# Social worker: Asiatou Bangura
# Registration number: SW66966
# Fitness to Practise
# Final Hearing

Dates of hearing: 24 to 28 November 2025

Hearing venue: Remote hearing

Hearing outcome:
Fitness to practise not impaired, no further action

## Introduction and attendees:

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

2. Ms Bangura attended and was not represented.

3. Social Work England was represented by Mr Corrie instructed by Capsticks LLP.

| **Adjudicators** | **Role** |
|---|---|
| Andrew Skelton | Chair |
| Joma Wellings-Longmore | Social worker adjudicator |
| Alison Lyon | Lay adjudicator |

| **Hearings team/Legal adviser** | **Role** |
|---|---|
| Hannah Granger | Hearings officer |
| Lauryn Green | Hearings support officer |
| Dido Ofei-Kwatia | Legal adviser |

## Service of notice:

4. The panel was satisfied that service had been complied with in accordance with the rules.

## Preliminary matters:

Application to hear part of the proceedings in private

5. Mr Corrie made an application for the parts of Ms Bangura's evidence that related to her health to be held in private due to its personal and sensitive nature. He relied upon Rule 38 of the Fitness to Practise Rules 2019 (as amended). The application was unopposed by Ms Bangura. The panel heard the advice of the legal adviser, and it decided to grant the application as there was no public interest in personal matters being heard in the open.

## Background:

6. Ms Bangura has been registered as a social worker since March 2005. At the material time, she was employed by Camden London Borough Council ("the Council") as a social worker in adult social care in the Access and Response Team ("A & R Team").

7. The concerns arise from alleged failures on the part of Ms Bangura in her care of two service users (referred to as "service user A" and "service user B"). The alleged failures arose during the period between August to November 2020. The initial complaint was received from the social worker's employer in December 2020.

8. Service user A and service user B were reported to the Council to have passed away on 9 and 24 November 2020 respectively. Retrospective safeguarding enquiries were carried out following each death pursuant to Section 42 of the Care Act 2014. These enquiries identified a number of systemic issues including those related to working

during the Covid 19 pandemic, staffing levels and poor management. They also criticised the conduct of individuals within the Council and other organisations. Ms Bangura was one of the individuals whose conduct was subject to criticism. Postmortems took place in respect of both service user A and service user B and it was determined that both died of natural cases. Consequently, there were no inquests into their deaths.

Service user A

9. Service user A was an elderly female who lived alone. Her son had contacted social services on 11 August 2020 to raise concerns that he was worried about her ability to self-care. In particular, it was reported that she was hoarding, not managing to maintain her property, had difficulty with her stairs, was eating out of tins and may not have had adequate food in the property. Further, it was reported that there may have been a reluctance by her to accept support.

10. The case was allocated to Ms Bangura's caseload on 25 August 2020 and remained allocated to her until service user A passed away on 9 November 2020.

11. The criticisms made of Ms Bangura are that she did not arrange contact with service user A or her son soon enough, remain in sufficiently regular contact, carry out or record a risk or mental capacity assessment or carry out a home visit when it was necessary to do so.

Service user B

12. Service user B was also an elderly female who lived alone. On 18 June 2020 service user B's niece contacted social services expressing concerns about service user B's ability to self-care. There were concerns about service user B hoarding, and whether she was eating and washing.

13. The criticisms made of Ms Bangura are that she did not make contact with service user B or her niece within a reasonable time, remain in sufficiently regular contact with service user B or her niece, arrange a professionals meeting or a home visit or carry out or record a risk assessment.

## Allegations:

14. The allegations against Ms Bangura are as follows:

    1) *Between 25 August and 9 November 2020, while registered as a social worker, you failed to respond adequately to concerns regarding service user A, in that you:*

        a. *Did not carry out a home visit to service user A;*

        b. *Did not, adequately or at all, carry out and/or record a mental capacity assessment in relation to service user A;*

c. *Did not, adequately or at all, carry out and/or record a risk assessment in relation to service user A;*

d. *Did not make contact with service user A and/or their son within a reasonable time;*

e. *Did not maintain sufficiently regular contact with service user A.*

2) *Between 3 August and 24 November 2020, while registered as a social worker, you failed to respond adequately to concerns regarding service user B, in that you:*

a. *Did not make contact with service user B and/or their niece within a reasonable time;*

b. *Did not maintain sufficiently regular contact with service user B and/or their niece;*

c. *Did not arrange a professionals meeting;*

d. *Did not carry out a home visit to Service user B;*

e. *Did not, adequately or at all, carry out and/or record a risk assessment in relation to service user B.*

*The matters outlined in paragraphs 1) and/or 2) amount to the statutory ground of misconduct.*

## Admissions:

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

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

16. Following the reading of the allegations the panel chair asked Ms Bangura whether she admits any of the allegations and whether she admits that her fitness to practise is currently impaired.

17. Ms Bangura denied the allegations and therefore in line with Rule 32c(i)(a) of the Fitness to Practise Rules 2019 (as amended) ("the Rules"), the panel went on to determine the disputed facts.

## Summary of evidence:

Social Work England

18. Mr Corrie in opening drew the panel's attention to all the relevant documents including, but not limited to, the statement of case, final statement bundle and final exhibit bundle.

19. Oral evidence was given by the witnesses; Ms Onslow (Safeguarding Lead Practitioner within Camden Council's Adult Social Care Service), Mr Ali (social worker and Team Manager within the Council's Access & Response Team) and Mr Stone (Service Manager of the Access & Response Team). All 3 witnesses adopted their witness statements in chief and gave supplementary evidence.

Ms Bangura

20. The panel's attention was drawn to the relevant documents including Ms Bangura's bundle named 'social worker's response' bundle. Ms Bangura also gave oral evidence.

21. At the close of the oral evidence the panel heard closing submissions on the facts from both parties. The panel also accepted the advice of the legal adviser, who reminded it that where facts are in dispute the panel is required to decide those facts. The burden of proving each allegation rests with Social Work England and the panel must be satisfied on the balance of probabilities.

## Findings and reasons on facts:

22. In reaching its decision the panel considered all of the evidence before it and the evidence from the live witnesses.

Particular 1a

23. *Between 25 August and 9 November 2020, while registered as a social worker, you failed to respond adequately to concerns regarding service user A, in that you: Did not carry out a home visit to service user A;*

24. The panel's consideration in relation to this particular relates to the alleged failure to visit service user A on 6 November 2020.

25. The panel accepted that service user A had been allocated to Ms Bangura in August 2020.

26. The panel was satisfied that there was an overriding duty on Ms Bangura to undertake a home visit to service user A who was a vulnerable lady living in conditions that other professionals (who had visited on 5 November 2020) were becoming increasingly concerned about.

27. The panel also drew from the fact that Ms Bangura herself accepted that a visit ought to have been conducted and in an attempt to execute a visit Ms Bangura had emailed Matt Conaghan (duty manager) on 6 November 2020 indicating that she was on duty, but

being bombarded with information from health professionals about service user A, and as such she needed to conduct a visit.

28. The panel noted that there is no record of Ms Bangura carrying out a home visit to service user A. The panel accepted the evidence of Ms Bangura that she was told by Matt Conaghan that she could not visit service user A on the 6 November 2020 as she was on duty. The panel also accepted Ms Bangura's evidence that at the time there was no one else available to cover her duty to enable her to conduct the visit.

29. The panel concluded that Ms Bangura responded adequately in all the circumstances and that she had no authority to disregard the management direction not to visit service user A. This was more pertinent due to the Covid pandemic procedures in place at the material time which necessitated management approval for a service user home visit. The panel was satisfied that Ms Bangura acted appropriately given the prevailing situation and given that she had competing responsibilities to service user A and remaining on duty as per management instruction.

30. The panel also took account of the fact that in Ms Bangura's supervision notes of 24 November 2020 post the passing of service user A, there was no criticism of Ms Bangura's handling of the case. The panel took the view that if indeed she had failed to act as alleged, it would have been clearly recorded within the supervision notes.

31. The panel did not find this allegation proved.

Particular 1b

32. *Between 25 August and 9 November 2020, while registered as a social worker, you failed to respond adequately to concerns regarding service user A, in that you: Did not, adequately or at all, carry out and/or record a mental capacity assessment in relation to service user A;*

33. The panel was satisfied that there was a requirement to undertake the mental capacity assessment as outlined in the London Multi-Agency Adult Safeguarding Policy and procedures of April 2019. The relevant section 2.6.3 states,

"*Response to self-neglect and hoarding*

*Given the complex and diverse nature of self-neglect and hoarding, responses by a range of organisations are likely to be more effective than a single agency response with particular reference to housing providers. It is important to recognise that assessments of self-neglect and hoarding are grounded in, and influenced by, personal, social and cultural values and staff working with the person at risk should always reflect on how their own values might affect their judgement. Finding the right balance between respecting the adult's autonomy and meeting the duty to protect their wellbeing may involve building up a rapport with the adult to come to a better understanding about whether self-neglect or hoarding are matters for adult safeguarding or any other kind of intervention. Crucial to all decision making is a robust risk assessment, preferably multi-agency that includes the views of the adult and their personal network."*

34. The panel considered that Ms Bangura was an experienced social worker who had undertaken training in this area and was aware that a mental capacity assessment was a necessary requirement and a fundamental part of social work practice.

35. The panel was satisfied that a mental capacity assessment was needed, as at the time there were conflicting reports from duty professionals regarding whether service user A was experiencing some cognitive decline.

36. The panel also accepted the evidence of Ms Onslow in which she stated that at the very least there ought to have been an attempt to form a view on mental capacity and document it for future use in any care plan for service user A.

37. The panel was satisfied there was nothing in the case records that indicated Ms Bangura had carried out a mental capacity assessment adequately, or at all, nor had she recorded any such assessment in respect of service user A.

38. The panel found this allegation proven.

Particular 1c

39. *Between 25 August and 9 November 2020, while registered as a social worker, you failed to respond adequately to concerns regarding service user A, in that you: Did not, adequately or at all, carry out and/or record a risk assessment in relation to Service user A;*

40. The panel noted the evidence of Ms Onslow who had confirmed that whilst there was no fixed risk assessment framework that was followed in Camden during the material period, assessing risk was fundamental to every decision made by a social worker and the recording of a risk assessment was instrumental in developing a proper care plan for a service user.

41. The panel noted the difficulties of carrying out assessments when a service user refuses to engage, as described by Ms Onslow. However, Ms Onslow also gave evidence, which was accepted by the panel, that an attempt should have been made to risk assess on the basis of concerns already known and on new information coming in from family and professional colleagues.

42. The panel was satisfied that given the multi professional involvement with service user A, the potential risk of cognitive decline, self-care and hoarding issues, and the lack of proximal family support, there was a duty on Ms Bangura to carry out and record a risk assessment. The panel noted that there was nothing in the case records that indicated Ms Bangura had done this adequately or at all.

43. The panel found this allegation proven.

Particular 1d

44. *Between 25 August and 9 November 2020, while registered as a social worker, you failed to respond adequately to concerns regarding service user A, in that you: Did not make contact with service user A and/or their son within a reasonable time;*

45. The panel accepted that service user A was allocated to Ms Bangura on 25 August 2020. From the case records the panel noted that Ms Bangura first made direct contact with service user A on 22 September 2020 and then made direct contact with her son on 7 October 2020.

46. The panel was satisfied that the time lapse of approximately four weeks post referral, before first contact with service user A and approximately six weeks for her son was unreasonable in all the circumstances. This was more evident given the personal history and multiple vulnerabilities of service user A, information that Ms Bangura would have been aware of at the time of the case allocation.

47. The panel noted that whilst Ms Bangura had recorded unsuccessful attempts to contact service user A and her son, the attempts were sporadic and not sufficiently proactive.

48. The panel found this allegation proven.

Particular 1e

49. *Between 25 August and 9 November 2020, while registered as a social worker, you failed to respond adequately to concerns regarding service user A, in that you: Did not maintain sufficiently regular contact with service user A.*

50. The panel noted from the case records that the only additional direct contact Ms Bangura had with service user A was on 15 and 20 October 2020. The panel was satisfied that given the background, two contacts within the material period was not adequate and did not demonstrate that Ms Bangura maintained the sufficiently regular contact that was necessary given the high level care needs of service user A.

51. The panel found this allegation proven.

Particular 2a

52. *Between 3 August and 24 November 2020, while registered as a social worker, you failed to respond adequately to concerns regarding service user B, in that you: Did not make contact with service user B and/or their niece within a reasonable time;*

53. The panel noted that service user B was allocated to Ms Bangura on 3 August 2020 and that Ms Bangura tried to establish direct contact with service user B on 15 September 2020 and with her niece on 22 September 2020. The panel accepted the evidence of Ms Onslow who stated that the timeframe of the response by Ms Bangura was unacceptable in that there was an approximate delay of six weeks post allocation in attempting to make contact. The panel was satisfied that the lapse in time was an inadequate response given the serious concerns raised about service user B.

54. The panel found this allegation proven.

Particular 2b

55. *Between 3 August and 24 November 2020, while registered as a social worker, you failed to respond adequately to concerns regarding service user B, in that you: Did not maintain sufficiently regular contact with service user B and/or their niece;*

56. The panel noted that the documentary evidence indicated that Ms Bangura spoke to service user B directly on 15 October 2020. It also noted that there were unsuccessful attempts via text messages and telephone calls to contact service user B's niece.

57. Although the panel noted Ms Bangura's evidence that she had more texts on her work mobile of attempts to contact service user B's niece (and this appeared to be supported by the evidence of both Mr Stone and Mr Ali who acknowledged the possible existence of these text messages), this documentary evidence was not before the panel and so could not be assessed. Ultimately, given that all witnesses stated difficulty with recollection given the passage of time, the panel preferred the documentary evidence before it on this matter.

58. The panel accepted the evidence of Ms Onslow who also noted the unsuccessful attempts to contact the niece however also identified that there were big gaps with no contact being made. Ms Onslow highlighted that there was no record of any activity from 21 October 2020 until service user B's death on 24 November 2020. Ms Onslow was of the view that Ms Bangura did not make sustained attempts to maintain contact with the service user.

59. The panel was satisfied that given the background of service user B, the attempts at contact were not adequate and did not demonstrate that Ms Bangura maintained the sufficiently regular contact with service user B and/or her niece that was needed given the concerns raised about service user B's health and wellbeing.

60. The panel found this allegation proven.

Particular 2c

61. *Between 3 August and 24 November 2020, while registered as a social worker, you failed to respond adequately to concerns regarding service user B, in that you: Did not arrange a professionals meeting;*

62. The panel noted that Ms Bangura herself recognised the need to arrange a professionals meeting and she accepted that she did not arrange such a meeting.

63. The panel observed that on case allocation Ms Bangura was immediately proactive in trying to arrange a meeting by sending an email on 3 August 2020 to colleagues, proposing that the meeting was scheduled for the following day. However, the panel noted that she failed to follow up her initial email, and no such meeting was arranged.

64. The panel was further satisfied from the evidence of Mr Ali and Ms Onslow that Ms Bangura had received a further management instruction given by Mr Ali in supervision on 30 September 2020 to arrange the professionals meeting.

65. The panel concluded that Ms Bangura had failed to respond adequately to the concerns raised in relation to service user B in failing to arrange a professionals meeting.

66. The panel found this allegation proven.

Particular 2d

67. *Between 3 August and 24 November 2020, while registered as a social worker, you failed to respond adequately to concerns regarding service user B, in that you: Did not carry out a home visit to service user B;*

68. The panel was satisfied that there was no documentary or oral evidence to demonstrate that Ms Bangura carried out a home visit even though she was instructed by her manager Mr Ali to do so on 22 September 2020. The panel also concluded that Ms Bangura had not provided an adequate response as to why the visit did not take place despite the management instruction to do so.

69. The panel found this allegation proven.

Particular 2e

70. *Between 3 August and 24 November 2020, while registered as a social worker, you failed to respond adequately to concerns regarding service user B, in that you: Did not, adequately or at all, carry out and/or record a risk assessment in relation to service user B.*

71. The panel took into account that service user B's case had been held by the duty team for 6 weeks from 18 June 2020 before being allocated on 3 August 2020 to Ms Bangura. The panel was satisfied that this increased the need for Ms Bangura to undertake a risk assessment once the case had been allocated to her. It concluded that a risk assessment would have ascertained service user B's care needs and enabled a care plan to have been instituted.

72. The panel accepted the evidence of Ms Onslow on this point, in which she highlighted the need for robust risk assessments irrespective of the operational climate, which was the Covid 19 pandemic at the material time. The panel agreed that, even in the absence of face to face contact, an initial risk assessment should have been formulated based on the information available at the time.

73. The panel noted that there was nothing in the case records that indicated Ms Bangura had carried out or recorded a risk assessment adequately or at all.

74. The panel found this allegation proven.

## Findings and reasons on grounds:

75. Mr Corrie made submissions as set out in Social Work England's statement of case and addressed the panel on the standards it believed Ms Bangura had breached. The panel was invited to find Ms Bangura's conduct was serious in nature and as such amounted

to the statutory ground of misconduct and that her fitness to practice is currently impaired.

76. Ms Bangura read a prepared statement and responded to additional questions from the panel.

77. The panel heard and accepted the advice of the legal adviser. The panel was reminded that the question of misconduct is a matter for its judgement and 'that the standard of propriety may often be found by reference to the rules and standards ordinarily required to be followed by a practitioner in the particular circumstances' as per *Roylance v General Medical Council (No 2) 2000 1 AC 311*. In line with *Roylance* the panel was advised to decide for itself the professional standards it believed Ms Bangura had breached.

78. The panel was wholly satisfied that Ms Bangura had departed from the professional standards expected of her as set out in the factual decisions above, and that this departure remained irrespective of the undoubted systemic issues within Camden Council and social work practice as a result of the ensuing challenges that prevailed due to working during the Covid 19 pandemic, as identified by Ms Onslow and Mr Stone.

79. The panel concluded that Ms Bangura had failed to adequately manage and progress the cases of service users A and B, both of whom were elderly, vulnerable and had complex care needs.

80. The panel was satisfied that the actions of Ms Bangura fell short of that which was expected of a social worker and that basic tenets of social work practice had not been observed. Ms Bangura failed collectively to initiate and maintain contact with the service users and their relatives, to carry out risk and mental capacity assessments, to arrange a professionals meeting and to carry out a home visit despite management instruction.

81. The panel decided that Ms Bangura had breached the following paragraphs of Social Work England's Professional Standards (July 2019):

> *3.2 Use information from a range of appropriate sources, including supervision, to inform assessments, to analyse risk, and to make a professional decision.*
>
> *3.3 Apply my knowledge and skills to address the social care needs of individuals and their families commonly arising from physical and mental ill health, disability, substance misuse, abuse or neglect, to enhance quality of life and wellbeing.*
>
> *3.4 Recognise the risk indicators of different forms of abuse and neglect and their impact on people, their families and their support networks.*
>
> *3.6 Draw on the knowledge and skills of workers from my own and other professions and work in collaboration, particularly in integrated teams, holding*

*onto and promoting my social work identity.*

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

*3.15 Recognise and respond to behaviour that may indicate resistance to change, ambivalent or selective cooperation with services, and recognise when there is a need for immediate action.*

82. The panel was satisfied that Ms Bangura's actions as set out in particulars 1b, 1c, 1d, 1e, 2a, 2b, 2c, 2d and 2e, all of which it found proven, were sufficiently serious in nature such that they amounted to misconduct.

## Finding and reasons on current impairment:

83. When considering the question of impairment, the panel took into account Social Work England's 'Impairment and sanctions guidance'.

84. The panel heard and accepted the advice of the legal adviser, who referenced *Cohen v GMC [2008] EWHC 581 (Admin)* in that it should consider if the conduct is easily remediable, has already been remediated, and if it is highly unlikely to be repeated. Further, as per the case of *Council for Healthcare and Regulatory Excellence v NMC and Grant [2011] EWHC 927 (Admin)* the panel was reminded to consider the following questions; a) If Ms Bangura has in the past acted and/or is liable in the future to act so as to put a service user at unwarranted risk of harm; and/or b) has Ms Bangura in the past and/or is she liable in the future to bring the profession into disrepute; and/or c) has Ms Bangura in the past breached and/or is she liable in the future to breach one of the fundamental tenets of the profession.

85. In determining the question of Ms Bangura's current fitness to practise the panel first considered the personal element of impairment. The panel was satisfied that both service user A and B had passed away from natural causes and that there was no causal link between their deaths and Ms Bangura's breach of standards, as submitted by Social Work England.

86. The panel accepted the evidence of Ms Bangura in relation to her current work within Islington Adult Social Services, a role she has remained in since 2022. Ms Bangura explained that whilst it was not as fast paced as her work with the Camden A&R team, her duties and responsibilities are similar in nature to those she had held at the material time. The panel was satisfied that Ms Bangura's aggregated unblemished practice (19 years pre the material period and 5 years post), and insight demonstrated made the risk of repetition highly unlikely.

87. The panel noted that Ms Bangura had developed her insight considerably since the material period and is genuinely remorseful. It was satisfied she has reflected upon her practice and indeed has continued to do so throughout the fitness to practice process.

The panel acknowledged that her journey of reflection and insight can be traced from her reflections in her supervision notes of November 2020, following the passing of service user A, through her witness statements that culminated in today's reflective statement.

88. The panel was satisfied that Ms Bangura has undertaken training, continuing professional development, and that her reflective practice over the years has further developed her insight. This was supported by some of the practical work examples she gave in her earlier oral evidence under oath, illustrating her case management skills and the recognition she had received, and by the fact that Ms Bangura had worked without concern since the material dates. The panel noted the lack of documentary evidence regarding training, but it accepted Ms Bangura's evidence in relation to her ongoing training and considered this alongside her work history since the incidents in question. The panel was satisfied that this was sufficient evidence of informed and safe practice.

89. Additionally, the panel acknowledged Ms Bangura's engagement with the fitness to practise process and participation at the hearing in what were clearly difficult circumstances. The panel determined that Ms Bangura had demonstrated that she had sufficiently remediated the shortfalls in her practice. The panel therefore concluded that Ms Bangura was no longer personally impaired.

90. In terms of the public element of impairment, the panel was clear that Ms Bangura's breaching of the identified professional standards was serious, and had led to a finding of misconduct. The panel noted that Ms Bangura's actions may have put both service user A and B at an unwarranted risk of harm. However, the panel balanced this with the unique and extenuating circumstances relating to social work practice during the Covid 19 pandemic. The panel took note of the evidence of Mr Stone who referred to it having been a 'terrible time, with many deaths' and the evidence of Ms Onslow who identified systemic issues in Camden including lack of management direction and policies, all of which have benefited from improvement since her investigation.

91. The panel was satisfied an informed and reasonable member of the public apprised of the extraordinary circumstances that prevailed at the time would not be concerned if there was no finding of impairment. Such a finding would not reduce the public's confidence in the social work profession.

92. The panel concluded that there is no public impairment in respect of Ms Bangura.

93. The panel considered Social Work England's impairment and sanctions guidance, and decided that neither advice nor a warning is an appropriate outcome, taking into account the length of time elapsed since the misconduct and Ms Bangura's overall work history.

94. The panel determined that in light of its findings in relation to personal and public impairment for the reasons given above, there will be no further action in this matter.

## The Professional Standards Authority:

95. 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.