpe submitted that there has been a significant departure from professional standards and that the panel should find the Social Worker's fitness to practice is currently impaired on both the personal and the public component.

Legal advice:

132. The panel heard and accepted the advice of the legal adviser on misconduct and impairment. That advice included reference to the law and Social Work England's Impairment and Sanctions Guidance as well as the following points:

    a. The overriding objective of Social Work England is to protect the public, which includes maintaining public confidence in social workers and maintaining professional standards of social workers.

    b. Whether facts proved or admitted amount to misconduct is a matter of judgment for the panel rather than a matter of proof. *Council for the Regulation of Health Care Professionals v GMC and Biswas* [2006] EWHC 464.

    c. The existence of impairment is also a matter for the panel's own independent judgment or assessment and, in considering whether Mrs George's fitness to

practise was impaired, the panel should take account of Social Work England's Impairment and Sanctions Guidance.

d. The legal adviser referred the panel to the cases of *Meadow v General Medical Council* [2006] EWCA Civ 1390, *Roylance v General Medical Council* (No.2) [2000] 1AC, *Solicitors Regulatory Authority v Day & ors* [2018] EWHC 2726 (Admin) and *Khan v Bar Standards Board* [2018] EWHC 2184(Admin).

e. Protection of the public, as defined in s.37 of the Children and Social Work Act 2017, comprises protecting, promoting, and maintaining the health, safety, and well-being of the public, promoting, and maintaining public confidence in social workers and promoting and maintaining proper professional standards for social workers. The panel should consider whether a finding of impairment is required for any or all of those three purposes.

f. The test for impairment, as set out by the court in *Council for Health and Regulatory Excellence v Nursing and Midwifery Council and Grant* [2011] EWHC 927 (Admin), is whether the panel's finding of misconduct in respect of Mrs George indicated that her fitness to practise is impaired in the sense that she had in the past (a) put service users at unwarranted risk of harm; (b) brought the social work profession into disrepute; (c) breached one of the fundamental tenets of that profession; and/or (d) acted dishonestly or, in each case, was liable to do so in the future.

g. As stated in *Cohen v General Medical Council* [2008] EWHC 581 (Admin), at the impairment stage the tribunal should take account of evidence and submissions that the conduct (a) is easily remediable, (b) has already been remedied and (c) is highly unlikely to be repeated.

h. When assessing whether a finding of impairment is required in order to protect the health, safety and well-being of the public, the panel should consider the extent to which the social worker's conduct gave rise to harm or a risk of harm and the likelihood of that conduct being repeated.

i. Assessment of the risk of repetition involves consideration of (i) the social worker's previous history and their conduct since the concerns about their conduct arose, (ii) the extent to which they have developed insight into their misconduct and (iii) the extent to which they have taken steps to remedy any failings on their part which led to that misconduct.

Finding and reasons on grounds:

133. In respect of those allegations found proved:

a. In relation to Allegation 1a (i) the panel considered this to have been a serious error of judgement and one that placed the children at risk of significant harm,

leaving two young children unsupported and unsupervised by returning to the office. The panel acknowledged that Mrs George had undertaken actions on the day in an attempt to safeguard the children; however, these were the wrong actions. The panel concluded that the threshold for serious misconduct had been breached.

b. In relation to Allegation 1a (ii) the panel found that there was no attempt to investigate these ongoing serious anonymous referrals other than one initial visit. Neither was there any recorded attempt to triangulate these concerns with other relevant agencies for a number of months. The panel agreed with Social Work England's submissions that the fact that these referrals were subsequently found to be unsubstantiated, does not diminish the seriousness of the failure to follow up these serious reported concerns. Therefore, due to the unexplored potential of risk of harm to the children, the panel concluded that the threshold for serious misconduct had been breached.

c. In relation to Allegation 1a (iii) the panel acknowledged that at the time of suspension, the assessment stood outside of the maximum timescale of 45 days (at 47 days) and reminded itself of Mrs George's assertion in evidence that but for the suspension, this assessment would have been completed. The panel had previously not accepted this assertion at the facts stage and was satisfied that the assessment was not "nearly ready", and therefore concluded that despite being only two days over the maximum timescale, the lack of timely intervention or liaison meant that the threshold for serious misconduct had been breached.

d. In relation to Allegation 1(b) (i) the panel considered Mrs George to have placed the service user at unnecessary risk of harm, and of concern to the panel was Mrs George's apparent lack of appreciation of the risk of harm. The panel have found that there were clear, necessary and significant reasons for an abridged timescale for the assessment in this instance, so as to ensure that the unborn child was safeguarded and also to feed into the bigger picture for the family which included older half-siblings who were subject to child protection plans. The panel determined Mrs George's inaction and her disregard of the clear management direction in this instance, to have met the threshold for serious misconduct.

e. In relation to Allegation 1(b)(ii) the panel concluded that whilst the risk assessment was outside of timescales and the quality of the assessment undertaken by Mrs George was considered by her manager to have been poor, she had completed it and in fact sent it to her manager on two separate occasions for review and authorisation. Mrs George's conclusion from the risk assessment undertaken was that the father posed a medium to high risk, and so reached a clear conclusion, that certainly other teams such as the Emergency Duty Team (who subsequently accessed the file) were able to understand. The panel also noted in particular that despite his criticism of the assessment

undertaken, Mrs George's manager subsequently authorised this assessment. The panel therefore concluded that the threshold for serious misconduct had not been breached.

f. In relation to Allegation 2 (b) the panel carefully considered whether the fact that this assessment was not completed within timescales and stood significantly overdue at 73 days of itself amounted to misconduct and concluded that it did not. Whilst it has been determined that Mrs George's completion of this assessment within set timescales fell short of what was expected of her as a social worker, it is acknowledged that despite there having been no written up assessment within timescales, there had been a high degree of proactivity, ongoing involvement, agency liaison and visits on Mrs George's part, to put services in place for the family and to safeguard them. The panel therefore concluded that for Allegation 2(b) the threshold for serious misconduct had not been breached.

134. The panel then went on to consider the standards. In respect of those allegations found proved and found to have also amounted to misconduct, the panel concluded that these instances of misconduct also amounted to serious breaches of the standards required of Mrs George at the relevant time.

135. In respect of HCPC Standards of Conduct, Performance and Ethics (2016), the panel concluded that there had been a breach of the following:

- **Standard 6.1 -** you must take all reasonable steps to reduce the risk of harm to service users, carers, and colleagues as far as possible.
- **Standard 6.2 –** you must not do anything, or allow someone else to do anything, which could put the health and safety of a service user, carer, or colleague at unacceptable risk.
- **Standard 7.3 –** you must take appropriate action if you have concerns about the safety or wellbeing of children or vulnerable adults.
- **Standard 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 do so.

136. Further, that there had been breaches of the HCPC Standards of Proficiency for Social Workers (2017) ("SOPS"):

- **Standard 1.2 –** recognise the need to manage their own workload and resources effectively and be able to practise accordingly;
- **Standard 1.3 –** be able to undertake assessments of risk, need and capacity and respond appropriately;
- **Standard 1.4 –** be able to recognise and respond appropriately to unexpected situations and manage uncertainty;

- **Standard 1.5 –** be able to recognise signs of harm, abuse, and neglect and how to respond appropriately, including recognising situations which require immediate action.
- **Standard 2.3 –** understand the need to protect, safeguard, promote and prioritise the wellbeing of children, young people, and vulnerable adults.
- **Standard 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.

Finding and reasons on current impairment:

137. Having found that Allegation 1a (i), (ii) and (iii) and Allegation 1b (i) amount to misconduct, the panel then considered whether Mrs George's fitness to practise was currently impaired by reason of that misconduct.

138. The panel considered Social Work England's Impairment and Sanctions Guidance and reminded itself of the legal advice that had been provided.

139. The panel first considered if the misconduct could be easily remediated and concluded that it was capable of remediation. Referring to the Impairment and Sanctions Guidance; " that remediation is best shown by objective evidence", it took into account the CPD produced by Mrs George and concluded that although it is clear that Mrs George has engaged in CPD, there was little evidence of training or learning directly focused on the facts found proved going to misconduct, i.e. assessing risk and taking appropriate safeguarding actions and timely assessment of needs.

140. The panel took into account that Mrs George has not been working as a social worker since November 2019, making it harder but still possible to demonstrate remediation. It had sight of one testimonial which predated these matters by many years and as such failed to comment directly on these matters and therefore the panel could not give it much weight.

141. The panel carefully considered if Mrs George has now fully accepted the findings of fact and has properly reflected on the seriousness of these findings. Mrs George was still not fully able to acknowledge that her actions and inactions had created unacceptable and unnecessary risks to service users. In her misconduct evidence she struggled to accept that she could and should have acted differently in the circumstances. In response to questions at this stage, she conceded that she should have called the police on 9 May and would do so in the future. She accepted some shortcomings insofar as conceding that her actions did not achieve the intended outcomes. However, the panel concluded that Mrs George has not fully accepted the panel's findings and properly reflected on them.

142. Taking into account the limited evidence of remediation, Mrs George not fully accepting the seriousness of the panel's findings and how she struggles to acknowledge that she could and should have acted differently, over six years, from the index incidents, the panel concluded that Mrs George has limited insight and that there remains a risk of repetition of the misconduct.

143. The panel determined that a finding of impairment is required to protect the health, safety, and well-being of the public.

144. In relation to the principles laid out in *Grant* the panel concluded that Mrs George's fitness to practise is impaired as she:

    i. has in the past acted and/or is liable in the future to act so as to put service users at unwarranted risk of harm

    ii. has in the past brought and/or is liable in the future to bring the profession into disrepute

    iii. has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the profession

145. In relation to the public component the panel concluded that public interest in this case requires a finding of impairment in order to promote and maintain public confidence in the social work profession, and to promote and maintain proper professional standards for social workers.

Social Work England's submissions on sanction

146. Ms Sharpe submitted that the appropriate sanction was a Suspension Order. Regarding the length of any suspension order, she submitted that the panel should balance the public interest of returning an experienced social worker to the profession with the need to protect the public. She submitted that taking no action, providing advice or issuing a warning would be inconsistent with the panel's findings of there being a current risk of repetition and would not adequately protect the public.

147. Ms Sharpe submitted the following mitigating factors:

- There have been no previous regulatory findings against Mrs George.
- Mrs George has engaged with the regulatory process, although she has not complied with all the directions.

148. Ms Sharpe highlighted the following aggravating factors:

- A lack of insight
- Serious safeguarding failures.

- Significant risk of harm to people who use services.

149. Ms Sharpe submitted that the panel may consider that Conditions would not be an appropriate sanction given the finding that Mrs George has inadequately developed insight. She submitted that suspension is the appropriate sanction, if the panel cannot form workable conditions to protect the public and the wider public interest. She stated that the appropriate length for the suspension is one year and that this will provide an opportunity for Mrs George to demonstrate remediation and insight. She stated that a removal order would be disproportionate in the circumstances and would only be appropriate if no other outcome was sufficient.

Submissions from Mrs George in respect of sanction

150. Mrs George was clear that she remained unhappy with the findings of the panel and had concerns regarding the decisions reached. Mrs George objected to the imposition of a suspension order, noting that she had already been subject to an interim suspension order since December 2022 that restricted her ability to practise and that she should not be penalised further.

151. She submitted that no further action was the most appropriate and fair outcome given her reflection, insight and taking into account the wider context. She further submitted that if the panel was not persuaded by no further action, that its decision should be advice

Legal Advice

152. The panel was referred to Social Work England's Impairment and Sanctions Guidance, December 2022 and advised to consider this guidance together with its own determination on grounds and impairment. The panel was advised to consider any aggravating and mitigating factors and to consider each available sanction in ascending order of severity, before going on to give reasons as to why a particular sanction has been discounted or accepted.

Findings on Sanction

153. The panel accepted the legal advice.

154. The panel carefully considered the mitigating and aggravating features in this case and concluded that:

Mitigating Factors

- Mrs George has no previous Fitness to Practise history.

- Mrs George has engaged with the regulatory process and this hearing.
- There were some delays in the provision of agreed reasonable adjustments at work.

Aggravating Factors

- Mrs George's limited insight.
- Mrs George does not fully accept the seriousness of the misconduct and her own professional responsibilities.
- The risk of harm created to the public, although there was no actual harm.

155. The panel considered that taking no action, or issuing advice or a warning, would not be consistent with the panel's findings and would not adequately reflect the serious nature of Mrs George's misconduct. The panel was also concerned that these outcomes would not adequately protect the public, as they would not restrict Mrs George's practice. Given that the panel has assessed there to be a risk of repetition, the panel concluded that the public would not be adequately protected unless Mrs George's practice is restricted. Further, taking no action, or issuing advice or a warning, would not maintain public confidence in the profession or promote proper professional standards.

156. The panel next considered whether it would be appropriate to impose conditions on Ms George's registration. It bore in mind that any conditions imposed should be appropriate, proportionate, and workable. The panel took into account the Guidance at paragraph 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*

157. The panel determined that Mrs George has limited insight into the seriousness of the misconduct and that she still struggles to fully acknowledge that her actions and inactions had created unnecessary and unacceptable risks to service users. Although the panel considered that the serious misconduct is capable of remediation, it has found that the misconduct has not yet been remedied. Nor has it

seen clear evidence of training and/or learning directly relevant to the misconduct found.

158. The panel carefully considered if imposing conditions would be sufficient to protect the public and the wider public interest in this case and in doing so it looked closely at the Conditions Bank. It concluded that conditions of practice would be neither appropriate, workable nor proportionate due to the limited insight demonstrated, the risk of repetition in relation to fundamental aspects of social work i.e. professional judgement and safeguarding, and the lack of remediation. It determined that conditions of practice would be so restrictive as to be tantamount to suspension.

159. The panel next considered whether it would be appropriate and proportionate to suspend Mrs George's registration. It considered the sanctions guidance in relation to suspension including paragraphs 137 and 138.

Paragraph 137 - *Suspension may be appropriate where (all of the following):*

- *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.*

When a suspension order may not be appropriate

Paragraph 138 - *Suspension is likely to be unsuitable in circumstances where (both of the following):*

- *the social worker has not demonstrated any insight and remediation*
- *there is limited evidence to suggest they are willing (or able) to resolve or remediate their failings.*

160. The panel reminded itself that it has determined that Mrs George has some limited insight. In her submissions on sanction, she stated that she would not repeat the same failings again, however she did not demonstrate any evidence to reassure the panel that the risk of repetition has yet been reduced. The panel however concluded that she is willing to remediate her failings.

161. Looking up to the next sanction, a removal order, the panel took into account that;

Paragraph 148 - A removal order must be made where the decision makers conclude that no other outcome would be enough to (do one or more of the following):

- *protect the public*
- *maintain confidence in the profession*

- *maintain proper professional standards for social workers in England*.

162. The panel determined that Mrs George's conduct was not so serious as to be fundamentally incompatible with continued registration as a social worker and has therefore concluded that a removal order would be disproportionate in the particular circumstance of this case.

163. The panel has decided that a period of suspension would be sufficient to balance the need to protect the public and mark the wider public interest with Mrs George's own interests. It has decided that a period of one year's suspension will be sufficient to allow Mrs George to properly reflect on the panel's findings, her misconduct and to develop her insight.

164. The panel has determined that a review should take place shortly before the end of the period of suspension. It will be Mrs George's responsibility to demonstrate that she is fit to practise at the review hearing, however the panel considered that any reviewing panel may be assisted by the following;

- A detailed reflective piece evidencing Mrs George's remediation, her understanding and reflections on the misconduct found and illustrating her insight into the panel's findings.
- Targeted CPD related to safeguarding, assessing risk, timely assessment of needs and any other themes that Mrs George has identified from her reflections.
- Evidence of Mrs George keeping her professional knowledge and skills up to date.

Interim Order:

165. In light of its findings on sanction, the panel next considered an application by Ms Sharpe on behalf of Social Work England for an interim suspension order to cover the appeal period before the final order becomes effective.

166. Mrs George opposed this application.

167. The panel considered whether to impose an interim order. It was mindful of its earlier findings and the risk of repetition and decided that it would be wholly incompatible with those earlier findings to permit Mrs George to practise during the appeal period.

168. Accordingly, the panel concluded that an interim suspension order for a period of 18 months is necessary for the protection of the public and in the public interest.

169. 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 shall take effect when the appeal period expires.

170. Ms Sharpe also invited the panel to revoke the interim suspension order that had been put in place in preparation for this hearing.

171. The Panel accepted the submissions of Social Work England and noted that the Interim Order imposed on 05 December 2022 is no longer necessary as the public are adequately protected by the final order made today on 21 October 2025. Mrs George was in agreement with this course of action.

172. The purpose of the Interim Order has now been superseded by the final order imposed on 21 October 2025. Mrs George is now subject to a Final Order of Suspension for a period of 12 months, which has been imposed following a finding of impairment. In addition, an Interim Suspension Order for a period of 18 months is in place to ensure public protection during the appeal period.

173. Accordingly, the Panel has decided to revoke the Interim Order imposed on 05 December 2022 under Schedule 2, paragraph 8(2) of the Social Workers Regulations 2018 (as amended). The Interim Order imposed on 05 December 2022 is revoked.

Right of appeal:

174. 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.

175. 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.

176. 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.

177. 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:

178. 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

179. 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:

180. 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.